The Nature of Social Anxiety Disorder

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The essential feature of social anxiety disorder (social phobia) is a fear of scrutiny by other people in social or performance situations. The level of anxiety experienced by the person with social anxiety disorder is excessive, and results in substantial impairment in the sufferer's social, family, and professional life. Three distinct subtypes of the disorder have been identified: generalized social anxiety disorder, in which the individual fears a multitude of social situations; nongeneralized social anxiety disorder, in which only 2 or 3 situations are feared; and public-speaking phobia. Results from a number of studies suggest that these subtypes of social anxiety disorder may represent distinct clinical syndromes, with the generalized subtype producing the most severe disability. Despite the prevalence of social anxiety disorder and the disability it causes, this condition remains underdiagnosed, and thus undertreated, by clinicians. This review discusses the barriers that prevent people who have this disorder from seeking help, and the steps that clinicians can take to aid their recognition and treatment of the disorder. It is only by effective diagnosis and treatment that the burden of social anxiety disorder will be lifted, allowing patients to resume a normal life. *(J Clin Psychiatry 1998;59[suppl 17]:20–24)*

Social anxiety disorder (social phobia) is a common, impairing, and chronic condition that afflicts a large proportion of the population. The U.S. National Comorbidity Survey reported a lifetime prevalence of 13.3% and a 1-month prevalence rate of 4.5%.[1] Similar results were found in Europe, where a French primary care study reported a lifetime prevalence of 14.4%.[2] Social anxiety disorder is, therefore, the most prevalent of the anxiety disorders.

When defining the nature of social anxiety disorder, 2 important questions need to be addressed: (1) What are the key symptoms of this condition? and (2) Where does normal shyness end and morbid social anxiety start? The second question concerns the boundaries between possible subtypes of social anxiety disorder and between social anxiety disorder and other psychiatric conditions.

Another important issue to be addressed is the burden that social anxiety disorder places on the patient and the community. Historically, social anxiety disorder has been underestimated in terms of incidence, the level of impairment associated with it, and the need for treatment. A variety of factors have contributed to this neglect of social anxiety disorder. The barriers that exist to prevent people who have this disorder from seeking professional help and that prevent doctors from recognizing and treating this condition will be discussed briefly.

THE DEFINITION OF SOCIAL ANXIETY DISORDER

Anxiety is a normal and even ubiquitous human experience. A certain level of anxiety is necessary for the individual to function normally, but when anxiety is exaggerated and interferes with normal functioning, it becomes a psychiatric condition. In psychiatry, diagnosis is based on operational diagnostic criteria, such as described in the DSM-IV and ICD-10. These criteria may help to set the threshold between normal shyness and anxiety as a disorder and to differentiate social anxiety disorder from other diseases. The essential feature of social anxiety disorder in both classification systems is the fear of being scrutinized or assessed by other people with the expectation that such an assessment will be negative or humiliating. The DSM-IV and ICD-10 criteria for social anxiety disorder are displayed in Table 1. There are a few differences between the 2 classification systems. In the ICD-10, public speaking to a large audience is not considered a phobic condition, as it is in DSM-IV, because ICD-10 specifies that the fear of scrutiny should be related to small groups of people (as opposed to crowds). Also, DSM-IV specifies that the disorder places a socioeconomic burden on the patient, in terms of impairment of academic or occupational functioning, whereas ICD-10 does not. The significance of this feature as a diagnostic criterion has been questioned because many people with social anxiety disorder have come to regard the condition as a way of life.

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Table 1. Diagnostic Criteria for Social Anxiety Disorder, According to DSM-IV and ICD-10

DSM-IV	ICD-10
A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others.	Centered around a fear of scrutiny by other people in comparatively small groups, usually leading to avoidance of social situations.
The person fears he or she will act in a way that will be humiliating or embarrassing.	Usually associated with low self-esteem and fear of criticism.
Exposure to the feared situation provokes anxiety, which may take the form of a panic attack.	May present as a complaint of blushing, tremor, nausea, or urgency of micturition. These symptoms may progress to panic attacks.
The person recognizes that the fear is excessive or unreasonable.	Feared situations are avoided or endured with dread. Avoidance is often marked, and may result in almost complete social isolation.
The feared situations are either avoided or endured with intense anxiety or distress.	The anxiety must be restricted to or predominate in particular social situations, and the phobic situation is avoided whenever possible.
The avoidance, anticipatory anxiety, or distress in the feared situation interferes significantly with the person's normal routine, occupational or academic functioning, or social relationships.	If the distinction between social anxiety disorder and agoraphobia is difficult, precedence should be given to agoraphobia. Panic disorder should only be diagnosed in the absence of phobia.
The fear is not better accounted for by another mental disorder, e.g., panic disorder with or without agoraphobia.	May be discrete (restricted to eating in public, interacting with opposite sex, or public speaking) or diffuse (involving almost all social situations).
Generalized social anxiety disorder is specified, as a fear of most social situations.	

They have adopted coping strategies and may not admit that the fear interferes with their daily activities. The ICD-10 recognizes the importance of specific physical symptoms, such as blushing, tremor, nausea, or urgency of micturition, while DSM-IV refers only to anxiety symptoms that may take the form of a panic attack. To differentiate normal shyness from social anxiety disorder, both classification systems refer to the intensity of the experience in terms of distress it may cause and the recognition that the fear is excessive or unreasonable.

The diagnostic criteria may also affect the prevalence rates found in epidemiologic surveys. Wacker et al.[3] carried out a study of 470 adults in the general population of Basel, Switzerland, using DSM-III-R and ICD-10 criteria. The lifetime prevalence of social anxiety disorder in this sample was found to be higher according to DSM-III-R (16.0%) than ICD-10 (9.5%) due to the more stringent criteria of ICD-10.

Typical precipitating situations that produce anxiety in the person who has social anxiety disorder include being introduced, meeting people in authority, initiating conversation with a member of the opposite sex, dating, using the telephone, receiving visitors, being watched while doing something such as writing or typing, and speaking in public. Most patients with social anxiety disorder have 3 to 5 specific feared situations, but some patients fear almost all social situations while others may fear only public speaking or some other specific social or performance activity, leading to the suggestion that subtypes of the disorder may exist.

SUBTYPES OF SOCIAL ANXIETY DISORDER

Three distinct subtypes of social anxiety disorder have been identified: generalized social anxiety disorder, in which the individual fears a multitude of social and performance situations; nongeneralized social anxiety disorder, in which only 2 or 3 situations are feared; and public-speaking phobia, sometimes referred to as discrete or specific social anxiety disorder. The question arises: Are these subtypes merely a spectrum of severity of social anxiety disorder or are there boundaries between these subtypes that distinguish quantitative differences between them?

A number of studies have addressed this question. Mannuzza et al.[4] compared the demographic and clinical characteristics of 129 patients with social anxiety disorder to assess whether the generalized and nongeneralized subtypes of the disorder could be reliably distinguished. Two clinicians independently assessed the patients and diagnosed generalized or nongeneralized social anxiety disorder. A high degree of reliability was achieved between the assessments, indicating that the subtypes are valid. Compared with patients with nongeneralized social anxiety disorder, patients with the generalized subtype were more often single, had an earlier onset of the disorder, were more likely to be characterized by fears of interpersonal interactions, and had higher rates of comorbid alcoholism and atypical depression. The investigators concluded that generalized and nongeneralized social anxiety disorder may represent distinct clinical syndromes.

Heimberg et al.[5] compared the characteristics of patients with generalized social anxiety disorder and public-speaking phobia. Those who had generalized social anxiety disorder were younger, less well educated, and less likely to be employed than patients with public-speaking phobia. Greater impairment was reported by patients with generalized social anxiety disorder (Table 2). Further evidence for the distinction between the subtypes of social anxiety disorder was provided by a behavioral challenge test. The patients were exposed to a simulation involving exposure to a situation that typically evoked anxiety for each individual. Compared with generalized social anxiety disorder, those with public-speaking phobia tended to report greater anticipatory anxiety before the simulation and experienced more heart-rate arousal during the stressful situation. The authors point out that while generalized social anxiety disorder and public-speaking phobia do appear to be distinct, patients with both subtypes reported a fear of negative evaluation far greater than that seen in

Table 2. Functional Ability in Generalized Social Anxiety Disorder Compared With Public Speaking Phobia*

Scale	Public Speaking Phobia	Generalized Social Anxiety Disorder
Social Avoidance and Distress Scale	15.00	22.90[b]
Fear of Negative Evaluation	22.90	26.06[a]
Social Interaction Self-Statement Test		
Positive statements	40.79	34.06[a]
Negative statements	39.95	56.23[b]
State-Trait Anxiety Inventory	49.58	56.79[a]
Beck Depression Inventory	11.82	17.06[a]

*Data from reference 5.
[a]$p<.05$, [b]$p<.01$ vs public speaking phobia.

members of the general population or patients with generalized anxiety disorders. Since this fear of scrutiny and criticism is a core feature of social anxiety disorder, they concluded that it is valid to classify public-speaking phobia as a subtype of social anxiety disorder.

Also consistent with the theory that generalized social anxiety disorder is a distinct subtype is the finding that it is highly familial, whereas the nongeneralized and discrete subtypes are not. Stein et al.[6] performed a direct-interview family study in which the rates of generalized, nongeneralized, and discrete social anxiety disorder were investigated in the first-degree relatives of patients with generalized social anxiety disorder and healthy control subjects. The relative risks for generalized social anxiety disorder were about 10-fold higher among the relatives of patients with social anxiety disorder than among the relatives of the control subjects. However, the risks for nongeneralized and discrete social anxiety disorder were not significantly different between the 2 groups of relatives. It is not possible to discern from this study to what extent the familial nature of generalized social anxiety disorder is genetic as opposed to what extent is the product of environmental factors, such as parenting styles. In a large-scale twin study reported by Kendler et al.,[7] concordance for social anxiety disorder was greater in monozygotic twins (24%) than dizygotic twins (15%). Statistical analysis of the variance in liability for social anxiety disorder indicated that about one third is attributable to genetic factors and two thirds to environmental factors.

There is some overlap between the symptoms of social anxiety disorder and agoraphobia or panic disorder. ICD-10 specifies that when differential diagnosis of social anxiety disorder or agoraphobia is difficult, agoraphobia should take precedence. The distinction between social anxiety disorder and panic disorder relates to the circumstances in which the individual experiences panic attacks. For patients with panic disorder, the panic attacks may be elicited by certain situations that vary between patients, or the panic attacks may occur in unexpected situations, but for patients with social anxiety disorder, the panic attacks always occur in social or performance situations.

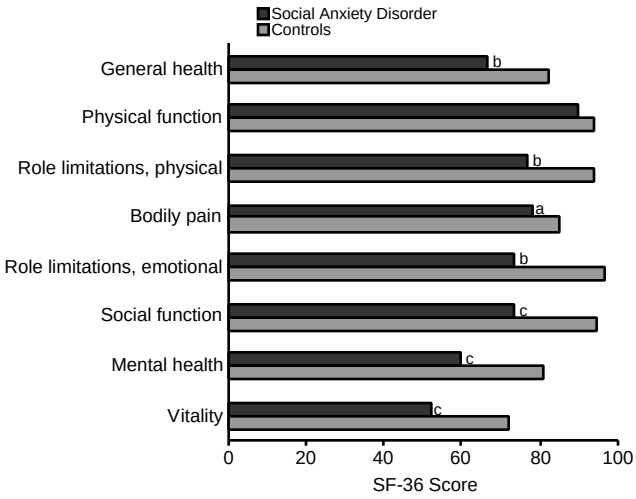
The distinction between social anxiety disorder and the Axis-II counterpart, avoidant personality disorder, is difficult to make. The diagnostic features of avoidant personality disorder largely overlap with those of generalized social anxiety disorder. Many investigators therefore take the perspective that the distinction is artificial. In Japanese culture, there are reports of the concept of *taijin kyofusho*.[8] Individuals are characterized by interpersonal sensitivity and avoidance and fear of interpersonal situations. Although *taijin kyofusho* is classified as social anxiety disorder in DSM-IV, there appears to be subtle differences. The criteria for social anxiety disorder tend to focus on patients' concern with their behavior, while in contrast, *taijin kyofusho* patients are more concerned about how they look and are upset by their appearance. It is suggested that *taijin kyofusho* may be closely related to avoidant personality disorder. On the basis of empirical findings so far, it has been suggested that avoidant personality disorder and generalized social anxiety disorder represent qualitatively different variants on the same spectrum of psychopathology,[9] as may the concept of *taijin kyofusho*.

THE BURDEN OF SOCIAL ANXIETY DISORDER

Social anxiety disorder is a chronic condition, with an average duration of 20 years, and is unlikely to remit spontaneously.[10,11] Epidemiologic studies have shown that only one quarter of patients recover, with the likelihood of recovery greater in patients with a higher educational level, higher age at onset, and no comorbid psychiatric conditions.[11] However, we would hope that the proportion of patients recovering will increase as more patients are given the opportunity to receive treatment.

Since social anxiety disorder typically starts in the teenage years (see Beidel, this supplement), the individuals are affected at a time when social, educational, and career development are of particular importance. What effect does the condition have on the sufferer's subsequent quality of life? Wittchen and Beloch[10] used the Social Functioning (SF-36) questionnaire to assess patients with adult social anxiety disorder. The study found that, compared with matched control subjects, patients with social anxiety disorder had a significantly impaired quality of life (Figure 1). Particularly strong impairments were evident for role limitations due to emotional problems, social functioning, and vitality. With respect to these 3 aspects of quality of life, almost 50% of the patients with social anxiety disorder were found to have severe or marked impairment, compared with less than 5% of the control group. The patients with social anxiety disorder rated their worst impairment as being in the areas of partner and

Figure 1. Quality of Life as Assessed by the Social Functioning (SF-36) Instrument in Patients With Social Anxiety Disorder and Matched Controls*



*From reference 10, with permission.
[a]p ≤ .05, [b]p ≤ .01, [c]p ≤ .001 vs controls.

family relationships, education and career development, and household or work management.

The impairment caused by social anxiety disorder not only places a personal burden on the individual, but also a burden on society in terms of lost work productivity due to emotional problems and illness. Wittchen and Beloch[10] found that patients with social anxiety disorder showed a reduction in work productivity of around 12% compared with control subjects. In addition, 11% of patients with social anxiety disorder were unemployed (compared with 3% of controls); 8% reported taking time off work because of their condition, amounting to an average of 12 hours in the previous week; and 23% reported substantially impaired working performance due to their social anxiety disorder symptoms.

Social anxiety disorder is frequently comorbid with other psychiatric conditions, with around 80% of patients developing further disorders such as depression and alcoholism.[1,12] Patients with comorbid social anxiety disorder experience even more disability than those with social anxiety disorder alone (see Lecrubier, this supplement).

RECOGNITION AND TREATMENT OF SOCIAL ANXIETY DISORDER

Epidemiologic studies have indicated that only a small proportion (around 5%) of individuals with social anxiety disorder in the community seek professional help for their condition.[1,12] It is estimated that up to 2.4 million sufferers in the United States are untreated.[13]

To assess the level of recognition of social anxiety disorder by general practitioners, Weiller et al.[2] interviewed more than 2000 consecutive patients of primary care clinics in Paris, France. The investigators found that 5% of patients had been diagnosed with current social anxiety disorder, as assessed by the Primary Health Care Version of the Composite Diagnostic Interview. While social anxiety disorder was common in this sample of patients, a diagnosis of anxiety disorder was made by the physicians in only 24% of these patients. This low recognition rate may have been due to the fact that the patients with social anxiety disorder did not report their phobic symptoms to their doctor; indeed, only 5% had consulted their doctor for psychological problems. Thus, in many cases, the opportunity to detect and treat social anxiety disorder is being missed.

There are many barriers that prevent the individual with social anxiety disorder from seeking professional help.[13] There is a lack of information, among both the public and health professionals, that social anxiety disorder is a treatable disorder. Persons with this disorder may believe that they are merely shy and that their condition is just part of their personality. In addition, because everyone experiences a certain amount of anxiety in social and performance situations, family and friends of the person with social anxiety disorder, and even health professionals, may trivialize the condition. There is inevitably a stigma attached to all mental illnesses that may prevent a person with this and other treatable disorders from seeking help. Lastly, it is an inherent feature of the disorder that the sufferer will avoid the contact with strangers that a visit to the doctor's office entails.

How can physicians recognize social anxiety disorder in their patients? Social anxiety disorder should be considered in patients who appear shy or reticent.[14] The disorder should also be considered in substance abusers and patients with depressive symptoms, as these conditions are so often comorbid with social anxiety disorder (see Lecrubier, this supplement). If the patient reports anxiety attacks, then the physician should ascertain whether the anxiety occurs predominantly in social situations.

Once the patient has been diagnosed, certain steps can be taken to reassure the patient and assist compliance with the treatment to be prescribed. First, it must be emphasized that the patient has a medically recognized condition. Second, the physician must stress that there are treatments that have been proved to be effective. It should be explained that the condition is caused by anxiety and that medications can alleviate anxiety. Last, it is important to emphasize that these medications are not addictive.

CONCLUSIONS

Social anxiety disorder is a common and disabling condition. It requires prompt diagnosis to prevent long-term disability in the patient's personal and professional life. However, social anxiety disorder is underdiagnosed and, therefore, undertreated. It is thus necessary that awareness of this disorder as a treatable condition is increased in both

the public and health professionals. It is only by effective diagnosis and treatment that the burden of social anxiety disorder will be lifted, allowing patients to resume a normal life.

REFERENCES

1. Magee WJ, Eaton WW, Wittchen HU, et al. Agoraphobia, simple phobia and social phobia in the National Comorbidity Survey. Arch Gen Psychiatry 1996;53:159–168
2. Weiller E, Bisserbe J-C, Boyer P, et al. Social phobia in general health care: an unrecognised undertreated disabling disorder. Br J Psychiatry 1996; 168:169–174
3. Wacker HR, Müllejans R, Klein KH, et al. Identification of cases of anxiety disorders and affective disorders in the community according to ICD-10 and DSM-III-R by using the Composite International Diagnostic Interview (CIDI). Int J Methods Psychiatr Res 1992;2:91–100
4. Mannuzza S, Schneier FR, Chapman TF, et al. Generalized social phobia: reliability and validity. Arch Gen Psychiatry 1995;52:230–237
5. Heimberg RG, Hope DA, Dodge CS, et al. DSM-III-R subtypes of social phobia: comparison of generalized social phobics and public speaking phobics. J Nerv Ment Dis 1990;178:172–179
6. Stein MB, Chartier MJ, Hazen AL, et al. A direct-interview family study of generalized social phobia. Am J Psychiatry 1998;155:90–97
7. Kendler KS, Neale MC, Kessler RC, et al. The genetic epidemiology of phobias in women: the interrelationship of agoraphobia, social phobia, situational phobia, and simple phobia. Arch Gen Psychiatry 1992;49: 273–281
8. Ono Y, Yoshimura K, Sueoka R, et al. Avoidant personality disorder and taijin kyoufu: sociocultural implications of the WHO/ADAMHA International Study of Personality Disorders in Japan. Acta Psychiatr Scand 1996; 93:172–176
9. Herbert JD, Hope DA, Bellack AS. Validity of the distinction between generalized social phobia and avoidant personality disorder. J Abnorm Psychol 1992;102:318–325
10. Wittchen HU, Beloch E. The impact of social phobia on quality of life. Int Clin Psychopharmacol 1996;11(suppl 3):15–23
11. Davidson JRT, Hughes DL, George LK, et al. The epidemiology of social phobia: findings from the Duke Epidemiological Catchment Area Study. Psychol Med 1993;23:709–718
12. Schneier FR, Johnson J, Hornig C, et al. Social phobia: comorbidity and morbidity in an epidemiologic sample. Arch Gen Psychiatry 1992;49: 282–288
13. Ross J. Social phobia: the consumer's perspective. J Clin Psychiatry 1993; 54(12, suppl):5–9
14. Stein MB. How shy is too shy? Lancet 1996;347:1131–1132