Social anxiety disorder

Synonym: social phobia

What is social anxiety disorder?

Social anxiety disorder was recognised as a psychiatric entity in 1980. It is persistent fear and anxiety about one or more social or performance situations.

We all have some degree of social anxiety. It may be regarding an interview or a public performance such as public speaking, acting, singing or playing a musical instrument. A certain amount of adrenaline (epinephrine) can enhance the performance but we are all aware of how too much can also ruin it. A fairly normal trait may become a disease when the severity interferes with normal everyday life.

How common is social anxiety disorder? (Epidemiology)

Social anxiety disorder is one of the most common anxiety disorders. Prevalence has increased in young people since the COVID-19 pandemic.[1] It has been estimated that worldwide prevalence is between 5-10% with a lifetime prevalence of 8.4-15%.[2] This compares to 6% for generalised anxiety disorder, 5% for panic disorder and 2% for obsessive-compulsive disorder.[3] Like most other phobias, social phobias are more common in women.[4] They are also more common in adolescents and young people with a median age of onset of 13 years.[5]

Features of social anxiety disorder[6]

- Social anxiety is a fear of being around people and having to interact with them. Those affected by the disorder fear being watched and criticised. Normal activities such as working, shopping, or speaking on the telephone are marked by persistent feelings of anxiety and self-consciousness. They feel dread as a situation approaches and afterwards they analyse or ruminate on how they could have done better. Hence, it may be seen as a fundamentally normal response but exaggerated to the point of being pathological.
- Physical symptoms include trembling, blushing, sweating and palpitations.
- They often experience chronic insecurity about their relationships with others, excessive sensitivity to criticism and profound fears of being judged negatively, mocked, or rejected by others.
- There are two forms of the condition:
    - **Generalised social anxiety** which affects most, if not all areas of life. This is the more common type and affects around 70% of those affected by the disorder.
    - **Performance social anxiety**, where these feelings only occur in a few specific situations such as public speaking, eating in public or dealing with figures of authority.
- Social phobias often start in adolescence and are centred around a fear of scrutiny by other people in comparatively small groups, often peer groups, rather than crowds, leading to avoidance of social situations. It can start in childhood and any assessment must take account of what is appropriate for age.
- There may be specific problems such as eating in public, public speaking, or encounters with the opposite sex; or, they may be diffuse, involving almost all social situations outside the family circle. A fear of vomiting in public is not uncommon. This is called emetophobia. Direct eye-to-eye contact may be avoided - but in some cultures it is inappropriate to look one's superiors in the eye, so ethnic and cultural norms need to be differentiated from the abnormal.

- There is usually low self-esteem and fear of criticism.[7] They may present to the doctor complaining of flushing, tremor, nausea, or urgency of micturition. They may be convinced that these physical manifestations of anxiety are the primary problem. It may progress to panic attacks. Avoidance may be marked or extreme, resulting in almost complete social isolation.
- Social anxiety disorder has a median age of onset of 13 years; however, it is often persistent and only about 50% with the problem will seek treatment. Commonly they only seek treatment after 15-20 years of symptoms.[3]
- There is some evidence that depression may be a common comorbidity.[8]

Identification and assessment

Identification of social anxiety disorder

The National Institute for Health and Care Excellence (NICE) recommends the use of identification questions for anxiety disorders, in line with their guidelines. These ask about feelings of anxiety and their ability to control worry using the two-item Generalised Anxiety Disorder scale (GAD-2). However, if social anxiety disorder is suspected then they recommend:

- Use of the 3-item Mini-Social Phobia Inventory (Mini-SPIN); or
- Considering asking two questions:
    - Do you find yourself avoiding social situations or activities?
    - Are you fearful or embarrassed in social situations?

Scoring 6 or more on the Mini-SPIN (see below), or answering 'yes' to either of the two questions, suggests further assessment for social anxiety disorder is warranted.

Important information

The Mini-SPIN is generally used as a screening instrument for social anxiety disorder.[9]
It contains three items that should be asked and are about avoidance and fear of embarrassment rated on experience in the previous week. The items are rated using a 5-point Likert scale: 0 = not at all, 1 = a little bit, 2 = somewhat, 3 = very much, 4 = extremely.
Ask the person to answer whether:
Fear of embarrassment causes me to avoid doing things or speaking to people.
I avoid activities in which I am the centre of attention.
Being embarrassed or looking stupid are among my worst fears.

It is also worth being alert to the possibility of depression and NICE recommends the use of two questions:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

Answering yes to either of these would point towards the need for further assessment.

Assessment of social anxiety disorder

Some people may find attending the surgery distressing and an initial contact may have to be made via telephone. However, face-to-face contact will be needed for ongoing assessment and treatment.

The initial assessment will need to consider fear, avoidance, distress and functional impairment while considering the possibility of comorbid disorders. The following factors should be considered in assessing the person's current social anxiety and associated problems:

- Feared and avoided social situations - as well as what they are afraid will happen to them in those situations (eg, blushing, sweating, trembling, etc).
- Anxiety symptoms.

- View of self and content of self-image.
- Safety-seeking behaviours.
- Focus of attention in social situations.
- Anticipatory and post-event processing.
- Occupational, educational, financial and social circumstances.
- Current and past medication, alcohol and recreational drug use.

It is possible that a person may not return after initial contact or assessment. This is in the nature of the disorder, so efforts should be made to contact them (by their preferred method) and reduce barriers to further assessment and treatment.

Differential diagnosis[6]

A degree of depression or another diagnosis may be present but the final diagnosis needs to be made on the basis of the most important features. The following conditions may need to be considered when coming to a diagnosis:

- Panic disorder with agoraphobia or agoraphobia without panic disorder.
- Separation anxiety disorder. This is really a behavioural pattern of small children that presents at an inappropriate age, as in adolescence.
- Generalised anxiety disorder, also known as anxiety neurosis.
- Specific phobias may need distinguishing from social anxiety disorder.
- Schizoid personality disorder - which is not the same as schizophrenia. They tend to be emotionally rather cold and isolated but it excludes Asperger's syndrome and autistic spectrum disorders.

- Avoidant personality disorder is a continuum, even perhaps a more severe form of social anxiety disorder. The European definition requires at least three of the following:

    - Persistent and pervasive feelings of tension and apprehension.
    - Belief that one is socially inept, personally unappealing, or inferior to others.
    - Excessive preoccupation with being criticised or rejected in social situations.
    - Unwillingness to become involved with people unless certain of being liked.
    - Restrictions in lifestyle because of the need to have physical security.
    - Avoidance of social or occupational activities that involve significant interpersonal contact because of fear of criticism, disapproval, or rejection.

- There is considerable association between social anxiety and alcohol-related problems.[10] A level of suspicion is required, as the potential for problematic or hazardous drinking may need exploration and the direction of causation may also be unclear.
- Performance anxiety, stage fright, and shyness are more personality traits than diseases.

Management of social anxiety disorder[3]

After diagnosis, NICE recommends that information be provided about the disorder and its treatment. Goals for treatment can be set. Treatment may be psychological, pharmacological or both.

If there are also symptoms of depression it is necessary to establish, if possible, which came first. If it is apparent that the depression preceded the significant social anxiety then the depression should be treated. Otherwise, it is reasonable to treat the social anxiety disorder first, depending on the preference of the patient.

Initial treatment options

- Adults with social anxiety disorder should be offered individual cognitive behavioural therapy (CBT).
- Adults who decline CBT can be offered CBT-based supported self-help.
- In adults who decline any cognitive behavioural interventions and express a preference for medication, NICE recommends a discussion to address any concerns. Should they still wish to have medication then NICE recommends a selective serotonin reuptake inhibitor (SSRI) such as escitalopram or sertraline.[11]
- Adults who decline medication and CBT could be considered for short-term psychodynamic psychotherapy.

Adults with no or only partial response to initial treatment

- There is some evidence that young people with social anxiety disorder have lower rates of treatment success with generic CBT than other anxiety disorders.[5]
- In adults having a partial response to CBT consider adding medication; or add individual CBT to those having a partial response to medication.
- In those with no response to an SSRI consider an alternative SSRI such as fluvoxamine or paroxetine. Alternatively, a serotonin noradrenaline reuptake inhibitor (SNRI) such as venlafaxine can be considered. Both venlafaxine and paroxetine can produce a discontinuation syndrome - but this can be reduced by use of an extended-release preparation.
- If there is no response to an alternative SSRI or SNRI then a monoamine-oxidase inhibitor may be considered.

Additional advice when using medications

NICE makes additional recommendations on the monitoring of pharmacological interventions which relate to the risk of side-effect and the problems of increased suicidal thinking and self-harm associated with medications in younger people.

- Full advice about benefits and risks of medication should be discussed with patients and in particular the risk of early activation symptoms (increased anxiety, agitation, jitteriness) and the development of the anxiolytic effect over two or more weeks
- People aged 30 years or more, who have been prescribed an SSRI or SNRI, should be reviewed within 1-2 weeks to discuss possible side-effects and for general advice and support. NICE recommends review every 2-4 weeks for the first three months of treatment.
- Warn people aged under 30 that SSRIs and SNRIs are associated with an increased risk of suicidal thinking and self-harm in a small number.
- Review people aged under 30 within one week of first prescribing and monitor them weekly for risk of self-harm and suicidal thinking for the first month.
- Anyone who is at increased risk of suicide and is prescribed medication needs careful monitoring and this may be best achieved by a community mental health service. They should be reviewed weekly until there is no suggestion of increased risk.

Other interventions

- NICE recommends that anticonvulsants, tricyclics, benzodiazepines or antipsychotic medication should not routinely be offered to treat social anxiety disorder.
- Mindfulness-based interventions or supportive therapy are not recommended by NICE.
- Botulinum toxin for excessive sweating is not recommended, as there is no good evidence of benefit and it may be harmful.
- There is some evidence that an online self-help tool based on CBT principles may be beneficial for those not receiving any other form of support.[12] .
- Virtual reality exposure therapy may be a promising future option.[13]

Prognosis[6]

Unrecognised and untreated, social anxiety disorder may become a lifelong problem with many negative consequences for the individual's quality of life. These may include poor attainment at school, negative impacts on forming relationships and finding a job, with subsequent financial implications. Many with the condition find it difficult to accept they have a disorder that can respond to treatment.[14]

Further reading

- Generalised anxiety disorder and panic disorder in adults: management; NICE Clinical Guideline (January 2011 - updated June 2020)
- Garakani A, Murrough JW, Freire RC, et al; Pharmacotherapy of Anxiety Disorders: Current and Emerging Treatment Options. Front Psychiatry. 2020 Dec 23;11:595584. doi: 10.3389/fpsyt.2020.595584. eCollection 2020.
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Authored by:	Peer Reviewed by: Dr Toni Hazell	
Originally Published: 20/11/2023	Next review date: 16/04/2023	Document ID: doc_2790

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