Unmasking social anxiety disorder

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"Man is the only animal that blushes ... or needs to."
—*Mark Twain*

Introduction

Shyness and self-consciousness are related constructs describing a tendency for some people to fear and avoid the scrutiny of others. In some cases, these characteristics are so pronounced that the individual shuns most forms of interpersonal contact or endures these encounters only with intense discomfort. Such people suffer from what is alternately referred to as "social anxiety disorder" or "social phobia." Once largely neglected by the medical community,[1] social anxiety disorder is now garnering increased attention and recognition as a serious but treatable condition.[2-4]

Clinical picture

People with social anxiety disorder are typically shy, timid, quiet in groups and uncomfortable being the centre of attention. They are not strange or "schizoid" — the Unabomber was not socially phobic. They crave the company of others but fear being found out as unlikable, stupid or boring. Accordingly, they avoid speaking in public, expressing opinions or even "hanging out" with peers; as a result, they are often mistakenly labelled as "snobs." Many social phobics lack self-esteem, find it difficult to deal with people in authority, and are unable to speak or perform in front of even small groups of people. In its most pervasive form — when it interferes with the individual's functioning in a wide range of social situations — the term "generalized" social anxiety disorder is applied. It is this generalized form of the disorder that accounts for most cases seen by psychiatric and general medical practitioners.

Social anxiety disorder begins early in life and often manifests in childhood.[5-7] Approximately 50% of those with the disorder report the onset before adolescence, many recalling that they have "always been this way." The others report the onset during or shortly after adolescence.[8-10] As an early-onset disorder, social anxiety disorder is frequently complicated over time by the occurrence of other comorbid conditions, most prominent among them being substance abuse disorders (particularly alcoholism) and major depression.[10,11]

Social anxiety disorder is the most common anxiety disorder among depressed patients.[12] Most people with social anxiety disorder will at some point experience one or more depressive episodes;[13] this is especially true of people with the generalized form of social anxiety disorder.[10,14] Several studies suggest

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Medical subject headings: anxiety disorders; cognitive therapy; comorbidity; cost of illness; drug therapy; quality of life

J Psychiatry Neurosci 2001;26(3):185-9.

Submitted Jan. 25. 2001
Revised Feb. 22, 2001
Accepted Mar. 6, 2001

that social phobia is a risk factor for early-onset depression,[15,16] perhaps through a shared genetic diathesis,[17,18] though this remains to be proven. In some studies, the presence of comorbid social phobia has been associated with a more malevolent course of depressive illness.[19,20]

Epidemiology

When prevalence estimates were based on the examination of psychiatric clinic samples, social anxiety disorder was thought to be a relatively rare disorder.[21] We now know that patients with social anxiety disorder in the community seldom seek or receive psychiatric care,[9] leading to a gross underestimation of the prevalence of the disorder. This is analogous to the situation 10 years ago with regard to obsessive–compulsive disorder (OCD): "rare" when viewed from the perspective of clinical samples because patients did not seek treatment, but common in the general population. It was not until community surveys were undertaken that the extent of this "hidden epidemic" of OCD became known.[22] And it was not until these data were publicized that patients with OCD began to seek treatment and to be more frequently diagnosed by their physicians.[23]

Similarly, it was not until community surveys were conducted that the true prevalence of social anxiety disorder became apparent. Data from one of the first of these North American surveys, the Epidemiologic Catchment Area (ECA) survey,[8] found an approximate 1% point-prevalence of social anxiety disorder, with a lifetime prevalence in the range of 2%–3%.[8,24] This was newsworthy at the time but, as it turns out, the ECA study surveyed only a limited range of social situations and therefore missed many cases of social anxiety disorder.[25] A more recent study, the National Comorbidity Survey,[9] found 12-month and lifetime prevalence rates of social anxiety disorder of 7.9% and 13.3%, respectively. Similar findings have come from contemporaneous Canadian and European epidemiologic surveys, with even the most conservative of these placing the point prevalence of the disorder in the range of 4%–5%.[26–28] Studies of social anxiety disorder in primary care settings find the disorder to be common in patients, but only a fraction of cases are diagnosed by general practitioners.[29,30] Thus, from all reports, social anxiety disorder appears to be a remarkably common — albeit largely unrecognized — disorder.

Functional disability and quality of life

In addition to being prevalent, social anxiety disorder is associated with substantial functional impairment.[31] Patients exhibit a wide range of educational, occupational and social disabilities.[32–34] This is a disorder of lost opportunities — individuals make major life choices to accommodate their illness. For example, they drop out of school early because of their fears of speaking in front of groups, or they take jobs that permit them to avoid interacting with others. They often do not date at all, and many become lonely and isolated.

If and when they eventually present for treatment, patients with generalized social anxiety disorder report tremendous dissatisfaction with their lives. They perceive their quality of life to be poor and report extensive illness intrusiveness (i.e., the extent to which an illness interferes with functioning) comparable to that reported by patients with other chronic illnesses such as multiple sclerosis, rheumatoid arthritis and end-stage renal disease.[35,36] Even in the general population, the burden of illness associated with social phobia is astonishing, rivaling that of its oft-present companion, major depression.[37]

Etiologic factors

As in other areas of psychiatry, the etiologic nature of social anxiety disorder remains obscure. Although there might be reason to expect that particular childhood adversities or developmental experiences might confer an increased risk for the disorder, this has yet to be demonstrated. The disorder is familial,[38,39] particularly in its generalized form where the risk to first-degree relatives is 5–10 times that of the general population.[40] These findings do not, of course, distinguish family environmental from genetic contributions to risk, both of which are presently active areas of research.[41]

Several biological models of social anxiety disorder are currently being investigated;[42] one of the most intriguing is the theory that the disorder involves dysfunction in brain dopaminergic systems. In support of this possibility, a single-photon emission computed tomography (SPECT) study from Finland[43] found that patients with generalized social anxiety disorder had significantly lower binding to the striatal dopamine transporter than a comparison group of healthy subjects. Reduced striatal dopamine D_2 receptor binding potential on SPECT has also been found in patients

with generalized social anxiety disorder compared with healthy control subjects.[44]

Treatment

A mere decade ago, a review of the treatment of social anxiety disorder would have been limited to a statement that monoamine oxidase inhibitors were possibly efficacious.[45] We now know from a number of randomized, controlled trials that social anxiety disorder is a treatable disorder and that several pharmacotherapeutic choices are available to the treating physician. We also know that a psychotherapy known as cognitive behavioural therapy, which is directed at changing patients' views about themselves and their expectations in social interactions, in concert with gradual exposure to and practice in feared social situations, leads to improvement in many patients. Although cognitive behavioural therapy may be as efficacious as pharmacotherapy,[46] providing this form of treatment to the vast number of patients with social anxiety disorder will require availability of and access to a cadre of highly trained therapists, a situation that does not currently exist in most localities. Most patients will, however, have access to pharmacotherapy through either a psychiatrist or their primary care physician.

Although the efficacy of monoamine oxidase inhibitors (e.g., phenelzine) in the treatment of social anxiety disorder has been confirmed,[47,48] their unfavourable side-effect profile and the need for a special low-tyramine diet has relegated them to second- or third-line status. A newer class of drugs, the reversible inhibitors of monoamine type A (e.g., moclobemide) — which carry no dietary restrictions at therapeutic doses — were hoped to be a safer, better-tolerated alternative to the monoamine oxidase inhibitors.[48,49] A series of subsequent clinical trials, however, has been disappointing,[50,51] leaving up-in-the-air the role of moclobemide in treating this disorder.

High-potency benzodiazepines (e.g., clonazepam) are efficacious for social anxiety disorder,[52] although their potential for abuse remains of some concern and may limit their use by some practitioners. β-Adrenergic blockers (e.g., propranolol, atenolol), although of some use on an as-needed basis to treat isolated performance anxiety, are probably of no benefit in the treatment of generalized social anxiety disorder.[47] This message will need to get out to physicians, many of whom equate social phobia with public speaking anxiety and, accordingly, prescribe β-blockers because of their familiarity with this class of drugs. Similarly, another medication frequently used to treat anxiety in primary care settings, buspirone, has been shown to be inefficacious in the treatment of social anxiety disorder.[53]

The efficacy of the selective serotonin reuptake inhibitors (SSRIs) for social anxiety disorder has been confirmed in several double-blind, placebo-controlled, randomized multicentre clinical trials. In the first of these,[54] the SSRI paroxetine was shown to result in clinically meaningful improvement in 55% of patients with generalized social anxiety disorder, compared with 24% of those taking placebo. Other SSRIs such as fluvoxamine and sertraline have subsequently also been proven efficacious,[55,56] (and it is likely that other newer antidepressants will follow as ongoing clinical trials programs are completed). In all of these studies, response rates peak at around 55%, meaning that further research is required to determine how to help patients who do not respond to these therapies. Newer pharmacotherapies must be tested, and the possibility of combining pharmacologic and psychotherapeutic modalities should be explored.

Conclusions

Social anxiety disorder is not just shyness,[2] nor for most sufferers does it consist merely of an inability to speak in public. For most patients with social anxiety disorder, it is a pervasive, disabling condition that steals away opportunities for a richer, fuller life. Combining high prevalence rates with serious negative effects on functioning and quality of life, social anxiety disorder is a public health problem of considerable magnitude.[57] Whether it is addressed as such will depend, in part, on health care professionals' awareness of its seriousness, and, in the United States, on the willingness of insurers to pay for its treatment.[58]

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