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Facing the challenge of social anxiety disorder

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Abstract

Social anxiety disorder is a serious and prevalent disorder that leads to significant disability in the social and professional lives of patients. It is a chronic condition that frequently coexists with other psychiatric conditions such as depression or alcoholism. Pharmacotherapy with benzodiazepines, monoamine oxidase inhibitors and selective serotonin reuptake inhibitors (SSRIs) has been assessed. Alprazolam has modest efficacy, while a more robust response to clonazepam has been reported. Benzodiazepines, however, are not suitable for long-term treatment of a chronic condition such as social anxiety disorder and are ineffective against comorbid depression. Phenelzine has demonstrated efficacy but the need for dietary restrictions has limited its use. Conflicting results have been reported in placebo-controlled trials for moclobemide, with two studies showing moclobemide to be more effective than placebo while recent trials have reported less robust results. Based on clinical evidence, SSRIs are the first-line treatment in social anxiety disorder. The most extensive database for the treatment of social anxiety disorder exists for the SSRI, paroxetine. Three large multicentre, placebo-controlled, trials have been completed. In all three studies, a significantly greater proportion of patients responded to paroxetine treatment compared with placebo. Paroxetine is currently the only SSRI licensed for use in this condition.

Keywords: Social anxiety disorder; Paroxetine; Selective serotonin reuptake inhibitors; Benzodiazepines; Monoamine oxidase inhibitors

1. Essential features of social anxiety disorder

Individuals with social anxiety disorder fear being scrutinised or assessed in a negative way by others in social situations. The feared situations are either avoided or endured with intense anxiety and distress. Social anxiety disorder is a highly disabling condition, causing impairment in the person's daily activities, social and family relationships, and academic or work functioning. This inevitably results in an economic burden on the patient and on society.

Social anxiety disorder is the most prevalent of the anxiety disorders, afflicting a large proportion of the population. Using DSM-III-R criteria for the disorder, the US National Comorbidity Survey reported a lifetime prevalence of 13.3% and a 1-month prevalence of 4.5% (Magee et al., 1996). Similarly, a French primary care study found a lifetime prevalence of 14.4% (Weiller et al., 1996). In a Swiss general population study, Wacker et al. (1992) investigated the prevalence of social anxiety disorder according to DSM-III-R or ICD-10 criteria. The major difference between these criteria is that ICD-10 specifies that the fear of scrutiny should relate to small groups of people. DSM-III-R (and DSM-IV) does not make this specification, and thus allows the inclusion of the fear of public speaking or performing in front of a large audience in the diagnostic criteria for social anxiety disorder. Thus, Wacker et al. (1992) found a lower lifetime prevalence of social anxiety disorder according to the more stringent ICD-10 criteria (9.6%) than with DSM-III-R criteria (16.0%).

Social anxiety disorder typically starts in the teenage years, at a time when individuals make important decisions for their future lives (Schneier et al., 1992). The harmful coping strategies that sufferers develop in response to their fears hinders their educational attainment, career progression, and development of relationships. The disorder is a chronic condition, with an average duration of 20 years, and is unlikely to remit spontaneously (Davidson et al., 1993a; Wittchen and Beloch, 1996). Thus, patients require long-term treatment to allow them to improve their quality of life (Ballenger et al., 1998).

Two subtypes of social anxiety disorder have been identified: generalised social anxiety disorder, in which the individual fears a multitude of social and performance situations, and non-generalised social anxiety disorder, in

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which only two or three situations are feared. Generalised social anxiety disorder is the most disabling form of the disease. Compared with patients with the non-generalised subtype, those with generalised social anxiety disorder have fewer years of education, are less likely to be employed, more likely to be single, and have higher rates of comorbid alcoholism and depression (Heimberg et al., 1990; Mannuzza et al., 1995). Also, the generalised subtype, unlike the non-generalised subtype, appears to be highly familial. For instance, Stein et al. (1998a) found that the relative risks for generalised social anxiety disorder were 10-fold higher among the first-degree relatives of social anxiety disorder patients than among the relatives of control patients. However, there were no differences between the two groups in the relative risks for non-generalised social anxiety disorder.

Patients with social anxiety disorder frequently develop comorbid conditions (Fig. 1). Agoraphobia is a very common comorbid condition; up to 45% of individuals with social anxiety disorder also suffer from agoraphobia (Schneier et al., 1992; Merikangas and Angst, 1995; Magee et al., 1996). It is often difficult to distinguish agoraphobia from social anxiety disorder, but the major differentiating factor is the fear of social interaction. Fear of 'going out and meeting people' is common in agoraphobia. Many such patients fear the activity leading to the social contact rather than the contact itself. In contrast, patients with social anxiety disorder particularly fear the social interaction. For example, in contrast to the agoraphobic patient, the patient with social anxiety disorder may be able to visit a large shopping centre without excessive anxiety as long as they do not have to speak with a shop assistant. Alcohol abuse is another common comorbid condition, with epidemiologic studies showing that individuals with social anxiety disorder have a two- to three-fold greater risk of developing alcoholism than members of the general population (Schneier et al., 1992; Davidson et al., 1993a; Degonda and Angst, 1993; Magee et al., 1996). Although patients use alcohol in an attempt to relieve their anxiety in a social situation, excessive alcohol consumption can actually precipitate symptoms of anxiety, thus creating a vicious circle of anxiety and alcohol abuse (Schuckit and Hesselbrock, 1994; Lépine and Pélissolo, 1998). Patients with social anxiety disorder also frequently suffer from comorbid major depression or dysthymia; it is estimated that up to 60% of patients receiving treatment for social anxiety disorder report a history of a depressive disorder (Schneier et al., 1992; Merikangas and Angst, 1995; Magee et al., 1996). The comorbid condition typically has an onset after that of social anxiety disorder. Thus, early diagnosis and appropriate treatment of social anxiety disorder will help to prevent the development of further psychiatric morbidity and disability.

2. Pharmacotherapy options in social anxiety disorder

The efficacies of benzodiazepines, monoamine oxidase inhibitors (MAOIs) and selective serotonin reuptake inhibitors (SSRIs) in social anxiety disorder have been investigated in placebo-controlled clinical trials. There are currently no published controlled trials of tricyclic antidepressants in this disorder.

2.1. Benzodiazepines and other anxiolytics

Benzodiazepines are the classical anxiolytics. They are used particularly for the treatment of generalised anxiety disorder, and the high potency benzodiazepines have demonstrated efficacy in panic disorder.

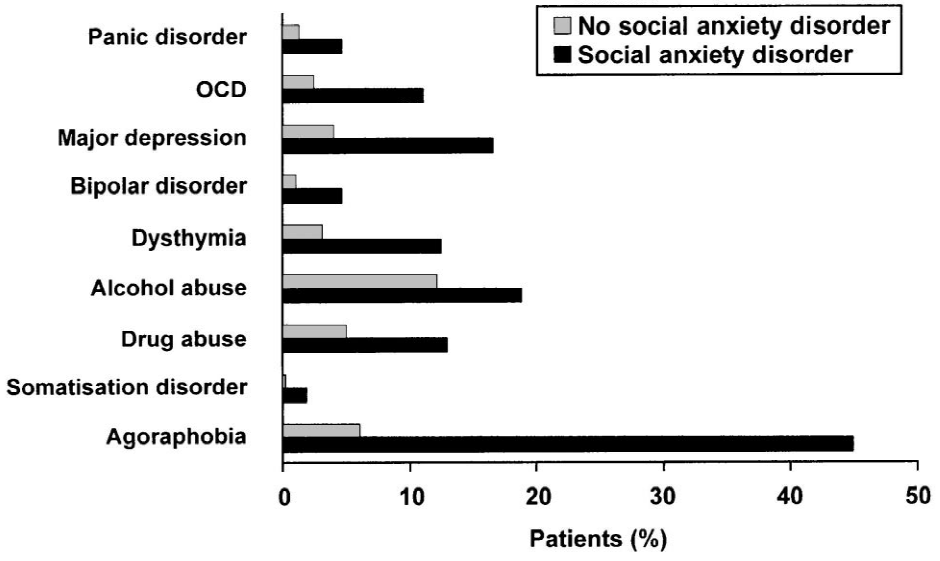

Fig. 1. Lifetime rates (%) of comorbid psychiatric disorders in patients with or without social anxiety disorder. Data from Schneier et al. (1992).