Social Phobia (Social Anxiety Disorder) and Specific Phobia

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Social Phobia

Definition and Criteria
The essential feature of social phobia is a marked and persistent fear of social or performance situations in which embarrassment may occur. In these situations, individuals are afraid that others will judge them to be anxious, weak, "crazy", or stupid. They may fear public speaking because of concern that others will notice their trembling hands or voice. They may experience extreme anxiety when conversing with others because of fear that they will appear inarticulate. They may avoid eating, drinking, or writing in public because of a fear of being embarrassed by having others see their hands shake. Individuals with social phobia almost always experience symptoms of anxiety (e.g., palpitations, tremors, sweating, gastrointestinal discomfort, diarrhea, muscle tension, blushing, confusion) in the feared social situations. In severe cases, these symptoms may meet the criteria for a panic attack. Blushing, which is less common in other anxiety disorders, is typical of social phobia.

Epidemiology
Epidemiological and community-based studies have reported a lifetime prevalence of social phobia ranging from 3% to 13% (Rapaport 1996). In one study of primary care patients, the one-month prevalence was 7.0% (Stein 1999). The reported prevalence may vary depending on the threshold used to determine distress or impairment and the number of types of specific social situations surveyed. In the general population, most individuals with social phobia fear public speaking, whereas less than half fear speaking to strangers or meeting
new people. Other performance fears such as eating, drinking, writing in public, or using a public restroom are less common.

Treatment
While women are about twice as likely to have social phobia as men, men are more likely to seek treatment (Schneier 1992). One might speculate that as more women enter the workforce and assume performance roles, they will increasingly find that social phobia symptoms interfere with career success and will seek treatment at higher rates.

SSRIs have become the medication treatment of choice for social phobia. This class of medications has a long onset of action and may cause increased anxiety symptoms especially during the initial treatment period. Benzodiazepines are also effective, but, due to risk of dependence, chronic use is reserved for refractory cases. Short-term benzodiazepine use in the initial treatment period can be very useful to relieve the increased anxiety associated with beginning an SSRI. Monoamine oxidase inhibitors remain highly effective alternatives to SSRIs. Preliminary evidence supports the use of buspirone as monotherapy (van Vliet 1997) or in augmentation of SSRIs (Van Amerigan 1996).

As with other anxiety disorders, cognitive behavioral therapy is effective in social phobia. Though combinations of psychotherapy and medications have not been studied vigorously, most clinicians believe that the combination is particularly effective in social phobia given its chronic course and significant morbidity.

Specific Phobia

Definition and Criteria
The essential feature of specific phobia is a clearly circumscribed situation or discrete thing, which consistently provokes fear and intense anxiety including a panic attack. The DSM-IV divides specific phobia into four types: animal (e.g.
spiders, snakes, dogs), natural environment (e.g. storms, heights, water), blood-injection type (e.g. medical or dental procedures) and situational (e.g. elevators, flying, public transportation). This diagnosis is only appropriate if symptoms cause marked distress or significant social or occupational dysfunction.

The primary care physician is likely to come in contact with the blood-injection-injury type specific phobia. A characteristic vasovagal response may occur up to 75% of the time, usually in the doctor’s office. This type of phobia can severely limit access to health care because people will avoid going to see the doctor. Bienvenu and Eaton studied this type of specific phobia in the general population and found that the lifetime prevalence of phobias of blood, injections or dentists was 3.5% with a median age of onset of 5.5 years. Almost 80% had had symptoms within the past six months. While over half had told a physician or other health care professional of their fears, none reported seeking mental health treatment. Medical phobias were more common in women and in people with less education. Those with phobias had 4-8 times the expected lifetime prevalence of other psychiatric conditions including major depression, obsessive-compulsive disorder, panic disorder, agoraphobia, social phobia, and other simple phobias. None of the community residents in this study sought mental health treatment (Bienvenu 1998). This study reminds clinicians that untreated health care-related phobias cause delays in seeking medical care and non-adherence with physicians’ recommendations.

Epidemiology
Phobias are common in the general population, but few reach proportions significant enough to meet criteria for specific phobia. Community samples have found a one-month prevalence of 9% in women and 4% in men (Bourbon 1988). Most phobias begin in childhood or adolescence, and the course is hard to predict in most patients.

Treatment
Specific phobias were an early clinical focus of behavior therapy research, and behavioral techniques are by far the most studied treatment. Although extremely common, specific phobias often are not impairing enough for persons to seek treatment. Many individuals are able to adapt their lifestyles to avoid contact with the feared stimulus without causing impairment in functioning. Peripheral symptoms of sweating, increased heart rate and tremor associated with specific phobias, such as fear of public speaking, respond moderately well to β-adrenergic receptor antagonists. Propranolol (10 to 60 mg per dose) blocks the physiological symptoms of excessive autonomic arousal (Tyrer 1988), but does not address the patient’s fear. Propranolol's short half-life makes it effective for presentations and performances. Musicians have reported using beta-adenergic blocking agents frequently without medical supervision (Lockward 1989). Because of potential adverse effects and unpredictability of response, the patient is strongly encouraged to discuss the usage of medication and to test these drugs before the actual event or performance.

If the situations associated with specific phobias become debilitating or severe enough, then psychotherapy is indicated. Such therapy includes systematic desentization, systematic exposure, flooding and modeling (Rachman 1990). With these techniques, the patient is gradually exposed to the anxiety producing stimulus until it can be confronted with little or manageable anxiety. Examples of its effectiveness are seen in needle phobias where medical procedures are needed, or flying phobias where airplane travel is required.

**Summary**

Anxiety disorders are prevalent in the primary care setting and common in women. A basic understanding of the five major anxiety disorders, GAD, panic disorder, PTSD, OCD, and social/specific phobias, is imperative for the primary care of women. Screening for other psychiatric disorders is important since comorbidity with anxiety disorders, depression, and substance abuse is so high. By understanding the medical mimics of anxiety disorders, the physician expands
her knowledge and differential diagnosis of patients who present with anxiety symptoms.

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INTRODUCTION


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