Applied & Preventive Psychology 4:39–51 (1995). Cambridge University Press. Printed in the USA.
Copyright © 1995 AAAPP 0962–1849/95 $9.00 + .10

An overview of the current status of social phobia

JAMES D. HERBERT

Hahnemann University

Abstract

Social phobia is a common and debilitating anxiety disorder that is associated with serious impairment in social and vocational functioning and increased risk of comorbid psychopathology. The disorder typically begins in adolescence and left untreated follows a chronic, unremitting course. Although little is currently known about the etiology of the condition, dramatic developments have been made in the assessment and treatment of social phobia over the past decade. Various medications and forms of behavior therapy have been shown to be effective, although many patients do not respond fully to treatment. The current status of social phobia and directions for future research are discussed.

Key words: Social phobia, Social anxiety, Anxiety disorders, Avoidant personality disorder, Behavior therapy, Pharmacotherapy

Social phobia is an anxiety disorder characterized by intense anxiety in and avoidance of social situations due to fear of being embarrassed, humiliated, or otherwise negatively evaluated by others. The onset of social phobia tends to be in early adolescence (Öst, 1987; Thyer, Parrish, Curtis, Nesse, & Cameron, 1985; Turner, Beidel, Dancu, & Keys, 1986), and left untreated, it follows a chronic, unremitting course. In contrast to earlier views of the disorder as relatively benign, we now know that social phobia is a serious condition associated with impaired social and vocational functioning (Liebowitz, Gorman, Fyer, & Klein, 1985; Turner et al., 1986), comorbidity with depression and other anxiety disorders (Sanderson, DiNardo, Rapee, & Barlow, 1990; Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992; Van Ameringen, Mancini, Styan, & Donison, 1991), increased risk of substance abuse (Chambless, Cherney, Caputo, & Rheinstein, 1987; Himle & Hill, 1991), and suicide (Schneier et al., 1992). Epidemiological data confirm that social phobia is common, with prevalence estimates of approximately 2% in adults (Davidson, Hughes, George, & Blazer, 1993; Myers et al., 1984), with an approximately equal distribution of men and women (Bourdon, Boyd, Rae, Burns, Thompson, & Locke, 1988).

Descriptions of social anxiety have a long history, dating back at least to the writings of Hippocrates (Marks, 1985). Early in this century, Janet (1903) described patients who became extremely anxious in performance situations. Despite these and other clinical descriptions, neither the first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published in 1952, nor the second edition, published in 1968, recognized social phobia as a distinct clinical entity.

Marks (1970) was the first contemporary writer to describe the syndrome of social phobia. Although Marks' work inspired research programs on the psychopathology and treatment of the condition in Great Britain, little work on the disorder was conducted in the United States prior to 1980 (Papp, Gorman, & Liebowitz, 1988) when social phobia was officially recognized as a diagnostic entity in the third edition of the DSM (DSM-III; American Psychiatric Association, 1980). Recognition of the disorder by clinicians and researchers alike was furthered in 1985 when Michael Liebowitz and colleagues at the New York State Psychiatric Institute wrote an important review, terming it the "neglected anxiety disorder" (Liebowitz et al., 1985). The past decade has witnessed a dramatic increase in interest in the study and treatment of social phobia. Although several important developments have occurred and social phobia is certainly no longer neglected, much work remains to be done.

Nosological Issues

A recurrent theme in the nosology of social phobia is whether the condition should be considered as a set of specific fears of discrete social situations (e.g., eating in public) or as a pervasive condition in which most or all social situations are feared and/or avoided. Social phobia was defined in the DSM-III as fear and avoidance of a specific situation in which the person expects to be humiliated. The examples given involve discrete performance situations, and it is

Send correspondence and reprint requests to James D. Herbert, Hahnemann University, Mail Stop 988, Broad and Vine Streets, Philadelphia, PA 19102–1192.

noted that "generally an individual has only one social phobia" (p. 227; American Psychiatric Association, 1980). This description led to the mental health community's viewing social phobia as a relatively benign condition.

In the mid-1980s, data began to accumulate to challenge this conceptualization. Studies by Liebowitz et al. (1985) and Turner, Beidel, Dancu, and Keys (1986) found that the majority of social phobics fear multiple situations and report substantial disruption in social and occupational functioning. These data led to the development of a generalized subtype of the disorder, in which most social situations are feared, in the revised third edition of the DSM (DSM-III-R; American Psychiatric Association, 1987). Recent research suggests that, at least among patients seeking treatment, the generalized subtype is the rule rather than the exception with most social phobics fearing and avoiding multiple situations (Holt, Heimberg, Hope, & Liebowitz, 1992). Nevertheless, the DSM-III-R is vague regarding distinctions between generalized and circumscribed (or discrete) subtypes of social phobia, and different investigators have used a variety of interpretations of the criteria (Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1993).

Distinctiveness from agoraphobia. Although the symptomatology of social phobia shares many features with agoraphobia and the two conditions may be comorbid, they are conceptually distinct. Social phobics fear social situations because they anticipate embarrassment and humiliation by others. Agoraphobics fear situations they associate with increased likelihood of panic attacks, whether or not these situations are social. Several studies have supported the distinction between social phobia and agoraphobia in terms of demographic variables, clinical presentation, response to biological challenges, and response to treatment (Amies, Gelder, & Shaw, 1983; Cottraux, Mollard, & Duinat-Pascal, 1988; Liebowitz et al., 1985; Mannuzza, Fyer, Liebowitz, & Klein, 1990). Nevertheless, although social phobia and agoraphobia are indeed different disorders, in clinical practice it is not uncommon to see features of both occur in the same patient. In making a differential diagnosis when symptoms of both panic disorder and social phobia co-occur, the clinician must assess the underlying basis of the fear. Social phobics who experience panic attacks fear the humiliation and embarrassment associated with interpersonal contact and are acutely concerned over others' witnessing a panic attack. Panickers, in contrast, fear the symptoms of a panic attack themselves (e.g., tachycardia, shortness of breath) due to the belief that these symptoms signify some catastrophic consequence (e.g., a heart attack). It is possible, of course, for both phenomena to be present simultaneously. For example, an individual may become intensely anxious in social interactions, even to the point that such situations often provoke panic attacks (social phobia). Although the panic attacks may initially occur only in the context of social interactions, the patient may develop irrational fears of having an attack even in nonsocial situations and begin to avoid these situations (agoraphobia).

Overlap with avoidant personality disorder. A more difficult and controversial nosological problem involves the overlap of social phobia with avoidant personality disorder (APD). The clinical descriptions of the two conditions in the DSM-III-R overlap substantially in their defining symptoms. Several studies have examined the comorbidity of the diagnoses (Herbert, Hope, & Bellack, 1992; Holt, Heimberg, & Hope, 1992; Schneier, Spitzer, Gibbon, Fyer, & Liebowitz, 1991; Tran, Chambless, & Walker, 1992; Turner, Beidel, & Townsley, 1992b). The results of these studies have been largely consistent, finding that APD is frequently diagnosed in patients with generalized social phobia, with comorbidity rates ranging between 25% and 70%. Moreover, patients rarely, if ever, meet the criteria for APD without also meeting the criteria for social phobia. Social phobics with APD tend to be more severe than social phobics without APD on a variety of measures, but have not been shown to differ qualitatively on any measure. Although there is a general agreement that social phobia and APD, as currently defined, probably represent quantitative points on a continuum of severity and impairment rather than distinct clinical entities, no consensus has yet emerged about how to revise the DSM to deal with this issue (Widiger, 1992). A similar pattern of symptom overlap has been found with social phobia and avoidant disorder of childhood (Francis, Last, & Strauss, 1992). Despite the difficulties in distinguishing social phobia and APD, and despite the failure of the current subtyping scheme to describe sufficiently the full range of symptoms of social phobia, the current nosology will remain without significant modifications in the upcoming fourth edition of the DSM (Heimberg et al., 1993).

Etiology

Little is known about the etiology of social phobia. Few comprehensive theories have been proposed to account for the disorder, and although numerous studies have examined clinical correlates, especially self-defeating cognitions and information processing anomalies, relatively little empirical research has examined etiological factors per se. The research on childhood temperament, heritability, biological measures, and behavioral and cognitive factors bears on the question of etiology and is reviewed briefly below.

Behavioral inhibition. In an ongoing longitudinal study, Kagan and colleagues have identified two stable temperamental styles in young children: inhibited and uninhibited (Kagan, Reznick, & Snidman, 1988). Inhibited children, who appear to make up between 10% and 15% of the population, tend to become distressed and withdraw from novel situations, especially novel social situations. Rosenbaum and colleagues have conducted a series of studies examining the hypothesis that childhood behavioral inhibition is a precursor to adult psychopathology, particularly to adult anxiety disorders. Rosenbaum et al. (1991) found higher rates of anxiety disorders, including social phobia, in the parents of inhibited children relative to the parents of uninhibited chil-

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
✓ امکان دانلود نسخه ترجمه شده مقالات
✓ پذیرش سفارش ترجمه تخصصی
✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
✓ دانلود فوری مقاله پس از پرداخت آنلاین
✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات