



Predictors of persistence of social anxiety disorder: A national study

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ABSTRACT

Social anxiety disorder (SAD) is highly prevalent and impairing. Little is known about rates and predictors of persistence of SAD in the community. The current study derived data from the National Epidemiologic Survey on Alcohol and Related Conditions, Wave 1 (2001–2002, $n = 43,093$) and Wave 2 (2004–2005, $n = 34,653$), a large survey of a representative sample of the United States adult population. Individuals with current DSM-IV SAD at Wave 1 were re-interviewed 3 years later at Wave 2 using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM IV Version (AUDADIS-IV). We found that in the community, 22.3% of respondents with SAD at the Wave 1 evaluation met DSM-IV criteria for SAD three years later, and endorsement of social interaction fears and a higher number of avoided social situations, treatment-seeking during past year, and comorbidity with mood disorders independently predicted persistence of SAD. These results suggest that persistence of SAD in the community is common and associated with symptom severity and comorbid mood disorders.

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1. Introduction

Social anxiety disorder (SAD) is highly prevalent (Kessler et al., 1994, 2005a, 2005b; Stein et al., 1994; Magee et al., 1996; Grant et al., 2005; Stinson et al., 2007), associated with significant social and occupational impairment (Schneier et al., 1992; Davidson et al., 1993; Wittchen and Beloch, 1996; Keller, 2003; Kessler, 2003), and often co-occurs with other psychiatric disorders (Rapee et al., 1988; Reich et al., 1994). SAD generally has an onset during adolescence or early adulthood (Rapee et al., 1988; Reich et al., 1994; Chartier et al., 1998) and is typically considered to be chronic (Reich et al., 1994; Yonkers et al., 2003; Grant et al., 2005).

Data from clinical samples have suggested that SAD seldom remits (Reich et al., 1994; Massion et al., 2002; Yonkers et al., 2003). Initial short-term treatment studies suggested that early age of onset (Yonkers et al., 2003) and comorbid alcohol use disorders (Versiani et al., 1988) were associated with persistence of SAD, whereas gender (Cameron et al., 1986) and duration of illness (Mersch et al., 1991) did not seem to affect its chronicity. More recently, prospective data (Reich et al., 1994; Massion et al., 2002; Yonkers et al., 2003) from the Harvard/Brown Anxiety Research Program (HARP), which followed treatment-seeking patients with

anxiety disorders for up to eight years, indicated that gender, age of onset, and comorbid anxiety and mood disorders did not predict persistence of SAD (Reich et al., 1994; Massion et al., 2002), but avoidant personality disorder (APD) did (Massion et al., 2002). In primary care settings, comorbid panic disorder and lower psychosocial functioning have also been found to predict the persistence of SAD (Beard et al., 2010).

Several studies using community samples have also examined persistence of SAD. Data from the Duke site of the Epidemiological Catchment Area study suggested that earlier age of onset and presence of psychiatric comorbidity were associated with the persistence of SAD (Davidson et al., 1993), whereas results from the National Comorbidity Survey indicated that endorsing more than one social fear predicted persistence of SAD (Kessler et al., 1998). Conflicting results have been reported from longitudinal studies. For instance, the Dresden Predictor Study found, in an 18-month follow-up of 91 young women with SAD, that having a lifetime history of depression, a higher number of comorbid psychiatric disorders, higher levels of stress, poorer mental status, and being unemployed at baseline predicted persistence of SAD (Vriends et al., 2007). However, data from the Early Developmental Stages of Psychopathology Study on 183 adolescents and young adults with SAD followed for up to 4 years indicated that most socio-demographic factors, clinical characteristics, comorbid psychiatric disorders, familial factors, and stressful life events did not predict the persistence of SAD (Müller, 2002).

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Although these previous studies have advanced our knowledge of the course of SAD, they have been constrained by having modest sample size (Davidson et al., 1993; Vriends et al., 2007), use of cross-sectional data (Kessler et al., 1998; DeWit et al., 1999), or reliance on clinical samples (Beard et al., 2010), limiting the generalizability of their findings. Large prospective studies in the community are essential for the identification of predictors of persistence of SAD in the general population.

To expand current knowledge on this topic, we used data from a large and nationally representative community sample of United States (US) adults, the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) ($n = 43,093$) and its 3-year prospective follow-up ($n = 34,653$). In the NESARC, the 12-month prevalence of SAD at baseline (i.e., Wave 1) was 2.76% (Grant et al., 2005). The large size and representativeness of the NESARC sample and the longitudinal design of the study provide an unusual opportunity to simultaneously examine a broad range of variables that have been hypothesized to predict the course of SAD. Specifically, we sought to: 1) investigate differences in sociodemographic characteristics among individuals with persistent and remitted SAD; 2) compare rates of psychiatric comorbidity among individuals with persistent and remitted SAD; 3) examine clinical characteristics of SAD among individuals with persistent and remitted SAD; and, 4) examine childhood and adulthood risk factors among individuals with remitted and persistent SAD.

2. Materials and methods

2.1. Sample

The NESARC is a longitudinal survey of a nationally representative sample of the US adult population conducted, as described elsewhere (Grant et al., 1995, 2004, 2005; Hasin et al., 1997; Canino et al., 1999; Grant et al., 2003a, 2004, 2005, 2009; Grant and Kaplan, 2005). The target population was the civilian non-institutionalized population 18 years and older, residing in households and group living quarters (Grant et al., 1995; Ruan et al., 2008). All procedures, including informed consent, received full ethical review and approval from the U.S. Census Bureau and U.S. Office of Management and Budget.

The NESARC consisted of a first wave conducted in 2001–2002 ($N = 43,093$) (Grant et al., 2003a, 2004) followed up by a second wave in 2004–2005 ($N = 34,653$) (Grant et al., 2005). In Wave 2, attempts were made to conduct face-to-face re-interviews with all 43,093 respondents to the Wave 1 interview. Excluding respondents ineligible for the Wave 2 interview (e.g. deceased) the Wave 2 response rate was 86.7%; thus, 34,653 respondents completed Wave 2 interviews. The cumulative response rate from the two waves was 70.2% and sample weights were developed to additionally adjust for Wave 2 non-response (Ruan et al., 2008).

At Wave 1, 1140 respondents met criteria for current DSM-IV SAD. Of these, 989 also participated in Wave 2 and constitute the present sample. The mean interval between Wave 1 and Wave 2 interviews was 36.6 (Standard Deviation (SD) = 2.62) months.

2.2. Measures

2.2.1. Sociodemographic factors

Sociodemographic measures included age, sex, race-ethnicity, nativity, education, marital status, urbanicity, employment status, and insurance type.

2.2.2. DSM-IV diagnostic interview

All psychiatric diagnoses were made according to DSM-IV criteria, using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM IV Version (AUDADIS-IV) (Grant

et al., 1995), a valid and reliable fully structured diagnostic interview designed for use by lay professional interviewers. Axis I diagnoses are separated into three main groups: 1) substance use disorders (including any alcohol abuse/dependence, any drug abuse/dependence, and any nicotine dependence); 2) mood disorders (including major depressive disorder, dysthymia, and bipolar disorder); and 3) anxiety disorders (including SAD, panic disorder, specific phobia, and generalized anxiety disorder). The test–retest reliability and validity of AUDADIS-IV of those DSM-IV diagnoses in the general population and clinical settings range from good to excellent (Grant et al., 1995, 2003b; Chatterji et al., 1997; Canino et al., 1999; Ruan et al., 2008).

Personality disorders (PDs) assessed at Wave 1 (Bronisch and Hecht, 1990; Chartier et al., 1998; The WHO World Mental Health Survey Consortium, 2004; Karlsson et al., 2010) included avoidant, dependent, obsessive-compulsive, paranoid, schizoid, histrionic and antisocial PDs. Due to concerns about the validity of psychotic diagnoses in general population surveys as well as the length of the interview, a diagnosis of psychotic disorder was assigned if the respondent answered affirmatively to a question about whether he or she had ever been told by a doctor or other health professional that he or she had schizophrenia or a psychotic disorder.

2.2.3. DSM-IV SAD

Diagnosis of SAD required a marked or persistent fear of social or performance situations in which embarrassment or humiliation may occur. The fear had to be recognized as excessive or unreasonable, and the feared social situation must have been avoided or endured with intense anxiety. All SAD diagnoses required that the clinical significance criterion of DSM-IV be met (i.e., symptoms of the disorder must have caused clinically significant distress and/or impairment in social, occupational, or other areas of functioning). The test-retest reliability of the diagnosis of SAD was fair ($\kappa = 0.42–0.46$) (Grant et al., 2005, 2009), similar to other instruments used in epidemiological studies (Ruscio et al., 2008).

2.2.4. Remission and persistence

Consistent with prior community studies (Kessler et al., 1998; Wang et al., 2005), individuals who met DSM-IV criteria for current SAD at both Wave 1 and Wave 2 interviews were considered persistent cases, whereas respondents who met criteria for DSM-IV SAD in Wave 1 but not in Wave 2 were considered remitters.

In view of the greater severity of disorders among treatment-seeking populations (The WHO World Mental Health Survey Consortium, 2004) and the particular importance of that information for clinicians and policy-makers, we also computed the persistence rates among the subgroups of individuals with SAD who reported having sought treatment during the year before their Wave 1 interview and those who did not.

2.2.5. Clinical characteristics

Variables describing clinical characteristics of SAD were measured at Wave 1, including subtype of SAD (generalized vs. non-generalized), presence of panic attacks in social situations, types and number of feared social situations, and whether the respondent ever used alcohol or illicit or non-prescribed drugs to help relieve symptoms of SAD. In DSM-IV, the generalized subtype of SAD is assigned when an individual endorses fear of “most social situations” (American Psychiatric Association, 1994), although the operationalization of that definition has not been standardized (Heimberg et al., 1995). Consistent with our prior work (Schneier et al., 2010), in the present study, the generalized subtype of SAD was operationalized as fear of more than seven of the 14 situations queried, with the remainder of SAD respondents classified as having the non-generalized subtype.

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