

# How to Treat

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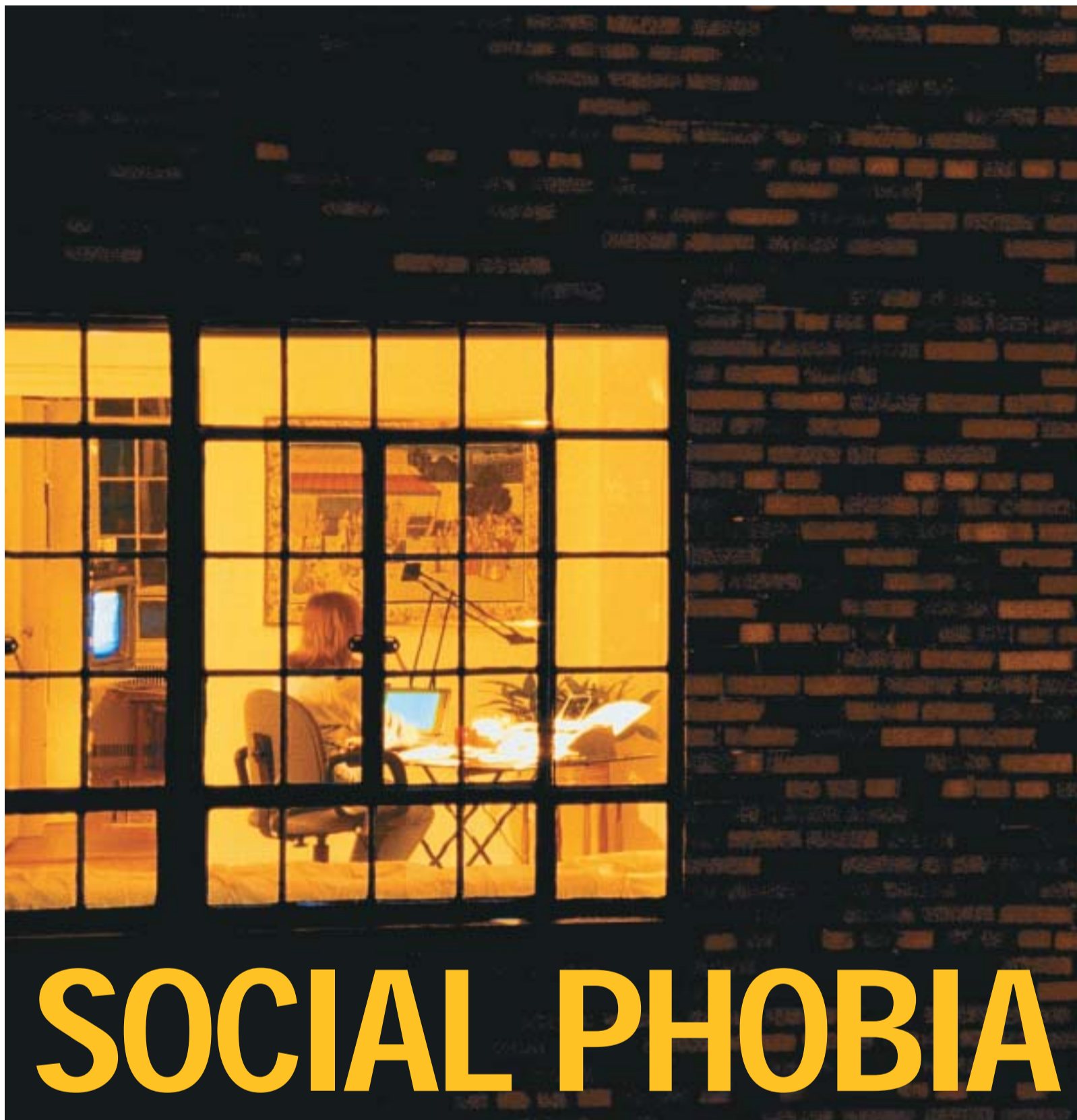
Avoidant personality disorder

Treatment

### The author



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# SOCIAL PHOBIA

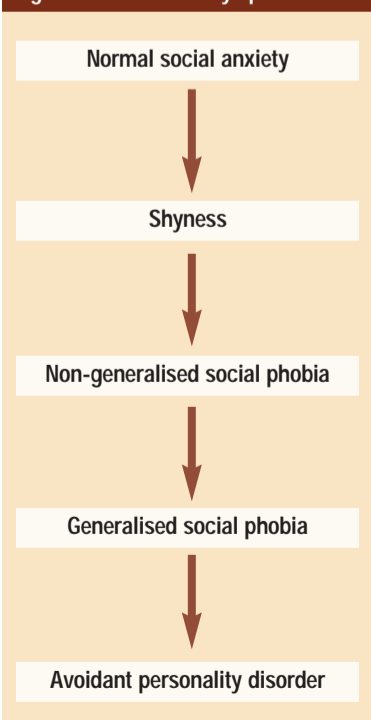
## Background and definition

THERE has been an explosion of knowledge about social phobia and its treatment since it was described as 'the neglected anxiety disorder' nearly 20 years ago. Despite this, recent Australian epidemiological data indicate that only 21% of people with the condition are receiving treatment and, of these, only one-third are receiving an evidence-based intervention.

Social phobia is common and far more disabling than formerly realised. However, effective treatments are available for reducing the subjective distress and functional disability of the disorder. Ensuring more people with the condition access appropriate treatments depends in part on better recognition of the disorder both by those affected and by primary care providers.

The main aims of this article are to assist in the recognition of social phobia and to encourage the effective

Figure 1: Social anxiety spectrum.



use of available treatment strategies in the general practice setting.

Social phobia is defined in the *DSM-IV* as "a marked and persistent fear of one or more social situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing".

It is more than just shyness or stage fright, since it must also meet the criterion requiring that "the avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia".

Two subtypes of social phobia are recognised: generalised and non-generalised. Generalised social phobia is

defined simply as including most social situations.

Non-generalised (or circumscribed) social phobia by convention refers to fears limited to one or a few social situations. Most individuals in clinical samples have this type of social phobia. However, enquiry usually reveals that, although a patient may be focused on one particular situation, they have fears in a range of social situations.

One-third of those affected meet criteria for avoidant personality disorder, now regarded as a severe variant of social phobia. Social anxiety can thus be viewed as a spectrum, with functional disability, distress and comorbidity increasing along the spectrum (figure 1).

It is now recognised that the underlying fear in social phobia is of negative evaluation from others. This is the most important feature in differentiating social phobia from other anxiety disorders.

## how to treat - social phobia

### Epidemiology, aetiology and course

THE National Survey of Mental Health and Well-Being,<sup>1</sup> a household survey of more than 10,000 Australian adults conducted in 1997, estimated the 12-month prevalence of social phobia at 2.3%. There is only a slight excess in women (relative risk 1.2), in contrast to panic disorder (RR 3.3) and agoraphobia (RR 2.1).

The highest rates of social phobia were evident in the 35-54-year age groups. The disorder is over-represented in those who are separated, divorced or never married and is more common in people who are unemployed or otherwise not in the labour force.

Perhaps surprisingly, genetic factors are believed to account for about 50% of

**Social phobia is associated with genetic rather than environmental factors.**

the variance in liability for developing social phobia. The generalised form of social phobia shows the strongest association with heritable factors. Shared (ie, familial) environmental factors appear to have little role in the aetiology of social phobia.

It has been estimated that non-shared environmental factors may account for up

to 30% of the variance. Hence there may be some contribution from aversive social events, such as bullying or acute severe embarrassment. Childhood adversity may also have an aetiological role but is not specifically linked to social phobia.

The onset of social phobia occurs most typically in the early to mid teens. Most

teenagers are self-conscious, but those with social phobia are often exquisitely so, and they do not grow out of it. Untreated, social phobia is a chronic disorder that tends not to resolve spontaneously. A large US epidemiological survey identified that 15% of those who met criteria for social phobia said that they had had it their whole lives.<sup>2</sup>

### Presenting signs and symptoms

THERE are two patterns of symptoms to consider: what the patient experiences and what the GP is likely to hear and see.

The subjective experience of social phobia is intense anxiety in particular social situations, which vary with the individual. Panic attacks are not uncommon. Although patients typically experience the range of symptoms seen in any type of acute anxiety, it is the visible signs of anxiety — blushing, sweating and shaking — that are most feared.

Nausea, associated with a fear of vomiting, is also common. Other physical symptoms that cause distress include a shaky voice or loss of speech volume, and a sensation of the 'mind going blank'.

The main feared consequence of engaging in anxiety-provoking situations or experiencing the symp-

toms and signs of anxiety is that the individual will do or say something embarrassing, or others will notice their symptoms of anxiety and think less of them in some way. Therefore, many sufferers avoid the situations they fear.

If this is not possible they may engage in subtle forms of avoidance such as attending a lecture or meeting but hiding down the back and saying nothing, wearing a high collar to hide any flushing of the neck that might appear, going out to a meal but making an excuse to avoid eating (for example, when the fear is of vomiting) or holding a glass (when the fear is of hands shaking). Even then the situation may be experienced as intensely distressing and anxiety-provoking.

Other behavioural aspects of the condition may see the sufferer more or less rearrange their life

#### Practice point

Recognition of social phobia may be enhanced by attention to clinical clues such as poor eye contact in the consultation, and the nature of any physical complaints. Concerns about excessive blushing, sweating or shaking in a young adult are social phobia until proved otherwise. Once recognised, patients should be educated about and directed towards evidence-based treatments.

around their phobia. Only a minority of sufferers seek treatment specifically for their social phobia, although it is known that they have a higher rate of attendance to medical services than the general population.

In a WHO study conducted in a French primary care setting,<sup>3</sup> GPs recognised their patients with social phobia as being psychologically ill in 62.5% of cases, but gave an anxiety disorder diagnosis in only 24.2%. In clinical samples it is common for individuals to have suffered from social phobia for periods of more than 15 years before coming to treatment.

The diagnosis is easily missed: patients are likely to present with symptoms of (a comorbid) depression, or with complaints focused on the most troublesome physical symptoms associated with disorder

— excessive sweating, trembling or shaking.

Patients may also present with more vague complaints such as stress, inability to relax, or with more general symptoms of anxiety, including insomnia. A reported fear of being sick is also often a presenting symptom of an underlying social phobia. To make the diagnosis, establish that the fear is of vomiting and the feared consequence is embarrassment. (Hypochondriacal concerns may also include a fear of vomiting; in this case it is the vomiting itself or the idea of being sick that is the principal concern.)

In the interview the patient with social phobia may appear noticeably ill at ease or find it hard to make eye contact. Blushing, sweating or shaking may be evident.

### Comorbidity and differential diagnosis

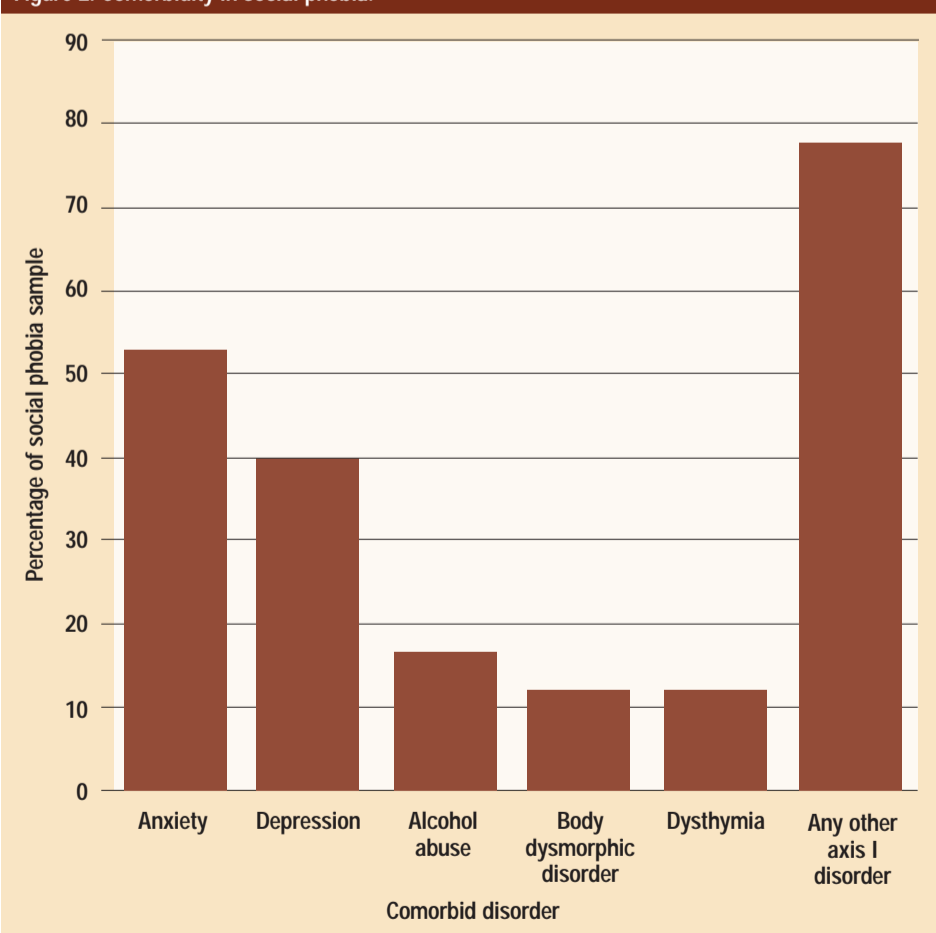
MOST of the important differential diagnoses for social phobia may also be encountered as comorbid conditions (figure 2). Social phobia is a risk factor for both depression and substance abuse, particularly alcohol abuse. Epidemiological research in Australia<sup>1</sup> and elsewhere has shown that these disorders occur secondary to social phobia in almost all cases.

The clinical significance of this is twofold: early recognition and treatment of social phobia may prevent significant later comorbidity; however, a depression or substance use disorder may mask an underlying social phobia. If the social phobia is not treated, it represents an ongoing risk factor for a recurrence of depression or alcohol abuse.

The association with alcohol abuse is particularly striking. Studies of populations described as 'alcoholic' have estimated rates of comorbid social phobia of between 16% and 25%. Clinical and epidemiological samples of individuals with social phobia suggest a rate of alcohol abuse of about twice that of the general population.

In terms of differential

Figure 2: Comorbidity in social phobia.



diagnosis, social phobia is easily confused with panic disorder or agoraphobia. Many of the same types of situations are feared, for example, crowded places,

public transport, elevators.

The diagnosis is determined by the underlying fear. Patients with either social phobia or panic disorder may fear having a

panic attack, but the patient with social phobia fears that this may be obvious to others, who may then believe that they are odd or incompetent in some way.

The patient with panic disorder fears that the physical symptoms of the panic attack may somehow cause serious physical or mental harm to them (for example, the pounding heart may lead to or be a symptom of a heart attack).

The effectiveness of cognitive behaviour therapy depends to a significant degree on treatment being targeted to the specific fears of the patient. While the same antidepressants are likely to be effective for each condition, the GP is likely to experience considerably more difficulty in establishing the patient with panic or agoraphobia on an antidepressant because of their tendency to interpret somatic symptoms as evidence of an underlying serious physical disorder.

Body dysmorphic disorder is another differential diagnosis that probably accounts for the relatively poor response to general treatment seen in some patients who appear to have a social phobia (see Author's case study: Beyond hyperhidrosis, page 41) It is estimated that in 11-12% of cases social phobia is comorbid with body dysmorphic disorder.

#### Practice point

Recognition of social phobia may be increased by good follow-up after treatment of a depressive episode or counselling for alcohol abuse, and enquiry as to the patient's view of what may have led to their excessive drinking or the development of depression.

## Avoidant personality disorder

AVOIDANT personality disorder is comorbid with social phobia in about one-third of cases in both clinical and epidemiological samples.<sup>4</sup> The condition typically has an earlier age of onset than social phobia, and higher rates of comorbid depression and substance abuse. It is more disabling than social phobia because it tends to affect almost every type of social interaction and results in widespread avoidance.

The underlying cognitive symptoms include the fear and anticipation of rejection and humiliation. This is associated with poor self-esteem and a sense of inferiority. The person believes they have little to offer, and rejection by others is an expected consequence. People with avoidant personality disorder frequently have an unstable job history. To avoid the pain of the anticipated rejection or humiliation they will often leave a job before others

can really get to know them. Others with this disorder find jobs that allow them to largely avoid interaction with others — night shift, work-from-home or isolated jobs.

Avoidant personality disorder responds to the same treatments as social phobia, and at about the same rate and to the same degree, but, as these patients start from a more severe and disabled position, they are also less functional after treatment.

## Treatment of social phobia

THERE are two types of effective treatment: cognitive behaviour therapy (CBT) and antidepressant pharmacotherapy. Benzodiazepines and beta blockers have limited utility and generally should not be first-line therapy.

A large number of generally small trials have established the effectiveness of CBT as a treatment for social phobia. In the small number of head-to-head trials, CBT and antidepressants show an equivalent response, although subjects tend to respond earlier to antidepressants.

### Problem-focused assessment

A problem-focused treatment approach ensures the symptoms most troublesome to the patient are targeted in treatment. It also readily provides a practical structure to guide treatment. The symptoms of any anxiety disorder may be classified under three domains: physical, cognitive and behavioural.

#### Physical

Identify the symptoms of anxiety the patient experiences. Ask about blushing, sweating, shaking and nausea if these are not volunteered.

#### Cognitive

What does the patient fear may happen to them in social situations? In what way do they fear they may embarrass themselves? What specific fears are held regarding what others may think? (see box: Interviewing the patient with suspected social phobia).

#### Behavioural (avoidance)

Patients can be asked about situations they avoid. To identify more subtle forms of avoidance and the associated disability, it is helpful to ask the question, "Is there anything you are not able to do in the way in which you would like, for example, only being able to attend parties after having several alcoholic drinks beforehand, or never feeling able to eat a proper meal at a restaurant in case of vomiting?".

### CBT for social phobia: practical techniques for the GP

The aims of CBT are to improve control over anxiety, reduce the fear of negative evaluation and improve function. The usual components of CBT for social phobia include:

- Education about the nature of anxiety and social phobia;
- Anxiety management and de-arousal strategies (hyperventilation control, progressive muscular relaxation);
- Cognitive challenging and cognitive restructuring;
- Graded exposure to feared situations.

Ideally patients are given written hand-outs that summarise or even expand on the material covered in each session. Alternatively, patients can be directed to download the appropriate treatment manual from [www.AforAnxiety.com](http://www.AforAnxiety.com), and treatment can be based around this resource. More detailed versions of these treatment manuals are also available in our book, *The Treatment of Anxiety Disorders*,<sup>4</sup> and may be photocopied for individual patient use.

#### 1. Education

Education is often underrated. Bear in mind that the response rate to 'placebo' conditions that consist of education about anxiety and social phobia and the chance to talk about it have an effect size of 0.4-0.5 — a moderate improvement. In 10-15 minutes a GP can teach about the flight-or-fight response and how this produces the physical symptoms of which the patient complains. Explain about hyperventilation and how this tends to heighten feelings of anxiety.

#### 2. Physical treatment strategies

The rationale for hyperventilation control will have been covered in the educational session. Breathing control forms the foundation of a good anxiety management program:

**We no longer advise deep breathing — in an anxious state patients are likely to take these deep breaths too frequently and exacerbate the effects of hyperventilation.**

when anxiety is reduced, patients can think more clearly and hence effectively employ the cognitive strategies essential to overcoming the disorder.

#### 2a. Breathing control technique

1. Take a small breath in and hold it for six seconds.
2. Think "relax", then breathe out. Try to feel as if you are releasing tension as you breathe out.
3. For the next minute, breathe in for three seconds and out for three seconds in a smooth and light way.
4. Repeat steps 1-3.

Demonstrate the breathing control technique by taking patients through it in the session. Stress that breaths should be smooth, light and preferably through the nose (as this automatically limits the quantity of air which can be taken in easily).

We no longer advise deep breathing — in an anxious state patients are likely to take these deep breaths too frequently and exacerbate the effects of hyperventilation. Paper bags are no longer recommended: they are simply unnecessary and do not teach real control.

Ask the patient to use a watch or clock that marks seconds and to time their breathing carefully (this helps them to re-focus away from the fears that are maintaining their anxiety). By saying "relax" to themselves before exhalation, a learned association is created which can be rapidly effective at lowering anxiety in real situations.

Many patients will find it initially feels a little unusual: you can reassure them that with time most people find this style of breathing comfortable and very relaxing. Patients with social phobia usually adapt to it more easily than more somatically focused anxious patients, such as those with panic disorder or hypochondriasis.

The breathing control technique needs to be practised frequently for it to become automatic. I generally suggest patients practise four times daily for five

### Interviewing the patient with suspected social phobia

#### Getting to the bottom of what is feared

**Patient:** I'm nervous around people.

**Doctor:** What seems to be the problem?

**Patient:** I might blush.

This makes social phobia the presumptive diagnosis, but can only be confirmed by establishing that blushing is a problem because it may lead to negative evaluation.

**Doctor:** What bothers you most about the blushing?

**Patient:** People will think I'm immature [negative evaluation].

#### Ask about a range of situations

**Patient:** I get too nervous in meetings.

**Doctor:** How does that cause problems for you?

**Patient:** I can't seem to get my words out ... I look nervous.

**Doctor:** What bothers you most about those things happening?

**Patient:** People will think I'm odd [negative evaluation].

**Doctor:** Do you have trouble in any other situations?

Allow the patient to answer then ask about: socialising (eg, parties), catching public transport, using lifts, standing in queues, signing their name in front of someone, using the telephone (with and without others around), eating and drinking in public, using public toilets. By asking about this range of situations the doctor will not miss a diagnosis of generalised social phobia. This is relevant with respect to treatment options.

minutes at a time. It should then become the patient's first response to feeling anxious. When used in real situations, patients should continue the breathing control technique until they feel less anxious.

#### 2b. Progressive muscular relaxation

This technique is surprisingly effective at reducing arousal and subjective sensations of anxiety when practised regularly. The technique of applied relaxation, in which a patient learns to transfer the relaxation response across situations, may be particularly helpful. The technique was first described by Lars-Goran Öst<sup>5</sup> and has robust research support. Öst's original script may be used to record a tape for the patient to use at home, if time allows.

Most commercially available relaxation tapes employ creative visualisation rather than progressive muscle relaxation. The latter may be preferable because it is specific, easily learned, provides numerous foci of attention (useful in re-focusing away from anxious concerns) and has an empirical basis.

Patients may be advised to try to practise daily. It gen-

erally requires a couple of weeks' practice before patients report subjective benefits.

#### 3. Cognitive strategies

Core cognitive distortions in social phobia centre around overestimates of the probability and cost of feared outcomes. Cognitive strategies in the management of social phobia are directed towards assisting patients to make more realistic estimates about how likely they are to attract attention, do something embarrassing or be judged negatively.

Cognitive distortions, or cognitive 'errors', refer to flaws in logic with respect to making inferences and drawing conclusions about experiences. For example, a patient reports having a conversation with someone else who happened to frown as they were talking, leading the patient to conclude, "They didn't believe me". This type of error is referred to as 'mindreading'.

In another example, a patient reports having had a conversation with someone, and remembers a period where they were momentarily lost for words. In reality this was a brief pause, but

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the patient tells you, "I ran into Mary but I had nothing to say". This cognitive error is referred to as the 'mental filter', or 'focusing on the negative'.

Matt's statement that "no one ever talks to me at parties" (Author's case study: Beyond hyperhidrosis) is almost certainly a case of the cognitive error of 'over-generalisation'. Another error is 'jumping to conclusions', as in Sally's conclusions (Author's case study: A better approach to problem blushing) that someone saying "You're blushing" means they are teasing her (it may be simply an observation) or means they think she doesn't know what she's talking about. These cognitive errors are especially common in social phobia. *The Treatment of Anxiety Disorders*<sup>4</sup> contains a more comprehensive list.

Helping patients to identify their own cognitive errors can be a useful learning experience and ideally is coupled with advice to restate things more helpfully. For example, "I got a bit stuck for words at one point, but overall I was able to have a bit of a chat with Mary".

The GP can also guide patients to ask themselves several questions about conclusions they draw regarding their experiences. What is the evidence for their conclusions? Would this evidence convince a jury, or is it based on 'mindreading', 'jumping to conclusions' or other cognitive errors? Is there in fact evidence to the contrary? For example, Sally was able to recall occasions where her boss had given positive feedback about her standard of work.

When worrying about feared outcomes such as having nothing to say, spilling food or drink, vomiting and so forth, patients can be encouraged to ask themselves, "How likely is it really?". For example, how many times have they eaten in front of others and on how many of these occasions did they actually spill their food or drink? Is this really a higher rate than anyone else? And, most importantly of all, how much did it really matter? Is it really likely that someone is going to change their whole opinion of them because they stumbled over their words? Is it really likely that they will be judged incompetent at their job because they blushed? We all aspire to be liked and accepted by others — it is important not to jump to conclusions that this is not happening simply because we have not been as 'cool, calm and collected' as we might have liked.

### Helping patients identify their own cognitive errors and restate things more positively can be helpful.

#### 4. Graded exposure

An essential goal of any treatment program is functional improvement. This is only achieved by physical engagement in situations that were formerly avoided and which the patient identifies as desirable. A graded approach is most likely to be tolerated and therefore to be successful.

In structured CBT, goals are identified by the patient and ranked according to how much anxiety is provoked by the thought or actuality of attempting to enter the identified situations. A subjective units of distress (SUDs) scale, running from 0-10, for example, is used to help rank the identified situations and behavioural goals.

Patients are encouraged to attempt the easier goals first and to master these through repeated performance before attempting the next most difficult goals. This process is assisted by record-keeping of the exposure task or exercise and the SUDs it provoked. When the SUDs scores are regularly 3 out of 10 or less, the patient is likely to have the confidence to move on to the next goal. Ideally each exposure exercise is linked with a cognitive challenging exercise to ensure the patient is thinking realistically and helpfully about their goal.

#### What is practical and realistic in general practice?

The educational components of treatment are highly valuable to patients and may have the additional benefit of ensuring that, if they seek further treatments, these are evidence-based. Similarly, the physical de-arousal and anxiety-management strategies are very appropriate to general practice.

Cognitive challenging is the most difficult CBT skill for both patients and clini-

cians to master. The average GP (or psychiatrist for that matter) is unlikely to have had the opportunity to develop much skill at it. It is also quite time-consuming. However, patients can usefully be introduced to some basic principles of cognitive therapy — the core premise that our emotions are strongly influenced by how we think about ourselves, our world and situations that we find ourselves in.

It can also be helpful for patients to have an understanding of the common cognitive errors that occur in social phobia. Such a discussion can be facilitated by educational handouts referred to above. Some gentle challenging of beliefs through discussion with patients may be a useful introduction to the idea that there may be other ways to interpret experiences.

It is important to encourage patients to confront, in a gradual way, activities that are feared and avoided, and to stay focused on the task at hand, rather than on themselves (and their symptoms of anxiety).

These interventions can be introduced over a series of short consultations and may be the extent of CBT that is practical for many GPs. When patients have mild or non-generalised social phobia and readily grasp the principles of treatment, this may be sufficient. For patients with generalised and more severe social phobia, it may be effective in combination with antidepressant therapy.

There is evidence that long-term outcome is enhanced by CBT, but no data as to how structured the CBT needs to be. Patients with severe generalised social phobia or avoidant personality disorder should be referred for structured CBT. Ideally they would be offered group treatment, but this is not

often available. These patients, as well as those with body dysmorphic disorder, may also benefit from a psychiatric opinion.

#### Pharmacotherapy for social phobia

Pharmacotherapeutic agents that have been employed in the treatment of social phobia fall into three main classes: beta blockers, benzodiazepines and antidepressants. Only the antidepressants are recommended as first-line therapy.

Beta blockers have commonly been offered to patients whose principal complaints relate to blushing, shaking and palpitations. However, as noted above, in clinical practice it is most likely that these are not isolated symptoms: they are more likely to be part of a generalised social phobia.

Beta blockers have not been shown to be better than placebo in controlled trials. They may have a limited place in truly circumscribed social phobias, in which the feared situation arises predictably but infrequently. Although they are reportedly used by many musicians, there are reports of a dose-related impairment in cognition and musical sensitivity. Beta blockers are not first-line therapy in generalised social phobia.

Benzodiazepines have been shown to reduce the psychic experience of anxiety but not to increase functionality. Because antidepressants do both without the risks of tolerance and dependence, they are recommended ahead of benzodiazepines.

Benzodiazepines are sometimes used as an initial adjunctive treatment when SSRIs are being introduced. This practice should not be routine because, if SSRIs are started slowly (ie, half the lowest-strength tablet available, with instructions to stay at this dose for a few

days or until comfortable with it) and abundant information provided about what to expect in the way of side effects, it is rarely necessary.

Antidepressants have been well studied in social phobia. Initial studies used MAOIs and, later, SSRIs, some of which now have a PBS indication for treatment of this disorder. Venlafaxine has also been the subject of placebo-controlled trials and recently also received TGA approval for use in social phobia in Australia.

As noted above, it is wise to start low and go slow. In practice, if an SSRI is chosen, I suggest to patients that they start with half a tablet of the minimum strength available and stay at this dose for a few days until they feel that they are tolerating it and feel comfortable with it. They should then increase to a full tablet and take this for the next two weeks, when a review may be scheduled.

With venlafaxine I recommend starting with the 75mg slow-release tablet (Efexor XR) rather than the 37.5mg tablet, as the latter is not slow release and is more prone to cause nausea. In anxiety disorders a response frequently takes longer than when these compounds are used to treat depression — six weeks to see a significant response is not uncommon.

Higher doses than are commonly effective in depression may be required by some patients. The treating doctor should monitor progress and be prepared to increase the dose as tolerated, up to the recommended daily maximum until an adequate response is achieved.

Given the rather slow response, it seems reasonable to adjust the dose, if required, at intervals of 3-4 weeks. If there is no response after this time, or earlier if the drug is poorly tolerated, another antide-

pressant of the same or a different class should be tried. The tricyclic antidepressants have not been studied in social phobia and there are likewise few or no published placebo-controlled trials of other, newer antidepressants.

Antidepressants are recommended at an early stage of treatment when there is comorbid major depression and when social phobia is severe and generalised. They are almost always required in treating avoidant personality disorder. Unfortunately the evidence indicates that relapse is the rule when antidepressants are discontinued. For this reason it is recommended that, whenever possible, patients also have some exposure to CBT because on current evidence this appears to enhance long-term outcome.

#### Effect sizes, dropouts and long-term outcome

The effect sizes of both pill placebo and psychological placebo conditions (for example, having patients meet and talk about their illness with a therapist but without instructions to confront feared situations or any attempt to modify their thinking about their illness) have been estimated at 0.4-0.5 in social phobia.

The average effect size of CBT has been estimated at 0.8-1.0, indicative of a strong treatment response. Dropout rates range from 10-25%. Effect sizes are generally not reported in the pharmacological treatment literature. However, results from the SSRI treatment literature are consistent in showing that twice as many subjects on SSRIs are classified as much or very much improved, compared with placebo. Functional improvement has also been demonstrated. Dropout rates for antidepressant treatment are usually of the order of 25%.

## Author's case studies

### A better approach to problem blushing

SALLY, 26, is a sales executive who presents with a request for a prescription for Inderal. She explains that her previous GP prescribed it for blushing. You ask her to tell you a little more about the problem. "It's totally unpredictable — sometimes I'm fine, other times I'll blush really badly. It's a real problem at work. If someone stops by my desk to talk to me, I blush. It looks really stupid. Having to present at a meeting is a complete nightmare. Luckily, my supervisor is really sympathetic and she will present for me, or at least do most of it."

You ask Sally why it bothers her so much. "It makes me look like I'm really nervous or something. Like I don't know what I'm talking about. People won't take me seriously." You ask her why she thinks that people won't take her seriously, and she says she gets teased — "You're blushing!" they say.

Sally believes that her boss will lose confidence in her if he sees her blushing, and will not give her important clients. If Sally has to present at a meeting and her supervisor cannot do it for her, she will often call in sick.

Blushing also occurs in other social situations. Mostly she can put up with it when she's with her friends. It happens when she speaks in front of others, especially if she doesn't know them well. "I don't like to be the centre of attention." It can also happen if she feels anyone is looking at her too closely, for example, when standing in a queue or interacting with a sales assistant.

#### Comment

It may appear at first glance that Sally's only problem is that she sometimes blushes in work meetings. However, it becomes clear that she has significant underlying beliefs about herself and how others will perceive her that occur across a range of situations and cause distress and disability consistent with generalised social phobia.

Beta blockers are unlikely to be effective in reducing the symptomatic burden or increasing function, even if they reduce her blushing. The treatment of choice is cognitive behaviour therapy. Depending on the severity of Sally's symptoms and the availability of CBT, an antidepressant could be added. Either an SSRI or venlafaxine (Efexor) would be a suitable first choice.

### Beyond hyperhidrosis

MATT is a 32-year-old single computer technician. He presents complaining of excessive sweating and asks for a referral for the "operation that fixes sweating" that he heard about on a current affairs program (endoscopic thoracic sympathectomy).

Matt appears ill at ease. When you shook his hand you noticed it was quite sweaty, sweat is visible on his brow, and his shirt is wet with perspiration. You discuss the various causes of excessive sweating with Matt. He has no previous medical history, takes no medications, and does not use illicit drugs.

There is no history to suggest pheochromocytoma. A physical and neurological examination is normal.

You ask Matt to tell you a little more about his sweating. He says he has always been "a sweaty guy". He finds it acutely embarrassing. He tries to avoid shaking hands with people, is careful to wear light-coloured clothing, and tries to dress to keep as cool as possible. He doesn't go out much anyway — mainly to the pub with a couple of other single friends from Uni — but will definitely not go if the place doesn't have good air conditioning. "I've never really been one to socialise," he says.

He won't catch public transport if the bus or train looks too crowded, but will wait for another one to come by. This made him late to work quite frequently and his job was under threat, so he found a job where he could work night shifts. "It suits me pretty well anyway," he says. "I can't really talk to people."

You ask Matt what bothers him the most about the sweating. He replies that it makes him look socially inept. "It's humiliating. People will think, 'What's wrong with him? Why is he so nervous?'. 'They'll think I'm a complete loser. No one ever talks to me at parties.'"

This leads you to ask whether Matt sweats excessively when he is alone, or only in company. He says it is mainly when he is around other people. It is really bad with people in positions of authority and with women. As result he does not date and has never had a relation-

ship. "I never know what to say. Anyway, I'm not much of a catch really."

Biochemical and haematological investigations are normal.

#### Comment

Matt may well have hyperhidrosis, but his concern about it is based on unrealistic beliefs about negative evaluation. He is even unwilling to come under scrutiny from strangers.

The degree of concern raises the possibility of body dysmorphic disorder as a differential diagnosis. There is objective evidence of excessive sweating, which argues against this, as does the main concern about the sweating being that it will trigger negative evaluation (in body dysmorphic disorder you would expect the patient to be totally focused on the [in their view] repellant nature of the sweating to others).

There is evidence of more generalised and longstanding social discomfort, with difficulty making conversations, few friends, and social avoidance unless facilitated by alcohol. He gives an impression of low self-esteem, possibly even a sense of inferiority, raising the possibility of a comorbid avoidant personality disorder. It would also be important to exclude comorbid depression, given his social isolation and negative views of himself.

Surgery is unlikely to relieve Matt's problems and give him a normal social life. The most appropriate treatment would be antidepressants and cognitive behaviour therapy. In view of the excessive sweating, an antidepressant with

noradrenergic activity is best avoided, so an SSRI would be first choice.

### Major depression underlying social phobia

ZOE, 18, is a first-year university student who presents towards the end of first semester. She has been unable to complete two recent assignments and can't see any way of passing forthcoming exams.

She is in tears as she tells you that she can't sleep, can't concentrate on her studies and some days can't even seem to get out of bed. She has no appetite and no energy, and has been crying a lot.

She has been feeling this way for a few weeks now, but says she has been having problems ever since the beginning of the year. She felt anxious about lectures and especially with tutorial presentations — so much so that that she kept putting them off and eventually failed to do her required presentations at all.

She hasn't really made any friends at university and feels quite isolated. She doesn't feel that she can cope with it and wonders if she should withdraw.

#### Comment

This case suggests a presentation of major depression with a strong hint of this really being secondary to a social phobia. Antidepressant medication would be appropriate treatment, with follow-up to look for underlying causes after acute symptoms have resolved (the underlying cause in the case being a social phobia).

### Summary

- Social phobia is a common and disabling disorder.
- It is commonly missed because patients may present with depression, substance abuse or physical complaints.
- Social phobia should always be considered when a patient complains of excessive blushing, sweating or shaking.
- CBT is an effective treatment for social phobia.
- Antidepressants are effective first-line pharmacotherapeutic agents: there is little role for benzodiazepines or beta blockers.

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4. Andrews G, et al. *The Treatment of Anxiety Disorders. Clinician Guides and Patient Manuals*. 2nd edition. Cambridge University Press, Cambridge, 2003.
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### Online resources

Anxieties.COM — a self-help website for people with anxiety: [www.anxieties.com](http://www.anxieties.com)

Anxiety Network Australia — "Providing information, education and support to consumers, carers, health practitioners and the wider community on all aspects of Anxiety": [www.anxietynetwork.com.au](http://www.anxietynetwork.com.au)

Anxiety Disorders Association of Victoria (Inc.) — support groups that provide friendship, encouragement and recovery management for people with panic disorder, social phobia, agoraphobia, generalised anxiety and depression: [www.adavic.org](http://www.adavic.org)

Anxiety Treatment Australia — provides information about anxiety disorders, treatment options, psychologists around Australia who treat anxiety disorders, group therapy and workshops, support groups, articles, resources and links to other sites: [www.anxietyaustralia.com.au](http://www.anxietyaustralia.com.au)

## how to treat - social phobia

### GP's contribution



**DR DIANNE CHAMBERS**  
Leichhardt, NSW

#### Case study: undue fear of attention

MS SW, 52, came to see me because of menopausal symptoms. She is single and works as a legal secretary. Her main complaint was of incapacitating hot flushes since her periods had stopped three months previously. On further inquiry it became apparent that her symptoms were an exacerbation of a pre-existing problem.

She told me that whenever she needed to sign any documents she would become hot and clammy and would go bright red. She had elected to not hold any credit cards because of this difficulty, and needed beta blockers when required to sign legal documents.

With further probing she gave a history of similar difficulties when required to perform any task that needed her to 'stand out'. Promotion at work had been side-stepped because she chose to work in a back-office role that would not require much contact with clients and would not provoke her symptoms.

She also admitted that many social situations would also precipitate acute blushing. She therefore avoided going out except to small gatherings of immediate close family or friends.

I spent time talking with her about her difficulties. We discussed the physiological fight-or-flight response as the precipitant of many of her symptoms. She is intelligent and had partly recognised the degree to which she had limited her life because of avoidance behaviour.

I offered CBT with or without SSRI medication. However, she stated that she had managed to cope until the recent onset of menopause. She resisted any other medications but was interested in a discussion about treatment of menopausal symptoms. With HRT she feels she is back to her previous level of functioning and has not wanted to take up any other therapeutic interventions.

#### Questions for the author

I present this case because of the very situational nature of this woman's symptoms, espe-

cially given her career choice as a legal secretary. Can you comment further? Do you find such localised symptoms often?

In my view, this woman's symptoms are not localised. She has difficulty in a wide range of situations, not just signing documents but also socialising (which she largely avoids), dealing with clients (which has limited her occupational functioning and perhaps job satisfaction) and, in fact, any activity that would cause her to stand out in any way.

If it now seems that relatively few situational triggers remain, this is because of the significant degree to which she has restricted her life. This case shows how the patient can underestimate the impact of social phobia because her focus is on what she sees as a physical problem and because over the years she has restricted her life around her illness so that its true impact is not obvious.

**This patient has a very specific situational anxiety, for which she has used beta blockers successfully. In your article you advised against their use; however, many patients who can predict their specific trigger, such as having to make a speech, find them very helpful. By reducing the symptoms of anxiety, patients can adopt a graded exposure to the precipitating event and, as in this woman's case, learn to mostly cope. Can you elaborate further on your recommendations against the use of beta blockers?**

In this case, Ms SW has coped by avoiding situations that made her anxious, and has used beta blockers to get through what she couldn't avoid. I see this as a life unnecessarily restricted, given that effective treatments could have enabled her to do more, and with less distress.

It is true that she has chosen to use beta blockers in a very specific situation (signing legal documents) but her illness extends to far more situations and, had she had treatment for the basic underlying condition — her social phobia — then she may well have found herself able to sign legal documents without needing beta blockers.

In her case, holding credit cards and regularly signing credit vouchers would have been excellent practice (graded exposure) for signing legal documents. Instead, she has chosen to avoid any type of signing situation and to use beta blockers for the one type of signing situation that she couldn't avoid.

In this woman, beta blockers have facilitated avoidance rather than graded exposure and, unfortunately, without specific advice this will often prove to be the result.

I would also like to comment on this woman's choice to decline further offers of treatment. It might depend on what, if anything, she thought she had to gain. If this woman thought that her usual level of functioning was the best she could expect, it is not surprising that she declined the offer of further treatment.

It would be good to explore her social 'wish list'. I note that she is single; did her social phobia prevent her from finding a life partner? Does she have a good social network? If not, would she like one? Would she prefer to socialise more widely, perhaps joining in exercise groups or community activities?

If these were aspirations of hers and she realised that further treatment might have made these things possible, would she still have declined it? Perhaps she may feel now that it is too late to attempt large-scale change, but what if she had been offered these alternatives at the time of writing the very first script for a beta blocker?

#### General questions for the author

**I have looked at the AforAnxiety.com website recommended in your article and found it to be excellent and would agree that is an excellent resource for both GPs and patients. Are you aware of moodgym, a similar online self-help website? What is the success rate of these and similar resources?**

The AforAnxiety website does not offer treatment, and

hence an evaluation in terms of 'success rate' is not applicable. It can be seen as more of a resource for both patients and clinicians, offering reliable information and some treatment resources that can be used in conjunction with clinician visits.

Regarding online resources in general, three main types of interventions have been evaluated. The least evaluated are stand-alone online treatment interventions with little or no therapist interaction. Such applications appear to suffer from high drop-out rates (eg, more than 50%) with few individuals completing treatment.

Web-based communication and support sites (depressionNet would be an example) are often felt to be of value by users of the sites. Computer-based applications (email, virtual reality exposure, behavioural recording and homework generation) used as an adjunct to face-to-face therapy have shown some potential to be able to reduce the amount of therapist time required for each patient, but require further evaluation (for a review, see: Tate DF, Zabinski MF. Computer and internet applications for psychological treatment: update for clinicians. *Journal of Clinical Psychology* 2004; 60:209-20).

**CBT often involves the use of problem solving and the completion of specific homework. Can you point us to a source for these printouts to distribute to patients?**

AforAnxiety has some materials that can be downloaded. They contain the basic outline of the technique (problem solving or graded expo-

sure, for example), and it is up to the clinician to provide the specifics tailored to the individual patient.

The clinical management and treatment education (CLIMATE) system offers more specific illustrations of CBT in practice and can generate appropriate homework for patients. You can evaluate this system (a not-for-profit initiative of St Vincent's Hospital, Sydney) at [www.climate.tv](http://www.climate.tv).

**Given the strong genetic predisposition for social phobia, what preventive actions would you recommend we take for children in families with recognised social phobia?**

I am not aware of any systematically evaluated primary prevention strategies and, of the limited research that has so far examined targeted prevention, long-term results have been disappointing.

Because avoiding social experiences reinforces social fears, prevents an individual from experiencing positive social outcomes and may also inhibit the acquisition of social skills as well as strategies to cope with social errors (an inevitable aspect of socialising), it would make clinical sense to give parents advice to encourage their children to socialise and to provide social opportunities for them.

It might also be helpful for parents to model coping strategies for managing anxiety, perhaps along the lines of 'having a go' despite feeling anxious about something.

**Depression often accompanies social phobia and it seems that SSRIs are the best choice for its treatment. Can you differentiate among the SSRIs as to their efficacy in treating the anxiety component of social**

**phobia? Would you consider using SSRIs long term? Is there a place for short-term use of anxiolytics?**

Clinically I cannot distinguish between the SSRIs for effectiveness in social phobia. Some SSRIs have been studied more extensively in social phobia than others but there are no comparative trials to suggest any outcome differences. I make a choice based on small differences in side-effect profiles, patient experience and patient preference.

Note that antidepressants do not just treat the anxiety component of social phobia but also result in functional gains, ie, they also reduce avoidance. Neither beta blockers nor benzodiazepines result in significant functional improvement.

I would certainly consider using SSRIs (and any other antidepressant that had proven to be effective for that individual) in the long term for the severely disabled patient.

There is a place for the short-term use of benzodiazepines in acute anxiety states, although social phobia is more often a chronic condition. Benzodiazepines may also be considered when all other treatments have failed.

**Do you have any feelings about the use of herbal treatments such as St John's wort or rescue remedies? I have some patients who carry half a Valium in their purse "just in case". It remains mostly unused but these crutches may help some to cope. Is the use of such probably placebo effects valid?**

Many patients are more comfortable trying herbal remedies when they first consider trying a pharmacological treatment to relieve their anxiety. I am completely comfortable with this and provide whatever information I can regarding their chosen remedy (including effectiveness and side effects).

I see the medical practitioner's role as also providing safety information; for example, St John's Wort can interact with other pharmacologically active compounds via the cytochrome P450 system.

The carrying of half a valium "just in case" is certainly not a placebo. It is like the high wire artist's safety net and, indeed, is often referred to as a 'safety behaviour' in CBT.

Many patients can function well despite never quite letting go of all their 'safety behaviours'. However, others with numerous or intrusive safety behaviours will need to let go of them and take more risks if they are to achieve their goals of social and occupational functioning.

#### HOW TO TREAT

Editor: Dr Lynn Buglar  
Co-ordinator: Julian McAllan

#### NEXT WEEK

The next How to Treat confronts the problem of communication as a barrier to indigenous health. The author, Dr Ernest Hunter, is regional psychiatrist, Queensland Health, and professor, North Queensland health equalities promotion unit, school of population health, University of Queensland.