

Assessment and Treatment of Social Phobia

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Social phobia is an anxiety disorder characterized by heightened fear and avoidance of one or more social or performance situations, including public speaking, meeting new people, eating or writing in front of others, and attending social gatherings. People with social phobia are typically anxious about the possibility that others will evaluate them negatively and/or notice symptoms of their anxiety. Social phobia affects up to 13% of individuals at some time in their lives and is usually associated with at least moderate functional impairment. Research on the nature and treatment of social phobia has increased dramatically over the past decade. As with many of the anxiety disorders, sensitive assessment instruments and effective treatments now exist for people suffering from heightened social anxiety. Typical assessment strategies include clinical interviews, behavioural assessments, monitoring diaries, and self-report questionnaires. Treatments with demonstrated efficacy for social phobia include pharmacotherapy (for example, phenelzine, moclobemide, selective serotonin reuptake inhibitor [SSRI] medications) and cognitive behaviour therapy (CBT) (for example, cognitive restructuring, in vivo exposure, social skills training). Although preliminary comparative studies suggest that both approaches are about equally effective in the short term, each approach has advantages and disadvantages over the other. Trials examining combined psychological and pharmacological treatments are now under way, although no published data on the relative efficacy of combined treatments are currently available.

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The diagnostic category of social phobia was introduced into the official psychiatric nomenclature in 1980 with the publication of DSM-III (1), although it took some time for researchers to develop a serious interest in this disorder (2). Despite exponential growth over the past decade in the number of studies related to social phobia, the state of this research is still several years behind that for certain other anxiety disorders, such as panic disorder and obsessive-compulsive disorder (3). In fact, the first comprehensive texts on social phobia were published only in late 1995 (4,5). Nevertheless, investigators are now beginning to have a better understanding of the nature and etiology of social phobia, and a number of different treatment approaches have been demonstrated to be effective for helping people to overcome the disorder (6).

Social phobia is an anxiety disorder characterized by extreme fear and phobic avoidance of social and performance

situations. Situations feared by individuals with social phobia may be grouped into 2 main types: social interaction and social performance. Feared situations demanding social interaction often include parties, dating, meeting strangers, engaging in casual conversation, maintaining eye contact, talking to people in authority, and being assertive. Performance situations that are often feared by people with social phobia include speaking in front of groups, eating or writing with others watching, using public bathrooms with others in the room, and performing in front of others (for example, sports, music). The number of situations feared by a person with social phobia can vary from one to many.

Although prevalence estimates for social phobia vary greatly, the most recent epidemiological data, based on more than 8000 individuals from the National Comorbidity Survey (7), suggest that about 13.3% of adults (11.1% of men, 15.5% of women) meet DSM-III-R criteria for social phobia at some point in their lives (8). This estimate is considerably higher than a previous estimate from the Epidemiologic Catchment Area Survey (9), which suggested a lifetime prevalence of 2.73% (based on DSM-III criteria). Regardless, social phobia appears to be a relatively common condition in men and women. Furthermore, among clinical samples, men and women tend to seek treatment in approximately equal numbers (6). On average, social phobia tends to begin in the middle to late teenage years (10,11) and often cooccurs with

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other problems, including anxiety disorders (12), depression (12), and substance use disorders (13,14). Social phobia is often associated with moderate to severe functional impairment in the areas of education, employment, family relations, romantic relationships, friendships, and other interests (15).

Diagnostic Considerations

In DSM-IV, social phobia is defined as a “marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others” (16, p 416–7). In social phobia, the individual primarily fears that he or she will act in a way that will be embarrassing or will show excessive anxiety symptoms (for example, shaking, sweating, blushing). Exposure to a feared social situation typically triggers a heightened level of anxiety or a panic attack. To be diagnosed with social phobia, the individual must recognize that the fear is excessive or unreasonable and must avoid the feared situations or endure them with extreme discomfort. In addition, the fear and/or avoidance must lead to significant distress or interference with the individual’s normal routine or functioning. The social anxiety must not be due to the direct effects of a substance or a general medical condition, nor may it be better accounted for by another mental disorder. If another mental disorder or a general medical condition is present, the social anxiety must be unrelated to it. For example, an individual with Parkinson’s disease who avoids socializing because others may notice his or her shaking hands would not be diagnosed with social phobia.

In children, social phobia is not diagnosed if the social anxiety occurs only around adults. Rather, excessive social anxiety must exist in the presence of individuals from the child’s peer group. In addition, children may express the anxiety differently than adults, crying, throwing tantrums, freezing, or shrinking away from social situations. Finally, for individuals under 18 years of age, the diagnosis of social phobia is not given unless the duration of the disturbance has been at least 6 months.

Differential Diagnosis

Differential diagnosis can be difficult for some individuals. First, social phobia must be distinguished from normal levels of shyness or performance anxiety. For example, many people feel uncomfortable speaking in front of large groups, attending social gatherings in which everyone is unfamiliar, or confronting a coworker about a problem behaviour. As mentioned earlier, such fears would be considered phobic in severity only if the individual was distressed about having the fear or if the fear interfered significantly with performance at work or school or with the person’s social or other important activities. For example, a teacher who fears speaking in front of groups would likely be distressed by such a fear and experience considerable impairment at work.

Social phobia must be distinguished from other mental disorders in which individuals sometimes avoid social situations. People suffering from depression often avoid spending time with friends because of a lack of motivation and interest in socializing. In contrast to people suffering from social phobia, depressed individuals tend not to avoid social situations when they are not depressed. In addition, patients with social phobia (but not depression) typically report a desire to socialize, although their anxiety prevents them from doing so.

Similarly, people with features of schizoid personality disorder often avoid socializing. Unlike individuals with social phobia, however, such individuals tend not to be distressed by their lack of social activity and are not particularly interested in socializing. In contrast, individuals with avoidant personality disorder tend to avoid socializing, specifically because they fear criticism from others. In fact, people with severe, generalized social phobia often meet diagnostic criteria for avoidant personality disorder as well. Currently, investigators believe that these 2 disorders differ more quantitatively (that is, in severity) than qualitatively (17).

As reviewed earlier, social phobia is not diagnosed when an individual’s anxiety is completely accounted for by another mental disorder. An individual who has unexpected panic attacks and meets diagnostic criteria for panic disorder would not be diagnosed with social phobia if the fear was exclusively related to having a panic attack in front of other people. For social phobia to be present in addition to the panic disorder, there would have to be evidence of social anxiety above and beyond the anxiety over having a panic attack (for example, anxiety about saying the wrong thing, seeming incompetent or boring to others, looking foolish). Similarly, patterns of avoidance in social phobia may resemble agoraphobia if the individual avoids crowded places such as shopping malls, crowded streets, or public transportation. People with social phobia tend to avoid these situations for different reasons than people suffering from panic disorder with agoraphobia, however. In the former, the fear and avoidance tends to be related to the possibility of others being critical or judging the way the individual looks or behaves. In panic disorder, avoidance of these situations is usually related to the possibility of having a panic attack and not being able to escape.

People with other disorders may also avoid social situations because people may notice symptoms of their disorder. People with eating disorders may avoid eating in front of others. People with obsessive–compulsive disorder often avoid being in situations in which others might notice their compulsive rituals. If the individual’s social anxiety is completely related to another disorder, he or she would not receive a diagnosis of social phobia. An individual may receive both

diagnoses, however, if the diagnostic criteria for both disorders are met and part of the social anxiety is clearly unrelated to the other problem.

Assessment of Social Phobia

A comprehensive assessment for social phobia consists of 3 main components: 1) a clinical interview, 2) self-report measures (questionnaires, monitoring diaries), and 3) behavioural assessment. Although detailed descriptions of the assessment process are available elsewhere (18–21), this section will include an overview of the assessment process. The clinician should be aware that the assessment process is in itself a phobic stimulus for many socially phobic patients. For example, the interview may arouse anxiety over the possibility of being judged negatively by the clinician. Likewise, self-report questionnaires may be difficult to complete in a public waiting room for an individual who is anxious about having shaky hands when writing. The clinician should be sensitive to the possibility that any visible signs of anxiety observed during the assessment may be attributable to the nature of the assessment situation rather than a reflection of how the patient appears in general, that is, in other settings.

The assessment process should not end when treatment begins. Rather, the clinician should continue to monitor the patient's progress using monitoring diaries, questionnaires, and repeated behavioural assessments periodically during and following treatment.

Clinical Interview

The clinical interview has several functions, including establishing a differential diagnosis, learning about the etiology and course of the disorder, learning about the patient's family history, and deciding upon a treatment plan that is likely to be effective. During the assessment, the interviewer should attempt to generate a list of situations that the patient fears and avoids. Attention should also be paid to subtle types of avoidance such as wearing a turtleneck to hide blushing, eating only in restaurants that have dim lighting, talking only to people who are perceived as "safe" (for example, people perceived to be nonjudgemental or of lower status), or having several glasses of wine to feel more comfortable at a party.

The clinician should also ask about the patient's beliefs, interpretations, and predictions regarding social situations. Typically, anxious thoughts are related to the possibility of being disliked by others and seeming unattractive, uninteresting, or incompetent. Patients also may report anxiety over experiencing particular physical symptoms of anxiety in front of other people because it might lead others to perceive them as being anxious, weak, or insecure. Patients' concerns about physical symptoms of anxiety should be assessed during the interview.

To help with selecting an appropriate treatment, the clinician should also pay attention to the patient's previous experience with treatment (for example, response to various treatments and compliance history), comorbidity, psychological mindedness, and possible social skills deficits (for example, lack of assertiveness, poor communication skills, poor eye contact).

Typically, clinicians rely on unstructured clinical interviews. For the purpose of differential diagnosis, however, structured diagnostic interviews are often incorporated into the assessment process, particularly in research settings. The most popular of these instruments for diagnosing social phobia are the Anxiety Disorders Interview Schedule for DSM-IV (22) and the Structured Clinical Interview for DSM-IV (23).

Self-Report Measures and Behavioural Assessments

Several self-report instruments exist for the assessment of social anxiety (Table 1) (24–34). Although these measures differ somewhat with respect to scope, ease of administration, and psychometric properties, all are commonly used with social phobic patients. Comprehensive reviews of these measures are available elsewhere (18,20). In addition to measuring social phobia symptoms, the clinician may want to consider using questionnaires to measure associated features including depression, fear of physical anxiety symptoms, generalized anxiety, and quality of life. Although an exhaustive list of such measures is beyond the scope of this paper, Table 2 includes a brief list of psychometrically sound questionnaires to measure these dimensions (35–53).

Monitoring diaries can be a helpful way to assess patients' symptoms before and during treatment and to minimize the likelihood of biased recall. Because memories for previous events are often affected by mood state at the time of the interview, monitoring forms should be used to assess the patient's fear level (using a numerical scale), physical symptoms, cognitions, and anxious behaviours (for example, subtle and overt avoidance strategies) during actual exposures to social situations that arise in the period between appointments. These diaries can also be a helpful way for patients to monitor their progress throughout treatment.

Anxiety during actual exposures to feared situations can also be measured during the interview with a behavioural role-play assessment. Essentially, this involves arranging for a patient to be exposed to a feared situation, such as giving an impromptu speech or engaging in a simulated job interview, and measuring the patient's reaction on the same dimensions tracked through monitoring diaries.

Table 1. Standard measures for social phobia and social anxiety

Measure	Year	Number of items	Description
Self-report scales			
Social Phobia and Anxiety Inventory	1989	45	Thirty-two-item social phobia scale and 13-item agoraphobia scale More difficult to score and interpret than other measures (18) Useful for measuring treatment outcome (25)
Social Interaction Anxiety Scale ^a	1989	20	Measures anxiety regarding social interactions Excellent psychometric properties (26) Brief, easy to score, sensitive to change (27)
Social Phobia Scale ^a	1989	20	Measures anxiety in performance situations Excellent psychometric properties (26) Brief, easy to score, sensitive to change (27)
Social Avoidance and Distress Scale (28)	1969	30	Measures fear and avoidance associated with social interactions True-false format, good psychometric properties (29) Does not distinguish among clinical anxiety disorder groups (30)
Fear of Negative Evaluation Scale (28)	1969	28	Measures expectations regarding negative evaluation True-false format, good psychometric properties (29) Does not distinguish among clinical anxiety disorder groups (30)
Clinician-rated scales			
Liebowitz Social Phobia Scale (31)	1987	24	Eleven social interaction items and 13 social performance items, each rated for fear and avoidance Only limited psychometric support (18,32)
Brief Social Phobia Scale (33)	1991	11	Rates fear and avoidance for 7 social situations and the presence of 4 physical symptoms during exposure to social situations Limited research regarding psychometric properties (33,34)

^a Mattick RP, Clarke JC. Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. Unpublished manuscript, January 1989.

Treatment of Social Phobia

Pharmacological Approaches

In recent years, investigators have examined the efficacy of various types of medication for social phobia, including monoamine oxidase inhibitors (MAOIs), reversible inhibitors of monoamine oxidase A (RIMAs), SSRIs, benzodiazepines, β -blockers, and various other medications (for example, buspirone). In-depth reviews of this literature are available in several other sources (3,54–58). This review will summarize some of the major findings regarding the use of medications for social phobia.

One of the earlier medications shown to be effective for treating social phobia was phenelzine, an MAOI antidepressant. In one of the more recent studies, Liebowitz and colleagues (59) compared phenelzine (mean dosage 75.7 mg/day) with atenolol (a β -blocker; mean dosage 97.6 mg/day) and placebo and found that whereas 64% of patients taking phenelzine responded to 8 weeks of treatment, the rates of response for atenolol and placebo were 30% and 23%, respectively. After 16 weeks of treatment, the response to atenolol was intermediate, falling between the rates for phenelzine and placebo. As with other MAOIs, the therapeutic advantages of phenelzine must be balanced with the disadvantages of stringent dietary restrictions and relatively intense side effects. Several investigators have therefore been prompted to examine the use of RIMAs (for example, moclobemide) in patients with social phobia. RIMAs are a new class of antidepressants that tend to have fewer and less severe

side effects than traditional MAOIs and do not require patients to refrain from consuming foods that contain tyramine.

In a comparison of moclobemide (mean dosage 580.7 mg/day), phenelzine (67.5 mg/day), and placebo, Versiani and others (60) found that moclobemide was only slightly and insignificantly less effective than phenelzine, but was tolerated much better. The most common side effects for phenelzine were fatigue, constipation, orthostatic hypotension, decreased libido, dry mouth, retarded ejaculation, insomnia, vertigo, and headache. Although the side effects for moclobemide comprised similar symptoms, they occurred much less frequently and were less intense. Subsequent studies (61,62) have confirmed that moclobemide is an effective treatment for social phobia, relative to placebo, although the magnitude of change over the course of treatment appears to be modest. In one multicentre trial (61), patients taking 600 mg/day of moclobemide were rated to be just under 25% improved, according to evaluators' clinical impressions of overall change. In contrast, the mean improvement ratings for those taking 300 mg/day of moclobemide and those receiving placebo were less than 15% and less than 10%, respectively. Furthermore, as with other medications, there appears to be a high rate of relapse (up to 88%) following discontinuation of moclobemide (62).

The reversible MAOI-A and serotonin uptake inhibitor brofaromine also seems to be an effective treatment for social phobia. In one placebo-controlled study (63), 78% of patients taking brofaromine (150 mg/day) and 23% of those taking placebo were judged to be much or very much improved after 12 weeks of treatment.

Table 2. A selection of self-report scales for variables of interest other than social anxiety

Measure	Year	Number of items	Description
Beck Depression Inventory, Second Edition (35)	1996	21	Updated version of the popular Beck Depression Inventory (36) Updated to assess depression symptoms from DSM-IV Initial data suggest good psychometric properties (35)
Beck Anxiety Inventory (37)	1990	21	Developed to measure clinical anxiety Good psychometric properties (38–40) Appears to favour physical symptoms of anxiety (eg, panic symptoms) over other types of symptoms (eg, worry, muscle tension) (41,42)
Depression Anxiety and Stress Scales (43)	1995	45	Three subscales measure depression, anxiety (ie, fear symptoms), and stress (ie, tension) Excellent psychometric properties in clinical and nonclinical samples (44,45)
Anxiety Sensitivity Index (46)	1987	16	Popular instrument for measuring anxiety over having physical arousal symptoms, including symptoms that others might notice Highest elevations are seen in panic disorder patients, but social phobia patients often have elevated scores as well (47) Excellent psychometric properties (46,48,49)
Illness Intrusiveness Rating Scale (50)	1983	13	Measures the impact of having an illness on 13 different domains of functioning (eg, work, recreation) Has been validated primarily in medical samples (50–52) Recent evidence from our group suggests that this measure is useful for patients with anxiety disorders, including social phobia (53)

A number of open-label trials have provided initial support for the treatment of social phobia with SSRI antidepressants, including paroxetine (64,65), fluoxetine (66,67), and sertraline (68,69). Although several placebo-controlled studies of SSRIs are currently under way, only 2 small placebo-controlled studies have been published. In the first of these studies, Katzelnick and colleagues (70) found that sertraline 50 to 200 mg/day but not placebo led to a statistically significant improvement in patients with social phobia. Similarly, van Vliet and others (71) found that 47% of patients taking fluvoxamine 150 mg/day but only 8% of those taking placebo were judged to be responders following 12 weeks of treatment.

Open trials with venlafaxine (72) and nefazodone (73) suggest that these antidepressants may also warrant additional controlled studies to establish their efficacy with patients suffering from social phobia. In general, tricyclic and heterocyclic antidepressants are thought not to be helpful for social phobia, although research on these medications is clearly lacking (54).

A number of open trials with clonazepam (74,75) and alprazolam (76,77) suggest that benzodiazepines may help to reduce symptoms of social phobia. In a placebo-controlled study, Davidson and colleagues (78) found that 78% of patients taking clonazepam (mean dosage 2.4 mg/day) and 20% of patients taking placebo responded to treatment, confirming the findings of earlier open-label trials. Gelernter and colleagues (79) found few differences on most measures in a controlled study that compared phenelzine (mean dosage 55 mg/day), alprazolam (mean dosage 4.2 mg/day), CBT, and placebo. On one measure, however, phenelzine was more effective than the other 3 groups, which did not differ from one another. Unfortunately, the interpretation of these results

is limited by the facts that the definition for “treatment responder” may have been overly stringent and that patients in all 4 groups were given instructions to expose themselves to feared situations, which may have blurred the differences between groups.

Although open trials of buspirone have yielded mixed results (80,81), subsequent controlled trials (82) have not confirmed the efficacy of buspirone for social phobia. In one uncontrolled study (83) with a relatively small sample, however, buspirone appeared to be useful for augmenting improvement in patients who had partially responded to an SSRI. As is the case for buspirone, initial open trials with β -blockers suggested that drugs such as atenolol might be helpful for social phobia (84), but subsequent controlled trials have failed to show an advantage for β -blockers over placebo (59,85). Although β -blockers are frequently used to treat performance anxiety (for example, fears about public speaking or musical performance), there are no controlled studies supporting their use in clinically diagnosed patients with either generalized or discrete social phobias.

Psychological Approaches

Numerous studies have confirmed that CBT is effective for individuals suffering from social phobia (3,6,58,86). Treatment strategies that are empirically supported for social phobia include cognitive therapy, exposure to feared situations, social skills training, and applied relaxation. Often, treatment packages include several of these components, depending on the needs of the patient. Treatment typically lasts 10 to 15 weeks and is often conducted in a group format (87).

People with social phobia hold beliefs, interpretations, and predictions that probably contribute to their anxiety in social

Table 3. Sample exposure hierarchy for social phobia

Items	Level of anxiety (0 to 100)
1. Be the best man at my brother's wedding	98
2. Go to work Christmas party for one hour without drinking	85
3. Invite friends over for dinner	80
4. Go for a job interview	75
5. Ask neighbour to turn down the volume on his stereo	73
6. Ask a question in class	65
7. Eat lunch with classmates	55
8. Talk to a stranger on a bus	50
9. Talk to a friend on the telephone for 10 minutes	45
10. Return an item of clothing to a department store	35

situations. Individuals with social phobia report elevated levels of perfectionistic thinking relative to nonclinical groups (88) and relative to individuals with other anxiety disorders (89). In addition, people with social phobia tend to judge themselves relatively harshly, assume that others are judging them negatively, and demonstrate biases in attention and memory which are consistent with their phobic cognitions (90,91). Cognitive therapy helps patients to change anxious beliefs (for example, "if others notice my blushing, they will think I am weak and incompetent") by considering alternative interpretations and examining the evidence that supports and contradicts their negative automatic thoughts. This is accomplished during treatment sessions through discussions with the therapist and between sessions by means of cognitive monitoring diaries. Patients are provided with a variety of strategies designed to help them challenge their anxious thoughts.

Exposure-based strategies involve repeatedly encountering a feared situation until it no longer arouses fear. To start, the patient and therapist develop an exposure hierarchy, in which situations are listed in order of difficulty, from most difficult to least difficult (Table 3). During the subsequent weeks, the patient practises the items listed in the hierarchy, beginning with easier items and progressing to more difficult items. As with other phobic disorders (92), exposure for social phobia probably works best when it is prolonged (allowing time for fear to decrease), predictable, repeated frequently, and when subtle avoidance strategies such as alcohol use or distraction are not permitted. Exposures may be conducted during treatment sessions through role play and between sessions in actual social situations (for example, meetings at work). Cognitive strategies are often combined with exposure to ensure that ambiguous signals from others during the exposure practices are not misinterpreted.

A long history of social avoidance is likely to prevent an individual from encountering opportunities for learning adequate social skills. Some patients with social phobia, particularly those with features of avoidant personality disorder, can

therefore benefit from social skills training, including modelling, behavioural rehearsal, corrective feedback, social reinforcement, and homework assignments. Social skills that are addressed during such training include self-expression, eye contact, nonverbal communication, assertiveness, and dealing with conflict.

Finally, applied relaxation for social phobia involves learning to relax one's muscles during rest, while moving, and eventually in anxiety-provoking situations (that is, during exposure). This method has been studied primarily by Lars-Göran Öst and colleagues (93).

Controlled outcome research investigating CBT for social phobia has included studies that compared CBT to alternative treatment conditions such as medication, supportive psychotherapy, or waiting list control conditions as well as studies which compared the various CBT strategies to one another, alone and in combination. Over the short term and during follow-up, CBT has repeatedly been shown to be more effective than supportive psychotherapy and waiting list conditions (94–96). Studies comparing CBT to pharmacological treatments have shown that CBT leads to improvements similar to those seen following treatment with medication. For example, Heimberg and colleagues (97) recently compared 4 treatments for social phobia: cognitive-behavioural group treatment (CBGT), phenelzine, supportive psychotherapy, and placebo. After 12 weeks of treatment, CBGT and phenelzine were equally efficacious and were more effective than placebo or supportive psychotherapy. Pharmacotherapy tended to work more quickly than CBGT and was more effective on a few measures. After discontinuation of treatment, however, gains were most likely to be maintained among individuals who underwent CBGT. Another study (85) found that CBT is more effective than atenolol or placebo, which did not differ from one another. Finally, as reviewed earlier, Gelernter and others (79) did not find many differences between CBT, phenelzine, alprazolam, and placebo on most measures. This study was confounded by the fact that all conditions included behavioural instructions, however, which appear to be effective in and of themselves for some phobic disorders (98). Currently, there are several trials under way to examine the efficacy of treatment combining CBT and pharmacotherapy, but no published data are yet available.

Studies that compare specific CBT strategies have yielded conflicting results. Some studies have found no differences in efficacy among cognitive strategies, exposure-based strategies, and their combination (99–101), whereas other studies have found an advantage to combining cognitive and behavioural strategies over using exposure-based treatments alone (27,102,103). Findings from metaanalytic studies examining the relative efficacy of the various CBT components have also yielded inconsistent results. A metaanalysis by Feske and

Chambless (104) that compared cognitive-behavioural packages with pure exposure-based treatments found no outcome differences between the 2 approaches. Although a metaanalysis by Taylor (105) also failed to show statistically significant differences between these 2 approaches, treatments combining cognitive and behavioural approaches tended to have larger effects.

Summary and Conclusions

Over the past decade, our understanding of the nature and treatment of social phobia has increased enormously; both CBT and pharmacological therapies for social phobia have been demonstrated to be effective for treating this condition. Nevertheless, several important questions remain to be answered. First, there are still no studies that address the question of whether the combination of medication and CBT works as well as or better than either approach alone. Second, if combined treatments do prove to be effective, the issue of treatment sequencing will need to be addressed (that is, should a clinician start with pharmacotherapy or CBT?). Third, more research should be conducted on predictors of outcome for various treatment modalities. To date, there is no way to predict which patients are likely to respond to a particular type of treatment. Finally, more research should be aimed at developing self-administered treatments for social phobia. As mentioned earlier, treatments with minimal therapist contact have been shown to be useful in other anxiety disorders (98) and may be helpful for social phobia. Despite the fact that most patients respond well to CBT and medications, many individuals continue to have significant anxiety following treatment. Continued research may help to improve existing treatments so that more patients achieve greater benefit.

Clinical Implications

- Reliable and valid assessment strategies exist for measuring social anxiety.
- Several cognitive-behavioural strategies are effective for treating social phobia.
- A number of medications have been shown to be effective for treating social phobia.

Limitations

- A substantial number of individuals with social phobia continue to experience significant anxiety following treatment.
- The effectiveness of combining psychological and pharmacological treatments for social phobia remains to be documented.
- More research is needed to establish reliable predictors of treatment outcome.

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Résumé

La phobie sociale est un trouble anxieux caractérisé par un accroissement de la peur ou de l'évitement d'une ou de plusieurs situations sociales ou de rendement, notamment parler en public, rencontrer des inconnus, manger ou écrire devant autrui et participer à des réunions mondaines. Les personnes atteintes de phobie sociale s'inquiètent habituellement de la possibilité que les autres les évaluent négativement et (ou) remarquent les symptômes de leur anxiété. La phobie sociale touche jusqu'à 13 % des personnes à un moment quelconque de leur vie, et elle est habituellement liée à une déficience fonctionnelle moyenne. La recherche sur la nature et le traitement de la phobie sociale a pris une ampleur spectaculaire pendant la dernière décennie. Comme pour de nombreux troubles anxieux, des instruments d'évaluation sensibles et des traitements efficaces existent maintenant à l'intention des personnes souffrant d'une anxiété sociale accrue. Les stratégies d'évaluation habituelles comprennent les entrevues cliniques, les évaluations comportementales, les journaux de contrôle et les questionnaires à remplir soi-même. Les traitements de la phobie sociale dont l'efficacité est avérée comprennent la pharmacothérapie (des médicaments comme la phénelzine, le moclobémide et l'inhibiteur spécifique du recaptage de la sérotonine, par exemple) et la thérapie cognitivocomportementale (la restructuration cognitive, l'exposition in vivo, la formation en matière d'aptitudes sociales, par exemple). Même si, selon des études comparatives préliminaires, les deux approches sont presque aussi efficaces à court terme, chacune possède des avantages et des défauts par rapport à l'autre. Des essais visant à étudier des traitements psychologiques et pharmacologiques en association sont maintenant en cours, bien que l'on n'ait à ce jour publié aucune donnée sur l'efficacité relative des traitements en association.