

**Does social phobia
remain the ‘Ugly
Duckling’ of anxiety
disorders?
A fobia social continua
sendo o “Patinho Feio”
dos transtornos de
ansiedade?**

Almost twenty five years ago, Liebowitz and colleagues called social phobia a “neglected anxiety disorder”,¹ since it was relatively little investigated when compared to the other anxiety disorders. The authors pointed out that many uncertainties remained regarding its classification, prevalence, severity, etiology, assessment, and treatment. They also highlighted that social phobia (also known as social anxiety disorder, SAD) was a fertile area for psychobiological and clinical investigation. This idea was supported by the fact that in 1985 no more than two dozen papers on social phobia were available via Medline.

Over the past decades, since the publication of that seminal manuscript, significant progress has been made in the literature on SAD, especially in relation to its epidemiology, diagnosis, neurobiology, and the pharmacological and psychotherapeutic management of the condition. However, the number of articles published since SAD was included in the formal diagnostic classification of DSM-III, in 1980, is still modest when compared to the other anxiety disorders – especially post-traumatic stress disorder (PTSD) - Figure 1a. It is particularly surprising considering that SAD is the most commonly found anxiety disorder (Figure 1b), with early onset, chronic course, often associated with considerable functional impairment and comorbid psychiatric disorders;² and remission rarely occurs without therapeutic intervention.

There are several possibilities for these discrepancies. As opposed to other psychiatric disorders, some authors have proposed a dimensional approach to the classification of SAD within a *continuum* of symptom severity, number of psychiatric comorbidities, degree of suffering and impairment, instead of having a more valid category.² This led some people to speculate on whether SAD is merely shyness or a condition created by the pharmaceutical industry to expand the market. Additionally, in the recent past, SAD was still thought of as having a purely psychological nature, whereas other anxiety disorders such as panic disorder (PD), obsessive-compulsive disorder (OCD), and PTSD have long been linked to brain abnormalities. For instance, a recent review noted the scarce number of morphometric Magnetic Resonance Imaging studies on SAD when compared to other anxiety disorders.³

Despite the high prevalence of the disorder and considerable level of functional impairment associated with it, SAD patients are less likely than people with other anxiety disorders to seek help for their psychiatric problems. In a recent epidemiological survey from our group, 10.2% (n = 235 out of 2319) of university students met DSM-IV criteria for SAD, but only 0.8% (n = 2 out of 235) had been diagnosed or used medication to treat their condition.⁴ Similar figures have been observed in clinical settings as well as in the ECA Duke study, in which only 3% of SAD patients reported seeking help for social anxiety.⁵ This fact may be related to the essential characteristic of SAD of presenting anxiety when feeling under scrutiny, which

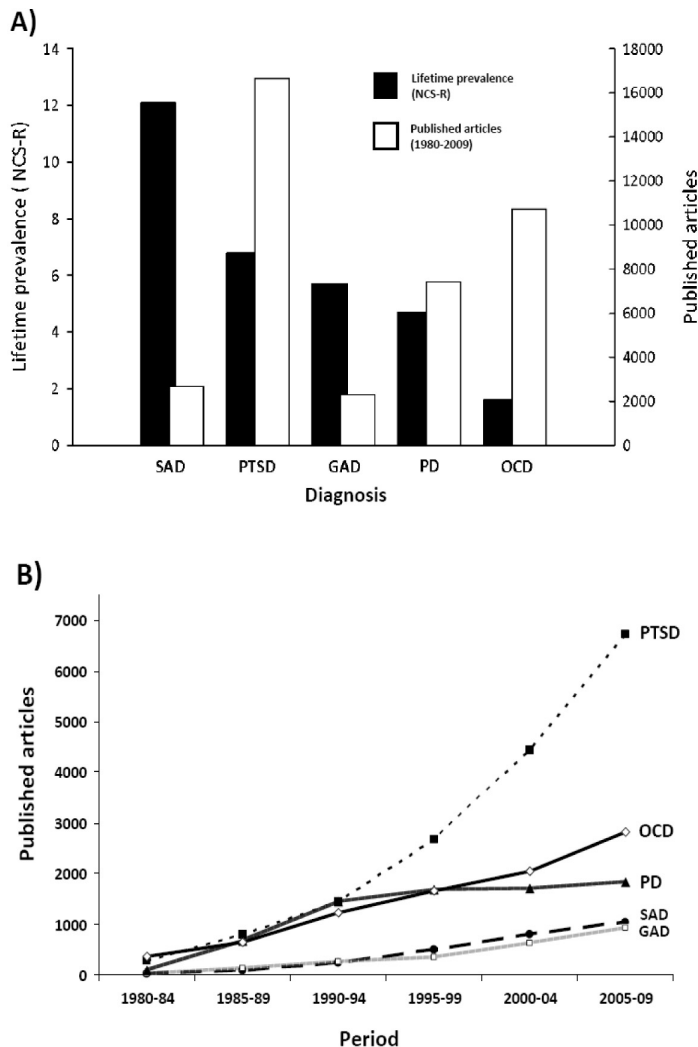


Figure 1 – A) Lifetime prevalence assessed in the National Comorbidity Survey Replication (NCS-R; Kessler et al, 2005) and number of anxiety disorders-related publications from 1980 to 2009. **B)** Number of anxiety disorders-related publications from 1980 to 2009. The source used was the 'MEDLINE' database with the keywords: SAD ("social phobia" OR "social anxiety disorder"); OCD ("obsessive compulsive disorder" OR "obsessive-compulsive disorder" OR OCD NOT osteochondritis); PTSD ("post-traumatic stress disorder" OR "posttraumatic stress disorder" OR PTSD); GAD ("generalized anxiety disorder"); and PD ("panic disorder").

may keep patients from revealing their social anxiety symptoms to a "potential authority" (e.g., physician) without being asked to do so. Therefore, clinicians normally do not diagnose SAD unless they ask about their patients' social fears and avoidances, particularly when social phobia is not the primary reason for seeking treatment.

Another potential reason for the SAD under-recognition by patients is the relative low attention given by the general media for social phobia when compared to other anxiety disorders. While television programs, newspaper articles, magazine reports, and even movies have been dedicated to PD in the 1980s, to OCD in the 1990s, and to PTSD in the 2000s, SAD is still waiting for its turn in the spotlights.

We can conclude that in the last few years a growing body of data on the pathogenesis of SAD has been consolidated, including the biological mechanisms that come from pharmacological and behavioral challenges, functional neuroimaging and cognitive-behavioral approaches. Effective pharmacological and psychotherapeutic interventions are available. However, many challenges remain. In particular, research advances have not been fully translated to the clinical community, as too many patients remain undiagnosed and under-treated. Thus, although additional research at all levels is desirable and needed, overcoming the current under-recognition and lack of awareness about this condition is the first step to turn SAD from the 'Ugly Duckling' into a 'graceful swan' among the anxiety disorders.

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Note: FMRP-USP = Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo; FAPESP = Fundação de Amparo à Pesquisa do Estado de São Paulo; CNPq = Conselho Nacional de Desenvolvimento Científico e Tecnológico; CAPES = Coordenação de Aperfeiçoamento de Pessoal de Nível Superior; FAEPA = Fundação de Apoio ao Ensino, Pesquisa e Assistência do Hospital das Clínicas da FMRP-USP; FUNPEC = Fundação de Pesquisas Científicas. For more information, see Instructions for authors.

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