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Assessing and managing social anxiety disorder

Of primary importance in assessing a patient with social anxiety disorder is judging the degree of functional impairment. Most patients with the condition will also have at least one comorbid psychiatric disorder, which should be assessed also.

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Social anxiety disorder is the extreme and persistent fear of social or performance situations, specifically the distress, anxiety and avoidance behaviours associated with the anticipatory belief that excruciating levels of embarrassment or humiliation will result from a social encounter. In the more severe cases, exposure to a particularly feared social situation (such as meeting strangers) may lead to a full-blown panic attack. Social anxiety disorder is also known as social phobia. Women are more likely to be affected than men, and the impact of the disorder on educational attainment and economic prospects can be severe.

Like depression, social anxiety disorder has a high prevalence rate – several large community studies claim that between 7.3 and 13.3% of the population will suffer from it at some time in their lives.[1,2] Estimates of lifetime prevalence are lower (around 2%) if social anxiety disorder with a greater degree of impairment and fears generalised to many situations is considered.[3] A specific fear of public speaking, for instance, is common in the general population, but may not significantly impair a person's overall functioning. By contrast, the fear of interacting with others is much more incapacitating. Typical situations that evoke fear in patients with social anxiety disorders are listed in Table 1.

Symptoms

Patients with social phobia may have symptoms ranging from excessive shyness to overwhelming and disabling panic associated with a particular situation. There are two broad types of social anxiety

IN SUMMARY

- **Social anxiety disorder, or social phobia, is an incapacitating fear of social or performance situations.**
- **Symptoms range from excessive shyness to overwhelming and disabling panic.**
- **Most patients with social anxiety disorder will have at least one comorbid psychiatric disorder, such as major depression, another anxiety disorder, avoidant personality disorder, or substance use disorder.**
- **Generalised social anxiety disorder is the more potentially disabling form and is typically chronic and unrelenting, extending to all aspects of a patient's social interactions and often associated with a family history. Comorbid disorders are more common.**
- **Nongeneralised social anxiety disorder is an excessive fear of one or a limited number or kinds of social situation, such as public speaking or eating in public.**
- **Causes of social phobia are multifactorial and thought to include prior experiences, negative thinking, genetic predisposition and, for some, a paucity of social skills.**
- **Current recommended treatment options include cognitive behavioural therapy and pharmacotherapy. Antidepressants are the first line pharmacotherapy; anxiolytics may sometimes be useful as short term or adjunctive measures.**

Table 1. Feared situations for patients with social anxiety disorder

- Speaking in public
- Taking tests and being examined
- Eating, drinking and writing in the presence of others
- Performing work duties under observation
- Using public toilets in the presence of others
- Interactive situations where there is an expectation to communicate with others

Table 2. Symptoms reported in social anxiety disorder

Physical symptoms

- Breathlessness or rapid, shallow breathing
- Sweating
- Shakiness/trembling
- Nausea or 'butterflies'
- Heart palpitations
- Dizziness

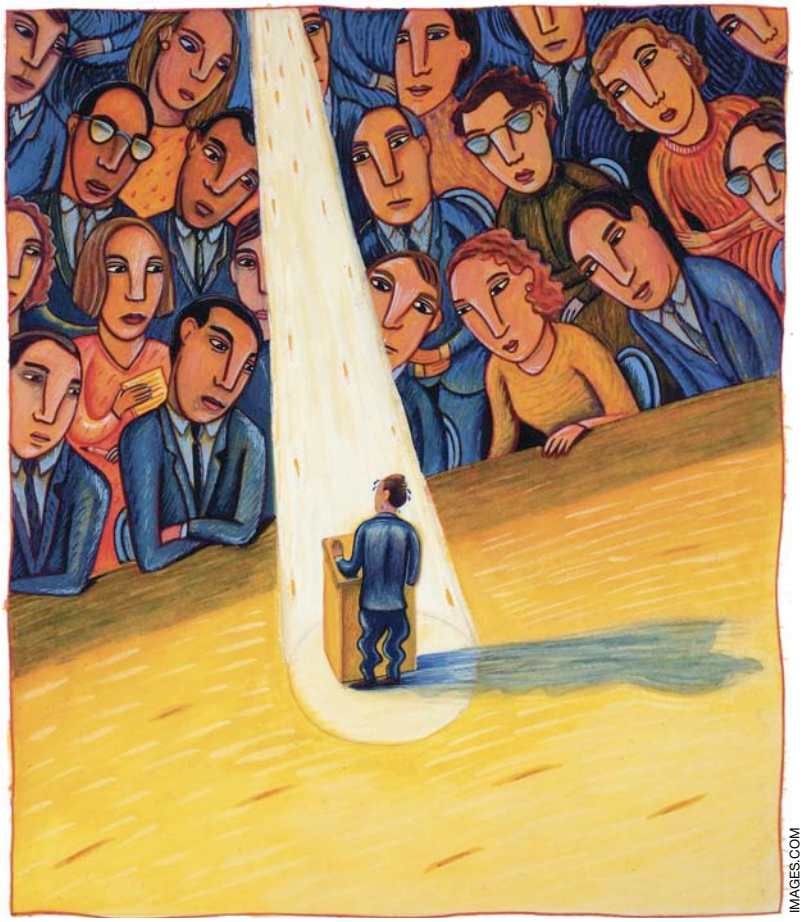
Behavioural symptoms

- Flight
- Avoidance
- Freezing

Cognitive/emotional symptoms

- Fear of evaluation, such as 'people will think I'm stupid/unattractive/incompetent'
- Emotions such as shame, embarrassment, anger or fear

disorder: generalised and nongeneralised. Generalised social anxiety disorder often develops in childhood or adolescence, and is the more potentially disabling form of the condition. It is typically chronic and unrelenting, extending to all aspects of a patient's social interactions, and is often associated with a family history and with comorbid disorders. Nongeneralised social anxiety disorder is an excessive fear of one social situation in particular or of a limited number or kinds of situation, such as eating in public. A genetic link seems to be stronger for generalised social anxiety disorder.



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In both types of social anxiety disorder, patients are likely to harbour irrational beliefs about themselves (for example, 'they don't like me' or 'I'm not interesting) and about their anticipated performance in social situations (for example, 'everyone will see my hand trembling and it will be a disaster'). There are usually involuntary physical symptoms associated with the anxiety, such as shaking or sweating, as well as behavioural symptoms, often manifested by a complete incapacitation during, or total avoidance of, the feared social situation. Table 2 lists some of the symptoms that patients with social phobia report when anticipating or facing a feared social situation.

If a panic attack occurs, the physical symptoms listed above are severe and there may be others as well, such as numbness or flushing. Additional cognitive symptoms are also often described, such as feeling 'unreal' or detached, commonly reaching a peak within 10 minutes. Thoughts may be compounded by fears of losing control or of dying.

Diagnosing social anxiety disorder

Summary of DSM-IV diagnostic criteria for 300.23 social anxiety disorder (social phobia)[4]

A. A marked and persistent fear of one or more social or performance situations. The individual fears that he or she will act in a way that will be embarrassing.

B. Exposure to the feared social situation almost invariably provokes anxiety.

C. The person recognises that the fear is excessive or unreasonable.

D. The feared social or performance situations are avoided.

E. Significantly interferes with the person's normal routine, occupational (academic) functioning, or social activities or relationships.

F. In individuals under age 18 years, the duration is at least six months.

Differential diagnoses

Social anxiety disorder often coexists with panic disorder. DSM-IV lists the differential diagnoses of social anxiety disorder as Panic Disorder with Agoraphobia and Agoraphobia without History of Panic Disorder. Social anxiety disorder also shares many features with avoidant personality disorder, which should be considered as an additional diagnosis. The distinction between social phobia and avoidant personality disorder is that social phobia is essentially a problem of performing in social situations, whereas the avoidant personality has a problem relating to other people.

Assessment

Taking a careful and complete psychiatric history as well as performing a thorough medical assessment in a patient who may have social phobia will enable an accurate diagnosis (see the box on this page).[4] Of primary importance is judging the degree to which the patient is disabled and/or functionally impaired by the anxiety. The severity of avoidance behaviours should also be established.

Most patients with social phobia will have at least one, and frequently more, comorbid disorders, and it is vital to assess these. Where the patient's social anxiety is of the generalised type, comorbid psychiatric conditions are even more likely. The association between social phobia and major depression is particularly strong; up to 37% of patients with social anxiety disorder have a diagnosis overlap with major depression.[3] Although diagnostic features are discrete, it may be that the frequent presence of low self-esteem ensures many patients have both diagnoses.

Often social anxiety coexists with other anxiety disorders as well as avoidant personality disorders. Comorbidity rates may be as high as 30 to 40% for simple phobia and social anxiety disorder. Similarly, 14% of patients with social anxiety disorder may have substance use disorders. The relationship between diagnoses is complex: for instance, the secondary use of alcohol to relieve social anxiety may lead to substance misuse. Clinical treatment therefore needs to take into account any comorbidities that may exist. Most treatments described for social anxiety disorder in this article also have benefits for depression and other anxiety disorders.

There are several rating scales that can be useful in screening for social anxiety disorder, such as the Mini-SPIN, the Brief Social Phobia Scale and the Social Phobia Inventory (SPIN).[5-7]

Social phobia is underdiagnosed. It is important to explore patient reports of avoidance of social interactions and to challenge patients who accept this as a way of life.

Causes of social anxiety disorder

Causes of social anxiety disorder are multifactorial and thought to include prior experiences, negative thinking, genetic predisposition and, for some, a paucity of social skills.

Prior experiences (conditioning models)

Traumatic or embarrassing social interactions in the past may have caused an individual to have an anxious response each time, characterised by humiliation, embarrassment or rejection. This may become a conditioned response that is then elicited in similar situations. Avoidance serves to maintain social phobias because avoidance of feared social situations decreases anxiety, thereby powerfully reinforcing the avoidance.

Negative thinking (cognitive model)

There is considerable research support for the role of cognitive factors in social anxiety disorder. Two themes commonly found in cognitive analysis of patients with social phobia are the anticipation that one will be evaluated negatively and fears of performance failure. This cognitive process is likely to be directly involved in the onset and maintenance of the condition. The 'social phobic' is often hypersensitive to signals from other people regarding personal acceptability (behaviour or appearance) and this interacts with a negative self-view, resulting in anxiety, which may impair performance and activate fears of failed performance.

Genetic predisposition

There is substantial evidence for the existence of family liability for social anxiety disorder. Relatives of patients with social phobia have been found to have a significant increased risk of social anxiety disorder but not of other anxiety disorders, although this may only be so for the

generalised type. What is inherited, however, may be a trait that predisposes individuals to social anxiety disorder. 'Behavioural inhibition' is a temperamental trait described in children who are wary of novel stimuli and may withdraw from unfamiliar objects or people. Behavioural inhibition increases risk of social phobia. While inherited traits may predispose a child to the condition, early life experiences and parental modelling no doubt modulate genetic predisposition.

Poor social skills (skill deficit model)

Controversy exists within the literature as to whether those individuals with social anxiety truly lack social skills or whether their anxiety inhibits the use of existing skills.

Treatment options

Current recommended treatment options for social anxiety disorder include cognitive behavioural therapy (CBT) and pharmacotherapy.

Psychological treatments

The use of CBT has gained increasing support. The advantages of cognitive behavioural programs include their efficacy in preventing relapse. Treatment can be delivered individually or in groups, the latter having the advantage of exposing the client to the feared situation and receiving direct feedback from others.

With the advent of Medicare funding involving psychologists, psychological treatment may become more routinely used in general practice. This will necessitate good relationships with GPs and basic knowledge of psychopharmacology.

Typical psychological treatment programs involve the components discussed below.

Basic information and self-monitoring

Informing patients about the symptoms and causes of social anxiety disorder is useful, as is teaching them how to develop behavioural skills such as self-monitoring of behaviour in feared situations. This forms the basis for understanding triggers and recognising progress when it occurs.

Cognitive therapy

Cognitive therapy based on the work of Beck and colleagues is a central component of treatment and aims to alter exaggerated thoughts and beliefs.[8] Patients with social anxiety disorder have beliefs that others will view them negatively, including judgements of incompetence and high expectations of performance.[9] Incorrect interpretation of a situation results in irrational beliefs, which then have a major influence on subsequent emotions and behaviour. Treatment

Table 3. Pharmacotherapy for social anxiety disorder*

First line drugs

Antidepressants

- SSRIs
  - escitalopram (Lexapro)
  - paroxetine (Aropax, Oxetine, Paxtine)
  - sertraline (Concorz, Eleva, Xydep, Zoloft)
- Tetracyclics
  - mianserin (Lumin, Tolvon)
  - mirtazapine (Avanza, Axit 30, Mirtazon, Remeron)
- SNRI – venlafaxine (Efexor)
- NARI – reboxetine (Edronex)
- Tricyclics (occasionally)
- MAOIs

Other drugs

Anxiolytics (for short term use only)

- Alprazolam (Alprax, Kalma, Xanax, Zamhexal)
- Diazepam (Antenex, Ducene, Valium, Valpam)
- Lorazepam (Ativan)
- Oxazepam (Alepram, Murelax, Serepax)

Beta blockers

Evidence for efficacy is controversial

* Not a comprehensive list

involves the two steps listed below:

- Monitoring and identifying thoughts and beliefs. For example, a patient may report unhelpful thoughts such as 'I will look stupid because I don't know how to ask to buy tickets correctly'. Helping patients learn to identify these thoughts and record them is a first step to treatment.
- Introducing more rational thoughts. This is achieved by challenging the probability and consequence of negative outcomes. It is helpful for challenging statements to be developed, such as 'There is no "correct" way of asking for tickets. Even if I ask in a way that is unusual, I will still get the tickets. If I worry too much about how I look to others, I may not get things done'. Patients are encouraged to use such positive self-statements and perhaps reward themselves for developing challenging thoughts.

Refocusing attention

Patients are encouraged to refocus attention away from negative thoughts to the task at hand.

Actual exposure

Actual exposure to feared social and performance situations addresses avoidance behaviour and achieves anxiety reduction by habituation. Exposure also reinforces the message that negative evaluation, even if it occurs, is not as terrible as anticipated. This treatment component involves setting goals and timetables for exposure and developing an exposure hierarchy. Ideally exposure should be graduated, repeated and prolonged. However, given the unpredictability of social situations, caution needs to be exercised. An example of exposure for a patient concerned with what people think is the trying on of four coats and the buying of none of them.

Improving social performance

Social performance can be improved by providing feedback and teaching social skills. This is only relevant for patients who are truly lacking in social skills because for most patients the problem is more negative self-evaluation of performance rather than a skill deficit. Nevertheless, for some it can be helpful to teach strategies to improve nonverbal communications (such as increased eye contact, an 'open' attitude and sufficient volume of voice) and verbal skills (such as active listening, communication of feelings, and the giving and receiving of criticism).

Relaxation techniques

Relaxation techniques are often used to reduce anxiety. Patients are taught behaviours that counteract the physical effects of anxiety (for example, exercises that aim to release tension in muscles) as well as the use of psychic techniques to reduce anxiety (for example, the use of pleasant imagery).

Pharmacotherapy

Medication in the management of anxiety may be an important part of treatment. The decision to use medication should be determined on an individual basis, and risk–benefit considerations vary with the disability caused by the symptoms and the age of the patient, as well as other factors.

Many drugs may be used in the treatment of social anxiety disorder (Table 3), the choice depending on the severity and the symptom complex, and also the physician or psychiatrist's personal experience. Patients taking medications for social anxiety disorder should be reviewed regularly, and some do better if they are on medication for a longer period.

Antidepressants

Antidepressants are the first line treatment and have been shown to be effective in the management of social anxiety disorder. Several classes of antidepressants are used:

- selective serotonin reuptake inhibitors (SSRIs) – sertraline, escitalopram and paroxetine; used most commonly
- tetracyclics – mianserin and mirtazapine
- serotonin and noradrenaline reuptake inhibitors (SNRIs) – venlafaxine
- noradrenaline reuptake inhibitors (NARIs) – reboxetine
- tricyclics; used only occasionally
- monoamine oxidase inhibitors (MAOIs).

The most commonly used antidepressants, the SSRIs, are generally well tolerated, have a benign side effect profile, are safe in overdose and are effective against

frequently occurring comorbid conditions such as depression.[10] These newer antidepressants are generally preferred over nonselective irreversible MAOIs such as phenelzine (Nardil) because of the latter's serious interaction with foods high in tyramine.

It is important to inform patients that taking antidepressants is not a sign of weakness and that these drugs are not addictive. Patients should also be aware that antidepressants need to be taken regularly and that it will be two to three weeks before they have any effect and up to six to eight weeks before they are having their full effect. It is usual to start on a low dose and then slowly increase the dose, depending on the effects and the patient's response. It is also important to remember that antidepressants interact with other medications, including herbal medicines such as St John's wort.

Anxiolytics

Anxiolytics, classically benzodiazepines, as a class are not a first line treatment for patients with social anxiety disorder because the condition requires long term treatment and dependence problems may arise. Furthermore, comorbid conditions such as depression or alcohol misuse are not effectively treated by anxiolytics.

Nevertheless, at times benzodiazepines may be considered useful as a short term or adjunctive measure and have shown efficacy with social anxiety disorder. Most benzodiazepines are relatively nontoxic in overdose, but there are differences between drugs (depending on their absorption rates and sedation effects). There are RACGP guidelines for the clinical use of benzodiazepines,[11] and the most frequently used include alprazolam, diazepam, lorazepam and oxazepam. Pharmacological properties of these drugs are essentially similar. When patients are prescribed anxiolytics, short term evaluation and/or intermittent courses should be considered.

Other drugs

Apart from anxiolytics and antidepressants, beta blockers have also been used to treat social anxiety disorder, although evidence for their efficacy is more controversial.

What the GP can do in the management of social phobia

Assessment

The GP plays an important role in the assessment of patients with social anxiety disorder, being well placed to take the history and diagnose the presence of the condition (generalised or nongeneralised) and comorbid conditions such as depression. Some GPs may find that the use of rating scales assists them with their

diagnosis and can be easily incorporated into general practice.

General practice management

For nongeneralised social anxiety disorder, referral to a specialist may not always be needed, and the principles outlined in this article can form the basis of a supportive approach. Simple anxiety management and positive thinking techniques can help, for example:

- help the patient to identify negative thoughts in social situations and then challenge them
- help the patient to develop relaxation techniques that can be applied before a feared performance or social situation.

Medication may be required when the condition is more severe and not responding to other approaches.

Referral

For severe and generalised social anxiety disorders a shared care arrangement is best. The GP is in an ideal position to monitor the progress of therapy and decide whether onward referral to a psychiatrist or psychologist is needed. In general, if progress is not occurring or the condition is severe then referral is appropriate. Referral to a psychologist is particularly helpful for in-depth work with psychological issues that may have emerged and for challenging entrenched negative thinking. The following questions should be kept in mind:

- is there a need for follow up?
- how will the patient's progress and the efficacy of therapy be monitored?
- what alternative therapy might be tried if the current therapy is unsuccessful?

Prognosis

Factors suggesting a poor prognosis include social anxiety disorder of a complex generalised subtype, very early onset (before age 7 to 11 years), greater initial severity, greater number of symptoms, co-occurring psychiatric disorders, presence of depression, presence of health problems and lower education.

Patients with social phobia can be slow to show a response to therapy. Those whose symptoms improve to the point of recovery tend to stay well.

Conclusion

While social phobia has a high lifetime prevalence (up to 13% suffer from it at some point in their lives), it is treatable using several pharmacological and psychological approaches. The GP can play a central role in assessing patients and deciding when simple management techniques and/or pharmacotherapy can help and when specialist help is needed. MT

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