



Treatment-seeking for social anxiety disorder in a general outpatient psychiatry setting

Kristy L. Dalrymple^{*}, Mark Zimmerman

Department of Psychiatry and Human Behavior, Alpert Medical School at Brown University, RI, United States
Department of Psychiatry, Rhode Island Hospital, Providence, RI, United States

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ABSTRACT

Many individuals with social anxiety disorder (SAD) seek treatment principally for another psychiatric disorder, but when directly asked, a majority of these individuals also desire treatment for SAD. Several reasons may exist for why individuals with SAD do not seek treatment for it, such as the severity or functional impairment related to SAD. The aim of the current study was to examine factors related to SAD severity, impairment, and comorbidity, to gain a better understanding of what factors may be related to treatment-seeking for SAD. In 819 psychiatric outpatients with SAD, initial results showed that age, duration of SAD illness, number of social fears endorsed, Clinical Global Impression score, Sheehan Disability Scale ratings for social life and distress, presence of major depressive disorder, and presence of depressive disorder not otherwise specified (DDNOS) were associated with treatment-seeking for SAD status. However, a regression analysis found that DDNOS was the most robust predictor of treatment-seeking for SAD status, followed by the number of feared social situations. Other factors should be examined in the future, such as knowledge of SAD and available treatment options.

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1. Introduction

Social anxiety disorder (SAD) is the fourth most prevalent psychiatric disorder based on epidemiological samples (Kessler et al., 2005), and one of the most common anxiety disorders in clinical samples (Brown et al., 2001; Dalrymple and Zimmerman, 2008b). The presence of SAD is associated with significantly lower wages, lower probability of earning a college degree, lower probability of being in a managerial, technical, or professional occupation, lower work and home productivity, greater disability in family, romantic, and social relationships, and a greater lifetime history of suicide attempts compared to individuals with no psychiatric disorder (Katzelnick et al., 2001). Despite the significant impairment associated with SAD, most individuals with SAD do not describe it as their chief complaint when presenting to general psychiatric outpatient settings. A prior report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project indicated that only 4% of patients with SAD noted it as their principal reason for seeking treatment (Zimmerman et al., 2008). Most of these patients had a mood disorder or another anxiety disorder as their principal reason for seeking treatment. Other studies also have found that individuals

with SAD tend to seek treatment for more acute conditions, such as Major Depressive Disorder (MDD; Weiller et al., 1996).

Although most SAD patients seek treatment principally for another psychiatric condition, 75% of these patients report that they would like treatment for SAD once directly asked (Zimmerman and Chelminski, 2003). In addition, individuals with SAD demonstrate a longer delay from symptom onset to treatment seeking compared to other psychiatric conditions such as other anxiety disorders (Wagner et al., 2006). There could be several reasons why individuals with SAD do not initiate treatment for it; one reason could be that, as with many disorders, the level of severity and impairment related to SAD may need to reach a certain threshold before someone will consider treatment for it. A study based on individuals participating in the 1996 National Anxiety Disorders Screening Day found that compared to individuals without SAD symptoms, those with SAD symptoms were more likely to report the following barriers to previously seeking treatment: uncertainty over where to go for treatment; a fear of what others might think or say; a lack of insurance; and an inability to afford treatment (Olfson et al., 2000). Other studies have examined barriers to treatment for individuals with SAD, such as demographic characteristics (Coles et al., 2004). However, these studies typically are conducted in specialty anxiety clinics.

Therefore, it was the aim of the current study from the MIDAS Project to examine some of these factors, particularly variables related to severity and impairment, in a general outpatient psychiatry setting. Gaining further understanding of these possible factors could help to determine what efforts may be needed to improve the identification

^{*} Corresponding author. Department of Psychiatry, Rhode Island Hospital, 235 Plain Street, Suite 501, Providence, RI 02905, United States. Tel.: +1 401 444 7095; fax: +1 401 444 7109.

E-mail address: kristy_dalrymple@brown.edu (K.L. Dalrymple).

and treatment of SAD. For example, if there is no difference in severity between individuals with SAD seeking versus not seeking treatment for it, then perhaps other variables such as awareness of the disorder and its treatment would need to be improved. This is important, given the disorder's chronic and unremitting course without treatment (Davidson et al., 1994; Herbert and Dalrymple, 2005), its association with reduced quality of life (Wittchen et al., 2000), and its significant public health impact (Schneier et al., 1992; Wittchen et al., 2000).

A prior study from the MIDAS Project examined desire of treatment for SAD in patients seeking treatment primarily for MDD, and found that the number of social fears endorsed and work functioning differentiated patients who did versus did not desire treatment for comorbid SAD (Dalrymple and Zimmerman, 2008a). In the current study, it was hypothesized that patients who cited SAD as their principal reason for seeking treatment would demonstrate a greater number of social fears, greater social impairment, an earlier age of SAD onset, and a longer duration of SAD compared to individuals with comorbid SAD not seeking treatment principally for it. It was also hypothesized that individuals with comorbid SAD who desired treatment for it in addition to their chief complaint would report greater severity on the above variables compared to patients with comorbid SAD who did not desire treatment for it.

2. Methods

2.1. Participants

The larger sample included 3000 psychiatric outpatients presenting for treatment at the Outpatient Psychiatry Practice of Rhode Island Hospital. The practice treats individuals with medical insurance on a fee-for-service basis (including Medicare but not Medicaid), and therefore is different from the hospital's residency training outpatient clinic that treats uninsured and medical assistance individuals. The majority of referrals come from primary care physicians (31.6%) and therapists in the community (15.8%). Participants' age ranged from 18 to 85 years old ($M = 38.5$, $S.D. = 13.0$), and the majority were female (60.6%, $n = 1818$). The majority also were Caucasian (87.4%; $n = 2622$), and either married (41.0%; $n = 1231$) or never married (31.6%; $n = 948$). Approximately half of the patients had a high school degree or equivalency (52.9%; $n = 1587$), and slightly more than one quarter received a 2- or 4-year college degree (28.8%; $n = 865$). More than one quarter (27.3%; $n = 819$) of the 3000 patients met current criteria for SAD. Other than SAD, the most frequent current Axis I diagnoses were MDD ($n = 1318$; 43.9%), generalized anxiety disorder ($n = 547$; 18.2%), panic disorder with agoraphobia ($n = 395$; 13.2%), posttraumatic stress disorder ($n = 361$; 12.0%), specific phobia ($n = 322$; 10.7%), alcohol abuse ($n = 247$; 8.2%), and obsessive-compulsive disorder ($n = 212$; 7.1%).

2.2. Procedure

Individuals seeking treatment at the outpatient practice were asked to participate in a comprehensive diagnostic evaluation prior to meeting with their treating clinician. All procedures were approved by the Institutional Review Board at Rhode Island Hospital. A modified version of the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID; First et al., 1997) was used for the diagnostic evaluation. All patients were interviewed with the full SCID, and informed consent was obtained prior to administering the SCID. Doctoral-level clinical psychologists and research assistants with bachelor's degrees in social or biological sciences served as diagnosticians. Diagnosticians received extensive training, and monitoring has occurred throughout the study to minimize rater drift. Psychologists first observe five interviews, then are observed while administering 15–20 interviews, and finally are required to demonstrate exact or near exact agreement with a senior diagnostician on five consecutive interviews. Research assistants are required to observe 20 interviews, administer over 20 interviews while being observed, and demonstrate agreement with a senior diagnostician on five consecutive interviews. During the course of training, every interview is reviewed on an item-by-item basis with the senior diagnostician who observed the interview.

Ongoing supervision of diagnosticians includes a weekly diagnostic case conference with all members of the team, and a review of item ratings for every case by M.Z. Inter-rater reliability was assessed for 65 cases, using the joint-interview method. In this design, one diagnostician observes another conducting the interview, but both diagnosticians make independent ratings and do not discuss ratings with each other. Results from the 65 joint-interview evaluations indicated good inter-rater agreement, particularly for MDD and the anxiety disorders (MDD $\kappa = 0.90$; panic disorder $\kappa = 0.95$; SAD $\kappa = 0.84$; obsessive-compulsive disorder $\kappa = 1.0$; specific phobia $\kappa = 0.93$; generalized anxiety disorder $\kappa = 0.85$; and posttraumatic stress disorder $\kappa = 0.87$).

The prevalence of patients with a principal diagnosis of SAD versus a comorbid diagnosis of SAD was determined using the *DSM-IV* convention (i.e., the disorder for

which the individual was mainly seeking treatment is considered the principal diagnosis; Zimmerman and Mattia, 2000). The SCID was modified such that after patients were determined to meet criteria for a particular diagnosis they were asked if those symptoms were the main reason why they decided to seek treatment at the present time. If so, that diagnosis was considered the principal diagnosis. If not, they were asked if they would like future treatment to address that problem ("Now that we've talked about it, would you like your treatment here to address these symptoms?"). Therefore, those with a principal diagnosis of SAD reported it as their main reason for seeking treatment (labeled as the "principal SAD-Tx" group). Patients who had SAD as a comorbid diagnosis but also desired treatment for it (in addition to their principal diagnosis) were designated as the "comorbid SAD-Tx" group. Those patients who had a comorbid diagnosis of SAD but who did not desire treatment for it were designated as the "comorbid SAD-No Tx" group.

2.3. Measures

The three groups (principal SAD-Tx, comorbid SAD-Tx, and comorbid SAD-No Tx) were compared on demographic variables and variables related to severity, such as Global Assessment of Functioning score (GAF), Clinical Global Index of depression severity (CGI), SAD age of onset, duration of SAD (current age minus age of onset), number of social fears endorsed, presence of past suicide attempts (yes or no), and current Axis I comorbidity. Inter-rater reliability for GAF and CGI scores was high (intraclass correlation coefficient [ICC] = 0.80 and 0.79 respectively, $p < 0.001$).

Number of social fears was measured by assessing the presence of 13 commonly reported social fears during the SAD module of the SCID: eating in public, writing in public, public speaking, saying something in a group of people, asking a question in a group of people, using public restrooms, business meetings, using the telephone or other job-related equipment, one-on-one conversations with strangers, conversations with sexually attractive others, conversations with authority figures, returning something to a store, and walking around a mall with no specific plan. Each of these fears was rated as either present or absent, regardless of the level of anxiety experienced. These social fears were based on items from the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987), a review of the literature, and clinical experience (Dalrymple and Zimmerman, 2008b). The list was initially developed for the MIDAS Project to briefly assess common social fears during the SAD module of the SCID, and to cue patients when answering the initial screening question in the SAD module. The social fears list also was used in the current study to examine SAD subtypes between the groups. Based on prior research (Stemberger et al., 1995; Herbert et al., 2005), the generalized subtype was defined as endorsement of three or more of the social fears; the specific subtype was defined as endorsement of only one or two of the social fears. Due to changes in assessment procedures over the course of the project, the list of social fears was administered to only 1800 participants. Cronbach's alpha for the social fears list was moderate (0.68), and the frequencies of social fears are presented in Table 5.

The three groups also were compared on variables related to impairment, such as time out of work in the past five years due to psychopathology, past social functioning (as a teenager), and current social functioning. These variables were measured using items from the Schedule for Affective Disorders and Schizophrenia (SADS; Spitzer and Endicott, 1977). Time out of work was measured on a Likert scale, ranging from 0 (not expected to work) to 9 (worked none or practically none due to psychopathology). Patients who were not expected to work (e.g., full-time students, those on disability for medical reasons) were excluded from this analysis, but were included in the inter-rater reliability analysis for this item. Inter-rater reliability was high (ICC = 0.95, $p < 0.001$). Past and current social functioning were rated by diagnosticians on Likert scales ranging from 1 (superior) to 7 (grossly inadequate). Inter-rater reliability for past and current social functioning was good (ICC = 0.74, 0.73, respectively; $p < 0.001$). Impairment ratings also were obtained for each disorder using the Sheehan Disability Scale (Leon et al., 1997), for 1200 patients. Patients were asked to rate the degree to which their social anxiety has disrupted their work, family life, and social life in the past month. The SDS also was modified for the MIDAS Project to assess the degree to which patients have been distressed by their social anxiety in the past month ("To what extent have problems with social anxiety bothered you in the last month?"). As with the other SDS items, ratings were made on a scale ranging from 0 (not at all) to 10 (extremely).

2.4. Analyses

Chi square tests and Kruskal–Wallis tests were used for analyses as appropriate. Mann–Whitney U nonparametric tests were used as follow-up tests for significant Kruskal–Wallis tests. Nonparametric tests rather than analyses of variance were used due to the difference in sample sizes of the groups. Due to the number of analyses conducted, the threshold to determine statistical significance was set at $\alpha = 0.01$ (two-tailed). Finally, a post-hoc multinomial logistic regression analysis was conducted with variables that differed between the groups (at the $\alpha = 0.01$ level), to examine their relative ability to predict membership in the three groups. The significance threshold was set at $\alpha = 0.05$ for this analysis (two-tailed). A multinomial logistic regression analysis was utilized due to the three classes of the dependent variable (i.e., treatment-seeking status). Because the social fears data were available for only a portion of the patients ($n = 518$), the regression was conducted only on this subsample.

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