ANXIETY DISORDERS

Social Anxiety Disorder (Social Phobia)

SAD

DSM-5-TR 300.23 | ICD-10-CM F40.10

Marked fear of scrutiny in social or performance situations, driven by dread of humiliation and negative evaluation.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~12% (US adults)	Median age 13; rare after 25	~1.5:1 female:male	Chronic; long treatment lag

CLINICAL PICTURE

- Fear concentrates on being judged anxious, boring, or incompetent; blushing, trembling, sweating, and a shaking voice are the dreaded giveaways.
- Avoidance is often invisible: declining promotions, sitting silent in meetings, texting instead of calling, or arriving late to skip small talk.
- The performance-only subtype is confined to public speaking or performing and leaves everyday conversation and dating largely intact.
- Post-event processing keeps patients replaying interactions for hours or days, cementing a distorted image of how they appeared.
- Alcohol is commonly used as pre-social anxiolysis, a pattern that converts smoothly into an alcohol use disorder over time.
- Children may show tantrums, freezing, clinging, or selective mutism rather than articulating any fear of being evaluated.

DIAGNOSTIC CRITERIA AT A GLANCE

- Marked fear or anxiety about one or more social situations involving possible scrutiny, including interaction, being observed, and performing.
- The person fears acting in a way, or showing anxiety symptoms, that will be negatively evaluated, humiliating, or lead to rejection.
- Such situations almost always provoke fear, are avoided or endured with intense distress, and the fear is out of proportion to actual threat.
- Duration is typically **six months or more**, with clinically significant distress or impairment in social or occupational functioning.
- Specify performance only when fear is restricted to speaking or performing publicly; exclude substance, medical, and other disorder explanations.

NEUROBIOLOGY & PHYSIOLOGY

- Amygdala and insula hyperreactivity to critical and even neutral faces, with weak dorsolateral and medial prefrontal down-regulation on fMRI.
- Striatal dopamine D2 receptor and dopamine transporter abnormalities distinguish social anxiety from other anxiety disorders in PET studies.
- Serotonin synthesis is elevated in amygdala and raphe regions, a counterintuitive direction that nonetheless accompanies robust **SSRI** response.
- Heritability approximates **30-40%**, and behaviorally inhibited temperament in toddlerhood is the strongest prospective risk marker.
- Exaggerated sympathetic output, including blush reactivity and beta-adrenergically mediated tremor, drives the performance subtype.
- Oxytocin signaling and receptor gene variants modulate social threat appraisal, an active but not yet clinically actionable target.

PSYCHOLOGICAL MECHANISMS

- Clark and Wells model: attention shifts inward to a distorted self-image built from felt anxiety rather than from actual external feedback.
- Safety behaviors such as scripting sentences, avoiding eye contact, or gripping a cup prevent disconfirmation and read as aloofness to others.
- Anticipatory rumination beforehand and post-event processing afterward convert ambiguous encounters into remembered social failures.
- High self-imposed standards for social performance combined with low social self-efficacy generate probability and cost overestimation.
- Peer victimization, shame-focused or critical parenting, and overcontrol interact with inhibited temperament to consolidate the disorder.

DIFFERENTIAL & COMORBIDITY

- Differentiate from avoidant personality disorder (pervasive inadequacy across contexts), autism (social communication deficit), and panic disorder.
- Body dysmorphic disorder centers on perceived appearance flaws, while **agoraphobia** avoidance concerns escape difficulty rather than evaluation.
- Normal shyness lacks the impairment threshold; a direct question about functional cost separates temperament from diagnosable disorder.
- Alcohol use disorder, major depression, and other anxiety disorders are the top comorbidities, with social anxiety usually the primary condition.
- Untreated social anxiety predicts later depression and suicidal ideation, and educational and occupational attainment suffer measurably.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **Paroxetine 20-60 mg/day**, **sertraline 50-200 mg/day**, and escitalopram 10-20 mg/day carry the strongest SSRI evidence in this disorder.
- **Venlafaxine XR 75-225 mg/day** is an equally first-line SNRI option; allow **8-12 weeks** at target dose before declaring nonresponse.
- **Propranolol 10-40 mg** taken 30-60 minutes before a performance blunts tremor and palpitations in the performance-only subtype.
- Benzodiazepines are second-line and problematic given the high rate of comorbid alcohol use disorder in this patient population.
- Gabapentin and pregabalin have modest trial support, and the MAOI **phenelzine** remains highly effective but is reserved for refractory cases.

PSYCHOTHERAPY

- **CBT** with in-session and in-vivo exposure plus deliberate dropping of safety behaviors over **12-16 sessions** outperforms medication at follow-up.
- **Clark and Wells cognitive therapy**, using video feedback and attention training, produces the largest effect sizes reported in the literature.
- Group **CBT** provides a built-in audience but is not superior to individual therapy; individual format is preferred when severity is high.
- Social skills training helps only where a genuine skills deficit exists; most patients possess the skills but have them inhibited by anxiety.
- Combining **CBT** with an SSRI adds modest benefit over either treatment alone in severe or heavily comorbid presentations.

ADJUNCT & SUPPORTIVE

- Track outcome with the **Liebowitz Social Anxiety Scale** or the Social Phobia Inventory at intake and every four to six weeks thereafter.
- Video feedback corrects the distorted self-image faster than verbal disputation; have the patient predict what they will see before viewing.
- School and workplace accommodations should support graded exposure rather than permit avoidance of presentations, which entrenches impairment.
- Address alcohol use directly, since pre-social drinking is negatively reinforced and systematically undermines exposure-based learning.
- Internet-delivered guided **CBT** matches face-to-face outcomes and suits patients who cannot tolerate a clinic waiting room.

CLINICAL PEARLS

- The fear is of visible anxiety itself; ask what others would conclude if they saw you blush.
- Dropping safety behaviors during exposure predicts outcome more than exposure duration does.
- Onset after age 25 is unusual; look for depression, substance use, or a medical cause instead.

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NOTE

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