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Editorial: Social Anxiety Disorder – New Understandings and New Standards

Social phobia, also known as social anxiety disorder (SAD), is characterized by marked anxiety about social or performance situations in which there is a fear of embarrassing oneself under scrutiny by others (1). It is a common disorder with early onset, significant comorbidity and functional impairment (2). SAD has been ranked as one of the top ten chronic disorders – mental or physical – in terms of its effects on objective outcomes, such as days of work lost and reduced health-related quality of life (3, 4). Despite the growing understanding of the condition, information is lacking on key aspects of the disorder and many individuals, including doctors, psychiatrists and patients, lack awareness about this condition. The current issue of the IJP aims to address some of these gaps and disseminate research findings on this important topic.

The last decades in the psychiatric field have been associated with a lot of controversy about the "real" prevalence of several disorders, especially those outside the realm of the familiar depressive and psychotic disorders. Examples of such debates include the eating disorders in the eighties, dissociative identity disorder in the nineties and today, the issue of bipolar disorder among children and adolescents. A similar controversy surrounds the existence and prevalence of SAD.

While first puzzled by the question whether SAD exists at all as a true psychiatric disorder, some psychiatrists still claim that SAD is either non-existent or is a pathologized description of normal shyness. Such psychiatrists are likely to be responding to the complexity of the condition due to the high rate of comorbidity and the low prevalence of such patients in secondary and tertiary psychiatric settings. Research clearly shows, however, that SAD is capable of causing "harmful dysfunction" (2), thus reaching the cutoff criteria for mental disorders.

The prevalence of SAD is not consistent across studies or continents, but a recent American study (from the NCS-R) found a lifetime prevalence of 12.1% (2). Meron Ruscio et al. (2) reported that the most common social fears were public speaking (21.2%) and speaking up in a meeting or class (19.5%), while the least common fears include using a bathroom away from home (5.7%) and writing, eating or drinking while being watched (8.1%).

What is the situation in Israel? While presenting a poster about an Israeli SAD study at the APA meeting in Atlanta in 2005, the first author was approached by an American colleague who mentioned in humor that he thought that SAD was absent in the tough Israeli society. Similar views see Israeli children as lacking shyness as compared to children from other cultures. While SAD was surprisingly not included in the Israel National Health Survey (5), a study in the Israel Defense Forces (IDF) with 850 soldiers revealed a rate of 4.5% as measured by the Liebowitz Social Anxiety Scale (LSAS), a self-report questionnaire (6). Based on a recent study (7), that showed that the cutoff could be lower than that set in the IDF survey, one could surmise that the rate of SAD in Israel is similar to that in the U.S. (i.e., above 10%).

In the NCS-R study, comorbidity, role impairment and treatment seeking had a dose-response relationship with the number of social fears (2). However, social phobia was the focus of clinical attention in only about half the cases where treatment was obtained (2). SAD, which so often begins in childhood, precedes other comorbid disorders and may be a direct or indirect risk factor for other disorders, such as depression and substance abuse.

Although etiology is still incompletely understood, it is likely that temperament, personality, genetic and environmental factors may predispose individuals to both SAD and to other mental disorders. There is increasingly more research being conducted in the area of pathogenesis of SAD and the literature suggests that SAD individuals interpret ambiguous social information in a threatening matter (8). Interestingly enough, alcohol seems to attenuate the impact of threatening social stimuli on SAD patients

(9), putting such individuals at risk for comorbid substance abuse disorders. Functional neuro-imaging studies point to increased activity in the amygdala and the insula in SAD (1), a finding that suggests some areas of neural systems convergence between SAD and other anxiety disorders (such as panic disorder). This is a rich area for future research.

A range of effective cognitive behavioral therapies and pharmacological treatments (mainly SSRIs and SNRIs) now exist. The challenge still lies in the integration and dissemination of these treatments and learning how to help the 30–40% of patients for whom treatment does not help (1). Meron Ruscio and associates (2) found that pure SAD cases involving a larger number of fears were less likely to receive treatment specifically for this disorder. It seems that people with the greatest need for SAD treatment are those least likely to receive it, perhaps due to fear of negative evaluation or disbelief in the possibility of changing.

So where are these individuals? Few are in psychiatric settings; some may show up in primary care clinics. They are certainly not on the radar of the psychiatric and primary care community and are thus not being identified. How could we improve this reality? By increasing awareness among psychiatrists, physicians and the general public and by establishing special clinics with interest in and experience with the treatment of patients with SAD. Additionally, studies are needed to determine whether early intervention for SAD might prevent the onset of comorbid conditions and improve long-term prognosis. We also recommend screening for SAD in patients with mood disorders, anxiety disorders, substance abuse and impulse control disorders. By increasing awareness and reaching out (to patients and to clinicians), we can do a better job of bringing effective treatments to those who may benefit.

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Iulian Iancu, Rehovot Mental Health Clinic, Beer Yaakov Ness Ziona Mental Health Center and the Sackler School of Medicine, Tel Aviv University, Ramat Aviv, Israel

Jennifer Levin, Department of Psychiatry, Case Western Reserve University School of Medicine and University Hospitals Case Medical Center, Cleveland, Ohio, U.S.A.

Murray B. Stein, Departments of Psychiatry and Family and Preventive Medicine, University of California, San Diego. California, U.S.A.

Guest editors