

Social anxiety disorder common, disabling and often untreated

Social anxiety disorder is more than shyness. It is associated with depression, alcohol abuse and suicidal ideation, and when severe leads to considerable disability and social isolation. Effective treatments are available but most patients with social anxiety disorder do not receive them.

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Social anxiety disorder affects about 3 to 5% of the population, with a small female excess. The usual age of onset is the early to mid-teenage years. It is a chronic disorder and recovery without effective treatment is rare. Despite increased patient sophistication and the unlimited horizons of internet information, the rates of receipt of effective treatment are low. Only 7% of those with social anxiety disorder in the Australian National Survey of Mental Health and Wellbeing (NSMHWB) were assessed as receiving treatment known to be effective.^{1,2} This was lower than that for any other anxiety disorder in the survey. The Figure illustrates service utilisation data for social anxiety disorder from the NSMHWB.

Similarly, the Harvard Brown Anxiety Disorders Research Project, a naturalistic study following patients with anxiety disorders for up to 12 years, found that the likelihood of recovery from social

phobia was far less than that for depression.³ It was also less than that for generalised anxiety disorder and panic disorder, both with and without agoraphobia.³

Is social anxiety disorder just medicalised shyness?

A substantial proportion of the population identify themselves as shy without any significant interference to social or occupational functioning. The key issue in regarding social anxiety as a disorder is the requirement for marked distress or significant interference with functioning (*Diagnostic and Statistical Manual of Mental Disorders, fourth edition – text revision; DSM-IV-TR*).⁴ Most experts recognise a spectrum of social anxiety from shyness to social anxiety disorder and on to avoidant personality disorder, a highly disabling condition affecting about a third of those with social anxiety disorder

IN SUMMARY

- Screen for social anxiety disorder in patients who present after frequently missing school or work, or with 'stress', depression or hazardous alcohol use.
- Effective treatments for social anxiety disorder include cognitive behaviour therapy (CBT) and antidepressants; however, few affected patients receive them.
- For patients with social anxiety disorder, chronic illness is the rule without effective treatment.
- The GP has an important role in providing information about social anxiety disorder and its treatment, prescribing antidepressants when indicated, referring patients for CBT and ensuring that referred patients are receiving good quality treatment.

(Table 1). The degree of disability and adverse impact on functioning increases up the spectrum. The typical burden includes failure to achieve to the individual's intellectual and occupational potential, and variable impact on the ability to enjoy friendships and intimate relationships.

Aetiology

The most prominent aetiological factor in patients with social anxiety disorder relates to inherited temperamental traits such as negative affectivity, which confers an elevated risk for both depression and anxiety, and behavioural inhibition, which appears to be a risk factor shared across the anxiety disorders. There may be a small component of specific inherited risk. Family environment is more likely to affect the expression of these risk factors. For example, parents who model an approach of acknowledging and confronting fears may assist their children to manage their anxious tendencies in a way that minimises impairment, in much the same way that parents in a family with a strong history of cardiovascular disease might model a lifestyle incorporating exercise and a healthy diet.

Presentation

There is evidence to suggest that those people most disabled by their social anxiety disorder may be the least likely to get effective treatment.⁵ Research indicates that the most common reason why people do not seek help for their social anxiety is that they prefer to try to manage the problem themselves. Some also believe that their social anxiety is an intrinsic aspect of themselves that cannot be changed. Table 2 shows the options endorsed when respondents in the NSMHWB who met



criteria for an anxiety disorder as their principal problem but who had not sought treatment were asked why they had not done so.²

Individuals with social anxiety disorder are most likely to present to their GP with general complaints of 'stress' or anxiety, with depression or because of the detrimental effects of their social anxiety disorder on function – for example, missing work or being unable to attend school or university. This can be an important opportunity for the health professional to screen for social anxiety disorder as well as to provide reliable information about treatment.

Detecting social anxiety disorder

Social anxiety disorder is highly comorbid with depression, other anxiety disorders and alcohol

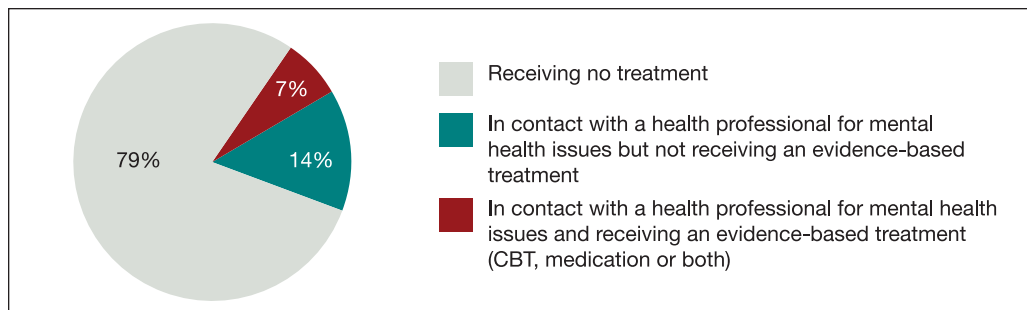


Figure. Treatment received by people meeting the criteria for social anxiety disorder in the Australian National Survey of Mental Health and Wellbeing (NSMHWB).^{1,2} Only 7% of this group were receiving treatment known to be effective for social anxiety disorder. CBT = cognitive behaviour therapy.

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Table 1. Features of social anxiety disorder and avoidant personality disorder

Feature	Social anxiety disorder	Avoidant personality disorder
Age at onset	Usually mid-teens	Early childhood
Principal fear	Looking anxious; saying or doing something embarrassing	Being rejected by others – in a global sense (e.g. being judged as not worthwhile as a person)
Sense of self	Generally good self-esteem – can compartmentalise problem to social arena rather than generalise to self	Sense of inferiority to others
Avoidance	Usually not total; often engages in at least some social situations in spite of anxiety	May be almost total
Disability	Mild to severe	Severe – usually results in failure to achieve occupational potential and very frequently in failure to establish lasting intimate relationship

abuse. In most cases the social anxiety disorder tends to be temporally primary, and represents a significant risk factor for depression and alcohol abuse. The importance of detecting social anxiety disorder thus includes not only the possibility of relieving considerable distress and disability, but also that of preventing the onset of additional psychiatric problems, with the consequent worsening in disability and prognosis.

Depression is usually accompanied by loss of confidence and social withdrawal. To assist in determining whether there may be an underlying social anxiety disorder, it is helpful to ask the patient about the chronology of these symptoms and whether they represent a change in

usual functioning, or more an exacerbation of pre-existing difficulties. For example:

- A patient who is depressed without a comorbid social anxiety disorder may say something like: ‘I don’t know what’s come over me. I used to be fairly confident and really enjoyed seeing my friends’.
- A patient with a pre-existing social anxiety disorder who has become depressed is more likely to describe longstanding anxiety or limited confidence with groups of people, with a more recent exacerbation and onset of low mood and other symptoms of depression.
- Patients who present with evidence of

hazardous use of alcohol might usefully be asked about the history of their alcohol use – for example, it may have started with using alcohol to ‘steady the nerves’ or enhance social interaction. Identifying a comorbid social anxiety disorder can inform treatment recommendations. For example, individuals with social anxiety may not cope well in settings where they are required to declare or discuss their problems in a group, and are often consequently labelled as ‘resistant’ to or unco-operative with treatment. Facilitating access to cognitive behaviour therapy (CBT) and problem solving around the additional problems of social anxiety may be helpful.

Some useful screening questions for social anxiety disorder include:

- Do you worry (too) much about what other people think of you?
- Do you feel very anxious around other people?
- Do you worry (too) much about looking anxious or embarrassing yourself?

If the answer to any of these questions is yes, ask patients about the interference that this causes to their lives. For example, are there situations they’d like to be able to engage in, but instead avoid because

Table 2. Social anxiety: reasons cited by patients for not seeking help*²

I preferred to manage myself	58.4%
I was afraid to ask for help, or was afraid of what others would think of me	19.5%
I did not know where to get help	15.8%
I didn’t think anything could help	13.8%
I got help from another source	9.8%

* Reasons endorsed by respondents in the Australian National Survey of Mental Health and Wellbeing (NSMHWB) who met the criteria for an anxiety disorder as their principal problem but had not sought treatment (n = 2005).

of these concerns? It is important to be aware that many people organise their lives around their anxiety and may have given up on certain situations so long ago that they don't come to mind when asked simply about 'avoidance'.

Patterns of social anxiety disorder

Many different social situations can be problematic. Public speaking is the single most common fear, and one endorsed by so large a proportion of people generally that on its own it is only significant if it causes particular difficulties (for example, if experienced by a university lecturer). Other commonly feared situations include talking in groups, being under scrutiny while performing some task, being around a lot of people, travelling on public transport, going to the cinema or theatre, eating or drinking in public, writing or signing one's name (for example, on a credit card voucher) in front of others, talking on the phone and using public toilets.

Treatments for social anxiety disorder

Nonpharmacological treatment

CBT is the psychological intervention with the most robust evidence basis for the treatment of social anxiety disorder. Although CBT for social anxiety disorder is quite specialised, and probably beyond the expertise of most GPs, it is helpful in this age of the new Mental Health Care items in the MBS to be aware of the components of good quality CBT. The GP has an important oversight role: when reviewing a patient who is receiving CBT from another practitioner, he or she should have some discussion ideally with both the patient and the therapist about what that treatment involves. The GP can also prepare the patient for CBT by providing information about the nature of the treatment, and during therapy can reinforce elements of treatment, such as encouraging exposure and supporting cognitive reframing of unhelpful beliefs.

It is likely that patients will require 10 to 15 sessions of therapy. Table 3 lists the elements of good quality CBT.

Results appear equivalent whether patients receive CBT individually or in a group setting. CBT targets the beliefs that are thought to perpetuate socially anxious concerns, as well as addressing behavioural avoidance. Functional improvement through reduced distress and avoidance is the goal of treatment.

Individuals with social anxiety disorder fear outcomes that will result in negative evaluation from others. They fear that showing signs of anxiety (especially blushing, sweating or shaking), saying something foolish or appearing socially inept will result in painful disapproval or negative regard. The weight of opinion is that social skills are not lacking in those with social anxiety disorder, rather it is a problem in skill expression. That is, the patient knows what to do, but is so fearful of doing it badly that he or she avoids interacting altogether. Social skills training is used in some treatment packages, but may work mainly through creating opportunities for exposure.

Research has shown that individuals overestimate how likely they are to act foolishly, but also how likely others are to notice or care (likelihood), and how awful it would really be if negative evaluation did occur (cost). It appears that CBT is most effective when the individual is able to be more realistic about the cost of negative evaluation. Hence, attempts to convince an individual that a feared outcome will probably not happen (for example, to spill his or her drink or be completely speechless in a social situation) are likely to be less effective than an 'inoculation' approach whereby the individual is able to move towards the view that perhaps being negatively evaluated is not so awful after all. This is both a more realistic and a more pragmatic approach given that social errors are inevitable unless one avoids social interaction altogether, and it is this type of avoidance that leads to much of

Table 3. Elements of good quality cognitive behaviour therapy

- Individualised formulation of the problem/s
- Therapy based on the here-and-now, not childhood
- Requirement for patients to make notes or keep journals – i.e. do 'homework'
- Cognitive therapy through active challenging (not 'thought stopping', not just positive affirmations)
- Strategies to target post-event processing and reduce self-focused attention
- A planned program of confronting previously feared situations
- Reduction in the use of subtle avoidance, including safety behaviours (see text)

the distress of social anxiety disorder.

Graded exposure remains a cornerstone of CBT. There is evidence that CBT may be better tolerated and more effective with appropriate cognitive preparation beforehand. This includes providing:

- strategies for challenging beliefs about likelihood and especially cost, as outlined above
- advice about the importance of focusing the attention externally, rather than trying to monitor every nuance of performance and feelings of anxiety
- very specific instructions about exposure tasks.

Designing exposure tasks as 'behavioural experiments' where the individual is assisted to plan a task that will test a belief is felt to be particularly effective. For example, a common belief is: 'If I behave in a way that isn't normal people will disapprove'. Behavioural experiments,

like any well-designed experiment, need defined variables and measurable outcomes. Hence it is necessary to work with the patient to describe some behaviours that he or she feels are not 'normal', and then to define more precisely how it would be possible to identify an outcome of 'disapproval'. Examples of 'abnormal' behaviours might include asking people for the time when one is clearly wearing a watch, calling out the stops on a bus or train, wearing odd socks and so forth. It is particularly important to define unambiguous evidence of disapproval – not just a frown or a question, for example, but rather a verbal statement clearly expressing disapproval, such as 'You are making a nuisance of yourself' but not 'Why are you doing this?'. Asking patients to predict what they believe will happen (for example, how many people do you expect to say something? What proportion of people will stare at you?) is valuable.

Following the behavioural experiment, a session to debrief and review is essential – for example, how accurate were the patient's predictions? How bad was it really to do the task?

Exposure must also target subtle avoidance or 'safety behaviours' that are designed to prevent or disguise the occurrence of a feared outcome. Examples include holding a glass very tightly in an effort to prevent shaking hands, or wearing a high collar to hide any blushing or flushing of the neck that may occur. The goal of treatment is for individuals to be able to live life as they would like to, rather than be constrained by overt or subtle avoidance.

CBT for social anxiety disorder presents some particular challenges. Unambiguous outcomes may make it easier to learn that feared situations are not as dangerous as predicted. For example, a typical concern in agoraphobia is that a heart attack or stroke will occur if a person forces him or herself to go through an anxiety-provoking situation such as driving across a bridge. If the

individual goes ahead with this type of challenge, he or she either does or does not experience a catastrophic physical event: the outcome is not ambiguous. By contrast, social situations contain many ambiguities. For example, if you met some new people at a party, you have no real way of knowing what they thought about you, positive or negative. Without clear proof that the feared negative evaluation did not occur, it may be harder to let go of such fears.

Another challenge to be overcome in social anxiety disorder is the tendency towards 'post-event processing' where individuals go over and over a social event in their head afterwards, much like a 'video replay'. This replay involves ruminating on the negative aspects of performance, with the result that anxiety is often increased rather than reduced by exposure tasks, unless this behaviour is preemptively addressed in therapy. For these reasons, it is recommended that patients be referred for CBT to practitioners with experience and training in treating social anxiety disorder.

Pharmacological treatments

Antidepressants are the preferred first-line pharmacological treatment for social anxiety disorder and have level 1 evidence of efficacy (that is, meta-analyses showing a positive effect).⁶⁻⁸ High potency benzodiazepines (for example, bromazepam [Lexotan], clonazepam [Paxam, Rivotril]) also have evidence of efficacy but are not recommended.

Of the antidepressants, the SSRIs and venlafaxine (Efexor-XR) have the most plentiful evidence of efficacy, have good safety profiles, and represent a sensible first choice. Of the older antidepressants, MAOIs are effective but tricyclics lack such evidence.

There is no good evidence to support a dose-response effect for antidepressants. The strongest evidence for increasing efficacy is found for the effect of time – double-blind studies show an increasing

response rate simply by waiting longer.⁶ Response time can be considerably longer when treating anxiety disorders than when treating depression. Practical recommendations for using antidepressants in social anxiety disorder are listed in the box on this page.

Beta blockers do not have evidence of superiority over placebo in the treatment of generalised social anxiety disorder and should not be used as first-line treatment. There are few placebo-controlled trials of atypical antipsychotics in social anxiety disorder, and they also cannot be recommended as first-line therapy.

CBT, antidepressants or both?

The choice of treatment for patients with social anxiety disorder can be based on patient preference and the availability of treatment resources. There is no clear evidence for the superiority of combined

Antidepressants for social anxiety disorder: practical recommendations

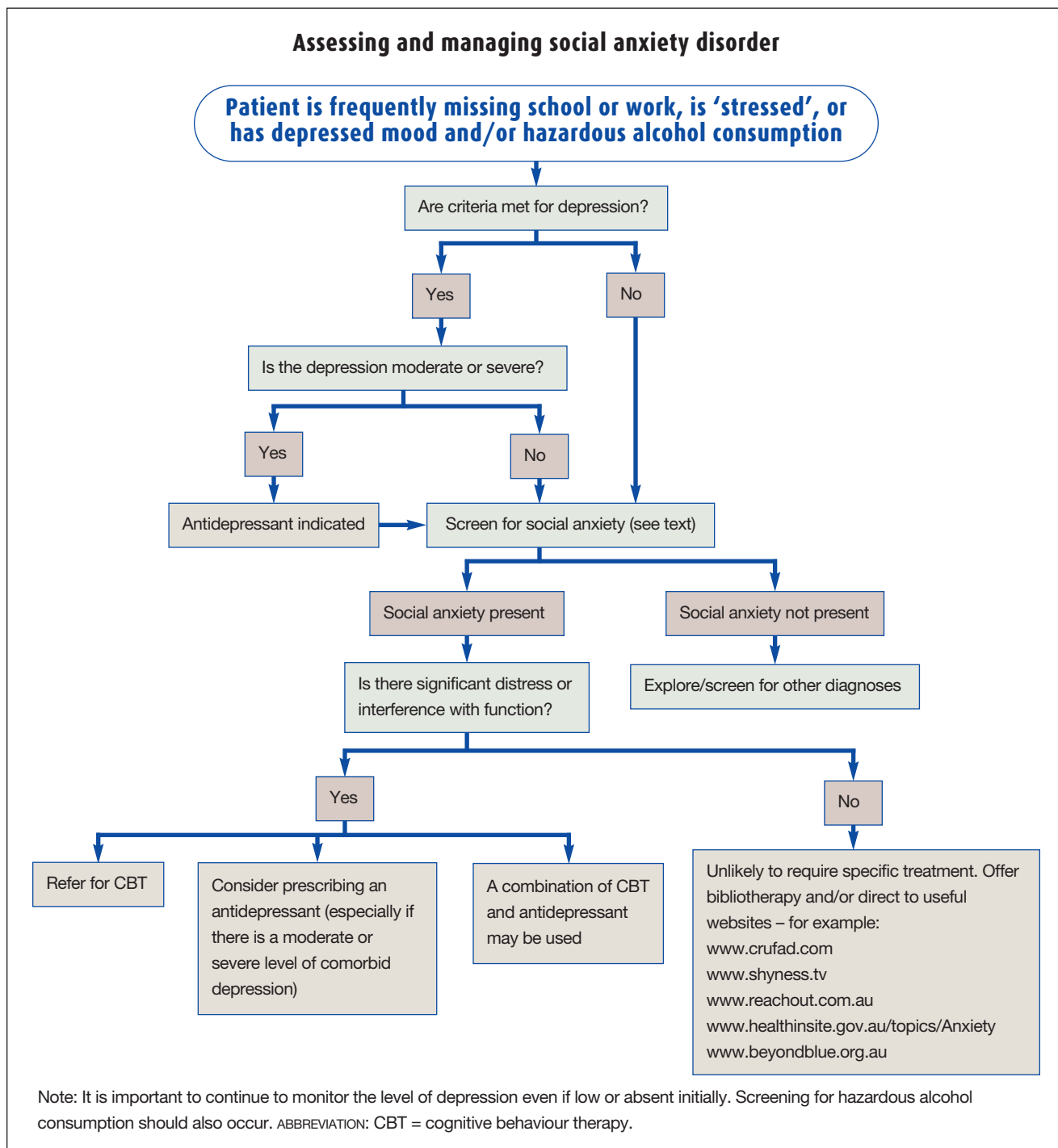
- Start with half the minimum dose (where possible) for a few days. This will minimise the adverse impact of the transient increase in anxiety symptoms that is common with most modern antidepressants and especially worrying to anxious individuals (and a common reason for early discontinuation).
- Do not expect to see a response until the patient has received four to six weeks of therapy and, therefore, resist the urge to increase the dose of antidepressant within this time frame. Doing so is unlikely to make the patient get better sooner but it may result in more side effects.
- It is usually unnecessary to use adjunctive benzodiazepines when antidepressants are started at the lower dose advocated above and patients are informed about the common but usually benign nature of side effects.

treatment. However, because CBT shows better maintenance of gains following treatment (relapse is common when antidepressants are discontinued), ideally patients should be offered CBT when

possible. CBT can be given in combination with or sequential to antidepressant treatment.

Patients who present with comorbid major depression of any more than mild

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severity should be offered antidepressants at assessment because such patients represent a more severe group with a higher risk of suicide. In such cases, CBT is often best deferred until the patient's

depressed mood and negative thinking have improved.

The flowchart on this page provides a guide to assessing and managing social anxiety disorder.

Novel approaches - computerised CBT

Good quality CBT is often not readily available to patients. An internet-based CBT program is being evaluated by the

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Clinical Research Unit for Anxiety Disorders in Sydney (www.shyness.tv). This program includes some therapist input via email, an addition that is associated with better engagement and outcomes of computer-assisted therapies. Preliminary results from this program are encouraging.^{9,10}

Conclusion

Social anxiety disorder is a common and often disabling condition with low rates of detection but effective intervention. GPs have a pre-eminent role in detecting the illness, providing psychoeducation, co-ordinating the provision of effective treatment and supporting patients into recovery. MT

References

1. Issakidis C, Sanderson J, Corry G, Andrews G, Lapsley H. Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. *Psychol Med* 2004; 34(1): 19-35.
2. Issakidis C, Andrews G. Service utilisation for anxiety in an Australian community sample. *Soc Psychiatry Psychiatr Epidemiol* 2002; 37: 153-163.
3. Bruce SE, Yonkers KA, Otto MW, et al. Influence of psychiatric comorbidity on recovery and recurrence in generalized anxiety disorder, social phobia, and panic disorder: a 12-year prospective study. *Am J Psychiatry* 2005; 162: 1179-1187.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, text revision. 4th ed. Washington DC: American Psychiatric Association; 2000.
5. Ruscio A, Brown T, Chiu W, Sareen J, Stein M, Kessler R. Social fears and social phobia in the USA: results from the National Comorbidity Survey Replication. *Psychol Med* 2008; 38(1): 15-28.
6. Baldwin DS, Anderson IM, Nutt DJ, et al. Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2005; 19: 567-596.
7. Bandelow B, Seidler-Brandler U, Becker A, Wedekind D, Ruther E. Meta-analysis of randomized controlled comparisons of

psychopharmacological and psychological treatments for anxiety disorders. *World J Biol Psychiatry* 2007; 8(3): 175-187.

8. Stein DJ, Ipser JC, van Balkom AJ. Pharmacotherapy for social anxiety disorder. *Cochrane Database Systematic Reviews* 2000, Issue 4. Art. No: CD001206. DOI: 10.1002/14651858.CD001206.pub2.

9. Titov N, Andrews G, Schwencke G, Drobny J, Einstein D. Shyness 1: distance treatment of social phobia over the Internet. *Aust N Z J Psychiatry* 2008; 42: 585-594.

10. Titov N, Andrews G, Schwencke G. Shyness 2: treating social phobia online: replication and extension. *Aust N Z J Psychiatry* 2008; 42: 595-605.

Further reading

Andrews G, Creamer M, Crino R, Hunt C, Lampe L, Page A. The treatment of anxiety disorders: clinician guides and patient manuals. 2nd ed. Cambridge: Cambridge University Press; 2003.

DECLARATION OF INTEREST: In the past five years Dr Lampe has received speaker fees and/or sponsorship to attend meetings from Lundbeck, Wyeth, Eli Lilly, Janssen-Cilag and AstraZeneca. She has been a member of the Wyeth Neuroscience and Pristiq Advisory Boards.

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