Social Anxiety Disorder

Operational Definition

A. Marked fear or anxiety about one or more social situations in which the person is exposed to possible scrutiny by others.

B. The individual fears that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated

C. The social situations consistently provoke fear or anxiety

Operational Definition

D. The social situations are avoided or endured with intense fear or anxiety

E. The fear or anxiety is out of proportion to the actual danger posed by the social situation.

F. The duration is at least 6 months.

G. The fear, anxiety, and avoidance cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Operational Definition

H. The fear, anxiety, and avoidance are not due to the direct physiological effects of a substance or a GMC

I. The fear, anxiety, and avoidance are not restricted to the symptoms of another mental disorder

J. If a general medical condition is present, the fear, anxiety, or avoidance is clearly unrelated to it or is excessive.

SAD Specifiers

- **Performance only**: If the fear is restricted to speaking or performing in public
- **Generalized:** If the fear is of most social situations (and is not restricted to performance situations)
- **Selective Mutism**: Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations

SAD Prevalence

- 7.1% for 12 months, 12.1% for lifetime in US
- Similar rates across Western countries, seen across all cultures in varying rates
- *Taijin kyofusho* in Eastern countries appears to be a culturally specific form of SAD

Stein & Stein (2008)

SAD Onset

- Early onset compared to many disorder, with rates of 6.8% in children
- 50% of adult cases report onset in childhood, over 80% reported starting by age 20
- Only half ever seek treatment, average time is after 15-20 years of diagnosable problems

Bogels et al. (2010); Stein & Stein (2008)

Gender Differences

- Higher rates of females in both adult and adolescent samples
- However, men more likely to seek treatment
- Different common symptoms
  - Men – eating in restaurants and writing in public
  - Women – using public restrooms and speaking in public

Ranta et al. (2007); Weinstock (1999)

SES & Cultural Differences

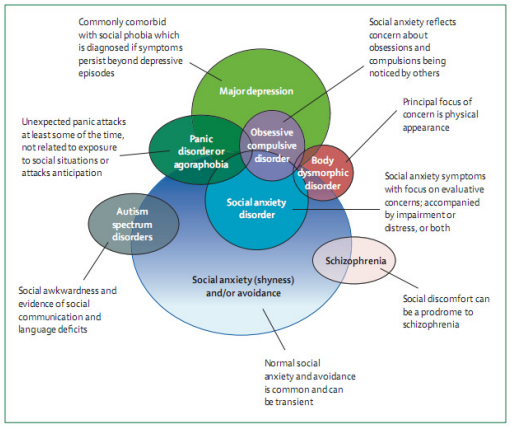
- More prevalent in low SES and less educated
- Fear of embarrassing self (Western) versus fear of offending others (Eastern)
- Native Americans at higher risk that whites or African-Americans, but this changes across ages

Lewis-Fernandez et al. (2009)

Comorbidity

- Very high, over 80% in clinical settings
- Most common are depression, panic disorder, GAD, specific phobias, and alcohol use disorders
- SAD often develops prior to comorbid problems, but relationship with AUD is uncertain
- Avoidant PD may be an extreme variant of SAD

Morris et al. (2005); Stein & Stein (2008)



Impact of SAD

- Common reason for school refusal in youth
- Only internalizing disorder highly associated with dropping out of school early
- Reduced workplace productivity, higher unemployment
- Reduced health-related QoL

Stein & Stein (2008)

Impact of SAD

- High rates of being single or divorced
- Wide range of sexual dysfunctions
- Smaller social networks and less social support
- Greater risk for suicide than general population
- Lowered positive psychological experiences

Kashdan (2007)

Etiology

- Behaviorally inhibited temperaments place individuals at high risk for SAD
- Modest heritability of SAD, likely due to BI or introversion, but could be shared environment
- Multiple gene variants and neurotransmitters seem to play a role (no one pathway)

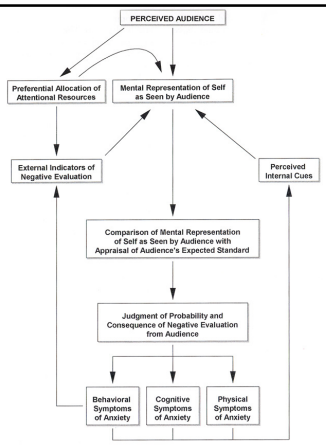
Morreale et al. (2010)

Etiology

- Family environment reported to be more overprotective, less affectionate
- Families also emphasize concern of other's opinions, lack of family sociability
- CBT model emphasizes role of negative aspects of self and situation

Morreale et al. (2010)

CBT model of SAD



SAD Treatment

- Large evidence base for pharmacology and psychotherapy, individually but not combined
- Effect sizes are roughly equal for SSRIs and CBT (1.5 vs 1.8)
- SSRIs work sooner, but CBT effects last longer

Stein & Stein (2008)

Pharmacology for SAD

- SSRIs (but not Prozac) or SNRIs are first line choice
- D-cycloserine (glutaminergic agent) may be useful as an adjunct to exposure therapy
- MAOIs and benzodiazepines can be useful, but are more a) dangerous or b) addictive

Stein & Stein (2008)

	Dose (mg per day)	Number of patients	Response rate for drug	Response rate for placebo
Citalopram[85]	40	36	50%	8%
Escitalopram[101,102]	5–20	1028	54–71%	39–50%
Fluvoxamine[103–105]	50–300	422	43–48%	7–44%
Fluoxetine[97,106]	20–60	108	40–51%	30–32%
Paroxetine[101,107–110]	20–50	2188	55–72%	8–50%
Sertraline[96,111–113]	50–200	616	40–53%	9–29%
Venlafaxine[108,114–116]	75–225	1547	44–69%	30–36%

*Patients undergoing concomitant cognitive behavioural psychotherapy were excluded.

Table 3: **Usefulness of selective serotonin and serotonin–noradrenaline reuptake inhibitors for social anxiety disorder**

CBT for SAD

- Treatment for SAD is longer and involves more components than for specific phobias
  - Psychoeducation
  - Applied relaxation
  - Social skills training
  - Imaginal and in-vivo exposure
  - Video feedback
  - Cognitive restructuring

Rodebaugh et al. (2004)

CBT for SAD

- EX/RP appears to be the most important ingredient among the components
  - CBT vs only exposure yield similar results
- Have to take care to catch and not allow *subtle* avoidance and focus on the situation itself
- Safety behaviors must also be curbed

Rodebaugh et al. (2004)

CBT for SAD

- Applied relaxation trains clients in PMR, and then has them implement it *in vivo*
  - PMR *alone* is not an effective treatment
- Similar to systematic desensitization, in which the likely active ingredient is EX/RP
- Likely the case for social skills training as well

Rodebaugh et al. (2004)

CBT for SAD

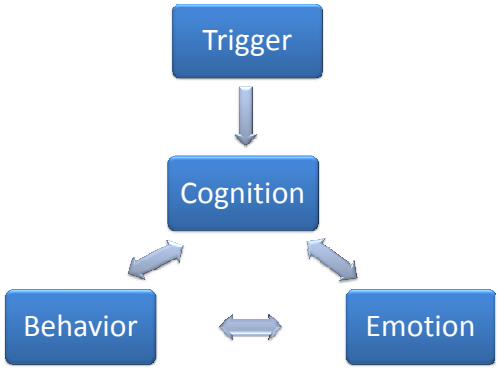
- Cognitive restructuring is often used to help prepare for exposures
- Exposures are seen as the "test" of if automatic negative thoughts are correct
- But again, EX/RP may be the key task

Rodebaugh et al. (2004)

EX/RP & Cog Restructuring

- Dichotomizing the two may be misleading
- Therapists may be mixing the two, rather than strictly using one or the other
- Behavior causes changes in thoughts, thoughts cause changes in behavior

Rodebaugh et al. (2004)



CBT for SAD

- Gains or even improvements seen from 6-12 months post treatment
- Low drop-out rates (10-20%)
- Group and individual formats both show large improvement rates, but individual is higher

Rodebaugh et al. (2004); Stein & Stein (2008)

Access to CBT

- With limited access, self-guided/minimal contact therapies may be a useful alternative
- One study found bibliotherapy + 3 hours of non-therapy contact with therapist clinically improved 40% of clients
- May be good option for mild-moderate SAD

Abramowitz et al. (2009)

Media Critique #3