

CHAPTER 8

Treatment of Social Phobia in Children and Adolescents

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INTRODUCTION

Social anxiety is a common, perhaps universal experience. For most children and adolescents, social anxiety is a mere transitory experience. For others it is a pervasive component of their social experience. When social anxiety causes extreme discomfort or results in impairment in interpersonal relations or academic performance, the diagnosis of social phobia should be considered. Social phobia is defined as a “marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others” (American Psychiatric Association, 1994, p. 416). In social phobia, the feared social stimuli (e.g., public performance situations; informal social interactions) elicit characteristic patterns of responding. The classic triple response mode of anxiety includes overt and covert (cognitive and physiological) behaviours. Overt behaviours include escape (e.g., leaving a party early) and avoidance (e.g., school refusal, reluctance to participate in classroom discussions). Characteristic cognitions include a negative evaluation component (e.g., “they are going to think I am stupid”). Typical physiological responses are increased heart rate, muscle tension, trembling, sweating, and blushing. Although all three response modes may be represented to a certain extent, individuals vary greatly as to the primary mode of response. For children and adolescents for whom cognitive or physiologic modes predominate, it may be difficult for others to note the extent of their social distress. Likewise, the overt behaviour of socially anxious children may be misinterpreted by others. Clinging, tantrums, and non-compliance with parental or teacher requests may be evident

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when children are unable to avoid feared social situations. Such responses may be mistaken as merely oppositional behaviour to the untrained observer.

In order to receive a diagnosis of social phobia, children must demonstrate capacity for age-appropriate social relationships (e.g., with family members). For children who appear to lack all capacity for social relatedness, the possibility of a pervasive developmental disorder should be explored. Further, the diagnosis of social phobia requires that the anxiety-related symptoms also occur in the presence of other children (not merely adult authority figures). Note that the term *social anxiety disorder* was introduced in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) as an alternative label for social phobia. The terms may be considered interchangeable.

Given the amount of time spent in school, it is not surprising that children and adolescents with social phobia report attending school to be a significant source of social distress (Beidel, 1991; Strauss & Last, 1993). In particular, informal peer interactions (e.g., having to talk to another child, joining peers at recess) have been cited as the most frequently occurring situations provoking anxiety in children and adolescents with social phobia (Beidel, 1991). Among adolescents with social phobia, 60% reported significant impairment at school (Essau, Conradt, & Petermann, 1999). Many children and adolescents with social phobia demonstrate concomitant social skills deficits. In an investigation by Beidel, Turner, and Morris (1999), children with social phobia were judged by independent observers to have significantly poorer social skills than age-matched controls in informal social interaction and public performance tasks. Similar findings were reported by Spence, Donovan, and Brechman-Toussaint (1999) for direct observation of children's performance in a role-play task, and for self- and parent reports of social skills. At this point, it is unclear whether impairments in social skills are a cause or consequence of social phobia. Reciprocal interactions are probably at play.

The DSM-IV provides for specification of a "generalized" subtype of social phobia if the child's fears include most social situations. Similarly, a "specific" subtype has been described in the literature (Heimberg et al., 1990b) referring to social fears and avoidance that occur only in limited contexts such as formal speaking or performing in public. The generalized subtype has been found to have an earlier onset, to be of greater severity, and to be associated with more pervasive affective symptoms (e.g., depression) than the specific subtype (Bruch & Heimberg, 1994; Turner, Beidel, & Townsley, 1992). Among clinic samples, the generalized form is the most prevalent type in children (89%; Beidel, Turner, & Morris, 1999).

Epidemiology

Lifetime prevalence estimates for social phobia vary widely depending on sampling procedures, method of assessment, and diagnostic criteria employed. A rate of 2.4% was found in the Epidemiological Catchment Area Survey (Schneier et al., 1992), versus 13.3% for the National Comorbidity Survey (NCS; Kessler et al., 1994). Comparison with international investigations (e.g., Lepine & Lellouch, 1995; Stein, Walker, & Ford, 1994) and evaluation of methodological procedures suggests that

the NCS data may be most representative of lifetime prevalence for the full spectrum of social phobia.

The distribution of social phobia among clinic populations has been reported to be approximately equal for males and females (Last et al., 1992; Turner & Beidel, 1989). Among epidemiological samples, slightly more females than males meet criteria for the disorder, for example, NCS lifetime prevalence estimates were 11.1% for males versus 15.5% for females (Kessler et al., 1994; Mannuzza et al., 1992; Pollard & Henderson, 1988). This is in contrast to the underlying construct of social anxiety that has been found to be slightly higher among girls than boys in community samples (Epkins, 2002; Morris & Masia, 1998). No consistent racial or ethnic differences in the prevalence of social phobia have emerged in the literature (Beidel & Turner, 1998).

The mean age of onset for social phobia ranges from early- to mid-adolescence (Amies, Gelder, & Shaw, 1983; Last et al., 1992; Liebowitz et al., 1985; Öst, 1987; Turner et al., 1986). However, it is quite common for adults seeking treatment for social phobia to report that they have been shy and socially anxious nearly all their lives. Increased social demands (e.g., recitals, parties, dating) coupled with heightened self-awareness during adolescence may account for the peak progression of social anxiety to social phobia during this developmental stage. In the absence of direct intervention, social phobia is considered to be a chronic disorder. A longitudinal investigation of adults with social phobia indicated complete remission for only 38% of women and 32% of men over an eight-year period (Yonkers, Dyck, & Keller, 2001).

High comorbidity rates have been reported for social phobia. The most prevalent comorbid conditions are other anxiety disorders (particularly generalized anxiety disorder) and depression (Schneier et al., 1992; Turner et al., 1991). Although more research is needed on developmental progression, it does appear that severe social anxiety may increase risk for the development of other disorders. For instance, Stein and colleagues (1990) found that in the majority of comorbid cases, depression began *after* the onset of social phobia. Avoidance of social activities in an attempt to decrease social anxiety hinders the development of interpersonal. Children and adolescents who experience extreme levels of social anxiety have fewer close friendships and lower levels of acceptance within the peer group (Morris, 2001). Not surprisingly, social withdrawal sets up a vicious downward spiral leading to depression. Social phobia also has been associated with substance abuse (Essau, Conradt, & Petermann, 1999). As with depression, social phobia has been found to precede alcohol abuse in the majority of comorbid cases (Kushner, Sher, & Beitman, 1990). The "self-medication" hypothesis has been proposed to explain the association. That is, adolescents who experience high levels of social anxiety may find that alcohol and other substances lower their sense of inhibition and general physiological arousal in social situations. With disinhibiting substances as a social lubricant, these adolescents may find themselves much more outgoing when under the influence. Their more gregarious behaviour in that state is often reinforced by others, thus increasing the likelihood that they will use alcohol (or other substances) to confront social situations in the future. Unfortunately, this can often lead to a pattern of abuse and dependence.

AETIOLOGY

Unitary causal models have not been identified for social phobia, but numerous potential causative agents have been suggested. Morris (2001) provides a review of aetiological factors and presents an exploratory model for the development of social phobia. This proposed framework is consistent with a developmental psychopathology perspective in which the principles of multifinality (any single factor may lead to diverse outcomes) and equifinality (a diversity of paths may lead to the same outcome) are emphasized (see also Ollendick & Hirshfeld-Becker, 2002). The model suggests multiple entry points that may place a child on the path toward social phobia and, conversely, multiple points at which the course may be diverted. Associations among aetiological factors are not necessarily linear and great diversity may be found in individual aetiological pathways.

As with most disorders, the development of social phobia is probably influenced by a complex interplay of biological and environmental factors. Empirical information on the potential role of genetic transmission in the development of social anxiety is extremely limited. However, family studies indicate increased rates of social phobia among first-degree relatives (Fyer et al., 1993; Perugi et al., 1990; Reich & Yates, 1988). This is particularly the case for the generalized subtype (Mannuzza et al., 1995). Although the specific mechanisms of any biological components of social phobia remain to be determined, there is growing evidence to support an association with inhibited temperament. Behavioural inhibition refers to a generally shy demeanour and tendency to approach new situations with restraint, avoidance, and distress. Inhibition is thought to have a biological component. Increased rates of anxiety disorders in general, and social phobia in particular, have been found among behaviourally inhibited children (Biederman et al., 1990, 1993; Hirshfeld et al., 1992).

Inhibited temperament most likely is neither a sufficient nor a necessary factor in the development of social phobia. The interaction between the family environment and any underlying disposition of the child is paramount. Parents may promote the adaptive development of their inhibited infants, or interact in a manner that may increase the likelihood of future dysfunction in otherwise uninhibited offspring (see Masia & Morris, 1998 for review of parental factors associated with social anxiety). Parents play the central role in providing young children with opportunities for social contacts (Bhavnagri & Parke, 1991; Bryant & DeMorris, 1992; Putallaz & Hefflin, 1990), and parents who experience social anxiety may model social avoidance and be less likely to facilitate their children's social interaction (Daniels & Plomin, 1985). This hypothesis has received support in that adults with social phobia have described their parents as engaging in limited social interaction and fostering family isolation (Bruch et al., 1989; Bruch & Heimberg, 1994; Rapee & Melville, 1997). Of course, retrospective investigations lend themselves to criticisms of possible biased recall. To address this concern, Greco and Morris (2002) conducted a study with children and found similar associations between perceived parenting style and social anxiety. Although more extended observational research is needed, recent laboratory investigations have found parents of socially anxious children to demonstrate more controlling and rejecting behaviour toward their children during joint interaction tasks than parents of non-anxious children (Greco & Morris, in press; Morris 2002).

Dadds and his colleagues have conducted a series of studies demonstrating that parents of anxious children are more likely to model threat interpretations to ambiguous cues and to provide and reinforce avoidant solutions in response to hypothetical social scenarios than parents of aggressive or non-clinical control children (Barrett et al., 1996; Dadds, Barrett, & Rapee, 1996). Further, parents may foster social anxiety by communicating information that promotes hypervigilance and concerns about negative social evaluation. For example, the mother who says to her child "Don't spill that ice cream on your clothes or all the kids will think you are a slob" or the father who says "You don't really want to go out for basketball do you? You know you are not very good at it".

Factors related to the development of social anxiety are not limited to the home environment. Children's peer interactions provide unique opportunities for learning specific skills that are not realized through adult-child contact. The nature and quality of children's peer relationships may play a contributing role in social phobia. Reciprocal associations have been found for peer acceptance and social anxiety in children and adolescents (La Greca et al., 1988; La Greca & Lopez, 1998; La Greca & Stone, 1993; Morris, 2001).

Specific traumatic social conditioning experiences (e.g., vomiting in front of the class and seeing classmates laugh or scream out in revulsion) also have been cited as a possible cause or trigger for social phobia. However, most children who have had traumatic social experiences do not develop social phobia, and a sizable proportion of those diagnosed with social phobia do not recall any specific traumatic conditioning experiences. It is possible that reports of traumatic social conditioning triggering the onset of social phobia are an artefact of selective recall among those already sensitized by pre-existing social anxiety. Some research suggests that children and adolescents with social phobia demonstrate self-defeating cognitive biases, underestimate their own level of social skill, and focus excessively on perceived errors in social behaviour (Chansky & Kendall, 1997; Vasey et al., 1995; Zatz & Chassin, 1985). The role of social cognition in social anxiety merits further investigation. In sum, there appear to be multiple pathways to the development of social anxiety. Multiple biological and environmental factors have been implicated and each factor may interact with others to ameliorate or exacerbate its effect.

ASSESSMENT OF SOCIAL PHOBIA

Comprehensive assessment of social phobia requires a multimethod, multimodal approach. When working with children and adolescents, it is important to solicit information from multiple sources, such as parents, teachers, and peers. Parents cannot be considered the gold standard for all information about their children. Information should be obtained from the relevant individuals who have access to the situations in which the problem behaviours occur (e.g., teachers may provide a wealth of data on the child's performance in school and interactions with peers). It is not uncommon to find inconsistencies in information provided by parents, teachers, and children—and the bases for such discrepancies should be explored. Cognitive, behavioural, and somatic responses should be assessed in a variety of social contexts (e.g., home and school). Implementation of a multicontextual

assessment strategy will help guide case conceptualization and treatment planning. The most commonly utilized assessment methods are noted below.

Structured Interviews

The Anxiety Disorders Interview Schedule for DSM-IV Child Version (ADIS-C/P; Silverman & Albano, 1996) is a semistructured interview developed to assist with the differential diagnoses of DSM-IV anxiety disorders. Even though the ADIS-C/P focuses primarily on childhood anxiety disorders, interview questions are also included to screen for affective and externalizing disorders. The child and parent(s) are interviewed separately and the resulting information is combined to determine diagnostic status. The ADIS-C/P includes items assessing children's cognitive, behavioural, and physiological responses across a range of potentially anxiety-provoking situations (e.g., interacting with peers, being separate from a parent). The social phobia section of the ADIS-C/P asks the child and parent(s) to provide fear, avoidance, and interference ratings across 13 social and performance situations.

To assess clinical significance, intensity ratings are obtained to indicate the extent to which particular fears interfere with daily functioning.

Self-Report Measures

Self-report questionnaires are routinely employed to obtain information on anxiety symptoms from children over 8 years of age. The most widely used (and psychometrically sound) measures of social anxiety are the Social Phobia and Anxiety Inventory for Children (SPAI-C), the Social Anxiety Scale for Children—Revised (SASC-R), and the Social Anxiety Scale for Adolescents (SAS-A).

The SPAI-C (Beidel, Turner, & Morris, 1995, 1998) is an empirically derived self-report measure developed to assess the frequency and range of social fears experienced by children and adolescents (8–14 years) in multiple social settings, such as home and school. The SPAI-C consists of 26 items evaluating cognitions (e.g., “what if I make a mistake and look stupid”), overt behaviour (e.g., avoiding social situations), and somatic responses (e.g., “feel sweaty”, “heartbeat fast”) across a range of potentially fear-inducing situations (e.g., school play, parties). The measure has demonstrated excellent internal consistency and high test–retest reliability across 2-week and 10-month intervals.

Beidel and coworkers (2000) provide data on the external and discriminative validity of the SPAI-C among 254 children aged 8–14 years. Behavioural validation was examined through read-aloud and role-play tasks. Independent observer's ratings of the children's anxiety and effectiveness in the behavioural tasks and the children's ratings of their own distress were significantly associated with SPAI-C scores. More importantly, the measure successfully discriminated not only between children with social phobia and normal controls, but also between children with social phobia and children with other anxiety disorders. This is quite notable given that other anxiety assessment instruments generally have failed to differentiate among children of varying diagnostic groups.

The SASC-R (La Greca & Stone, 1993) is a 22-item measure of social anxiety that focuses on both subjective experiences and behavioural consequences (e.g., avoidance, withdrawal) associated with social anxiety. The SASC-R comprises three factors: Fear of Negative Evaluation (FNE), and two subscales reflecting Social Avoidance and Distress (SAD) with new or unfamiliar peers (SAD-New) and more generalized social avoidance and distress (SAD-G). Scores on the SASC-R have been associated with peer relationship difficulties, such as peer rejection and neglect, and low self-esteem (e.g., La Greca & Stone, 1993). The measure has been shown to have good reliability and validity. An adolescent version (SAS-A; La Greca & Lopez, 1998) also has been developed.

Morris and Masia (1998) examined the association of the SPAI-C and the SASC-R among 277 grade school children. A moderate association was found indicating that the measures assess overlapping, but not identical constructs. One consideration is that the SPAI-C was developed specifically to assess the construct of social phobia as defined in the DSM-IV whereas the SASC-R was designed to assess the general construct of social anxiety. Epkins (2002) also examined the association between the SPAI-C and SASC-R for community ($n = 178$) and clinic ($n = 57$) samples. Results were consistent with those of Morris and Masia.

Behavioural Observation

Behavioural observation is an important component of the assessment of anxiety. Ideally, the child will be observed in the natural setting in which the anxiety manifests. For example, in the case of social phobia, it may be particularly useful to observe the child in the classroom and during school recess periods. However, with consideration and preparation, the clinician may set up situations in and around the office that will provide the proper setting events in which relevant behaviours may be displayed (e.g., reading aloud, delivering a speech).

Peer Report

A child's peer status typically is identified using sociometric nomination methods. The classic sociometric nomination procedure involves asking each child in a classroom to name three children with whom he or she most likes to play, and three with whom he or she least likes to play. Categorization of social status generally is based on two dimensions: how much a child is liked or disliked by his or her peers (social preference) and the child's visibility within the peer group (social impact; see Coie, Dodge, & Coppotelli, 1982). Other forms of peer report include sociometric rating procedures and the Revised Class Play (Matsen, Morrison, & Pelligrini, 1985). Sociometric rating procedures involve asking children to rate their classmates on various dimensions of liking and acceptance using a Likert-type scale. The Revised Class Play (RCP), asks children to assign their peers to various roles (usually positive and negative roles) in an imaginary play. Children might, for example, be asked to name which classmates are very shy. In addition to peer report, direct

observation of children's interactions with classmates and friends can provide clinicians with valuable data regarding social interaction style and friendship quality.

TREATMENT OF SOCIAL PHOBIA

Behavioural Treatment

Behavioural approaches to the treatment of childhood anxiety have received strong empirical support. The most commonly employed strategies to decrease social anxiety and improve social functioning are presented below. Formulation of specific intervention goals and methods should follow from a functional analysis of each individual case. However, comprehensive treatment of social phobia in children and adolescents generally involves the integration of several techniques within an organized framework.

Relaxation Training

The most widely used procedures to promote relaxation are progressive muscle relaxation (systematic training involving tensing and relaxing of each major muscle group), positive visual imagery, or a combination of both. When working with very young children, presenting the relaxation skills in the form of a game—such as having the child pretend she is a turtle, stretching out her neck and limbs, and then pulling them back into the shell—may be most effective. Although relaxation training in itself is not considered sufficient for the treatment of social phobia, when practiced regularly relaxation techniques may be useful in lowering the child's overall level of arousal.

Exposure Therapy

The literature suggests that exposure is a necessary component to the successful treatment of all anxiety disorders including social phobia. Exposure-based approaches require that the child face the feared situation(s) and remain in the presence of feared stimuli for a sufficient period of time to allow for habituation and extinction of anxious responding. Such approaches include systematic desensitization and graduated exposure. Systematic desensitization involves relaxation training and the development of a fear hierarchy. Once the child is able to learn to put herself in a relaxed state, items from the fear hierarchy are presented (from least to most anxiety producing). These pairings may be presented through imagery or live in a clinic or natural setting. With repeated pairings, the child is able to remain in the presence of successively more salient fear stimuli for progressively longer periods of time. Graduated exposure is similar to systematic desensitization, but relaxation procedures are not implemented during the presentation of the feared objects or situations. Most clinicians prefer to use a graduated exposure approach when working with children (rather than sustained flooding), working slowly

through a hierarchy, gradually exposing children to more challenging situations for increasingly longer periods of time. No evidence is available to suggest that the inclusion of relaxation training (as in systematic desensitization) is a necessary component or even adds incrementally to the success of exposure in the treatment of social phobia. However, when working with an extremely fearful child the clinician may find that the process of relaxation training helps to establish rapport and as such may foster more cooperation among children during subsequent exposure work.

Contingency Management

Contingency management involves arranging specific consequences for performance of target behaviours. The therapist works with the child (and parents) to develop a contract that explicitly states what the child is to do in order to receive reinforcement, as well as how and when the reinforcement will be delivered. Contracts often include a response cost for failure to meet a given goal. Parents and/or teachers generally are relied upon to administer consequences, although some adolescents may be able to self-contract. An example of a simple contract may be as follows: "If Jane initiates an interaction with a peer during recess on three of five days in a school week, the family will go to a movie of her choice on Friday evening. In addition, if Jane attempts to refuse to attend school on any day, she will forfeit her allotted video-game playing time for two days." Contingency management can be an important adjunct to exposure-based strategies in maintaining a system of reinforcement for completion of generalization or "homework" assignments detailed in the treatment plan.

Social Skills Training

Many anxious children exhibit social skills deficits, which is particularly the case with social phobia. These children often avoid social situations in which they may miss out on opportunities to learn age-appropriate skills. Most social skills training (SST) programs involve coaching, modelling, and social problem-solving components. Typical skills trained include joining in activities with peers, establishing and maintaining conversations, developing friendships, and communicating assertiveness. SST components are commonly included in systematic intervention programs for social phobia (see section on multicomponent treatment packages below).

Peer Involvement

Children's peer relationships provide important contexts for social, emotional, and interpersonal growth, and children who experience interpersonal difficulties with their peers are at substantial risk for further complications. It is important, therefore, to identify children's prominent socialization agents (e.g., parents, siblings, peers, teachers) and to solicit their active participation throughout the course of

therapy. In peer-mediated or “peer-helper” interventions, children’s peers serve as change-change agents and are trained to initiate, model, and reinforce desired change. In contrast, peer-pairing interventions involve strategically matching children with more socially skilled peers and providing opportunities for them to engage in activities together, but no formal training is provided to the peer. For example, a socially withdrawn child would be paired with a popular, socially adept “buddy”. This peer pair could be asked to sit together, play with one another during recess, and be assigned to work together on an upcoming classroom project. In general, peer-pairing techniques are less time-consuming than peer-mediated interventions because the peers do not undergo specialized training prior to or during participation in the program. An advantage of peer-pairing is the naturalistic nature of the activities, thus facilitating generalization. Outcome data suggest that peer-mediated and peer-pairing interventions lead to improved sociometric status, increased rates of positive interactions, and decreased rates of solitary behaviour (e.g., Morris, Messer, & Gross, 1995).

Multicomponent Treatment Packages

Cognitive-Behavioural Group Treatment for Adolescents

Albano and Barlow (1996) have developed a cognitive-behavioural group treatment for adolescents diagnosed with social phobia. Cognitive-Behavioural Group Treatment for Adolescents (CBGT-A) is a modified version of CBGT for adults (see Heimberg et al., 1990a). CBGT-A is a 16-week program consisting of psychoeducation, skill-building (e.g., social skills, problem-solving, and assertiveness training), cognitive restructuring, and behavioural exposure to socially distressing or fearful situations.

The short-term efficacy of CBGT-A has been evaluated in two studies. Albano and colleagues (1995) reported 3- and 12- month follow-up data for five adolescents; four were completely diagnosis free at both follow-up evaluations, and substantial improvements were noted for the fifth adolescent. In a subsequent investigation, Hayward et al. (2000) randomly assigned 35 adolescent girls ($M = 15.8$ years) with social phobia to treatment ($n = 12$) or control ($n = 23$) conditions. Significantly fewer of the adolescents who participated in CBGT-A met diagnostic criteria for social phobia following intervention. Notably, however, there were no diagnostic differences between the treated and untreated groups at one-year follow-up or in mean scores on a self-report measure of social phobia.

Social Effectiveness Therapy for Children

Beidel, Turner, and Morris (2000) have published the first controlled trial of behavioural treatment for social phobia in pre-adolescent children. Social Effectiveness Therapy for Children (SET-C) is a manualized behavioural intervention that incorporates both peer-generalization and friendship-making components. SET-C is a 12-week, multicomponent program developed specifically to treat children diagnosed

with social phobia. Components of SET-C include parent education, social skills training (SST), peer generalization, and graduated in vivo exposure. One group social skills training (SST) session and one individual graduated in vivo exposure session are held each week. The individual in vivo exposure sessions last approximately 60 minutes each and involve exercises constructed to address each child's unique pattern of social fears. The SST sessions (conducted in small groups of 4–6 children and of 60 minutes' duration) focus on conversational and friendship-making skills. Instruction, modelling, behaviour rehearsal, feedback, and social reinforcement are used to teach and reinforce appropriate social behaviour. A unique and essential component of SET-C is the use of peer interaction experiences (developmentally appropriate group recreational activities, e.g., pizza parties, skating, bowling) to assist in the generalization of social skills to situations outside the clinic. Similar to peer-pairing approaches, non-anxious "peer facilitators" are recruited to participate in the treatment on a voluntary basis and asked to initiate and maintain interactions with the target children.

Fifty children (ages 8–12) were randomized to Social Effectiveness Therapy for Children (SET-C) or an active treatment for improving test taking and study skills. The SET-C and study skills programs each lasted 12 weeks and were equivalent in terms of therapist/participant contact. Following treatment, children receiving SET-C demonstrated statistically and clinically significant improvements across multiple domains (e.g., decreased levels of social and general anxiety, increased social skill and performance ratings, and more adaptive functioning in daily situations). These improvements were maintained six months post-treatment. Notably, 67% of children who participated in the SET-C program no longer met diagnostic criteria for social phobia post-treatment compared to only 5% of those receiving the active control treatment.

Cognitive-Behavioural Treatment plus Parental Involvement

Incorporation of parents in the treatment process is a valuable strategy, particularly given the accumulating evidence that many parents may (unwittingly) play a role in maintaining anxious behaviour. Spence, Donovan, and Brechman-Toussaint (2000) investigated the effectiveness of a cognitive-behavioural treatment (CBT) program with or without parental involvement for children and adolescents diagnosed with social phobia. Fifty children (aged 7–14 years) were randomly assigned to CBT, CBT plus parental involvement (CBT-PI), or a wait-list control condition. The CBT components included SST, relaxation training, positive self-instruction, cognitive challenge, and graded exposure. The purpose of the parent involvement component was to help parents to learn to model and reinforce the social skills taught in CBT; to ignore avoidance and socially anxious behaviour; to encourage child participation in social activities; and to reinforce homework completion. Parents observed the children's group sessions behind a one-way mirror and participated in a 30-minute weekly training session while their children were practicing skills in another room. Both interventions included 12 weekly group sessions and two booster sessions (occurring three and six months post-treatment). Although there was a trend for greater improvement in the CBT-PI group, differences were

not statistically significant. Both treatment groups showed improvement in social skills from pre-treatment to 12-month follow-up based on parent report. However, neither treatment (in comparison to one another or to a control group) yielded significant differences for children's total number of peer interactions, parental report of competence with peers, or independent observer ratings of assertiveness during behavioural observation from pre- to post-treatment. The findings indicate that the CBT and CBT-PI approaches were effective in reducing social anxiety symptoms, but did not substantially affect social behaviour, thus providing further support for the inclusion of peers in the treatment process.

Pharmacological Treatment

A substantive review of pharmacological approaches to the treatment of social phobia is beyond the scope of this chapter. The reader is referred to Beidel et al. (2001) and Federoff and Taylor (2001) for more thorough discussion of the topic. Selective serotonin reuptake inhibitors (SSRIs) are the most frequently prescribed medications for the treatment of social phobia in children and adolescents. The most common SSRIs include paroxetine (Paxil), fluoxetine (Prozac), sertraline (Zoloft), and fluvoxamine (Luvox). These drugs generally are well tolerated, with only minimal side-effects (Velosa & Riddle, 2000). It has been a long-held contention by many clinicians that when anxiolytic medication is used, treatment success will be enhanced if the pharmacological approach is implemented in conjunction with cognitive-behavioural intervention. Chavira and Stein (2002) provide initial data in support of such a combined approach.

SUMMARY AND FUTURE DIRECTIONS

Social phobia is a prevalent, often chronic, disorder affecting large numbers of children and adolescents. Temperament, parent-child attachment, peer relations, and traumatic conditioning all have been implicated in the development of social phobia, and the condition is probably influenced by the interplay of multiple factors. Knowledge regarding the assessment, treatment, and correlates of social phobia in children and adolescents is expanding at an accelerated pace. In terms of assessment, the last decade has seen a shift from mere reliance on broad band measures of anxiety to the development of specific measures of social anxiety and phobia. The treatment literature has followed suit, with the advent of intervention programs designed specifically for the treatment of social phobia rather than anxiety in general. Great strides have been made in recent years, although the overall database remains relatively limited. Much work remains to be done with respect to controlled trials of behavioural, pharmacological, and combined interventions.

A commonly stated clinical position is that treatment tends to be more effective when implemented earlier, as opposed to later, in an individual's lifespan. Behaviour patterns generally are regarded as less well established in young children and thus more responsive to change. No doubt, certain approaches will be found to be more effective for specific age periods than will others. For too long, efforts toward

intervention with children reflected mere downward extensions of work with adults. The trend toward inclusion of parents and peers in the treatment process suggests increasing developmental sensitivity to the needs of children and adolescents.

Early onset social phobia appears to be a chronic condition. However, one would be remiss without noting the vast opportunities for early intervention. At virtually any point in the lifespan a naturally occurring experience or targeted intervention may alter the individual's course. As the effect of risk factors tends to compound as time progresses, making it more difficult to return to a more adaptive path, intervention efforts may have a greater likelihood for success the earlier that they occur. Given this state of affairs, it is crucial that we expand our knowledge with respect to aetiological factors and developmental pathways. It is important that we determine which intervention strategies will be most successful, cost-effective, and practical for which behaviours, at which point in the child's development. The next decade promises much progress toward this goal.

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