Clinical review

Social phobia: epidemiology, recognition, and treatment

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Fear of being stared at is common to most animals, including humans. Normal social discourse involves being under the gaze of strangers, friends, and colleagues—interactions that are usually navigated without conscious thought.

Most people admit to social discomfort while under public scrutiny—for example, before performing in public.[1] Social phobia, however, is the excessive fear that a performance or social interaction will be inadequate, embarrassing, or humiliating—people with social phobia avert their gaze from their interlocutors and often avoid a feared social setting.

Social phobia is a poorly investigated and misunderstood condition.[2] The resulting disability severely impairs educational attainment and gainful productivity. Unless the disorder is accurately diagnosed and promptly treated, a burden is placed on society.

This review examines the epidemiology, recognition, and treatment of this debilitating condition. It is based on articles selected (in December 1995 and January 1996) from the full Medline database. The term "phobic-disorder$ or social adj phobi$" was used to find review articles newer than 1992 and published in English. This search retrieved approximately 70 citations; these were supplemented by papers from my own collection.

Summary points

- Social phobia is probably underreported in the general population
- Patients may delay seeking help, leading to a high prevalence of comorbidity and increased risk of suicide. The functional disability raises the cost to society
- Accurate diagnosis of social phobia depends on careful attention to the patient's history and application of DSM-IV criteria
- The causes of the disease have still to be fully elucidated; a combination of biological and psychological factors seem to be involved
- Clear guidelines for the management of social phobia have not been established—too few studies have been published to clarify the roles of pharmacotherapy and psychotherapy
- Selective serotonin reuptake inhibitors, which have already proved their worth in depressive and anxiety disorders, are a promising treatment, and cognitive-behavioural therapy may benefit some patients

Epidemiology

Social phobia is common in the general population. A review of epidemiological studies found that the lifetime prevalence of social phobia in adults varied between 2% and 5%[3] (fig 1) with a female:male ratio of 2.5:1.[2] Patients may not consult their family doctor until they have had the condition for many years.[2] The chronic course increases the risk of comorbid conditions, which may mask the social phobia.[4 5]

In children and adolescents the prevalence of social phobia is 0.9%-1.1%.[3] The lifetime prevalence of simple phobia and social phobia in young adults (mean age 18 years) was found to be 23%; about half met the criteria for social phobia only.[6]

The lifetime prevalence of social phobia in published surveys of adults ranges from 0.4% in a rural Taiwanese village to 16% in the Basle epidemiological study.[7 8] Differences in patient selection, age range, culture, or survey methodology may explain some of the variation. The surveys that found the highest rates in adults (Basle and the American national comorbidity study[9]) used the criteria of the composite international diagnostic interview and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R); however, when *International Classification of Diseases* (ICD-10) criteria were applied in the Basle study, only 9.6% of subjects were diagnosed as having social phobia,[8] suggesting that the DSM-III-R criteria were more sensitive.[3] It is not known why the prevalence rates were lower in the surveys conducted in southeast Asia (0.4-0.6%).[7 10]

Defining and diagnosing social phobia

Both the updated DSM (DSM-IV) and the ICD-10 criteria state that social phobia is a separate phobia involving marked fear or anxiety of behaving in an embarrassing or humiliating manner while under the gaze of other people, which then leads to avoidance of the situations that stimulate this fear.[3 11] To aid the differential diagnosis of social phobia, I used the DSM-IV criteria for social phobia (table 1) in preference to ICD-10 criteria.

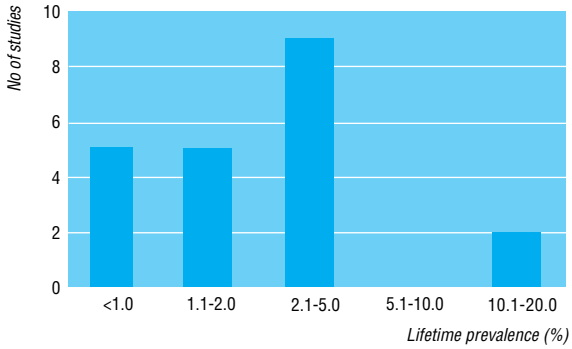

Fig 1 Lifetime prevalence (% of general population) of social phobia reported in published surveys

Obtaining a clear history from the patient may be delayed by the patients' fear of social interaction.[12] Social phobia and agoraphobia (often a comorbid condition) have a feature in common—namely, avoidance of specific social situations—but careful questioning (such as, "Could you go to a busy shopping complex without talking to anyone?") will help to clarify the diagnosis. The person with social phobia will reply affirmatively whereas the person with agoraphobia will be negative and fearful about becoming stranded or forced to make a speedy and embarrassing exit.[2 11]

Other conditions from which social phobia should be distinguished are panic disorder, separation anxiety (in children), atypical depression, and avoidant personality disorder, which lies at the extreme end of the spectrum that includes shyness and social phobia.[11 13]

Clinical characteristics

Social phobia is more than just shyness—everyday social situations which are readily negotiated by most people can provoke extreme fear and anxiety in others. The severe nature of the phobia causes considerable disruption to patients' normal functioning and personal relationships.[3 4 11 14]

Most commonly, onset is in childhood, often in children under 5, and there is another high risk period at puberty.[11] The onset may abruptly follow a stressful or humiliating experience, or it may be insidious.[6 11]

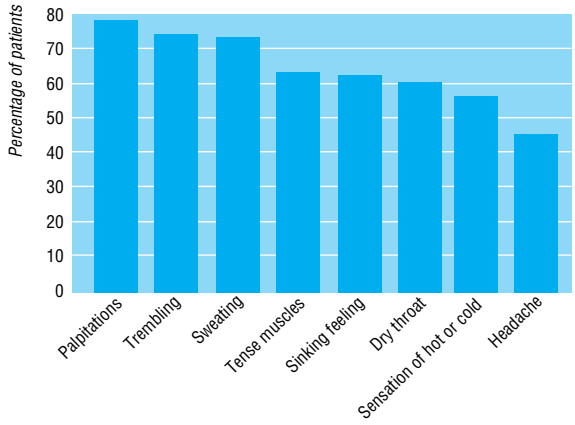

Fig 2 Physical symptoms reported by patients with social phobia. Adapted from Amies et al[15]

The course of the disease is lifelong and unremitting unless treated.

Social phobia may be discrete (limited to a few social or performance situations) or generalised (associated with most social locations). Conversing or speaking in small social groups, speaking to strangers or meeting new people, and eating in public places are common anxiety provoking events.

The physical symptoms experienced by people with social phobia when they anticipate, or are placed in, a stressful social situation are appropriate to a fear response. Palpitations, trembling, and sweating are the most common symptoms (fig 2).[15]

Aetiology

The causes of social phobia are multiple, involving genetic and developmental factors and later life experiences. Family and twin studies show a tendency for social phobia to be inherited.[5]

Developmentally, fear of strangers begins as early as 7 months in babies.[11] Children who are behaviourally inhibited at 21-31 months have an increased risk of future childhood anxiety disorders, phobias, and panic disorders.[16] They may be born with a lower threshold for arousal to unexpected or novel stimuli and have difficulty assimilating such stimuli.[17] Social phobia may be triggered if this genetically derived psychological "template" is coupled with chronic exposure to an environmental stressor in early life (for example, death of or separation from a parent). These key early experiences are maintained in the symptomatology of social phobia.[17]

Differential diagnosis of social phobia (abbreviated from DSM-IV)

- Marked, persistent fear of one or more social or performance situations in which the patient is exposed to strangers or possible scrutiny by others. The person fears that he or she will act in a humiliating or embarrassing manner. (Note: In children, there must be the capacity for age-appropriate social interaction with familiar people; the anxiety must occur in peer settings, not just with adults.)
- Exposure to the feared social situation almost invariably provokes anxiety in the form of a situationally related panic attack. (Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.)
- The patient has insight that the fear is excessive and unreasonable. (Note: This feature may be absent in children.)
- The patient avoids the feared situation or endures the situation with intense anxiety or distress.
- The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with everyday routine and activities (occupational or social), or there is marked distress about having the phobia.
- In people aged under 18 years, the duration is at least six months.
- The fear or avoidance is not due to the direct physiological effects of a substance (for example, drug misused or taken for treatment) or a general medical condition or another mental disorder (panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, pervasive developmental disorder, or schizoid personality disorder, etc).
- If a general medical condition or another mental disorder is present, the fear criterion is not related to it (for example, not a fear of stuttering, parkinsonian tremble, or exhibiting an abnormal eating disorder).
- If the fears include most social situations, also consider additional diagnosis of avoidant personality disorder).

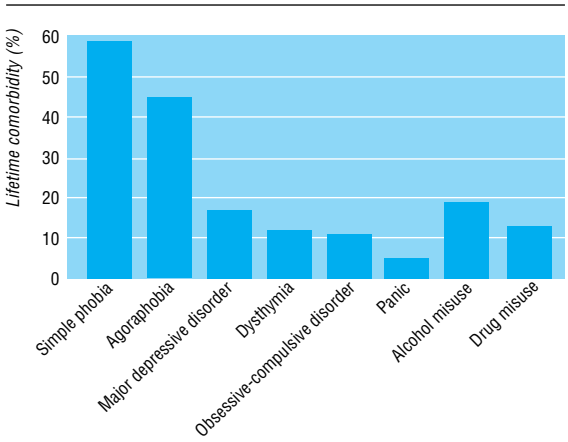

Fig 3 Lifetime prevalence (lifetime rates per 100, base n=361) of comorbidity in social phobia. Adapted from Schneier et al[4]

Comorbidity

In clinical and community populations, social phobia has been shown to be strongly associated with other anxiety disorders, substance abuse, and affective disorders. On average, 80% of people with social phobia met the diagnostic criteria for another lifetime condition, suggesting that comorbidity tends to be the rule rather than the exception.[5]

Anxiety disorders were most often associated with social phobia (about 50% of subjects), followed by major depressive disorder (20%) and alcohol abuse (15%).[5] These figures agree with those from an American analysis of four epidemiological catchment area sites involving 361 patients with social phobia diagnosed by DSM-III-R criteria (fig 3).[4]

Management options

There are no precise clinical guidelines for the management of social phobia because much information is lacking about the role both of pharmacological and non-pharmacological strategies.[18] Data on effective dosages, optimal duration of treatment, response rates, and relapse rates are still required from controlled pharmacological studies. In addition, the role of combined or sequential psychotherapeutic and pharmacological treatment has still to be clarified.[19]

Pharmacological approaches

The psychopharmacological treatment of social phobia has become established only in the past decade. Currently, the most interesting drug class to be investigated is the selective serotonin reuptake inhibitor group, for which there is growing support.[20] Other options include monoamine oxidase inhibitors, tricyclic agents, benzodiazepines, and β blockers.[21]

Selective serotonin reuptake inhibitors

Data for individual selective serotonin reuptake inhibitors are limited, but promising results have been found in case reports and small scale trials (table 2).[21-27] These drugs may be effective and well tolerated when used for depression[28 29] and panic disorder,[30 31] both of which may be comorbid with social phobia.

Tricyclic agents

Commentators have indicated that tricyclic antidepressants are useful for a range of anxiety disorders including social phobia,[32] but these drugs may be more appropriate for agoraphobia, panic disorder, or obsessive-compulsive disorder.[33] Open studies suggested a good response with clomipramine, a non-selective serotonin reuptake inhibitor.[34 35] It was more effective than diazepam in a double blind trial in patients with agoraphobia or social phobia.[36]

Monoamine oxidase inhibitors

Recent, well designed studies have shown a better response in patients with social phobia treated with phenelzine (an irreversible monoamine oxidase inhibitor) than with alprazolam or atenolol.[37 38] Previous studies with phenelzine suffered from methodological problems, making interpretation of the results difficult.[39]

Reversible monoamine oxidase inhibitors, such as brofaromine and moclobemide, do not exhibit the tyramine pressor effect seen with older monoamine oxidase inhibitors. Moclobemide, phenelzine, and brofaromine seem to be comparable in terms of improved scores on the Liebowitz social anxiety scale and Hamilton anxiety scale.[40]

Benzodiazepines

Clonazepam and alprazolam have been evaluated in a few open studies and found to be effective in social phobia.[41] In controlled trials, clonazepam was significantly superior to placebo,[42] while alprazolam was inferior to phenelzine.[37] Larger trials should be performed to confirm these findings.

Benzodiazepines have a strong sedative effect and it is not clear whether their putative efficacy in social phobia is due to sedation or to true anxiolysis. Long term use may lead to dependency.

Table 1 Summary of effect of selective serotonin reuptake inhibitors in patients with social phobia

Type of study	No of patients	Outcome
Paroxetine		
12 Week, open study	18	Paroxetine produced an 83% response (15 patients), assessed by a moderate to marked symptomatic improvement on the Liebowitz social phobia scale
11 Week, forced escalation, open study	37	23 of 30 patients who completed the study (77%) were "much" or "very much" improved on the clinical global impression scale. Reductions from baseline to week 11 were 35.5 (SD13.1) *v* 19.7 (17.4) (P<0.0005) on the Duke social phobia scale and 75.1 (25.4) *v* 37.2 (32.5) (P<0.0005) on the Liebowitz social phobia scale
Fluoxetine		
Open study	10	Five patients were "much improved" or "better"
Open study	14	10 Patients had a moderate to marked improvement
Open study	13	10 Patients had a moderate to marked improvement independent of changes on the Beck depression Inventory
Fluvoxamine		
12 Week, double blind, placebo controlled study with 12 week follow up	30	Fluvoxamine was significantly better than placebo on symptom checklist 90 (P<0.05) and superior to placebo on social anxiety item of social phobia scale. Further improvements observed during follow up period

In a retrospective review of the use of medical services and treatment for anxiety disorders in 100 patients (28 with social phobia), benzodiazepines seem to have been overprescribed.[43]

β Blockers

β Blockers may alleviate anxiety as a secondary consequence of the reduction in autonomic symptoms (tremors, palpitations). These drugs have been effective in the short term for performance anxiety,[21 44 45] but longer term studies are needed. Despite promising early work with atenolol,[46] subsequent investigations established that β blockers were of limited use in generalised social phobia.[21]

Alcohol

Many people with social phobia use alcohol to reduce anxiety before attending social events. There is an added danger of excessive sedation if the individual is also taking a benzodiazepine or the possibility of a hypertensive crisis with concurrent use of older monoamine oxidase inhibitors. For such patients, a selective serotonin reuptake inhibitor may be the drug of first choice.[50]

Non-pharmacological approaches

The biological and psychological factors underlying social phobia may be interdependent. Recognising the psychodynamic themes (feelings of shame and guilt and separation anxiety) behind patients' social anxiety can be an aid to tailoring treatment.[17] An integrated treatment strategy might include drug therapy, behavioural techniques, and dynamic psychotherapy.[47]

Cognitive-behavioural therapy

Cognitive-behavioural therapy aims to help people to overcome anxiety reactions in social and performance situations and to alter the beliefs and responses that maintain this behaviour. One type of treatment, cognitive-behavioural group therapy, is given in 12 weekly sessions, each lasting about two and a half hours. It has six elements: cognitive-behavioural explanation of social phobia; structured exercises to recognise maladaptive thinking; exposure to simulations of situations that provoke anxiety; cognitive restructuring sessions to teach patients to control maladaptive thoughts; homework assignments in preparation for real social situations; and a self administered cognitive restructuring routine.[48]

A comprehensive critique of cognitive-behavioural therapy found that cognitive techniques seemed to enhance behavioural procedures; cognitive-behavioural group therapy was associated with long term benefit in moderately impaired patients and compared well with pharmacological treatment (phenelzine, alprazolam).[19] Group therapy has been shown to be an effective treatment of social phobia in comparison with control groups or pill placebo.[13 48]

Other techniques

Social skills training and relaxation training have been used in the treatment of social phobia. The reported outcomes do not provide convincing evidence of a specific anxiolytic effect in social situations.[13]

Impact of comorbidity on treatment strategies

Comorbidity may reflect a more severe psychopathology, with more disability and impaired functioning than in the absence of comorbidity. This may create the expectation of a more difficult treatment course and a less favourable outcome, resistance to treatment, the need to treat each disorder effectively, and extended or long term maintenance treatment to prevent relapse.[49]

Empirically, there are four general considerations for dealing with comorbid disorders: tailor treatment to individual patients; use monotherapy in preference to polypharmacy, provided that the chosen drug is effective in both disorders and the comorbid disorder is secondary to the social phobia; consider compatible drugs for some patients; and administer a combination of psychotherapy and pharmacotherapy.[49] Social phobia comorbid with alcoholism is a special case because of the risk of excessive sedation with concomi-

Treatment scheme for comorbid conditions

	Suggested treatment		
Disorder	**One drug for both disorders**	**One drug per disorder**	**Combined approach**
Social phobia and major depression	SSRI or MAOI		
Social phobia and panic disorder	SSRI, MAOI, or benzodiazepine		
Social phobia and obsessive-compulsive disorder		Clonazepam for social phobia, clomipramine for obsessive-compulsive disorder	SSRI, clomipramine, or MAOI and behaviour therapy
Social phobia and alcoholism		SSRI for social phobia, disulfiram for alcohol abuse	SSRI, disulfiram, and Alcoholics Anonymous
Social phobia with no comorbidity			SSRI, MAOI, or benzodiazepine (with or without cognitive-behavioural therapy)

Based on Rosenbaum and Pollock[49] and Jefferson.[20] SSRI = selective serotonin reuptake inhibitor; MAOI = monoamine oxidase inhibitor.

tant medication (benzodiazepines, for example), and patients should be carefully questioned about their use of alcohol, as well as the amount and the pattern of intake.[50] The box shows a treatment scheme.

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A patient who changed my practice

The importance of touch

In a busy neurosurgical practice the patients are presented by the residents after examination. Often the diagnosis is apparent, as in the case of the 80 year old woman who had severe trigeminal neuralgia and who came from a remote village in south India. From the way she walked in, guarded her face against the fan breeze, and showed painful spasms of the face, the diagnosis was clear. I explained the disease to the woman and suggested a trial of medicines before we thought about any surgical intervention.

As I handed over the prescription she had a strange, sad look on her face and, while taking the prescription in her hand, she observed that this was not going to help her. I was rather surprised, and began to explain that the drug was very useful for her condition. She cut me short and exclaimed that I had not placed my hand on her, touched her, or examined her. How could any drug or treatment be effective without the healing touch of a doctor? I was humbled at the great faith of this old woman and realised the error in my approach. My apologies were brushed aside and after I examined her pulse, she left with a smile.

Since that day I have understood the faith that patients in India have in the healing touch and I never fail to touch and examine them and whenever feasible give them a gentle pat on shoulder in a gesture of reassurance.

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