

ECNP position paper on social phobia Proceedings from an ECNP workshop in Jerusalem, October 1994¹

S.A. Montgomery*, D. Bakish, R. Buller, A. Gjerris, H. Katschnig, Y. Lecrubier, J.-P. Lepine, M. Mauri, N. Sartorius, A. Cameron, G. Cassano, J. Costa e Silva, J.A. den Boer, C. Freeman, L. von Knorring, H. Loo, D. Nutt, R. Rosenberg

Received 18 July 1995; accepted 26 September 1995

1. Introduction

In October 1994 a workshop was held under the auspices of the European College of Neuropsychopharmacology to address the status of current knowledge about social phobia. The workshop focused on the epidemiology of the disorder, the burden of the illness and the need for effective treatment. Detailed assessment of the relative efficacy of current treatments was outside the limit of the workshop. This paper presents the position paper which was arrived at from the meeting.

2. Social phobia

Social phobia as a separate diagnostic entity is a relatively new arrival in internationally recognised diagnostic systems. Characterised by persistent and excessive fear of scrutiny in social situations, social phobia is differentiated in the DSM (American Psychiatric Association, 1987) and ICD10 (World Health Organisation, 1992) systems from other phobias and anxiety disorders by being specific to or to predominate in social situations. DSM-III-R developed the criteria in DSM-III (American Psychiatric Association, 1980) stressing the invariability of the phobic response and allowing the possibility of comorbid diagnoses and DSM-IV also uses the concept of social anxiety with the possibility of a phobic response in advance of the situation (Table 1).

The commonest social phobias are reported to be public speaking, eating in public, writing in public, using public lavatories, being stared at or being the centre of attention.

Generally sufferers avoid those situations in which others could judge them to be clumsy, ridiculous, weak or stupid. The sufferer does not always consider this fear to be unreasonable. There are cultural differences in the features of social phobia. For example in Japan, where emphasis is placed on harmonious interrelationships, an individual may have a fear of blushing, erythrophobia, because it discomforts others, rather than because it reveals the individual's own embarrassment (Takahashi, 1989).

The distinction between social phobia and agoraphobia may not always be easy. The distinction between social phobia and agoraphobia with panic attacks in which there is avoidance of situations such as restaurants, parties, etc. can be made. In agoraphobia the individual has a range of associated phobias, for example travelling alone, queuing up etc., and also would be embarrassed to have a panic attack in public. This would more properly be defined as a secondary social phobia (Perugi et al., 1990). Social phobia and agoraphobia are often comorbid.

Social phobia is characterised by an anxiety reaction which distinguishes the disorder from an avoidant personality disorder. In other words, symptoms are necessary to fulfil criteria for the diagnosis. The few studies that have compared avoidant personality disorder and social phobia suggest that many characteristics are shared and it is not always easy to differentiate clinically. There is considerable overlap with a high proportion of social phobias fulfilling criteria for avoidant personality disorder (Turner et al., 1986, 1992).

3. Social phobia is a common disorder

The ECA study provides a conservative estimate of lifetime prevalence of social phobia at 2.4% (Schneier et al., 1992). A range of prevalence estimates (from 0.5 to

*Corresponding author. Department of Psychiatry, St. Mary's Hospital Medical School, Paterson Centre for Mental Health, 20 South Wharf Road, London W2 1PD, UK.

¹Rapporteur: D. Montgomery

Table 1
ICD-10 and DSM-IV diagnostic criteria and guidelines for social phobia

Social phobia ICD-10

Fear of scrutiny by other people in comparatively small groups (as opposed to crowds), usually leading to avoidance of social situations. They may be discrete (i.e. restricted to eating in public, to public speaking, etc.) or diffuse, involving most social situations. It is often associated with low self-esteem and fear of criticism. The individual is sometimes convinced that one of the secondary manifestations of anxiety is the primary problem. Symptoms may progress to panic attacks. Avoidance is often marked, and in extreme cases may result in almost complete isolation.

All of the following criteria should be fulfilled for a definite diagnosis:

- (a) the psychological, behavioural, or autonomic symptoms must be primarily manifestations of anxiety and not secondary to other symptoms such as delusions
- (b) the anxiety must be restricted to or predominate in particular social situations;
- (c) the phobic situation is avoided whenever possible

DSM-IV diagnostic criteria for social phobia

- (A) Marked and persistent fear of one or more social or performance situations involving exposure to unfamiliar people or to scrutiny. The individual fears humiliation or embarrassment
- (B) Exposure to the feared social situation almost invariably provokes anxiety
- (C) The person recognises that the fear is excessive or unreasonable
- (D) The feared social or performance situations are avoided or else are endured with intense anxiety or distress
- (E) The avoidance, anxious anticipation, or distress interferes significantly with the person's normal routine, occupational functioning, or social activities or relationships, or there is marked distress
- (F) In individuals under age 18 years, the duration is at least 6 months
- (G) The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition
- (H) If a general medical condition is present the fear in criterion A is not related to it

22.6%) have been reported, much of the variation probably being due to the different methodologies employed. The rates derived are likely to be affected by the diagnostic system used, the level of disability addressed, as well as by the interview instruments which have varied between epidemiological studies (Lepine and Lellouch, 1995). For example, the rates might be underestimated as a result of probing too few situations or by the use of the criterion of a contact with a doctor (Wacker et al., 1992; Stein et al., 1994). This may be an inappropriately restrictive case criterion in a disorder where such contact is experienced as particularly painful and would be likely to be avoided. The French study of social phobia conducted in parallel to the WHO study on psychological problems in general health care which used the CIDI found a lifetime prevalence of 14.4% with a 1 month prevalence of 4.9% (Weiller et al., 1994).

Prevalence rates may also be subject to cultural bias as, for example, cultural expectation of treatment varies. The Chinese are reported to have very low rates because as some responders suggested 'Everybody suffers from something, why go to a doctor for such a thing?'. Age may also affect the apparent prevalence rates since being socially avoidant may be seen as more normal at different ages in a person's life. For example, in the elderly avoiding social contact may be seen as a consequence of age; being socially avoidant may be more culturally acceptable in young women than in young men. Social phobia in a child or adolescent would tend to be identified because of the relative importance at that age of establishing links to other people.

The type of coping mechanisms adopted by sufferers can also have a rate-lowering effect. The socially phobic patient might reach a general practitioner only after

receiving added responsibility, for example, a promotion, their syndrome not having been manifest before. Many such individuals simply refuse promotions altogether, thereby avoiding becoming a clinical statistic.

The preponderance of females reported in many, though not all, of the community samples (Weissman et al., 1991; Davidson et al., 1993; Degonda and Angst, 1993) is not always seen in clinical samples (Lepine and Lellouch, 1995). A gender difference might reflect the different coping mechanisms adopted by the sexes, for example men may successfully self-medicate with alcohol which could lead to social phobia being underestimated in males.

There is general agreement that social phobia is a disorder with an early onset. It can be difficult to establish from sufferers exactly when the condition started as for the most part they regard themselves as having always had the problem. Mean age of onset is reported in the different studies as from 14.6 years to 20 years (Marks and Gelder, 1966; Shafar, 1976; Amies et al., 1983; Davidson et al., 1993; Degonda and Angst, 1993), a substantial proportion of sufferers starting before the age of 10 with a peak in adolescence.

4. Underrecognition of social phobia

In spite of the acceptance of diagnostic criteria by psychiatrists and the commonness of the disorder reported in the epidemiological studies, both in the general population and in clinical surveys, the importance of social phobia is not yet fully recognised. To some extent this reflects the time lag between the production of information and its dissemination and assimilation into practice. As no clearly effective, specific pharmacological treatment has

been available it is perhaps understandable that sufferers do not seek medical help. The experience of specialist clinics is that when information on a treatment becomes available the patients soon start to seek treatment.

A major contributing factor in the continuing underrecognition of the disorder is the perception of social phobia, with its associated avoidance and behavioural inhibition as an exaggerated manifestation of 'normal' shyness or social unease. Many sufferers do not reach medical services as they do not see their condition as a disorder for which consultation with a doctor is appropriate. Medical practitioners, many of whom are unfamiliar with the concept of social phobia, may perpetuate this attitude by their dismissive response. When the social phobia is recognised as impairing it may nonetheless be seen as a behavioural problem for which adjustments have to be made rather than as a condition or disorder which needs to be treated. A non-specific, psychological approach of unproven efficacy is unfortunately often used rather than initiating treatment within the domain of the medical or related professions.

The stigma of mental illness also contributes to the underrecognition of social phobia. Some of those with social phobia who may recognise their need for help are discouraged from discussing the problem with a medical practitioner through embarrassment and fear of the stigma associated with suffering from a psychiatric disorder.

The condition itself is recognised both by the sufferer and by physicians; however, the sufferer may complain of the disability rather than the anxiety symptoms of an illness. The problem is not so much one of recognition *per se* as recognition of the condition as a disorder. Level of incapacity on its own may not always be enough to trigger the perception of the condition as a disorder because the conversion of a disability into a disorder is culture dependent. In some societies a greater degree of social inhibition is tolerated than in others.

Many of those who reach the clinic present with conditions other than social phobia, for example major depression, panic disorder, alcoholism, etc., since social phobia is usually a contributing rather than the single reason for a medical consultation. The treating physician may detect and treat the comorbid condition but miss the primary social phobia. General practitioners are reported to be more likely to recognise as cases of psychiatric illness patients presenting with comorbid diagnoses than patients with uncomplicated social phobia (Weiller et al., 1994). In this study uncomplicated social phobia was, however, more frequently identified as an anxiety disorder than another disorder.

5. Disability

The evidence is overwhelming that social phobia is associated with considerable functional impairment which

stems from the symptoms of the syndrome itself, from the consequences of social phobia interfering in social development at an early age, from the learning of maladaptive coping behaviours in a chronic condition, and from the associated development of comorbid conditions. The level of impairment has been largely underestimated due in part to the overall underrecognition of social phobia but also to some extent to the perception that social phobia is a disability, rather than a disorder, that many psychiatric organisations view as being the concern of other social agencies.

It is important to establish the threshold for intervention; setting the threshold too low carries the dual risk of on the one hand trivialising the condition and on the other of applying interventions where an improvement would be unlikely to be measurable.

The difficulty of measuring severity of impairment has not been adequately addressed though DSM-IV includes a fifth axis to record impairment. The lack of a well constructed and validated measure of functioning makes it difficult to determine the threshold for intervention. Measuring impairment by whether sufferers seek treatment is unreliable as the rates depend on knowledge of available treatment, accessibility and availability of services. There is a need for good, operationalised measures of functioning, broken down to cover the chronicity of the disorder, the extent to which and the amount of time a social phobia interferes, and the number of areas of interference, and taking contextual factors into account in measuring subjective well-being.

Global estimates of impaired performance attributable to social phobia have pointed to academic underachievement, vocational limitation, reduction in social potential, and increased financial dependence (Ross, 1993; Schneier et al., 1994; Davidson et al., 1993). In the study in France in general health care there was a significant increase in unemployment in the social phobia group: 9.3% compared with 1.3% in the no anxiety-no depression group (Weiller et al., 1994).

The early onset of social phobia is particularly important in the genesis of later impairment since the condition, which has a peak age of onset in adolescence, appears at a time which is critical for the learning of the technical skills necessary for successful social interaction. A disorder that interferes with this learning process leaves the person at a significant social disadvantage with long-term consequences. The onset of the disorder in adolescence is also a time that is likely to have the most detrimental effect on the person's education leading to educational and consequently vocational underachievement.

The phobic avoidance of a feared social situation as a coping mechanism to reduce acute anxiety can have far reaching effects in limiting social interaction. It is well established that those with social phobia are less likely to marry and tend to be single, divorced, or widowed. The subject may arrange their working life to accommodate the

limitations imposed by the social phobia and not reach their full employment potential because they are unable to confront social situations.

More information is needed on the course of the disorder as there are few long-term follow-up studies. The best information available from clinical samples suggests that it is a debilitating condition that runs a chronic, largely unremitting, course fluctuating in only a small percentage (Solyom et al., 1986) though in the community sample there may be a higher rate of recovery, 27% in the Duke ECA study (Davidson et al., 1993). The early age of onset and chronic course of the disorder lead to a great deal of suffering.

The disability associated with social phobia is at least as great as with other anxiety disorders. For example patients with social phobia in one comparison reported more disability than patients with panic disorder, with more anxiety, and more avoidance behaviour (Gelernter et al., 1991). Marked impairment was recorded on the Sheehan Disabilities Scale in patients with social phobia entering studies of moclobemide (Buller, 1994). The level of disability is similar to panic disorder patients included in studies.

6. Comorbid conditions

Reluctance by professionals to get involved with social phobia has its price. There is a high level of comorbid psychiatric disorders with social phobia. The ECA study found a lifetime prevalence of comorbid psychiatric illness of 69% in social phobia (Schneier et al., 1992), the most frequent disorders being simple phobia (59%), agoraphobia (45%), alcohol abuse (19%), major depression (17%) and drug abuse (13%). Similar proportions of comorbidity in social phobia are reported in clinical samples with percentages of comorbid mood disorders (major depression) of up to 70% (Van Ameringen et al., 1991). A French clinical sample found that nearly 50% of patients with a current diagnosis of social phobia had an additional diagnosis of anxiety or depressive disorder. Generalised anxiety disorder was, however, not more frequent. Rates were higher still in patients with a lifetime psychiatric diagnosis (Weiller et al., 1994).

Social phobia appears to act as a precipitant to other syndromes as it is seen to predate the episodes of psychiatric disorders in the majority of cases (Schneier et al., 1992). All the studies that have reported on age of onset of social phobia and agoraphobia give an earlier age for social phobia. In the ECA study only 31% of those with social phobia did not have another psychiatric disorder and the social phobia preceded the comorbid condition in 70% or more of the cases (Schneier et al., 1992; Marks and Gelder, 1966; Amies et al., 1983; Ost et al., 1981; Shafar, 1976; Solyom et al., 1986; Thyer et al., 1986). In the French study in general practice social phobia preceded

agoraphobia in 50% of cases. In some 35% of cases agoraphobia and social phobia were reported to start in the same year.

The raised rates of alcohol or drug misuse reported in social phobia, for example 15–26% alcohol abuse in social phobia compared with 4–7% in controls (Davidson et al., 1993; Weiller et al., 1994; Schneier et al., 1989), are of considerable concern. It should also be noted that a large proportion of stimulant abusers do so because it reduces social anxiety. Investigations of samples in alcohol dependence clinics find more than half suffer from social phobia. The alcohol or drug abuse may reflect the learning of potentially harmful coping strategies. There is certainly evidence from these studies that in more than 70% of cases the social phobia preceded the alcohol abuse (Weiller et al., 1994) yet alcohol use helps perpetuate and exacerbate the syndrome (Marshall, 1994).

Severity of the disabilities associated with social phobia appears to increase when there are comorbid conditions particularly where there is an increased rate of major depression. Suicidal ideation is reported to be raised in both simple social phobia and social phobia with comorbid conditions (Schneier et al., 1992). This is a consistent finding in a number of studies. For example, Cox et al. (1994) reported that 34% of those with social phobia had suicidal ideation during the past year. This rate is even higher than the 31% reported in the ECA study for panic disorder where the association with suicidality has been noted with concern (Schneier et al., 1992). An increase in suicide attempts is reported in social phobia in a comparison with agoraphobia (Amies et al., 1983). The increase is greater in comorbid social phobia. In uncomplicated social phobia no excess of suicide attempts is reported but when there are comorbid conditions the suicide attempt rate is increased (Schneier et al., 1992) and a nearly fivefold increase in suicide attempts has been reported compared to controls (Weiller et al., 1994).

Data on treatment show that when untreated social phobia exists in the comorbid condition, for example with depression or panic disorder, it complicates the treatment of the other condition and outcome may be compromised. What this suggests is that the primary social phobia needs to be recognised and treated.

7. How much of social phobia is currently treated

It is difficult to estimate how many patients with social phobia are in need of treatment but it is clear that the numbers reaching medical attention represent only a fraction of the total sufferers with this relatively common disorder. The apparent precipitating effect of social phobia into comorbid psychiatric disorders is a pressing reason to consider early treatment of the primary social phobia. This strategy would aim to avoid the consequences of other serious psychiatric disorders developing, for example

Table 2
Treatment take up by social phobia reported in ECA study

	ECA studies	
	Uncomplicated	Comorbid
Any outpatient treatment	19.6	51.0
Medical outpatient	17.0	28.9
Psychiatric outpatient	5.4	37.8
Emergency department	1.8	11.2
Psychiatric inpatient	0.9	13.7

From Schneier et al., 1992.

major depression, and to avoid the consequences of maladaptive coping mechanisms such as alcoholism.

The substantial numbers coming forward clinically at the moment suggest a high total prevalence of clinically relevant social phobia and treatment issues need to be addressed.

In the epidemiological studies there is evidence of substantial undertreatment and the number of people with social phobia who are recognised for medical treatment represent only a small proportion of those at risk. In the ECA study only 5.4% of those with uncomplicated social phobia sought medical help despite substantial disablement (Schneier et al., 1992). It is estimated that only around 25% of sufferers receive treatment (Ross, 1991). This low treatment rate for social phobia is in line with the low treatment rates for other psychiatric disorders, for example major depression, where only some 33–38% of sufferers attend for treatment (Angst and Dobler-Mikola, 1985) and a smaller proportion receive treatment. In the ECA data it appears that the most disturbing complaint leading to specialist consultations is the fear of speaking to new people (14.2%) and the fear of eating in public (10.2%). This is not surprising since these phobias are likely to impair the ability of an individual to function at work.

In the epidemiological studies it appeared that only some 5% of those with uncomplicated social phobia sought help in spite of the fact that a quarter of them suffered sufficient disability for them to be financially dependent

(Schneier et al., 1992) (Table 2). The average length of time before a person with social phobia seeks treatment is reported to be in the order of 6–10 years and they usually consult for a comorbid condition which by that time has developed rather than the primary social phobia.

Many individuals with social phobia are currently not treated and those with uncomplicated social phobias appear less likely to receive treatment than patients with other disorders. Nevertheless, sufferers from social phobia seen in clinical practice consume substantial health care resources and levels of take up are similar to those for panic disorder (Swinson et al., 1992). The evidence suggests that in those with social phobia a variety of treatments are likely to be used, most of which are of dubious benefit. Swinson et al. (1992) found that potentially effective treatments were used in only small numbers with 4% each receiving cognitive therapy, monoamine oxidase inhibitors, or selective serotonin reuptake inhibitors, 75% received active medication, mainly benzodiazepines, 39% analytical psychotherapy, 82% supportive counselling, and 29% alternative medicine (Table 3). Reorganisation of treatment priorities to encourage the use of effective therapy would therefore be expected to produce maximum benefits at little or not additional cost.

8. Treatment

There is a good evidence that pharmacological treatments are effective in social phobia and there is also evidence for the efficacy of behavioural and cognitive treatment. It is not the intention of this position paper to fully assess the relative efficacy of different treatments but to address the impairment associated with social phobia and the need for treatment. There is sufficient evidence to regard the MAOI phenelzine and the RIMA moclobemide as effective and some limited but suggestive evidence in favour of SSRIs and high potency benzodiazepines. There is no evidence to support the use of classical benzodiazepines or β -blockers.

Table 3
Treatment received by social phobia sufferers

Treatment	Social phobia	Panic disorder with agoraphobia
Psychoactive medication	75%	89%
Benzodiazepines (excluding alprazolam)	68%	78%
Alprazolam	0%	13%
Tricyclic antidepressants	32%	40%
Fluoxetine	4%	10%
Monoamine oxidase inhibitors	4%	3%
Cognitive behavioural therapy	4%	11%
Psychotherapy/analysis	39%	46%
Supportive counselling	82%	87%
Others (e.g. hypnosis)	29%	17%

From Swinson et al., 1992.

9. Need for effective treatments

There is now an increased awareness that social phobia is a debilitating illness associated with considerable morbidity. Effective treatment would be expected to bring considerable benefit in restoring individuals to better functioning with obvious social and employment advantages. The level of associated impairment, which is greater than in many other psychiatric disorders, underlines the need for treatment. It is also clear that social phobia is associated with an increase in secondary and/or comorbid psychiatric illness, alcohol abuse and substance abuse.

Patients with social phobia are already taking up medical resources but the treatment they receive may not be appropriate or may be directed only at the comorbid condition. Treatment rates for the pure social phobia group are low and one of the aims of effective treatment would be to intervene early to reduce or reverse the social and occupational morbidity and hopefully prevent the evolution of complicated comorbid social phobia.

The nature of social phobia with its fear of social situations creates additional difficulty for many to obtain treatment. Any treatment strategy should take into account the distress experienced by sufferers in social encounters. Many sufferers may find it difficult to confront the social interaction implicit in group therapy. It could be expected that pharmacological treatments would be a more readily applied intervention than cognitive or behavioural approaches as the social component is less intrusive and more readily avoidable. For a behavioural approach it is suggested that the development of electronic self training programmes which would reduce the social interaction element might offer an advantage over group treatment.

There is a clear need for efficacious and safe treatment that is readily available so that it can be applied to the majority of patients in need without undue delays and complications.

The promotion of the idea of a treatment package could be encouraged with a distinction between medical intervention to alleviate the primary disability by treating the condition and other interventions aimed at management and coping strategies for the secondary disability.

10. Need for education and information

There is a need for education in the medical profession on social phobia and the available treatments to improve recognition and treatment. This calls for an educational programme with at least five possible focuses: academic psychiatrists whose influence would be felt by colleagues and students, practising psychiatrists whose influence would spread to general practitioners, trainers of general practitioners, general practitioners directly, the general population.

An effective educational campaign must take account of

a number of factors: (1) the attitude of the recipient, (2) the fact that retention of knowledge is limited and maintenance of training is needed, (3) the packaging of the educational programme is as important as its content, (4) any educational package has to lend itself to adjustment according to the context.

One of the most effective ways of improving patients' access to care is to educate the general public. This has proved a powerful tool in other disorders, for example obsessive compulsive disorder. Pressure from the public for treatment from the general practitioner reinforces education that the general practitioner is receiving and supports the partnership for care.

References

- American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. APA, Washington, DC.
- American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, 3rd edn. revised. APA, Washington, DC.
- Amies, P.L., Gelder, M.G. and Shaw, P.M. (1983) Social phobia: A comparative clinical study. *Br. J. Psychiatry* 142, 174–179.
- Angst, J. and Dobler-Mikola, A. (1985) The Zurich study: A prospective epidemiological study of depressive, neurotic and psychomatic syndromes. IV. Recurrent and non-recurrent brief depression. *Eur. Arch. Psychiatry Clin. Neurosci.* 234, 408–416.
- Buller, R. (1994) Presented at ECNP Congress, Jerusalem.
- Cox, B.J., Drenfeld, D.M., Swinson, R.P. and Norton, G.R. (1994) Suicidal ideation and suicide attempts in panic disorder and social phobia. *Am. J. Psychiatry* 151 882–887.
- Davidson, J.R.T., Hughes, D.L., George, L.K. and Blazer, D.G. (1993) The epidemiology of social phobia. findings from the Duke Epidemiologic Catchment Area Study. *Psychol. Med.* 23 709–718.
- Degonda, M. and Angst, J. (1993) The Zurich Study. XX. Social phobia and agoraphobia. *Eur. Arch. Psychiatry Clin. Neurosci.* 243, 95–102.
- Gelernter, C.S., Uhde, T.W., Cimbalic, P., Arnkoff, D.B., Vittone, B.J., Tancer, M.E. and Bartko, J.J. (1991) Cognitive-behavioral and pharmacological treatments of social phobia: a controlled study. *Arch. Gen. Psychiatry* 49, 938–945.
- Lepine, J. and Lellouch, J. (1995) Classification and epidemiology of social phobia. *Eur. Arch. Psychiatry Clin. Neurosci.* 244, 290–296.
- Marks, I.M. and Gelder, M.G. (1966) Different ages of onset in varieties of phobia. *Am. J. Psychiatry* 123, 218–221.
- Marshall, J.R. (1994) The diagnosis and treatment of social phobia and alcohol abuse. *Bull. Menninger Clin.* 58 (Suppl. A), 58–66.
- Ost, L.G., Jerremalm, A. and Johansson, J. (1981) Individual response patterns and the effects of different behavioral methods in the treatment of social phobia. *Behav. Res. Ther.* 19, 1–16.
- Perugi, G., Simonini, E., Savino, M., Mengalli, F., Cassano, G.B. and Akiskal, H.S. (1990) Primary and secondary social phobia: psychopathological and familial differentiation. *Comp. Psychiat.* 31, 245–252.
- Ross, J. (1991) Social phobia: The Anxiety Disorders Association of America helps raise the veil of ignorance. *J. Clin. Psychiat.* 52 (Suppl 11), 43–47.
- Ross, J. (1993) Social phobia: The consumer's perspective. *J. Clin. Psychiatry* 54 (Suppl. 12), 5–9.
- Schneier, F.R., Martin, L.Y., Liebowitz, M.R., Gorman, J.M. and Fyer, A.J. (1989) Alcohol abuse in social phobia. *J. Anxiety Dis.* 3, 15–23.
- Schneier, F.R., Johnson, J., Hornig, C.D., Liebowitz, M.R. and Weissman,

- M.M. (1992) Social phobia: Comorbidity and morbidity in an epidemiological sample. *Arch. Gen. Psychiatry* 49, 282–288.
- Schneier, F.R., Heckelman, L.R., Garfinkel, R., Campeas, R., Fallon, B.A., Gitow, A., Street, L., Del Bene, D. and Liebowitz, M.R. (1994) Functional impairment in social phobia. *J. Clin. Psychiatry* 55, 322–331.
- Shafar, S. (1976) Aspects of phobic illness: A study of 90 personal cases. *Br. J. Med. Psychol.* 49, 221–236.
- Solyom, L., Ledwidge, B. and Solyom, C. (1986) Delineating social phobia. *Br. J. Psychiatry* 149, 464–470.
- Stein, M., Walker, J. and Ford, D. (1994) Setting diagnostic thresholds for social phobia. *Am. J. Psychiatry* 151, 408–412.
- Swinson, R.P., Cox, B.J. and Woczyna, C.B. (1992) Use of medical services and treatment for panic disorder with agoraphobia and for social phobia. *Can. Med. Assoc. J.* 147 878–883.
- Takahashi, T. (1989) Social phobia syndrome in Japan. *Comp. Psychiatry* 30, 45–52.
- Thyer, B.A., Parrish, R.T., Himle, J., Cameron, O.G., Curtis, G.C. and Nesse, R.M. (1986) Alcohol abuse among clinically anxious patients. *Behav. Res. Ther.* 24, 357–359.
- Turner, S.M., Beidel, D.C., Dancu, C.V. and Keys, D.J. (1986) Psychopathology of social phobia and comparison to avoidant personality disorder. *J. Abnorm. Psychol.* 95, 389–394.
- Turner, S.M., Beidel, D.C. and Townsley, R.M. (1992) Social phobia: A comparison of specific and generalized subtypes and avoidant personality disorder. *J. Abnorm. Psychol.* 101, 326–331.
- Van Ameringen, M., Mancini, C., Styan, G. and Donison, D. (1991) Relationship of social phobia with other psychiatric illness. *J. Affect. Disord.* 21, 93–99.
- Wacker, H.R., Mullejans, R., Klein, K.H. and Battegay, R. (1992) Identification of cases of anxiety disorder and affective disorders in the community according to ICD-10 and DSM-III-R by using the Composite International Diagnostic Interview (CIDI). *Int. J. Methods Psychiat. Res.* 2, 91–100.
- Weiller, E., Amorim, P., Boyer, P., Lepine, J. and Lecrubier, Y. (1994) Social phobia in general health care. *Eur. Neuropsychopharmacol.* 4, 186 (Abstract).
- Weissman, M., Livingston Bruce, M., Leaf, P.J., Florio, L.P. and Holzer, C. (1991) Affective Disorders. In: N. Robins and D.A. Regier (Eds.), *Psychiatric Disorders in America. The Epidemiologic Catchment Area study*, Free Press, New York, pp. 53–80.
- World Health Organisation (1992) *International Classification of Diseases, 10th revision (ICD-10)*. World Health Organisation, Geneva.