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# Can parent training for parents with high levels of expressed emotion have a positive effect on their child's social anxiety improvement?

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ABSTRACT

The role that parents' involvement may play in improving their child's social anxiety is still under debate. This paper aimed to investigate whether training parents with high expressed emotion (EE) could improve outcomes for adolescent social anxiety intervention. Fifty-two socially anxious adolescents (aged 13–18 years), whose parents exhibited high levels of expressed emotion, were assigned to either (a) a school-based intervention with an added parent training component, or (b) a school-based program focused solely on intervening with the adolescent (no parental involvement). Post-treatment and 12-month follow-up findings showed that school-based intervention with parent training was superior to the adolescent-specific program, yielding significant reductions in diagnosis remission, social and depressive symptomatology, particularly when the EE status of parents changed. Overall, the findings suggest that high-EE parents of children with social anxiety need to be involved in their child's therapy.



## 1. Introduction

Social anxiety disorder (SAD) tends to be a chronic, stable condition that severely disrupts long-term functioning, if left untreated (Beesdo-Baum et al., 2012; Beidel & Turner, 1998; Garcia-Lopez, Piqueras, Diaz-Castela, & Ingles, 2008). The estimated mean lifetime prevalence in adolescents is 4.42%, ranging anywhere between 2% and 9% (Burstein et al., 2011; Demir, Karacetin, Demir, & Uysal, 2013; Essau, Conradt, & Petermann, 1999; Gren-Landell et al., 2009; Ranta, Kaltiala-Heino, Rantanen, & Marttunen, 2009; Wittchen, Stein, & Kessler, 1999). Research shows that adolescents with social phobia present substantially increased risks of depression, suicide attempts, substance abuse, severe social restrictions, early school leaving, lower educational attainment, and victimization (Beidel, Turner, & Morris, 1999; Essau, Conradt, & Petermann, 2002; Essau et al., 1999; Garcia-Lopez, Irurtia, Caballo, & Diaz-Castela, 2011; Ranta, Kaltiala-Heino, Fröjd, & Marttunen, 2013; Ranta, Kaltiala-Heino, Pelkonen, & Marttunen, 2009; Storch & Masia-Warner, 2004; Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 2000). All of these serious consequences cause lifelong suffering and economic costs to society (Fehm, Pelissolo, Furmark, & Wittchen, 2005; Wittchen et al., 2011).

In recent decades, developmentally adapted Cognitive Behavioral Therapy (CBT) interventions aimed at adolescents with social anxiety disorder have been specifically designed and tested: CBGT-A (Cognitive Behavioral Group Therapy for Adolescents; Albano, Marten, & Holt, 1991; Albano, Marten, Holt, Heimberg, & Barlow, 1995; Garcia-Lopez et al., 2002; Garcia-Lopez, Olivares, et al., 2006; Garcia-Lopez, Ruiz, et al., 2006; Hayward et al., 2000; Olivares, Garcia-Lopez, Beidel, et al., 2002); SET-Asv (Social Effectiveness Therapy for Adolescents-Spanish version; Garcia-Lopez et al., 2002; Garcia-Lopez, Olivares, et al., 2006; Garcia-Lopez, Ruiz, et al., 2006; Olivares, Garcia-Lopez, Beidel, et al., 2002); the original IAFS (Intervención en Adolescentes con Fobia Social-Treatment for Adolescents with Social Phobia; Garcia-Lopez, 2007; Garcia-Lopez et al., 2002; Garcia-Lopez, Olivares, et al., 2006; Garcia-Lopez, Ruiz, et al., 2006; Olivares & Garcia-Lopez, 2001; Olivares, Garcia-Lopez, Beidel, et al., 2002); SASS (Skills for Academic and Social Success; Fisher, Masia-Warner, & Klein, 2004; Masia et al., 1999; Masia-Warner, Klein, Storch, & Corda, 2001; Masia-Warner et al., 2005; Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007; Miller et al., 2011); the protocol entitled "To be myself among the others" (Salvador & Pinto-Gouveia, 2009); and Cognitive-Behavioral Group Therapy for Social Anxiety (Aydin, Teksinsav-Sütçu, & Sorias, 2010).

Even though CBT interventions have proved their efficacy, treatment outcome rates still range from 40% to 70%, and dropout rates are considerable (20–30%) (Garcia-Lopez & Storch, 2008). Further research on augmentative treatment approaches and/or

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ways to improve existing interventions is warranted (Kerns, Read, Klugman, & Kendall, 2013). For instance, the role that parents' involvement may play in the treatment outcome of their socially anxious children is still under debate. In particular, some data have suggested better, but not statistically significant, treatment outcomes for children with social anxiety (mean age of 10.94 years) whose parents participate in their treatment (Spence, Donovan, & Brechman-Toussaint, 2000). However, there is certainly a need for more studies on adolescents. To address this issue, some studies have examined the role that high levels of expressed emotion (EE) may play in treatment outcome, development and maintenance of social anxiety.

Parental emotional overinvolvement (EOI), criticism and hostility are part of the EE construct. Prospective studies on adolescents with social phobia provide evidence that parental rearing styles marked by high levels of EE (EOI, criticism and hostility) are associated with the development and maintenance of social anxiety in these children (Aslam, 2014). Specifically, Greco and Morris (2002) found that parents of socially anxious adolescents exhibited more controlling behaviors. In a study by Anhalt and Morris (2008), paternal criticism predicted social anxiety, and overprotection was associated with increased social anxiety. Gulley, Oppenheimer, and Hankin (2013) found parental criticism to be an especially potent predictor of social anxiety, thereby having a direct effect on the development of social anxiety in youth. Similarly, Rork and Morris (2009) saw how parental overprotection and negative commands correlated with the presence of social anxiety in adolescents. Furthermore, Östürk, Sayar, Ugurad, and Tüzün (2005) found that mothers of socially phobic children scored higher in hostility. Merikangas, Lieb, Wittchen, and Avenevoli (2003) and Lieb et al. (2000) reported parental overprotection and rejection to be associated with SAD in adolescents. In addition, parental rearing was retrospectively assessed by Knappe, Beesdo-Baum, Fehm, Lieb, and Wittchen (2012) who found that maternal overprotection and parental rejection was observed only in adolescents with SAD. Recently, Lewis-Morrarty et al. (2012) identified that maternal overcontrol predicts lifetime rates of SAD during adolescence. Furthermore, isolation from social events and the use of shame as a means of discipline in social situations (Leung, Heimberg, Holt, & Bruch, 1994) are commonly associated with the construct of EE (Fogler, Tompson, Steketee, & Hofmann, 2007). After reviewing the available data, Elizabeth et al. (2006) reported that parent–child interactions play a role in the development and maintenance of social anxiety, although the bidirectional influence between parenting and child anxiety must be taken into account (Majdandžić, de Vente, Feinberg, Aktar, & Bögels, 2012).

Overall, there is evidence that parental high-EE status (EOI, criticism and/or hostility) is associated with SAD in adolescence. However, impact of expressed emotion on treatment outcome for CBT for SAD is limited to one study (Garcia-Lopez et al., 2009). These authors explored whether high levels of EE in parents could be associated with lower treatment outcome in adolescents with social phobia. Findings revealed that parents' high EE levels were significantly associated with their children's poor treatment outcome. In particular, the parents' level of EE moderated the treatment outcome of their adolescents. These data may explain why CBT interventions do not work well for all socially anxious adolescents, and why involving parents only improves outcome in some cases.

Because parental high EE (or some of its components) has been found to be related to treatment outcome in socially anxious adolescents, this study aimed to examine whether adding a parent training intervention to decrease high levels of parental EE would improve treatment outcome for socially anxious adolescents. Using a sample of parents high in expressed emotion, adolescents were assigned to either a school-based intervention with sessions for parent training (entitled IFAFS; Intervencion en Familias & Adolescentes con Fobia Social; Therapy for Families and Adolescents with Social Phobia; Garcia-Lopez, Espinosa-Fernandez, Muela, & Diaz-Castela, 2011), or a school-based program focused solely on intervening with the adolescent (no parental involvement) called IAFS (Intervencion en Adolescentes con Fobia Social; Therapy for Adolescents with Social Phobia; Garcia-Lopez, 2000, 2007). We examined whether adolescents in the IFAFS condition would show more improvement than those in the traditional IAFS group. Second, we tested whether parent training would have a positive impact on parental EE in the IFAFS condition. Third, we evaluated whether a decrease in parents' EE post-treatment had a positive effect on their child's improvement. We hypothesized that adolescents whose parents changed from high to low EE following treatment would show significantly more improvement compared to adolescents whose parents continued exhibiting high EE levels.

## 2. Method

### 2.1. Participants

The sample comprised 52 adolescents with SAD aged 13–18 years ($M = 15.42$, $SD = 1.40$). Specifically, 18 (34.6%) were boys and 34 (65.4%) were girls. All adolescents had a primary diagnosis of social phobia, and 61.5% exhibited some form of comorbid disorder. In particular, 30.7% had a secondary disorder (specific phobia or GAD), 23.07% presented with two comorbid disorders (specific phobia and GAD), and 7.7% presented with 3 or more diagnoses (separation anxiety, specific phobia, GAD, or dysthymia). Overall, the average number of comorbid disorders ranged from 0 to 4, with a mean of 1.08 ($SD = 1.15$) diagnosis. No behavioral disorders criteria were met.

With regard to the sample of the adolescents' parents, 75% of them agreed to an interview to classify them with high or low EE. Parents who refused to be interviewed were excluded. No statistical differences were found between those who agreed to participate in the interview and those who did not ($p > .05$). A total of 52 families (see Procedure) exhibited high EE, and were randomly assigned to either the school-based intervention IAFS ($n = 32$) or to the family, school-based treatment IFAFS ($n = 20$). Regarding the IAFS condition, the sample comprised 32 adolescents with SAD aged 13–16 years ($M = 14$, $SD = .72$); eleven (34.4%) were boys and 21 (65.6%) were girls. Half of the sample exhibited some form of comorbid disorder. In particular, 25% had one secondary disorder (specific phobia or GAD), and 25% presented with two comorbid disorders (specific phobia and GAD). Overall, the average number of comorbid disorders ranged from 0 to 2, with a mean of .75 ($SD = .84$) diagnosis. Concerning the IFAFS condition, the sample comprised 20 adolescents with SAD aged 14–17 years ($M = 15.80$, $SD = 1.20$); seven (35%) were boys and 13 (65%) were girls. Eighty percent exhibited comorbid disorders secondary to social phobia, 40% had one secondary disorder (specific phobia), 20% presented with two comorbid disorders (specific phobia and GAD), and 20% presented with 3 or more diagnoses (separation anxiety, specific phobia, GAD, or dysthymia). Overall, the average number of comorbid disorders ranged from 0 to 4, with a mean of 1.6 ($SD = 1.39$) diagnosis.

In summary, the study comprised adolescents with SAD from high-EE families assigned to one of two experimental conditions: (a) the IFAFS group, a school-based intervention aimed at treating adolescents with SAD whose parents received training sessions to reduce their high EE levels ($n = 20$), or (b) the IAFS group, a school-based intervention focused solely on adolescents with no parental involvement ($n = 32$).

### 2.2. Measures

The *Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Version* (ADIS-IV-C/P; Silverman & Albano, 1996) was conducted by trained clinical psychology graduate students to diagnose social phobia in adolescents. This semi-structured interview assesses current and lifetime child psychopathology according to DSM-IV criteria. The social phobia section (ADIS-SP) consists of 22 dimensional ratings that evaluate social fear and avoidance using a clinical severity rating. This instrument was used as a diagnostic tool. In the present study, Cronbach's alpha coefficient value was .79. The ADIS-IV-C/P has moderate to strong interrater reliability, adequate concurrent validity, and strong retest reliability for English and Spanish-speaking populations (Lyneham & Rapee, 2005; Puliafico, Corner, & Kendall, 2007; Rapee, Barrett, Dadds, & Evans, 1994; Sandin, 2003; Silverman, Saavedra, & Pina, 2001; Wood, Piacentini, Bergman, McCracken, & Barrios, 2002). This interview has been used extensively in the assessment of children with anxiety disorders (Silverman et al., 2001; Westenberg, Siebelink, Warmenhoven, & Treffers, 1999). For this study, a random sample totaling 15% of child and parent interviews was audiotaped and scored by another interviewer who was blind to diagnosis, assessment time (pre-treatment, post-treatment and follow-up), and experimental condition assignment. Interviews were conducted by clinical psychology graduate students who were trained in a 12-h workshop and supervised by a licensed clinical psychologist. A Kappa value of .92 was found in the social anxiety section. This ADIS interview served as the diagnostic measure before and after treatment, and classified adolescents as responders and non-responders. The Clinician's severity rating (CSR) was also used as a treatment outcome measure. A CSR ranging from 0 to 8 was assigned, with 4 being the level that indicates clinical severity. CSR were assigned by the trained interviewers and supervised by a licensed clinical psychologist.

*Social Anxiety Scale for Adolescents* (SAS-A; La Greca & Lopez, 1998). This questionnaire contains 22 Likert-type items (1–5): eighteen descriptive self-statements and four filler items. The SAS-A includes three subscales: Fear of Negative Evaluation (FNE; eight items), Social Avoidance and Distress specific to new situations or unfamiliar peers (SAD-New; six items), and Social Avoidance and Distress that is experienced more generally in the company of peers (SAD-General; four items). This scale has demonstrated a similar factor structure and invariance in the Spanish-speaking population (Ingles, La Greca, Marzo, Garcia-Lopez, & Garcia-Fernandez, 2010; Olivares et al., 2005; Olivares, Garcia-Lopez, Hidalgo, & Caballo, 2004). In the present study, the internal consistency values were .92 for the Total score, .89 for the FNE subscale, .83 for the SAD-N subscale, and .74 for the SAD-G subscale.

The *Social Phobia and Anxiety Inventory, Brief form* (SPAI-B; Garcia-Lopez, Beidel, et al., 2008) consists of 16 items using a 5-point Likert scale (1–5), so the sum of the scores is up to 90 points, but there is a need for deleting 16 points (as minimum score is 16). As a result, a total score can be computed (range: 0–64). It is a brief version of the SPAI, albeit different in terms of the Likert scale format used, the number of items, and avoidance of heterocentric language, as recently proposed by Weiss, Hope and Capozzoli (2013). The authors reported good psychometric properties in Portuguese and Spanish adolescents and among young adults using either paper-and-pencil or online administration (Garcia-Lopez, Beidel, et al., 2008; Garcia-Lopez, Beidel, & Muela-Martinez, 2014; Piqueras, Espinosa-Fernandez, Garcia-Lopez, & Beidel, 2012; Vieira, Salvador, Matos, Garcia-Lopez, & Beidel, 2013). In this study, the scale has demonstrated excellent internal consistency (Cronbach's alpha coefficient value = .92).

*Five-Minute Speech Sample* (FMSS; Magana et al., 1986). This assessment instrument specifically measures EE in a family setting. It consists of a short interview where a family member is asked to talk for 5 min about the patient in his/her own words, and where the interviewer is not allowed to interrupt with any questions or comments. If during the interview the family member makes a comment of a critical or hostile nature, or one which expresses emotional overinvolvement (EOI), this family is considered to have high EE. In our study, it was administered to the adolescents' parents to determine their (high or low) level of EE. All information was recorded. Two independent, blind diagnosticians with training in FMSS (different from those assessing their children) administered the interviews and coded the parents' language (Kappa coefficient .97). This interview has demonstrated excellent psychometric properties (Gottschalk et al., 1988; Magana et al., 1986).

The *Children's Depression Inventory* (CDI; Kovacs, 1985) contains 27 items and is used to assess the severity of self-reported symptoms of childhood depression. Subscales include negative mood, interpersonal difficulties, negative self-esteem, ineffectiveness, and anhedonia. Figueras Masip, Amador-Campos, Gomez-Benito, and del Barrio (2010) have confirmed its good psychometric properties in the Spanish population. The measure has shown good internal consistency (.82) in this study.

### 2.3. Procedure

Following the procedure devised by Garcia-Lopez (2000, 2007), this study was conducted across 4 stages: screening, pre-treatment, post-treatment, and a 12-month follow-up assessment in the school environment. The study was approved by the School District and the University Research Ethics Committee.

At the initial stage, participants were recruited from two private and eight public high schools located in a medium-size state in the south of Spain. Schools were informed as to the objectives of the study and their cooperation was requested. They were selected using a clustered, random sampling method from the school lists of the Department of Education. The use of this method meant that the socioeconomic status and ethnic compositions of the overall sample was representative of the community. 2541 adolescents, who agreed to participate and provided a signed parental consent form, filled out the SPAI-B and SAS-A questionnaires in a group classroom setting at their own school.

In the second phase, 480 (18%) of the 2541 students who scored higher than the SAS-A and SPAI-B cut-off scores proposed by Olivares, Garcia-Lopez, Hidalgo, et al. (2002), and Garcia-Lopez, Beidel, et al. (2008)) were subsequently interviewed using the ADIS-IV-C/P (Silverman & Albano, 1996) to confirm whether these adolescents met criteria for a social anxiety disorder diagnosis. This interview was carried out by eight psychology graduate students from the University of Jaen. They were previously trained in the use of diagnostic interviewing, and were supervised by this study's first author who boasts a wealth of expertise in these instruments. The researchers conducted diagnostic interviews on adolescents individually in a private room or office at school. The time required for administering the assessment tool and questionnaires was about 2 h. Adolescents were accompanied by a researcher at all times. One hundred and thirty-nine adolescents (5.5% of the initial sample, consistent with prevalence reported by other studies; see Introduction) with a clinical diagnosis of generalized social anxiety disorder[1] were detected and offered cognitive-behavioral group treatment at school. Of these subjects, 92 (75%) adolescents and their parents signed the consent forms (see Fig. 1). No statistical differences were found in any measure for those who expressed their interest in the treatment and those who did not ($p > 05$). When

[1] Based on the DSM-5, the sample would have met criteria for social anxiety disorder.

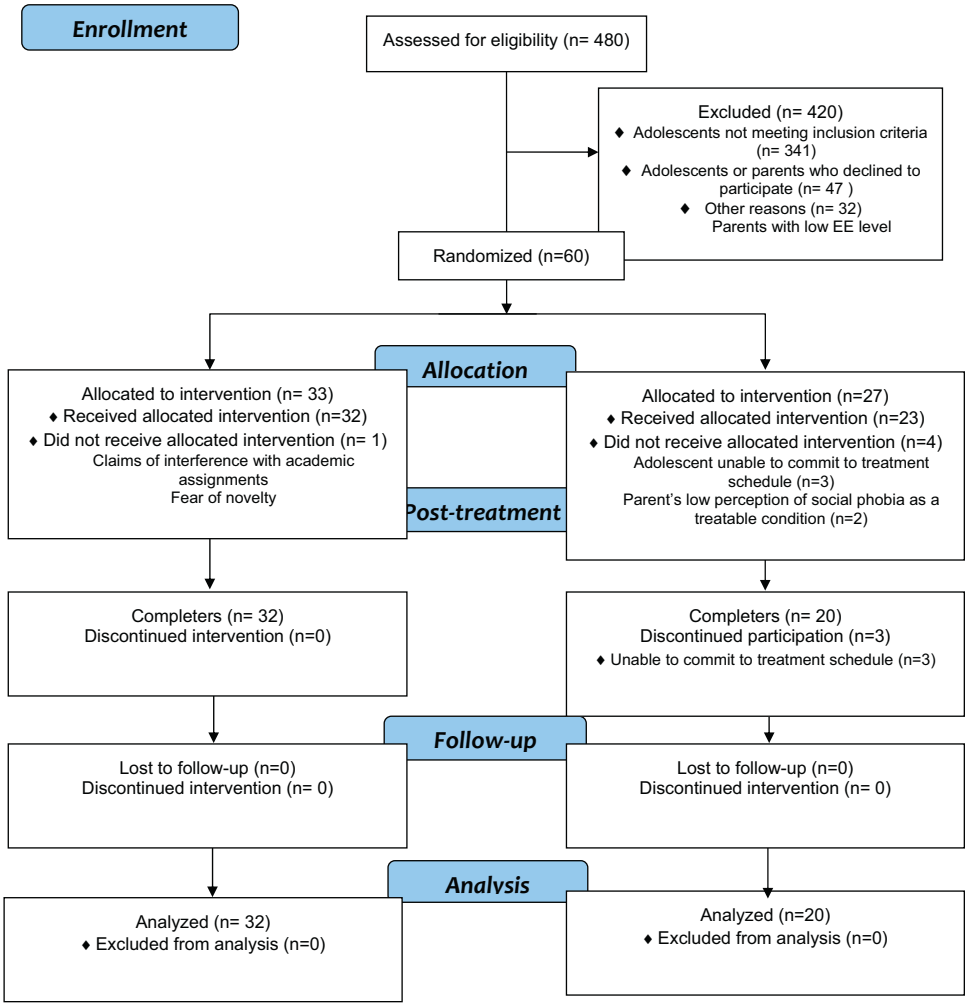


**Fig. 1.** Flow chart of participants.

parents attended an individual assessment to confirm their child's diagnosis, the FMSS was also administered to classify parents as having high or low EE. Based on the FMMS guidelines, 60 and 32 parents were classified with high and low EE, respectively.

The inclusion criteria were: (a) primary diagnosis of social anxiety disorder, as diagnosed using the ADIS-IV-C/P; (b) subjects aged 12–17 years; (c) high levels of EE in the family; and (d) written informed consent from both adolescent and parents. Exclusion criteria, on the other hand, were: (a) current suicidal intent or risk, and (b) a positive diagnosis of mental retardation, psychosis, or other psychiatric conditions that would limit their ability to understand assessment and treatment. During clinical assessment at pre-treatment, evaluators were blinded to screening social anxiety scores. At post-treatment and follow-up, additional evaluators conducted the assessment and were blinded to assignment to experimental conditions and assessment time (pre-treatment, post-treatment, and follow-up assessments). In total, 60 families met inclusion criteria following assessment.

Adolescents and parents with a high EE dyad ($N = 60$) were randomly assigned to either the school-based intervention, namely IAFS ($n = 33$), or the family, school-based intervention IFAFS ($n = 27$), by means of stratified random assignment to groups. Groups within each school were randomly assigned to the two conditions.

Before the first session, one adolescent declined to enter the IAFS program claiming that it would interfere with academic assignments and because of fear of novelty. As for the IFAFS, four of the adolescent-parent dyads were unable to commit to a treatment schedule and had a low self-perception of social phobia as a treatable condition. An intention-to-treat (ITT) analysis revealed no significant differences ($p > 05$) between the sample group assigned initial treatment and the one which actually benefited from experimental treatment conditions. As a result, adolescents were allocated to either the IAFS ($n = 32$) or IFAFS ($n = 23$) group. During treatment, 3 families dropped out of the IFAFS, leaving 20 adolescents and their parents. Thus, the attrition group consisted of 4 adolescent-parent dyads. There were no differences between the completers and non-completers.

Specifically, 17 parents (father and mother) and 3 mothers attended the IFAFS intervention condition, while 27 parents and 5 mothers were part of the IAFS condition (no parental involvement). During post-treatment and follow-up assessment periods, parents and adolescents were reassessed. All parents received a 20€ gift card for their participation following the assessment, and another card was given to the IFAFS completers.

### 2.4. Treatments

Adolescents with a clinical diagnosis of generalized social phobia and parents with high EE were assigned to receive either a free, school-based, cognitive-behavioral intervention aimed at overcoming social anxiety in adolescents called IAFS (Intervencion en Adolescentes con Fobia Social; Therapy for Adolescents with Social Phobia; Garcia-Lopez, 2000, 2007), or a family, school-based CBT protocol entitled IFAFS (Intervencion en Familias & Adolescentes

con Fobia Social; Therapy for Families and Adolescents with Social Phobia; Garcia-Lopez et al., 2011). In other words, IAFS focuses solely on intervening with the adolescent and IFAFS includes additional family sessions focused on parent training to reduce EE levels, as parents' high EE is associated with poor treatment outcome (Garcia-Lopez et al., 2009).

The original IAFS stems from CBGT-A and SET protocols, and consists of 12 weekly group sessions, each lasting 90 min. Techniques include psychoeducation, social skills, exposure, and cognitive therapy. The treatment also includes exposure to social situations by using peer assistants and video feedback, which differs from other CBT interventions. Additional individual sessions are optional. The intervention protocol is conducted during school hours (for more details, please see Masia-Warner, Colognori, Brice, & Sanchez, 2014; Mesa, Le, & Beidel, 2014). This treatment has demonstrated its efficacy across cultures for adolescents and young adults with social anxiety disorder (Antona, Delgado, Garcia-Lopez, & Estrada, 2012; Garcia-Lopez et al., 2002; Garcia-Lopez, Olivares, et al., 2006; Garcia-Lopez, Ruiz, et al., 2006; Olivares & Garcia-Lopez, 2001; Olivares, Garcia-Lopez, Beidel, et al., 2002; Olivares, Garcia-Lopez, Hidalgo, et al., 2002). Here it was implemented by an advanced doctoral student with 5 years' experience running groups of adolescents with social phobia. She acted as therapist in the groups, and graduate students served as co-therapists. Sessions and therapists were supervised by a clinical child psychologist with over 15 years' experience working with socially anxious adolescents (the first author, who co-developed the original IAFS) during weekly supervision meetings. All sessions were videotaped, and a random 10% were rated by an independent clinician to examine treatment fidelity. The clinician was blind to diagnosis, time of intervention (pre-treatment, post-treatment, follow-up) and experimental condition assignment. The mean completion rating of the session-specific intervention components was 96% and 94% for the IAFS and IFAFS, respectively. The quality of implementation was classified as high. The group size ranged from 5 to 8 adolescents per group.

The IFAFS follows the same structure as the IAFS, but includes a parent training component specifically designed for targeting EE. This module consists of 5 additional 120-min group sessions, separate for the parents. The group size ranged from 8 to 12 parents per group. Parents received psychoeducation about social anxiety and the role of expressed emotion in their children's symptomatology. Social learning theory states that negative or anxious verbal communication by parents may model anxious behaviors in children (Albano, 2013). Thus, training was given in communication skills to replace the use of rejection, EOI, criticism and hostile verbal comments. Contingency management training aimed at teaching them strategies to better manage their child's social anxiety was also included. Parents were instructed to ignore and not encourage avoidance and safety behaviors in their children; rather, emphasis was placed on providing adequate positive reinforcement to their exposure behaviors (Garcia-Lopez, 2013). Parent sessions were conducted by two clinical psychologists with extensive experience in parent training and treating EE (fourth and third authors, respectively). Sessions were conducted separately for parents and children.

## 3. Results

### 3.1. Pre-treatment comparisons

This research examined two school-based interventions for adolescents with SAD, one of which included a parent training module to address EE. First, the two experimental conditions were compared with respect to gender, age and social anxiety measures through an analysis of variance (ANOVA) or $\chi^2$ test. No significant differences were obtained at pre-treatment (all $p$ values >.05), except for comorbidity rates. The IFAFS presented significantly higher comorbid disorders ($M = 1.60$, $SD = 1.40$) than the IAFS condition ($M = .75$, $SD = .84$), $t(50) = 2.75$, $p = .02$, with a medium-to-high effect size, $d = .76$, according to the criteria set out by Cohen (1988), where .2 means a small effect size, .5 corresponds to medium size, and .8 indicates large. Second, the mean social anxiety CSR score on the ADIS was 5.5 ($SD = 1.13$; range: 4–7) and 5.6 ($SD = 1.05$; range: 4–8) at the pre-treatment stage for the IAFS and IFAFS, respectively. Regardless of experimental condition, data suggest that adolescents' level of social anxiety prior to treatment was in the 'markedly disturbing/disabling' range. Similarly, SPAI-B and SAS-A scores were on the extreme range of severity at pre-treatment. In contrast, the mean of CDI was 13.75 ($SD = 5.25$), which indicates that the sample did not exhibit clinical levels of depressive symptomatology.

### 3.2. IFAS versus IFAFS

The first objective was to test whether adolescents whose parents exhibited high EE and received parent training sessions (IFAFS; family, school-based condition) would obtain better treatment outcome rates than those without parental involvement (IAFS, school-based intervention).

#### 3.2.1. Between-group comparisons

Between-group comparisons supported the hypotheses on most measures. At post-treatment, significant differences with large and medium-to-large effect sizes were found on the SAD-N, $F(1, 50) = 16.18$, $p = .001$, $d = 1.36$; the total score of the SAS-A, $F(1, 50) = 4.68$, $p = .035$, $d = .65$; the SPAI-B, $F(1, 50) = 4.42$, $p = .041$, $d = .64$; the CSR, $F(1, 50) = 10.41$, $p = .002$, $d = .91$; and the CDI, $F(1, 50) = 6.64$, $p = .013$, $d = .74$. At follow-up, significances remained on the SAD-N subscale of the SAS-A, $F(1, 50) = 4.85$, $p = .032$, $d = .74$, and were marginally significant on the CSR, $F(1, 50) = 2.88$, $p = .06$, $d = .53$, yielding a medium effect size. Table 1 summarizes the means (standard deviations) for all measures and assessment periods, as well as the $p$ values and effect sizes for pre-post-follow-up comparisons. As shown in Table 1, the level of social anxiety scores at follow-up for both the IAFS and IFAFS was rather low, raising the possibility of a floor effect.

#### 3.2.2. Within-group comparisons

Tables 2 and 3 revealed that both the IAFS and IFAFS showed significant decreases in depressive and social anxiety symptomatology (both cognitive and behavioral) in most cases using paired $t$-tests. Effect sizes were large for both the IAFS and IFAFS, ranging from .60 to .95 and .60 to .99, respectively. The effect sizes were interpreted using Cohen's (1988) convention for repeated measures with effect sizes, whereby >6 is considered "large," effect sizes between .30 and .59 are considered "medium," and effect sizes below .29 are considered "small".

#### 3.2.3. Responders versus non-responders

Remission rates (no diagnosis of SAD based on the ADIS-IV-C/P) were analyzed. We examined the percentage of adolescents who did not exhibit a clinical diagnosis after treatment (responders). At post-treatment, 59% and 65% of adolescents did not meet DSM criteria for social anxiety on the IAFS and IFAFS, respectively. A similar trend was observed at follow-up: 75% and 80%. No statistical differences between groups were obtained, but the IFAFS recorded a greater number of adolescents free of diagnosis over time compared to the IAFS. At post-treatment, responders and non-responders differed only in (a) the number of feared situations from the ADIS-C, which ranges from 0 to 22, $t(50) = 3.97$, $p = .001$, $d = 1.12$ ($M = 10.38$ and $SD = 3.30$ for responders, whereas

**Table 1**
Means (standard deviations) for self-report measures for each treatment condition at pre-treatment, post-treatment and follow-up assessments.

| Measures | Baseline/pre-treatment Mean (*SD*) | | Post-treatment Mean (*SD*) | | 12-month F-U Mean (*SD*) | | Effect size Cohen's *d* | |
|---|---|---|---|---|---|---|---|---|
| | IAFS | IFAFS | IAFS | IFAFS | IAFS | IFAFS | Post | F-U |
| SAS-A/FNE | 29.37 (5.47) | 31.60 (3.98) | 23.125 (6.73) | 20.60 (7.41) | 15.12 (6.41) | 14.40 (3.87) | | |
| SAS-A/SAD-N | 21.50 (4.51) | 22.40 (5.60) | 17.50 (5.40) | 12.40 (2.11) | 11.75 (4.92) | 9.20 (1.99) | 1.36*** | .74* |
| SAS-A/SAD-G | 11.87 (4.61) | 12.80 (4.07) | 7.62 (3.37) | 7.20 (1.88) | 5.25 (1.66) | 5.60 (1.23) | | |
| SAS-A/TOTAL | 62.75 (12.15) | 66.80 (11.78) | 48.25 (14.38) | 40.20 (10.53) | 32.12 (12.12) | 29.20 (6.07) | .65* | |
| SPAI-B | 32.90 (8.64) | 37.18 (9.35) | 25.66 (9.01) | 20.86 (6.04) | 9.42 (8.45) | 6.74 (2.64) | .64* | |
| CDI | 13.75 (5.25) | 15.20 (6.57) | 8.50 (3.77) | 11.20 (3.52) | 9.37 (4.87) | 9.20 (5.63) | .74* | |
| CSR | 5.37 (1.01) | 6.00 (1.45) | .75 (1.11) | 1.8 (1.20) | 1.00 (1.44) | .40 (.82) | .091** | .53* |

IAFS: Intervención en Adolescentes con Fobia Social (Treatment for Adolescents with Social Phobia); IFAFS: Intervención en Familias & Adolescentes con Fobia Social (Treatment for Families and Adolescents with Social Phobia); SAS-A: Social Anxiety Scale for Adolescents; FNE: Fear of Negative Evaluation; SAD-N: Social Avoidance and Distress specific to new situations or unfamiliar peers; SAD-G: Social Avoidance and Distress that is experienced more generally in the company of peers (SAD-General); SPAI-B: Social Phobia and Anxiety Inventory, Brief form; CDI: Children's Depression Inventory; CSR: Clinician's severity rating (ADIS).
* $p \leq .01$.
** $p \leq .05$.
*** $p \leq .001$.

**Table 2**
Means (standard deviations) for IAFS.

| Measures | Baseline/pre-treatment Mean (*SD*) | Post-treatment Mean (*SD*) | 12-month F-U Mean (*SD*) | Effect size Cohen's *d* | | |
|---|---|---|---|---|---|---|
| | | | | Pre-post | Post-F-U | Pre-F/U |
| SAS-A/FNE | 29.37 (5.47) | 23.125 (6.73) | 15.12 (6.41) | .81** | .76*** | .92*** |
| SAS-A/SAD-N | 21.50 (4.51) | 17.50 (5.40) | 11.75 (4.92) | .80*** | .48** | .76*** |
| SAS-A/SAD-G | 11.87 (4.61) | 7.62 (3.37) | 5.25 (1.66) | .71*** | .63*** | .81*** |
| SAS-A/TOTAL | 62.75 (12.15) | 48.25 (14.38) | 32.12 (12.12) | .86*** | .68*** | .88*** |
| SPAI-B | 32.90 (8.64) | 25.66 (9.01) | 9.42 (8.45) | .52** | .89*** | .90*** |
| CDI | 13.75 (5.25) | 8.50 (3.77) | 9.37 (4.87) | .81*** | | .76*** |
| CSR | 5.37 (1.01) | .75 (1.11) | 1.00 (1.44) | 3.45*** | | 2.95*** |

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* $p \leq .01$.
** $p \leq .05$.
*** $p \leq .001$.

$M = 14.20$ and $SD = 3.50$ for non-responders); and (b) the FNE subscale (which taps cognitions) of the SAS-A, $t(50) = 2.53$, $p = .014$, $d = 1.18$ ($M = 28.90$ and $SD = 4.87$ for responders, whereas $M = 32.50$ and $SD = 4.64$ for non-responders). However, at follow-up, differences in the responders and non-responders was limited to the CSR, $t(50) = 2.67$, $p = .01$, $d = .94$ ($M = 5.8$ and $SD = 1.23$ for responders, whereas $M = 4.83$ and $SD = .83$ for non-responders). It must be noted that every adolescent who lost their social phobia diagnosis at post-treatment or follow-up was also free of any diagnosis, except for specific phobia. Specifically, half of those who presented with comorbid specific phobia (SP) at pre-treatment met SP criteria after intervention.

In addition to remission rates (based on ADIS diagnosis), social anxiety and depression scores for both conditions were compared to means established for a non-clinical population in these measures. For the SAS-A and SPAI-B, 20 out of 32 (62.5%) and 24 (75%) adolescents obtained scores in the IAFS within the normal range of those scales at post-treatment and 12-month follow-up,

**Table 3**
Means (standard deviations) for IFAFS.

| Measures | Baseline/pre-treatment Mean (*SD*) | Post-treatment Mean (*SD*) | 12-month F-U Mean (*SD*) | Effect size Cohen's *d* | | |
|---|---|---|---|---|---|---|
| | | | | Pre-post | Post-F-U | Pre-F/U |
| SAS-A/FNE | 31.60 (3.98) | 20.60 (7.41) | 14.40 (3.87) | .76*** | .80*** | .93*** |
| SAS-A/SAD-N | 22.40 (5.60) | 12.40 (2.11) | 9.20 (1.99) | .81*** | .89*** | .83*** |
| SAS-A/SAD-G | 12.80 (4.07) | 7.20 (1.88) | 5.60 (1.23) | .71*** | .99*** | .88*** |
| SAS-A/TOTAL | 66.80 (11.78) | 40.20 (10.53) | 29.20 (6.07) | .81*** | .91*** | .92*** |
| SPAI-B | 37.18 (9.35) | 20.86 (6.04) | 6.74 (2.64) | .79*** | .96*** | .95*** |
| CDI | 15.20 (6.57) | 11.20 (3.52) | 9.20 (5.63) | .66*** | .60** | .82*** |
| CSR | 6.00 (1.45) | 1.8 (1.20) | .40 (.82) | 3.57*** | 2.05** | 4.34*** |

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* $p \leq .01$.
** $p \leq .05$.
*** $p \leq .001$.

respectively. Similarly, a large number of adolescents in the IFAFS condition scored within the normal range at post-treatment, with a different percentage for the SAS-A (15 out of 20; 75%) and SPAI-B (13 out of 20; 65%). At follow-up, the percentage increased to 80% (16 of 20) for both SPAI-B and SAS-A values. Between-group percentage comparisons were significant at post-treatment in the SAS-A, $\chi^2(1) = 5.0$, $p < .05$, but not in the SPAI-B ($p = 18$). At follow-up, differences between the IAFS and IFAFS were statistically significant for the SAS-A and SPAI-B, $\chi^2(1) = 7.2$, $p < 01$. This demonstrates that adolescents who received IFAFS reported social anxiety scores lower than the clinical scores range. CDI scores were in the normal range (below the cut-off score of 19) for every subject, both before and after treatment.

### 3.3. EE status following therapy

The second aim of this study was to examine whether parents' EE status in the IFAFS condition changed from pre-treatment to post-treatment and pre-treatment-follow-up. In other words, the goal was to see whether those in the IFAFS condition experienced EE level changes (from high to low) after receiving parent training. As EE level is a dichotomous variable, a McNemar test was computed. Data revealed that 12 (60%) out of 20 parents went from high to low EE at post-treatment, with statistically significant pre-post differences ($p = .0015$). At one-year follow-up, the percentage of parents with low EE increased to 70%. Pre-treatment-follow-up comparison was also statistically significant in the IFAFS ($p = .0005$). No statistical differences were observed in the post-follow-up comparison in the IFAFS ($p = .48$). In addition, we examined whether there were any differences in EE status of the parents in the IAFS condition, that is, those who received no specific intervention to address high EE levels. No differences were observed in the IAFS condition, meaning that no parents went from high to low EE after their child received treatment. EE status changes in the IFAFS condition significantly differed from those of the IAFS condition ($p < .05$). This comparison provides a time and attention control for the IFAFS condition.

### 3.4. Does parents' EE status after parental training sessions have a positive effect on their children?

Consistent with our hypothesis, data revealed that adolescents of formerly high-EE parents exhibited significantly lower scores than those whose parents were still classified as high EE at post-treatment for the CSR, SPAI-B, FNE, SAD-G subscale, and Total score of the SAS-A scale. Similarly, differences were obtained for these measures at follow-up, except for the SPAI-B. When significant, effect sizes were high (see Table 4).

In summary, all adolescents benefited from school-based, CBT interventions, but those in the IFAFS group scored significantly lower than those in the IAFS at post-treatment. Reductions were maintained at follow-up. IFAFS demonstrated higher remission rates at post-treatment and 12-month follow-up. In addition, parents involved in the IFAFS were able to modify their level of EE from high to low at post-treatment and follow-up. Finally, a decrease in parental EE after treatment had a positive effect on the child's improvement.

## 4. Discussion

As parental high EE (or some of its components) seems to be related to social anxiety symptomatology, and indeed appears to have a negative effect on the efficacy of the treatment (Garcia-Lopez et al., 2009), this study aimed to examine whether adding parent training sessions in high-EE families to reduce EE would play a role in the treatment outcome of their adolescents. Data revealed that adolescents under the IFAFS condition reported greater improvement following treatment in both social distress and avoidance to strangers, general social anxiety, clinician-rated severity, and depression measures in comparison to the IAFS condition. In other words, a child's improvement was enhanced by including a parent training module aimed at reducing parents' level of EE. However, this finding contrasts with that of Spence et al. (2000) in a sample of children (aged 7–14 years) with social phobia, which revealed that the inclusion of parents in treatment was superior (but not statistically significant) to child-focused treatments. Our sample comprised older adolescents, which might explain the differences, along with a number of other variables such as culture and different parent training protocol. Similar to that study, some authors have observed a trend toward an enhanced effect by including the parents of children with anxiety disorders, although not statistically significant (Heyne et al., 2002; Wood et al., 2006). However, our data are consistent with studies that examined whether child anxiety treatment may be improved if parents were involved in treatment (Barrett, 1998; Barrett, Dadds, & Rapee, 1996; Cobham, Dadds, Spence, & McDermott, 2010; Creswell & Cartwright-Hatton, 2007; Ginsburg & Schlossberg, 2002; Ginsburg, Silverman, & Kurtines, 1995; Ishikawa, Okajima, Matsuoka, & Sakano, 2007; Mendlowitz, Manassis, Bradley, Scapillato, Miezitos, & Shaw, 1999), but differ from others (Barrett, Duffy, Dadds, & Rapee, 2001; Bodden et al., 2008; Cobham, Dadds, & Spence, 1998; Nauta, Scholing, Emmelkamp, & Minderaa, 2003).

A possible explanation is that parent–child interactions changed after parent training sessions. New parental skills may have resulted in parents encouraging and reinforcing their children to

**Table 4**
Means (standard deviations) for self-report measures for EE responding parents at post-treatment and follow-up assessments.

| Measures | Post-treatment Mean (*SD*) | | 12-month F-U Mean (*SD*) | | Effect size Cohen's *d* | |
|---|---|---|---|---|---|---|
| | High EE ($n = 8$) | Low EE ($n = 12$) | High EE ($n = 6$) | Low EE ($n = 14$) | Post | F-U |
| SAS-A/FNE | 25.67 (2.61) | 13.00 (5.34) | 17.00 (3.10) | 13.28 (3.71) | 1.72*** | 1.09* |
| SAS-A/SAD-N | 13.00 (1.48) | 11.50 (2.67) | 9.29 (2.40) | 9.00 (2.12) | | |
| SAS-A/SAD-G | 8.34 (.99) | 5.50 (1.60) | 7.00 (1.12) | 5.00 (.97) | 1.51*** | 1.91*** |
| SAS-A/TOTAL | 47.00 (2.56) | 30.00 (9.62) | 33.00 (3.10) | 27.57 (6.37) | 1.72*** | 1.15* |
| SPAI-B | 24.88 (1.39) | 14.82 (5.16) | 8.00 (1.55) | 6.20 (2.87) | 1.72*** | |
| CDI | 10.33 (3.23) | 12.50 (3.74) | 11.33 (.52) | 8.29 (6.58) | | |
| CSR | 2.50 (.53) | 1.33 (1.30) | 1.33 (1.03) | .00 (.00) | 1.28* | 2.58* |

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* $p \leq .01$.
** $p \leq .05$.
*** $p \leq .001$.

use the cognitive-behavioral techniques acquired in their treatment sessions. By doing so, parents may have prompted and encouraged their children to be more open to social situations and ignore avoidant behaviors (Ginsburg et al., 1995; Nauta et al., 2003; Spence et al., 2000; Stallard, 2009). As a result, as Silverman and Berman (2001) suggested, parental involvement in treatment can enhance treatment effects and help parents to change dysfunctional parent–child interactions when children face social situations. Parental rearing focused on positive communication rather than expressing negative emotions toward children by means of EOI, hostility and criticism may have an influence, thus strengthening their children's sense of security (Garcia-Lopez, 2013). The present study's data support that the addition of a parent training component for parents high in expressed emotion improves symptom reduction and diagnosis remission (including remission of comorbid disorders) at post-treatment and long-term follow-up.

Limited differences between the IAFS and IFAFS at 12-month follow-up were observed. As can be seen, there is little cause to suggest the prevalence of one intervention over another in the long term. However, a more in-depth analysis of the findings (see Tables 1–3) revealed that the absence of significant differences at follow-up might be due to low social anxiety scores in both the IAFS and IFAFS conditions (floor effect). It must be noted that the IFAFS effect sizes were consistently superior to those found in the IAFS. Furthermore, remission rates were greater and statistically significant for the IFAFS. Remission rates for the traditional IAFS (59% and 75% at post-treatment and follow-up, respectively) were similar to those found by previous studies implementing the IAFS, and in line with those found in literature on socially anxious adolescents (Albano et al., 1995; Aydin et al., 2010; Garcia-Lopez et al., 2002; Garcia-Lopez, Olivares, et al., 2006; Garcia-Lopez, Ruiz, et al., 2006; Hayward et al., 2000; Ishikawa et al., 2007; Olivares, Garcia-Lopez, Beidel, et al., 2002; Olivares, Garcia-Lopez, Hidalgo, et al., 2002; Salvador & Pinto-Gouveia, 2009). A slight increase has been observed in the IFAFS (65% and 80% at post-treatment and follow-up, respectively). This seems to be because it has targeted the parental style that was affecting treatment outcome. In short, our data are in line with remission rates (33–87.5%) found at post-treatment when parents were involved in therapy (Beidel, Turner, & Morris, 2000; Gallagher, Rabian, & McCloskey, 2004; Masia-Warner et al., 2005, 2007; Melfsen et al., 2011; Spence et al., 2000).

The IAFS and IFAFS not only resulted in reductions in social anxiety symptomatology but also resulted in similar decreases in depressive symptomatology. This is consistent with literature suggesting that childhood depressive symptoms may be a consequence of anxiety (Cole, Peeke, Martin, Truglio, & Seroczynski, 1998; Muris, Meester, & van Melic, 2002). In addition, remission of social anxiety diagnosis has led to the absence of comorbid disorders at post-treatment and follow-up, except for specific phobia. Similar findings have been reported by Albano et al. (1995)and Garcia-Lopez, Olivares, et al. (2006). Furthermore, the absence of a solid pre-treatment predictor for identifying responders versus non-responders is consistent with some previous studies (Kley, Heinrichs, Bender, & Tuschen-Caffier, 2012) but not with others, that is, in line with mixed results reported in literature (for a review, please see Eskildsen, Hougaard, & Rosenberg, 2009).

As for the second objective, there is a significant change in the parental EE status in the IFAFS condition. Sixty percent and 70% of parents were classified as having low EE following intervention or follow-up, respectively. These results are consistent with those found in literature, which reports changes in EE for other psychopathologies such as schizophrenia, with the most frequent being those in the direction of high to low EE (McCreadie et al., 1993; Stirling et al., 1991), and less so the other way round (low to high EE) (Smith & Birchwood, 1990). However, unlike our research, these studies did not include an intervention specifically designed to address EE, and it is possible that the EE changes observed were a result of symptom changes over time rather than an EE-specific intervention.

Finally, in terms of the third objective, it has been observed that adolescents with families who went from high EE to low EE (recently acquired low EE) showed greater improvement following treatment than those adolescents whose families did not experience this change. This treatment outcome was seen in overall social anxiety, as well as the cognitive component of SAD and Social Avoidance and Distress that is experienced more generally in the company of peers. These findings are consistent with those reported in family-based interventions where better results have been obtained for low-EE families than for high-EE families following treatment for disorders such as schizophrenia (Linszen et al., 1997; Muela, 1999; Muela & Godoy, 2003) and adolescent depression (McCleary & Sanford, 2002).

### 4.1. Limitations

First, only child measures were used to evaluate treatment outcome. Information about the adolescents' social anxiety levels from teachers and parents may also be useful in view of the differences found among informants (e.g. Garcia-Lopez, De Los Reyes, & Salvador, 2014). Second, the same therapist ran all of the groups, so the possibility remains that the differential treatment effects of the IAFS and IFAFS merely reflect therapist bias. Third, because there was no parent comparison condition in the IAFS treatment, parental expectations could not be controlled. Fourth, the group nature of the interventions in the school system meant that participants were assigned to conditions in groups. Fifth, the number of dropouts increased in the IFAFS condition, as parents claimed they were unable to attend the parent training sessions. Thus, data suggest that including a mandatory parent component may negatively impact attrition and limit IFAFS implementation, despite its efficacy. Future studies may want to examine how to increase parental attendance. Finally, limited sample size prevented us from analyzing results separately for each component of EE.

## 5. Conclusions

The study's findings revealed that the inclusion of parent training to reduce EE in a treatment program designed to address SAD in adolescents had a positive effect on their improvement. This is particularly the case when the parents' EE status changed from high to low expressed emotion after treatment. It must be noted that adolescents in the IFAFS condition improved more than those in the IAFS group, even though the former had a higher rate of comorbidity at pre-treatment. Unexplored parental high EE in past studies may explain the heterogeneity of previous results in scientific literature concerning whether it is relevant to involve parents in therapy. Future studies may want to examine this topic further in order to identify the components of EE that affect the efficacy of the treatment of SAD in adolescents.

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