Chapter 6

THE TREATMENT OF SOCIAL ANXIETY AND SOCIAL PHOBIA IN YOUTHS

Previous chapters have covered the major characteristics and assessment strategies for youths with social anxiety and social phobia. In this chapter, a *brief* introduction is made regarding the major psychosocial and pharmacological treatments that have been designed to ameliorate these problems. In addition, empirical evidence is discussed for these treatments. A greater explication of these procedures for clinical settings is made in the remaining chapters of this book. Many of the procedures described here can also apply to youths who are shy, inhibited, or otherwise socially withdrawn. However, the focus of this and remaining chapters will be on youths with social anxiety and social phobia.

PSYCHOSOCIAL TREATMENT PROCEDURES FOR YOUTHS WITH SOCIAL ANXIETY AND SOCIAL PHOBIA

Psychosocial treatments for youths with social anxiety and social phobia involve child-, parent-, and family-based and other procedures. Each of these is discussed in turn.

Child-Based Treatment Procedures

Child-based psychosocial techniques for this population are generally cognitive-behavioral in nature, and include psychoeducation,

self-monitoring, somatic control exercises, cognitive therapy, social skills and assertiveness training, and exposure-based practices. Each of these is briefly discussed in turn.

Psychoeducation

A common treatment technique for youths with social phobia is *psychoeducation*. Psychoeducation in this context partially refers to informing a child and often his or her family members about the nature of anxiety and its main response components: physiological, cognitive, and behavioral. Furthermore, children and family members are educated about how anxiety is triggered and maintained (Birmaher & Ollendick, 2004). In doing so, specific examples from a child's own experience can be used. In addition, the sequence of anxiety-based response components particular to that child can be illustrated to show how anxiety builds over time.

Psychoeducation is often helpful when conveying treatment rationales to family members, and so is usually conducted early in treatment (March & Ollendick, 2004). Specifically, different treatment techniques can be discussed that are most pertinent to the primary anxiety-based response components for a particular child. Supportive psychotherapy is also intertwined with psychoeducation in many treatment approaches for anxious children (Last, Hansen, & Franco, 1998; Silverman et al., 1999b).

Self-Monitoring

In conjunction with psychoeducation, *self-monitoring* is often used to further identify and understand aversive physiological symptoms, irrational thoughts, and avoidant behaviors associated with social phobia (Ginsburg & Walkup, 2004). Self-monitoring may take the form of diaries or logbooks (see Chapters 4 and 5), and can focus on specific episodes of fear or anxiety that a child experiences during a certain time. Self-monitoring helps a clinician and child recognize important antecedents and consequences to these episodes as well as anxiety sequences that are specific to different situations. In addition, self-monitoring is an excellent and sensitive method for gauging treatment progress.

Somatic Control Exercises

To help control aversive physiological symptoms of anxiety, *somatic control exercises* may be used. Two common forms of such exercises are relaxation training and breathing retraining. *Relaxation training* can

involve many methods, including meditation, guided imagery, distraction, hypnosis, biofeedback, and even pharmacological intervention. One popular and portable relaxation training procedure, though, involves tensing and releasing different muscle groups. Examples include the hands, shoulders, face, jaw, stomach, and leg areas (Ollendick & Cerny, 1981). In this procedure, a child works with a therapist to practice tensing and releasing these areas and to comprehend the difference between a tense muscle and a relaxed one. Home-based practice of such relaxation is encouraged in addition to its regular use in anxiety-provoking situations.

In addition, *breathing retraining* is useful when a child is not inhaling appropriately during anxiety-provoking situations or is hyperventilating. The technique may require a child to practice inhaling slowly through his or her nose and exhaling slowly through his or her mouth. In younger children, counting or imagery may be used to enhance the technique (Eisen & Kearney, 1995). As with relaxation training, breathing retraining is simple, portable, and popular among children with anxiety disorders. Somatic control exercises are almost always integrated with other treatment techniques and are predominantly useful when a child's anxiety involves a strong physiological component.

Cognitive Therapy

To control irrational thoughts that help maintain anxiety, *cognitive therapy* or restructuring may be used. This process often involves key steps such as educating a youth about various types of cognitive distortions, identifying and classifying irrational thoughts during anxiety-provoking situations, evaluating these thoughts via reflection and questioning, appraising events more realistically, and modifying irrational thoughts in an adaptive fashion. Specific techniques to do so include psychoeducation, examining evidence for and against specific thoughts, decatastrophizing, cognitive self-control, decentering, reattribution training, reframing/relabeling, behavioral experiments, self-instructional training, and cognitive rehearsal (Bond & Dryden, 2002; Friedberg & McClure, 2002; Reinecke, Dattilio, & Freeman, 2003).

Cognitive therapy is often embedded with other techniques such as social skills training and exposure-based practices. The therapy is indicated most when a youth has adequate verbal/intellectual abilities to absorb pertinent information, where cognitions are especially problematic in anxiety-provoking situations, and where compliance is good with respect to self-monitoring of thoughts and practice during exposures. However, the utility of cognitive therapy for youths with social phobia has been questioned by some researchers (see Chapter 3), and the general technique

is not a central element of *all* treatment protocols for this population (see below). In general, cognitive techniques should be used cautiously, with care, and perhaps more so with adolescents than children.

Social Skills and Assertiveness Training

Another commonly used treatment technique for youths with social anxiety and social phobia is *social skills training*. This involves instructing youths about their skill deficiencies in various social and/or evaluative situations and training them to perform more adaptive behaviors (Blonk, Prins, Sergeant, Ringrose, & Brinkman, 1996; LaGreca & Santogrossi, 1980). Many social skills can be targeted in this regard, but key ones include making introductions, initiating and maintaining conversations, practicing appropriate social problem-solving methods, coping adaptively with anxiety-provoking events, engaging in oral/written presentations and other performances before others, expressing affection appropriately, and cooperating effectively with others. In addition, assertiveness to acquire information (e.g., directions, homework assignments) or stop unwanted behaviors from others (e.g., excessive requests, inappropriate touching) is a key social behavior and often enhanced via *assertiveness training* (Emmelkamp & Scholing, 1997).

Social skills and assertiveness training methods typically include modeling and role play procedures involving presentation of or interaction with a peer model, rehearsal of key social behaviors, feedback to enhance social and performance skills, and practice in real-life situations (Cartledge & Milburn, 1995). Other methods include developing and implementing alternative solutions to social problems (Christoff et al., 1985). Social skills training methods are often incorporated into exposure-based practices (King, Murphy, & Heyne, 1997). Social skills training may be less necessary in cases where a child has excellent social skills but simply fails to perform these skills at acceptable levels (Gresham & Evans, 1987). In many cases of childhood social phobia, however, social skills and assertiveness training are essential treatment components because the child's anxiety has impeded the development of these skills (see Chapter 2).

Exposure-Based Practices

To help control avoidant and other problematic behaviors related to anxiety, *exposure-based practices* may, and in most cases should, be used. Indeed, exposure is often considered to be the key ingredient of treatment for social anxiety and phobia (Albano, Detweiler, & Logsdon-Conradsen, 1999). Successful exposure treatment is likely based on habituation,

beneficial emotional processing of anxious events, and a heightened sense of perceived self-efficacy in anxiety-provoking situations (see Chapter 9).

As mentioned earlier, exposure-based practices are often used in conjunction with somatic control exercises, cognitive therapy, and social skills training. The general goal of this treatment approach is to have a child practice somatic/cognitive anxiety management and social skills and experience lessened anxiety in different social and evaluative situations. In essence, the child should come to understand that avoidance, a maladaptive response, can be replaced with anxiety management/social skills and expositions that are more adaptive and more socially acceptable responses to anxiety.

Exposure-based practices typically begin with psychoeducation and the development of an *anxiety/avoidance hierarchy*, or a list of situations that range from least to most anxiety-provoking (Silverman & Kurtines, 1996). In cases of social phobia, these situations would naturally involve those that are social and/or evaluative in nature. Hierarchy items may be derived by examining stimuli that are most upsetting to youths with social phobia (see Chapter 2). Specific examples of hierarchy items for a particular child may be derived from formal assessment information. Each stimulus hierarchy item is rated (e.g., on a 0-10 scale) for level of fear or anxiety as well as degree of avoidance.

Exposure may begin on an *imaginal basis*, in which children are exposed to different scenes that may be verbally described by a therapist. These scenes may involve outcomes that a child fears most in social and evaluative situations, and should serve as a precursor to later in vivo exposures (Kearney & Albano, 2000). *In vivo exposures*, or real-life exposures, are also based on a child's stimulus hierarchy and involve practicing adaptive behaviors in actual, feared social and evaluative situations (e.g., Beidel, Turner, & Morris, 2000b). Initially this process may be more controlled and assisted by others in-session, but can later involve more independent practice in a child's natural environment. Finally, *interoceptive exposure* involves exposure to internal physical sensations that one may fear in social and evaluative situations (Craske, Barlow, & Meadows, 2000). This may be particularly useful for youths with clear panic attacks in these situations.

Exposures may be *contrived* in nature, meaning that contact with a feared stimulus is actively sought, or *non-contrived* in nature, meaning that contact with a feared stimulus is unavoidable (March & Albano, 2002). In addition, Albano and Barlow (1996) discussed the concept of *double exposures* in which youths with social phobia participate in exposures designed for other youths with social phobia. In fact, exposure-based practices are often conducted in a group format to do so, and even individual therapy for a youth with social phobia will likely require interaction with peers.

Exposure-based practices also involve extensive *generalization training* in which a child practices newly learned skills in situations that are ancillary to the primary targets of treatment (e.g., Beidel, Turner, & Morris, 2000b). For example, a child could apply skills learned in therapy to subclinical or even developmentally appropriate fears or apply them to upcoming stressful situations. Generalization training may be used in conjunction with *relapse prevention*, which involves identifying future stressors or challenges that may trigger anxiety and developing specific interventions to address them (see Chapter 10). Imaginal exposure to these future-based situations with somatic control exercises and cognitive therapy is often useful in this regard. Generalization training may also be used in conjunction with *response prevention*, or ongoing practice of nonavoidant strategies and/or control of compulsive rituals when encountering stressful stimuli (March & Albano, 2002).

Parent-Based Contingency Management Procedures

Parent-based treatment regarding youths with social anxiety and social phobia generally involves contingency management procedures, or structuring consistent parental consequences for appropriate and inappropriate child behavior (Briesmeister & Schaefer, 1998). For youths with social anxiety or social phobia, contingency management and child-based treatment procedures are often integrated. Therefore, parental consequences may apply most to child behaviors such as compliance to therapeutic homework assignments (including exposures), attendance at school and social events, and daily social interactions and performances before others, among others (Kearney & Albano, 2000).

Contingency management may also involve other parent-based procedures such as providing disincentives or extinguishing inappropriate behavior, improving commands, and establishing daily routines to foster appropriate skills. In addition, the use of token economies with response cost as well as shaping and guiding appropriate behavior is common. Parental consistency in using these procedures is also emphasized.

Family-Based and Other Treatment Procedures

Family-based procedures are also relevant for treating youths with social anxiety and social phobia. *Contingency contracting*, for example, involves the development of written agreements between youths and parents to provide incentives for appropriate behavior and disincentives for inappropriate behavior (e.g., Cretekos, 1977; Vaal, 1973). In addition, the technique is very useful for developing negotiation and problem-solving

strategies among family members (Kearney, 2001). Contracts may pertain to concurrent problems to social phobia such as school refusal behavior, but typically surround compliance to exposure-based and other therapeutic procedures (Silverman et al., 1999b). Contingency contracting may also conjoin other family therapy techniques such as reframing or communication and formal problem-solving skills training.

Other treatment procedures for socially anxious youth may focus on school-based techniques. Teachers and other school officials, for example, can help implement many of the procedures described here, including self-monitoring, reinforcement of proactive social behavior, token economies, and exposures. In addition, classroom environments can be altered to reduce peer-based threats or teasing, unnecessary stressors, excessive teacher-based reprimands, and child-based behavior problems such as absenteeism (Albano & Hayward, 2004). At a minimum, school officials should be consulted to derive information pertinent for treatment (see Chapter 5) and to help remove any obstacles to treatment success. The development of strong parent-school official relationships and the provision of booster sessions within school settings may also be crucial for relapse prevention.

GENERAL ANXIETY TREATMENT OUTCOME STUDIES

Several researchers have treated youths with various anxiety disorders, including youths with social phobia, using the procedures described here. Three excellent sets of examples are briefly presented next. First, Kendall (1994) utilized psychosocial treatment for 47 youths aged 9–13 years with various anxiety disorders. The treatment protocol (Coping Cat Workbook) involved helping youths recognize physical and cognitive anxiety symptoms, modify irrational cognitions and develop coping plans during anxiety-provoking situations, engage in self-evaluation of performance and self-reinforcement, complete therapeutic homework assignments, and undergo behavioral techniques such as modeling, role play, relaxation training, in vivo exposure, and contingent reinforcement.

Results from 16-session treatment indicated significant improvement on various dependent measures of anxiety and related constructs. In addition, 64% of treated youths no longer met criteria for an anxiety disorder at posttreatment. Subsequent studies have also supported the strength of this approach and its modifications (Flannery-Schroeder & Kendall, 2000; Kendall et al., 1997; Kendall & Southam-Gerow, 1996; Mendlowitz et al., 1999). Poorer treatment outcome seems best predicted by higher

pre-treatment levels of child internalizing symptoms, maternal depression, and older child age (Southam-Gerow, Kendall, & Weersing, 2001).

Second, Barrett, Dadds, and Rapee (1996) compared cognitive-behavioral treatment (CBT), CBT with family-based treatment, and no treatment for youths aged 7–14 years with various anxiety disorders, including social phobia. Child-based treatment was similar to Kendall's approach (Coping Koala Workbook). Family-based treatment consisted of parent training to reinforce approach behaviors and extinguish anxiety-based behaviors, to address parent-based anxiety responses and model appropriate responses to anxiety, and to improve family communication and problem-solving skills. Results from 12-sesssion treatment indicated that both groups improved significantly on various dependent measures compared to controls. In addition, family-based treatment substantially enhanced the effects of CBT alone. For example, elimination of anxiety diagnoses at posttreatment was 57% for the CBT group and 84% for the CBT plus family treatment approach. Subsequent studies have generally supported these treatment approaches as well (Barrett, Duffy, Dadds, & Rapee, 2001; Cobham et al., 1998; Dadds et al., 1999; Dadds, Spence, Holland, Barrett, & Laurens, 1997).

Finally, Silverman and colleagues (1999a, 1999b) conducted two treatment outcome studies of youths aged 6-16 years with various anxiety disorders, including social phobia. The first study consisted of group CBT with parent-based contingency management procedures (GCBT), and the second study consisted of 10-session exposure-based cognitive self-control (SC) procedures versus exposure-based contingency management (CM). All treatments except CM were substantially more effective than control conditions. Elimination of anxiety diagnoses at posttreatment was 64% for GCBT, 88% for SC, and 56% for CM. Poorer treatment outcome seems best predicted by levels of child depression and trait anxiety and by parental depression, hostility, and paranoia (Berman, Weems, Silverman, & Kurtines, 2000).

A consensus has thus formed that child-based and parent/family-based cognitive-behavioral procedures are effective for treating youths with anxiety disorders, and may even inform prevention efforts (e.g., Albano & Kendall, 2002; Barrett, 2000; Essau & Petermann, 2001; Hudson, Kendall, Coles, Robin, & Webb, 2002; Nauta, Scholing, Emmelkamp, & Minderaa, 2003; Ollendick & March, 2004; Silverman & Treffers, 2001; Toren et al., 2000). Practice parameters for treating this population also concentrate heavily on education, exposure-based procedures, family interventions, and pharmacotherapy (American Academy of Child and Adolescent Psychiatry, 1997). Applying these procedures to youths with specific anxiety disorders such as social phobia has thus begun in earnest.

TREATMENT OUTCOME STUDIES FOR YOUTHS WITH SOCIAL PHOBIA

Several treatment outcome studies have been conducted specifically for youths with social phobia. Albano and colleagues (1995), for example, evaluated a 16-session group treatment protocol for five adolescents with social phobia. Uncontrolled treatment consisted of psychoeducation about the nature of social anxiety, rationale for treatment, skills building with modeling, role play, and shaping (i.e., social and problem-solving skills, assertiveness training, and cognitive therapy), and in-session and external in vivo exposures to feared social situations. Parents also received psychoeducation and treatment rationales and were prepared for exposure-based sessions. At three-month follow-up, 4 of 5 participants no longer met formal diagnostic criteria for social phobia.

This cognitive-behavioral group treatment approach has been expanded and refined with time (Albano, 1995; Albano & Barlow, 1996; Albano et al., 1999). The primary structure of this treatment consists of two, 8-session phases, the first of which includes psychoeducation, skills building, and snack time practice. The latter component involves eating-based exposures with therapist self-disclosure of socially embarrassing moments, guided imagery, relaxation training, modeling appropriate coping and problem-solving skills, social interactions, and shaping and feedback. The second treatment phase concentrates heavily on within-session contrived and more community-based exposures to feared social and performance situations as well as relapse prevention strategies. Parents are also involved intermittently to understand treatment and to prepare for exposure-based practices. An outline of this protocol is presented in Table 6.1.

Hayward and colleagues (2000) examined this protocol versus no treatment in female youths (mean age, 15.8 years) with social phobia. At posttreatment, treated youths showed statistically significant though moderate improvement in social phobia symptoms compared to controls. In addition, 55% of the treatment group still met criteria for social phobia at posttreatment compared to 96% of the control group. These figures improved to 40% and 56%, respectively, at one-year follow-up. Differences between the two groups were even more exaggerated when comorbid depression was considered.

Albano and Hayward (2004) issued several treatment recommendations for youths with social phobia with varying symptom severity levels. For youths with mild symptoms of social anxiety that cause little functional disturbance, psychoeducation and 6-month follow-up may be most appropriate. For youths with moderate symptoms of social anxiety that

TABLE 6.1. Session Content for CBGT-A

Session 1	(Parents attend) Ground rules for group Situations causing social anxiety Cognitive-behavioral model of social anxiety Snack time: Therapists share information Overview of treatment program and rationale Monitoring Homework: Monitoring and setting treatment goals
Session 2	(Parents attend) Review self-monitoring Three-component model of anxiety Dissecting social anxiety into three components: Use a common situation Snack time: Therapist's embarrassing moment Expectations for treatment Becoming detectives: Studying the three components Homework: Monitoring and life goals
Session 3	Review of self-monitoring, goals, and model of anxiety Labeling distortions: Introduction to automatic thoughts (ATs) Therapists' role play of ATs Snack time: Guided imagery to the moon Rational responses: Countering ATs Review of session Homework
Session 4	Review of homework Four steps to cognitive restructuring Therapists' role play of cognitive restructuring Snack time: Therapist deals with a problem Steps to problem solving Review Homework
Session 5	Review of homework Therapists model social skills versus "unskilled" Social skills training I: Identifying and improving upon weaknesses Snack time practice: Shaping oral reading skills Social skills training II: Assertiveness Review of session and homework assignment: Preparing a paragraph for next week's snack time
Session 6	Review of homework Social skills training III: Review of skill building steps and focus on perspective taking Group role play: Conversing in the cafeteria Snack time: Reading aloud prepared paragraphs Social skills training IV: More assertiveness Review and homework

(*Continued*)

TABLE 6.1. (*Continued*)

Session 7	Overview and review of skills covered to date: cognitive restructuring, problem solving, social skills Treatment rationale: Simulated exposures Evaluating expectations: "How much better should I be now?" Snack time: Group interaction exercise What to do with your parents: How to access support and be understood Homework
Session 8	(Parents attend) Review of homework Review of expectations: "What should have changed by now?" Treatment rationale: Simulated and between-session exposures Snack time: Informal socializing Role play: Perspective taking—parents and teens switch roles Enlisting support: The coaching team Homework
Sessions 9–14	Review of homework Simulated exposure #1 Snack time: Mini exposures to situations such as taking compliments, giving critical feedback to a friend, etc. Simulated exposure #2 Homework: individual hierarchy items are assigned for between-session exposure
Session 15 or 19	(Parents attend: Next to last session) Review of monitoring and exposure homework Exposures: Each group member is targeted in an exposure that all parents observe Snack time: Informal socializing Expectations and future plans: Relapse prevention; homework
Sessions 16–20	Review of self-monitoring and exposure homework Final exposures and relapse prevention Snack time: Pizza party Processing of termination and relapse prevention

Note. CBGT-A, Cognitive Behavioral Group Treatment for Adolescent Social Phobia. (Used with permission).

do cause some functional disturbance, child-based cognitive-behavioral treatment methods may be most appropriate. For youths with severe symptoms of social anxiety and substantial functional disturbance, child-based cognitive-behavioral therapy, medication, and possible adjunctive treatments (e.g., parent-based procedures) may be most appropriate. Finally, for youths with extreme symptoms of social anxiety and highly severe functional disturbance, child-based cognitive-behavioral therapy, medication, and adjunctive treatments for sessions over a lengthy time period may be most appropriate.

Others have also investigated variations of CBT for socially anxious youths. For example, Spence and colleagues (2000) examined youths aged 7–14 years with social phobia and assigned them to 12-session (and two booster session) child-based cognitive-behavioral treatment (CBT), CBT with parental involvement, or wait-list control. CBT consisted primarily of relaxation training, social skills training, social problem solving skills training, cognitive therapy (i.e., positive self-instruction and cognitive challenging), gradual exposure to various social situations, and therapeutic homework assignments. Treatment was modified for younger children by deemphasizing cognitive components.

Parental involvement included modeling, prompting, and reinforcing child skills practice and homework assignments, modeling appropriate social behaviors for children, and not reinforcing anxiety-related behaviors in children. At posttreatment, 87.5% of the CBT group no longer met criteria for a clinical diagnosis, compared to 58.0% and 7.0% for the parental involvement and control groups, respectively. At 12-month follow-up, these figures were 81.0% and 53.0% for the two treatment groups, respectively. The authors concluded that both treatments were effective, particularly the use of social skills training. However, including parents may have diluted or impeded treatment outcome in some cases.

Another variation of CBT was investigated by Gallagher and colleagues (2004), who evaluated a brief, controlled, 3-week cognitive-behavioral group intervention in 12 youths aged 8–11 years with social phobia. Three, 3-hour treatment sessions consisted of psychoeducation, cognitive therapy, and in-session and external exposure-based practices. Furthermore, parents were informed of their children's homework assignments but no formal parent-based treatment was used. At posttreatment, 41.7% of children and 58.3% of parents in the treatment group still endorsed social phobia diagnoses, compared to 81.8% and 100.0%, respectively, for controls. Further improvement in the treatment group was noted at 3-week follow-up (16.7% and 50.0%, respectively). Findings regarding other dependent measures were more mixed. The authors concluded that short-term CBT group treatment for this population is effective but also that longer-term treatment may be necessary for more complete benefits.

Others have modified CBT procedures for school-based settings. Masia and colleagues (2001), for example, tested the Skills for Academic and Social Success, a 14-session, group-oriented treatment that focuses on education, realistic thinking, social skills training, exposure-based practices, and relapse prevention. Six adolescents received treatment at their school. At posttreatment, three participants no longer met criteria for social phobia and, overall, social phobia symptoms were significantly reduced. An advantage of this approach is that treatment was applied at school where

impairment is often greatest, though several obstacles from school officials were also noted.

Finally, others have evaluated a more behavioral approach to treating youths with social phobia. Beidel, Turner, and Morris (2000) treated youths (mean age, 10.5 years) with social phobia via their Social Effectiveness Therapy for Children (SET-C). SET-C components include child and parent education, social skills training via modeling and role play, peer generalization experiences, in vivo behavioral exposures, and therapeutic homework assignments. Treatment was provided twice per week, once per week in group format and once per week individually. Control participants received study and test-taking skills training for the same length of time.

At posttreatment, the SET-C group showed more significant improvement than controls with respect to general and social anxiety, social skill and performance, and daily functioning in social encounters. In addition, two-thirds of the SET-C group no longer met criteria for social phobia compared to only 5% of the control group, and improvement largely continued to 6-month and 3-year follow-up (D.C. Beidel, personal communication, March 18, 2004). This study was one of the first to show that the use of strictly behavioral (and not cognitive) procedures was effective for treating youths with social phobia.

COMPARISON OF PSYCHOSOCIAL TREATMENTS

Three major psychosocial treatments for childhood social phobia were compared by the main authors of these protocols (Garcia-Lopez, Olivares, Turner, et al., 2002; Olivares, Garcia-Lopez et al., 2002) (see also Olivares & Garcia-Lopez, 2002; Olivares-Rodriguez et al., 2003; Rodriguez & Garcia-Lopez, 2001; Rodriguez et al., 2003). Spanish adolescents with generalized social phobia were assigned to either Social Effectiveness Therapy for Adolescents-Spanish version (SET-A_{SV}) ($n = 14$), Cognitive-Behavioral Group Therapy (for Adolescents) (CBGT-A) ($n = 15$), Intervencion en Adolescentes con Fobia Social Generalizada (IAFSG) (Therapy for Adolescents with Generalized Social Phobia) ($n = 15$), or a control group ($n = 15$). The treatment groups consisted of 29, 16, and 12 sessions, respectively. Measures were taken at pre- and post-treatment and one-year follow-up.

From pre- to post-treatment, active treatment participants were superior to controls with respect to measures of social and public speaking anxiety, lack of impairment, self-esteem, and number of feared social situations. In addition, from pre-treatment to follow-up, active treatment participants were superior to controls with respect to measures of social anxiety, lack of impairment, and social skills. From post-treatment to follow-up, active

treatment participants were superior to controls with respect to measures of social anxiety (fear of negative evaluation), social skills, and number of feared social situations. At follow-up, participants in the SET-A_{SV} and IAFSG groups tended to maintain gains or show improvement, whereas improvement for the CBGT-A group was less well maintained with respect to social and public speaking anxiety and number of feared social situations.

The researchers also examined effect sizes for the active treatments. Effect sizes per dependent measure were generally quite strong for each treatment condition (range = 0.95–2.72). The researchers also found the SET-A_{SV}, CBGT-A, and IAFSG groups, utilizing a 100% criterion, to have effectiveness rates of 35.7%, 53.3%, and 33.3%, respectively, at post-treatment and 57.1%, 26.7%, and 46.7%, respectively, at follow-up. This indicates that CBGT-A is somewhat better in the short-term than the long-term compared to other treatment methods. Using a 75% criterion, effectiveness rates for the SET-A_{SV}, CBGT-A, and IAFSG groups were 71.4%, 53.3%, and 66.7%, respectively, at post-treatment and 78.6%, 46.7%, and 73.3%, respectively, at follow-up.

The authors concluded that a cognitive component to treatment does not necessarily produce significant behavioral change over and above exposure-based practices. However, changes in anxious cognitions were noted. In addition, social skills training per se seemed less useful than integrating the technique with exposure-based sessions where participants must actively practice these skills and where a therapist can tailor an exposure to a child's unique social skill needs (Garcia-Lopez, Olivares, Turner, et al., 2002). The small sample size of the study and its heavy basis on adolescent self-report are significant limitations, however. Therefore, these conclusions are muted to some extent.

PHARMACOTHERAPY

Pharmacological treatments for youths with anxiety disorders have also been studied. However, these treatments are controversial because their efficacy is not strong and because many child-based pharmacological outcome studies are confounded by use of concurrent behavioral therapies, varying dependent measures, methodological drawbacks, and lack of control groups (Kearney & Silverman, 1998). In general, the use of selective serotonergic reuptake inhibitors (SSRIs) and the treatment of obsessive-compulsive disorder seem to show the strongest outcome effects (Albano & Hayward, 2004).

For youths with social phobia, SSRI treatment has been evaluated in conjunction with youths with other anxiety disorders, and moderate outcomes have been reported (Birmaher et al., 1994, 2003; Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001; Van Ameringen, Mancini, Farvolden, & Oakman, 1999). More specific to social phobia, however, Compton and colleagues (2001) evaluated 14 youths (mean age, 13.6 years) with the disorder in an 8-week open trial of the SSRI sertraline (Zoloft) (mean 123.2 mg/day by end of study). Participants also received brief sessions of cognitive-behavioral treatment prior to drug treatment. At posttreatment, youths were classified as responders (5), partial responders (4), or nonresponders (5). In addition, substantial reductions were evident for social and general anxiety, depression, avoidance, and parent ratings of behavior problems. The authors concluded that the drug may be an effective short-term treatment for social phobia in youths, although the study was uncontrolled and perhaps confounded by the use of cognitive-behavioral treatment. Others have also reported some success using sertraline, paroxetine, or nefazodone for individual cases of youths with social phobia (Mancini, Van Ameringen, Oakman, & Farvolden, 1999).

As mentioned earlier, practice parameters for youths with social phobia have included both psychosocial and pharmacological treatment components. However, psychosocial treatments for this population have been subjected to substantially more frequent and stringent empirical analysis than pharmacological treatments. Therefore, the use of pharmacological agents should be used with substantial caution, perhaps only as an adjunctive or short-term treatment, and/or in cases with extreme social anxiety symptoms.

FINAL COMMENTS

The treatment of social anxiety and social phobia in youths has undergone substantial analysis in recent years, though certainly much more work remains. In particular, greater attention is needed with respect to dismantling studies that examine the efficacy of individual treatment components, prescriptive treatment studies that tailor different therapies to children of different ages and with other characteristics, and outcome studies that utilize a wide range of standardized and comparable dependent measures (Beidel, Ferrell, Alfano, & Yeganeh, 2001). In addition, outcome studies that better integrate the treatment of social phobia with related therapies for shyness, inhibition, and social withdrawal would be beneficial.