Concluding Remarks

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This volume brings together several perspectives on the development, manifestations, and treatment of social anxiety and phobia in adolescence. Following the general outline of the volume, we present some concluding remarks on the field, with an emphasis on future challenges and directions.

Aetiology and Epidemiology

SAD is a common and highly comorbid disorder among adolescents that has high societal and personal burden. Improved understanding of factors that maintain and provide risk for this disorder is critical to help reduce its impact (Chaps. 2 and 3). Evidence suggests that risk factors such as genetic influence, temperament, parental variables (i.e., parental level of expressed emotion), and peer experiences play a major role in the onset of SAD during adolescence (Chaps. 2, 3, 4, 5, and 7), although efforts to evaluate other potential risk factors for SAD onset in

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K. Ranta et al. (eds.), *Social Anxiety and Phobia in Adolescents: Development, Manifestation and Intervention Strategies*, DOI 10.1007/978-3-319-16703-9_15

adolescence are needed (Chap. 2). For example, relatively little is known about how the common developmental transitions of adolescence (in school settings, romantic relationships, biological transitions, individuation process) affect or exacerbate SAD in youth (Chap. 5).

Epidemiological research indicates that the onset of social anxiety symptoms severe enough to warrant a clinical diagnosis typically occurs during the second decade of life. This body of research signals a risk for youths' continued distress and impairment in social functioning well into young and middle adulthood as well as for the subsequent onset of depressive and substance use disorders. Although less studied, it is possible that the consequences of early SAD may even include such severe problems as personality disorders and even psychosis (Chap. 3). The differential maturation between the subcortical regions of the brain (e.g. amygdala) in combination with late development of the regulatory prefrontal cortical regions during adolescence, paired with the vulnerability brought about by increased sensitivity to social rewards in adolescent peer contexts, may act as precipitating factors to heighten social anxiety in this developmental period (Chaps. 2, 3, and 4).

The influence of problematic peer processes on social anxiety has been studied across a broad developmental age range, from childhood through adolescence, and the results reveal the stability of this negative effect (Chaps. 2, 3, 5, and 7). However, surprisingly little is known about the relative weight of family factors and interactions that may contribute to social anxiety during the adolescent period.

Recognition and Manifestations

Early detection of adolescents at risk for SAD is an important practice goal. Using a comprehensive, multidisciplinary perspective and focusing on evidence-based and culturally adapted screening protocols may facilitate the assessment of SAD in adolescents (Chap. 6). Studies conducted in ecological peer groups, such as among classmates, have begun to reveal the complex mechanisms by which socially anxiety may persist and worsen in school settings. For example, factors in youths' overt appearance, behaviour, and social skills may contribute to their being disliked or treated poorly, and their internalized negative expectations about their peer relations may also lead to further social withdrawal (Chap. 7).

Social anxiety has consequences for youths' social and emotional development, such as by causing distress and impairment in emerging romantic relationships and undermining the transition to more independent functioning outside of the family (Chaps. 5, 8, and 9). Adding to the evidence gained from population studies, clinical observations confirm the negative influence on adolescents' social anxiety of dysfunctional parental behaviours, such as modelling of shame, dependency of other's opinions, and low sociability and also stress the need to address family factors in clinical interventions (Chap. 9).

Treatment and Prevention

Social skills training and cognitive-behavioural treatments (CBT) are efficacious in treating SAD in adolescents (Chaps. 10, 12, and 13). CBT-based interventions have seen a gradual evolution towards advanced developmental sensitivity of the content (e.g. CBGT-LEAP for emerging adults; Chap. 9) and advanced ecological validity of the settings (e.g. school-based programmes such as the original IAFS, IFAFS and the SASS; Chap. 12). Also, treatment applications using new technology, such as computer-aided virtual environment social skills training programmes, allow gradual exposure and practising of socially adaptive behaviour (Chap. 13). Computer-based CBM protocols that train socially anxious youth to direct their attention away from threat or to construct benign interpretations of ambiguous social situations (Chap. 10) also hold promise. Efforts to assess and intervene in school settings may facilitate the identification and treatment of youth with SAD (or youth at risk for the disorder); as such youth are not likely to seek traditional clinical services (Chaps. 6, 11, and 12).

Interpersonal approaches to the treatment and prevention of SAD also appear promising and are currently being investigated. The most recent developments based on the interpersonal model acknowledge the significance of problematic peer relationships and peer victimization as risk factors for SAD and seek to prevent it by focusing on peer relationships, interpersonal skills, and assertiveness (Chap. 11). The pharmacological treatment of SAD has advanced during the last 10 years; however, most controlled studies have been performed in mixed child-adolescent samples and in samples consisting of mixed disorders. Future studies that specifically target adolescents aged 12–19 years with SAD are needed. Despite these drawbacks, evidence supports the use of SSRI, and possibly SNRI, at least in complex and treatment resistant cases (see Chap. 14).

Finally, in closing, significant developments have been made in recent years in the study of etiological and precipitating factors of adolescent social anxiety/SAD, their manifestations in both clinical and real-life contexts, and their treatment. We hope that the present volume will encourage further developmental research and clinical efforts that ultimately will lead to enhanced early detection and intervention of SAD and to better outcomes for youth who suffer from it.