Generalized Anxiety Disorder & Social Anxiety Disorder Across the Lifespan — Children, Adolescents, Adults (2025)

Definitions • Epidemiology • Etiology • Clinical Features • Diagnosis • Treatment • Prognosis • References
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Overview & Definitions

- • Generalized Anxiety Disorder (GAD): excessive, hard-to-control worry occurring more days than not for ≥6 months about multiple domains, with ≥3 associated symptoms (adults) such as restlessness, fatigue, concentration difficulty, irritability, muscle tension, sleep disturbance; in children, only 1 associated symptom required.
- • Social Anxiety Disorder (SAD): marked fear or anxiety about one or more social situations where scrutiny is possible (e.g., conversations, being observed, performing); fears of negative evaluation lead to avoidance or intense anxiety; persistent (typically ≥6 months) and impairing.
- • In youth, anxiety often presents with somatic complaints (headache, stomachache), school refusal, and irritability; in adults, worry/avoidance patterns are more articulated.

Epidemiology & Course

- • GAD: 12-month prevalence ~2–3% adults; lower in children but increases through adolescence. Often chronic with waxing/waning course; high comorbidity with MDD and other anxiety disorders.
- • SAD: lifetime prevalence ~7–12% adults; commonly begins in early adolescence; can be chronic without treatment; impairment across academic/occupational and interpersonal domains.
- • Gender: females generally show higher rates for both GAD and SAD from adolescence onward.
- • Onset: GAD often later than SAD; SAD commonly starts in adolescence; early onset predicts greater persistence.

Etiology & Risk Factors

- • Multifactorial: genetic liability (moderate heritability), temperament (behavioral inhibition, negative affectivity), cognitive biases (threat interpretation, intolerance of

uncertainty), information-processing biases (attention/vigilance), and learning (conditioning, modeling, avoidance reinforcement).

- • Family factors: parental anxiety/overprotection, criticism, low warmth, and adverse childhood experiences increase risk.
- • Neurobiology: dysregulated amygdala-prefrontal circuitry, heightened autonomic reactivity; HPA-axis contributions; in GAD, intolerance of uncertainty and worry as cognitive avoidance; in SAD, heightened self-focused attention and fear of evaluation.
- • Sociocultural: peer victimization, social media stressors, minority stress, and academic pressure can maintain symptoms, especially in adolescents.

Clinical Features — Cross-Age Profiles

Generalized Anxiety Disorder (GAD)

- • Core: excessive, pervasive worry; difficulty controlling worry; restlessness, fatigue, poor concentration, irritability, muscle tension, insomnia.
- • Youth: worry themes include school performance, family safety, social acceptance; somatic complaints common.
- • Adults: broader domain worries (work, finances, health), muscle tension, sleep disturbance prominent.

Social Anxiety Disorder (SAD)

- • Core: fear of negative evaluation; avoidance/endurance with marked distress in social/performance situations; anticipatory anxiety; post-event rumination.
- • Youth: school avoidance, reluctance to speak in class, limited peer engagement; may appear “shy,” oppositional, or mute (in selective mutism).
- • Adults: avoidance of meetings, presentations, networking; safety behaviors (notes, rehearsing, avoiding eye contact).

Assessment & Diagnosis

- • Clinical interview: onset, duration, triggers, avoidance patterns, impairment; screen for depression, substance use, ADHD (in youth), autism spectrum traits (for social difficulties), and medical contributors (thyroid, arrhythmia, asthma, GI issues, medications/caffeine).
- • Measures (examples): GAD-7, PSWQ (worry); SPIN, LSAS (social anxiety); SCARED (youth), RCADS (youth); PHQ-9 for depressive comorbidity; Columbia-Suicide Severity Rating Scale when indicated.
- • Differential:

– GAD vs. OCD (intrusive ego-dystonic obsessions/compulsions), PTSD (re-experiencing/avoidance after trauma), illness anxiety, MDD (pervasive low

mood/anhedonia), ADHD (inattention from executive issues rather than worry), Autism (social communication differences beyond performance fear).

– SAD vs. agoraphobia/panic disorder (panic-linked avoidance), body dysmorphic disorder (appearance preoccupation), autism (primary social communication deficits), MDD (social withdrawal without fear of evaluation).

Psychotherapy — First-Line

- • Cognitive Behavioral Therapy (CBT) with exposure is first-line across ages.

– GAD-focused: psychoeducation, worry awareness, stimulus control, cognitive restructuring (probability/magnitude reappraisal), intolerance of uncertainty (IU) modules, problem-solving, relaxation as skills-building (not safety behaviors).

– SAD-focused: fear hierarchy, in-session and in-vivo exposures (social mishap tasks), cognitive restructuring targeting social cost/likelihood and self-focused attention, video feedback to correct negative self-imaging, reduction of safety behaviors.

- • Youth: family-involved CBT (Coping Cat/BI/BI-based), parent training to reduce accommodation and reinforce brave behavior.
- • Group CBT helpful for SAD (peer practice of exposures) and adolescents.
- • Other evidence-based options: Acceptance & Commitment Therapy (ACT), Mindfulness-based therapies; for youth, school-based programs can reduce barriers.
- • Selective mutism: behavioral shaping, stimulus fading, and exposures in school settings; consider comorbid SAD.

Pharmacotherapy — Evidence-Based

- • SSRIs/SNRIs are first-line medications for both GAD and SAD when symptoms are moderate-severe, comorbid, or CBT alone insufficient.

– Common SSRIs: sertraline, fluoxetine, escitalopram, paroxetine (adults); SNRIs: venlafaxine, duloxetine (adults).

– Youth: fluoxetine, sertraline have evidence; start low, go slow; monitor for activation/suicidality.

- • Buspirone: sometimes used in adult GAD (modest effect; not helpful for SAD).
- • Benzodiazepines: short-term, situational use in select adults; avoid routine use due to dependence/cognitive side effects; generally avoided in youth.
- • Beta-blockers (e.g., propranolol): performance-only situations (adults) for tremor/tachycardia; not core treatment for generalized SAD.
- • Adjuncts: hydroxyzine (short-term), gabapentinoids (off-label, mixed evidence).

- • Duration: continue meds 6–12 months after remission, with gradual taper; combine with CBT for relapse prevention.

Exposure Design & Safety

- • Build graded hierarchies collaboratively; focus on approaching, not avoiding.
- • Drop safety behaviors (e.g., scripted answers, sunglasses indoors) during exposures to maximize learning.
- • Embrace inhibitory learning principles: vary contexts, durations, and stimuli; violate catastrophic predictions and practice post-event processing.
- • For GAD, include worry exposures (imaginal/behavioral) and IU exercises (planned uncertainty, “maybe” statements).

School/Work Accommodations & Lifestyle

- • School: predictable routines, gradual return plans after avoidance, reduced accommodation of anxiety while supporting exposures, test-taking supports, presentation scaffolding for SAD.
- • Work: flexible presentations (small-group first), rehearsal opportunities, feedback coaching; structured task lists for GAD.
- • Lifestyle: regular sleep, exercise, caffeine/nicotine reduction; breathing skills; digital hygiene (limit reassurance-seeking online).

Special Populations

- • Children: emphasize parent-led contingency management and brave behavior plans; integrate school exposures; address bullying and social skills deficits.
- • Adolescents: peer-based exposures, address social media and evaluation fears; motivational interviewing to boost engagement.
- • Adults: comorbidity management (MDD, SUD); brief-format or blended digital CBT to increase access.
- • Cultural considerations: normalize help-seeking; adapt examples and exposures to cultural and religious contexts; address minority stressors and stigma.

Prognosis & Outcomes

- • Many respond to CBT and/or SSRIs; combined treatment often yields faster, broader gains.
- • Untreated GAD/SAD linked to academic underachievement, reduced occupational attainment, relationship strain, increased risk of depression and substance use.
- • Early treatment, parental involvement (youth), and reduction of accommodation predict better outcomes; relapse risk reduced by continued skills practice and booster sessions.

Clinical Snapshots (Checklists)

GAD (all ages)

- □ Excessive worry most days ≥6 months; difficulty controlling worry
- □ ≥3 associated symptoms (adults) / ≥1 (child): restlessness, fatigue, poor concentration, irritability, muscle tension, sleep disturbance
- □ Rule out medical/substance causes; assess comorbidity (MDD, other anxiety)

SAD (all ages)

- □ Marked fear/anxiety in social/performance situations with negative evaluation fears
- □ Avoidance or endured with intense distress; persistent (≥6 months) and impairing
- □ Include performance-only specifier when relevant; differentiate from autism/BDD

First-line Plan

- □ Offer CBT with exposure; for youth include parents/school
- □ Consider SSRI/SNRI for moderate-severe impairment or CBT-refractory cases
- □ Set functional goals; track with GAD-7/SPIN/LSAS/RCADS; schedule booster sessions

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