

# MORE ABOUT...DEPRESSION, ANXIETY AND PANIC DISORDER

## SOCIAL ANXIETY DISORDER IN YOUTH

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Social anxiety disorder (SAD), also known as social phobia, manifests itself primarily as fearful apprehension, somatic symptoms and distress occurring in relation to certain social situations and leads to the avoidance of such situations, with functional impairment. Currently adult criteria (*DSM-IV-TR*) are applied to children and adolescents, but with some specific qualifications: (i) evidence must exist for the capacity for age-appropriate social relationships; (ii) anxiety must not only occur in relation to interaction with adults but also in peer settings; (iii) in children the primary expression of the anxiety may be in the form of crying, tantrums, freezing or shrinking from certain situations or people; (iv) children may be unable to recognise their fear as excessive or unreasonable; and (v) in individuals under 18 the duration of symptoms must have been at least 6 months.

### Diagnosis

When making the diagnosis, clinicians should be alert to the fact that anxious children may exhibit multiple anxiety symptoms when seen in clinical settings, as well as to the considerable symptom overlap between the different

anxiety disorders. Specifically, panic attacks can occur within the context of SAD but they are situationally predisposed or situationally bound. Other very important differential diagnoses to consider include: (i) normal social anxiety (anxiety appropriate for the stage of development); (ii) avoidance (where the behaviour is due to factors other than social anxiety); (iii) school refusal (first consider other patient-specific factors); (iv) specific phobias (fears not clearly related to embarrassment, humiliation or social evaluation); and (v) generalised anxiety disorder (broader spectrum of worries). A further issue arises when children present with a diagnosis of selective mutism (SM) (*DSM-IV-TR*). Research has shown that shyness, fear of embarrassment and social withdrawal are common features in this group. Within this context some support exists for the notion that SM should be viewed as a symptom or subtype of SAD rather than as a distinct disorder.

### Epidemiology

As a group, the anxiety disorders are the most common psychiatric disorders found in children and adolescents. Estimates for their prevalence in this group range from 7.5% to 26%, with a 1% prevalence for SAD. However, with the majority of adult sufferers reporting onset of symptoms before the age of 20, this figure may be a significant underestimate when rates for adult SAD (lifetime prevalence of 13.3%) are considered.

### Aetiology

Family studies have shown that first-degree relatives of adults with SAD have a threefold increased risk of developing the condition; furthermore,

a high familial prevalence of SAD and SM has been demonstrated in first-degree relatives of subjects diagnosed with SM. With regard to temperament, children with 'behavioural inhibition to the unfamiliar' have been shown to be at increased risk for later development of an anxiety disorder. In addition to these genetic and temperamental factors, research has also associated parental fear modelling, peer relationships and specific cognitive features with the onset of SAD. However, current knowledge suggests that, at best, the various factors exert their influence as a network of complex transactions rather than directly causing the development of SAD.

### Treatment

Any treatment programme for child or adolescent anxiety disorder needs to be formulated with the relevant professional input and should include psycho-education for the patient and parents, an appropriate psychotherapeutic intervention (individual cognitive behavioural therapy in the case of SAD) and pharmacotherapy when indicated. There is a paucity of pharmacological treatment research for SAD in youth, but small open-label trials provide some support for the use of sertraline and citalopram, and controlled trials demonstrate support for fluvoxamine and fluoxetine. Selective serotonin re-uptake inhibitors (SSRIs) are, therefore, at present considered to be the first-line pharmacotherapy choice, starting at low doses and providing the patient and parents with information about possible side-effects. Importantly, although SSRIs have been proven efficacious and safe in adult SAD, caution should be exercised owing to recent concerns over the pos-

sible increased risk of self-harm and suicidal thoughts with these drugs in children and adolescents with depression. Once initiated, if well tolerated and associated with good response, medication should be continued for at least 12 months before being gradually tapered and withdrawn.

## **Prognosis**

Although very few systematic studies have been done in adolescents with SAD (and virtually none in children), available data suggest that SAD often has an early age of onset (mean of 15 years). Furthermore, significant co-morbidity exists with other anxiety disorders and an increased risk of early-onset alcohol abuse, more suicidal behaviour and an increased use of health services have been reported in young sufferers. With longitudinal studies in adults pointing to SAD as a chronic disorder, it is clear that further research on SAD in children and adolescents is much needed, especially with regard to aetiology and treatment options.

## **Further reading**

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