Social anxiety disorder

When is shyness abnormal?

Social anxiety disorder, or social phobia, is the most common anxiety disorder in western countries. This article aims to help the clinician gain an understanding of the prevalence and associated impairment of social anxiety disorder and develop skills in how to recognise and treat it.

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When anxiety is pathological

For most people, anxiety is an important part of normal daily activity. It is a useful sensation that improves performance. This is the normal and beneficial part of anxiety, and as it increases, performance in general gets better. However, anxiety becomes 'pathological' when it is so great that it impairs and causes marked distress and, in some cases, avoidance of certain places, situations or people. Thus, the first step in determining what is normal anxiety and what has become pathological or impairing is to ask if the anxiety is causing any occupational, interpersonal or social distress and/or impairment. An important question to ask is does it cause the individual to avoid any people, places, situations or events.

Once it is clear that the anxiety is pathological, the next step is to determine what disorder best fits the anxiety the patient is experiencing.

Panic attacks and their classification

In 1994, there were some major changes in the conceptualisation and classification of anxiety disorders. Panic attacks no longer automatically mean panic disorder. It is now recognised that panic attacks can occur in any anxiety disorder and sometimes as part of depression. Before 1994, panic attacks were described only as 'spontaneous' or unexpected. Since the recognition that panic attacks can occur in all anxiety disorders, they have been reclassified into three types:

- spontaneous
- situational bound (cued)
- situational predisposed (likely but not inevitable).

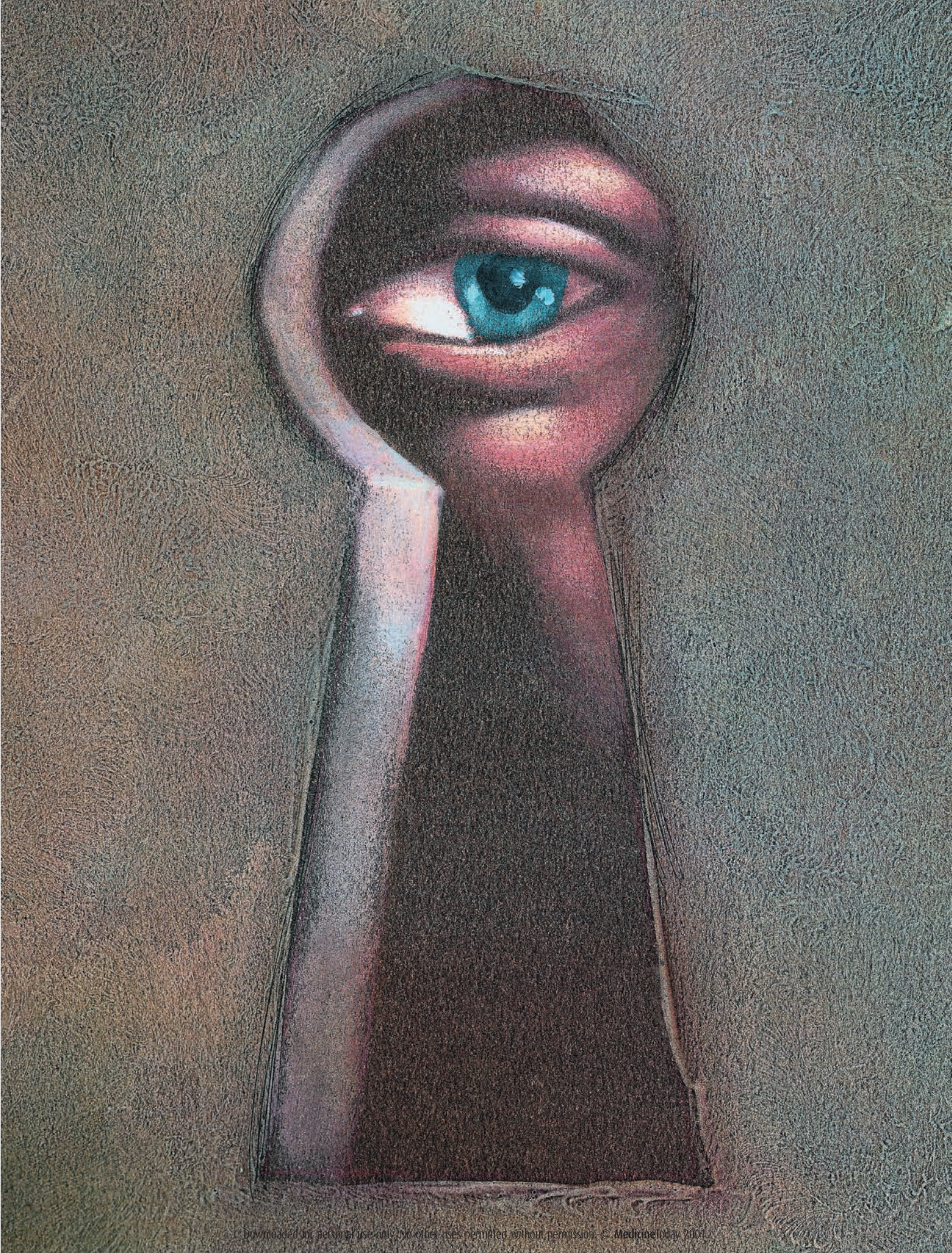
When determining the type of panic attack, one should ask about cognitive or thought triggers of anxiety because they will help separate spontaneous from situational bound or predisposed panic attacks.

Distinguishing social anxiety disorder from panic disorder

People with social anxiety disorder or social phobia worry about symptoms that will draw attention or focus on them, such as blushing, heart

IN SUMMARY

- **Social anxiety disorder is common in the community but poorly recognised.**
- **Social anxiety disorder is often associated with depression and possible alcohol abuse or dependence.**
- **Because the disorder is rarely diagnosed, GPs need to screen certain 'at risk' patients.**
- **The Mini-SPIN is an effective and quick screening tool for social anxiety disorder.**
- **Social anxiety disorder is treatable with education, cognitive behaviour therapy and (in more severe cases) pharmacotherapy.**



What is social anxiety disorder?

- Subjects fear humiliation in social or performance situations.
- In the feared situation, subjects experience:
  - anxiety symptoms and fear of showing them
  - negative cognition that they appear foolish, inadequate or boring to others.
- Subjects attempt to avoid feared situations or endure them with distress.

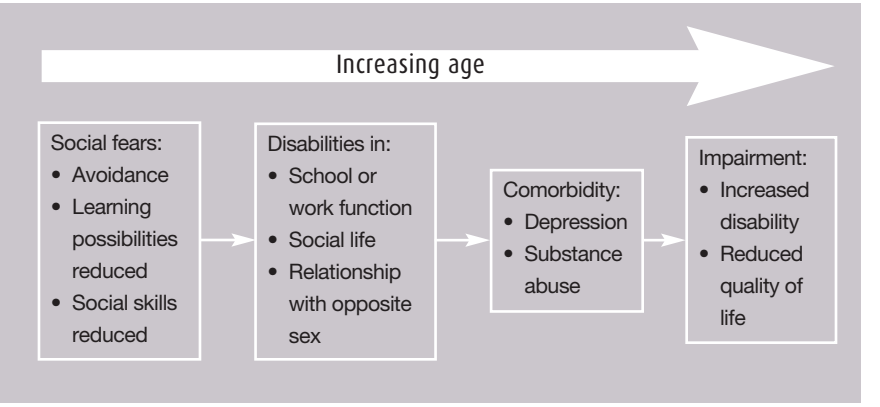


Figure 1. Clinical course of untreated social anxiety disorder. With increasing age, there is an increase in overall disability and comorbid conditions.

racing, sweating and trembling, when having panic attacks. This is highlighted in the following description by an individual with the diagnosis:

'Went to Centrelink. I usually avoid using the fax machine because of its proximity in relation to people waiting to be seen. I decided to use it for the first time. There were three people there and they were looking at the fax machine. I tried to operate it but I found it extremely hard to focus on the task at hand. I started to get nervous because I felt that they were watching me and starting to wonder why I couldn't use it. I became extremely anxious and started to blush and sweat… I began to have a panic attack.'

The patient's concern about these symptoms will often help the clinician differentiate social anxiety disorder from panic disorder because people with panic attacks as a part of panic disorder often have the respiratory-based tightness in the chest, smothering, choking and fear of impending doom, rather than blushing, sweating or shaking.

Also, it is the idea of embarrassment and fear of a negative evaluation that are the core fears leading to the anxiety in social anxiety disorder (see the box on this page).

The anxiety is not spontaneous, but generally bound or cued to situations when the individuals have to perform a task in front of others. This includes tasks as 'simple' as eating or drinking. Common situations precipitating social anxiety disorder include:

- public speaking
- eating or drinking in public
- writing (or using a keyboard) in front of others
- meeting new people, members of the opposite sex or people in authority
- using a public toilet with others present.

Thus, social anxiety disorder is characterised by a typical triad of physical, cognitive and behavioural symptoms that separate it from the other anxiety disorders (Table).

Table. Features of social anxiety disorder

Physical
Blushing
Palpitations
Speech block
Sweating
Tachycardia
Trembling or shaking

Cognitive
Extreme embarrassment and maladaptive thoughts about social situations

Behavioural
Resultant phobic or avoidance behaviour

Prevalence of social anxiety disorder

Social anxiety disorder is the most common anxiety disorder found in western countries. Current prevalence rates of 6 to 10%, and lifetime prevalence rates of 13 to 15%, have been found in large epidemiological studies.[1,2] A study in Paris showed that about 5 to 7% of people attending general practitioners met the criteria for social anxiety, but less than 20% of them were being actively treated for the disorder.[3] In a recent study of 2500 South Australians, approximately 7.2% met the criteria for social anxiety disorder (unpublished data).

The profile of those who develop the disorder is becoming clearer. Affected individuals are more likely to be female, and 60 to 65% of patients have lower socioeconomic and educational status and higher unemployment rates. Another finding is that the profile of the minority of patients who actively seek out treatment is the direct opposite to those who most commonly suffer from it. People do not present for treatment because there is a lack of awareness of the disorder,

and doctors do not consider it as a diagnosis. Sometimes the doctor may call it shyness. However, in most cases it is more than shyness, rather it is a severe fear of embarrassment or humiliations that leads to disability and often to comorbid depression and/or alcohol abuse and dependence as it progresses (Figure 1).

People with social anxiety have higher rates of depression and, in some studies, increased suicide rates.[4] Often, the GP is able to make the diagnosis of depression and/or alcohol abuse, but unfortunately the patients get misrecognised because the comorbid disorders 'mask' the underlying anxiety disorder. The GP may not explore what may be precipitating the depression or alcohol abuse.

Individuals with the disorder do not use the words 'I've got social anxiety' or 'I'm worried what people think about me'. They often present with vague symptoms of blushing, sweating and shaking. It starts early in life and often interferes with all aspects of functioning, including socialising, educational opportunities, work opportunities and relationships. This is demonstrated dramatically in a recent US study.[5] When the researchers examined the economic burden of anxiety disorders as a group, they found that anxiety disorders cost the US economy roughly US$45 billion per year. It is equivalent to the economic burden seen with mood disorders.

The need to screen for social anxiety disorder

Healthcare workers rarely diagnose the majority of sufferers with social anxiety disorder. Between 70 and 80% of people with social anxiety are never diagnosed with it. Thus, healthcare professionals such as GPs need to screen specific patient populations for this disorder.

The Social Phobia Inventory (SPIN) was developed in the late 1990s and has been shown to be a consistently effective tool for the screening of social anxiety in the general population. More recently, a three-item condensed version, called the Mini-SPIN (Figure 2), has been found to be a highly effective rapid screening tool.[6] It is a questionnaire, which the patient fills in and the GP scores. A score of 6 or more indicates a high likelihood of social anxiety disorder.

The Mini-SPIN should be administered to patients who present with the following symptoms and behaviours:

- anxiety or avoidant features
- prominent physical symptoms of blushing, sweating, shaking or palpitations
- depression or treatment-resistant or relapsing depression
- alcohol abuse or dependence
- work or relationship problems
- increasing social withdrawal, especially in adolescence.

Mini-SPIN questionnaire

Initials.....Age.....Sex.....Date.....ID#.....

Please indicate how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

	Not at all	A little bit	Somewhat	Very much	Extremely
1. Fear of embarrassment causes me to avoid doing things or speaking to people:	0	1	2	3	4
2. I avoid activities in which I am the centre of attention:	0	1	2	3	4
3. Being embarrassed or looking stupid are among my worst fears:	0	1	2	3	4

Total:

Figure 2. The Mini-SPIN screening tool.[5] A total score of 6 or more indicates a high likelihood of social anxiety disorder.

Treatment

Once a diagnosis of social anxiety disorder is confirmed, treatment issues need to be determined. One should never aim to eradicate anxiety completely because most anxiety is beneficial. The goal is to get the anxiety back to a level where it helps performance rather than hinders it. Other treatment goals are to:

- reduce avoidance

Pharmacological management of social anxiety disorder

- Use psychosocial treatments in conjunction with medication.
- Consider initial choice of an SSRI.
- Give an initial dose for two to four weeks, then increase if necessary.
- Look for some benefit evident by two to four weeks.
- If no response by six to eight weeks, switch to a different drug.
- Continue pharmacotherapy and CBT for at least one year.

- reduce autonomic/physiological distress
- reduce disability
- improve quality of life.

GPs play an important role in the treatment of patients with social anxiety disorder. Treatment requires a multimodal approach. GPs can provide education and psychological management, including exposure therapy, challenging inappropriate thoughts, and restructuring thoughts with rational evidence-based ones. Initially, the GP should instruct the patients to keep a daily record of people, places, thoughts or situations that make them nervous, how nervous they become, and what they do to reduce their anxiety. This serves to confirm the diagnosis and helps the GP develop an effective treatment program using basic cognitive behaviour therapy.

If there is a poor response to treatment, the patient should be referred to a psychiatrist.

Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is based initially on education and understanding of the illness. Cognitive restructuring follows, and then exposure therapy, based on a hierarchy of feared situations with gradual progression from least feared to most feared. Importantly, exposure therapy must induce the anxiety, be repeated and prolonged, and be associated with a reduction in anxiety over time.

One other area of psychosocial treatment is attention focus. This is based on the premise that because of the core fear of embarrassment people with social anxiety don't focus on the social interaction but on how they are being perceived. Because of this lack of focus on the interaction, they increase their chances of making mistakes (i.e. a self-fulfilling prophecy).

Once the focus on the interaction is mastered, the next step for the patient is to begin to make mistakes intentionally in social situations and observe the reaction. This helps the patient develop the true belief that people do make mistakes and blush and tremble at times but the negative evaluation does not occur.

The book *Overcoming shyness and social phobia* is a very good resource for both patients and healthcare providers that discusses this treatment in more detail, yet is very readable.[7]

Pharmacotherapy

In a subpopulation of people, it is evident that medications will be needed to help the patients overcome their anxiety and successfully engage in CBT. These include people with comorbid depression or avoidant personality disorder and those unable to use or benefit from a standard cognitive behaviour program. The box on this page outlines the pharmacological management of social anxiety.[8]

The selective serotonin reuptake inhibitors (SSRIs) in general have anxiolytic properties. Recently, paroxetine (Aropax) has been shown to be effective treatment in two large multicentre trials.[9,10] It has been approved in Australia for the treatment of social anxiety. Although the other SSRIs have not yet been shown to be effective for this condition in controlled trials, it is reasonable to assume that they would be similarly therapeutic. Moclobemide (Aurorix) has also been shown to be beneficial, but one trial in the US failed to show benefit. Another medication that is helpful is phenelzine (Nardil); however, because of its greater side effect profile, if it is being considered, a referral to a specialist psychiatrist would be a reasonable approach.

With the combination of medication and a CBT program, even the more severe forms of social anxiety disorder can be treated with success. It is important to remember that the best predictor of sustained success after discontinuation of therapy is the degree of behavioural change the person has integrated during treatment.

Conclusion

Social anxiety disorder is poorly recognised; therefore, general practitioners need to screen certain 'at risk' patients. As with the other anxiety disorders, GPs can provide effective treatment for this disorder. However, if the GP feels that he or she does not have the skills for CBT, or if the patient is proving difficult to treat or resistant to treatment, a referral to a regional anxiety disorder or mental health centre is appropriate, as is a referral to a psychiatrist or psychologist. MT

A list of references is available on request to the editorial office.

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