# Fear in the Presence of Others

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We have all met people who are somewhat shy, self-conscious, and introverted and minimize their social contact. This personality style falls within that portion of the bell-shaped curve that we consider to represent the "normal personality."

It seems clear, however, that some people are substantially restricted by what appears to be a similar constellation of traits. As children, they were *terrified* of being called on in class. They are often unable to eat in a restaurant with friends. Typically, they don't date much. At work, they cannot make public presentations. They may be unable to use a public restroom.

This picture defines a less well-known component of the anxiety disorder spectrum known as *social anxiety disorder*. Once the disorder was conceptualized so that cases could be tabulated, it was found to be the third most common psychiatric disorder in the United States (after major depression and alcoholism).

Fortunately, it is treatable with selective serotonin reuptake inhibitor (SSRI) antidepressant medication (even in the absence of depression), as well as with brief cognitive therapy. Cognitive distortions are a common feature of the syndrome of social anxiety disorder, making this form of psychotherapy particularly applicable. Sufferers anticipate social rejection, fear uncontrollable anxiety, and often desire social approval. They "validate" their negative expectations by avoiding social situations.

## PRESENTATION OF THE PROBLEM

The patient is a 30-year-old, married radio broadcaster who consulted his primary care physician for chronic abdominal pain. The evaluation revealed gastritis, without evidence of ulcer. His doctor suggested that Rick consult a psychiatrist to shed some light on emotional factors that might be contributory. She referred Rick to me for further evaluation.

The patient described himself as "nervous talking to people, avoiding social opportunities, and periodically finding job-related interviewing difficult to do." He had always been shy and introverted, but did not begin actively avoiding social contact until 1 year ago. He successfully completed high school and college, achieving a fine academic record. He had, however, no close friends. He was aware of being extremely uncomfortable at public functions, and tried to "get out of going." He was at ease only in the presence of his wife or his sister. Married for 4 years, he and Sarah had no children. He frequently felt anxious, but never had experienced a panic attack. There was no evidence of posttraumatic stress disorder (PTSD), no depression, no specific phobia.

His parents had divorced when Rick was 3 years old, and he and his brother and sister were raised by their mother. His brother was 2 years younger and emotionally stable. His younger sister had suffered 1 bout of depression and had received treatment. There was no other family history of emotional disorder.

My diagnosis was social anxiety disorder. I suggested to Rick that a brief course of cognitive therapy might be helpful. I told him that medication is sometimes helpful for this problem, but that I would recommend a brief therapy approach to start. If successful, medication would not be needed. He agreed to the plan I outlined. I sent a note detailing my diagnosis and plan to his primary care physician.

## PSYCHOTHERAPY

In our second session, I taught Rick the cognitive model for identifying meanings in the context of a situation that might explain the anxiety he felt or the avoidant behavior he had chosen. We utilized examples from his history to stress the relevance of the model to his situation. In describing a difficult anxiety-provoking encounter with his boss, Rick identified the relevant automatic thought (or meaning) as: "He will see me as a slacker." We examined his logic and considered alternative explanations. His first homework assignment was to keep a triple column (listing situations, feelings, and thoughts) to catalog events associated with distress.

Key automatic thoughts identified in session 3 included: "Others' attention is drawn to me," and "I fear that

people will not like me." Rick was asked to support his predictions, and then to consider alternate cognitive approaches to his situations. In the following session, he noted strong anticipatory anxiety prior to meeting a new group of people. Once again, we identified (similar) meanings and worked to find reasonable alternatives. He noted that he was "beginning to see results from using cognitive tools."

In session 5, we focused on his frequent error of polarization: a tendency to think in black and white terms. He told me that he "rarely saw grays." We worked to expand his thinking to include a range of options rather than only 2 extreme categories. He noted that "as a side effect of therapy" he was becoming "more assertive" in his interactions with people. Session 6 considered the pros and cons of a potential work promotion that would alter some of his job duties. He also told me about a social evening spent among his wife's friends that "would have been impossible before." His wife had commented to him about "a major change in his social ease."

In our seventh and final session, Rick said that therapy had "helped overcome years of shyness and avoidance." His life had "become much busier." He saw little, if any, self-imposed restriction now. He was spending much less time in rumination about himself. We discussed the changes he had made, and how he understood them. We agreed to end psychotherapy "for now," with a promise of availability at his initiative.

A year has passed since our work together, and a follow-up phone call found him maintaining his gains.

***Editor's note:*** Dr. Schuyler is a board-certified psychiatrist at the Medical University of South Carolina who works part-time in a primary care clinic. Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

For further reading: *A Practical Guide to Cognitive Therapy*. 1st ed. by Dean Schuyler, New York, NY: WW Norton & Co; 1991. ISBN: 0393701050