



Behavioral treatment of social phobia in youth: Does parent education training improve the outcome?



Lars-Göran Öst*, Rio Cederlund, Lena Reuterskiöld

Department of Psychology, Stockholm University, Sweden

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ABSTRACT

Social phobia is one of the most common anxiety disorders in children and adolescents, and it runs a fairly chronic course if left untreated. The goals of the present study were to evaluate if a parent education course would improve the outcome for children with a primary diagnosis of social phobia and if comorbidity at the start of treatment would impair the outcome of the social phobia. A total of 55 children, 8–14 years old, were randomly assigned to one of three conditions: 1) Child is treated, 2) Child is treated and parent participates in the course, or 3) A wait-list for 12 weeks. The treatment consisted of individual exposure and group social skills training based on the Beidel, Turner, and Morris (2000) SET-C. Children and parents were assessed pre-, post-, and at one year follow-up with independent assessor ratings and self-report measures. Results showed that there was no significant difference between the two active treatments and both were better than the wait-list. The treatment effects were maintained or furthered at the follow-up. Comorbidity did not lead to worse outcome of social phobia. Comorbid disorders improved significantly from pre- to post-treatment and from post- to follow-up assessment without being targeted in therapy.

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Introduction

Social phobia is one of the most prevalent psychiatric disorders in children and adolescents. In the largest ($N = 10,123$) epidemiological study of mental disorders in adolescents (13–18 years of age) Burstein et al. (2011) reported a lifetime prevalence for social phobia of 8.6% (9.2% in females and 7.9% in males). The mean age of onset was 9.2 years, with the generalized form of social phobia having a significantly earlier onset (8.7) than the non-generalized type (9.4). The mean duration of social phobia was 6 years, however, only 8.6% had obtained any treatment for their social phobia (12.6% in the generalized vs. 3.4% in the non-generalized group, a significant difference) during its duration. Furthermore, social phobia is regarded as a chronic disorder if left untreated. In a review of the area Wittchen and Fehm (2003) found that onset of social phobia before the age of 11 predicted non-recovery in adulthood and that the remission rates in untreated samples of patients varied from 11% to 48%. These facts strongly point to the

necessity of developing effective treatment methods for social phobia in children and adolescents.

There are at least 35 randomized clinical trials (RCTs) of CBT for the mixed diagnostic categories generalized anxiety disorder, separation anxiety, and social phobia (Öst, 2011). However, in these studies the outcomes for the separate diagnoses are not reported, and thus they cannot be used to evaluate the efficacy of CBT for social phobia. However, during the last 12 years there have been 12 randomized clinical trials (RCT) published on various cognitive behavioral treatments for social phobia in children and adolescents.

Social Effectiveness Training for Children (SET-C) was developed by Beidel, Turner and Morris (2000) and consists of 12 individual sessions of exposure in-vivo, 12 group sessions of social skills training, and 12 group sessions of peer generalization training. In their first study (Beidel et al., 2000) SET-C was significantly better than a credible psychological placebo treatment and at post-treatment assessment 67% no longer fulfilled the diagnostic criteria for social phobia. At the 5 year follow-up assessment this figure had increased to 81% (Beidel, Turner, & Young, 2006). In their second study Beidel et al. (2007) reported that SET-C was significantly better than both the SSRI Fluoxetine and a pill placebo. The proportion that no longer fulfilled criteria for social phobia was 53% at post and 60% at 1 year follow-up.

* Corresponding author. Department of Psychology, Stockholm University, S-106 91 Stockholm, Sweden.

E-mail address: ost@psychology.su.se (L.-G. Öst).

Modified versions of SET-C have been used by other researchers; Baer and Garland (2005) found that a group treatment (12 sessions à 90 min) combining exposure and social skills training was significantly better than a waitlist control for adolescents with social phobia. Masia-Warner and co-workers modified SET-C into a school-based intervention called Skills for Social and Academic Success to use for adolescents. It consisted of 12 weekly group school sessions à 40 min plus two brief (15 min) individual sessions. In their first study (Masia-Warner et al., 2005) they found that the treatment was significantly better than a waitlist and in the second (Masia-Warner, Fisher, Shrout, Rathoe, & Klein, 2007) that it was better than a credible attention control condition.

Another specific group treatment has been developed by a group of Spanish researchers. They have published two RCTs on a method called Treatment for Adolescents with Social Phobia (TASP). In the first study (Olivares–Olivares, Rosa-Alcázar, & Olivares-Rodríguez, 2008) on teenagers they found that adding 12 individual sessions to the original 12 group sessions yielded significantly better effects than only group treatment, whereas 6 individual sessions did not make that difference. In the second study (Sanchez-Garcia & Olivares, 2009) on 10–14 year old children they found that the full TASP including the cognitive restructuring component yielded better effects than TASP without the cognitive restructuring, and both were better than a waitlist condition.

In addition there are a number of studies in which treatments just called CBT have been evaluated. These treatments are more or less similar to each other but the results vary from very small effect sizes (0.06 and 0.11) reported by Herbert et al. (2009) to very large ones (1.64 and 2.22) reported by Spence, Donovan, and Brechman-Toussaint (2000). Thus, there are a number of promising treatments for social phobia that have been evaluated in RCTs.

One issue that has been discussed in connection with the treatment of children having anxiety disorders is the involvement of the parents. A literature review of 9 RCTs by Barmish and Kendall (2005) found inconclusive results concerning the importance of involving parents. The reviewed studies were divided into two categories: (1) Trials in which parent and child sessions were conducted conjointly (e.g. Barrett, Dadds, & Rapee, 1996), and (2) Trials in which parent and child sessions were conducted separately (e.g. Nauta, Schooling, Emmelkamp, & Minderaa, 2003). The authors concluded that it was not possible to say that parent involvement led to either better or worse outcome for the anxious child.

Within the social phobia research area only one study has investigated whether parent involvement in therapy makes a difference when it comes to the outcome for children (Spence et al., 2000). A better (but not significantly so due to low power) outcome was found for the children in the condition with parental involvement compared to the condition in which only the child was treated. Taken together, we cannot to date be confident that adding parental involvement will significantly increase treatment outcome for the children.

The primary purpose of the current study was to test whether letting the parents of socially phobic children participate in a group educational course would lead to a better outcome for the children compared to a condition where only the children were treated and the parent did not receive the educational course. It was predicted that both active treatments would be better than a wait-list condition, but no prediction was made concerning the possible added effect of parental involvement.

Another issue of interest pertaining to children with various anxiety disorders is the high comorbidity rates, especially with other anxiety disorders. In a study specifically on social phobia, Burstein et al. (2011) found that the most common comorbidities were other anxiety disorders (varying from 21.5% specific phobia to

32.4% agoraphobia), mood disorders (major depression 18.7% and dysthymia 17.4%), substance-use disorders (alcohol-use 17.5% and drug-use 20.1%), and behavior disorders (conduct disorder 16.9%, oppositional defiant disorder 17.8%, and attention deficit hyperactivity disorder 11.7%). Subjects with the generalized form of social phobia had significantly higher proportions of comorbidity than those with the non-generalized form. The question of importance for therapists is what influence, if any, comorbidity at pre-treatment has on the outcome of therapy.

In a qualitative review of 16 RCTs for anxiety disorders that addressed the effect of comorbidity, Ollendick, Jarrett, Grills-Taquechel, Hovey, and Wolff (2008) reported that only two found small differences (Berman, Weems, Silverman, & Kurtines, 2000; Rapee, 2003). These authors concluded that comorbidity “does not typically have a significant influence on treatment outcomes among youth treated for anxiety disorders” (p. 1460). The same result was found in a recent study of specific phobias in youth (Ollendick, Öst, Reuterskiöld, & Costa, 2010).

A related issue is in what way the comorbid disorders are affected when treatment is focused on the specific anxiety disorder at hand. Öst, Svensson, Hellström, and Lindwall (2001) reported that a one session treatment of specific phobias in children and adolescents led to a significant pre-post change and a further significant post-follow-up change in the comorbid disorders. This effect was replicated in the recent study by Ollendick et al. (2010), also with youth having specific phobia. However, this issue has only been investigated in one RCT of children and adolescents with social phobia. In this Masia-Warner et al. (2005) found that a significantly higher proportion of the treated patients compared to the wait-list patients had lost their comorbid diagnoses at post-treatment assessment. However, they did not report the mean Clinician Severity Ratings at each assessment point. Based on previous research we predicted that the presence of comorbidity at pretreatment would not impair the treatment effect on social phobia. Furthermore, we predicted that the focused treatment on social phobia should have a generalizing effect, i.e. the comorbid disorders would improve significantly without being targeted in treatment.

Method

Participants

The 55 participants for the present study were recruited through referrals from the child psychiatric services and the school health services in the Stockholm County, Sweden.

Inclusion criteria

In order to be included in the study the subjects had to fulfill the following criteria.

1. Be between 8 and 14 years of age.
2. Presenting with social phobia according to the DSM-IV (APA, 1994) criteria and this had to be the child's primary diagnosis.
3. The severity of the phobia had to be at least 4 on the 0–8 clinician severity scale (ADIS-C/P, Silverman & Albano, 1996).
4. The duration of the phobia had to be at least one year.
5. Be motivated for treatment.
6. The patient must not fulfill criteria for any of the disorders leading to exclusion, i.e. primary depression, drug or alcohol abuse, developmental disorder or displaying psychotic symptoms.
7. The parents and participants had to agree to discontinue any other form of psychotherapy or antianxiety medication for the duration of the treatment.

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