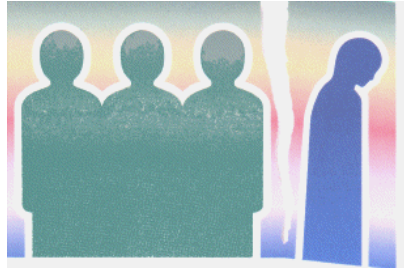


Social Phobia



**A comprehensive course
for medical practitioners**

- 1. Introduction**
- 2. Integrated scenario**
- 3. Slide presentation**
- 4. Slide copies**
- 5. Case histories**

Introduction

Acknowledgements

Introduction from the WPA

How to use the workshop programme

Specimen invitation letter to the workshop

Specimen reply card

Specimen certificate of attendance

Acknowledgements

WPA educational programme on social phobia was made possible by the guidance and expertise of the WPA social phobia task force.

WPA Social Phobia Task Force

Chairman:

Prof. J.A. Costa e Silva, Brazil

Members:

Prof. J. Angst, Switzerland

Dr. J. Davidson, USA

Prof. M. Keller, USA

Prof. J-P Lépine, France

Dr M. Liebowitz, USA

Prof. J.J. Lopez-Ibor, Spain

Prof. S. Montgomery, UK

Prof. R. Priest, UK

Dr J. Siegel, USA



Dear Colleague,

The World Psychiatric Association in cooperation with E Hoffmann-La Roche Ltd. has organized an international educational program to increase awareness, diagnosis, and treatment of social phobia, an anxiety disorder increasingly recognized to cause significant harm to individuals, families, and society as a whole.

The workshops that you have agreed to lead are an integral and critical element of the programme. They serve several vital purposes:

1. Introduce physicians to the concept and importance of social phobia as a major, treatable psychiatric disorder.
2. Improve their recognition, diagnosis and management of social phobia
3. Encourage them to follow the full WPA Social Phobia Educational Programme to completion to ensure their maximum effectiveness in daily practice.

Your commitment and enthusiasm as a trainer will be crucial in achieving these objectives.

On behalf of the World Psychiatric Association - and all the patients who will surely benefit from your efforts - may I personally thank you for your contribution to this important undertaking.

Fraternally yours,

Prof. JA. Costa e Silva
Chairman of WPA social phobia task force

How to use the workshop programme

The materials in this binder are designed to offer a flexible and practical approach to education on social phobia. They may be used to provide a simple, straightforward slide lecture on the subject, or can be expanded into a full interactive workshop.

The core element of the programme consists of 15 slides with full commentaries. Used alone this 'master module' will provide a slide lecture of approximately 30 minutes duration.

In addition there are also six 'mini modules' of one or two slides each. These can be added, individually or together, to extend the slide presentation to a maximum of around 60 minutes.

To aid identification the mini modules are clearly labeled and have been printed on green paper.

For trainers who wish to present a more interactive session, an 'integrated scenario' is provided. This incorporates all the slides together with a number of questions that may be answered by use of an interactive voting system (IVS). The IVS system is explained in full in Chapter 2. The full-integrated scenario lasts around two hours. By removing the mini modules, this may be shortened to 90 minutes.

To complete the interactive workshop, five case histories have been provided together with instructions on how to use these in live role playing exercises. A video of real patients talking about their condition can also help the teaching of practical diagnostic skills.

This modular structure of the workshop may be summarized as follows:

The modules are:

- Master module - 15 slides with commentaries
- 6 mini modules - of 1-2 slides each, all with commentaries
- Integrated scenario - Slides and commentaries integrated with interactive questions · Case histories - video showing real patients talking about their condition. Plus 5 written case histories to be used in role playing.

This design allows variations around 5 presentation options:

- 30 minute slide presentation - using master module
- 60 minute slide presentation - using master module plus 6 mini-modules
- 90 minute interactive workshop - using integrated scenario minus the 6 mini-modules
- 120 minute interactive workshop - using the integrated scenario
- 150 minute interactive workshop - using integrated scenario plus video and role playing

To help you organize interactive workshops, this binder also contains specimen copies of an invitation letter to prospective participants, a reply card and a certificate of attendance.

Specimen invitation letter

**Invitation to a
World Psychiatric Association Workshop on Social Phobia**

Dear colleague

In recent years the anxiety disorder social phobia has been receiving increased scientific and public attention. This has resulted in vastly improved diagnostic techniques, new effective treatments and, of course, an increased public demands for professional help.

Unfortunately, despite this growing public profile, social phobia still remains under-diagnosed and poorly treated. It has been estimated that fewer than 25 per cent of social phobia sufferers receive treatment. Those who do receive medical help often receive inappropriate therapies.

In part, the reason for this is simply that the improved knowledge and understanding of social phobia has yet to filter through from the academic journals to clinical practice. Most sufferers are also unaware that the medical profession may be able to help them with their problems.

To help improve the dissemination of research advances to as wide as possible an audience, that the World Psychiatric Association has recently prepared a comprehensive educational programme aimed at improving the diagnosis, management and general understanding of social phobia.

An integral part of this educational initiative is an interactive workshop programme.

By involving practicing physicians in stimulating and interactive training workshop the WPA believes it can substantially improve the diagnosis and management of a disabling and distressing condition.

If you would like to attend a WPA interactive workshop on social phobia, please complete and return the enclosed form.

Yours sincerely

Name

Title

Specimen reply card

Yes I am interested in the WPA Social Phobia Educational Programme:

Please enroll me for the workshop

Please send me more information

Name.

Address

Post code

Tel No

Integrated scenario

Master module

+

Mini modules

+

Interactive questions

Integrated workshop scenario

Introduction

This chapter is a comprehensive guide to conducting a complete workshop. It contains all the IVS questions and slides in the order they are intended to appear, plus an indication of when to use the live role playing exercises. The suggested commentaries are offered as a guide to how each slide or question should be presented to the participating GPs.

The modular format of the workshop allows three options for interactive sessions:

- For a 2.5-hour workshop use the full scenario with video case histories and live role-playing
- For a 2-hour interactive presentation use the full scenario
- For a 90-minute interactive presentation use the full scenario minus the 6 mini modules

How to use the Interactive Voting System (IVS)

The workshops have been designed to maximize participation and facilitate commitment by incorporating an electronic Interactive Voting System (IVS).

- Each physician is provided with a small keypad linked to a portable computer
- At appropriate moments during the workshop, the leader asks a pertinent multiple-choice question
- Each participant anonymously responds by pressing the appropriate button(s) on the keypad
- The computer collates the responses and instantly displays them as a histogram on a screen.

Using the Interactive Voting System allows the leader to assess the knowledge (or lack of it) of the group on every significant aspect of the subject and tailor his or her comments accordingly.

It also provides the opportunity to open a discussion on key points raised by the group's responses.

Objectives of the Interactive Voting System

In addition to stimulating participation, the questions developed for the IVS have been structured to achieve several specific objectives:

Create sensitization

At the beginning of the workshop, the participants are asked a few general questions about social phobia, which the majority may answer incorrectly. Demonstrating to the participants - individually and anonymously - to what degree their knowledge is incomplete or erroneous will make them much more open to the information which follows.

Reinforce the slide programme

At key points IVS questions are asked to evaluate comprehension of a previously shown slide, or to prepare the participants for the succeeding slide.

Reinforce role-playing

The participants are asked questions specific to the role-playing exercise in order to bring out and highlight key educational messages.

- For live role playing, questions are asked and discussion engaged after the role playing session to avoid interrupting the proceedings.
- For videotape role playing, questions are asked and discussion engaged at key points during the role playing exercise (the tape is stopped at key points).

How to use Interactive Questions and Answers (IQA)

Interactive Questions and Answers (IQA) are designed to serve in place of the Interactive Voting System (IVS) where use of IVS is impractical. The IQA concept preserves the benefits of IVS. Specifically:

- Workshop participants will be able to respond to key questions in complete anonymity
- The workshop leader will have an immediate gauge of the knowledge and concerns of the group, in order to tailor the workshop to the group's specific interests
- The participants will have an immediate gauge of how their know(ledge and opinions compare with those of their colleagues
- IQA will act as a catalyst for generating fruitful discussion, initiated either by the participants or the workshop leader

Structure of IQA

The same list of key questions available for IVS is used for IQA. The questions will be displayed to the participants via overhead projector transparencies. There are two ways to respond:

- For non-controversial questions, response may be by a show of hands.
- For controversial questions, where it is important to preserve anonymity, response will be by specially prepared answer sheets.

These answer sheets have been carefully designed to ensure anonymity, and to permit rapid collation and analysis so that the workshop leader can almost immediately report and comment on the results. There are five stages in this process:

1. Each participant will receive a separate sheet with questions and answers
 2. Each answer will have a box at the far right-hand side of the page where the participants will tick their choice or choices
 3. After each question, the sheets will be collected
 4. The workshop leader (or preferably an assistant) will align a corresponding template with each sheet and rapidly transcribe the ticks
 5. Once the ticks have been transcribed, the sheets will be redistributed to the participants at random
- In other words, participants will always receive a different sheet to respond to succeeding questions; this ensures complete anonymity

Sample question and answer Sheet

Question 1

What percentage of the population will suffer social phobia at some stage in their lives?

- | | | | |
|---|------------------|---|-------------------------------------|
| 1 | 0 - 4 per cent | 1 | <input type="checkbox"/> |
| 2 | 5 - 9 per cent | 2 | <input type="checkbox"/> |
| 3 | 10 - 14 per cent | 3 | <input checked="" type="checkbox"/> |
| 4 | 15 - 19 per cent | 4 | <input type="checkbox"/> |
| 5 | Over 20 per cent | 5 | <input type="checkbox"/> |

Question 2

What is the average age of onset for social phobia?

- | | | | |
|---|---------|---|-------------------------------------|
| 1 | 0 - 10 | 1 | <input type="checkbox"/> |
| 2 | 11- 20 | 2 | <input checked="" type="checkbox"/> |
| 3 | 21 - 30 | 3 | <input type="checkbox"/> |
| 4 | 31 - 40 | 4 | <input type="checkbox"/> |
| 5 | 41-50 | 5 | <input type="checkbox"/> |
| 6 | Over 50 | 6 | <input type="checkbox"/> |

Sample answer template

Question 1

Question 2

To record the answers, the workshop leader (or preferably an assistant) simply aligns the first answer sheet with the template and transcribes the tick or ticks; he then aligns the second answer sheet with the template and transcribes the ticks, and so on.

When all the ticks have been transcribed, it is easy to read the results directly from the template.

Introduction to the workshop

Describe the Interactive Voting System

Warm-up questions

IVS question

How did you come here today?

1. By car
2. By bus
3. By train
4. On foot
5. By camel

IVS question

Why are you here?

1. To learn
2. To eat
3. To meet colleagues
4. TV broken
5. No idea

Introduction

Commentary

We are here today to talk about a relatively recently recognized psychiatric condition called social phobia. Most of you will have heard of this condition but many of you will be unsure of exactly what it is. Some of you may even doubt its existence.

General introductory questions

These questions precede the first slide. A short commentary is suggested after each of these introductory questions to set the scene for the workshops. The correct answer is underlined.

IVS question

What is social phobia?

- 1 Extreme shyness
- 2 A personality disorder
- 3 An anxiety disorder
- 4 A mood disorder

Show slide 1 after vote



Slide 1

Commentary

Social phobia has been recognized by both the World Health Organization's International Classification of Diseases (ICD-10) and the American Psychiatrist's Association (DSM-IV) as a widespread and debilitating anxiety disorder.

ICD-10 further classifies it as a phobic anxiety disorder.

Points for discussion:

1. While a sufferer of social phobia may interpret his or her symptoms as an unfortunate trait of personality, the disability and avoidance behaviour caused by social phobia go far beyond the discomfort caused by shyness.
- 2, 4 Although many sufferers of social phobia may go on to develop conditions such as avoidant personality disorder or major depression, these are comorbid conditions and not part of the primary social phobia.

IVS question

Compared with panic disorder and agoraphobia, the distress, disability and drain on medical resources due to social phobia is:

- 1 Substantially greater
- 2 Marginally greater
- 3 About the same
- 4 Marginally smaller
- 5 Substantially smaller
- 6 No opinion

Commentary after the vote

The evidence suggests that the disability due to social phobia is greater than that due to the other conditions. Whether the difference is marginal or substantial is probably a matter of opinion.

Nevertheless one comparison using the Sheehan disability score found that patients with social phobia reported significantly more disability than those with panic disorder, with more anxiety and more avoidance behaviour.

Points for discussion

1,2 If there is a consensus around marginally greater or substantially greater, suggest that this is a good starting point for a fruitful workshop.

4,5 If there is a consensus around marginally less or substantially less, suggest that this opinion may change during the workshop.

6 If there are a lot of no opinions, suggest that the aim of the workshop is to help participants form opinions on important topics such as these.

- If there is a wide distribution of opinion, suggest that the participants may move towards more of a consensus by the end of the workshop.

Epidemiology of social phobia

IVS question

What percentage of the population will suffer social phobia at some stage in their lives?

- 1 0 - 4 per cent
- 2 5 - 9 per cent
- 3 10 - 14 per cent
- 4 15 - 19 per cent
- 5 Over 20 per cent

Commentary after the vote

Although early estimates of social phobia's prevalence suggested that it was a relatively rare disorder, recent advances in diagnostic techniques have led to the recognition that social phobia affects at least one person in ten at some time in their lives.

Slide 2



Commentary

Recent European studies have estimated the lifetime prevalence at between 9.6 per cent and 16 per cent. This is broadly in line with the US estimated prevalence of 13.3 per cent. About 3 per cent of the US population are suffering social phobia at any one time. This slide also nicely illustrates the difference in prevalence rates obtained by the DSM and ICD-10 diagnostic criteria. Wacker et al used both criteria on the same study population and obtained quite different results.

IVS question

What is the average age of onset for social phobia?

- 1 0 - 10
- 2 11-20
- 3 21 - 30
- 4 31 - 40
- 5 41 - 50
- 6 6 Over 50

Show slide 3 after vote.

Slide 3



Commentary

Social phobia characteristically begins in the mid teenage years - a time when it is likely to cause the greatest damage to psychological development, the formation of relationships and the establishment of life goals.

Apart from this onset at an early age, there are few other risk factors identified for social phobia. It appears not to discriminate on grounds of gender nor between social classes. However, the detrimental effects of social phobia on sufferers' education, performance at work and ability to form relationships leads to it being found most often in single people of reduced financial means.

Burden of social phobia

Slide 4



Commentary

Social phobia is a debilitating, chronic, largely unremitting disorder which, if left untreated, can lead to a high risk of morbidity, alcoholism, drug abuse and suicide. Its effects exert a severe personal burden on individual sufferers.

Slide 4a



Commentary

Social phobia also exerts an economic burden, not only on sufferers themselves, but also on society at large.

This slide shows that, although social phobia is still a poorly diagnosed condition, it still accounts for a considerable amount of health care costs.

This is largely due to the extensive degree of comorbidity in social phobia which means that even if patients are not offered treatment for their primary condition they are likely to receive it for something else.

Slide 4b



Commentary

Other contributions to the overall cost to society of social phobia include sufferers' reduced earning potential, their higher rate of dependence on welfare benefits. Sufferers of social phobia are more likely than the general population to suffer alcohol problems. And one study has found that juveniles with social phobia are more likely than controls to steal and to fight at school.

Slide 5



Commentary

A major contributor to the suffering caused by social phobia and its cost to society is the link with alcohol abuse. The World Health Organization estimates that European countries spend approximately 6.8 per cent of their Gross National Products coping with the problems of alcohol abuse. It is therefore of strong economic significance that social phobia sufferers are twice as likely as the general population to have problems with alcohol. People with alcohol problems are nine times as likely as the general population to have social phobia.

Under-recognition

Slide 5a



Commentary

Despite the epidemiological evidence that social phobia is a widespread disorder, it is still very rarely diagnosed in general practice. There are several reasons for this.

Patients and doctors are equally affected by cultural attitudes to shyness. This may lead some to conclude, wrongly, that social phobia is in fact just an exaggerated trait of personality.

Patients may be reticent about seeking help, either because they want to avoid the stigma of a mental illness or because, due to the very nature of social phobia, they are anxious about meeting strangers.

Finally, it is only recently that effective treatments have become available, so patients may have felt there was no point in seeking professional help.

Slide 5b



Commentary

The relatively recent recognition of social phobia as a discrete clinical entity means that many medical practitioners, particularly in primary care, are still unfamiliar with the concept of social phobia. Many GPs may be unclear over the point at which a patient's disability meets the diagnostic threshold for social phobia.

The very high rate of comorbidity in social phobia can also complicate diagnosis. Social phobia symptoms are often masked by those of the comorbid condition. Coping strategies such as alcohol abuse may also mask symptoms.

Presentation and diagnosis

Slide 6



Commentary

ICD-10 defines social phobia as being centered around a fear of scrutiny by other people in comparatively small groups (as opposed to fear of crowds).

Sufferers may go to extreme lengths to avoid the feared situation. Or, if the situation cannot be avoided, the sufferer will find the experience extremely distressing.

Slide7



Commentary

There are two forms of social phobia.

In its diffuse or generalized form the condition will cause fear of almost all social situations outside the family circle.

In its non-generalized form social phobia is discrete and relates to specific situations such as eating in public, public speaking or encounters with the opposite sex.

In order to qualify as social phobia, the fear must be both excessive and disabling. The normal performance anxiety we all experience when speaking in public does not qualify as social phobia, however uncomfortable it may seem at the time.

Slide 8



Commentary

The situations that most commonly bring on symptoms of social phobia are listed in this slide. Exposure to the feared situation causes the sufferer to experience the typical somatic symptoms of anxiety - palpitations, trembling, sweating, tense muscles, a sinking feeling in the stomach, dry throat, hot or cold feelings or headache.

The sufferer may go to extreme lengths to avoid the situations that precipitate the phobic symptoms. This avoidance behaviour can be just as debilitating as the symptoms themselves and in extreme cases may lead to almost complete social isolation.

Comorbidity

IVS question

What proportion of social phobia sufferers will experience another psychiatric disorder in their lifetime?

- 1 0 - 19 per cent
- 2 20 - 39 per cent
- 3 40 - 59 per cent
- 4 60 - 80 per cent
- 5 80 - 100 per cent

Commentary after the vote

Over 75 per cent of patients with social phobia will suffer at least one other psychiatric disorder at some stage in their life.

Slide 8a



Commentary

So, far from being the exception, it appears that comorbidity is the norm for patients with social phobia. Indeed, the diagnosis of uncomplicated, non-comorbid social phobia almost certainly indicates the need to probe for the existence of other psychiatric disorders.

Slide 9



Commentary

A wide range of comorbid conditions has been described for social phobia. These include (read from slide).

Slide 9a



Commentary

The significance of this high rate of comorbidity is that, quite apart from complicating the diagnosis, comorbid conditions also dramatically increase the disabling consequences of social phobia.

In particular sufferers of comorbid social phobia are far more likely to commit suicide than those with the uncomplicated condition.

Slide 10



Commentary

In over 70 per cent of cases where a patient is suffering social phobia in conjunction with another condition, it is the social phobia that appears first.

The primary onset suggests that social phobia is precipitating the onset of the subsequent condition.

The earlier detection and treatment of social phobia could therefore help prevent comorbidity and thereby save many patients from a great deal of disability and distress.

IVS question

Differential diagnosis between social phobia and agoraphobia should focus on:

- 1 The extent of the avoidance behaviour (i.e.: situations always avoided or only sometimes avoided)
- 2 The source of the patients fears (i.e.: specific situations or generalized fear of losing control)
- 3 The presence or absence of panic attacks
- 4 The use of coping strategies such as alcohol or drug abuse
- 5 The somatic anxiety symptoms experienced by the patient (i.e.: blushing, sweating, palpitations etc)

Commentary after the vote

In social phobia the essential feature is fear of being scrutinized. In agoraphobia the feared situations are more generalized. For instance, while fear of travelling by train is common in both social phobia and agoraphobia, the social phobia sufferer will have no problems if the train carriage is empty.

Points for discussion

- 1 Avoidance behaviour is a typical feature of both agoraphobia and social phobia.
- 2 Although more common in agoraphobia, panic attacks are also experienced by sufferers of social phobia. The key diagnostic feature is not the attack, but the fear, which brought it on.
- 3 Sufferers of social phobia are probably more likely than agoraphobic to self-medicate with alcohol, but this should not be used as a diagnostic pointer.
- 4 Blushing is more common in social phobia, dizziness and weakness more common in agoraphobia. But as both conditions feature a wide range of anxiety symptoms, the physician should concentrate more on the precipitating fear than the symptomatic consequences.

Video case histories/role playing

At this stage of the presentation you may wish to show the video of real patient case histories. These may be used to stimulate discussion on specific points of diagnosis.

The WPA social phobia educational programme also includes printed case histories. These may be used for live role playing within the workshop.

Biology of social phobia

Slide 10a



Commentary

Before we talk about the treatment of social phobia, I would like to say a few words about the neurological defects that are thought to lead to its onset. These may help to explain the biological basis for the pharmacological treatment of the condition.

The underlying mechanisms of social phobia are still unclear but neuroendocrine and neuroimaging studies have identified dopaminergic, noradrenergic and serotonergic abnormalities in sufferers. This suggests that pharmacological agents that act on these pathways may be of benefit in treating social phobia.

Family and genetic studies have also suggested a genetic component in the disorder. However it is debatable whether genetic contributions are as strong as environmental factors.

Treatment

Slide 11



Commentary

The typical social phobic patient enters a slowly descending spiral of impairment. The inability to learn social skills during adolescence may lead to educational difficulties and problems forming relationships. In later years the sufferer is likely to find his or her job performance badly affected. Efforts to deal with the impairment may lead to harmful coping strategies such as alcohol or drug abuse. Finally the sufferer is likely to succumb to further psychiatric illnesses such as depression or agoraphobia.

So is there anything we can do to halt this sequence of events?

The answer is emphatically 'Yes'. In recent years it has become clear that the physician has a number of effective pharmacological and/or psychosocial options that can effectively prevent or alleviate much of the impairment caused by social phobia.

Unfortunately, at present, only around 25 per cent of sufferers ever receive therapy for their social phobia. Substantially fewer receive treatment of proven efficacy.

IVS question

Treatment should be initiated:

- 1 When patient first experiences anxiety symptoms in social situations
- 2 When patient first experiences avoidant behaviour
- 3 When patient first experiences interference with social or occupational life
- 4 When patient first experiences harmful coping strategies (e.g.: alcohol or drug abuse)
- 5 When patient first experiences comorbidity

Commentary after vote

The decision to treat social phobia should be reserved for those cases where the symptoms or avoidance behaviour are associated with significant psychosocial impairment.

Points for discussion

1 Unless there is a degree of social or occupational impairment, the presence of anxiety in social situations is not sufficient to warrant a full treatment programme.

2 Avoidant behaviour is a diagnostic pointer to social phobia. These patients should be assessed at a later stage for impairment to their daily lives.

4,5 Although treatment of social phobia can offer considerable benefit to patients with alcohol problems or suffering comorbidities, by this stage the chance has been lost to prevent these distressing sequelae.

Slide 12



Commentary

Although social phobia has been receiving increasing amounts of media attention in recent years, there is still a lack of awareness about the condition. Many sufferers may not realize that their problems are due to a medical illness. They may therefore need to be convinced that a long-term treatment plan can be of help. Spending time to explain the rationale for pharmacotherapy can therefore greatly improve patient compliance.

This slide lists five complementary strategies for presenting the issue of medication to a patient. The aim is to reassure patients that they are suffering a recognized illness that will respond to a tried, tested and above all safe pharmacotherapy.

These points may be laid out in a written contract with the patient.

Slide 12a



Commentary

This patient contract should, once again, reassure patients that their symptoms are recognized as social phobia and that they will respond to therapy.

The treatment plan should be discussed and the patient given the opportunity to air any doubts or anxieties.

It is important not to raise false expectations, so the treatment contract should also lay out how long the patient should expect to wait before noticing an improvement. Depending on severity this time should be around one to two months.

Finally the contract should agree to review the treatment programme at regular intervals.

IVS question

Which of the following medications should you use to treat social phobia?

- 1 RIMAs
- 2 MAOIs
- 3 Benzodiazepines
- 4 Beta blockers
- 5 SSRIs
- 6 TCAs

Commentary after the vote

The only pharmacological agents that have consistently been shown to benefit sufferers of social phobia are those that inhibit the monoamine oxidase activity in the central nervous system - the RIMAs and the MAOIs.

Points for discussion

3. Benzodiazepines are not considered appropriate in the treatment of social phobia. The possible exception is clonazepam, which also has serotonergic effects. This has shown benefit in one placebo-controlled trial. In general, however, there are drawbacks to treating social phobia with benzodiazepines, not least the danger of physical dependency in patients on long-term therapy. The link between social phobia and alcohol abuse also suggests that benzodiazepines may not be the best choice of treatment.
4. Beta blockers have no effect on the underlying disease in social phobia. They may, however, be useful when taken acutely to combat the tremor, palpitations and tachycardia often experienced by social phobia sufferers in performance situations.
5. Early trials of SSRIs fluoxetine and fluvoxamine have shown some promise but this needs to be confirmed in larger placebo-controlled studies.
6. TCAs have no beneficial effect in social phobia.

Slide 13



Commentary

RIMAs are a new class of drugs which are selective for the A isoenzyme of monoamine oxidase. They have been extensively studied in social phobia, with three trials involving over 1,000 patients. The efficacy seems to be very good and side effects are infrequent and generally mild.

Slide 14



Commentary

Until recently MAOIs were the most extensively studied medication in social phobia. They have proved to be very effective, although there is a major disadvantage in that they can cause serious and dangerous side effects.

Although the efficacy of MAOIs and RIMAs is comparable, RIMAs' inhibition of monoamine oxidase is achieved with a reversible bond which significantly reduces the potential for side effects.

RIMAs are also selective in their action by inhibiting only the MAO-A subtype of monoamine oxidase. RIMAs therefore concentrate on the transmitters considered to play a role in social phobia.

IVS question

You have a patient with social phobia and major depression. What medication do you choose?

- 1 1 RIMA
- 2 2 MAOI
- 3 3 SSRI
- 4 TCA
- 5 Benzodiazepine
- 6 Beta blocker

Commentary after the vote

One of the major problems in treating social phobia is the extremely high prevalence of comorbidity.

As a general rule it is preferable to treat with a single agent known to be efficacious for each disorder separately. So in this case, a RIMA, MAOI or possibly an SSRI would be appropriate.

Slide 14a



Commentary

Many sufferers of social phobia are prone to negative thoughts - such as thinking failure is inevitable in social situations. Cognitive or behavioural therapy can be effective in confronting these beliefs. Used in well-motivated patients these psychological techniques can be very effective, either as an adjuvant or an alternative to pharmacological therapy.

Slide 14b



Slide 14c



Commentary

The recently published *Pocket Reference To Social Phobia*, by Science Press and the WPA gives the following recommendations for the treatment of comorbid social phobia. (read from visuals).

IVS question

Treatment of social phobia should last a minimum of:

- 1 3 months
- 2 6 months
- 3 9 months
- 4 12 months
- 5 15 months
- 6 18 months

Commentary after the vote

It is important to emphasize to the patient that social phobia is a chronic condition that is likely to require long-term management. Even after 6 months of treatment there is a relapse rate of around 50 per cent. Drug therapy should therefore be continued for at least a year.

Slide 15



Commentary

I would like to conclude this presentation by summarizing the key points. I hope the evidence I have presented today has convinced you that social phobia is a serious disorder that causes widespread distress and disability. More importantly I hope the information on diagnosis and treatment will help you to identify sufferers and offer them the best possible help.

End of programme question

A final question to conclude the presentation and to help gauge how successful the session has been.

IVS question

What is your evaluation of this workshop

1 Worthless

2

3

4

5

6

7

8

9 Outstanding

Slide presentation

Master module

+

mini modules

Slide presentation

This chapter is intended for those who wish to carry out non-interactive slide presentations. It contains a detailed description of how to present all the slides found in chapter 4 of this binder.

Both the master module and the mini modules are provided, with full commentaries for each slide.

The modular format allows for variations on two presentation options:

- For a 30-minute slide lecture use the master module
- For a 60-minute slide lecture use the master module plus the six mini modules.

Of course individual mini modules may be added or subtracted according to the requirements of the audience. For instance, while the mini module on biology is appropriate for an audience of specialists, you might choose to omit it for a presentation to GPs.

Introduction

Commentary

We are here today to talk about a relatively recently recognized psychiatric condition called social phobia. Most of you will have heard of this condition but many of you will be unsure of exactly what it is. Some of you may even doubt its existence.

Nevertheless by the end of this presentation I hope I will have shown you that social phobia is...

Slide 1



. . . a very common anxiety disorder, that causes a lot of distress and disability. And most importantly of all, that it is a treatable disorder. You, as a physician, can do a great deal to help these people.

Social phobia has been recognized by both the World Health Organization's International Classification of Diseases (ICD-10) and the American Psychiatric Association (DSM-IV) as a widespread and debilitating anxiety disorder. ICD-10 further classifies it as a phobic anxiety disorder.

Slide 2



Commentary

Recent European studies have estimated the lifetime prevalence at between 9.6 per cent and 16 per cent. This is broadly in line with the US estimated prevalence of 13.3 per cent. About 3 per cent of the US population are suffering social phobia at any one time.

This slide also nicely illustrates the difference in prevalence rates obtained by the DSM and ICD-10 diagnostic criteria. Wacker et al used both criteria on the same study population and obtained quite different results.

Slide 3



Commentary

Social phobia characteristically begins in the mid teenage years - a time when it is likely to cause the greatest damage to psychological development, the formation of relationships and the establishment of life goals.

Apart from this onset at an early age, there are few other risk factors identified for social phobia. It appears not to discriminate on grounds of gender nor between social classes. However, the detrimental effects of social phobia on sufferers' education, performance at work and ability to form relationships leads to it being found most often in single people of reduced financial means.

Burden of social phobia

Slide 4



Commentary

Social phobia is a debilitating, chronic, largely unremitting disorder which, if left untreated, can lead to a high risk of morbidity, alcoholism, drug abuse and suicide. Its effects exert a severe personal burden on individual sufferers.

Slide 4a



Commentary

Social phobia also exerts an economic burden, not only on sufferers themselves, but also on society at large.

This slide shows that, although social phobia is still a poorly diagnosed condition, it still accounts for a considerable amount of health care costs.

This is largely due to the extensive degree of comorbidity in social phobia which means that even if patients are not offered treatment for their primary condition they are likely to receive it for something else.

Slide 4b



Commentary

Other contributions to the overall cost to society of social phobia include sufferers' reduced earning potential, their higher rate of dependence on welfare benefits. Sufferers of social phobia are more likely than the general population to suffer alcohol problems. And one study has found that juveniles with social phobia are more likely than controls to steal and to fight at school.

Slide 5



Commentary

A major contributor to the suffering caused by social phobia and its cost to society is the link with alcohol abuse. The World Health Organization estimates that European countries spend approximately 6.8 per cent of their Gross National Products coping with the problems of alcohol abuse. It is therefore of strong economic significance that social phobia sufferers are twice as likely as the general population to have problems with alcohol. People with alcohol problems are nine times as likely as the general population to have social phobia.

Under-recognition

Slide 5a



Commentary

Despite the epidemiological evidence that social phobia is a widespread disorder, it is still very rarely diagnosed in general practice. There are several reasons for this.

Patients and doctors are equally affected by cultural attitudes to shyness. This may lead some to conclude, wrongly, that social phobia is in fact just an exaggerated trait of personality.

Patients may be reticent about seeking help, either because they want to avoid the stigma of a mental illness or because, due to the very nature of social phobia, they are anxious about meeting strangers.

Finally, it is only recently that effective treatments have become available, so patients may have felt there was no point in seeking professional help.

Slide 5b



Commentary

The relatively recent recognition of social phobia as a discrete clinical entity means that many medical practitioners, particularly in primary care, are still unfamiliar with the concept of social phobia. Many GPs may be unclear over the point at which a patient's disability meets the diagnostic threshold for social phobia.

The very high rate of comorbidity in social phobia can also complicate diagnosis. Social phobia symptoms are often masked by those of the comorbid condition. Coping strategies such as alcohol abuse may also mask symptoms.

Presentation and diagnosis

Slide 6



Commentary

ICD-10 defines social phobia as being centered around a fear of scrutiny by other people in comparatively small groups (as opposed to fear of crowds).

Sufferers may go to extreme lengths to avoid the feared situation. Or, if the situation cannot be avoided, the sufferer will find the experience extremely distressing.

Slide 7



Commentary

There are two forms of social phobia.

In its diffuse or generalized form the condition will cause fear of almost all social situations outside the family circle.

In its non-generalized form social phobia is discrete and relates to specific situations such as eating in public, public speaking or encounters with the opposite sex.

In order to qualify as social phobia, the fear must be both excessive and disabling. The normal performance anxiety we all experience when speaking in public does not qualify as social phobia, however uncomfortable it may seem at the time.

Slide 8



Commentary

The situations that most commonly bring on symptoms of social phobia are listed in this slide.

Exposure to the feared situation causes the sufferer to experience the typical somatic symptoms of anxiety - palpitations, trembling, sweating, tense muscles, a sinking feeling in the stomach, dry throat, hot or cold feelings or headache.

The sufferer may go to extreme lengths to avoid the situations that precipitate the phobic symptoms. This avoidance behaviour can be just as debilitating as the symptoms themselves and in extreme cases may lead to almost complete social isolation.

Slide 8a



Commentary

So, far from being the exception, it appears that comorbidity is the norm for patients with social phobia. Indeed, the diagnosis of uncomplicated, non-comorbid social phobia almost certainly indicates the need to probe for the existence of other psychiatric disorders.

Slide 9



Commentary

A wide range of comorbid conditions has been described for social phobia. These include (read from slide).

Slide 9a



Commentary

The significance of this high rate of comorbidity is that, quite apart from complicating the diagnosis, comorbid conditions also dramatically increase the disabling consequences of social phobia.

In particular sufferers of comorbid social phobia are far more likely to commit suicide than those with the uncomplicated condition.

Slide 10



Commentary

In over 70 per cent of cases where a patient is suffering social phobia in conjunction with another condition, it is the social phobia that appears first.

The primary onset suggests that social phobia is precipitating the onset of the subsequent condition.

The earlier detection and treatment of social phobia could therefore help prevent comorbidity and thereby save many patients from a great deal of disability and distress.

Biology of social phobia

Slide 10a



Commentary

Before we talk about the treatment of social phobia, I would like to say a few words about the neurological defects that are thought to lead to its onset. These may help to explain the biological basis for the pharmacological treatment of the condition.

The underlying mechanisms of social phobia are still unclear but neuroendocrine and neuroimaging studies have identified dopaminergic, noradrenergic and serotonergic abnormalities in sufferers. This suggests that pharmacological agents that act on these pathways may be of benefit in treating social phobia.

Family and genetic studies have also suggested a genetic component in the disorder. However it is debatable whether genetic contributions are as strong as environmental factors.

Treatment

Slide 11



Commentary

The typical social phobic patient enters a slowly descending spiral of impairment. The inability to learn social skills during adolescence may lead to educational difficulties and problems forming relationships. In later years the sufferer is likely to find his or her job performance badly affected. Efforts to deal with the impairment may lead to harmful coping strategies such as alcohol or drug abuse. Finally the sufferer is likely to succumb to further psychiatric illnesses such as depression or agoraphobia.

So is there anything we can do to halt this sequence of events?

The answer is emphatically 'Yes'. In recent years it has become clear that the physician has a number of effective pharmacological and/or psychosocial options that can effectively prevent or alleviate much of the impairment caused by social phobia.

Unfortunately, at present, only around 25 per cent of sufferers ever receive therapy for their social phobia. Substantially fewer receive treatment of proven efficacy.

Slide 12



Commentary

Although social phobia has been receiving increasing amounts of media attention in recent years, there is still a lack of awareness about the condition. Many sufferers may not realize that their problems are due to a medical illness. They may therefore need to be convinced that a long-term treatment plan can be of help. Spending time to explain the rationale for pharmacotherapy can therefore greatly improve patient compliance.

This slide lists five complementary strategies for presenting the issue of medication to a patient. The aim is to reassure patients that they are suffering a recognized illness that will respond to a tried, tested and above all safe pharmacotherapy.

These points may be laid out in a written contract with the patient.

Slide 12a



Commentary

This patient contract should, once again, reassure patients that their symptoms are recognized as social phobia and that they will respond to therapy.

The treatment plan should be discussed and the patient given the opportunity to air any doubts or anxieties.

It is important not to raise false expectations, so the treatment contract should also lay out how long the patient should expect to wait before noticing an improvement. Depending on severity this time should be around one to two months.

Finally the contract should agree to review the treatment programme at regular intervals.

Commentary

The choice of treatment is, of course, very important.

The only pharmacological agents that have consistently been shown to benefit sufferers of social phobia are those that inhibit the monoamine oxidase activity in the central nervous system - the RIMAs and the MAOIs.

Benzodiazepines are not considered appropriate in the treatment of social phobia. The possible exception is clonazepam, which also has serotonergic effects. This has shown benefit in one placebo-controlled trial. In general, however, there are drawbacks to treating social phobia with benzodiazepines, not least the danger of physical dependency in patients on long-term therapy. The link between social phobia and alcohol abuse also suggests that benzodiazepines may not be the best choice of treatment.

Beta blockers have no effect on the underlying disease in social phobia. They may, however, be useful when taken acutely to combat the tremor, palpitations and tachycardia often experienced by social phobia sufferers in performance situations.

Early trials of SSRIs fluoxetine and fluvoxamine have shown some promise but this needs to be confirmed in larger placebo-controlled studies

TCA's have no beneficial effect in social phobia

Slide 13



Commentary

RIMAs are a new class of drugs which are selective for the A isoenzyme of monoamine oxidase. They have been extensively studied in social phobia, with three trials involving over 1,000 patients. The efficacy seems to be very good and side effects are infrequent and generally mild.

Slide 14



Commentary

Until recently MAOIs were the most extensively studied medication in social phobia. They have proved to be very effective, although there is a major disadvantage in that they can cause serious and dangerous side effects.

Although the efficacy of MAOIs and RIMAs is comparable, RIMAs' inhibition of monoamine oxidase is achieved with a reversible bond which significantly reduces the potential for side effects.

RIMAs are also selective in their action by inhibiting only the MAO-A subtype of monoamine oxidase. RIMAs therefore concentrate on the transmitters considered to play a role in social phobia.

Whatever treatment is chosen, it is important to emphasize to the patient that social phobia is a chronic condition that is likely to require long-term management. Even after 6 months of treatment there is a relapse rate of around 50 per cent. Drug therapy should therefore be continued for at least a year.

Slide 14a



Commentary

Many sufferers of social phobia are prone to negative thoughts - such as thinking failure is inevitable in social situations. Cognitive or behavioural therapy can be effective in confronting these beliefs. Used in well-motivated patients these psychological techniques can be very effective, either as an adjuvant or an alternative to pharmacological therapy.

Slide 14b



Slide 14c



Commentary

The recently published Pocket Reference To Social Phobia, by Science Press and the WPA gives the following recommendations for the treatment of comorbid social phobia- (read from visuals).

Slide 15



Commentary

I would like to conclude this presentation by summarizing the key points. I hope the evidence I have presented today has convinced you that social phobia is a serious disorder that causes widespread distress and disability. More importantly I hope the information on diagnosis and treatment will help you to identify sufferers and offer them the best possible help.

Slide copies

Slide 1

Social phobia is a:

- widespread
- debilitating
- treatable

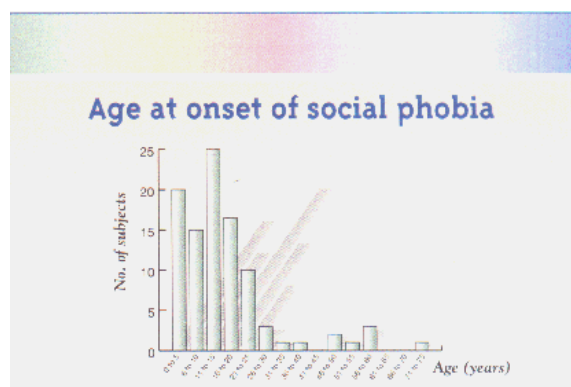
} anxiety disorder
(a phobic anxiety disorder in ICD-10)

Slide 2

Lifetime prevalence of social phobia

Diagnostic criteria	Investigator	Year	Site	Prevalence (%)
DSM-III-R	Kessler et al	1994	NCS (USA)	13.3
DSM-III-R	Weiller et al	1994	France	14.4
DSM-III-R	Wacker et al	1992	Basle (Switzerland)	16.0
ICD-10	Wacker et al	1992	Basle (Switzerland)	9.6

Slide 3



Slide 4

Burden of social phobia

Compared to the general population sufferers of social phobia are more likely to:

- be single
- be of lower education
- be dependent on state benefits
- suffer additional psychiatric disorders
- abuse alcohol
- abuse drugs
- commit suicide
- have an unstable employment record
- be socially isolated

Slide 4a Mini module 1

Use of medical services in social phobia

Treatment sought	Uncomplicated (n = 112)	Rate/100 Comorbid (n = 249)	No disorder (n = 9953)
Any outpatient	19.6	51.0	14.7
Medical outpatient	17.0	28.9	9.2
Psychiatric outpatient	5.4	37.8	7.9
Emergency department	1.8	11.2	1.4
Psychiatric inpatient	0.9	13.7	1.5

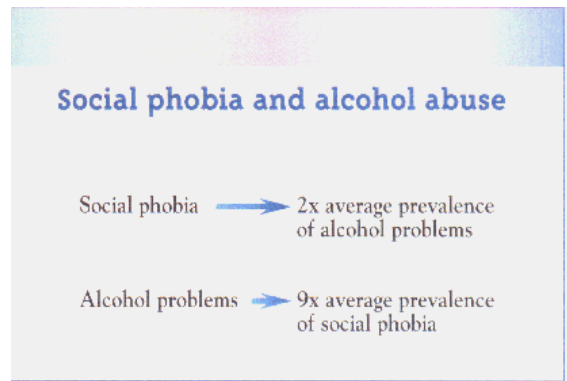
Schneier et al. Arch Gen Psychiatry 1992

Slide 4b Mini module 1

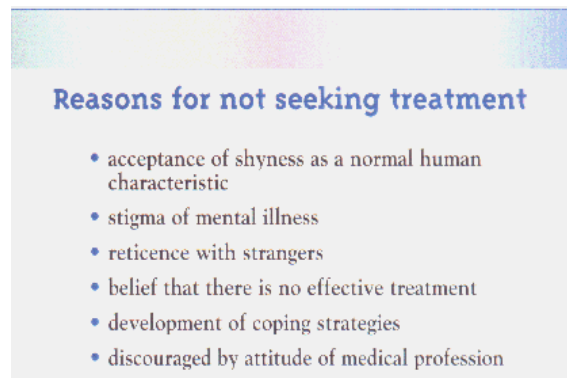
Economic burden

- reduced earning potential
- higher risk of dependency on welfare
- greater use of health resources
- higher rate of alcohol problems
- higher rate of juvenile crime

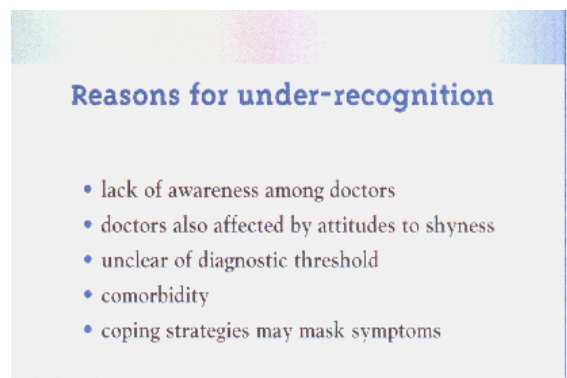
Slide 5



Slide 5a Mini module 2



Slide 5b Mini module 2



Slide 6

Essential features of social phobia

- a fear of scrutiny by other people in social situations
- a marked and persistent fear of performance situations in which embarrassment or humiliation may occur
- avoidance of the feared situations
- fear is disabling or causes marked distress

Slide 7

The two forms of social phobia

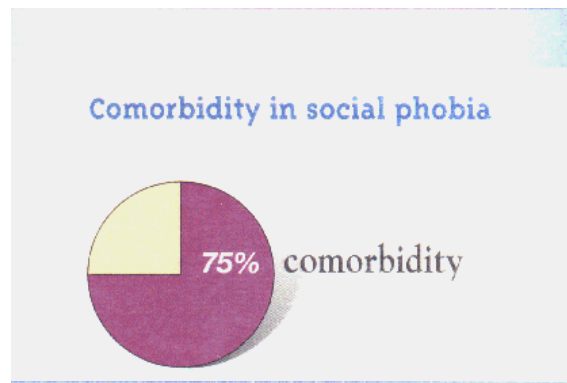
- generalised
where the fears involve almost all social contacts
- or non-generalised
where the fears relate to specific social activities or performance situations

Slide 8

Precipitating situations

- being introduced
- meeting people in authority
- using the telephone
- receiving visitors
- being watched doing something
- writing in front of others
- speaking in public

Slide 8a



Slide 9

Prevailing comorbid conditions

- simple phobia 59 %
- agoraphobia 45 %
- alcohol abuse 19 %
- major depression 17 %
- drug abuse 17 %

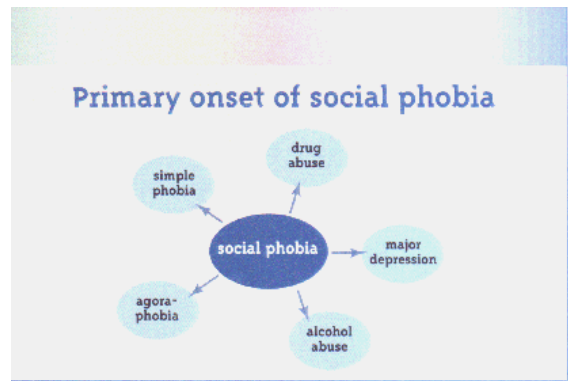
Slide 9a Mini module 3

Suicide in simple and comorbid social phobia

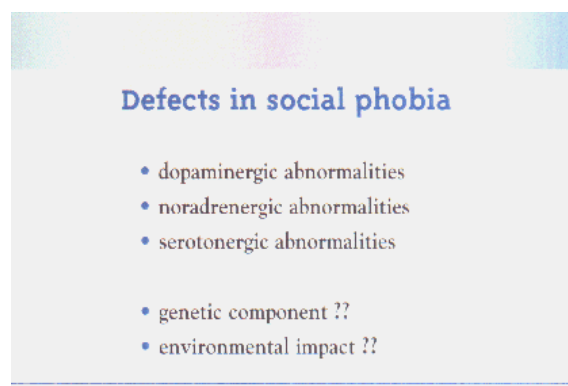
	Simple (%)	Comorbid (%)
Suicide attempts	0.9	15.7
Thought a lot about death	26.8	53.8
Felt like you wanted to die	8.9	27.7
Felt so low you wanted to commit suicide	9.8	37.3

Schnitzer et al. 1992

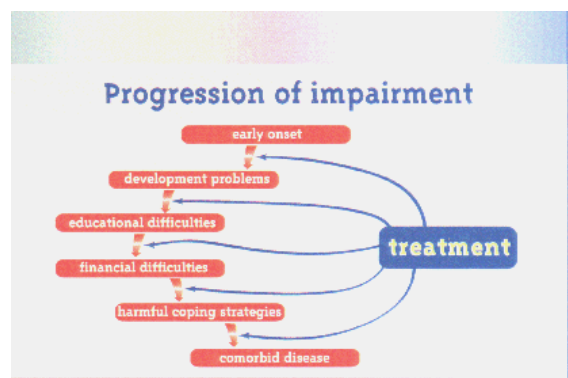
Slide 10



Slide 10a Mini module 4



Slide 11



Slide 12

Introducing treatment

- emphasise social phobia is medically recognised condition
- stress that treatment is effective
- explain that the source of the phobia is anxiety. Medication can alleviate this anxiety
- stress that treatment is **not** addictive
- establish a treatment contract with the patient

Slide 12a Mini module 5

The treatment contract

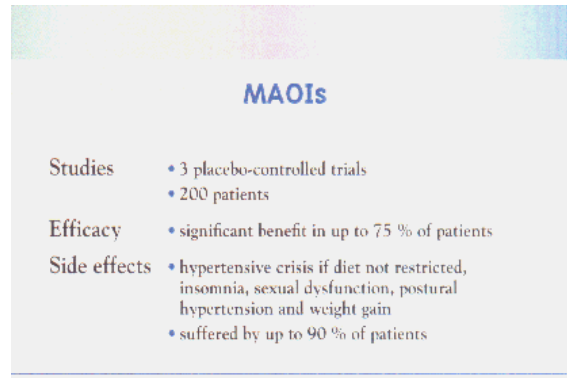
- reframe the patients symptoms as social phobia
- emphasise that the condition responds to therapy
- negotiate treatment
- list problems and priorities
- set realistic time for improvement
- agree to review the medication regularly

Slide 13

RIMAs

Studies	<ul style="list-style-type: none">• 3 placebo controlled trials• over 1,000 patients
Efficacy	<ul style="list-style-type: none">• significant benefit in up to 75 % of patients• strong dose/response relationship
Side effects	<ul style="list-style-type: none">• insomnia, dizziness, nausea and headache• suffered by around 12 % of patients

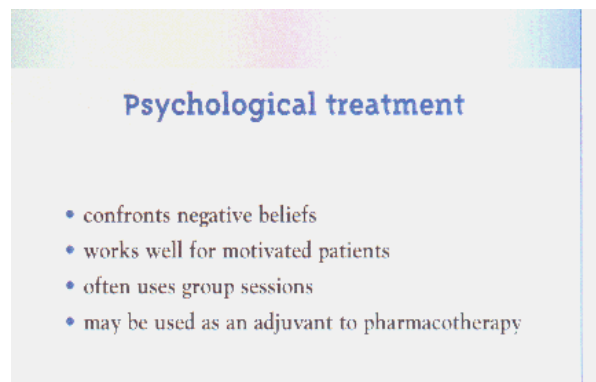
Slide 14



MAOIs

Studies	<ul style="list-style-type: none">• 3 placebo-controlled trials• 200 patients
Efficacy	<ul style="list-style-type: none">• significant benefit in up to 75 % of patients
Side effects	<ul style="list-style-type: none">• hypertensive crisis if diet not restricted, insomnia, sexual dysfunction, postural hypertension and weight gain• suffered by up to 90 % of patients

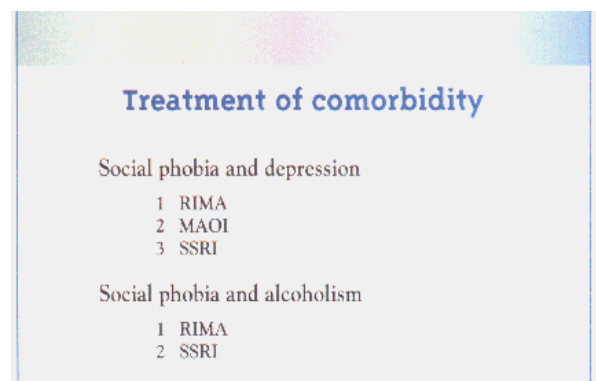
Slide 14a Mini module 6



Psychological treatment

- confronts negative beliefs
- works well for motivated patients
- often uses group sessions
- may be used as an adjuvant to pharmacotherapy

Slide 14b Mini module 6



Treatment of comorbidity

Social phobia and depression

- 1 RIMA
- 2 MAOI
- 3 SSRI

Social phobia and alcoholism

- 1 RIMA
- 2 SSRI

Slide 14c

Treatment of comorbidity

Social phobia and obsessive-compulsive disorder

- 1 SSRI
- 2 Clomipramine
- 3 MAOIs
- 4 RIMA

Social phobia and panic disorder/agoraphobia

- 1 RIMA
- 2 MAOI
- 3 Clonazepam
- 4 SSRI

Slide 15

Key points

Social phobia is	Diagnosis	Treatment
<ul style="list-style-type: none">• a fear of scrutiny in social situations• widespread and debilitating• linked to comorbidity and harmful coping strategies• linked to an increased risk of suicide	<ul style="list-style-type: none">• should concentrate on the source of the fear• requires patient to avoid the feared situation or experience extreme discomfort during it	<ul style="list-style-type: none">• is effective• can involve pharmacotherapy and/or psychological therapy• should be carried out for at least one year

Case histories

**Five written case histories
for role playing**

**Transcript
of video case histories**

Case histories

This chapter provides all the tools you need to include live role playing exercises and a full analysis of real patient cases in your workshops.

Written case histories, based on real patients, are provided as a guide for live role playing scenarios. These role-playing exercises are a useful element in the workshop structure to increase participation and learning.

In general the workshop leader will play the role of the patient while one of the participants plays the role of the physician seeking to uncover and diagnose the condition.

These exercises aim at achieving specific educational objectives:

- Reinforcement of key ideas: The patient case histories for role playing have been carefully conceived to ensure that they bring out and reinforce key ideas about social phobia.
- Practical experience in interviewing: It is always useful for a physician to have some practical experience with a new indication before integrating it into daily practice. Social phobia is a subtle and concealed disorder whose essential conditions and symptoms can be difficult to discern. The practical experience of the role playing exercise can help develop interviewing skills. The case histories are sufficiently subtle and complex to achieve this objective.

The video provided shows real patients talking about their condition. It is intended to be shown during the workshop to stimulate discussion on key elements of social phobia.

Key issues highlighted by the video cases include:

- Impact of social phobia on sufferers' professional lives
- Impact of social phobia on sufferers' social lives
- The variety of physical anxiety symptoms caused by social phobia -trembling, blushing, sweating etc.
- The link between social phobia and alcohol abuse
- The fear of scrutiny by others
- Sufferers' low self-esteem

Case history 1

Ruth the secretary

Ruth is a 34-years old secretary and an alcoholic.

She has been drinking on and off since her early 20s when she first began using alcohol to help cope with social gatherings.

“I was always so nervous when meeting people for the first time. I would start blushing and trembling and this made me feel even more self-conscious and stupid. But with a couple of drinks inside me, things didn't seem so intimidating.”

This pattern of heavy social drinking continued until, at the age of 24, Ruth married.

Over the next few years she had two children and her drinking steadily declined.

“I just didn't need it anymore. I stayed at home all day with the children and we hardly ever went in the evenings. This suited me fine.”

However, Ruth's reluctance to go out and her refusal to allow her husband to invite friends over for dinner soon began to create tension within the family home.

“I tried to be more sociable but it was just too difficult. For days before a dinner party I would be nervous and became really irritable with my husband. He soon gave up trying.”

Ruth had only one friend and often felt lonely and isolated.

At the age of 30, the couple's financial situation became difficult and she was forced to look for a job.

“That was just terrifying. I was so unsure of myself that I started drinking again just to be able to face the interviews.”

Eventually she found a job as a secretary in a big insurance company. However, going to work soon became a daily ordeal. Ruth's colleagues all seemed so at ease with themselves.

“I felt so left out. Whenever anyone spoke to me I felt awkward and started blushing and trembling.”

She was also terrified of her superiors.

“I felt so stupid and incompetent. It was like I was fooling everybody and I always felt that sooner or later someone was bound to find out what a useless coward I was.”

“I found I needed a drink every morning just to be able to face going to work and I always carried a flask of whisky in my handbag.”

Ruth never drank at home and her husband was unaware of her growing problem.

After several unsuccessful attempts to give up drinking, Ruth finally decided to seek professional help.

Diagnosis

Although Ruth is primarily worried about her alcohol dependence, it is her fear of social situations that is clearly at the root of the problem.

Her social anxiety is significantly restricting her social and professional life and she seems to fit the diagnostic criteria of a marked and persistent fear of social or performance situations in which embarrassment may occur.

The diagnosis is therefore generalized social phobia with comorbid alcohol dependence.

Case history contributed by Dr. Jean-Pierre Lépine, Hopital Fernand Widal, Paris, France

Case history 2

John the sales assistant

John is the sales assistant in a well-known record shop. He is 28-years old and lives alone.

John describes his childhood as happy and fairly extroverted. He was completely at ease with his classmates and had no problems in making friends. However, during his final year in school he began to feel uneasy in small social groups. These situations caused him to blush and perspire intensely. Girls terrified him and the fear of rejection prevented him from asking anyone out on a date.

He soon began to avoid group activities and parties, preferring to stay in his bedroom listening to records.

John managed to gain enough qualifications to enter university but once there he found the social side of university life intimidating. He dropped out before the end of his first year.

At 20 John found his present job in the record shop. He is good at his work and has no problems dealing with the customers.

“Music is my passion. I know I can answer all the customer's questions and I feel totally in control”.

Dealing with his work colleagues and superiors is far more difficult.

“I feel awkward and never know what to say to them”.

“I avoid my boss as much as possible. She seems so strong and self-confident and I always end up blushing when I speak to her. It's really embarrassing.

On several occasions John has refused opportunities for promotion because it would mean having contact with suppliers and supervising other sales assistants.

“I'm also afraid of the responsibility because it means I'm more likely to be criticized. I can't stand criticism.”

John has a few close male friends but has never had a girlfriend. On the few occasions when he forces himself to accept invitations to dinners and parties he cannot cope.

“It's always a disaster. I start blushing uncontrollably and sweat just pours off me. I often have to leave in the middle of a meal because I think everyone is looking at me, watching me blush and sweat. They must think I'm a bit strange.”

John eventually consults his family doctor.

Diagnosis

John's case is typical of generalized social phobia. His anxiety seems to be exclusively related to specific social situations and his main fears are of being embarrassed, rejected or criticized. These fears have been strong enough to restrict his social and professional life to a significant degree.

Case history 3

Brian the business man

Brian is a 40 year old business man who has been suffering panic attacks since the age of 20. Over the past year these have become increasingly frequent and he now suffers at least one major panic attack per day. The attacks are characterized by symptoms of dizziness, chest pain, hot and cold flushes, feelings of apprehension, and feelings that the world is about to end.

The attack occurs both spontaneously and during specific social situations, such as whenever he has to give a presentation at work.

Brian has also developed agoraphobia to the point where he refuses to travel. He complains of some secondary depressive symptoms, including sadness, hopelessness about his panic attacks, and mild hypochondriacal tendencies.

During his childhood, Brian suffered school phobia and was always afraid to get up in front of the class to make presentations. These symptoms were present for many years prior to the onset of his panic attacks.

When he began work, Brian found he was unable to chair meetings and refused promotions because of this.

Brian's family history may have contributed to his problems.

"One of my brothers also suffers panic attacks, and both my sisters are fairly intense and obsessive. My mother had a major depression but was never treated."

Medically, Brian is physically well, he does not smoke cigarettes, drink alcohol or use recreational drugs. He even avoids coffee.

Eventually Brian is referred by his family doctor for a psychiatric assessment. On the Marks Matthews Phobia Scale, he describes his main phobia as public speaking and on the social phobia sub-scale he scores 12. This is over 50 per cent of his total phobia score of 23.

Apart from the anxiety and some mild symptoms of depression Brian has no other psychiatric illness.

Diagnosis

It is quite clear from Brian's history that he had the social phobia symptoms prior to the spontaneous panic attacks. His fear of social situations started when he was in school and continued throughout his adult life. His avoidance behaviour is limiting his professional and financial performance. These are classic signs of social phobia.

But, because he has started to experience spontaneous panic attacks, he also fills the criteria for panic disorder.

After the spontaneous panic attacks began, the agoraphobia and depressive symptoms developed. Although the depressive symptoms were troubling, he did not meet the criteria for depressive disorder.

The diagnosis is therefore social phobia with secondary panic disorder with agoraphobia.

Case history contributed by Dr. David Bakish, Royal Ottawa Hospital, Canada

Case history 4

Mary the trembler

Mary, a 35-year-old secretary, has suffered a tremor in her hands for more than 20 years. She remembers first experiencing the problem when she helped out as a child in her parent's small rural restaurant.

"There were a lot of young farm laborers who are there, and they would often tease and make jokes about me as I served the dishes."

Mary's parents had moved the rural district after suffering financial problems and there were frequent rows between father and mother over money.

"I often felt ashamed of my parents and would cry a lot because my family was poor."

Mary's characterized herself as introverted and shy.

"For as long as I can remember I have never been able to assert myself."

She is always avoided eating and drinking in the company of others and is also unable to talk in front of strangers. She knows that her fear is exaggerated and unreasonable.

After finishing high school Mary trained to be a waitress which she thought might help her to overcome her tremor.

While she was training, she met a 29-years-old economist who, compared to her, was very self-confident. However, this boyfriend was over-sensitive to noise. They never went out to restaurants, because she trembled and he was annoyed by the noise. They traveled a lot together but lived on tinned food in order to avoid restaurants.

This relationship lasted for 11 years during which time she studied languages and obtained a job as a secretary in a large company where she worked to the satisfaction of her boss.

However, she never went to the cafeteria for lunch because she wanted to avoid the company of other people there.

Because of her good record, Mary was promoted in her company and had to attend social events, which she found unbearable. At one of these events she had a breakdown.

This led her to seek medical help and she was then referred to Psychiatry.

On examination it turned out that Mary's tremor was only manifesting itself in the presence of other people when she had the impression of being under these people's scrutiny.

Apart from a slightly depressed mood, she didn't present any psychopathological abnormalities during the psychiatric interview.

Diagnosis

Mary fulfils all criteria of social phobia. She suffers from a persistent fear of several social performances situations in which she is exposed to unfamiliar people or possible scrutiny by others.

She recognizes that the fear is exaggerated and unreasonable and she avoids the feared situations. However, she has been able to function for quite a long time due to a symbiotic relationship with her boyfriend who is impaired in similar situations and provides psychological shelter.

Case history 5

Tom the plumber

Tom, a 20-year-old plumber, has extreme difficulties in communicating with other people. Whenever he has to speak in public or before other people he can only do so in a very low voice. He also finds himself sweating and suffering increased muscle tension, especially in the neck. This is extremely painful in the French evening classes he attends, where he always tries to sit in the first row so that he can speak in a low voice when asked by the teacher.

Tom has avoided speaking before other people for as long as he can remember. Evens among his own family he was a shy young boy.

He had few friends as a child and tended to avoid situations where he was together with other people.

But despite being socially handicapped, he finished school and trained as a plumber, achieving excellent results. Once he began work however; his communication problems really came to the fore.

“I can never say “no” to other people’s demands. I often feel exploited at work because of this and I’m sure my colleagues are laughing at me.”

Over the past two years Tom as learned to endure his problems at work and at leisure by using alcohol to overcome his anxiety.

He has already lost his driving license twice, due to drunken driving.

His social life largely revolves around the disco and the pub, where he habitually gets drunk at weekends.

“Socially I prefer going to the disco, as the loud music means I never really need to talk to anyone. I don’t think my friends have ever realized I’ve got a problem.”

Several weeks ago Tom started a relationship with a new girlfriend. At first he tried to cover up his problems. Finally he told her about his “speech problem”. The girlfriend had seen a behaviour and she persuaded Tom to seek psychiatric help. Eventually Tom consults the Behaviour Therapy Unit at an Academic Psychiatric Department.

Diagnosis

Tom has a long history of avoiding speaking in front of other people and being afraid of being laughed at. While recognizing that his fear is unreasonable, he has tried to avoid speaking in front of others whenever possible. His use of alcohol is obviously to overcome his fear.

The diagnosis is social phobia with comorbid alcohol abuse.

Video case histories

Full transcript of the video

Stephen, 35, Nurse

- Consultant* First of all I'd just like to find out when you first noticed that something was wrong with your health, and what you actually did notice?
- Stephen* It was when I was eighteen-nineteen when I started my first proper job as it were, and it was the blushing that I noticed the first. I was working in hotel management and obviously that involved meeting people on a regular basis, day in day out, and I used to blush terribly. In it's extreme case I used to sweat really badly. The overriding thought in my head would be I'm red, I'm red, I just want to get away. Even just meeting people on a casual basis. In the street if I recognize someone I know or sitting on a bus, and someone gets on that knows me and starts talking, I could feel myself burning up.
- Consultant* Did you notice any other symptoms as well as the blushing?
- Stephen* I had butterflies in my stomach, my heart pounds.
- Consultant* What is actually going through your mind when you actually blush?
- Stephen* That I'm aware that I'm red.
- Consultant* Right.
- Stephen* I'm aware that the other person's aware that I'm red and I just want to get away.
- Consultant* Do you find any situations bring the symptoms on?
- Stephen* Well as I mentioned before, when talking to people in authority or talking to strangers.
- Consultant* Could you tell me what kind of effect it had on your life in the intervening years?
- Stephen* It's had a hell of an effect. It's ruined my life basically. I've had so many opportunities and I've just let them all go. As I say, I started off in hotel management and I had to give that up eventually because I found it very hard to give people orders, to tell people what to do. Even if I told someone could you do that, do this, I'd still go red telling them and I was at the junior end of the management. I got really panicky talking to my colleagues as they were, but I saw them as superiors really and that was stupid.

Consultant Right.

Stephen I just couldn't hold a conversation with my boss, the hotel general manager. I used to be bright red. I applied to an airline as cabin crew. I got through the first interview and they flew me down to Gatwick for the second interview and on the flight down I just happened to ask one of the stewardesses where the admin offices were at Gatwick for British Caledonian as it was then, it doesn't exist anymore. Once she knew I was going for an interview she said "come to the front of the plane" and so I went down to the front of the plane and I was talking to the other cabin crew, and walking back to my seat, - I was right at the back of the plane - I remember just walking down the aisle and having all these people on either side of me, everyone else sat down, but here is me, walking down the aisle, and I just got back to my seat and I was absolutely sweating. I knew then that I couldn't do it.

Consultant Could you tell me what kind of situations you tended to avoid?

Stephen It's very rare that I will avoid a situation.

Consultant So you will endure it but feel very uncomfortable?

Stephen To say the least.

Consultant One thing that people sometimes do to help alleviate the symptoms are to self medicate with alcohol. Did you find that you were drinking any more?

Stephen I know that alcohol does help. I very rarely drink when at home but I have found that when I go to a nightclub or a pub my initial going-in, walking-in, my stomach is turning and I'm red, but once I've had a few pints I start to relax. I haven't isolated myself, I do have a social life. I do go out, I do have friends, I do go out for a drink.

Consultant If say, you are sitting at home alone would these symptoms come on?

Stephen No, that's the only time I feel safe really, when I'm on my own.

Bart, 43, Manager

Bart I think I'm afraid of not meeting the ideas people have about me. I want to be as good as possible. I want to do my work really very good and I think that's coming more or less from my education. My parents were very demanding. I was a good boy, I think I was the dear son of my mother. She had very great expectations for me so I had to fulfil something. I always had this idea, and I think that still I have, that when I'm doing things, I want to do it as good as possible in the eye of my superiors.

Consultant Can you remember when it all started ?

Bart I was 26, 27. I had to go to my insurance man and he presented me a cup of coffee. He put the cup of coffee on his desk and I had to take it. It was somewhere here and when I took that cup of coffee I was trembling and he noticed that so he asked me "do we have some problems?" and then I found my first trick, my first lie, I said that I'd done some heavy work so my muscles were trembling.

Consultant Do you have more tricks ?

Bart Yes, when I'm going to visit a customer or supplier and I'm sitting together with him in his room, most of the time he was sitting beside the table. When a cup of coffee is presented to me and it's standing on the table in front of me I feel nervous, the man is watching me all the time so I don't dare to take my coffee and then I look for a trick to lead his attention to something else. I remember that sometimes I say you have a very nice poster on your wall, where is that picture taken, and he turns his head and in that time I take my cup of coffee and when it is here, and in my mouth I can control it most of the time better.

Consultant Is the real problem that people could see you trembling, or is it just the trembling?

Bart I feel very easily ashamed so if people see that I'm trembling they will surely ask themselves what's going on with this man. I've always been very nervous in situations where I had to meet people, especially in working situations. I was sweating very much and perspiring very much in my hands and when it was cold, they were very cold and I felt ashamed when I had to shake hands with people. I'm a manager of a ply wood importing company and OK I'm the boss in daily life but I have also shareholders to whom I have to once a year explain things to. That's a terribly difficult day for me. Especially because I'm sitting on a big table with 10-12 people and I'm the middle point of the attention so I have to tell my story. I have to write also while I'm talking, there is coffee in front of me, and 12 pairs of eyes are on me. I have avoided a lot of nice things which I meet in my work. I'm working very internationally and I have a lot of contacts, foreign contacts. People invite me to come to their companies but also invite me in private. I've refused all these invitations for one simple reason, that I was afraid of trembling.

Consultant Can you imagine how you will be without trembling?

Bart Yes, I can imagine that. It's a wonderful idea that I can do my work without that.

Chris, 30, Prison Officer

Chris I was married for six weeks once and I've got a daughter from another girl and my personal life is just a mess really. Basically I was drunk most of the time and I didn't realize, at the time, that it was because I couldn't stand being in the situation of being with a lot of people.

Consultant Is that why you drank?

Chris Yes, because it was a lovely relief. I'd have say a pint, just a pint would automatically release me from this sort of cage and two pints, three pints I'd become a very gregarious and outgoing person which really I thought was I felt to be my true self. I actually do lecture on subjects which, I don't know if I should mention really, but it is alcohol and I don't know if I should be saying this, but I do actually do lectures for people who have got a drink problem and I find that I can speak very well and get the point over very well, but I have to have a drink before I actually do the lectures, then I become very self confident, can speak quite fluently and present the lecture very well. But I would be a complete mess if I didn't have that drink beforehand.

Consultant Did you have to have a drink to come here today ?

Chris Yes, I must admit I did have a drink immediately prior to coming into the interview and that made me feel quite relaxed and I do actually feel quite relaxed now, a little bit nervous but I felt that the means justified the end, because I felt that if I didn't have a drink I'd be that uptight that you probably wouldn't get that much out of me in the interview.

Consultant What are the problems now?

Chris If any more than one or two people, especially in a confined space, I get very nervous, edgy, shy butterflies in the stomach.

Consultant Do you blush?

Chris Yes I'm a terrible blusher. If ever the focus of attention is on myself for any reason at work, or even at home or even relations people I know, I feel like everybody is looking at me and I always blush. It's actually the fear of the attention coming onto yourself which is the worst thing, its almost fear of the fear.

Consultant Yes

Chris It's a fear of authority figures as well, for some reason they tend to bring out the worst in me. If I speak to anybody who is an authority figure, I tend then to start blushing and I get very nervous and self conscious.

Consultant Are there situations at work that are particularly difficult?

Chris One of the worst times is dining hall patrol. You stand in front of the hot plates as the inmates are being served and there's 460 inmates in the dining room. There's yourself and one other officer who's about ten feet away from you and its almost fear that something's going to happen at the hot plate, such as an incident over food. Not because you're afraid of actually getting involved physically but because the attention will then turn to myself, by the other inmates and everybody will be looking at me.

Consultant Have you sought any help before?

Chris No, none at all because I didn't know it was actually a recognized condition and it was completely by accident that I saw it in a newspaper.

Consultant Can you remember what rang very true in that?

Consultant Really got home?

Chris Yes, I think it was the actual situation in the paper where you said people who go to a checkout, in say a supermarket, and they feel very self conscious that people are looking at them. I thought that's me. As I say I'm not really a shy person, I don't think and I'm quite a gregarious person but its been locked in and the only way I can get over that is by using alcohol, and if I use alcohol it's like being a completely Jekyll and Hyde character .

Claire, 29, Housewife

- Claire They started when I was 17, when I was working for an estate agents. I had to carry a tray of coffee into the directors room in the conference and I just went to pieces. I started shaking, I managed to put the tray on the table and I just walked out. I stood outside and my heart was pounding, my mouth was very dry and then I started shaking from head to toe.
- Consultant Would you sweat?
- Claire Yes, yes, very much so.
- Consultant Would you blush?
- Claire I'm not sure if I blushed.
- Consultant Would supermarkets or shops be difficult?
- Claire No, only if I had to ask for something, like at the meat counter. I had to wait in a queue I'd find that hard and actually when it got to my place to be served I would find that I would be shaking while I was waiting there. It seems worse if you're waiting, like if you're in a queue at the supermarket and you want to sign a check. It seems worse waiting in queues, waiting in bus queues, waiting to pay the fare sort of thing.
- Consultant Could you write in public?
- Claire We were in a shop and I had to sign a check and I'd done this all the time do you know what I mean, and suddenly my hand started to shake and I could not write the check.
- Consultant What about eating in public?
- Claire I was always very embarrassed.
- Consultant Driving?
- Claire The thing, is if anyone asks me for a lift I can't give them a lift because I feel that they are watching me all the time.
- Consultant Can you drive on your own?
- Claire Yes
- Consultant What about when you're in-groups?
- Claire Well I find it very hard to speak, very hard for my voice to come out and I get very confused with what I'm saying.

Consultant Would you ever have a panic out of the blue, like come on for no reason?

Claire No, no.

Consultant What about effects on your social life or family life ?

Claire I haven't got any friends and I do find it hard to make friends.

Consultant How big an effect has all this had on your life ?

Claire Oh, it's been terrible. If I had stuck with my first job, I could have done quite well for myself as I was promoted then. I always wanted to go to college or something and I feel now that I've missed out on so much.

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