Consensus Statement on Social Anxiety Disorder From the International Consensus Group on Depression and Anxiety

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Objective: The goal of this consensus statement is to provide primary care clinicians with a better understanding of management issues in social anxiety disorder (social phobia) and guide clinical practice with recommendations for appropriate pharmacotherapy. ***Participants:*** The 4 members of the International Consensus Group on Depression and Anxiety were James C. Ballenger (chair), Jonathan R. T. Davidson, Yves Lecrubier, and David J. Nutt. Other faculty invited by the chair were Julio Bobes, Deborah C. Beidel, Yukata Ono, and Herman G. M. Westenberg. ***Evidence:*** The consensus statement is based on the 7 review papers published in this supplement and on the scientific literature relevant to the issues reviewed in these papers. ***Consensus process:*** The group met over a 2-day period. On day 1, the group discussed each review paper, and the chair identified key issues for further debate. On day 2, the group discussed these issues to arrive at a consensus view. After the group meetings, the consensus statement was drafted by the chair and approved by all attendees. ***Conclusions:*** The consensus statement underlines the importance of recognizing social anxiety disorder and provides recommendations on how it may be distinguished from other anxiety disorders. It proposes definitions for response and remission and considers appropriate management strategies. Selective serotonin reuptake inhibitors are recommended as first-line therapy, and effective treatment should be continued for at least 12 months. Long-term treatment is indicated if symptoms are unresolved, the patient has a comorbid condition or a history of relapse, or there was an early onset of the disorder.

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Social anxiety disorder is a chronic prevalent psychiatric condition imposing persistent functional impairment and disability on the individual and an economic burden on society. Sufferers from the disorder are also at risk of developing major depression, other anxiety disorders, or alcoholism. Despite the morbidity associated with it, social anxiety disorder remains a condition that is underrecognized by clinicians and patients alike and consequently undertreated.

Social anxiety disorder was the subject of the second meeting of the International Consensus Group on Depression and Anxiety. Our objective was to provide clinicians with a better understanding of the condition by identifying what is known in the field and what requires further research. This paper represents our views and clinical recommendations on the management of the disorder based on our assessment of the available clinical evidence.

DISTINGUISHING SOCIAL ANXIETY DISORDER FROM OTHER ANXIETY DISORDERS

Fear of negative evaluation in social or performance situations is the essential feature of social anxiety disorder, and there is a strong tendency for sufferers to avoid the feared social interaction or social situation. The most common precipitating situations are speaking or eating in public, writing (or using a keyboard) in front of others, and meeting new people, members of the opposite sex, or people in authority.

Blushing is the principal physical symptom and distinguishes social anxiety disorder from all other anxiety disorders. Trembling, sweating, speech block, and difficulty performing toilet functions in public are other notable

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Table 1. Clinical Features That Distinguish Social Anxiety Disorder From Other Anxiety Disorders

- Onset in childhood
- Impairment restricted to social situations
- Blushing as a principal symptom
- Social precipitating situations (social interactions or performance)
- Unique cognitions

physical symptoms. Maladaptive thoughts about social situations are an important cognitive symptom in adults, whereas adolescents and children do not experience negative cognitions.

We recognize the need to educate clinicians and their patients about the difference between normal anxiety experienced, for example, during public speaking and pathologic anxiety. The physiologic response is different. Whereas normal anxiety reaches a peak during the initial minutes of a presentation and can facilitate it, the sustained level of intense anxiety experienced in social anxiety disorder can severely impair functional ability.

Onset and Course

Social anxiety disorder occurs predominantly in childhood, with a mean age at onset between 14 and 16 years. An age at onset earlier than 11 years is predictive of poor recovery.

The development of social anxiety disorder at a critical formative period in adolescence, when peer groups and social interpersonal relationships assume importance for the individual, probably explains the burden of disability imposed by the condition. Social anxiety disorder can interfere with normal growth and lead to the development of harmful coping mechanisms. The earlier the onset, the more severe and disabling is the impairment in interpersonal development, educational attainment, and career progression. For example, subjects with social phobia are less likely ever to marry, and more likely to divorce, than matched controls without the disorder, and they are more likely to be unemployed.

Social anxiety disorder generally follows a chronic unremitting course. Longitudinal analysis has demonstrated the stability of symptoms over time, with an increase in interpersonal sensitivity and persistent functional impairment.[1]

Parental behavior is an important factor in maintaining and, perhaps, contributing to social anxiety disorder. Whereas excessive parental fear might serve as a model for fear acquisition or maintenance, positive parental action can help children to be less anxious about social situations and learn to handle them more effectively.

Clinical Recommendations

Social anxiety disorder can be distinguished from other anxiety disorders, notably panic disorder, by the characteristics listed in Table 1. Frequently, there is a lack of awareness on the part of the sufferer that they have a disorder for which treatment is available. Unlike the depressed patient, who perceives that something is wrong, the sufferer from social anxiety disorder often shares the common public misconception that what they experience is merely shyness. By the very nature of their condition, they are reticent about social contact, including medical consultation, and it is often the presence of a comorbid condition such as depression that actually brings them to their physician (see later section on comorbidity).

The presentation of social anxiety disorder can resemble panic disorder, with subjects experiencing panic attacks, and it is the reasons for the subjects' fear (fear of symptoms versus fear of social interaction) that will enable the clinician to distinguish between the conditions. In differentiating social anxiety disorder from agoraphobia, the type of shop feared by the sufferer is a useful guide to the clinician. Sufferers from social anxiety disorder fear buying goods in a small shop, where they will have to ask for what they want, whereas subjects with panic agoraphobia fear supermarkets or shopping malls, where the crowded nature of the setting, not the possibility of social interaction, drives the fear. Whereas the sufferer from social anxiety feels anxious in a supermarket queue because of a fear of having to talk to the checkout clerk, the anxiety in the subject with agoraphobia is related to feeling trapped in the queue.

As social anxiety disorder is a prevalent and often disabling condition and patient self-awareness often is low, we advise clinicians to consider the disorder in patients who appear to be reticent or shy by asking 2 simple questions: (1) Are you uncomfortable or embarrassed at being the center of attention? and (2) Do you find it hard to interact with people? Once diagnosed with social anxiety disorder, the patient must be reassured that he or she has a recognized medical condition for which there is effective treatment.

HOW COMMON IS SOCIAL ANXIETY DISORDER?

Social anxiety disorder occurs more commonly in the general population than any other anxiety disorder. The lifetime prevalence of the disorder in the community is 10% to 15%, and recent studies indicate that its current prevalence in primary care is 5% to 7%.

The prevalence rates for social anxiety disorder vary according to whether ICD or DSM diagnostic criteria were used to define the disorder, with lower lifetime rates reported in studies using ICD-10 criteria. The two classification systems differ in their recognition of public speaking anxiety and symptoms. In ICD-10, fear of speaking in small groups is recognized as social anxiety disorder, but public speaking anxiety is considered to be a normal anxiety. Similarly, the subject must experience either blushing, fear of vomiting, or fear of urinary incontinence in a social

situation to meet ICD-10 diagnostic criteria, whereas the presence of these symptoms is not mandatory in the DSM-IV classification.

Research Need: Unlike panic disorder, for which there are prevalence data across countries and cultures, little is known about cross-cultural differences in the prevalence of social anxiety disorder. The prevalence may well be higher in third world countries than in the West, because of the intense societal pressure on adolescents to make the transition to adulthood in some third world countries. Research is needed on cultural differences in not only the prevalence but also the presentation of symptoms in social anxiety disorder.

WHAT IS THE BIOLOGICAL BASIS FOR SOCIAL ANXIETY DISORDER?

There is no clearly defined biological abnormality in social anxiety disorder, although there is evidence for serotonergic and dopaminergic dysfunction in subjects who suffer from the condition. The consensus group gave extensive consideration to whether the most appropriate etiologic model is one based on learning theories or genetic predisposition. There was a strong view that, as social fear is a primitive fear, social anxiety disorder may involve activation of an innate fear or anxiety system with pronounced behavioral inhibition. We agreed that social anxiety disorder involves heightened social anxiety that is either innate or learned and is maintained by cognitions and avoidance behavior at a high level.

Research Need: Further study of brain mechanisms involved in social anxiety disorder is needed.

Behavioral inhibition requires further study to assess its relationship to the adult form of social anxiety disorder and how it is affected by treatment.

SUBTYPES OF SOCIAL ANXIETY DISORDER

In discussing the evidence for different subtypes, we focused on public speaking anxiety and whether it should be considered as a discrete or specific form of social anxiety disorder. We agreed that there are 2 subtypes of social anxiety disorder, nongeneralized and generalized, and that public speaking anxiety as the sole or principal anxiety should be subsumed into the nongeneralized form.

Nongeneralized social anxiety disorder involves 1 or 2 social or performance situations, such as public speaking, writing in front of others, or using a public lavatory. Public speaking is the single most common phobia in the nongeneralized subtype, whether this is giving a formal presentation to a large audience or speaking to a small group.

The generalized form of social anxiety disorder involves 3 or more social or performance situations. It is the more severe and disabling subtype, highly familial, and associated with a high level of comorbidity, and generally requires more intensive treatment.

From our review of social anxiety disorder in childhood (see article by Beidel in this supplement), we propose that the condition of selective (formerly elective) mutism is probably a severe form of childhood social anxiety disorder, although other factors may also contribute to this condition.

Research Need: Is there a qualitative or quantitative difference between the 2 subtypes? If the difference is only quantitative, can the nongeneralized form become more severe and develop into the generalized form? The question would then arise as to whether early intervention could prevent the development of the more severe disorder.

BURDEN OF SOCIAL ANXIETY DISORDER

Social anxiety disorder is an illness of adolescence with lifetime consequences. By interfering with the normal development of social and personal relationships, the disorder can have a long-term effect on the social, familial, and working lives of sufferers. It is associated with increased rates of suicidal ideation, and probably of suicide attempts, compared with subjects who have no psychiatric disorder.

The socioeconomic impact of social anxiety disorder is no less significant. By disrupting schooling in adolescence, the disorder limits educational attainment and career progression. Throughout the working lives of sufferers, continuing functional impairment has an economic impact, reflected in the loss of working days to illness and reduced work performance. Productivity is significantly reduced in at least one third of subjects with social anxiety disorder in comparison with subjects who have a recurring physical illness. Sufferers from social anxiety disorder tend to make more use of medical outpatient services than subjects without a psychiatric disorder, although only rarely for the treatment of the social anxiety disorder.

COMORBIDITY OF SOCIAL ANXIETY DISORDER

In 70% to 80% of cases, social anxiety disorder is complicated by the presence of comorbid conditions, which add to the burden of the condition. Comorbidity increases symptom severity, causes greater disability, and increases suicidality: the suicide attempt rate is 1% for the uncomplicated disorder and 16% for comorbid social anxiety disorder; the comparable figures for suicidal ideation are

Table 2. Common Scales for Measuring Improvement in the Principal Domains of Social Anxiety Disorder

Domain	Measure	Rater
Symptoms	Liebowitz Social Anxiety Scale (LSAS)	Clinician
Functionality	Sheehan Disability Scales	Patient
Well-being/overall severity of illness	Clinical Global Impression (CGI) Scale	
	Improvement	Patient
	Severity	Clinician

27% and 54%. Comorbidity also increases the demand on health care resources.

Major depression is one of the psychiatric conditions most frequently comorbid with social anxiety disorder. The lifetime prevalence of comorbid depression in patients with social anxiety disorder in a primary-care setting is between 40% and 50%. Simple phobia, agoraphobia, and alcoholism are other commonly occurring comorbid conditions. The possible association with eating disorders and posttraumatic stress disorder is often overlooked, but in our view should not be neglected in the patient with social anxiety disorder.

Social anxiety disorder precedes the development of major depression by at least 1 year in 75% of patients, and a similar temporal relationship is seen with agoraphobia and other comorbid conditions. This contrasts with panic disorder in which, for example, major depression and panic occur concurrently in around one third of the cases of comorbidity of the 2 conditions. It would appear that social anxiety disorder predisposes individuals for the development of other psychiatric disorders.

The patient with social anxiety disorder commonly seeks medical help only when suffering from a comorbid condition, notably major depressive disorder or alcoholism. As there is a low rate of recognition of social anxiety disorder in primary care, often it is the comorbid condition alone that is treated. For example, the clinician is most likely to recognize the existence of a psychological problem when the patient presents with depressive symptoms but is unlikely to detect the comorbid anxiety disorder. Analysis of data from the Social Phobia Inventory (SPIN) indicates that marked avoidance of public speaking is a key differentiator of patients with social anxiety disorder from normal control subjects. It is our considered view that a screening question based on 3 social situations or symptoms would have discriminatory value for the detection of social anxiety disorder in primary care.

The coexistence of disorders typically makes treatment more difficult and outcome less favorable than it is for a single disorder, which underlines the importance of detecting social anxiety disorder. Comorbidity affects the choice of treatment, as well as its efficacy. Although some studies suggest that cognitive behavioral therapy is effective when used as sole therapy for comorbid social anxiety disorder, our consensus opinion was that a selective serotonin reuptake inhibitor (SSRI) is frequently indicated for the patient with comorbid depression.

Research Need: Social anxiety disorder commonly coexists with other psychiatric disorders and generally precedes them. Intervention studies are needed to assess whether early recognition and treatment of social anxiety disorder will prevent the development of secondary complications.

Clinical Recommendations

Social anxiety disorder is the most common anxiety disorder in the community but it remains underrecognized in primary care. Given that sufferers themselves often lack awareness that they have a disorder, they sometimes only present in primary care when they have developed a depressive disorder or alcohol dependence or may be troubled by distressing sweating, blushing, or trembling as a presenting symptom. Social anxiety disorder is a treatable condition, but it is often overlooked and management directed solely at the secondary complication. It is our view that the clinician should screen for social anxiety disorder when presented with a depressed or alcohol-dependent patient with an apparent trait of shyness. We propose the following screening question:

> Are you markedly embarrassed and/or do you blush and tremble when asked to do things in public, like speak or eat or sign a check?

MEASURING IMPROVEMENT IN SOCIAL ANXIETY DISORDER

We can identify 3 principal domains in which improvement should be observed: symptoms, functionality or impairment, and well-being or overall improvement. As there is no single instrument that can measure improvement across these domains in social anxiety disorder, we recommend using a combination of measures (Table 2).

Several members of the consensus group proposed that another domain should also be included: self-assessment of the level of disability and distress induced by the disorder. The most appropriate measure was discussed, and the use of the patient version of the Clinical Global Impressions scale (CGI) and the SPIN was recommended for this important aspect of evaluation.

Research Need: The Liebowitz Social Anxiety Scale is used extensively in clinical trials and likely to be accepted as the gold standard for clinician rating of clinical severity in social anxiety disorder. One area requiring further research, however, is the psychometric properties of the instrument. Similarly, further investigation of self-rating scales such as the SPIN is warranted.

RESPONSE AND REMISSION IN SOCIAL ANXIETY DISORDER

While recognizing that there is limited consensus on how to define treatment outcome, the consensus group took the view that it is important to formulate definitions for response and remission in social anxiety disorder. By analogy with our recommendations in panic disorder, we agreed on the following proposals for these definitions:

Response: a stable, clinically meaningful improvement, such that the patient no longer has the full range of symptoms but has more than minimal symptoms.

Full remission: almost complete resolution of symptoms across the 3 domains of social anxiety disorder, which is maintained for a period of 3 months.

MANAGEMENT OF SOCIAL ANXIETY DISORDER

Social anxiety disorder is defined with reference to the impairment and disability it imposes on sufferers. We share the view that treatment should be considered for any subject who meets diagnostic criteria for the disorder. Our current state of knowledge on therapeutic intervention is based predominantly on clinical trials in the generalized subtype, which represents around 80% of all social anxiety disorder.

To provide guidance on the appropriate management strategy in social anxiety disorder, we have considered the following questions:

1. Which drugs are effective and how well do they work?
2. What aspects of the disorder respond to drug therapy?
3. What is the place of psychosocial treatment?

Social anxiety disorder can also be secondary to other conditions, for example, stuttering. There is a view, implicit in the formulation of DSM criteria, that treatment of the secondary condition is unnecessary because there is a clear reason for its development. In our opinion, a treatment trial is as appropriate for secondary social anxiety disorder as it is for the primary condition.

Pharmacotherapy

The consensus panel considered the quality of clinical evidence for the effectiveness of current therapeutic options in social anxiety disorder: SSRIs, monoamine oxidase inhibitors (MAOIs), and benzodiazepines.

SSRIs. Most of the data are from large multicenter placebo-controlled studies of paroxetine in generalized social anxiety disorder and provide strong evidence for the efficacy of paroxetine in improving fear and anticipatory anxiety and reducing disability. Treatment was generally well tolerated. Smaller studies with many other SSRIs have similarly reported positive results in the generalized subtype. The consensus group would like to underline the importance of the consistent positive outcome with SSRIs in social anxiety disorder.

MAOIs. The earliest placebo-controlled evidence for the efficacy of this therapeutic class was obtained with phenelzine, but concerns about its tolerability and safety make it an inappropriate choice of first-line therapy. Promising results were obtained in clinical trials of brofaromine, a reversible inhibitor of monamine oxidase (MAOI-R), but this agent is no longer marketed, and placebo-controlled studies of the MAOI-R moclobemide have shown evidence of positive but weak effects.

Benzodiazepines. There are limited, but well-controlled, data for the effectiveness of clonazepam in social anxiety disorder, but the only controlled trial of alprazolam suggests that it is significantly less effective in this condition than clonazepam. There is no evidence that benzodiazepines as a class are effective in social anxiety disorder.

Other medications. There are no controlled data for the efficacy of tricyclic antidepressants (TCAs) in social anxiety disorder. Positive results are claimed for a large open trial of clomipramine, but the study was reported 20 years ago with a population that was not adequately defined. The lack of efficacy of TCAs in social anxiety disorder contrasts with their efficacy in panic disorder (see consensus statement on pharmacotherapy of panic disorder).[3]

In addition, there was vigorous debate about beta-blockers, with strong expression of the view that these agents have no place in the management of social anxiety disorder. Beta-blockers are used by musicians and other professional performers to help with normal performance anxiety, but no controlled trial has shown that they are helpful for the pathologic anxiety of generalized social anxiety disorder. They are not indicated and may have deleterious effects, especially in patients with asthma.

Finally, there is no evidence for the efficacy of the azapirone anxiolytic buspirone in social anxiety disorder.

Clinical recommendations. The consensus group recommends SSRIs as the first-line treatment for social anxiety disorder. Most of the evidence in support of this recommendation comes from the well-controlled clinical data on paroxetine. The appropriate dosage for treatment with an SSRI has been defined for paroxetine: an initial dose of 20 mg/day for 2 to 4 weeks, then increased as necessary to obtain a response.

An adequate trial of treatment is generally 6 to 8 weeks, although some patients may start to experience clinical benefit during the first 4 weeks. Clinicians and their patients should expect to see some improvement within 8 weeks, but treatment may have to be continued for several months to consolidate response and achieve a full remission. If treatment is effective, we recommend that it be

continued for a minimum of 12 months. Long-term treatment is indicated if symptoms are unresolved, the patient has a comorbid condition or a history of relapse, or there was an early onset of social anxiety disorder.

As well as for first-line therapy, we suggest that SSRIs might be effective in treating those patients who have failed to respond to other treatments for social anxiety disorder.

Research Needs: (1) Only the generalized subtype of social anxiety disorder has been studied in treatment trials, and there is a need to study how the nongeneralized subtype should be treated. (2) There are inadequate clinical data on which to base a recommendation for the appropriate management strategy when a patient fails to respond to treatment with an SSRI. We need further research on the effectiveness of augmentation therapy with clonazepam or switching to alternative treatment, including MAOIs or anticonvulsant therapy. (3) Social anxiety disorder is a chronic condition, and long-term outcome studies are needed to define the optimal duration of effective treatment to prevent relapse. These studies should include outcome measures for the 3 domains affected by the condition. (4) Inclusion of health-economic endpoints in long-term treatment trials would be valuable to demonstrate both the disability of social anxiety disorder and the economic benefit to society of returning patients to full productivity. (5) Clinical trials on the efficacy of pharmacotherapy in social anxiety disorder have excluded subjects with comorbid conditions from the study population. As there is now clear evidence for the efficacy of SSRIs, there is a need to research their effectiveness in a population with comorbid symptoms. Since major depression is one of the most common comorbidities in clinical practice, a 1-year trial in a population with social anxiety disorder and comorbid depression is warranted.

Psychosocial Treatment

There is good evidence for the effectiveness of exposure-based strategies of cognitive behavioral treatment in social anxiety disorder. In contrast to that for pharmacotherapy, this evidence has been gained in relatively small trials.

Traditional psychosocial treatments have not been studied, an observation that led us to speculate that there is no reason to think that they would be effective in this condition. On the current state of knowledge, we feel that psychodynamic and other traditional psychotherapies probably have no place in the treatment of social anxiety disorder.

For those not trained in behavioral therapy, behavioral interventions are hard to perform and require more clinical time, and we recognize that these sophisticated psychological treatments have not been generally established outside of research centers. If a trained and confident clinical psychiatrist wanted to start using cognitive-behavioral therapy, in our view it would probably take at least 3 months to gain experience in using the entire protocol in social anxiety disorder inasmuch as most treatment trials are 12 weeks in length.

Research Needs: (1) There is only one well-controlled comparison of cognitive-behavioral therapy and pharmacotherapy (phenelzine), now in press, and studies of comparative and combined efficacy are needed. (2) There are no published data on the appropriate strategy for combining cognitive-behavioral therapy and pharmacotherapy, but 2 well-designed comparative studies are in progress. (3) There is a need to generalize the ability to perform cognitive-behavioral therapy from a specialist setting to nonspecialist psychiatry and to study its effectiveness in such settings. (4) The question of whether continued cognitive-behavioral therapy can prevent relapse in social anxiety disorder requires investigation. (5) Initial data suggest that exposure is the effective component of cognitive-behavioral treatments. Deconstruction studies are needed to provide greater understanding of the key components of cognitive-behavioral therapy and, for example, the value of breathing training.

CLINICAL SUMMARY

- Social anxiety disorder is estimated to affect between 10% and 15% of subjects in the community at some time in their lives.
- With an onset typically in adolescence, social anxiety disorder interferes with normal development of social and personal relationships, often leading to long-term disability in the social, working, and family lives of sufferers.
- Social anxiety disorder appears to predispose individuals to the development of other psychiatric disorders, most notably depression. Some 70% to 80% of cases of social phobia are complicated by comorbid conditions that increase the burden of disease.
- As there is a low rate of recognition of social anxiety disorder in primary care, management is often directed only at secondary complications.
- SSRIs are the drugs of first choice in social anxiety disorder; most evidence for their efficacy is derived from the data from well-controlled studies of paroxetine.
- The appropriate dosage for treatment with an SSRI has been defined for paroxetine: an initial dose of

20 mg/day for 2 to 4 weeks, then increased as necessary.

- An adequate trial of treatment is 6 to 8 weeks. If treatment is effective, it should be continued for a minimum of 12 months.
- Less evidence of efficacy is available for the MAOI phenelzine, the benzodiazepine clonazepam, and the MAOI-R moclobemide.
- As social anxiety disorder is a prevalent, disabling, but treatable condition, clinicians should consider the disorder in patients who appear to be reticent or shy.

Drug names: alprazolam (Xanax), buspirone (BuSpar), clomipramine (Anafranil), clonazepam (Klonopin), moclobemide (Manerix), paroxetine (Paxil), phenelzine (Nardil).

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