



Brief Treatment of Child Social Anxiety Disorder

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Abstract

Social Anxiety Disorder (SAD) is a prevalent disorder in youth that follows a chronic course if left untreated and is associated with a myriad of problematic short- and long-term consequences. Cognitive Behaviour Therapy (CBT) has been shown to be efficacious in treating SAD, however the majority of youth with SAD do not receive help for a number of reasons. Brief and/or intensive treatments for SAD might circumvent some of these barriers to treatment, yet only two studies to date have been conducted in this area. This paper provides an overview of SAD, the rationale and evidence for the use of brief/intensive therapy for the disorder, and suggestions for where research might be directed as we move into the future.

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Introduction

Social Anxiety Disorder (SAD) is one of the most common anxiety disorders in children (Costello, Egger, & Angold, 2005), with prevalence estimates of around 5% (American Psychiatric Association, 1994). Previously known as "Social Phobia" (SP) in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV: American Psychiatric Association, 1994), SAD was relabeled in the DSM-5 (American Psychiatric Association, 2013) due to the recognition that social fears tend to occur in a variety of social situations in addition to performance situations. Youth and adults afflicted with SAD become anxious in social situations due to an underlying fear of negative evaluation or scrutiny by others. For a diagnosis to be made, the fear experienced must be of proportion in terms of frequency or duration, must have been occurring for at least six months, and there must be significant distress or impairment in social settings, work, school, and everyday activities.

There have been a number of small diagnostic changes from DSM-IV to DSM-5. The time specifier of 6-months previously only applicable to children now extends to adults, and insight on behalf of the sufferer is no longer required. The list of behaviours typically demonstrated by children with SAD outlined in DSM-IV (crying, tantruming,

freezing up, and shrinking away from others) has now been extended to include excessive clinginess and inability to speak, and there is recognition that these behaviours may occur in response to either familiar or unfamiliar people. Finally, the 'generalised' specifier has been replaced by a 'performance only' specifier.

With respect to the effect of SAD on children, their life is not easy. School refusal, depression, loneliness, conduct problems, and difficulties with peer acceptance and friendships are but a few of the short-term consequences associated with child SAD (Beidel, Turner, & Morris, 1999; Last, Perrin, Hersen, & Kazdin, 1992). In the long-term, youth SAD has been found to predict failure to attend college, occupational impairment, social impairment, depression, and substance abuse (Kessler, 2003; Merikangas & Avenevoli, 2002; Turner, Beidel, & Dancu, 1996). Furthermore, children as young as three have been found to suffer with SAD (Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2010) and the disorder tends to follow a chronic course if left untreated (Weissman et al., 1999). Thus, SAD is a prevalent and chronic disorder associated with problematic future trajectories.

Rationale and Benefits of Brief or Intensive Treatments for SAD

It is fortunate, given the prevalence and detrimental consequences of SAD, that it can be treated effectively with cognitive behaviour therapy (CBT). Although transdiagnostic CBT programs designed to treat a number of anxiety disorders have been shown to be effective in treating SAD, there is some evidence to suggest that children with SAD respond less well to these treatments (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008; Ginsburg et al., 2011). SAD-specific programs such as the behaviourally-oriented SET-C program developed by Beidel and colleagues (Beidel, Turner, & Morris, 2000), the largely social-skills based program developed by Spence, Donovan, and Brechman-Toussaint (2000), and the more cognitively-oriented program developed by Melfson and colleagues (2011) have all demonstrated efficacy with youth SAD.

Although efficacious treatments for SAD exist, the majority of youth with mental health issues do not receive treatment (Merikangas et al., 2011; Sawyer et al., 2001) due to reasons such as concern about confidentiality, the stigma associated with seeing a mental health professional, lack of knowledge about services, concerns about not being understood or taken seriously, long waitlists, cost, and lack of availability of services (Booth et al., 2004; Boyd et al., 2007; Stallard, Udwin, Goddard, & Hibbert, 2007). In addition, families are time poor. Traditional therapy usually comprises weekly, hour-long appointments over a course of 10-20 weeks. It can be difficult for families to work such a commitment into their already busy schedules.

One way to circumvent at least some of these barriers to treatment is to conduct the treatment in a briefer or more intensive manner. For families in rural or remote areas, or in areas where services are limited, the extended travel involved in attending therapy would be less frequent and therefore treatment might seem more attractive. For busy families, the commitment involved is less, with fewer clinic visits and therefore less frequent disruptions to family schedules. Finally, if less time overall is required, brief/intensive treatments may also be cost-efficient.

Review of Research on Brief, Intensive Treatments for SAD in Youth

Only two studies to date have investigated the usefulness of brief / intensive CBT for SAD. The first was a study by Gallagher, Rabian, and McCloskey, (2004) in which 23 children aged 8-11 years were randomly allocated into either a control condition or a group-based CBT program for SAD. The program comprised three 3-hour child sessions and involved psychoeducation, recognition of the physiological, cognitive and behavioural aspects of anxiety, cognitive work and exposure. At post-assessment, 41.7% of treated children were free of their SAD diagnosis compared to 0% of the waitlist children. At 3-week follow-up, 50% of treated children compared to 9.1% of waitlist children were free of their SAD diagnosis. Although promising, the results are somewhat weaker than those found in the traditionally conducted SAD treatment programs. For instance, Beidel et al. (2000) found that 67% of treatment children were diagnosis free at post-assessment, compared to 5% of the control group. Similarly, Spence et al. (2000) found that 87.5% and 58% of the parent- involved and parent-not-involved treatment groups respectively, compared to 4% of the waitlist group, were free of their primary diagnosis at post-treatment.

The lower remission rates evident at post-treatment in the Gallagher et al. (2004) study may be due, at least in part, to the omission of both social skills training and parents from the treatment program. The studies by Beidel et

al. (2000) and Spence et al. (2000) both included social skills training with efficacious results, and the Spence et al. (2000) study found higher remission rates for the parent-involved group compared to the parent-not-involved group. In order to address these potential concerns, Donovan, Cobham, and Waters (under review) conducted a study investigating intensive, group-based CBT for SAD, that included social skills training, parent training, and a 6-month follow-up. Forty children aged 7-12 years with a primary diagnosis of SAD were allocated to either the intensive therapy group (N=21) or a waitlist control group (N=19). Treatment was conducted over three weekends, with families attending the clinic for 3 hours on Saturday and 3 hours on Sunday of the first weekend, 3 hours on the Saturday of the second weekend, and 3 hours on the Saturday of the third weekend. Thus, treatment was conducted in 12 hours over the course of 15 days.

Table 1 provides an outline of the treatment program used in the Donovan et al study. As can be seen in Table 1, the child sessions included psychoeducation, recognition of the physiological signs of anxiety, relaxation, cognitive restructuring, in-session exposure, problem solving, social skills training and self-reinforcement. Parents were also taught these strategies, but in addition, were educated in parenting strategies to better manage their child's social anxiety. The intensive nature of this program seemed particularly beneficial with respect to exposure, which was conducted each day in session, in a group format. Exposure tasks ranged from children explaining a particular fact they learned during the session to the other children and parents (session 1) to each child delivering a short talk in a large auditorium in front of parents, children and other invited guests (session 4). Following each child's exposure task, the other children and parents gave examples of what they liked about the child's performance, thus providing the child with peer and other reinforcement, as well as allowing the opportunity for vicarious learning by the other children. Furthermore, by providing this reinforcement, children in the audience received their own exposure to a feared social situation (speaking in front of a group) and simultaneously had the opportunity to practice important social skills (giving compliments and use of verbal and nonverbal social skills). The intensive format allowed for the setting up of each exposure task, delivery of the exposure, provision of group-based reinforcement, and subsequent discussion of the exposure task. It also allowed other session components (i.e., relaxation, thoughts, coping statements, social skills) that were being taught within the same 3-hour session, to be integrated and reinforced within the exposure task. Such exposure delivery and integration is more difficult within the confines of a traditional length treatment session, and the opportunity for such integration made the exposure experiences very powerful as a result.

Assessments were completed at 12-weeks post-baseline and 6-month follow-up to allow a more accurate comparison with more traditional SAD treatment programs. At post-assessment, 52.4% of the treatment group, compared to 15.8% of the waitlist group, were diagnosis-free, and by 6-month follow-up, the number of treatment children free of their SAD diagnosis had risen to 76.9%. The treatment response rate found in this study at post-assessment is comparable to that found in the Gallagher et al. (2004), and therefore somewhat lower than that found in the more traditional delivery modes employed by Beidel et al. (2000) and Spence et al. (2000). However, by 6-month follow-up, the response rates were comparable to the traditionally delivered programs. Thus, it might be that improvement with intensive SAD treatments is slower, but over time is comparable, to that found in traditionally delivered programs. However, replication and future research is clearly required.

Table 1: Outline of the Donovan et al (under review) program.

Duration	Children	Parents
DAY 1		
45 mins	1. Introduction to the program	
	45 minute break	
45 mins	1. Psychoeducation	1. Psychoeducation 2. Cognitive model
	45 minute break	
1 hour	1. Exposure task 2. Rewards given & homework set	
DAY 2		
45 mins	1. Review of previous session 2. Review of homework 3. Relaxation	1. Psychoeducation on parenting 2. Development of a parenting plan
	45 minute break	
45 mins	1. Exposure task 2. Problem solving	1. Problem solving 2. Psychoeducation regarding avoidance and exposure
	45 minute break	
1 hour	1. Discussion regarding avoidance and the anxiety cycle 2. Exposure hierarchy development 3. Rewards given & homework set	
DAY 3		
45 mins	1. Review of previous session 2. Review of homework 3. Cognitive model	1. Review 2. Cognitive restructuring
	45 minute break	
45 mins	1. Cognitive restructuring	1. Relaxation
	45 minute break	
1 hour	1. Exposure task 2. Rewards given & homework set	
DAY 4		
45 mins	1. Review of previous session 2. Review of homework 3. Social skills training	1. Review 2. Social skills training
	45 minute break	
45 mins	1. Social Skills training	FREE SESSION
	45 minute break	
1 hour	1. Exposure task 2. Review and maintenance 3. Rewards given	

Future Directions

Given the dearth of studies in this area, there are numerous avenues for future research. The two pilot studies conducted to date require replication and extension, with both children and adolescents. Research might also examine adjustments to the timing of the sessions. For instance, might treatment be improved if spaced in 3-hour sessions over 4 weekends or 2-hour sessions across 6 weekends, therefore allowing greater opportunities for practice of the skills and therapist support over a longer time-frame? Future research might also examine whether, given the complexity and breadth of social skills training, addressing component social skills in each session rather than addressing them all in one session, is beneficial. In addition, future research should investigate whether therapy could be supplemented through therapist telephone or email contact after the completion of sessions, in order to retain the benefits of convenience while at the same time extending therapist contact over time. Finally, future research might also investigate whether the programs could be made briefer as well as more intensive. In the two intensive SAD programs to date, the amount of actual therapy time is similar to traditional approaches. Is it necessary to present the full repertoire of CBT strategies? Although briefer programs have been tested for other youth anxiety disorders, they are yet to be conducted for SAD.

In conclusion, intensive group-based CBT programs for youth SAD have demonstrated promising results. Still, further research is necessary. It is hoped that the intensive approach is taken up by researchers and clinicians, so that additional research might be generated and more families might be assisted. Assuming so, the problematic trajectories of youth suffering with SAD may be addressed.

References

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. American Psychiatric Association: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.)*. . Arlington, VA: American Psychiatric Publishing.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (1999). Psychopathology of childhood social phobia. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(6), 643-650. <http://dx.doi.org/10.1097/00004583-199906000-00010>
- Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology*, 68(6), 1072. <http://dx.doi.org/10.1037//0022-006X.68.6.1072>
- Booth, M. L., Bernard, D., Quine, S., Kang, M. S., Usherwood, T., Alperstein, G., & Bennett, D. L. (2004). Access to Health Care Among Australian Adolescents Young People's Perspectives and Their Sociodemographic Distribution. *Journal of Adolescent Health*, 34, 97-103.
- Boyd, C., Francis, K., Aisbett, D., Newnham, K., Sewell, J., Dawes, G., & Nurse, S. (2007). Australian rural adolescents' experiences of accessing psychological help for a mental health problem. *Australian Journal of Rural Health*, 15(3), 196-200. <http://dx.doi.org/10.1111/j.1440-1584.2007.00884.x>
- Costello, E. J., Egger, H. L., & Angold, A. (2005). The developmental epidemiology of anxiety disorders: phenomenology, prevalence, and comorbidity. *Child and Adolescent Psychiatric Clinics of North America; Child and Adolescent Psychiatric Clinics of North America*. <http://dx.doi.org/10.1016/j.chc.2005.06.003>
- Crawley, S. A., Beidas, R. S., Benjamin, C. L., Martin, E., & Kendall, P. C. (2008). Treating Socially Phobic Youth with CBT: Differential Outcomes and Treatment Considerations. *Behavioural and Cognitive Psychotherapy*, 36, 379-389. <http://dx.doi.org/10.1017/S1352465808004542>
- Donovan, C. L., Cobham, V., & Waters, A. (under review). Intensive Group-Based CBT for Child Social Phobia: A Pilot Study.
- Gallagher, H. M., Rabian, B. A., & McCloskey, M. S. (2004). A brief group cognitive-behavioral intervention for social phobia in childhood. *Journal of Anxiety Disorders*, 18(4), 459. [http://dx.doi.org/10.1016/S0887-6185\(03\)00027-6](http://dx.doi.org/10.1016/S0887-6185(03)00027-6)

- Ginsburg, G. S., Kendall, P. C., Sakolsky, D., Compton, S. N., Piacentini, J., Albano, A. M., ... March, J. (2011). Remission After Acute Treatment in Children and Adolescents With Anxiety Disorders: Findings From the CAMS. *Journal of Consulting and Clinical Psychology, 79*(6), 806-813. <http://dx.doi.org/10.1037/a0025933>
- Kessler, R. (2003). The impairments caused by social phobia in the general population: Implications for intervention. *Acta Psychiatrica Scandinavica, 108*(s417), 19-27. <http://dx.doi.org/10.1034/j.1600-0447.108.s417.2.x>
- Last, C. G., Perrin, S., Hersen, M., & Kazdin, A. E. (1992). DSM-III-R anxiety disorders in children: Sociodemographic and clinical characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry, 31*(6), 1070-1076. <http://dx.doi.org/10.1097/00004583-199211000-00012>
- Melfsen, S., Kühnemund, M., Schwieger, J., Warnke, A., Stadler, C., Poustka, F., & Stangier, U. (2011). Cognitive behavioral therapy of socially phobic children focusing on cognition: A randomised wait-list control study. *Child and adolescent psychiatry and mental health, 5*(1), 5. <http://dx.doi.org/10.1186/1753-2000-5-5>
- Merikangas, K. R., & Avenevoli, S. (2002). Epidemiology of mood and anxiety disorders in children and adolescents. *Textbook in psychiatric epidemiology, 657-704*. <http://dx.doi.org/10.1002/0471234311.ch24>
- Merikangas, K. R., He, J. P., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., ... Olfson, M. (2011). Service utilization for lifetime mental disorders in US adolescents: results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(1), 32-45. <http://dx.doi.org/10.1016/j.jaac.2010.10.006>
- Rapee, R. M., Kennedy, S. J., Ingram, M., Edwards, S. L., & Sweeney, L. (2010). Altering the Trajectory of Anxiety in At-Risk Young Children. *American Journal of Psychiatry, 167*, 1518-1525. <http://dx.doi.org/10.1176/appi.ajp.2010.09111619>
- Sawyer, M. G., Kosky, R. J., Graetz, B. W., Arney, F., Zubrick, S. R., & Baghurst, P. (2001). The National Survey of Mental Health and Wellbeing: The child and adolescent component. *Australian and New Zealand Journal of Psychiatry, 34*(2), 214-220. <http://dx.doi.org/10.1046/j.1440-1614.2001.00964.x>
- Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of a social skills training-based cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 41*(6), 713-726. <http://dx.doi.org/10.1111/1469-7610.00659>
- Stallard, P., Udwin, O., Goddard, M., & Hibbert, S. (2007). The availability of cognitive behaviour therapy within specialist child and adolescent mental health services (CAMHS): A national survey. *Journal of Anxiety Disorders, 17*(6), 605-625.
- Turner, S. M., Beidel, D. C., & Dancu, C. V. (1996). *SPAI: Social Phobia & Anxiety Inventory*: Multi-Health Systems.
- Weissman, M. M., Wolk, S., Wickramaratne, P., Goldstein, R. B., Adams, P., Greenwald, S., ... Steinberg, D. (1999). Children with prepubertal-onset major depressive disorder and anxiety grown up. *Archives of General Psychiatry, 56*(9), 794. <http://dx.doi.org/10.1001/archpsyc.56.9.794>