Chapter 10

PREVENTION, DIFFICULT CASES, AND FUTURE DIRECTIONS

Previous chapters concentrated on important clinical processes that occur following the identification of youths with social anxiety or social phobia. In this chapter, however, a summary is presented of the emerging field of prevention with respect to childhood anxiety disorders in general and social phobia in particular. Specifically, an emphasis will be placed on general and relapse prevention. In addition, recommendations are made for addressing difficult cases of childhood social phobia, including cases that involve extensive comorbidity, intense symptomatology, noncompliance, and desires for early termination. Finally, future directions are covered in the area of childhood anxiety disorders in general and social phobia in particular.

GENERAL PREVENTION OF CHILDHOOD ANXIETY DISORDERS AND SOCIAL PHOBIA

To address childhood social anxiety and social phobia, most researchers have focused on intevention, but some investigators have begun to explore prevention-based efforts as well. Evolving prevention efforts in this area will likely focus on key risk factors for anxiety, including genetic predisposition, behavioral inhibition and other temperaments, threat-based cognitions, anxious-resistant attachment, parental psychopathology

and certain childrearing behaviors, stressful life events, poor social support and coping skills, and salient sociocultural factors, among others (Donovan & Spence, 2000) (see also Chapter 3). In related fashion, Spence (2001) outlined several groups that seem to be at particular risk for developing anxiety disorders. These groups include children with emerging anxiety symptomatology, children born to parents with anxiety and/or faulty childrearing styles, children with problematic attachment and temperaments (i.e., behavioral inhibition and/or negative affect/neuroticism and/or low effortful control), and children exposed to frequent trauma and/or difficult life transitions.

Spence (1994, 2001) outlined as well an integrated developmental model for preventing childhood anxiety disorders, with special emphasis on tailoring various techniques to different phases of an at-risk child's lifespan. Some prevention techniques could apply to *all* phases of a child's lifespan, of course, and may include counseling during problematic times (e.g., trauma, divorce), developing coping skills, and preparing a child for upcoming difficult events (e.g., movement to a new school). Prevention techniques during pre-birth and infancy periods would obviously concentrate on parents and could include training to improve parenting skills as well as treatment for existing parental psychopathology. For older children and adolescents, prevention efforts may focus on parent-based contingency management, family-based communication and problem-solving skills training, environment-based reduction of trauma, and child-based techniques for enhancing adjustment to new situations, understanding the difference between dangerous and nondangerous situations, and managing somatic, cognitive, and behavioral aspects of anxiety.

Investigators have begun to explore early intervention and prevention programs for youths with anxiety disorders. A prominent example was a controlled trial conducted by Dadds and colleagues (1997), who initially screened 1786 youths aged 7–14 years via child self-report measures and teacher information. Later screening was done to exclude youths with disruptive behaviors and, via structured diagnostic interview, to identify youths with subclinical features of an anxiety disorder. A minority of youths had features of social phobia. Youths were then assigned to an intervention ($n = 61$) or a simple monitoring/control ($n = 67$) group.

The intervention consisted of 10 group sessions held weekly at the childrens' schools, and included child-based cognitive-behavioral techniques to manage somatic, cognitive, and behavioral anxiety responses as well as parent-based psychoeducation, contingency management procedures, and strategies to manage parental anxiety. Youths in the prevention program progressed toward a formal anxiety disorder in only 16% of cases compared to 54% in the control group. These results did not translate well

to changes on child self-report measures, however. At two-year follow-up, Dadds and colleagues (1999) reported that formal anxiety disorder was present in 20% of the intervention group and 39% of the control group. The authors concluded that a brief intervention for youths with mild to moderate anxiety symptoms can be effective for preventing more debilitating future problems.

Prevention efforts such as this one have largely focused on children with a wide variety of anxiety symptoms and not youths with specific features of one disorder per se. Some have successfully targeted very young children with *anxious-withdrawn* behavior using parent-based strategies (e.g., LaFreniere & Capuano, 1997), but future work will need to target youths with features of social phobia. Such work will likely parallel the general cognitive-behavioral child- and parent-based procedures described in this book and elsewhere. Several authors have outlined other areas of future preventative work as well, including the need to examine (1) universal prevention strategies (as opposed to secondary, at-risk approaches), (2) children of various ages and developmental levels, (3) multivaried sources of information, (4) techniques that are tailored to individual child characteristics, (5) cost-effectiveness, (6) utility and funding of prevention versus intervention, (7) various prevention targets (e.g., anxiety versus many behavior problems), and (8) appropriate assessment devices to identify youths most in need of prevention programs (Barrett & Turner, 2004; Donovan & Spence, 2000; Ferdinand, Barrett, & Dadds, 2004; Spence, 2001).

RELAPSE PREVENTION OF CHILDHOOD ANXIETY DISORDERS AND SOCIAL PHOBIA

Although much work remains with respect to *general* prevention of anxiety in children, more attention has been paid to *relapse* prevention for individual cases. Relapse prevention in this context refers to techniques designed to help youths and parents maintain the skills they have learned in therapy to appropriately address future anxiety-provoking situations and to prevent regression to a poor level of functioning. Again, work in this area has generally targeted youths with anxiety disorders in general and less so youths with social phobia per se. As with general prevention, however, parallels between these two populations can be drawn for relapse prevention.

Relapse prevention efforts generally occur late in the therapy process as a child and family members approach their final treatment goals. However, children and parents should be relatively proficient at whatever skills

were emphasized during treatment prior to detailed discussions of relapse prevention and termination. For example, the child should be functioning at a high level that involves managing anxiety effectively, demonstrating good social skills, and entering and remaining in many difficult social and evaluative situations. As mentioned in Chapter 9, however, relapse prevention efforts can overlap in some cases with later exposures from a child's anxiety/avoidance hierarchy. Pertinent relapse prevention techniques for youths with social phobia include:

- Addressing slips and relapse
- Presenting hypothetical scenarios of future problematic situations
- Issuing formal reminders of skills to manage anxiety
- Developing structured routines and activities
- Monitoring social anxiety regularly
- Providing booster sessions

Addressing Slips and Relapse

Slips refer to small problems that may spawn minor regression from final treatment status and limited interference in daily functioning (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). *Relapse*, however, refers to substantial regression from final treatment status and severe interference in daily functioning (Kearney, 2001). For youths with social phobia, slips can involve spiked anxiety during one or more social or evaluative situations, overwhelming physical symptoms or irrational cognitions that instigate minor avoidance or escape, temporary refusal to attend school, mild depression, moderate disruptive behaviors to test parental resolve, or transient distance from friends. Given the frequent ebbs and flows of emotions and events in childhood and adolescence, slips are expected and common. As slips become more frequent and intense, however, the risk of formal relapse becomes greater. Family members should be educated about the difference between slips and relapse prior to termination.

The most important way for youths and parents to address slips is to redouble their efforts to practice the therapy skills they learned to manage anxiety and maintain progress. Periodic contact with the therapist for several months after the end of treatment is often helpful in this regard. In addition, reframing may be beneficial. Instead of focusing on the child's new deficits, for example, a therapist can remind family members that some social anxiety is normal and can help them understand that new challenges offer everyone the chance to "brush up" on key aspects of treatment. These key aspects will likely include somatic control exercises, cognitive therapy

techniques, further practice of social and assertiveness skills, and more thorough entry into various social and evaluative situations. Should relapse occur, however, then resuming formal treatment may be the best option.

Presenting Hypothetical Scenarios of Future Problematic Situations

Near the end of treatment, a therapist can also introduce hypothetical anxiety-provoking scenarios to see whether youths and/or family members develop appropriate plans to manage anxiety and deter avoidance (see also Chapter 9). These scenarios could involve transitions or special events that will certainly occur in the near future (e.g., new school year, final examinations), but they could also involve new situations that may or may not occur soon (e.g., asking someone on a date). As with imaginal exposure, the therapist can describe a particular situation, ask the child and/or family members to visualize the scene, and solicit general and specific ideas about how everyone would address that situation. Of course, family members would hopefully give detailed answers that are heavily based on the skills they learned in therapy. If someone struggles with the scenario, however, then further practice of skills may be necessary prior to termination.

Issuing Formal Reminders of Skills to Manage Anxiety

Researchers have also designed more formal methods for helping youths remember skills to manage anxiety. Kendall and colleagues (1992), for example, discussed the concept of videotaping a child who has completed treatment and who describes his or her success and methods for managing anxiety and resisting avoidance. In doing so, the child may concentrate on treatment components that were most helpful to him or her. The child can also use the videotape in the future as a formal reminder of what needs to be done in anxiety-provoking situations.

Other methods in this regard involve photographing youths during successful exposures and placing the pictures in an album. This serves as a reminder of what the child has accomplished and increases perceived self-efficacy. In addition, instructions for managing anxiety and avoidance can be written and placed in an obvious spot in the house (e.g., refrigerator door), or reminders can be placed on index cards that the child carries surreptitiously. Of course, the index cards per se must not serve as safety signals to help a child cope with anxiety-provoking situations.

Developing Structured Routines and Activities

Relapse prevention is generally enhanced for this population when a child is on a fairly regular (though not rigid) daily routine. This is especially pertinent to youths with social phobia *and* school refusal behavior. In general, youths should maintain a regular bedtime and morning routine, even on weekends and during vacation times, to reduce the stress associated with new transitions such as going back to school. These routines can also be linked to contingency management procedures so that parents continue to practice appropriate ways of addressing compliance and noncompliance.

Another good method for preventing slips and relapse in this population is to have a child practice social and anxiety management skills in day-to-day situations and during extracurricular activities. Parents may, for example, ask a child to regularly answer the telephone or door, order food in a restaurant, or approach peers at a mall for information. In addition, the child could enroll in various activities that are fun and that require interaction or cooperation with, or performance before, peers and others. In this way, therapy-based skills and exposures are continually practiced, natural social reinforcement from others is received, and friendships will hopefully be developed.

Monitoring Social Anxiety Regularly

For effective relapse prevention, key behaviors should continue to be monitored daily. For youths with social phobia, this may involve general ratings of social anxiety, time missed from school, and severity of somatic complaints, among others. Daily or weekly behavior reports from teachers, as well as observations from relevant others about attempted avoidance or escape, would also be helpful. In this way, spikes in anxiety or other difficulties can be addressed before they create greater problems. Any sudden changes in behavior or attitude may be noteworthy as well.

Providing Booster Sessions

Relapse prevention may be enhanced as well by a therapist's provision of booster sessions during particularly stressful times for a child. Booster sessions allow a therapist to review and enhance key skills learned in treatment and allow a child to articulate his or her current concerns in a comfortable setting. Booster sessions may be conducted individually or with others and can be either very focused on a child's specific concerns at that point or broader in nature to include a more general review of social and anxiety management skills. Booster sessions can be linked to

specific stressors that a child is facing (e.g., entry into a new school, SAT) and can even be combined with upcoming, inadvertent exposures (e.g., tour of a new school, practice test). These sessions are particularly useful for reducing anticipatory anxiety, improving perceived self-efficacy, and short-circuiting regression to old patterns of avoidance and escape.

DIFFICULT CASES

Although the procedures described in this book largely pertain to prototypical examples of childhood social phobia, many cases of social and performance anxiety are difficult, severe ones that involve extensive comorbidity, intense symptomatology, treatment noncompliance, and/or desires for early termination. These areas of concern are discussed in turn.

Extensive Comorbidity

Common comorbidities were covered in Chapter 2, but therapists treating youths with social phobia should be especially watchful of concurrent school refusal behavior, depression and suicidality, and substance abuse. In these cases, many of the treatment techniques described in this book can be tailored to some extent to simultaneously address social/performance anxiety *and* these comorbid problems.

With respect to school refusal behavior, for example, anxiety about school attendance can be managed using the techniques described previously, and reentry into school can be done on a gradual basis in conjunction with an anxiety/avoidance hierarchy. The urgency of ameliorating school refusal behavior, however, often demands a fast therapy pace. Therefore, therapists are urged to consult with school officials about school-based areas (e.g., library, main office) that a child can attend without necessarily having to confront extremely stressful stimuli (e.g., classroom). If a child with social phobia and school refusal behavior displays considerable attention-seeking behavior, then parent-based contingency management procedures may be emphasized. If a child is refusing school for tangible rewards outside of school, then family-based procedures (e.g., contracts) to increase incentives for school attendance may be helpful. More detailed procedures for addressing school refusal behavior are available elsewhere (Kearney, 2001; Kearney & Albano, 2000).

With respect to comorbid depression and suicidality, therapists may need to concentrate on cognitive therapies and behavioral activation within the context of general social phobia treatment. Addressing safety and crisis issues must, of course, supercede other treatment procedures, and

therapists may have to adopt a very slow approach in these cases. With respect to substance abuse, therapists may need to increase parental monitoring and supervision, mandate regular drug testing as necessary and appropriate, identify triggers to substance abuse, and develop a child's strategies to better cope with stressors and negative emotions. Such treatment can also address a youth's desire to medicate his or her anxiety symptoms (see Chapter 2).

Intense Symptomatology

Intense symptomatology can also deter treatment progress for youths with social phobia. Examples include very severe or unusual somatic complaints, rigid cognitions or obsessions or delusions, and more overt behaviors that lead to intransigent avoidance. In these cases, therapists are encouraged to make referrals to a pediatrician and psychiatrist to rule out or address organic problems and to consider the use of medication to lower excess levels of arousal. In addition, a very slow psychosocial therapy approach may be needed, which may involve widely spaced exposures over a long period of time. Coordination with school officials is typically necessary in these cases, and changes to a child's educational plan to accommodate these slow therapeutic steps may need to be pursued. Other reasons for a child's extreme symptomatology, such as recent traumatic experiences and/or maltreatment, should be identified and addressed as well.

Treatment Noncompliance

Noncompliance is a common threat to psychotherapy effectiveness in general, but is quite damaging to the treatment of childhood social phobia in particular. For example, failure to practice therapy-based procedures between sessions will likely result in poor social and anxiety management skill development, limited generalization of treatment effects, and high risk of future relapse. Sporadic therapy attendance will likely produce uneven treatment effects, laziness, and backsliding as well. Even less severe noncompliance, such as failure to maintain daily logbook information, can indicate a lack of motivation and commitment to the therapy process.

To address noncompliance in this population, its reasons should be clearly understood and addressed as early as possible. Noncompliance may result from fixable problems such as confusion about daily measures or treatment rationales, overly difficult therapeutic homework assignments, resistance from school officials regarding a certain therapy step, lack of sufficient rapport with the therapist, and inconvenient scheduling of

sessions. However, noncompliance may also result from intractable problems such as serious lack of motivation regarding treatment, refusal of key family members to participate in treatment, family exigencies that mandate long breaks from therapy, and deliberate treatment sabotage. In these circumstances, family members may not be adequately prepared for treatment, which may have to be delayed. In other cases, severe behavioral problems must be addressed prior to social phobia symptoms.

Desire for Early Termination

Another key problem when treating youths with social phobia is premature therapy termination once major crises have passed. Family members, for example, may press for treatment termination (or simply stop coming) when a child has returned to school full-time, completed all makeup work, experienced temporary anxiety reduction, or joined a social group. Unfortunately, the child may not yet have fully grasped the skills needed to manage social and performance anxiety, or may not have fully progressed along his or her anxiety/avoidance hierarchy. In these cases, an extensive discussion with family members should be held to inform them of the risks of premature therapy withdrawal. In doing so, an analogy may be drawn to the use of antibiotic treatment for a bacterial infection: although outward symptoms may disappear, underlying problems likely remain and may worsen if treatment (antibiotic or psychosocial) ends before it should. If family members continue to insist on termination, however, then periodic follow-up contact may be pursued as appropriate.

FUTURE DIRECTIONS

Much has been accomplished with respect to understanding, assessing, and treating childhood anxiety disorders in general and social phobia in particular, but much more work remains. With respect to childhood anxiety disorders in general, key areas of future work include a clearer understanding of normal and abnormal anxiety, developmental factors that influence diagnoses/clinical symptom presentation and assessment and treatment, long-term treatment and developmental outcomes, maintaining factors, parent roles for treating anxious children and adolescents, variables that influence effective therapist-child relationships, medications and their treatment utility, new and positive psychosocial treatment components, individual treatment component effectiveness, and outcome evaluations based on normative data (Kashdin & Herbert, 2001; Kendall & Ollendick, 2004).

These key areas of future work for childhood anxiety disorders apply, of course, to childhood social phobia research as well. Beidel, Morris, and Turner (2004), however, articulated several *additional* directions for future work regarding childhood social phobia per se. One important research direction involves examining daily social experiences of youths with social phobia to obtain a detailed functional analysis of their anxiety. This would include data from children with social phobia and their parents, peers, and clinicians from multiple settings, both natural and in-session. A second important research direction involves family-based methods of transferring anxiety from parents and other family members to children. A third important research direction involves transferring known, effective treatments such as in vivo exposure from specialized urban clinics to more widespread familial, academic, community, and rural venues.

FINAL COMMENTS

Knowledge regarding the conceptualization, diagnosis, assessment, and treatment of youths with social anxiety and social phobia has advanced in leaps and bounds in recent years, though much work remains. This book, while a thorough summary of research conducted so far, presents work that is simply a prelude of the much more sophisticated models and techniques to come. As such, professionals are encouraged to aggressively maintain their knowledge base in this area. In this regard, I invite future comments from readers regarding this book or this population.