of Health: São Paulo, 2007, no prelo – não autorizam conclusão semelhante.

Os gastos federais absolutos em saúde mental (e saúde em geral) vêm crescendo consistentemente ao longo dos últimos dez anos, e a proporção GSM/GTS vem se mantendo praticamente estável (em torno de 2% e 2,5%). Todos estamos de acordo que é necessária uma melhora significativa desta proporção (a OMS recomenda uma taxa de 5%, desempenho este que só se observa em alguns dos países europeus[3]), mas não existem dados para indicar que ela sofreu redução. Se o Brasil ostentasse de fato 5,8% do orçamento da saúde destinados à saúde mental, estaríamos melhor, em 1995, que a maioria dos países europeus herdeiros da época de ouro do Welfare State![4] O que houve foi um aumento regular em termos absolutos e um redirecionamento dos recursos para o sistema extra-hospitalar (em 1995, mais de 90% dos recursos SUS em saúde mental financiavam o sistema hospitalar). Ocorreu, sim, redução proporcional dos gastos hospitalares que, pela primeira vez, em 2006, ficaram menores que os extra-hospitalares (48,7% contra 51,3%),[5] caracterizando a desejável mudança do modelo assistencial psiquiátrico público do Brasil. Esta nos parece a questão real do debate sobre o financiamento da saúde mental no SUS: como sustentar a mudança de modelo, que exigirá sempre novos investimentos. O futuro, não o passado.

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Are there differences between early- and late-onset social anxiety disorder?

Existem diferenças entre transtorno de ansiedade social de início precoce e tardio?

Dear Editor,

We read with great interest the article by Menezes et al.,[1] in which the authors highlighted that early-onset social anxiety disorder (SAD) patients presented more commonly with the generalized subtype, were more frequently inactive and had higher prevalence of psychiatric comorbidities. They could not find differences between groups regarding severity of the symptoms and therapeutic responses. The authors concluded that there is a subgroup of SAD patients with early-onset of social anxiety symptoms with different clinical characteristics.

In the framework of a prevalence study of SAD with undergraduate students, we evaluated 2,319 subjects taking several different courses at the University of São Paulo (USP) *campus* Ribeirão Preto and from the Universidade de Franca (UNIFRAN). The Social Phobia Inventory (SPIN)[2] was collectively administered to all subjects who agreed to participate. After this first phase of the study, individuals with

Table 1 – Comparison of the socioeconomic and clinical characteristics of patients with early- and late- onset social anxiety disorder. SPIN – Social Phobia Inventory

Variable	Early-onset		Late-onset	
	< 15 years n = 168 (70.9%)	< 18 years n = 211 (89.0%)	≥ 15 years n = 69 (29.1%)	≥ 18 years n = 26 (11.0%)
Age (years)	21.31 (± 2.7)	21.43 (± 2.8)	21.26 (± 3.8)	21.88 (± 4.0)
Sex				
Male	60 (35.7%)	70 (33.2%)	16 (23.2%)	6 (23.1%)
Female	108 (64.3%)	141 (66.8%)	53 (76.8%)	20 (76.9%)
Economic activity				
Work and study	35 (20.8%)	40 (19.0%)	9 (13%)	4 (15.4%)
Only study	133 (79.2%)	171 (81.0%)	60 (87%)	22 (84.6%)
Use of medication	37 (22%)	46 (21.8%)	18 (26.1%)	9 (34.6%)
Academic performance	7.07 (± 1.0)	7.02 (± 1.1)	6.96 (± 1.1)	7.20 (± 0.9)
Subtype (DSM-IV)				
Circumscribed	79 (47%)	100 (47.4%)	34 (49.3%)	12 (46.2%)
Generalized	89 (53%)	111 (52.6%)	35 (50.7%)	14 (53.8%)
Severity (DSM-IV)				
Mild	34 (20.2%)	44 (20.9%)	18 (26.1%)	8 (30.8%)
Moderate	107 (63.7%)	137 (64.9%)	44 (63.8%)	14 (53.8%)
Severe	27 (16.1%)	30 (14.2%)	7 (10.1%)	4 (15.4%)
SPIN total score	37.20 (± 10.7)	36.75 (± 10.2)	35.31 (± 7.8)	35.92 (± 7.9)
Factor 1	10.78 (± 3.3)	10.66 (± 3.1)	10.43 (± 2.6)	10.80 (± 2.9)
Factor 2	6.10 (± 3.7)	6.01 (± 3.6)	5.56 (± 3.2)	5.50 (± 2.8)
Factor 3	8.53 (± 3.9)	8.45 (± 3.1)	8.12 (± 2.9)	8.08 (± 3.0)
Factor 4	2.99 (± 2.0)	2.98 (± 2.0)	2.88 (± 1.5)	2.77 (± 1.7)
Factor 5	8.80 (± 2.2)	8.65 (± 2.2)	8.32 (± 2.2)	8.77 (± 2.1)

scores ⩾ 6 in the brief version of the SPIN (Mini-SPIN)[3] were included. All selected individuals were then interviewed with the Portuguese version of the SAD module of the SCID-IV.[4] Diagnosis was confirmed for 237 (10.2%) of the total sample; the average age at SAD onset was 11.4 years (± 0.27) with an average time of disease of 10.2 years (± 0.3). All subjects gave written informed consent after being fully informed of the research procedure, following approval by the local Research Ethics Committee (no. HCRP 11570/2003).

Patients with early- (< 18 years) and late- (⩾ 18 years) SAD onset were compared and contrasted regarding clinical and sociodemographic aspects, and academic performance (evaluated by weighted average grades) - Table 1. There were no statistical differences between groups in respect to symptom severity as assessed by the SPIN[2] scale and its factors scores, academic performance, severity of SAD according to the SCID-IV,[4] and use of general and psychotropic medications. In contrast to the study by Menezes et al.,[1] we have not found differences between groups in respect to the frequency of the generalized subtype of social phobia and economic productivity. In addition, there was no significant correlation between age at onset of SAD and the SPIN scores ($r = -0.08$, $p = 0.21$) and academic performance ($r = 0.01$, $p = 0.75$). All of these results persisted even when we adopted an age cut-off point of 15 years old to define early onset[5] (Table 1).

These different findings may be explained by the fact that in the study by Menezes et al. the sample was composed solely of subjects who sought treatment spontaneously at a specific research center, whereas in our study the SAD population was found in the scope of an epidemiological survey, not consisting of a clinical sample. Moreover, at this point of our study we did not systematically assess psychiatric comorbidity and only a subsample accepted treatment, not allowing for any conclusions regarding the influence of the therapeutic response and the effect of other psychiatric conditions between groups.

Thus, in conclusion, our data are not supportive of differences between early- and late-onset SAD subtypes. Nevertheless, future studies in different settings and SAD populations are clearly needed and opportune.

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Conflict of interests: None

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Reply to Dr. Crippa's letter "Are there differences between early- and late-onset social anxiety disorder?"

Resposta à carta do Dr. Crippa "Existem diferenças entre transtorno de ansiedade social de início precoce e tardio?"

Dear Editor,

We appreciate the thoughtful letter from Dr. Crippa and colleagues, who raised some interesting issues based on the findings of our article entitled "Early-onset social anxiety disorder in adults: clinical and therapeutic features",[1] which was published in the *Revista Brasileira de Psiquiatria*. In our study, we evaluated the sociodemographic and clinical characteristics of a sample of adult patients diagnosed with social anxiety disorder (SAD). The objective of our analysis was the identification of differences between the subgroups presenting early- and late-onset forms of the disorder. We found that patients from the former group were more frequently economically unproductive, presented a higher frequency of the generalized subtype of SAD, and exhibited greater rates of multiple comorbid psychiatric disorders.