Some of the people in your care are shy. Some have social phobia or anxiety. Helping recognize this disorder in your folks may help someone overcome a debilitating condition. Read on for more information.

Helping Hearts Heal

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Social Anxiety Disorder: A Common, Underrecognized Mental Disorder

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Social phobia is a highly prevalent yet often overlooked psychiatric disorder that can cause severe disability but fortunately has shown responsiveness to specific pharmacotherapy and psychotherapy. Recognition of its essential clinical features and the use of brief, targeted screening questions can improve detection within family practice settings. Cognitive behavioral therapy, with or without specific antidepressant therapy, is the evidence-based treatment of choice for most patients. Adjunctive use of benzodiazepines can facilitate the treatment response of patients who need initial symptom relief. The use of beta blockers as needed has been found to be helpful in the treatment of circumscribed social and performance phobias. Treatment planning should consider the patient's preference, the severity of presenting symptoms, the degree of functional impairment, psychiatric and substance-related comorbidity, and long-term treatment goals. (Am Fam Physician 1999;60:2311-22.)

For years, social anxiety disorder, also known as social phobia, has been underrecognized and undertreated. That situation is beginning to change, however, because recent research has shown that the disorder is highly prevalent, chronic in its untreated course, often associated with comorbid mental and substance-related problems, and capable of disabling those who have it. We now know more about recognizing social phobia and the types of interventions to which it is responsive.

Clinical Features

The Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV),[1] describes social phobia as an intense, irrational and persistent fear of being scrutinized or negatively evaluated by others (Table 1). In patients with this disorder, feared social or performance situations typically provoke an immediate anxious reaction ranging from diffuse apprehension to situational panic. The types of fears and avoidance commonly

Social phobia is an intense, irrational and persistent fear of being scrutinized or negatively evaluated by others.

associated with social phobia (Table 2) are, to some degree, experienced by most people. However, to meet the diagnostic criteria for this disorder, the symptoms must be severe enough to cause significant distress or disability. Social phobia can be generalized, meaning that the patient fears many or most social interactions, or it can be limited to one or a few situations, such as public speaking or performing.

TABLE 1
Diagnostic Criteria for Social Phobia

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. NOTE: In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under 18 years of age, the duration is at least six months.

G. The fear or avoidance is not due to the direct physiologic effects of a substance

(e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder or schizoid personality disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it; (e.g., the fear is not of stuttering, trembling in Parkinson's disease or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa.)

Specify if:
Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder).

In social phobia, fear and avoidance typically develop into a vicious cycle that can become severely distressing, debilitating and demoralizing over time. Although patients are usually aware that their fears are unreasonable, they still find themselves experiencing significant dread before facing a feared social encounter. The encounters themselves often evoke physical sensations of anxiety (e.g., blushing, sweating) and a preoccupation with possible embarrassment or humiliation. Encounters may be endured with distress or, more typically, avoided--either subtly (e.g., by modifying one's interactions within encounters) or overtly (e.g., by nonattendance). These various forms of avoidance preclude any change in the patients's core pathologic social fears and cause significant distress or functional impairment.

It should be noted that not everyone who suffers from social phobia appears shy, withdrawn or overtly nervous. Presentation of symptoms varies widely (Table 3). In some situations, the patient may not appear anxious, thus obscuring the underlying fear, avoidance, distress and disability.

Epidemiology, Course and Disability

Recent epidemiologic studies report that social phobia has a lifetime prevalence rate of 13.3 percent and a one-year prevalence rate of 7.9 percent in community samples, making it the third most prevalent psychiatric disorder, following substance abuse and depression.[2] In community samples, circumscribed fears of public speaking or performing are most prevalent. In clinical samples, generalized fears of many social interactions predominate, perhaps because of the greater likelihood of disability, and consequent help-seeking, in generalized social phobia.

TABLE 2
Common Fears in Social Phobia

- Public speaking
- Being watched or performing doing something
- Making "small (e.g., eating, writing)
- talk"
- Attending social Small group gatherings discussion
- Using the telephone
- Asking questions in groups
- Using public restrooms
- Interacting with "important" people
- Being introduced
- Indirect evaluation (e.g., test taking)
- Meeting or talking with strangers
- Being assertive

Onset of social phobia typically occurs between 11 and 19 years of age. Onset after age 25 is rare,[3,4] although it is not uncommon for an existing social phobia to remain unprovoked for years until some new social or occupational demand (e.g., meeting new people, public speaking, promotion) forces these persons into social encounters that trigger the syndrome. Slightly more females than males have social phobia.[3] In one study,[5] about one half of the patients reported that their phobia began in response to a specific embarrassing experience; the others reported that it had been with them for as long as they could remember.

Untreated, social phobia is chronic and unremitting. Selective avoidance of social situations may temporarily reduce symptoms but usually leaves underlying fears intact. Disability from social phobia can be pervasive and severe. Approximately 85 percent of patients with the disorder experience academic and occupational difficulties caused by their inability to meet the social demands of securing and maintaining employment or relationships. In one epidemiologic sample,[3] nearly one half of those with social phobia were unable to complete high school; 70 percent were in the lowest two quartiles of socioeconomic status; and approximately 22 percent were on welfare.

TABLE 3
Clinical Dimensions of Social Phobia

The following are some of the ways in which patients with social phobia may vary in symptom presentation:

- Generalized versus specific fears or avoidance
- Severe versus mild physiologic reactivity to social encounters
- Socially skilled versus unskilled
- Fear of familiar versus unfamiliar social situations
- Fear of formal versus informal social situations
- Fear of group versus individual social interactions
- Presence versus absence of preoccupation with and fear of specific anxiety sensations (e.g., blushing, shaking)

Comorbidity and Detection

Approximately one half of patients with social phobia have comorbid mental, drug or alcohol problems.[6,7] The disorder increases a patient's lifetime risk of depression approximately fourfold.[3] Up to 16 percent of patients who present with social phobia have alcohol abuse problems[8]; conversely, many patients presenting for treatment of substance abuse problems meet the criteria for social phobia.[9] Interestingly, longitudinal data show that social phobia precedes approximately 70 percent of these comorbid conditions,[3] suggesting that some comorbid conditions arise in response to the phobia. Importantly, the presence of comorbidity in social phobia has been associated with an increased lifetime incidence of suicidal ideation and suicide attempts.[3] Although these data underscore the need for early detection, social phobia often goes undetected.

In a recent epidemiologic study of 2,096 primary care patients in France,[10] it was found that approximately 5 percent of those detected through screening met the criteria for social phobia. Of those patients with early onset (before age 15), 70 percent had comorbid major depression. Interestingly, of patients presenting with social phobia alone, only 46 percent were initially recognized as having any psychiatric disorder. Of patients presenting with social phobia and depression, 76 percent were recognized as having psychiatric problems, although the social phobia was specifically identified in only 11 percent. These data reemphasize the importance of comprehensive psychiatric screening and highlight the need to screen for social phobia, particularly in patients who present with other common mental health disorders, such as depression or substance abuse.

As with all psychiatric conditions, detection can be facilitated by the use of a brief screening instrument that assesses for the primary features of disorders. This method is particularly relevant for social phobia, because patients often avoid volunteering their fears face-to-face. Some general screening devices for mental disorders (e.g., the Structured Clinical Interview for DSM-IVScreen [SCID-Screen]) include questions related to social phobia but are quite lengthy, requiring up to 25 minutes to complete; others do not screen for social phobia (e.g., the Primary Care Evaluation of Mental Disorders [Prime-MD]). Instruments designed specifically to measure social phobia (e.g., the Fear of Negative Evaluation Scale, the Social Avoidance and Distress Scale)[11] are extensive and more applicable to monitoring outcome than to screening.

TABLE 4
Obstacles to Effective Treatment of Social Phobia

- Patient avoids treatment because of fear, shame or stigma.
- Screening devices for assessing social phobia are unavailable.
- Assessment and treatment are misdirected toward specific symptoms (e.g., somatic complaints) or comorbid conditions (e.g., depression, substance use problems) rather than toward the social phobia syndrome.
- Affordable and expert care is unavailable.
- Physician or patient lacks knowledge about effective treatment options.
- Patient or physician trivializes phobia or views it as characterologic and unchangeable (e.g., patient is "just shy").

In the absence of a brief yet thorough instrument for detecting social phobia, family physicians can improve detection by adding selected questions to their existing screening instrument. In a recent study of 9,375 managed care patients, the following yes-or-no statements were sensitive to detecting 89 percent of social phobia cases: (1) being embarrassed or looking stupid are among my worst fears; (2) fear of embarrassment causes me to avoid doing things or speaking to people; (3) I avoid activities in which I am the center of attention. Positive responses can be followed up to determine whether the phobia is a problem for which the patient desires treatment.
A number of obstacles to prompt recognition and effective treatment have been identified (Table 4). When these obstacles are overcome, social phobia is responsive to specific pharmacologic and psychologic interventions.

Pharmacologic Treatments

It is important to distinguish between the circumscribed and generalized types of social phobia before initiating pharmacotherapy, because the circumscribed type has responded to an "as-needed" schedule (typically of beta blockers), whereas the generalized type has responded better to standing dosage schedules (typically of specific antidepressants) of at least three months' duration. Although the outcome literature supports the efficacy of several agents, it does not indicate a clearly superior one. Treatment selection therefore involves matching the individual patient's preferences, symptoms and treatment goals with the relative benefits and risks of the following treatment options.

Monoamine Oxidase Inhibitors

The monoamine oxidase inhibitors (MAOIs) have performed well in clinical trials for treatment of generalized social phobia. Phenelzine (Nardil), in particular, has been tested extensively in placebo-controlled studies.[12,14] Open and controlled trials suggest that approximately two thirds of patients will show clinically significant improvement during acute treatment with these agents.

The MAOIs have restrictions and adverse-effect risks that should be considered during treatment planning. The required lowtyramine diet, which prohibits many popular foods (Table 5), will deter some patients from accepting therapy with MAOIs.

Patients risk a potentially fatal hypertensive reaction if they do not comply with the diet. Common adverse effects at therapeutic dosages (usually 45 to 90 mg per day for phenelzine) include postural hypotension, sedation, sexual dysfunction and weight gain. Some common over-the-counter medications, such as cold and cough remedies, are contraindicated in patients using MAOIs. Reversible MAOIs such as moclobemide, which do not require dietary restrictions, showed promise in early trials[15] but mixed results in more recent ones,[16,17] and to date they are not available in the United States.

The advantages and disadvantages of MAOI therapy for social phobia are summarized in Table 6. Although their advantages have led many to consider MAOIs an

TABLE 5
Food Restrictions During Monoamine Oxidase Inhibitor Therapy

Foods to be avoided

- Cheese (except for cream cheese, cottage cheese and American processed cheese)
- Broad (fava) bean pods
- Aged overripe fruit (e.g., bananas)
- Pickled herring, anchovies, sardines
- Salami, sausage, pepperoni, bologna, liver, Spam, canned ham; any smoked, pickled or fermented meat, fish or protein product
- Chianti and other red wines, sherry, vermouth, liqueurs, tap or draft beer
- Monosodium glutamate
- Sauerkraut
- Yeast extracts
- Meat extracts

Foods to be used in moderation

- White wine, ale, bottled beer, foods cooked in wine
- Soy sauce
- Soybean paste (tofu)
- Chocolate
- Yogurt
- Raspberries
- Cream cheese, cottage cheese,
- American processed cheese
- Avocado
- Foods and beverages that contain aspartame

appropriate first-line treatment, their disadvantages have prompted others to relegate them to a second-line position behind the newer antidepressants.[18]

Selective Serotonin Reuptake Inhibitors

Several studies support the efficacy of selective serotonin reuptake inhibitors (SSRIs), including large controlled trials of paroxetine (Paxil)[19,20] and fluvoxamine (Luvox)[21]; smaller controlled trials of sertraline (Zoloft)[23] [22] and fluvoxamine and, most recently, an open, uncontrolled trial of citalopram (Celexa).[24] As a group, SSRIs have shown acute-treatment improvement rates ranging from 50 to 75 percent of patients. Relatively safe and well tolerated, SSRIs are currently considered an appropriate first-line consideration. The advantages and disadvantages of SSRI therapy for social phobia are shown in Table 6.

SSRIs and monoamine oxidase inhibitors have been shown to be effective in the treatment of generalized social phobia.

Benzodiazepines

The benzodiazepines are fast-acting, well-tolerated anxiolytics that have shown efficacy in the acute treatment of social phobia, but they have also revealed some significant drawbacks related primarily to difficulties with discontinuation. Controlled studies of alprazolam (Xanax)[12] and clonazepam (Klonopin)[25] report acute-treatment improvement rates ranging from approximately 40 to 80 percent, with clonazepam showing more favorable results. However, standing dosages are sometimes difficult for patients to taper and discontinue without symptomatic worsening and a high risk of acute relapse.[12]

When used in low doses on an as-needed basis, beta blockers appear to be a clinically effective treatment for mild to moderate circumscribed performance anxiety.

Because of their ability to produce physical dependence, benzodiazepines must be used with caution in patients with a history of substance abuse, a condition often associated with social phobia. When these drugs are used as needed in performancerelated situations, sedation and psychologic reliance can develop. Given those risks, benzodiazepines are considered for use in patients with a low risk for substance abuse who are unresponsive to alternative treatments. The most common use of these agents, however, is in lowdose therapy (e.g., 0.25 to 0.5 mg of clonazepam twice a day) for initial symptom relief in conjunction with an antidepressant, psychotherapy, or both. The advantages and disadvantages of benzodiazepine therapy for social phobia are shown in Table 6.

Beta-Adrenergic

Blockers Treatment studies of beta blockers for social phobia show mixed results. Controlled trials using standing dosages for generalized social phobia have been discouraging.[13,26] Beta blockers such as propranolol (Inderal) appear to be clinically effective when used in low doses (10 to 40 mg for propranolol) on an as-needed basis for mild to moderate circumscribed performance anxiety. Risk of chronic overuse suggests that these drugs should be used only intermittently until the patient's confidence in performance situations is restored. Except for use in circumscribed social phobia, beta blockers lack consistent empiric support to recommend them as a first-line treatment for generalized social phobia. The advantages and disadvantages of beta blockers for social phobia, including important contraindications, are shown in Table 6.

Other Agents

A recent initial controlled trial of gabapentin (Neurontin) reported that it produced a significant reduction in social phobia symptoms compared to placebo.[27] An open trial of

TABLE 6

Selected Advantages and Disadvantages of Major Treatment Modalities for Social Phobia

	CBT	SSRIs	MAOIs	BZDs	Beta blockers
Advantages					
Established efficacy	X	X	X	X	X*
Maintenance of gains	X				
Antidepressant effects		X	X		
Favorable side effect profile	X	X		X	X
Non habitforming	X	X	X		X
Generic form available			X	X	X
Disadvantages					
Delayed onset	X	X	X		
Contraindications					X†
Dependence / abuse				X	
Withdrawal syndrome		X		X‡	
Sedation		X‡		X	X‡
Orthostatic hypotension			X		
Dietary restrictions			X		
Sexual dysfunction		X	X	X	X
Weight gain		X‡	X		
Multiple dosing / sessions	X		X	X	
High cost	X	X‡			
Limited availability	X				

CBT = cognitive behavior therapy; SSRI = selective serotonin reuptake inhibitors; MAOIs = monoamine oxidase inhibitors; BZDs = benzodiazepines. *--As-needed use for specific social/performance fears. †--Contraindications include asthma, sinus bradycardia and greater than first-degree heart block, cardiogenic shock and some cases of congestive heart failure.

‡--In some cases.

nefazodone (Serzone) reported that 70 percent of 23 participants showed improvement.[28] Although initial open trials of buspirone (Buspar)[29,30] looked promising, a recent controlled study found no significant differences between this drug and placebo.[31] Results of a recent open trial suggest that buspirone may be useful in augmenting partial response to an SSRI.[32]Although the tricyclic antidepressant imipramine (Tofranil) has performed well in some case reports, larger trials have not supported its efficacy in treating social phobia.[33] Agents such as bupropion (Wellbutrin) and clonidine (Catapres) have yet to be investigated outside of case reports and clinical anecdotes. Common therapeutic dosage ranges and cost estimates for the evidenced-based options discussed in this section are given in Table 7.

Psychotherapeutic Interventions

General supportive psychotherapy has not been found to be as useful in treating social phobia as more directive therapies focused on reducing anxiety by reducing avoidance. Social phobia has been particularly responsive to behavioral and cognitive behavioral therapy involving the use of exposure (gradual reentry into feared situations). Cognitive behavioral therapy is a multicomponent treatment that typically is tailored to patients based on their presenting features (Table 3). It is conducted in individual or (preferably) group formats and usually lasts for 16 to 24 sessions. Components of cognitive behavioral therapy for social phobia often include symptom management skills, social skills training, cognitive restructuring aimed at changing patients' anxious thought processes, and exposure (Table 8).

Patients with social phobia who have been treated with cognitive behavior therapy experience significantly less relapse than those treated only with pharmacotherapy.

Approximately 20 controlled studies have examined various components of behavioral and cognitive behavioral interventions for social phobia. Results indicate that cognitive behavioral therapy involving exposure and focusing on changing phobic thinking can benefit as many as 75 percent of patients.[34] Evidence suggests that treatment gains made during cognitive behavioral therapy generally endure after treatment is discontinued.[35] Initial comparative data show that relapse rates after discontinuation of cognitive behavioral therapy are significantly less (range: zero to 17 percent) than those following discontinuation of effective pharmacotherapy (~50 percent).[36] Taken together, the study data support the use of cognitive behavioral therapy as a first-line consideration in the treatment of social phobia. Whether the common clinical practice of combining pharmacotherapy and cognitive behavioral therapy provides any benefit over either modality alone or for specific subgroups (e.g., the severely symptomatic) awaits direct study.

TABLE 7
Drugs Used in Treating Social Phobia

Drugs	Dosage*	Cost (generic)†
MAOIs Phenelzine (Nardil)	45 to 90 mg per day	$1.50
Tranylcypromine (Parnate)	40 to 60 mg per day	2.00
SSRIs Fluoxetine (Prozac)	10 to 100 mg per day	2.50 (1.50)
Paroxetine (Paxil)	20 to 60 mg per day	2.00
Sertraline (Zoloft)	50 to 200 mg per day	2.50
Fluvoxamine (Luvox)	50 to 150 mg per day	2.50
Citalopram (Celexa)	40 mg per day	2.00
Benzodiazepines Alprazolam (Xanax)	2 to 10 mg per day	2.00 (1.50 to 2.00)
Lorazepam (Ativan)	2 to 6 mg per day	1.50 (.85 to 1.00)

Clonazepam (Klonopin)	1 to 3 mg per day	0.50 (0.75 to 1.00)
Nonbenzodiazepine, azaspirone Buspirone (Buspar)	35 to 60 mg per day	4.50
Beta blockers 12 Propranolol (Inderal)	40 mg as needed	0.50 (0.20 to 0.40)
Nadolol (Corgard)	40 to 80 mg as needed	1.50 (1.00 to 1.50)
Atenolol (Tenormin)	50 to 100 mg as needed	1.00 (0.50 to 1.00)

MAOIs = monoamine oxidase inhibitors; SSRIs = selective serotonin reuptake inhibitors.
*--Dosages as used in trials for treatment of social phobias may vary somewhat from dosage ranges listed in
Physicians' Desk Reference (PDR) for treatment of panic disorder and depression.
†--Estimated cost to the pharmacist based on average wholesale prices (rounded to the nearest half dollar) for one day of treatment at the lowest dosage level in Red book. Montvale, N.J.: Medical Economics Data, 1999. Cost to the patient will be greater, depending on prescription filling fee.

The average cost of 16 to 24 weekly sessions of cognitive behavioral therapy ($750 to $2,000, depending on the type of provider) can be prohibitive for some patients, although most third-party payers cover 50 to 80 percent of costs when the therapy is delivered by a licensed professional. Specialized training is required for cognitive behavioral therapy, limiting its availability. The Anxiety Disorders Association of America (ADAA; www.adaa. com; 301-231-9350) can help patients or physicians to identify qualified cognitive behavioral therapy providers in their area. Advantages and disadvantages of cognitive behavioral therapy are summarized in Table 6.

Treatment Selection

Relapse after discontinuation of cognitive behavioral therapy is significantly less than after discontinuation of effective pharmacotherapy.

Treatment planning should be done after the benefits and risks of treatment options have been discussed with the patient. Considerations in treatment planning should include the patient's preference, the severity of presenting symptoms, the degree of functional impairment, psychiatric and substance-related comorbidity, and long-term treatment goals. To date, there is no empirically derived algorithm for the treatment of social phobia, although evidence-based options include cognitive behavioral therapy, pharmacotherapy, or both. Expert consensus guidelines[18] are consistent with consideration of cognitive behavioral therapy alone for mild to moderate cases and combined cognitive behavioral therapy and pharmacotherapy (e.g., paroxetine) for moderate to severe cases of generalized social phobia. Time-limited use of low-dose benzodiazepine therapy (e.g., clonazepam) may help with initial symptom relief until slowreacting pharmacotherapy or cognitive behavioral therapy takes effect. For circumscribed social phobia, cognitive behavioral therapy with or without initial as-needed use of beta blockers is supported.

TABLE 8
Components of Cognitive Behavior Therapy for Social Phobia

Anxiety management skills
May involve controlled breathing, relaxation and other calming techniques

Social skills training
May involve verbal and nonverbal skills that facilitate social effectiveness, such as initiating and maintaining conversation, making appropriate eye contact and asserting oneself appropriately

Cognitive restructuring
Involves learning to identify, challenge and change fearful thinking that overestimates social threat, underestimates one's ability to manage social demands and catastrophizes the consequences of social miscues

Gradual exposure to feared situations
Involves gradual reentry into feared social situations to reduce the anxiety that they engender

Some form of gradual reentry into feared situations should be a part of every treatment plan for social phobia, particularly because evidence is emerging that it may facilitate longer-term gains. Clinical experience also suggests that although many patients respond to acute treatment and maintain those gains over the long term, those who do not may need some form of continuing therapy involving pharmacotherapy and/or cognitive behavioral therapy to optimally restore or maintain gains. Whatever options are selected, patients should be educated about the phobia, reassured of their normalcy and instilled with a realistic hope of recovery. The role of the family physician in the management of social phobia is summarized in Table 9.

TABLE 9
Role of the Family Physician in the Management of Social Phobia

Identify the syndrome through screening and assessment.
Educate the patient about the disorder (e.g., it is common and responsive to treatment).
Educate the patient about the benefits and risks of available treatment options (pharmacologic and psychologic).
Initiate and manage indicated pharmacotherapy or make a referral to a psychiatrist specializing in anxiety disorders.
Make a referral to or work in conjunction with a specialist in cognitive behavioral therapy.
Provide support and instill hope.

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