Approach to treating social anxiety disorder in adults

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INTRODUCTION

Social anxiety disorder (SAD), also known as social phobia, is a condition marked by extreme fear of situations that involve possible scrutiny by others. The individual is concerned that embarrassment or humiliation will result, and so they avoid such situations, or endures them with intense anxiety.

SAD is a prevalent condition, estimated to affect between 4 and 10 percent of the adult United States population over a 12-month period. SAD typically begins in childhood or adolescence and, untreated, can be associated with the subsequent development of major depression, substance use disorder, and other mental health problems. The disorder can be associated with extensive functional impairment and reduced quality of life [1].

This topic describes our approach to selecting treatments for SAD (algorithm 1) and performance-only SAD (algorithm 2). The epidemiology, pathogenesis, clinical manifestations, assessment, and diagnosis of SAD are discussed separately, as are the efficacy, side effects, and administration of individual psychotherapies and medications for SAD. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis" and "Social anxiety disorder in adults: Psychotherapy" and "Pharmacotherapy for social anxiety disorder in adults".)

NEWLY DIAGNOSED PATIENTS

Decision to treat — Not all patients with social anxiety disorder (SAD) require immediate treatment. Young adults, in particular, may benefit from education about their disorder and may need time to reflect on the extent to which social anxiety and avoidance have negatively impacted their lives. It is not unusual for a newly diagnosed patient with SAD to be surprised that these symptoms can diminish or resolve with treatment as opposed to being an inalterable aspect of their self. The need for treatment of SAD is rarely an emergency. Most patients have had SAD for many years, and the decision to seek a diagnosis may have taken a long time.

After the diagnosis of SAD is established, if the patient prefers to meet further before deciding about treatment, the clinician and patient can further discuss the need for treatment in the context of a longitudinal evaluation of the extent to which social anxiety has impacted the individual's quality of life, as well as consideration of future life goals and how those may be affected by social anxiety and avoidance. Once a mutual decision is reached that treatment is indicated, the next step involves discussion of treatment options.

SAD versus SAD, performance only — In the transition from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) to DSM-5, the subtypes of generalized and nongeneralized social anxiety disorder (SAD) were replaced by SAD and SAD, performance only, respectively [2]. We take the same approach for the two SAD types for psychotherapy, but different approaches to medication treatment. Clinical trials of treatments for SAD studied samples primarily composed of patients with the generalized form of the disorder. (See 'Social anxiety disorder, performance only' below and "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Diagnosis'.)

Choosing between psychotherapy and medication — For both types of SAD, we suggest first-line treatment of SAD with either pharmacotherapy or cognitive-behavioral therapy (CBT). Both treatments reduce social anxiety compared with placebo, but clinical trials (described below) have not found one modality to be superior to the other. The selection between pharmacotherapy and CBT should be made on the basis of informed patient preference and treatment availability.

Onset of symptom response may be faster with pharmacotherapy, although CBT appears to result in a more durable response [3]. Speed of onset is rarely an important attribute in the treatment of SAD, as most patients have had the disorder for many years and a difference of a few weeks in response time is largely irrelevant.

Randomized trials comparing CBT with pharmacotherapy for SAD have not demonstrated clear superiority of one treatment modality over the other [4-6]. As an example, a randomized clinical

trial of 128 patients with SAD compared the monoamine oxidase inhibitor phenelzine with drug placebo, group CBT tailored for SAD, and the combination of phenelzine and group CBT [4]. After 12 weeks, there was not a statistically significant difference in response rates (as measured by the Clinical Global Improvement scale) between the CBT group and the phenelzine group; both groups had higher response rates compared with the placebo group (47.1 versus 54.3 versus 33.3 percent).

Clinical trials have not reliably shown the combination of CBT and medication to be superior to either modality individually. As examples:

- CBT and antidepressants – Clinical trials have found mixed results for the combination of CBT and antidepressant medications [4-6]. As examples:
  - A trial randomly assigned 295 patients with DSM-IV generalized SAD to one of five groups: fluoxetine, group CBT, combined group CBT and placebo, combined group CBT and fluoxetine, or placebo [5]. A higher proportion of patients responded to fluoxetine (51 percent), group CBT (52 percent), combined group CBT and placebo (51 percent) and combined group CBT and fluoxetine (54 percent) than to placebo (32 percent). However, the group receiving combined medication and CBT did not differ significantly in response compared with groups receiving either monotherapy.
  - In the randomized trial of 128 patients with SAD described above, combined group CBT-phenelzine resulted in higher response rates compared with either modality as monotherapy (71.9 versus 47.1 and 54.3 percent) [4].
- CBT and d-cycloserine – A large clinical trial examining augmentation of CBT with d-cycloserine, a partial N-methyl-d-aspartate receptor agonist, showed no benefit over placebo augmentation at posttest or follow-up [7]. In another trial including 152 patients with SAD, superior response to treatment was found in individuals receiving d-cycloserine, as compared with placebo or a tailored condition, when given immediately before or after their exposure therapy sessions. [8].

There is some evidence that the patient's beliefs about the etiology of SAD should be factor in selecting between psychotherapy and medication for the disorder. Among patients receiving the SSRI paroxetine for SAD, those who attributed the onset of their SAD to genetic, biological, and early life experiences had the most rapid response to paroxetine [9].

Patient preference for psychotherapy — For patients with either SAD or SAD, performance-only who prefer psychotherapy rather than medication, we suggest first-line treatment with either individual or group CBT customized for SAD rather than other psychotherapies.

Comparative efficacy — There are a small number of head-to-head clinical trials comparing CBT with other psychotherapies for SAD, providing some evidence favoring CBT. Individual trials found CBT to be superior to interpersonal psychotherapy [10] and applied relaxation plus exposure [11]. Direct comparisons of CBT with psychodynamic psychotherapy did not convincingly favor either treatment [12-14]. As an example, a 2013 clinical trial compared CBT with psychodynamic therapy customized to treatment of SAD against waitlist in 495 patients with SAD [13]. Patients in both CBT and psychodynamic psychotherapy groups experienced reduced SAD symptoms compared with baseline, and compared with waitlist at postassessment. CBT demonstrated superior response compared with psychodynamic psychotherapy on some social anxiety measures at postassessment; however, differences were small in magnitude and not found during the follow-up assessments conducted up to 24 months after treatment [12].

A network meta-analysis including 101 clinical trials found CBT to be superior to no treatment, pill placebo, psychological control conditions, and several psychotherapies including psychodynamic psychotherapy, interpersonal psychotherapy, mindfulness, and supportive therapy [15]. Network meta-analyses utilize all available data from randomized clinical trials to estimate the effect of each intervention relative to other interventions (even those that have never been compared directly).

Comparison of placebo controlled trials of psychotherapies for social anxiety disorder suggests that CBT is the best studied and most efficacious of the psychotherapies for SAD.

A meta-analysis of five randomized trials totaling 318 patients found traditional CBT to be efficacious for SAD compared with placebo control (odds ratio 4.21, 95% CI 2.07-8.98). Medium to large positive effects (Hedges g 0.84, 95% CI 0.72; 0.97) on social anxiety symptoms have been seen for group CBT tailored for SAD compared with waitlist [16,17]. More limited evidence supports the efficacy of attention retraining for SAD [18-20], while trials testing the efficacy of interpersonal therapy [10,21] and psychodynamic therapy [13] for SAD were inconclusive. (See "Social anxiety disorder in adults: Psychotherapy".)

In CBT tailored for SAD, the therapist works with the patient to identify and challenge maladaptive cognitions associated with social situations. More recent, tailored CBT protocols, which target specific maintenance factors, have been shown to be more efficacious for SAD, compared with standard CBT approaches to the disorder [11,22].

CBT has traditionally been provided to groups of four to six patients with SAD by two therapists in 12 weekly two and a half hour sessions. More recent modifications of this format include

individual treatment sessions lasting 60 minutes scheduled weekly for up to 15 weeks. (See "Social anxiety disorder in adults: Psychotherapy", section on 'Cognitive-behavioral therapy'.)

Patient preference for medication — Medications with efficacy in SAD (the generalized form) include selective serotonergic reuptake inhibitors (SSRIs), serotonergic noradrenergic reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs), and benzodiazepines. Information on the dosing and side effects of SSRIs and SNRIs are described in tables (table 1 and table 2).

Medication treatment of SAD, performance only subtype, is described separately below. (See 'Social anxiety disorder, performance only' below.)

SSRI/SNRI — For patients treated with medication, we suggest first-line treatment with an SSRI or an SNRI rather than other medications. Multiple clinical trials have shown SSRIs and SNRIs to be efficacious in the treatment of SAD [15,23-26]. Other medications with efficacy in SAD are supported by fewer trials, have more problematic side effect profiles (MAOIs [4,23] and benzodiazepines [27,28]), or show less robust treatment effects (gabapentin [29] and pregabalin [30-32]) in comparison with placebo [33]. There have been no clinical trials comparing medications from different classes in the treatment of SAD. Clinical trials comparing these medications with placebo in SAD are reviewed separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Monotherapy'.)

Information on the dosing and side effects of SSRIs and SNRIs are reviewed separately and in tables (table 1 and table 2). (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Selective serotonin reuptake inhibitors' and "Pharmacotherapy for social anxiety disorder in adults", section on 'Serotonin-norepinephrine reuptake inhibitors' and "Sexual dysfunction caused by selective serotonin reuptake inhibitors (SSRIs): Management".)

TREATMENT RESPONSE

Further treatment of social anxiety disorder (SAD) is based on the patient's response to the first-line intervention.

Response to cognitive-behavioral therapy

Robust response — Patients who have a robust response to treatment should be encouraged to continue practicing their skills on a maintenance basis. Some therapists would recommend the inclusion of maintenance sessions (eg, two or three visits annually) as part of a relapse-prevention plan.

Poor or partial response — Patients who fail to respond to a full trial of cognitive-behavioral therapy (CBT) should be reassessed for remaining cognitive errors or avoidance strategies contributing to maintenance of social anxiety; these would be addressed in additional CBT sessions. The patient would also be reassessed for associated problems such as depression, complicated grief, interpersonal trauma, or substance use disorder, which should be treated if present. (See "Social anxiety disorder in adults: Psychotherapy", section on 'Strategies for nonresponse'.)

For patients who continue to show little response to CBT after 8 to 12 weeks of modified treatment, we suggest substitution of CBT with a selective serotonergic reuptake inhibitor (SSRI) or serotonergic noradrenergic reuptake inhibitor (SNRI). Patients who experienced a partial response to CBT should continue the therapy and receive an SSRI or SNRI adjunctively. (See 'SSRI/SNRI' above.)

Response to SSRI/SNRI — For patients who experience a minimal response to an initial (8- to 12-week) trial of an SSRI or SNRI, a second trial of a different SSRI or SNRI should be tried. A randomized clinical trial of patients with no or partial response after 10 weeks of sertraline treatment compared continued use of sertraline at the same dose with switching to venlafaxine [34]. Both groups improved somewhat over time, but no difference in response was seen between the two groups. While some patients may accrue additional benefit by remaining on their initial SSRI or SNRI beyond 10 weeks of treatment, it is difficult to justify leaving a patient with minimal or no response on the same medication for an extended duration.

If the response to the second SSRI/SNRI trial is inadequate:

No substance use disorder history — For patients who experience a **minimal response** to an SSRI or SNRI and have no history of a substance use disorder (SUD), our practice would be to substitute clonazepam for the serotonergic drug or switch to CBT. Clonazepam is a long-acting benzodiazepine with a relatively slow rate of onset. Benzodiazepines have been shown in clinical trials to be efficacious in SAD [27,28]. Treatment of SAD with benzodiazepines is reviewed in detail separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Benzodiazepines'.)

A substantial number of patients with SAD experience a partial response to monotherapy with an SSRI or SNRI [35]. After an 8- to 12-week trial at the maximally tolerated dose, a partial response would be generally treated with the addition of CBT or an augmenting medication.

For SAD patients with no SUD history who experience a **partial response** to an SSRI or SNRI and prefer medication rather than psychotherapy, our practice is to augment the SSRI/SNRI with clonazepam. Sedation, the principal dose-limiting adverse effect of clonazepam, can be

minimized by starting with low doses and titrating upwards slowly until a satisfactory response is achieved. Side effects and dosing of benzodiazepines are reviewed separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Benzodiazepines'.)

For patients who do not respond to or do not tolerate benzodiazepine treatment, pregabalin or gabapentin can be tried, either as augmentation of an SSRI/SNRI or as monotherapy.

Clinical trials have found modest reductions in SAD symptoms with pregabalin or gabapentin monotherapy [29,30]; augmentation with these drugs has not been tested. Treatment of SAD with pregabalin and gabapentin is reviewed separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Gabapentin' and "Pharmacotherapy for social anxiety disorder in adults", section on 'Pregabalin'.)

Substance use disorder history — Benzodiazepines are generally avoided as a treatment for SAD in patients a history of an SUD due to the drugs' potential for abuse and physiologic dependence.

SAD patients with a **minimal response** to an SSRI/SNRI can be switched to an irreversible monoamine oxidase inhibitor (MAOI) such as phenelzine, provided that MAOI-related restrictions on diet and certain medications are feasible. Phenelzine has been found to be efficacious in SAD in clinical trials [23]. A washout period is needed after stopping the SSRI/SNRI and before starting the MAOI, due to the risk of precipitating a hypertensive reaction known as serotonin syndrome. One to two weeks are needed for most SSRI/SNRIs; five to six weeks are needed following cessation of fluoxetine. Treatment of SAD with MAOI medication, including dietary and medication interactions, is reviewed separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Monoamine oxidase inhibitors'.)

There is little evidence available to guide augmentation of an SSRI/SNRI for patients with an SUD history and a **partial response** to the serotonergic drug. Phenelzine cannot be used, because of the risk of serotonin syndrome with concurrent use of phenelzine and an SSRI/SNRI. Consideration could be given to adding gabapentin, pregabalin, or buspirone, although little research supports these steps. A small, uncontrolled trial found an association between SSRI augmentation with buspirone and a reduction in SAD symptoms [36]. Treatment of SAD with these medications is discussed briefly above and in more detail separately. (See 'No substance use disorder history' above and "Pharmacotherapy for social anxiety disorder in adults", section on 'Augmentation'.)

If these strategies are not effective, patients with an SUD history could be judiciously prescribed an adjunct benzodiazepine provided that the SUD was not active or recent (eg, in the past 12

months) and the patient's use of the medication was carefully monitored. (See 'No substance use disorder history' above.)

MEDICATION RESISTANT

For patients who do not respond to any one or all of these medications, cognitive-behavioral therapy remains an option, either as monotherapy or in conjunction with the medication providing some benefit. (See "Social anxiety disorder in adults: Psychotherapy", section on 'Cognitive-behavioral therapy'.)

SOCIAL ANXIETY DISORDER, PERFORMANCE ONLY

For most patients with social anxiety disorder (SAD), particularly those who will encounter performance symptoms on a recurring basis, we suggest first-line treatment with cognitive-behavioral therapy (CBT) for SAD. Patients with public-speaking anxiety can benefit from exposure to practicing public speaking in classes or clubs such as Toastmasters, but generally only after the completion of a course of CBT. (See 'SAD versus SAD, performance only' above and "Social anxiety disorder in adults: Psychotherapy", section on 'Components' and "Social anxiety disorder in adults: Psychotherapy", section on 'Toastmasters'.)

For a patient requesting help with a single or rarely recurring performance (eg, giving the toast at a friend's wedding), pharmacotherapy may be a suitable alternative. When medication is used, either a beta-adrenergic blocker or a benzodiazepine can be given 30 to 60 minutes before the performance. Patients should try the medication in advance of a potentially precipitating event; a dose adjustment may be needed for effectiveness or side effects.

- **Beta blocker** – We would be more inclined to use a beta blocker in patients who have prominent awareness of physiological symptoms such as tachycardia or tremor. Several small trials found beta-blockers to reduce performance anxiety, although not in patients diagnosed with SAD [37,38]. Side effects, contraindications to, and dosing of beta-blockers are reviewed separately. (See "Pharmacotherapy for social anxiety disorder in adults", section on 'Beta-adrenergic blockers'.)

- **Benzodiazepine** – The efficacy and side effects of benzodiazepines are reviewed separately .(See 'Poor or partial response' above and "Pharmacotherapy for social anxiety disorder in adults", section on 'Benzodiazepines'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Anxiety and anxiety disorders in adults".)

SUMMARY AND RECOMMENDATIONS

- Social anxiety disorder (SAD), or social phobia, is marked by extreme fear of situations that involve possible scrutiny by others, the possibility of embarrassment or humiliation, and avoidance or intense distress when confronted with such situations. (See 'Introduction' above.)

  Performance anxiety that causes significant distress or affects functioning may be part of SAD; when limited to performance situations this is considered a specifier of SAD in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

- Treatment with either pharmacotherapy or cognitive-behavioral therapy (CBT) is effective for SAD. Direct comparisons of CBT and pharmacotherapy have not demonstrated clear superiority of one treatment modality over the other. Choice of treatment is based on patient preference and/or geographic availability (algorithm 1 and algorithm 2). (See 'Choosing between psychotherapy and medication' above.)

- For patients who prefer psychotherapy for SAD, we suggest first line treatment with CBT tailored to SAD rather than other psychotherapies (**Grade 2B**). (See 'Choosing between psychotherapy and medication' above.)

- Patients who do not respond to a full trial of CBT should be further assessed for avoidance strategies or associated clinical problems. If additional sessions addressing these issues if present do not lead to improvement, our practice would be to switch to a selective serotonergic reuptake inhibitor (SSRI) or serotonergic noradrenergic reuptake inhibitor (SNRI). Patients showing partial response to CBT should continue therapy while starting an SSRI or SNRI adjunctively. (See 'Treatment response' above.)

- For patients who prefer medication for SAD, we suggest first-line treatment with an SSRI or SNRI rather than other medications (**Grade 2B**). (See 'SSRI/SNRI' above.)

- There are few comparative trials to guide medication selection for patients who do not respond to an initial 8- to 12-week trial of an SSRI or SNRI at the maximally tolerated dose. Our practice is to treat with a different SSRI or SNRI. For patients who respond poorly to the second SSRI/SNRI trial, our choice of treatment is influenced by the patient's history. (See 'Response to SSRI/SNRI' above.)

  - For patients without a history of a substance use disorder (SUD), we substitute clonazepam for the serotonergic drug or switch to CBT. Patients with a partial response would continue the SSRI or SNRI, augmented by clonazepam or CBT. (See 'No substance use disorder history' above.)

  - For patients with an SUD history, we switch to phenelzine (in patients who can adhere to dietary and medication restrictions) or CBT. A washout period is needed between stopping the serotonergic drug and starting phenelzine, due to the risk of a severe hypertensive reaction or serotonin syndrome. In patients with a partial response, we would continue the SSRI or SNRI, augmented by gabapentin, pregabalin, or CBT. (See 'Substance use disorder history' above.)

- For patients with performance-only SAD (DSM-5 performance-only specifier) who will encounter performance situations on a reoccurring basis, we suggest first-line treatment with CBT tailored for SAD (**Grade 2C**). Peer-led programs that provide opportunities for practicing public speaking (eg, Toastmasters), can be helpful for these patients, but generally only after a course of CBT. (See 'Social anxiety disorder, performance only' above.)

- For a patient needing help with a single or rarely reoccurring performance, patients may prefer pharmacotherapy. Options include propranolol, a beta-adrenergic blocker, or a benzodiazepine such as lorazepam or clonazepam. (See 'Social anxiety disorder, performance only' above.)

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