Social Anxiety Disorder/Social Phobia

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“The human brain is a wonderful thing. It operates from the moment you’re born, until the first time you get up to make a speech.”

–Howard Goshorn

Social Anxiety Disorder (SAD) Outline

- Definition
- Relationship to Other Psychiatric Illnesses
- Treatment

Question #1

What are the 2 Social Anxiety Disorder (SAD) Subtypes?

Question #2

Which SAD Subtype would be Described as…

- **More Common**
- **Familial**
- **Earlier onset**
- **Greater Impairment**
- **Lower Remission Rate**

Question #3

True or False

Patients with SAD are more likely, as compared to those without SAD, to do the following…

- **Remain Single**
- **Not Finish High School**
- **Earn Lower Income**

Question #4

What are three psychiatric illnesses that are commonly comorbid with SAD?

Question #5

What is First Line Treatment for SAD and… Does it vary between the 2 Subtypes?

Teaching Point #1

Social Anxiety Disorder has TWO SUBTYPES:

Early Onset Generalized Familial Subtype

Later Onset Non-Generalized Non-Familial Subtype

Teaching Point #2

Social Anxiety Disorder (SAD) usually has

ONE or more COMORBID Psychiatric Illnesses

with SAD usually PRECEDING the Comorbidity

Teaching Point #3

Pharmacologic Treatment varies between the two Subtypes…

Generalized Type -

SSRI or SNRI

Non-Generalized Type -

PRN Pharmacotherapy Targeting Symptoms

Social Anxiety Disorder
Part One

Definition

Social Anxiety Disorder is Not New

Symptoms as Described by Hippocrates:

[A man who] “through bashfulness, suspicion and timorousness, will not be seen abroad; … his hat still in his eyes, he will neither see nor be seen by his goodwill. He dare not come in company for fear he should be misused, disgraced, overshoot himself in gestures or speeches or be sick; he thinks every man observes him.”

Robert Burton: Anatomy of Melancholy (1652)

Social Anxiety Disorder, also known as…

Name	Author
Ereuthrophobia	Casper, 1842
Kontacktneurosen	Stockert, 1929
Tai-jin-kyofu	Morita, 1932
Social Neurosis	Shilder, 1938
Social Anxiety Neurosis	Myerson, 1945
Social Phobia	Marks, 1968

Social Anxiety Disorder (SAD)

Is Included in the DSM-IV and can be summarized as follows…

- Fear that Performance will lead to Embarrassment, Exposure, and Scrutiny

with

- Exposure to Feared Situation Predictably Eliciting Anxiety

resulting in

- Avoidance, or the Endurance of Distress in most Social Interactions

The patient with SAD knows the Fear is Excessive

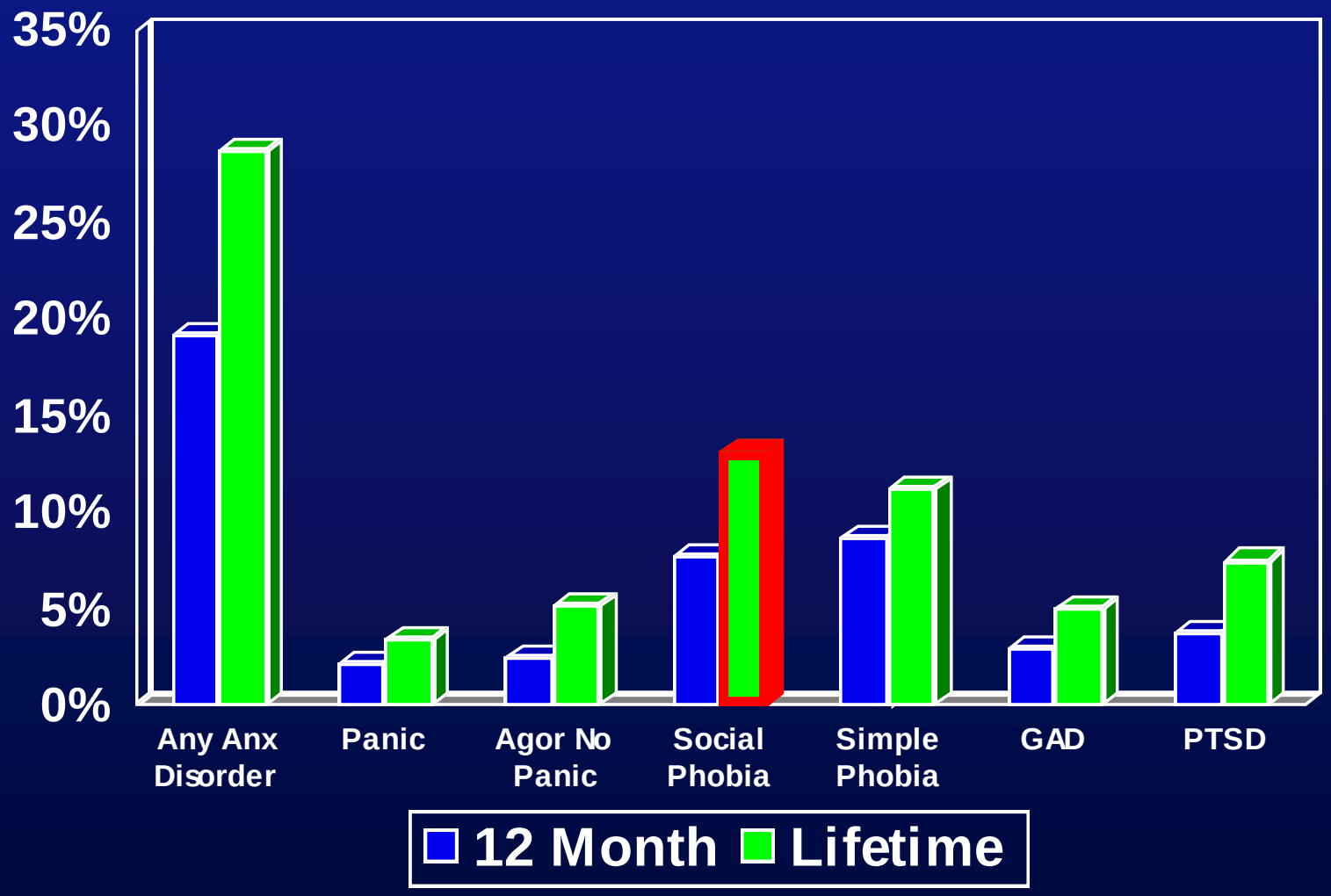
but

Continues to Suffer Interference in Occupational, Social, and Familial Roles

Important to Note…

If there is a General Medical Condition (colostomy) or Mental Disorder (rituals in OCD or Anorexia) present which has the potential to be Embarrassing, the Fears Associated with these situations are not considered in a diagnosis of SAD

SAD has the Greatest Lifetime Prevalence as Compared to Other Anxiety Disorders



Adapted from Kessler et al. *Arch Gen. Psychiatry.* 1994;51:8

Two SAD Subtypes

- Generalized Subtype
- Non-Generalized Subtype

Generalized (~70%)

- Pervasive Social Fears, Avoidance
- Early Onset
- Familial
- More Comorbidity
- More Impairment
- Low Remission Rate
- Requires Chronic Treatment

Non-Generalized (~30%)

- Limited Social Fear
- Later Onset
- Not Familial
- Less Comorbidity
- Limited Impairment
- Remission Not Unusual
- PRN Treatment Adequate

Typical Social Fears

Social Type Fears

- Attending Social Events
- Conversing in a Group
- Speaking on Telephone
- Interacting with an Authority Figure
- Making Eye Contact
- Ordering Food in a Restaurant

Performance Type Fears

- Public Speaking
- Eating in Public
- Writing a Check
- Using a Public Toilet
- Taking a Test
- Trying on Clothes in a Store
- Speaking up at a Meeting

Non-Generalized Subtype may have only One or Two of the Above.
Generalized Subtype may have Most of the Above.

Typical Symptoms in Social Anxiety

- **Physical Symptoms**
  - Tachycardia
  - Trembling
  - Blushing*
  - Shortness of Breath
  - Sweating*
  - Abdominal Distress
  - Socially-Cued Panic Attacks
- **Cognitive Patterns**
  - Exaggerated Fear of Negative Evaluation, Sense of Scrutiny
  - Misinterpretation of Social Cues
- **Stereotypical Behaviors**
  - Avoidance
  - Freezing

Beidel. J Clin Psychiatry. 1998;59(Suppl 17):27; van Vliet et al, 1994; Taylor and Arnow, 1991

SAD and Distress

Physical Symptoms that are Usually the Most Bothersome and Feared are Those that are Perceived as Visible to Others.

Beidel. J Clin Psychiatry. 1998;59(Suppl 17):27; van Vliet et al, 1994; Taylor and Arnow, 1991

The Course of SAD…

- Chronic
- Modal Onset at 13 years
- Average Duration at Diagnosis is 20 Years
- Only 27% of Recover

Davidson et al 1993

Patients with SAD, as compared to those without SAD, often…

- Fail to Finish High School
- Earn Lower Income
- Remain Single
- Have No Skilled Occupation
- Live with Parents

Magee et al 1996

Differential Diagnosis of SAD

- Avoidant Personality Disorder
- Panic Disorder / Agoraphobia
- Posttraumatic Stress Disorder
- Depression-Related Social Avoidance
- Atypical Depression
- Schizotypal / Schizoid Personality Disorder
- Body Dysmorphic Disorder

It Is Important to Distinguish Between the Different Anxiety Disorders

Key Diagnostic Questions

can be Helpful

Key Diagnostic Questions

- Do you Experience Anxiety or Fears?
- Do you Consider your Fears Excessive?
- Are you Afraid of Situations such as Speaking in Public? Social Events? Crowds?
- Do you Fear…
  - Being Watched Closely While Doing Something?
  - Being Humiliated or Embarrassed?
  - Sweating, Blushing?

It is Important to Distinguish between the Anxiety Disorders…

SAD vs. Panic Disorder

Disorder	Common Fear	Key Concerns	Example
SAD	Fear of Negative Evaluation or Humiliation in Social Situations	Public Scrutiny	Avoids speaking, eating, using restrooms *only in public*
Panic Disorder	Fear of having a Heart Attack, Dying, or “Going Crazy”	Sudden, Unexpected Panic Attacks Alone or in Public; Not Limited to Social Situations	Attacks last about 10 Minutes, including Chest Pain, Fear of Dying, Smothering Sensations; Avoidance of Places Where Attacks have Occurred

SAD vs. Agoraphobia

Disorder	Common Fear	Key Concerns	Example
SAD	Fear of Negative Evaluation or Humiliation in Social Situations	Public Scrutiny	Avoids Speaking, Eating, Using Restrooms *only in public*
Agora-phobia	Fear that Help Won't be Available or Escape Won't be Possible	Being Caught in A Situation Where Escape may be Difficult	Avoids being Alone, Away from Home, in a Crowd, Traveling in a Car

SAD vs. Generalized Anxiety Disorder (GAD)

Disorder	Common Fear	Key Concerns	Example
SAD	Fear of Negative Evaluation or Humiliation in Social Situations	Public Scrutiny	Avoids Speaking, Eating, Using Restrooms; *only in public*
Generalized Anxiety Disorder	Fear of Everyday Routine / Life Circumstances	Anxiety Shifting From One Concern To Another - No Fear of Social Situations	Worries Almost Constantly about Routine, Everyday Matters

Something To Consider… SAD and Adolescents

Have High Index of Suspicion in Adolescents with New Onset of:

- **Depression**
- **Truancy and Other Conduct Problems**
- **Substance Abuse**

Social Anxiety Disorder
Part Two

Relationship to Other Psychiatric Illnesses

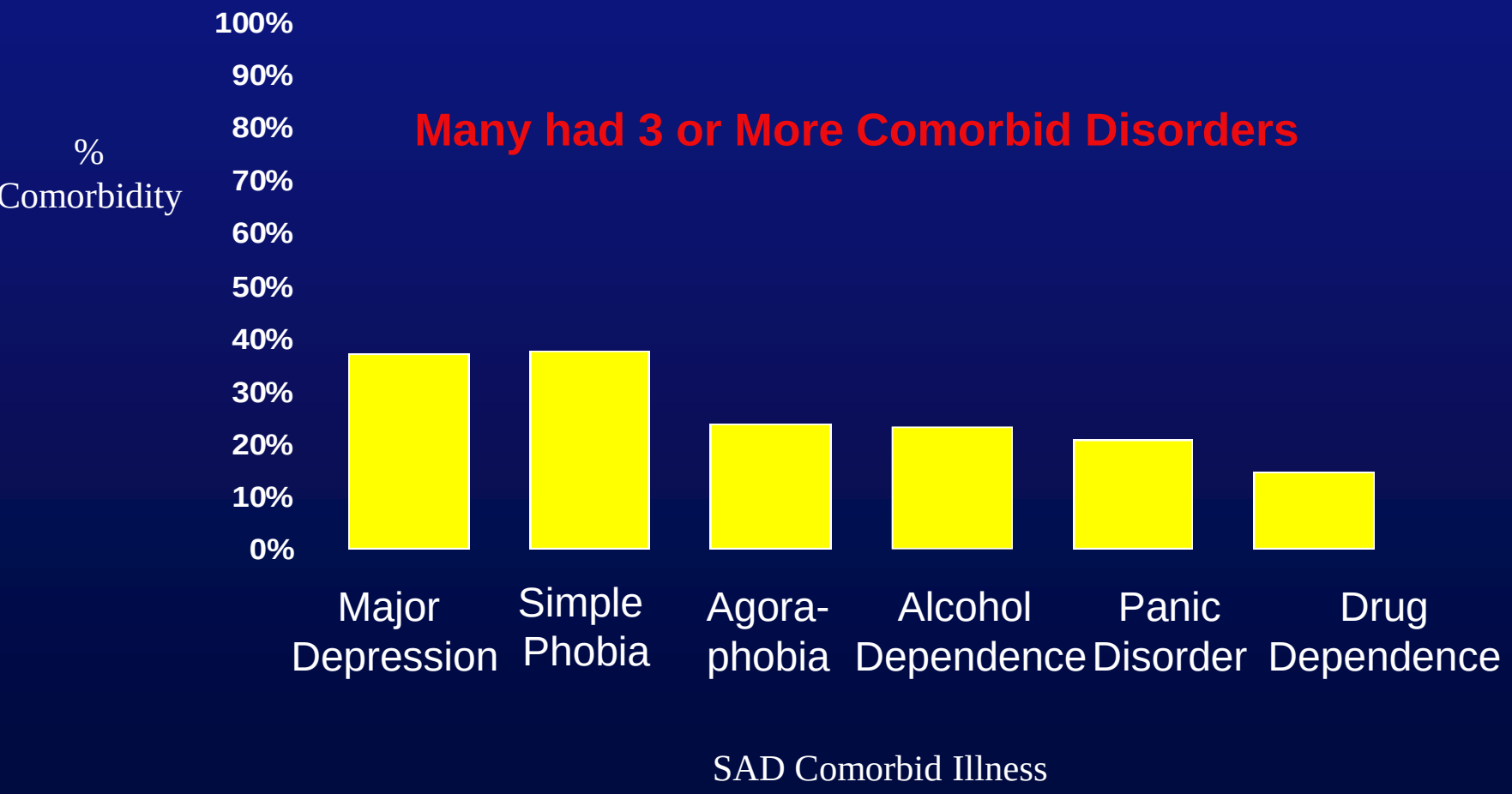
(Comorbidity)

Comorbidity

- More Often Seen in Generalized Subtype
  - 80% of Patients with SAD Report at Least One other Psychiatric Disorder
  - SAD Typically Occurs First

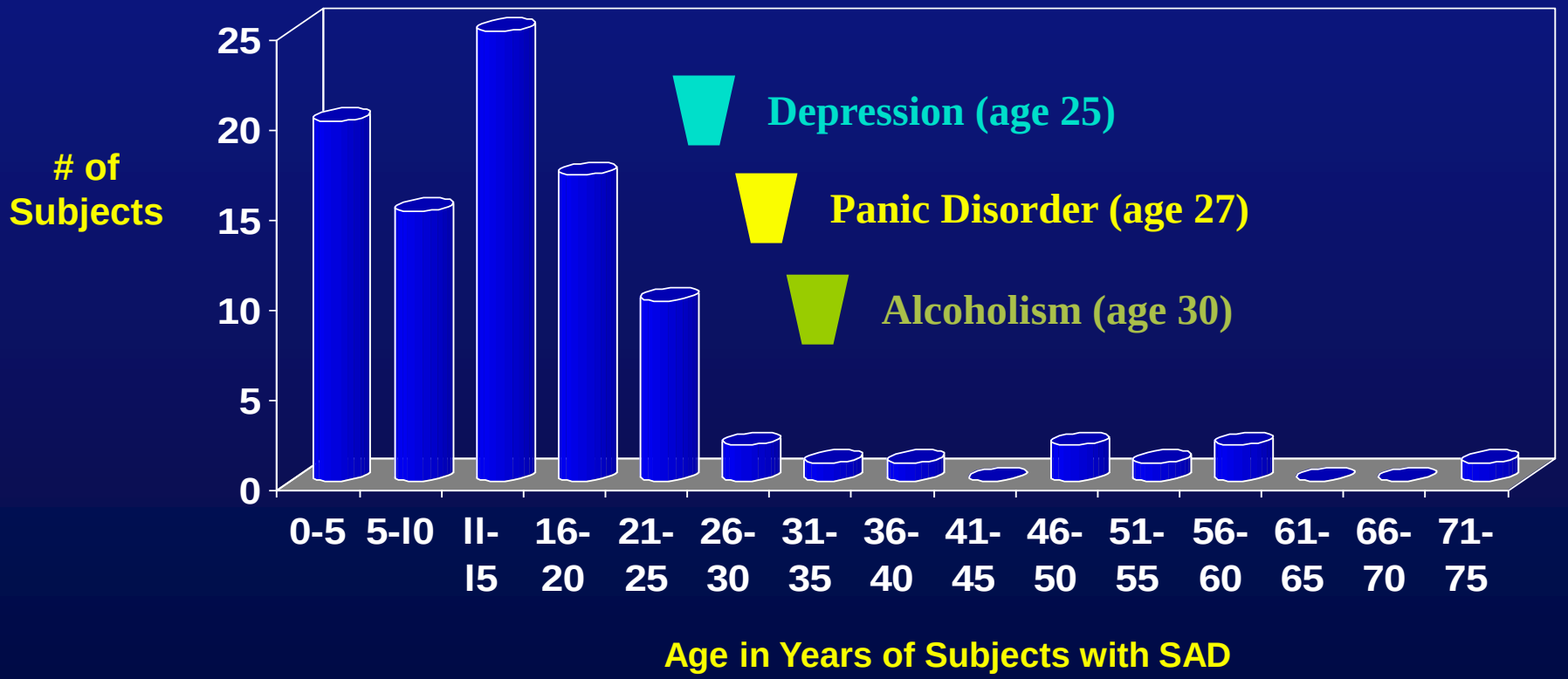
(Magee et al, 1996; Schneier et al, 1992)

~ 80% of Patients with Generalized Subtype have 1 or More Comorbid Psychiatric Disorder



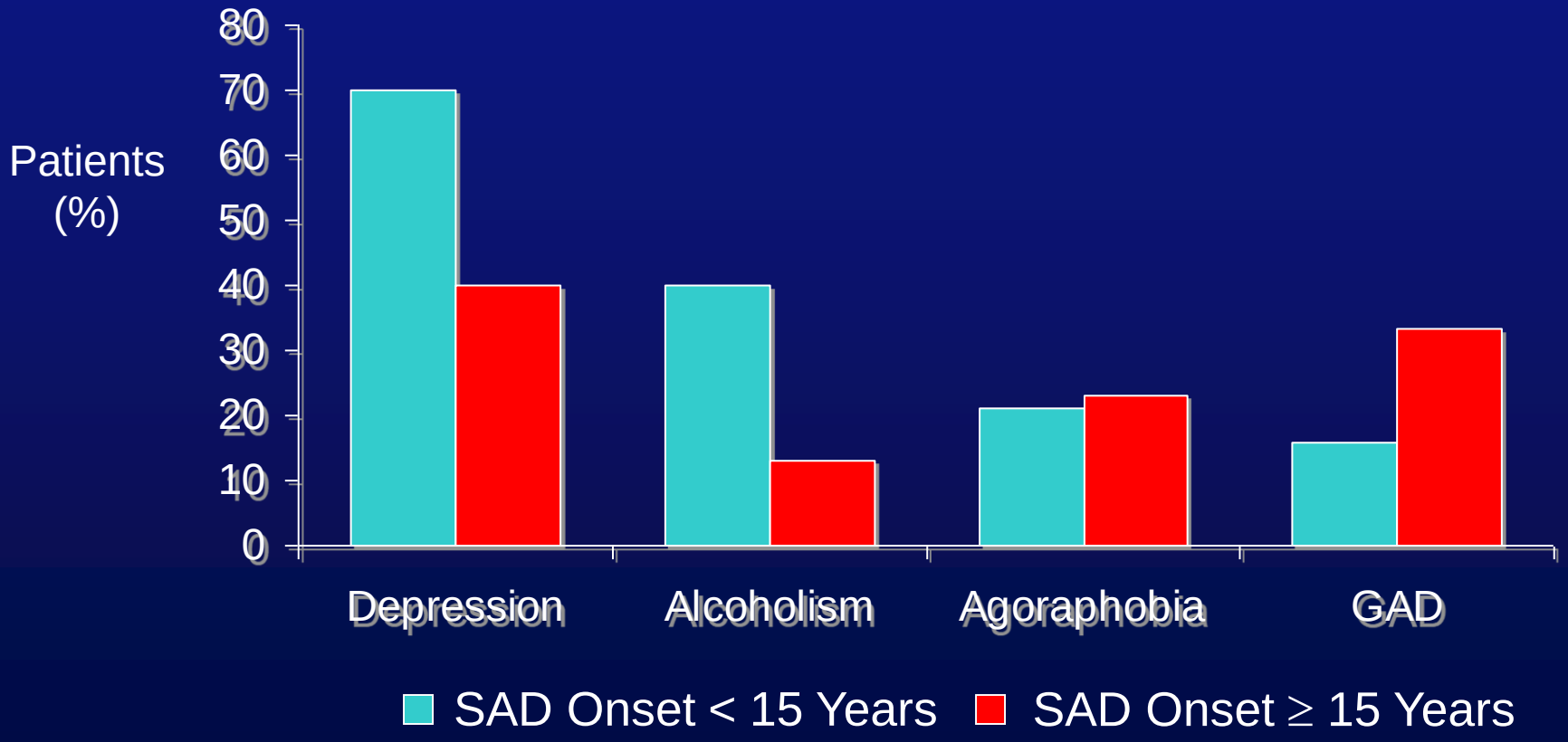
Magee et al, 1996

Age of Onset of Disorders Co-Existing with SAD



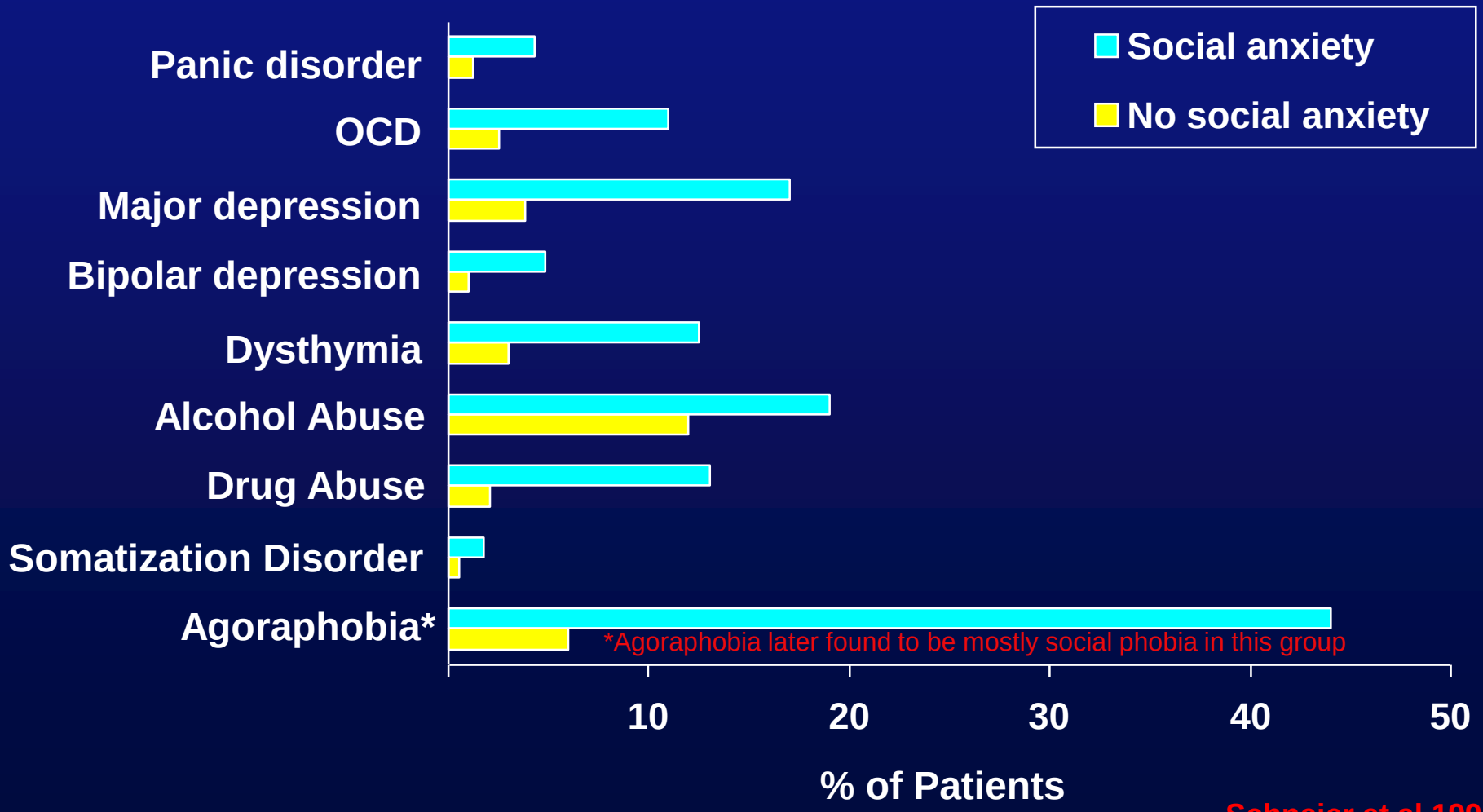
Schneier et al, 1992

Social Anxiety Disorder and Comorbid Illnesses



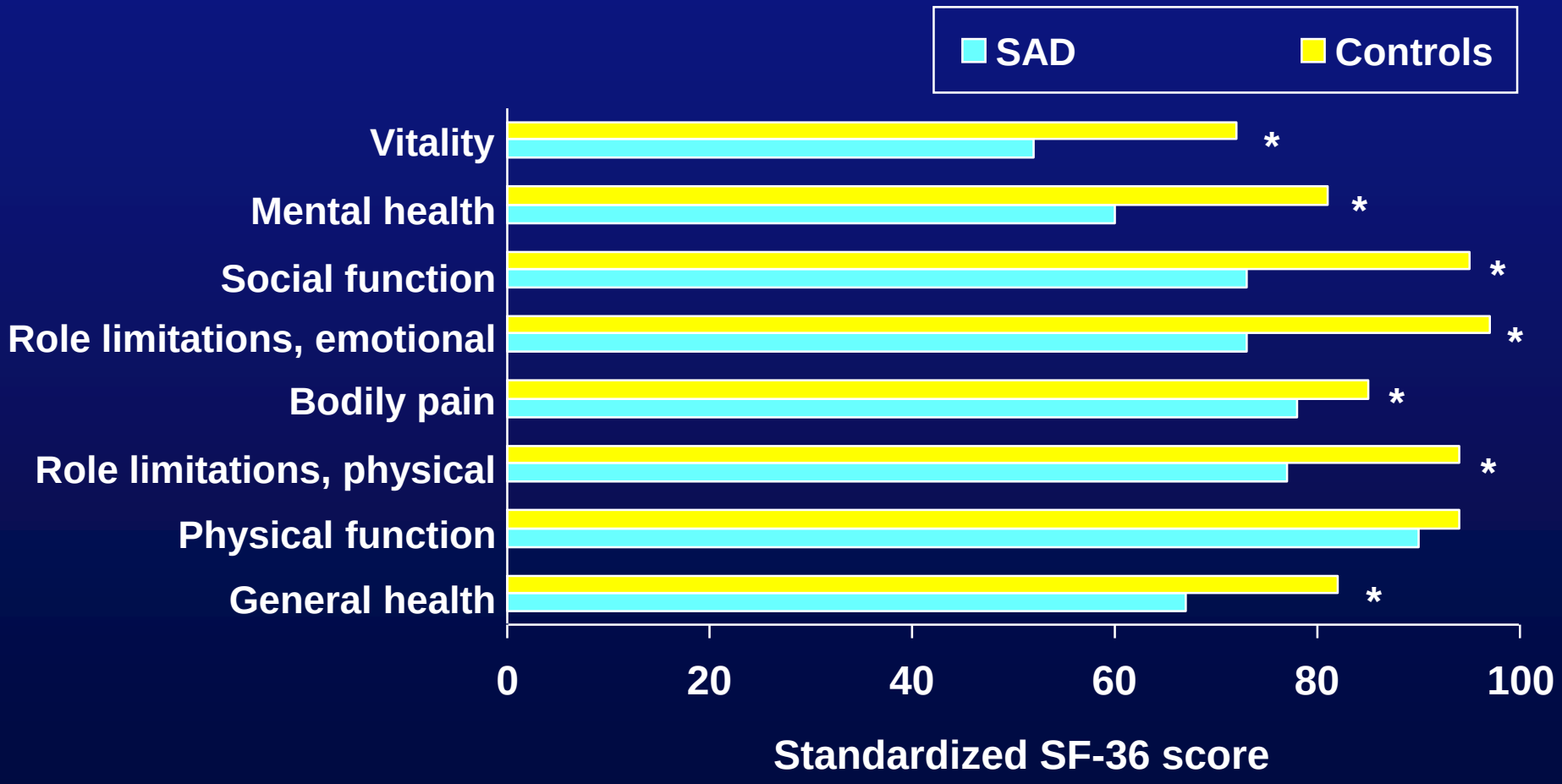
Lecrubier. *Eur Neuropsychopharmacol*. 1997;7(Suppl 2):S85

Other Psychiatric Illnesses and SAD...



Schneier et al 1992

Quality of Life in Patients with SAD Assessed with the SF-36 Scale



*p<0.05

Wittchen, 1996

Suicidality In SAD

Schneier et al. *Arch Gen Psychiatry*. 1992;49:282

Social Anxiety Disorder
Part Three

Treatment

SAD Treatment Goals

- Determine Subtype
- Reduce Anxiety and Phobic Avoidance
- Reduce Disability and Impairment
- Identify and Treat Comorbid Disorders

Summarized from Davidson. *J Clin Psychiatry*. 1998;59(Suppl 17):47

SAD Assessment of Treatment

Rating Scales

- **SPIN**
  - **Social Phobia Inventory**
- **BSPS**
  - **Brief Social Phobia Scale**
- **LSAS***
  - **Liebowitz Social Anxiety Scale**

*Most Often Used in Clinical Trials; Tracks well with BSPS

Liebowitz Social Anxiety Scale

	Fear or Anxiety	Avoidance
1. Telephoning in public. (P)		
2. Participating in small groups. (P)		
3. Eating in public places. (P)		
4. Drinking with others in public places. (P)		
5. Talking to people in authority. (S)		
6. Acting, performing or giving a talk in front of an audience. (P)		
7. Going to a party. (S)		
8. Working while being observed. (P)		
9. Writing while being observed. (P)		
10. Calling someone you don't know very well. (S)		
11. Talking with people you don't know very well. (S)		
12. Meeting strangers. (S)		
13. Urinating in a public bathroom. (P)		
14. Entering a room when others are already seated. (P)		
15. Being the center of attention. (S)		
16. Speaking up at a meeting. (P)		
17. Taking a test. (P)		
18. Expressing a disagreement or disapproval to people you don't know very well. (S)		
19. Looking at people you don't know very well in the eyes. (S)		
20. Giving a report to a group. (P)		
21. Trying to pick up someone. (P)		
22. Returning goods to a store. (S)		
23. Giving a party. (S)		
24. Resisting a high pressure salesperson. (S)		

Liebowitz, MR. Mod Probl Pharmacopsychiatry 1987; 22:141-173

Scoring the LSAS

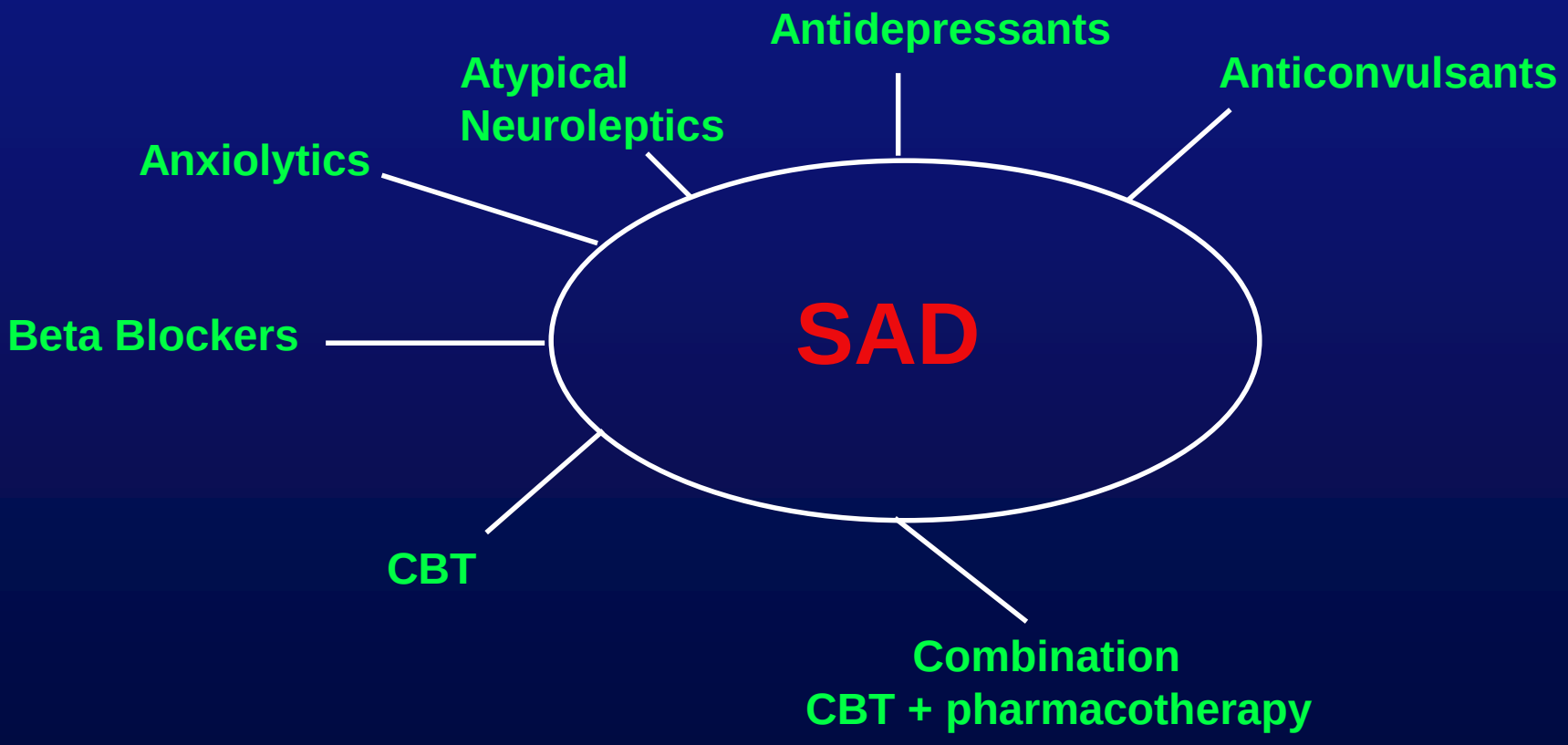
- ≥80: Severe
- 60-80: Moderate
- ≤30: Normal

SAD Treatment Options Vary Greatly in Efficacy

Three D's of Treatment

- Adequate Dose
- Adequate Duration
- Appropriate Documentation

*


Antidepressants
Atypical Neuroleptics
Anticonvulsants
Anxiolytics
SAD
Beta Blockers
CBT
Combination
CBT + pharmacotherapy

*

SAD Subtypes and Treatment Considerations

Non-Generalized

- Limited Social Fears
- Often Predictable
- PRN Medication can be Effective
  - Beta-Blockers
    - Atenolol
    - Propranolol
  - Benzodiazepines
    - Lorazepam
    - Alprazolam

Generalized

- Social Skills Deficit
- Pervasive Social Fears
- Disabling and Severe
- Daily Medication Needed
  - SSRI
  - SNRI

Psychosocial Treatment may be Helpful for Both Subtypes

*

Psychosocial Treatments for SAD

- Psycho-Education
- Social Skills Training
- Cognitive Behavioral Therapy (CBT)
- Individual or Group Therapy

Summarized from Heimberg 2001 J Clin Psych

CBT Pros and Cons

- Advantages
  - It Works
  - It Keeps Working
  - Most People Like It
  - Time-Limited
  - Few Side-Effects
- Disadvantages
  - More Work
  - Limited Supply
  - May Not be Covered by Insurance
  - Not for Everyone

Psychosocial Treatment vs. Pharmacotherapy

Phenelzine vs. CBGT (Group CBT):

- Phenelzine Results in Greater Improvement Short-Term
- CBGT Shows More Durable Improvement at Follow-Up

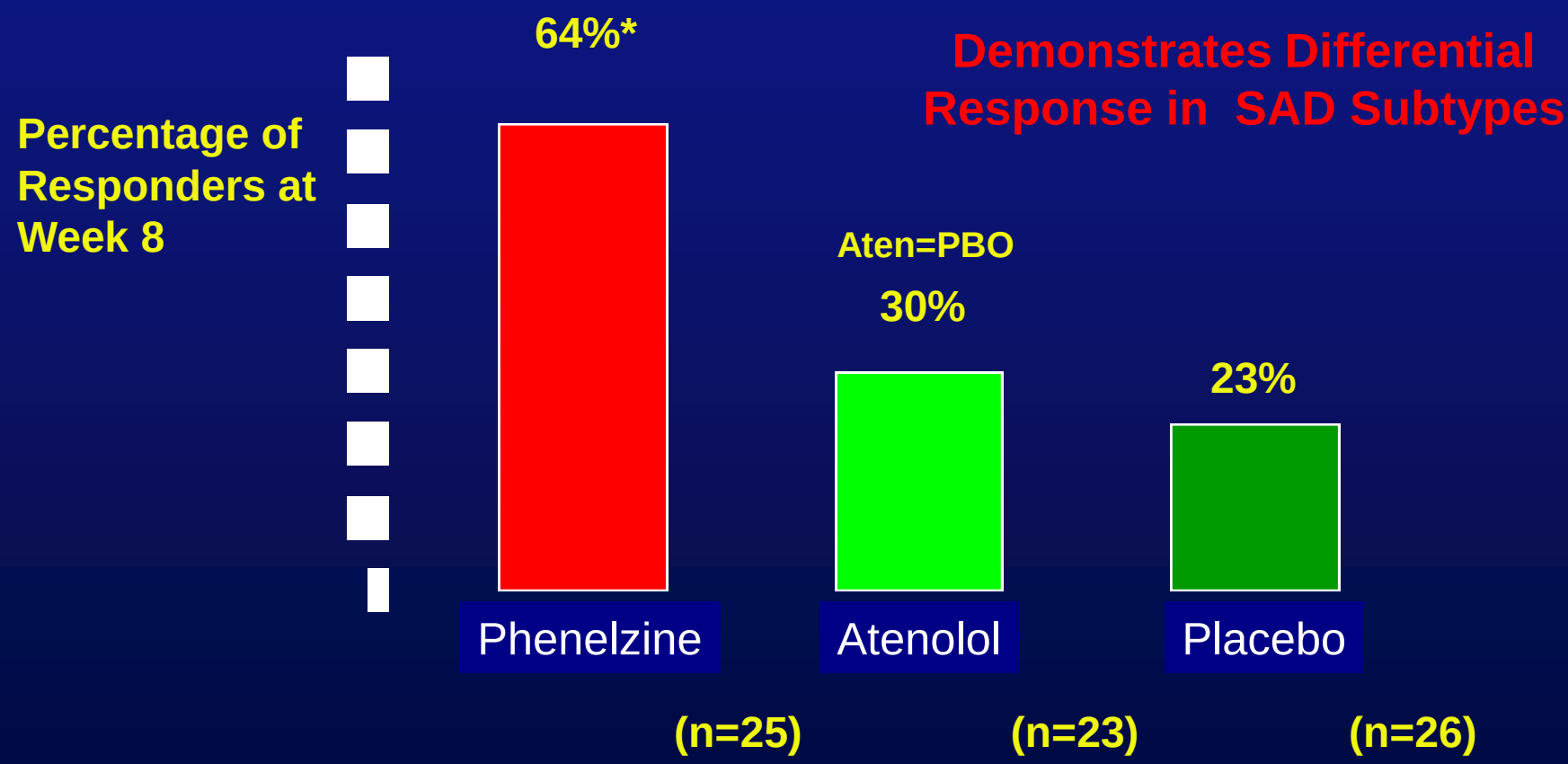
*

Pharmacotherapy

SAD Subtypes are Important When Considering Pharmacotherapy

First Pharmacotherapy for Social Anxiety Disorder

2/3 Generalized, 1/3 Non-Generalized
***p<0.05**



Demonstrates Differential Response in SAD Subtypes

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Liebowitz et al, 1992

Non-Generalized Subtype Pharmacotherapy…

Beta Blockers

Beta Blockers (cont'd)

- Effective for Discrete "Performance Anxiety"
  - Not effective for Generalized SAD
  - Not Effective for Depression or Other Comorbidities
- Decreases Symptoms of Physiologic Arousal, Not Emotional Experience of Anxiety
- Given 1-2 hours before event

*

Beta Blocker Dosing

Examples:

- Propranolol: 10-40 mg PO
- Atenolol: 50-150 mg PO

*

Beta Blockers and Stage Fright in Musicians

In 24 String Players,

Oxprenolol (40 mg):

- **Decreased Heart Rate, Tremor, Nervousness**
- **Improved Performance Subjectively and Objectively**

*

James et al. Lancet. 1977;2:952-954

Beta Blockers: Scholastic Aptitude Test (SAT) and Performance Anxiety

On Retest…

- Expected Improvement was: 14 points
- With Propranolol (40 mg), Improvement was: 130 points

(N=32)

*

Faigel HC. Clin Pediatr. 1991 (July)

Generalized Subtype and Pharmacotherapy

Principles

Generalized Subtype Pharmacotherapy: Pros and Cons

- Advantages
  - Works Quickly
  - Less Initial Time/Effort
  - More Robust Initial Response in Some Patients
- Disadvantages
  - Patient Concerns About Psychological Dependence
  - Cost
  - Adverse Effects
  - Relapse Rate after D/C

*

Classes with Proven Efficacy in Generalized Subtype*

Selective Serotonin Reuptake Inhibitors (SSRIs)
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
Benzodiazepines*
Monoamine Oxidase Inhibitors (MAOi)
Clomipramine
Gabapentin*

•Not Reliably an Antidepressant or Insufficient Information

*Consideration includes comorbid disorders
Not all agents in all classes approved by FDA but all empirically supported in RCTs; Duloxetine insufficiently studied but likely resembles venlafaxine

*

Adapted from: Lydiard RB. Textbook ***of Anxiety Disorders*****. Washington, DC: APPI; 2002:348-**

Classes with Limited or No Proven Efficacy in Generalized Subtype

Anti-Epileptic Drugs[1] (AEDs)
Bupropion
CMI-
But not other TCAs

[1]AEDs-Gabapentin, Topiramate, Levetiracetam

*

Adapted from: Lydiard RB. In: *Textbook of Anxiety Disorders*. Washington, DC: American Psychiatric Press, Inc; 2002:348-3613

Generalized Subtype Pharmacotherapy

- Recommended First-Line = **SSRI** or **SNRI**

- Initial dose for 2-4 weeks, then increase if necessary

Should see some benefit in 2-4 weeks

*

If No Response in 6-8 weeks…

- Switch to Another Class

or

- Augment with a Benzodiazepine or a Beta Blocker

*

Generalized Subtype Pharmacotherapy (cont'd)

- Typical Pattern is Continued Improvement for Months

(may take ≥ 1 yr for optimal response)

- Continue Pharmacotherapy A*fter* Gains Maximized to Allow for Resumption of Psychosocial Development

*

Generalized Subtype: SSRIs and SNRIs

- Advantages
  - Broad Efficacy
  - Safe
  - Well Tolerated
  - Easy to Use
- Disadvantages
  - Initial side effects (jitteriness, insomnia, nausea)
  - Long-term side effects (weight gain, sexual dysfunction)
  - Expensive

*

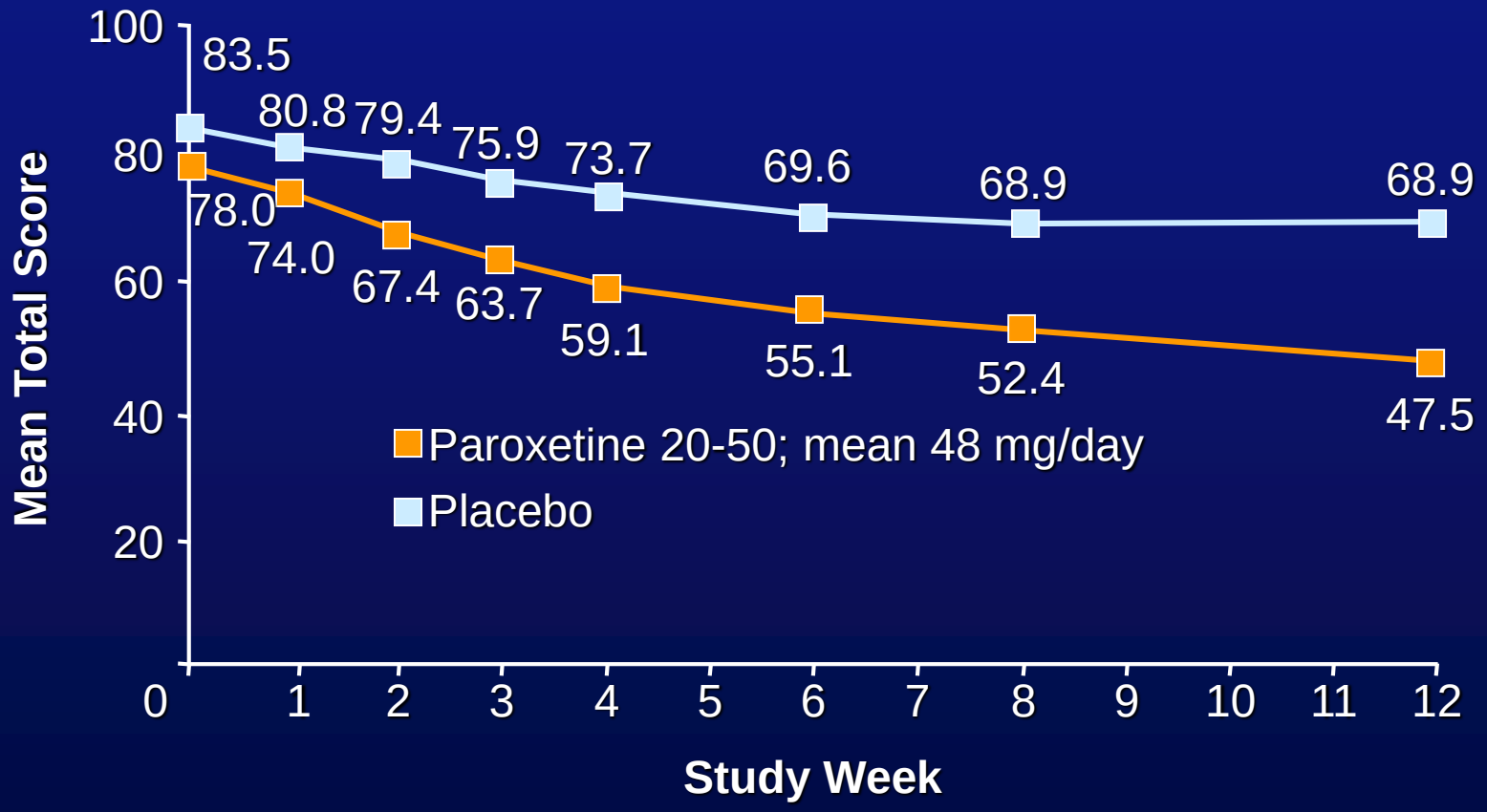
Clinical Wisdom: Drugs Within a Class are the the Same, but "Different".

(Example--with SSRIs, Consider Trying More than One Before Switching Classes)

Q: "Are all your sons like you?"
A:"Yeah, we're all alike, but our similarities are different."
Yogi Berra

Typical SSRI vs Placebo in SAD

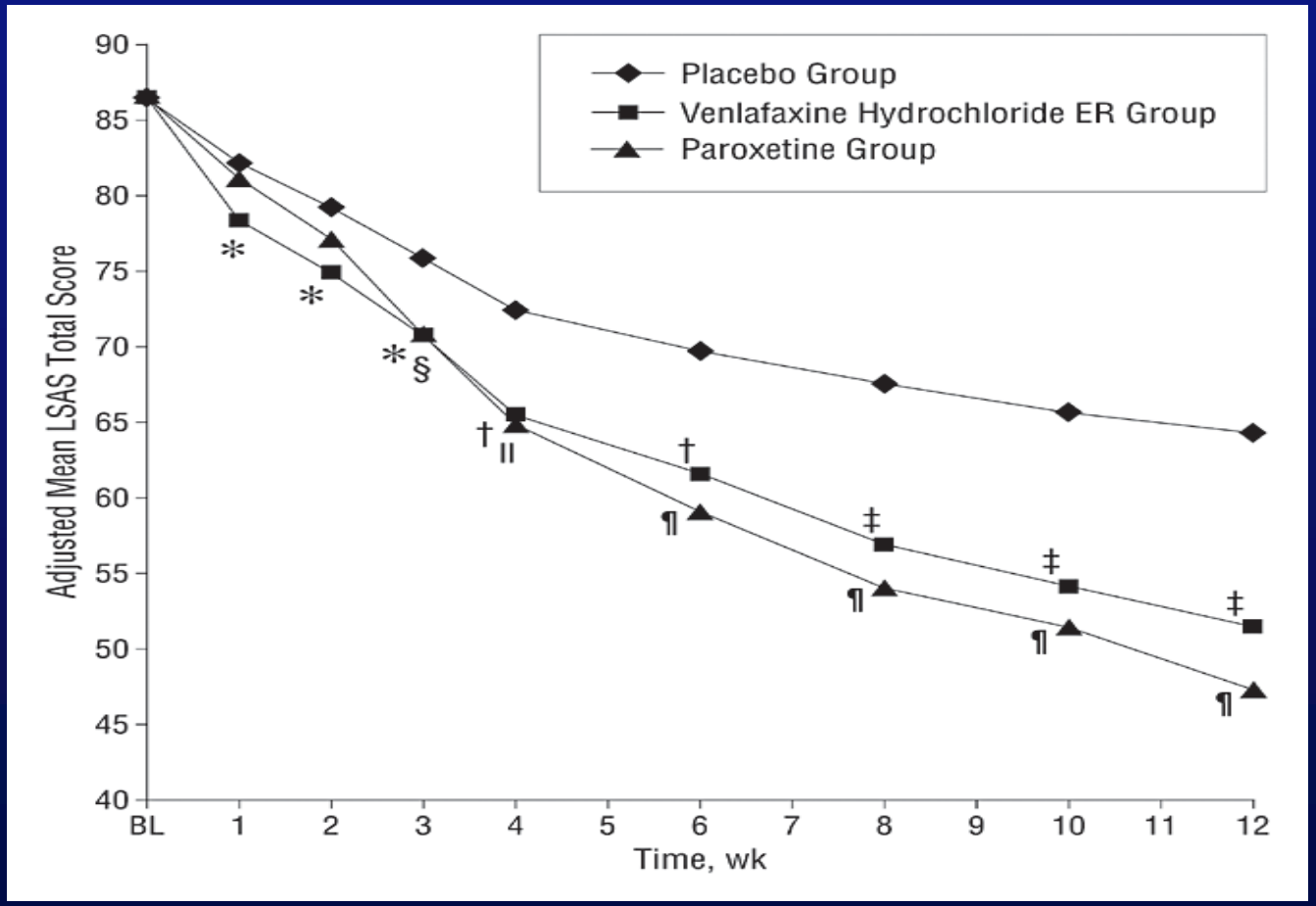
Paroxetine --Total Change in LSAS



* *P*<.05 versus placebo Stein et al. *JAMA*. 1998;280:708

*

Generalized Subtype: SNRI vs. SSRI vs. Placebo



n= Ven-146; PAR n=147; PBO=147 Dose Ven 75-225 PAR 20-50

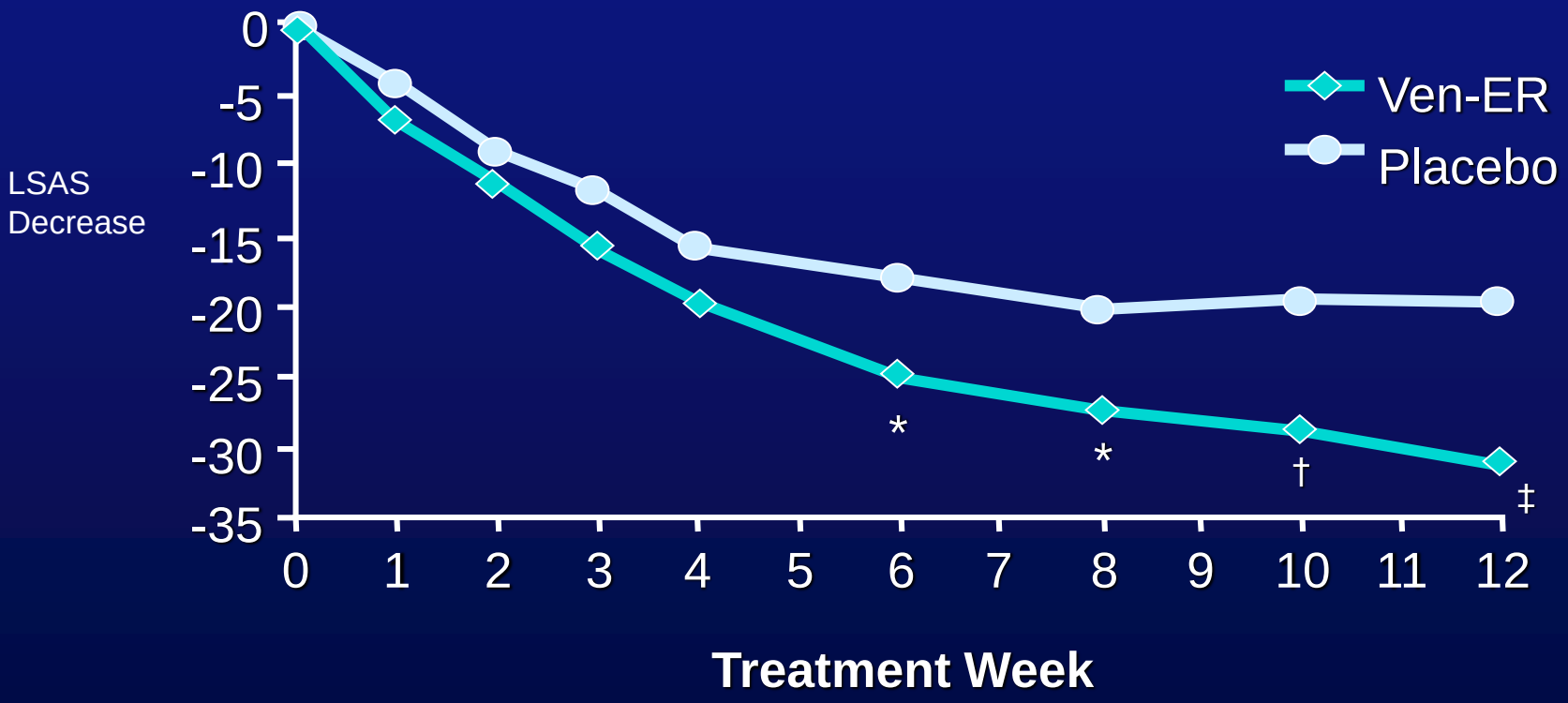
*

Liebowitz, M. R. et al. Arch Gen Psychiatry 2005;62:190-198

SNRI : Venlafaxine ER Flexible Dose 75-225 mg/day

271 randomized, 173 completed

Response Ven XR 44%; PBO 30% // Remission Ven XR 20%; PBO 7 %



*

*P = 0.022; †P = 0.003; ‡P = 0.0002.

ITT Population, LOCF Analysis Liebowitxz et al, J Clin Psych 2005;66:238-47

Monoamine Oxidase Inhibitor Treatment Of SAD

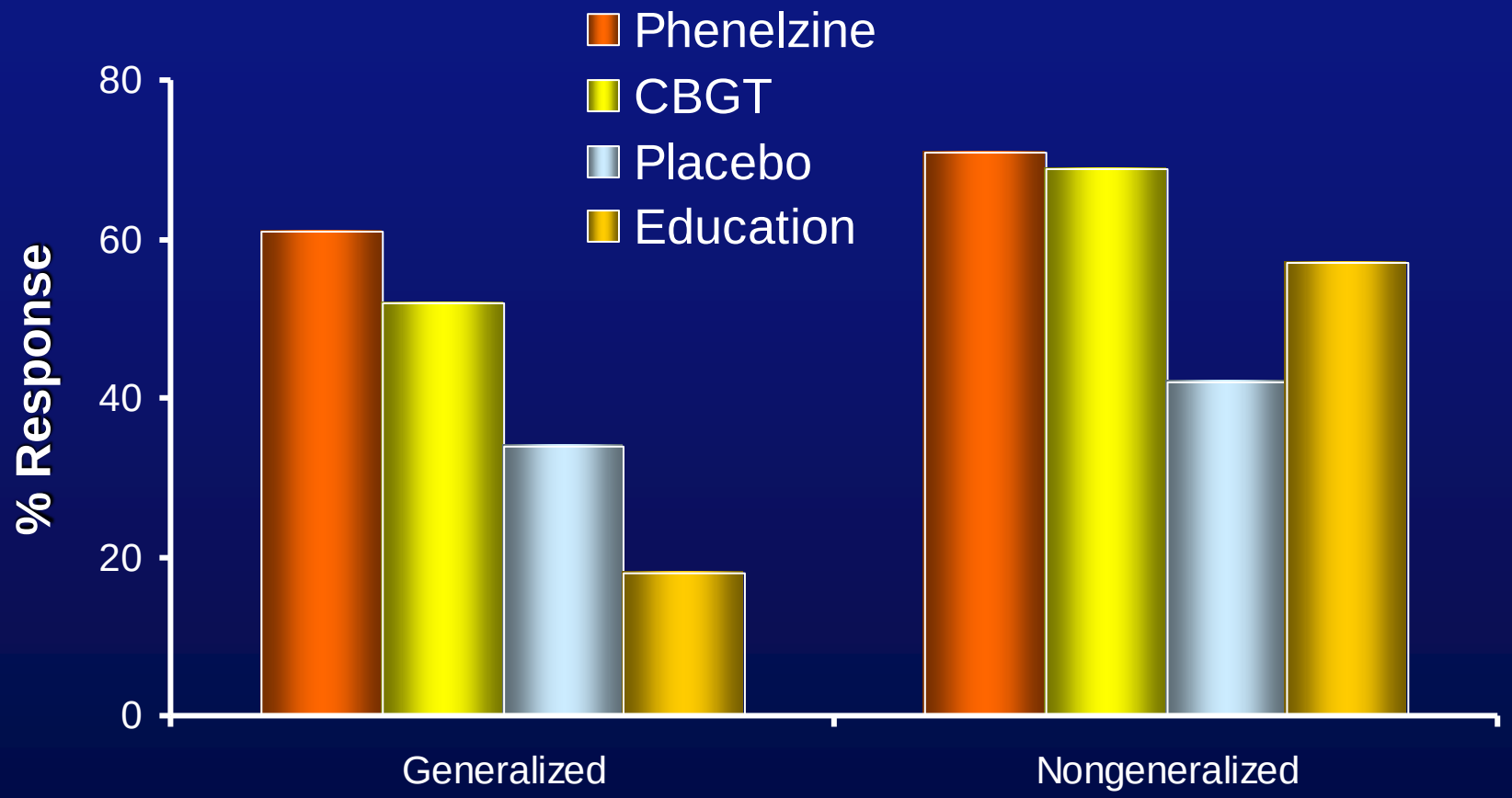
- Irreversible (nonselective)
  - — **Phenelzine,**
  - — **Tranylcypromine**
    - – Very Effective
    - – Poorly Tolerated
    - – Hazardous Interaction with Tyramine

- Reversible Inhibitors of Monoamines (RIMAs)
  - — Reversible, selective for MAO-A
    - – Well tolerated
    - – Not Available in US
      - » Moclobemide Weak Response in Most Studies
      - » Brofaromine-Very Effective

*

Response by Subtype of SAD

CBT (Group) vs. MAOi



*Intent to treat.

Two-site study; One Pharmacotherapy-Oriented, the Other CBT-oriented.

No outcome differences between sites.

*

Heimberg, Liebowitz, et al Arch Gen Psych 1998;55:.1143-41

Benzodiazepine Treatment for Social Anxiety Disorder

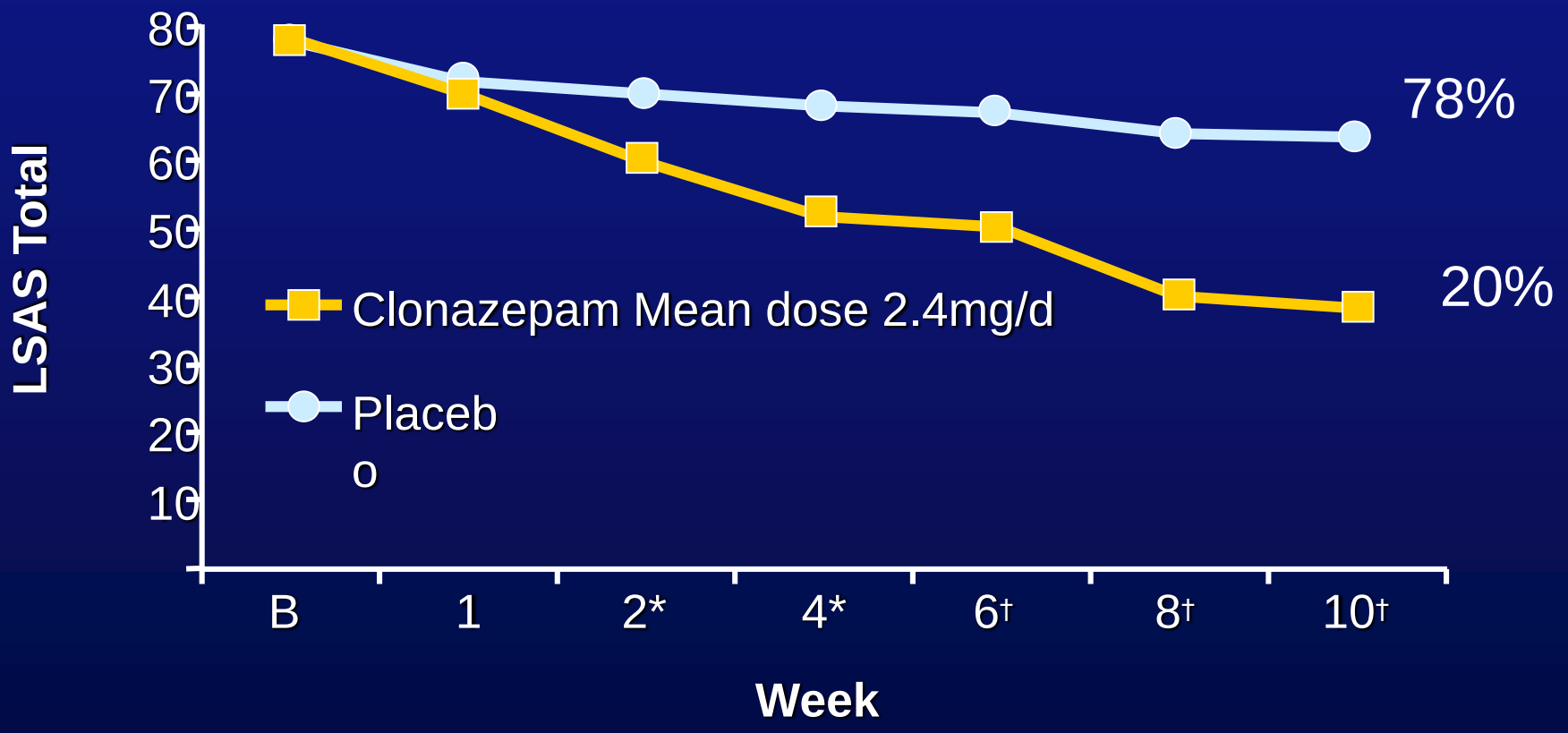
- Effective--Highest Response Rates
- Potential Problems in Patients with Substance abuse
- *Not an Antidepressant*
- Side Effects

— Disruption of Cognition / Sedation

— Tolerance / Dependence / Withdrawal

*

Benzodiazepines in SAD: Clonazepam vs. Placebo



* $P \leq .01$; † $P \leq .0001$ (LOCF MANCOVA).

Davidson et al. *J Clin Psychopharmacol*. 1993;13:423.

*

Tricyclic Antidepressant Treatment Of SAD

- Doubtful Efficacy

- Side Effects

— Sedation, Tremor, Dry mouth

— Decreased Cognition

— Sexual Dysfunction

— Weight Gain

— Constipation

*

Tricyclic Antidepressants

- Clomipramine Appears Effective
- Imipramine - Ineffective in only Controlled Study
  - N=41, 8-week trial ; Mean dose: 149 mg/d
    - Intent-to-treat (ITT)
  - 20 dropped out (most-adverse effects)
  - Responders:
    - Imipramine: 2/18
    - Placebo 1/23

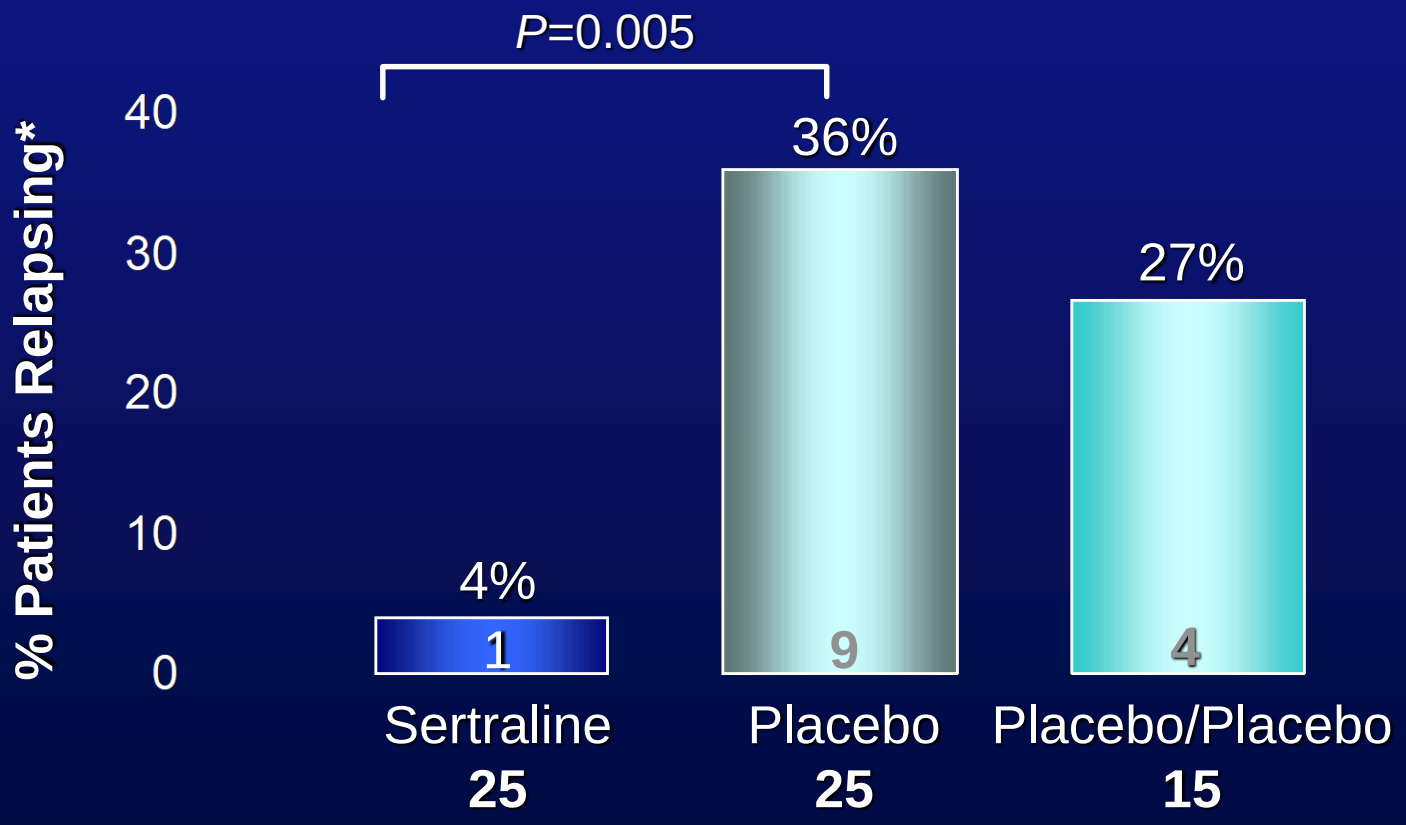
*

Emmanuel, Lydiard et al, ACNP 1997

Maintaining Gain in SAD

Relapse* Prevention in Social Anxiety Disorder: Sertraline

Proportion of Patients Relapsing During 24 Weeks of Double Blind Treatment



*Relapse = Responders by CGI who Worsened from Double Blind Continuation Study Baseline or for Discontinuation Due to Lack of Efficacy. Placebo / Placebo is the Group Initially Receiving and Responding to Placebo.

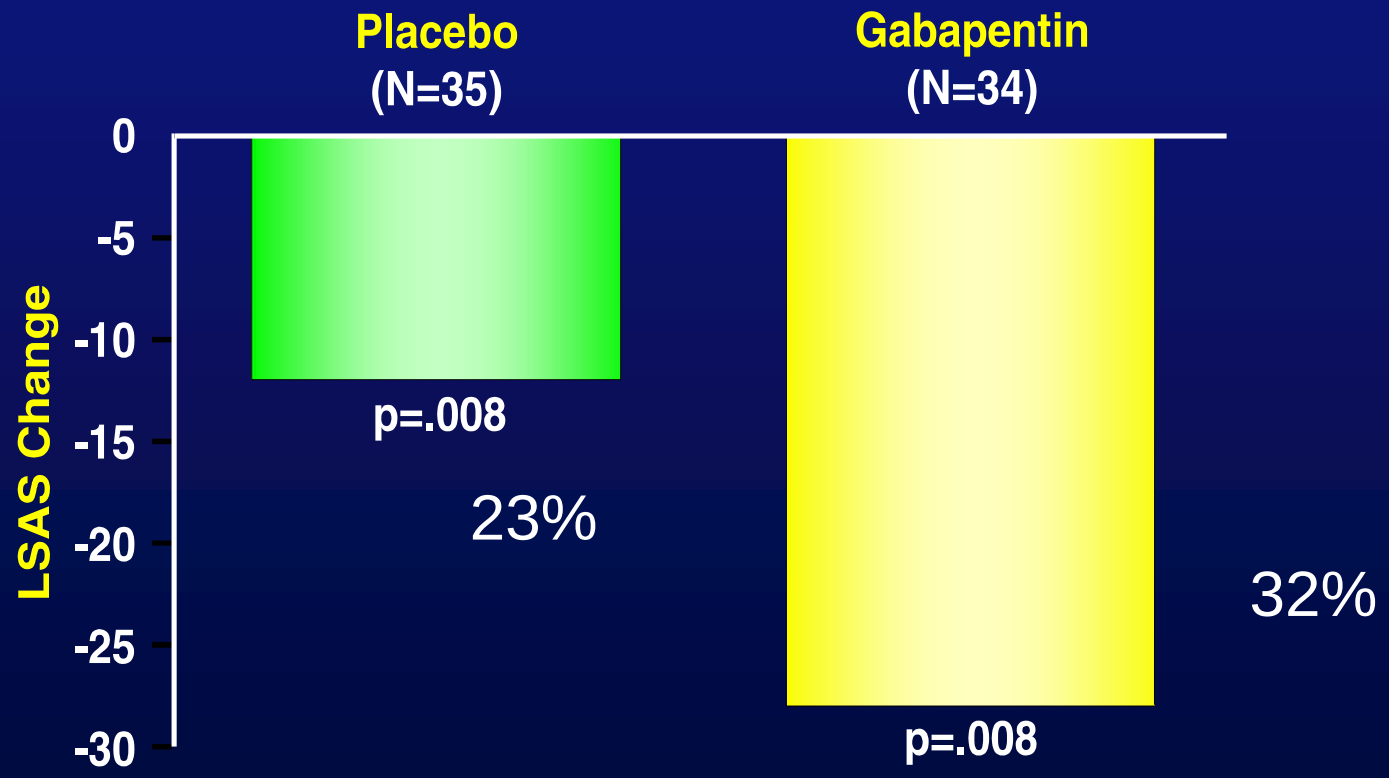
*

Walker et al. *J Clin Psychopharm*. 2000

Novel Treatments: Gabapentin in SAD

8-week study ITT Analysis--Marginal efficacy

300-1200 mg tid



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Pande AC et al J Clinical Psychopharmacol 2004; 24:141-149

Summary of Pharmacological Management of SAD

Generalized SAD

First Line: SSRI or SNRI

(Broad Spectrum Activity Against Comorbid Disorders)

Titrate over 2-4 weeks, then Increase if Necessary

Some Benefit often Evident by 2-4 weeks

*

Summary of Pharmacological Management of SAD (cont'd)

If No Response by 6-8 weeks,

Switch to Another Drug

or

Augment

Continue Pharmacotherapy for ≥ 1 year
After Maximal Gain is Achieved

CBT is a Reasonable Therapy

*

Daily Dose Range for SAD and Most Comorbid Disorders*

Venlafaxine	75-300 mg
Paroxetine	20-80 mg
Sertraline	50-300 mg
Escitalopram	10-40 mg
Fluvoxamine	50-300
Citalopram	20-60 mg
Clomipramine	25-300 mg
Buspirone	30-60 mg
Clonazepam	0.5- 4 mg
Alprazolam	1-8 mg
Diazepam	5-40 mg

*

* Based on literature and experience of authors

Tips…

- Start Low and Titrate Individually Based on Side Effects and Efficacy

- The “Right” Dose is the One which Provides Efficacy *and* Tolerability

*

Tips (cont'd)…

- May Require Higher Doses for Anxiety or SAD and Comorbid Disorder(s)
- Document Your Rationale and Patient Assent if Using Outside Labeling Dosage

*

Long Term Treatment is Required by Many Patients to Maintain Gains

*

Long-Term Treatment Indications

- Persistent Social Anxiety Symptoms which Cause Impairment
- History of Relapse After Stopping Prior Treatment
- Comorbid Conditions which Require Prophylaxis

Selection Considerations

- Evidence for Efficacy
- Safety
- Tolerability
- Half-Life
- Drug-Drug Interactions
- Protein Binding

Conclusions

- SAD is Common and Disabling
- SAD Requires Prompt Diagnosis to Prevent Long-Term Disability
- SAD is
- Underdiagnosed
- Undertreated
- SAD Demands Increased Awareness from Health Professionals and the Public

Question #1

What are the 2 Social Anxiety Disorder (SAD) Subtypes?

Question #2

Which SAD Subtype would be Described as…

- **More Common**
- **Familial**
- **Earlier onset**
- **Greater Impairment**
- **Lower Remission Rate**

Question #3

True or False

Patients with SAD are more likely, as compared to those without SAD, to do the following…

- **Remain Single**
- **Not Finish High School**
- **Earn Lower Income**

Question #4

What are three psychiatric illnesses that are commonly comorbid with SAD?

Question #5

What is First Line Treatment for SAD and… Does it vary between the 2 Subtypes?

Answer #1

Non-Generalized Subtype

Generalized Subtype

Answer #2

Generalized Subtype

Answer #3

TRUE!

Answer #4

- **Agoraphobia… in almost 1/2 of patients with SAD**
- **Alcohol Abuse… in almost 1/5 of patients with SAD**
- **Major Depressive Disorder… in almost 1/5 of patients with SAD**

Answer #5

Yes.

Pharmacotherapy can vary between the 2 Subtypes.

Generalized… First Line: SSRI or SNRI

Non-Generalized… PRN Pharmacotherapy Targeting Symptoms

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