

05 - 9.5 Social Anxiety Disorder (Social Phobia)

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9.5 Social Anxiety Disorder (Social Phobia)

Social anxiety disorder (also referred to as social phobia) involves the fear of social situations, including situations that involve scrutiny or contact with strangers. The term social anxiety reflects the distinct differentiation of social anxiety disorder from specific phobia, which is the intense and persistent fear of an object or situation. Persons with social anxiety disorder are fearful of

embarrassing themselves in social situations (i.e., social gatherings, oral presentations, meeting new people). They may have specific fears about performing specific activities such as eating or speaking in front of others, or they may experience a vague, nonspecific fear of “embarrassing oneself.” In either case, the fear in social anxiety disorder is of the embarrassment that may occur in the situation, not of the situation itself. **EPIDEMIOLOGY** Various studies have reported a lifetime prevalence ranging from 3 to 13 percent for social anxiety disorder. The 6-month prevalence is about 2 to 3 per 100 persons (Table

9.5-1). In epidemiological studies, females are affected more often than males, but in clinical samples, the reverse is often true. The reasons for these varying observations are unknown. The peak age of onset for social anxiety disorder is in the teens, although onset is common as young as 5 years of age and as old as 35 years. **Table 9.5-1 Lifetime Prevalence Rates of Social Anxiety Disorder** **COMORBIDITY** Persons with social anxiety disorder may have a history of other anxiety disorders, mood disorders, substance-related disorders, and bulimia nervosa. **ETIOLOGY** Several studies have reported that some children possibly have a trait characterized by a consistent pattern of behavioral inhibition. This trait may be particularly common in the children of parents who are affected with panic disorder, and it may develop into severe shyness as the children grow older. At least some persons with social anxiety disorder may have exhibited behavioral inhibition during childhood. Perhaps associated with this trait, which is thought to be biologically based, are the psychologically based data indicating that the parents of persons with social anxiety disorder, as a group, were less caring, more rejecting, and more overprotective of their children than were other parents. Some social anxiety disorder research has referred to the spectrum from dominance to submission observed in the animal kingdom. For example, whereas dominant humans may tend to walk with their chins in the air and to make eye contact, submissive humans may tend to walk with their chins down and to avoid eye contact. **Neurochemical Factors**

The success of pharmacotherapies in treating social anxiety disorder has generated two specific neurochemical hypotheses about two types of social anxiety disorder. Specifically, the use of β -adrenergic receptor antagonists—for example, propranolol (Inderal)—for performance phobias (e.g., public speaking) has led to the development of an adrenergic theory for these phobias. Patients with performance phobias may release more norepinephrine or epinephrine, both centrally and peripherally, than do nonphobic persons, or such patients may be sensitive to a normal level of adrenergic stimulation. The observation that MAOIs may be more effective than tricyclic drugs in the treatment of generalized social anxiety disorder, in combination with preclinical data, has led some investigators to hypothesize that dopaminergic activity is related to the pathogenesis of the disorder. One study has shown significantly lower homovanillic acid concentrations. Another study using SPECT demonstrated decreased striatal dopamine reuptake site density. Thus, some evidence suggests dopaminergic dysfunction in social anxiety disorder. **Genetic Factors** First-degree relatives of persons with social anxiety disorder are about three times more likely to be affected with social anxiety disorder than are first-degree relatives of those without mental disorders. And some preliminary data indicate that monozygotic twins are more often concordant than are dizygotic twins, although in social anxiety disorder, it is particularly important to study twins reared apart to help control for environmental factors. **DIAGNOSIS AND CLINICAL FEATURES** The DSM-5 diagnostic criteria for social anxiety disorder is listed in Table 9.5-2. The clinician should recognize that at least some degree of social anxiety or selfconsciousness is common in the general population. Community studies suggest that roughly one-third of all persons consider

themselves to be far more anxious than other people in social situations. Moreover, such concerns may appear particularly heightened during certain developmental stages, such as adolescence, or after life transitions, such as marriage or occupation changes, associated with new demands for social interaction. Such anxiety only becomes social anxiety disorder when the anxiety either prevents an individual from participating in desired activities or causes marked distress during such activities. DSM-5 also includes a performance only diagnostic specifier for persons who have extreme social phobia specifically about speaking or performing in public. Table 9.5-2 DSM-5 Diagnostic Criteria for Social Anxiety Disorder

Ms. B was a 29-year-old computer programmer who presented for treatment after she was offered promotion to a managerial position at her firm. Although she wanted the raise and the increased responsibility that would come with the new job, which she had agreed to try on a probationary basis, Ms. B reported that she was reluctant to accept the position because it required frequent interactions with employees from other divisions of the company, as well as occasional public speaking. She stated that she had always felt nervous around new people, whom she worried would ridicule her

for “saying stupid things” or committing social faux pas. She also reported feeling “terrified” to speak before groups. These fears had not previously interfered with her social life and job performance. However, since starting her probationary job, Ms. B reported that they had become problematic. She noted that when she had to interact with others, her heart started racing, her mouth became dry, and she felt sweaty. At meetings, she had sudden thoughts that she would say something very foolish or commit a terrible social gaffe that would cause people to laugh. As a consequence, she had skipped several important meetings and left others early. (Courtesy of Erin B. McClure-Tone, Ph.D., and Daniel S. Pine, M.D.)

DIFFERENTIAL DIAGNOSIS Social anxiety disorder needs to be differentiated from appropriate fear and normal shyness, respectively. Differential diagnostic considerations for social anxiety disorder are agoraphobia, panic disorder, avoidant personality disorder, major depressive disorder, and schizoid personality disorder. A patient with agoraphobia is often comforted by the presence of another person in an anxiety-provoking situation, but a patient with social anxiety disorder is made more anxious by the presence of other people. Whereas breathlessness, dizziness, a sense of suffocation, and a fear of dying are common in panic disorder and agoraphobia, the symptoms associated with social anxiety disorder usually involve blushing, muscle twitching, and anxiety about scrutiny. Differentiation between social anxiety disorder and avoidant personality disorder can be difficult and can require extensive interviews and psychiatric histories. The avoidance of social situations can often be a symptom in depression, but a psychiatric interview with the patient is likely to elicit a broad constellation of depressive symptoms. In patients with schizoid personality disorder, the lack of interest in socializing, not the fear of socializing, leads to the avoidant social behavior.

COURSE AND PROGNOSIS Social anxiety disorder tends to have its onset in late childhood or early adolescence. Existing prospective epidemiological findings indicate that social anxiety disorder is typically chronic, although patients whose symptoms do remit tend to stay well. Both retrospective epidemiological studies and prospective clinical studies suggest that the disorder can profoundly disrupt the life of an individual over many years. This can include disruption in school or academic achievement and interference with job performance and social development.

TREATMENT Both psychotherapy and pharmacotherapy are useful in treating social anxiety disorder. Some studies indicate that the use of both pharmacotherapy and psychotherapy produces better results than

either therapy alone, although the finding may not be

applicable to all situations and patients. Effective drugs for the treatment of social anxiety disorder include (1) SSRIs, (2) the benzodiazepines, (3) venlafaxine (Effexor), and (4) buspirone (BuSpar). Most clinicians consider SSRIs the first-line treatment choice for patients with more generalized forms of social anxiety disorder. The benzodiazepines alprazolam (Xanax) and clonazepam (Klonopin) are also efficacious in social anxiety disorder. Buspirone has shown additive effects when used to augment treatment with SSRIs. In severe cases, successful treatment of social anxiety disorder with both irreversible MAOIs such as phenelzine (Nardil) and reversible inhibitors of monoamine oxidase such as moclobemide (Aurorix) and brofaromine (Consonar), which are not available in the United States, has been reported. Therapeutic dosages of phenelzine range from 45 to 90 mg a day, with response rates ranging from 50 to 70 percent; approximately 5 to 6 weeks is needed to assess the efficacy. The treatment of social anxiety disorder associated with performance situations frequently involves the use of β -adrenergic receptor antagonists shortly before exposure to a phobic stimulus. The two compounds most widely used are atenolol (Tenormin) 50 to 100 mg taken about 1 hour before the performance, or propranolol, 20 to 40 mg. Another option to help with performance anxiety is a relatively short- or intermediate-acting benzodiazepine, such as lorazepam or alprazolam. Cognitive, behavioral, and exposure techniques are also useful in performance situations. Psychotherapy for social anxiety disorder usually involves a combination of behavioral and cognitive methods, including cognitive retraining, desensitization, rehearsal during sessions, and a range of homework assignments.

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