

# Social anxiety disorder in children and adolescents



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Anxiety disorders are a defined mental diagnosis which are characterised by “ levels of anxiety that impair one’s ability to properly function” (Beidel, 1998). One such type of condition is labelled as social anxiety disorder or social phobia. Beidel (1998) highlights that this diagnosis is sub-categorically defined by excess levels of distress and inhibition in one’s engagement with social situations that may involve personal attention and assessment. From a clinical perspective, social anxiety presents itself as a phobia to that of one’s engagement with social circumstance - like performing a specific behaviour, communicating, or anything else that is perceived as being under the judgement of others.

Rapee & Spence (2004) state that it is important to recognise that the diagnostic classification of social phobia is based from a continuum that defines an impairment in general social functioning. That is, the difference between a seemingly shy person and a person with a social phobia is that although a shy person may be hesitant in their engagement with a social situation (like presenting a speech or meeting new people) they are able to adapt to the circumstances of their engagement and gradually become more relaxed. Whilst in comparison, a person with a social anxiety disorder is most at ease when they are alone - they are dictated by personal fear and consistently worried about being placed in a situation that could lead to embarrassment or humiliation by others.

Historically, although defining elements of social anxiety have been acknowledged throughout the ages, this disorder was not labelled until the 1960s and furthermore was not accredited in psychiatric documentation until the 1980s (Gilbert & Trower, 2001). In 1980, the phenomenon of social

phobia was officially recognised as a psychiatric diagnostic classification with the publication of the Diagnostic Statistical Manual of Mental Disorders: Third Edition (DSM-III) (American Psychiatric Association), but even so, it took some time for practitioners to further examine and properly define this disorder. As reinforced in the workings of Wittchen and Fehm (2003), despite the increasing focus and study of social anxiety over the last decade, in contrast to that of other anxiety disorders (such as obsessive compulsive and panic disorders) current research has fallen several years behind - with the first clinically endorsed texts on social phobia only released in 1995 (Stein, 1995). Regardless of this late progress, current research is beginning to further develop the diagnostic nature and etiology of social anxiety disorder, from which a number of treatment approaches have been deemed to be effective in not only overcoming this disorder but in also further understanding it (Beidel, 1998).

In reference to the definition of social anxiety disorder in the DSM-IV (Appendix 1; as cited from the American Psychiatric Association), social phobia is formed on the basis that an individual maintains " A persistent fear of one or more social, or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others." A person with a social phobia primarily fears that he or she will act in a way or show excessive anxiety symptoms (For example: shaking, sweating, fidgeting etc) that will be negatively evaluated by others (Henderson & Zimbardo, 2001). The experience of such intimidating social situations will typically trigger an increasing level of anxiety and often a panic attack. As stated in the DSM-IV, a defining characteristic of social phobia is that a sufferer will recognise the

personally intimidating nature of a social situation and thus attempt to either avoid them or endure them with extreme discomfort. Additionally, when exposed to such a situation, the instigated fear and/or avoidance must lead to significant distress or difficulty that inhibits one's functioning - With this in mind, such anxiety mustn't be reflective of the effects of another general medical condition (or other mental disorder) or substance use. For example, it would not be considered a social anxiety disorder if an obese individual avoids socialisation because they are self-conscious that others may notice their weight.

In light of the clinical diagnosis of social phobia in children, such a disorder is not diagnosed if the social anxiety is only prevalent around adults (Kashdan & Herbert, 2001). Instead, childhood social anxiety must be evident in the child's engagement with their own peer group.

For suspected sufferers under the age of 18 years old, as to be diagnosed with a social phobia, the duration of the disturbance must be present for at least 6 months. Furthermore it is to be noted that children may also express such social phobia traits differently from that of adults - It may be presented in the form of crying, general defiance, mutism and/or retreating from social situations. Current statistical data presented from Essau, Conradt & Petermann (2002) highlights that in the general population, the lifetime prevalence of social anxiety disorder in children and adolescents ranges from 4% to 9%. This data is indicative of a wide prevalence which is often attributed to the fact that such anxiety-based dysfunction often goes unnoticed and is consistently undertreated in younger subjects.

Although seemingly equal, research reinforces that the occurrence of social phobia is statistically less common in males than that of females (Wittchen & Fehm 2003). This disorder is more commonly associated with younger people that are subject to a poor education, abusive family environment and a low socio-economical status; which are all common variables that coincide with the diagnosis of many other mental disorders. Correspondingly, past studies specify that 60 to 80% of clients that have been initially diagnosed with a social phobia are likely to experience comorbidity with other mental disorders - Most commonly; agoraphobia, substance abuse and depression (Wittchen & Fehm 2003). Accordingly, social anxiety can be seen as a formational basis in the developmental onset of psychiatric episodes - which statistically represent a high-risk group for suicidal ideation and attempted suicide (Rapee & Spence, 2004)

The causation and maintenance of Social Anxiety Disorder have been attributed to that of a combination of genetic and environmental influences (As depicted in - Appendix 2; as cited from Rapee & Spence, 2004).

Researchers of biological factors propose that some children can have a genetic predisposition towards being reserved and inhibited, which can often eventuate into social phobia when pressured with stress and hardship.

Moreover, environmental elements such as: certain family situations, childhood upbringing and general life experiences have also been labelled as influencing the causation of social phobia. According to the research of Gilbert & Trower (2001), current studies reinforce that the parents of children with Social Anxiety Disorder tend to maintain less sociable lifestyles and often exhibit socially anxious behaviours. Consequently, children and

adolescents that are consistently exposed to this parental style could be intrinsically structured to see the process of socialisation as being characterised with personal jeopardy, embarrassment and character deformation. In contrast, Albano (2000) specifies that another theory of causation could be evident in parents being overprotective when it comes to their child experiencing failure and rejection. The basis for this theory being that such inexperience may subconsciously support a child's disengagement with social situations and subsequently perpetuate a lifestyle governed with social fear and anxiety.

In combining the genetic and environmental perspectives of causation, Rapee & Spence (2004) acknowledge that the principles of equifinality and multifinality are both relevant variables in the development of social phobia. The concept of equifinality emphasises that individuals can be exposed to different pathways and upbringings, but can seemingly result in the same characteristics of behaviour. Contrastingly, multifinality refers to how individuals may begin with the same circumstances, but branch into various pathways and result in differing characteristics - E. g. If two children that are exposed to divorce at an early age; one child may need little support in adapting to new familial arrangements, while the other may become repressed and miserable. Evidently, there are a variety of possible developmental pathways that may prompt social fears. However singular factors are unlikely to be solely specific to the causation of social anxiety - For in light of genetic disposition, it is a combination of influential issues or a series of personally traumatic experiences which are usually attributed to the development of social phobia (Rapee & Spence, 2004).

In reference to childhood development, by the coming of adolescence, people engage with a variety of complex socially-dependant developmental tasks such as: developing relationships, establishing personal independence, and initiating long-term goals. One's successful engagement with these tasks is fruitful to the many key life-skills which form from that of self-confidence, self-control and recognition of appropriate social behaviour. Social anxiety disorders are typically evident in early adolescence (the early teenage years) however many suffers recall a prior disposition towards being social inhibited. Kashdan & Herbert (2001) state that the dangers of such early development of social phobia only increases as adolescents grow older and develop higher-order cognitive skills which endorse their ability to evaluate themselves comparatively to others and are furthermore able to interpret outside perspectives.

The development of social anxiety over increasing age-ranges reflects different behavioural responses in light of aversion to social circumstance (Kashdan & Herbert, 2001). Socially anxious toddlers may become excessively reserved in social situations, avoid unfamiliar people, decrease discourse and disengage from activities. As their age increases, younger children with basic social anxiety may begin to avoid social situations, become reluctant to associate with others and seek safe haven in familiar environments and isolated conditions. With this in mind, it is clear that these aversion techniques develop in complexity and if not addressed this underlying symptomology may provide the means for a social phobia to develop. The level to which one experiences the diminishment in personal, academic and social functioning is an important variable that will determine

whether the diagnosis of social phobia can be justified. The subjective distress caused by everyday functions for children and adolescents with social phobias are only tolerated as to meet the demands of everyday life. Thus, the achievement of certain life goals and objectives can often be postponed or even fail to occur due to such social fear.

As we develop over our lifetime, temporary episodes of increased social anxiety are considered a normal developmental experience; they cause relatively little interference in functioning and usually lessen with repeated exposure to social situations (Henderson & Zimbardo, 2001). The typical adolescent is confronted with social-evaluative situations on a daily basis. For most adolescents, these concerns are temporary and such transient anxious episodes serve as a learning experience, nonetheless there are a proportion of adolescents that will further develop the clinical signs of a social phobia. Henderson & Zimbardo (2001) make it clear that while the physiological symptoms of social anxiety during socially-intimidating situations are embodied in parasympathetic functioning (which can come in the form of increased respiration, elevated heart rate, perspiration etc), a mild to moderate presence of such symptoms shouldn't be viewed as anything abnormal in light of developmental expectation.

In reference to the clinical diagnosis of Social Phobia; behavioural responses, such as the stuttering of speech and the aversion of eye contact are all commonly generalised functions of anxiety that should only be acknowledged in light of a excessive reaction that inhibits proper functioning; which may be evident in severe panic attacks, consistent

behavioural and social disengagement, ongoing tantrums, or excessive somatic complaints.

The reality of Social phobia in childhood is that it is not only characterised with that of personal distress, it is often the forerunner of many other disorders. Many youths that are diagnosed with social anxiety disorder run a high risk for complications such as major depression, antisocial behaviour and suicidal ideation (La Greca & López, 1998). Not only has social phobia been directly linked to influencing the development of alcohol abuse by late adolescence; it is also associated with failure to attain lifestyle/qualification goals; which correspond with reduced vocational options, financial hardship and a decrease to personal health. Social phobias endorse low self-esteem, high sensitivity to subjective evaluation and submissiveness. La Greca & López (1998) identify that adolescent females with this disorder are often ruled by increasing levels of loneliness, seclusion, and personal severance from peers. Comparatively, adolescent boys with such disorder report feelings of incompetence and self-originated perceptual dislike from that of their peers.

Traditionally, the treatment for social anxiety was formed on the concept that children and adolescents would become less anxious towards socially challenging situations if they were given the opportunity to gain exposure to a variety of situations. The foundation for this treatment being that as the individual is prompted to become accustomed to their personal dynamics of anxiety, from which they are able to control and/or tolerate the corresponding subjective feelings of anxiety. Nonetheless, it needs to be acknowledged that not all children and adolescents with social phobia are

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able to fully adapt to their anxiety response – This disorder dictates that their bodily response remains a signal for aversion; it is the failure to adapt to these personal sensations that is indicative of the severity of their social anxiety. Additionally, much of the hardship that impairs the treatment of people with a social phobia originates from the fact that many educators and healthcare practitioners also fail to identify and support children that are governed with high levels of social anxiety. Hence, it would appear that early identification of social anxiety maintains key to treatability.

In correlation to therapeutic popularity, most children and adolescents are responsive to Cognitive Behavioural Therapies (CBT) in the treatment process (Taylor, 1996). Clients with social phobia, are systematically trained to utilise social skills as to confront (instead of avoid) their fears and generate personally relevant coping strategies. The logic behind such cognitive behaviour therapy is built from a desensitisation to that of the phobic antecedent. That is, with tiered and risk-free exposure to that of the confronting situation, clients are provided with the opportunity to learn personally relevant skills that are structured and reinforced with realistic and proactive experiences. In turn, they are able to better understand the causes of their phobic response and thus learn to manage such anxious arousal. The therapeutic benefits of such ‘group’ therapies is that they cater for a healing environment that promotes the discussion and employment of newly gained or refined anxiety management practices. Overall, the personal benefits of current cognitive behaviour group treatments are only reinforced with their underlying values – for as the formation of new friendships and the development of everyday social skills takes place, levels of personal solitude

decrease and one's willingness and desire to become involved in the academic, social, communal and professional elements of their lives increases.

In addition to the use of psychotherapies (E. g. CBT), for some adolescents medications are also used as to assist with decreasing levels of anxiety as to thus allow the client to better assess and maintain a commitment to the developmental benefits of their treatment. Pharmacotherapies have been increasingly utilised in the treatment of various anxiety disorders (Albano, 2000). There have been several types of medications that have proven to be effective in the management of social anxiety disorder and thus the reduction of social phobia. In particular, the main medications being used in this field include the monoamine oxidase inhibitors (MAOIs) (an enzyme that breaks down monoamines; one of the major types of neurotransmitters that manipulate mood and arousal), benzodiazepines (a depressant drug that works to slow physical, mental and emotional responses from the brain to the body), and the most tolerated drug in anxiety treatment; selective serotonin reuptake inhibitors (SSRIs) (which promote serotonin in the brain as to activate nerve cells and thus support the regulation of mood) (Kashdan & Herbert, 2001).

Regardless, current treatments (I. e. psychotherapies and pharmacotherapies) only represent a 50-70 % success rate of clients that have had a delayed diagnosis of severe social phobia (Crozier 2001). Furthermore, with a widespread general-population prevalence (4-9% - Essau, Conradt & Petermann, 2002), the complication that arises from social anxiety disorders is that when it comes to the provision and maintenance of <https://assignbuster.com/social-anxiety-disorder-in-children-and-adolescents/>

treatment methods, there are great numbers of clients that remain unrecognised and unsupported. The tragic nature of this disorder is that it entraps many sufferers with a lack of self-confidence and determination to seek help and maintain their commitment to treatment methods.

Evidently, it is clear that the development of additional treatment programs and options for social anxiety are a necessity. Current therapies often reside on a costly and long-term basis, whilst the utilisation of pharmacotherapies is often not overly endorsed due to its addictive properties.

Consequently, as severe social phobia patients are physiologically characterised with sympathetic overactivity, a lot of research has now been placed on investigating surgical procedures, such as endoscopic sympathetic blocks, where areas of sympathetic nervous system are blocked as to reduce symptoms of anxiety for clients that are resistant to both psycho- and pharmaco-therapies (Pohjavaara, Telaranta & Väisänen, 2001).

Over the past decade, our understanding of the nature and treatment of social phobia has increased enormously. For today's youth suffering from social phobia, the early implementation of cognitive behavioural therapies and pharmacological treatments seem to hold key to addressing this disabling condition (Beidel, 1998). The continuation of research can be seen as essential in the development of identifying the warning signs of social anxiety disorders within youths and thus form primary prevention strategies for this disorder. Currently there hasn't been any major studies in examining the effectiveness of combined treatment methods (i. e. Cognitive Behavioural Therapy and medication-based) or predicting how each

individual patient will react to chosen treatments (Rapee & Spence, 2004). Moreover, if stand alone treatments prove to be more beneficial, the issue of treatment sequencing will also need to be addressed - That is, should the treatment process begin with cognitive behavioural therapy or pharmacotherapy? And more importantly; how can we maintain a balance in the provision of support and the effectiveness of treatability?

In summary, despite of the fact that the majority of younger social anxiety disorder patients respond well to current treatments upon early diagnosis, it is important to acknowledge that many of them maintain high levels of anxiety beyond that of the therapeutic environment (Albano, 2000). More focus should be placed on developing treatments with minimal therapist contact. The regulation of such self-help therapies and lower levels of service contact have proven to be beneficial in promoting the engagement of sufferers with anxiety disorders, and thus may be supportive in the treatment of social phobia. In essence, although social anxiety can have a crippling effect on one's life, it is essential to recognise that there are methods to overcome such phobic response - Whether you're a parent, caregiver, peer or a member of a community, promoting social environments that are individually considerate and personally empowering are powerful ways of weaning child and adolescent sufferers away from detrimental behavior that interferes with their ability to be functioning and effective members of our society.