REVIEW ARTICLE

Social anxiety disorder in adolescence

Niyazi Cem Odemis, Sefa Bulut*

Odemis NC, Bulut S. Social anxiety disorder in adolescence. J Child Psychol 2023;7(1):1-7.

ABSTRACT

Anxiety disorders are one of the most common mental problems worldwide. Between these psychological issues, social anxiety disorder is an early onset, frequent and significant anxiety problem. As an early onset problem, social anxiety is mostly seen among adolescents, and it affects young individuals negatively in their social life. Due to the importance of the adolescence period for the whole life of individuals, it is significant to give attention to this kind of mental disease to create accurate prevention ways and help patients in their social life experiences. On the other hand, social anxiety disorder has comorbidity with other mental problems, such as depression, substance use, alcohol, suicide, and several anxiety problems. For this reason, preventing and treating social anxiety disorder helps to stop serious comorbid problems. In treatment, pharmacologic treatments and therapies are common and effective ways used by experts on social anxiety disorder first. However, there are several barriers to treatment in different dimensions. In this review paper, a social anxiety disorder in adolescence is examined. Secondly, comorbid disorders with a social anxiety disorder are handled. Lastly, the prevention and treatment process and barriers ahead of treatment are discussed.

Keywords: Mental health; Anxiety disorders; Social anxiety disorder; Adolescence; comorbidity

Abbreviations: SAD: Social Anxiety Disorder; WHO: World Health Organizations; DSM: The Diagnostic and Statistical Manual of Mental Disorders; ADHD: Attention Deficit and Hyperactivity Disorder; CBT: Cognitive Behavioral Therapy

INTRODUCTION

In certain ways, it is both normal and anticipated that some social settings would cause people to feel uncomfortable and anxious. It is safe to believe that everyone has, at some point, been embarrassed, had stage fright, or maybe even had their tongues tied during a talk. If such kinds of experiences become inevitable in daily life, and the communication and relationship skills are affected negatively by these experiences, this shows that an anxiety disorder has occurred. Clinically, this condition is referred to as Social Anxiety Disorder (SAD). According to the research "depression and other common mental disorders" conducted by World Health Organization (WHO), the percentage of the world's population with anxiety disorders was approximately 3.6% in 2015. In other words, 264 million people with anxiety disorders in the world were estimated, and the proportion of increase from 2005 to 2015 was 14.9%. When looking at the frequency of different types of mental illnesses; the most prevalent mental problems are anxiety disorders, which include separation anxiety disorder, generalized anxiety disorder, SAD, and panic disorder with or without agoraphobia. The possible reason is that patients suffering from anxiety disorders who are typically treated as outpatients, likely receive less focus by clinical psychiatrists than patients with other illnesses, such as schizophrenia or bipolar affective disorders, which require in-patient therapy but are less common [1].

LITERATURE REVIEW

According to the centers for disease control and prevention, about half of adults between the ages of 18 and 29 reports experiencing signs of anxiety or despair. Teenagers are predisposed to social anxiety. It has been demonstrated that social anxiety causes college aged youth to develop social impairment and diminished peer support. In recent study screening university students for DSM-5 social anxiety symptoms, it was found that 28.6% scored highly and 10% rated moderately [2,3]. Men who scored in the middle were more likely to have struggled with social anxiety as teenagers or young children. Moreover, higher scoring males were more likely to exhibit behavioral inhibition (e.g., shyness, avoiding social situations). Early life experiences often lead to the onset of SAD in children. About 50% of those who have the illness say it started before adolescence, and many of them remember that they "had always been this way." According to the others, adolescence or just after is when it starts. SAD, as an early experienced disorder, also brings several problems together, and it becomes more challenging with time as additional comorbid conditions develop such as substance abuse, or major depression [4,5].

Anxiety disorders are one of the most important mental problems in the world, and frequently, these are based on early life experiences at the onset. SAD is one of the most frequent anxiety disorders in childhood and youth. Furthermore, it has comorbid problems that occurred as a result of the negative experiences of SAD. In this case, understanding this mental problem during the period of adolescence has an important role to create prevention ways, and stopping comorbid illnesses occurred with SAD. In this article, SAD in adolescence is handled at first. Secondly, comorbid disorders that have connected with SAD are discussed, and prevention ways, barriers head solutions, and future directions are explained in the last part [6].

Social anxiety disorder in adolescence

SAD is described as a constant, unreasonable fear or worries about social and performance settings by the diagnostic and statistical manual of mental disorders (DSM-V) (e.g., initiating and maintaining conversations, musical or athletic performances, assertion, etc.). The symptoms of a SAD include extreme anxious reactions brought on by exposure to social situations as well as unfavorable assessments of one's performance in those situations [7]. Many young individuals may be in danger of these symptoms developing into a debilitating condition if they are not outgrown, according to research on SAD. This may be especially true during the transition from adolescence to early adulthood. Although SAD is one of the most common and significant mental health problems, it cannot be categorized and recognized easily because of its comorbidity with other mental problems [8,9]. For this reason, it needs to be understood clearly in order to develop correct prevention strategies.

A crucial time in a person's social development is adolescence, which is characterized by the growth of peer interactions, the significance of intimate

Department of Guidance and Counseling Psychology, University of Ibn Haldun, Istanbul, Turkey

Correspondence: *Sefa Bulut, Department of Guidance and Counseling Psychology, University of Ibn Haldun, Istanbul, Turkey, E-mail:* anderson.h@yahoo.com

Received: *21-Sep-2022, Manuscript No. PULJCP-22-5385;* ***Editor assigned:*** *23-Sep-2022, PreQC No. PULJCP-22-5385 (PQ);* ***Reviewed:*** *05-Oct-2022, QC No PULJCP-22-5385;* ***Revised:*** *18-Jan-2023, Manuscript No. PULJCP-22-5385 (R);* ***Published:*** *25-Jan-2023, DOI:10.37532/PULJCP.2023.7(1).1-3.*

relationships, and the emergence of romantic friendships. In the transition period from middle school to high school, the proportion of adolescents' social interactions, networks, and relationships increases [10]. During adolescence, close friends start to take the place of parents as the main source of social support for adolescents and make significant contributions to their self-concept and well-being as well. Furthermore, teens increasingly prioritize romantic connections. The beginning of disorders like SAD is more likely in young people who find social interaction more challenging because of new social expectations that force teenagers to act more independently in their social connections and increased peer influences [11,12].

The cognitive development requirements for SAD are established in adolescence, particularly the understanding that one's appearance and behavior serve as the basis for other people's judgments of them and the awareness that other people may have opinions that are different from one's own. Towards the end of childhood and early adolescence, social fears and assessment are in the foreground. SAD is supposed to evolve from normal anxiety that is amplified by the social requirements of pre-adolescence. Early teens often take on the responsibility of initiating opportunities for socializing, including dating, as their parents are typically no longer in charge of organizing their children's social activities [13,14]. These requirements, along with early adolescent cognitive developments in perspective taking and self-awareness, create the conditions for the genesis of SAD [15].

There are various predictors of SAD during adolescence based on particularly social interactions, social groups, peer relations, and friendship conditions, moreover, adolescent social anxiety is strongly correlated with other psychopathological diseases. According to research conducted on a group of adolescents, it is indicated that when other factors were taken into account, it was found that females reported more social anxiety than boys did, despite the fact that gender and social anxiety were initially unrelated [16]. Additionally, teenagers who belonged to peer groups both high and low status groups reported having less social anxiety. Furthermore, contributing to the prediction of social anxiety are higher levels of relational victimization, lower levels of better positive friendships, and higher levels of better negative friendships. Lastly, those who were not dating reported higher levels of social anxiety than those who were. Early experiences before the period of puberty and genetic factors have an association with SAD in adolescence. Through a stage of social anxiety that occurs in early childhood, maternal shyness may pass on the risk for SAD in teenagers. According to the research, it is claimed that maternal shyness causes SAD in adolescence and social wariness in childhood is a brokerage for the occurrence of SAD during the adolescence period [17]. Peer victimization also seems as an effective predictor of SAD. Peer aggression entails the victim's unwilling involvement in potentially harmful and dangerous exchanges. Such interactions have the potential to reinforce negative self-assessments and avoid social interactions. Others have hypothesized that harmed teenagers may internalize unfavorable criticism from hostile peers, which would heighten their social anxiety.

Comorbid disorders with social anxiety disorder

Identifying the risk factors, the connections between anxiety symptoms, the developmental continuities and discontinuities, and the validity of the major anxiety syndromes themselves in the study of anxiety disorders, in general, depends on the question of comorbidity. In as many as 90% of patients with SAD, psychiatric comorbidity has been found in community research to occur frequently. With the exception of particular phobia, ADHD, and separation anxiety disorder, SAD typically manifests earlier than the comorbid disorder across many situations. Additionally, it was discovered that SAD was a predictor of future major depression and alcohol use disorder onset. In comparison to those without comorbidity, SAD patients with comorbid psychiatric disorders have higher rates of suicide, increased symptom severity, treatment resistance, and impaired functioning like not going to work severally, or dropping out from school. As a significant part of the treatment process of SAD, the diagnosis of comorbid mental health problems, such as substance use, depressive symptoms, other anxiety disorders, and suicidal thoughts, plays a crucial role as well. For this reason, experts should give attention to this situation, and if there is a complaint from patients about co-occurred mental health issues, these complaints should be searched with care [18].

The majority of those who suffer from social anxiety disorders will go through one or more depressive episodes at some point; this is especially true for those who have the generalized form of SAD. The existence of SAD in adolescence or early adulthood is a significant risk factor for the development of depressive problems in the period of early adulthood. Furthermore, the chance of developing a depressive disorder later in life is substantially increased when depression and SAD co-occur in adolescence. In adolescence, the use of alcohol and cigarette is connected with a range of detrimental health and interpersonal effects, and when started early in life, alcohol and cigarette use problems are more likely to develop in maturity. SAD has a significant impact on adolescent alcohol and cigarette usage given the importance of peer influences on drug use in adolescence. Alcohol can be used by SAD patients as a kind of self-medication to lessen anxiety. This characteristic could be the reason why the risk of alcoholism rose after SAD. Suicide or suicidal ideation is mostly seen as a comorbid problem with SAD. According to research, 35% of people with SAD will have suicidal thoughts at some point in their lifetime and 22% of people with SAD will suffer suicidal thoughts in the preceding month. The majority of people who have one anxiety disorder also fit the criteria for other comorbid anxiety disorders. According to both community and clinical studies, about half of SAD patients had at least one comorbid anxiety illness in their lives, such as specific phobia, panic disorder, and generalized anxiety disorder [19].

Preventions, treatments, and barriers

In the treatment process of SAD, a comprehensive evaluation of SAD and its indications is an important factor. In this treatment, interview focused clinical observations, and using correct measures provide a proper diagnosis, and treatment process. It is necessary to do a thorough investigation into a variety of social circumstances that cause anxiety and/or are avoided. Additionally, it is useful to monitor carefully the patient's reports of physiological responses and in-session behavior. Several signs, such as poor eye contact, agitation, trembling hands, brief replies to questions, being late for appointments, and asking to leave early, show us that patient feels uncomfortable during the interview, which is a form of social interaction. Furthermore, the patient may also not follow the dialog during the session because of the mixing of anxiety and attention.

It is known from randomized and controlled studies that SAD is a kind of treatable mental problem and experts use pharmacotherapeutic choices. It is also known that Cognitive Behavioral Therapy (CBT), a type of psychotherapy aimed at altering patients' self-perceptions and social expectations, together with gradual exposure to and practice in dreaded social settings, improves many patients' lives. Due to the early age of onset of social anxiety disorder and the potentially modifiable underlying risk factors, such as behavioral inhibition, the effectiveness of an early CBT intervention to treat social anxiety disorder and prevent its consequences is an important area for future research and practice.

According to the understanding of the CBT approach to treating anxiety, social anxiety is a typical and anticipated emotion. CBT addresses the causes of anxiety and its components through specific psychoeducation, skills training, exposure methods, and relapse prevention plans. Reparative knowledge about anxiety and worried stimuli is provided through psychoeducation. Autonomic arousal and related physiological responses are focused by somatic management techniques while developmentally appropriate cognitive restructuring skills concentrate on identifying and teaching realistic, coping-focused thinking. Lastly, relapse prevention methods focused on consolidating and generalizing treatment gains over time, whereas exposure techniques entail graduated, systematic, and controlled exposure to feared situations and stimuli.

DISCUSSION

Historically, research into pharmacologic treatments for SAD has stalled behind other anxiety disorders. The signs of a SAD being mistaken for a

typical personality trait like shyness or as a specific condition like a subset of performance anxiety. Because of these reasons, DSM did not introduce SAD until 1980, and psychotherapy was used as a prevention method for SAD. Early on, SAD pharmacotherapy was mostly disregarded, but in recent decades, the development of medication-based treatment has dramatically increased. This increase occurred as a result of various factors. The first of these was the formal diagnosis of SAD, which is both extremely common and significantly debilitating. The proven efficacy of particular pharmaceutical treatments for SAD, as well as the recent rise of biological psychiatry and psychopharmacology as therapeutic specialties, have both been significant. The drug companies have sponsored and undertaken significantly more research in a quest to find precise SAD indications for various therapeutic products.

Although there are different prevention and treatment ways for SAD, based on several studies, several reasons become barriers to the starting of the treatment process, or during the treatment. The most often mentioned obstacles were shame and stigma, such as afraid of what other individuals may say or think, and logistical and financial challenges, such as a lack of insurance or the inability to pay for care, follows. In a group of patients with social anxiety who had not previously received mental health care, not knowing where to turn for assistance was the most often cited barrier. Many patients decided against getting help sooner because they thought they could manage their symptoms on their own. Only when symptoms are so severe, bothersome, critical, or unexpected that an individual can no longer manage or control them on their own may they decide to seek treatment.

CONCLUSION

The rate of mental health problems among adolescent people has a dramatic increase, and SAD is one of the problems that have increased in proportion among young people day by day. After the prevalence of SAD increased, it gained the part between other mental problems, and also particular treatment styles were developed by experts. SAD, as a mental problem that has occurrence in the early years of life, causes negatory experiences in daily life. In order to stop these negative effects of SAD needs help from mental health experts. However, individuals with SAD may prefer not to get support until they feel unfavorable effects at high levels. In this case, this important process may result in more problematic conditions, such as depression, substance use, or suicide. To prevent this depends on the attitude of patients toward the treatment process. Furthermore, the approach of other people to individuals with SAD is important as well. If patients feel separated and excluded, particularly in schools, social zones, and between friend groups, they do not want to express their problems and try to keep the problem covert due to stop exclusion. In this context, awareness of children, adolescents, and parents should be raised. Thus, this consciousness may help patients to find the road to follow in order to solve SAD. It also helps early prevention, so this problem may be stopped before developed and prevented from starting to affect the next periods of life. Furthermore, financial condition is a significant factor for patients to get support. For this reason, it is important to serve support to individuals who have inadequate financial resources. It may be solved with the support of the health institutions, or the states social applications.

REFERENCES

1. Belzer KD, McKee MB, Liebowitz MR, et al. Social anxiety disorder: Current perspectives on diagnosis and treatment. Primary Psychiatry. 2005;35-48
2. World Health Organization. Depression and other common mental disorders: global health estimates (No. WHO/MSD/MER/2017.2). World Health Organization. 2017;5-20.
3. Bandelow B, Michaelis S. Epidemiology of anxiety disorders in the 21st century. Dialogues Clin. Neurosci. 2022; 327-35
4. Cao R. The Impact of Social Anxiety during the COVID-19 Pandemic in Adolescence. Front Educ Res. 2021;1(2):36-43.
5. Stein MB, Gorman JM. Un masking social anxiety disorder. J Psychiatry Neurosci, 2001; 26(3):185-9
6. Whitmore MJ, Kim-Spoon J, Ollendick TH, et al. Generalized anxiety disorder and social anxiety disorder in youth: are they distinguishable? Child Psychiatry & Human Development, 2014; 45(4):456-63
7. Stefan CA, Cheie L. Self-compassion and social anxiety in late adolescence: Contributions of self-reflection and insight. Self and Identity, 2022;21(2):210-22.
8. Zeytinoglu S, Neuman KJ, Degnan KA, et al. Pathways from maternal shyness to adolescent social anxiety. J Child Psychol Psychiatry. 2022;63(3):342-49.
9. La GAM, Harrison HM. Adolescent peer relations, friendships, and romantic relationships: Do they predict social anxiety and depression? J Clin Child Adolesc Psychol, 2005;34(1):49-61.
10. Delgado B, Ingles CJ, Garcia-Fernandez, JM. Social anxiety and self-concept in adolescence. Rev de Psicodidactica, 2013;18(1):179-95.
11. Velting ON, Albano AM. Current trends in the understanding and treatment of social phobia in youth. J Child Psychol Psychiatry. 2001; 42(1):127-40.
12. Storch EA, Masia WC, Crisp H, et al. Peer victimization and social anxiety in adolescence: A prospective study. Aggressive Behavior: Official J Int Soc Res Aggress, 2005;31(5):437-52.
13. Koyuncu A, Ince E, Ertekin E, et al. Comorbidity in social anxiety disorder: diagnostic and therapeutic challenges. Drugs in context, 2019;8:212573: 1-13
14. Savage JE, Kaprio J, Korhonen T, et al. The effects of social anxiety on alcohol and cigarette use across adolescence: Results from a longitudinal twin study in Finland. Psychology of addictive behaviors. Addict Behav. 2016;30(4):462–74.
15. Stein MB, Fuetsch M, Muller N, et al. Social anxiety disorder and the risk of depression: a prospective community study of adolescents and young adults. Arch Gen Psychiatry. 2001;58(3):251-56.
16. Arditte KA, Morabito DM, Shaw AM, et al. Interpersonal risk for suicide in social anxiety: The roles of shame and depression. Psychiatry Res.. 2016;239:139-44.
17. Stein MB, Stein DJ. Social anxiety disorder. The Lancet, 2008;371(9618):1115-25.
18. Goetter EM, Frumkin MR, Palitz SA, et al. Barriers to mental health treatment among individuals with social anxiety disorder and generalized anxiety disorder. Psychological Services, 2020;17(1):5.
19. Olfson M, Guardino M, Struening E, et al. Barriers to the treatment of social anxiety. Am J Psychiatry. 2000;157(4):521-27.