Journal of Anxiety Disorders 26 (2012) 12–19

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

Gender differences in social anxiety disorder: Results from the national epidemiologic sample on alcohol and related conditions

Yang Xu[a], Franklin Schneier[a], Richard G. Heimberg[b], Katherine Princisvalle[a], Michael R. Liebowitz[a], Shuai Wang[a], Carlos Blanco[a,*]

[a] Department of Psychiatry, New York State Psychiatric Institute, College of Physicians and Surgeons, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032, United States
[b] Adult Anxiety Clinic, Department of Psychology, Temple University, 419 Weiss Hall, 1701 N. 13th Street, Philadelphia, PA 19122-6085, United States

ARTICLE INFO

Article history:
Received 6 April 2011
Received in revised form 10 August 2011
Accepted 10 August 2011

Keywords:
Social anxiety disorder
Social phobia
Human sex differences
Epidemiology

ABSTRACT

This study examined gender differences among persons with lifetime social anxiety disorder (SAD). Data were derived from the National Epidemiologic Survey on Alcohol and Related Conditions ($n = 43{,}093$), a survey of a representative community sample of the United States adult population. Diagnoses of psychiatric disorders were based on the Alcohol Use Disorder and Associated Disabilities Interview Schedule—DSM-IV Version. The lifetime prevalence of SAD was 4.20% for men and 5.67% for women. Among respondents with lifetime SAD, women reported more lifetime social fears and internalizing disorders and were more likely to have received pharmacological treatment for SAD, whereas men were more likely to fear dating, have externalizing disorders, and use alcohol and illicit drugs to relieve symptoms of SAD. Recognizing these differences in clinical symptoms and treatment-seeking of men and women with SAD may be important for optimizing screening strategies and enhancing treatment efficacy for SAD.
© 2011 Published by Elsevier Ltd.

1. Introduction

Social anxiety disorder (SAD) is highly prevalent (Grant, Hasin, Blanco, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 1994; Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Stein, Walker, & Forde, 1994), often co-occurs with other Axis I and Axis II disorders (Kessler, Berglund, et al., 2005; Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 1994; Magee et al., 1996; Stein et al., 1994), and is associated with significant social, interpersonal and professional impairment (Davidson, Hughes, George, & Blazer, 1993; Keller, 2003; Kessler, 2003; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992).

Research in other anxiety disorders, including generalized anxiety disorder (GAD) (Vesga-Lopez et al., 2008), obsessive-compulsive disorder (Bogetto, Venturello, Albert, Maina, & Ravizza, 1999), panic disorder (Barzega, Maina, Venturello, & Bogetto, 2001; Sheikh, Leskin, & Klein, 2002), and post-traumatic stress disorder (Fullerton et al., 2001), has documented gender differences in their prevalence, symptoms, course, and patterns of comorbidity. However, whereas gender differences in prevalence of SAD have been well documented (Bourdon et al., 1988; Kessler et al., 1994), knowledge of gender differences in specific features of SAD is scarce.

Investigating gender differences in SAD is important because identifying those aspects of SAD which are most similar across genders may increase our understanding of the core features of SAD. On the other hand, isolating the aspects of SAD that differ across genders may guide identification of gender-specific target behaviors for therapeutic interventions (Turk et al., 1998). Furthermore, such examination may also help illuminate which features are disorder-specific and which reflect broader effects of gender on the phenomenology (and potentially the etiology) of anxiety disorders in general.

A limited number of studies have primarily focused on gender differences in patterns of comorbidity and level of psychosocial functioning among individuals with SAD. For example, a report from the Harvard/Brown Anxiety Research Program (HARP), an observational study of individuals seeking treatment for anxiety disorders, found that lifetime SAD was associated with more comorbid anxiety disorders and greater functional impairment in women than in men (Yonkers, Dyck, & Keller, 2001). Although this study did not find gender differences in the probability of remission from SAD in the overall sample, women were less likely than men to remit among the subgroup with low scores on the Global Assessment of Functioning Scale (Yonkers et al., 2001). Symptom presentation has also been found to vary by gender. The Early Developmental Stages of Psychopathology Study (EDSP), an epidemiological study of a community sample of young adults, found that fear of embarrassment while eating or drinking in public, writing while someone was watching, talking to others,

* Corresponding author. Tel.: +1 212 543 6533; fax: +1 212 543 6515.
E-mail address: cb255@columbia.edu (C. Blanco).

0887-6185/$ – see front matter © 2011 Published by Elsevier Ltd.
doi:10.1016/j.janxdis.2011.08.006

and participating in social events were more common among women than men with SAD (Wittchen, Stein, & Kessler, 1999), whereas another study in a treatment-seeking sample (Turk et al., 1998) found that women with lifetime SAD feared more social situations and had more intense fears than men with lifetime SAD.

The goal of present study was to build on existing knowledge of gender differences in SAD by drawing on data from a large and nationally representative community sample of US adults, to yield more stable and generalizable results than can be derived from geographically localized or clinical samples. Specifically, we sought to compare men and women with lifetime SAD on: (1) lifetime prevalence and sociodemographic characteristics of DSM-IV SAD; (2) rates and patterns of psychiatric comorbidity; (3) course and clinical presentation; and (4) patterns of treatment-seeking (Wittchen & Jacobi, 2005).

2. Method

2.1. Sample

The 2001–2002 National Epidemiologic Sample on Alcohol and Related Conditions (NESARC) is a survey of a representative sample of the United States adult population, conducted by the National Institute on Alcohol Abuse and Alcoholism (Grant, Hasin, Blanco, et al., 2005; Grant, Moore, et al., 2003; Grant, Hasin, Stinson, et al., 2004). The NESARC targeted the civilian population residing in households or group living quarters, 18 years and older. Face-to-face interviews were conducted with 43,093 respondents. The survey response rate was 81%. Blacks, Hispanics, and young adults (age 18–24 years) were over-sampled, with data adjusted for over-sampling, household- and person-level non-response.

The weighted data were then adjusted to represent the U.S. civilian population based on the 2000 Census. All potential NESARC respondents were informed in writing about the nature of the survey, the statistical uses of the survey data, the voluntary aspect of their participation and the Federal laws that rigorously provide for the strict confidentiality of identifiable survey information. Those respondents consenting to participate after receiving this information were interviewed. The research protocol, including informed consent procedures, received full ethical review and approval from the U.S. Census Bureau and the U.S. Office of Management and Budget.

2.2. Measures

2.2.1. Sociodemographic measures

Age, race-ethnicity, nativity, education, marital status, urbanicity, employment status, and insurance type were compared among men and women with lifetime SAD.

2.2.2. DSM-IV diagnostic interview

The diagnostic interview used to generate diagnoses was the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule, DSM-IV Version (AUDADIS-IV; Grant, Dawson, et al., 2003). This structured diagnostic interview designed for lay interviewers was developed to advance measurement of substance use and mental disorders in large-scale surveys.

2.2.2.1. Social anxiety disorder. Consistent with DSM-IV (American Psychiatric Association, 1994), diagnosis of SAD required a marked or persistent fear of one or more social or performance situations (here operationalized as at least 1 of 14 social interaction or performance situations, including a residual "other situation" category) in which embarrassment or humiliation may occur. The fear had to be recognized as excessive or unreasonable. Also, exposure to the situation must have almost invariably provoked anxiety (which may have taken the form of a situationally bound or predisposed panic attack), and the feared social situations must have been avoided or else endured with intense anxiety. These latter DSM-IV criteria for SAD helped to further define the feared situation(s) as both excessive and unreasonable. 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 or impairment in social, occupational, or other areas of functioning). The AUDADIS-IV questions used to operationalize the clinical significance criterion were disorder-specific and included: (1) being upset or made uncomfortable by the phobic symptoms and/or avoidance, (2) interference with relationships with other people, (3) interference with occupational or other role responsibilities, (4) restriction of usual activities, and (5) preventing the respondent from engaging in usual activities. Unlike the diagnoses provided by other instruments used in epidemiologic surveys (Alonso et al., 2004; Kessler, Wittchen, et al., 1998; Wittchen, Essau, Zerssen, Krieg, & Zaudig, 1992), AUDADIS-IV diagnoses of SAD excluded persons with SAD symptoms that were substance-induced or due to medical conditions (Grant, Hasin, Stinson, et al., 2004).

2.2.2.2. Other psychiatric disorders. As described in detail elsewhere (Grant, Hasin, Stinson, et al., 2005; Grant, Hasin, Stinson, et al., 2004), the AUDADIS-IV also assessed three other DSM-IV anxiety disorders (panic disorder, specific phobia, and GAD) and four mood disorders (major depressive, bipolar I disorder, bipolar II disorder, and dysthymia). All of these disorders followed DSM-IV criteria, required that the clinical significance criteria be met, and ruled out substance-induced episodes or those due to a general medical condition. The AUDADIS-IV questions operationalize DSM-IV criteria for alcohol and drug-specific abuse and dependence for 10 drug classes. Consistent with DSM-IV, a lifetime AUDADIS-IV diagnosis of alcohol abuse required that at least 1 of the 4 criteria for abuse be met prior to interview. The AUDADIS-IV lifetime alcohol dependence diagnosis required that at least 3 of the 7 DSM-IV criteria for dependence be met prior to interview. Drug abuse and dependence and nicotine dependence used the same algorithms (Grant, Hasin, Chou, Stinson, & Dawson, 2004). The AUDADIS-IV assessments of DSM-IV personality disorders have been described in detail previously (Grant et al., 2008; Grant, Hasin, Stinson, et al., 2004). These include avoidant, dependent, obsessive-compulsive, paranoid, schizoid, and antisocial personality disorders. As reported elsewhere, test–retest reliability of the AUDADIS diagnosis of SAD was fair ($\kappa = 0.42–0.46$) (Grant, Hasin, Blanco, et al., 2005; Grant, Moore, et al., 2003), comparable to other interviews used in epidemiological studies (e.g., Ruscio et al., 2008). The reliability ($\kappa > 0.74$) and validity were good to excellent for substance use disorder (Grant, Harford, Dawson, Chou, & Pickering, 1995; Grant, Moore, et al., 2003; Grant, Stinson, et al., 2004; Vrasti, Grant, & Chatterji, 1997). Reliability was fair to good for mood and other anxiety disorders ($\kappa = 0.40–0.60$) and personality disorders ($\kappa = 0.40–0.67$) (Grant, Dawson, et al., 2003; Grant, Moore, et al., 2003).

2.2.3. Clinical characteristics and course of SAD

Variables describing clinical characteristics of SAD included subtypes of SAD, the presence of panic attacks in social situations, type of feared social situations, and numbers of feared social situations. The Short Form-12v2 (SF-12) (Ware, Kosinski, & Keller, 1996), a reliable and valid measure commonly employed in population surveys, was used to assess health-related quality of life. Higher scores on the SF-12 are indicative of better health-related quality of life. Variables describing the course of SAD included age of onset, duration of the disorder, duration of the longest and most recent episodes,

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
✓ امکان دانلود نسخه ترجمه شده مقالات
✓ پذیرش سفارش ترجمه تخصصی
✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
✓ دانلود فوری مقاله پس از پرداخت آنلاین
✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات