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Social Phobia: A Comparative Clinical Study

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Summary: Eighty-seven people with the symptom of social phobia were compared with 57 people with the symptom of agoraphobia to determine whether these symptoms were part of distinct syndromes. Comparisons were made on demographic, clinical and questionnaire data. Significant differences were found on important variables. The social phobics were younger and more often male, unmarried, and from social classes I and II. The pattern of phobic situations was different in the two groups and so was the pattern of autonomic symptoms experienced in these situations. Symptoms visible to others were more frequent among social phobics. Fainting was more frequent among the agoraphobics.

The classification of phobic disorders is still disputed. Most clinicians follow the scheme that has recently been given official approval in the 3rd edition of the American Psychiatric Association's Diagnostic Manual (DSM-III) (1980). Following Marks' (1969) report of 23 cases, this divides phobic disorders into three syndromes, agoraphobia, social phobia and simple phobias. In this way it differs from the 9th edition of the International Classification of Diseases (WHO, 1978) which recognizes only one phobic syndrome. In fact, there is little evidence to support the idea that the symptoms of agoraphobia and social phobia are part of separate syndromes rather than minor variations of a single syndrome—some patients complaining more of one or other symptom but all sharing other common features. Doubts about the validity of social phobia as a distinct syndrome have been expressed by Slater and Roth (1969) and by Snaith (1968). The present paper reports results from a series of consecutive phobia patients and compares those complaining in the first place of social phobia with those whose presenting symptom was agoraphobia.

Method

Definitions

The symptom of *agoraphobia* is unreasonable anxiety experienced by a person when away from home, especially in situations that are enclosed, crowded and difficult to leave quickly, such as large shops and public transport. Anxiety tends to increase with the distance from home. It is accompanied by a strong desire to avoid the situations in which it is experienced.

The symptom of *social phobia* is unreasonable anxiety experienced by a person when in the company of other people. The anxiety usually increases with the degree of formality of the situation and the extent to which the person feels under scrutiny. It is accompanied by a desire to avoid the situations in which it is experienced.

Subjects

The 144 patients were consecutive referrals whose main complaints were the symptoms of either agoraphobia or social phobia. In each case phobic anxiety state was the primary diagnosis. The patients were grouped, using the above definitions and the assessor's global rating of severity for each phobia. There were 87 complaining of social phobia and 57 of agoraphobia. The greater number of social phobics reflects our known interest in the treatment of the condition at the time. All patients had experienced symptoms for at least a year, and severity of the principal phobia was at least 4 on a 0–8 scale.

Source of data

A structured interview was used to collect information about phobic symptoms, associated symptoms and family and personal history. Patients filled in a check list of autonomic symptoms, a fear survey schedule (65 items each rated 0–4), and the Eysenck Personality Inventory (EPI). One person (PMS) interviewed all the patients.

Results

Age, sex and social class (Table I)

At referral, social phobia patients were younger

TABLE I

Age, sex and social class

	Social phobia	Agoraphobia	P
Number	87	57	
Age at referral			
Age range (yrs.)	16–51	20–65	.001*
Mean	30.7	37.2	
Sex distribution:			
Male	60%	14%	.001+
Female	40%	86%	
Social class:			
Patients—I & II	54%	35%	.05+
III, IV, V	46%	65%	
Parents—I & II	33%	26%	NS
III, IV, V	67%	74%	

* t test
+ chi square

(mean age 31 years) than agoraphobia patients (mean age 37 years). There was a marked excess of women among the agoraphobia patients (6:1) and a slight excess of men among those with social phobia. Social class differed between the groups, social phobia patients being more often from classes I and II than were agoraphobia patients. In addition, social phobia patients were often more from classes I and II (54 per cent) than were their parents (33 per cent) ($P < .05$). This was not true of the agoraphobia patients.

Marital status

More of the social phobia patients had never married (32 per cent compared to 5 per cent; chi square $P < .001$). More social phobia patients were cohabiting (9 per cent compared to none of those with agoraphobia, $P < .02$), and many more were of single status—i.e. single, divorced, separated or widowed (38 per cent compared to 12 per cent; chi square $P < .001$). In considering these findings it should be noted that the social phobic patients were on average six years younger than the agoraphobics.

Onset and duration

Onset was later among the agoraphobia patients (24 years compared to 19 years; t test $P < .001$) and was more often acute in this group (54 per cent compared to 18 per cent; chi square $P < .001$). On average, both groups had experienced phobic symptoms for about a decade before seeking treatment (12 years for those complaining of social phobia; 10 years for those with agoraphobia). However, the range was wide in both: 1-40 years for the social phobia and 1-28 years for the agoraphobia patients. There was a suggestion of a

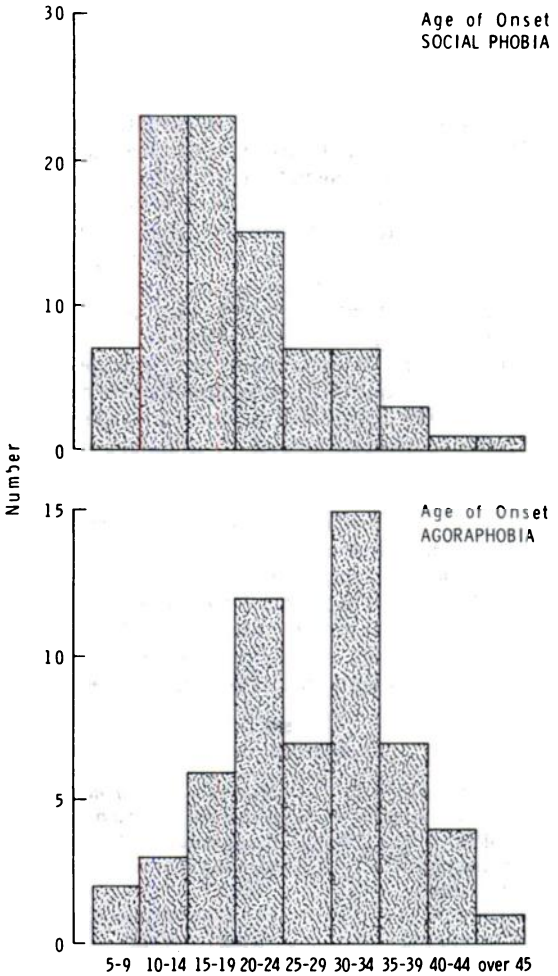

FIG.—Age of onset of social phobia and agoraphobia. (Note: when agoraphobic patients had experienced marked travel fears in childhood, this was taken as the onset of the phobic symptoms, even though the full syndrome of agoraphobia was not present in childhood).

bimodal distribution of the age of onset of the agoraphobia patients with peaks in the early twenties and early thirties (Fig.).

Situations which provoked the phobic symptoms

The two groups were separated only by their main phobic complaints. This allows us to examine whether they differed in other ways. One possible difference is in the pattern of other situations that provoke symptoms.

The assessor asked all patients whether they experienced anxiety in five social situations, viz. eating with others, speaking with others, being with others,

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writing/manual tasks while observed, telephoning; and five situations related to the symptom of agoraphobia, viz. leaving home, public transport, crowded buildings, open spaces, being left alone. The severity of anxiety was rated from 0–4 for each situation.

These groups of patients, who had been separated by their presenting symptom, recorded significantly less severe anxiety in the situations 'belonging' to the other group (Mann-Whitney test, $P < .001$ for each item). Thus, in no situation commonly regarded as 'social phobic' did symptom severity reported by the agoraphobia patients approach that of the social phobia patients, and vice versa. However, it was found that agoraphobia patients had more often experienced some anxiety in one or more of the situations generally associated with social phobia than had social phobia patients experienced anxiety in situations generally associated with agoraphobia (50 per cent compared to 25 per cent).

Next, the rank order of severity of items characteristic of the other phobias was examined for each group. It was found that agoraphobia patients rate their fears of social situations in the same rank order as do social phobia patients (i.e. the order listed above), even though the severity is much less. However, for the social phobia patients, the rank order of their fear in any situations characteristic of agoraphobia is slightly different from that of the agoraphobia patients. Interestingly, open spaces are feared least; agoraphobics rate this third in rank order of severity. Again absolute severity is much less among the social phobia patients. The patient's own ratings of the situations that provoke fear were obtained by using a *modified fear survey schedule* consisting of 65 items. Each was rated on a 5-point severity scale and a significance level of $P < .01$ was used in comparing the groups. A summary of results is presented in Table II. The social phobia patients rated the following situations as giving rise to more severe anxiety; meeting people they do not know; meeting people who are in authority; situations in which they are observed; and situations in which they may be criticized. Social phobia patients gave responses that suggested that they were particularly concerned about how they appear when others look at them. They were also anxious when using the telephone, although this was less marked. It is noteworthy that they reported being anxious when eating in front of people in their own homes. The items which were rated as more severe by the agoraphobia patients make up the well known

TABLE II
Fear survey schedule

More severe when main complaint is agoraphobia:	*More severe when main complaint is social phobia:*
Being alone	Being introduced
Unfamiliar places	Meeting people in authority
Crossing streets	Using the telephone
Public transport	Visitors to home
Department stores	Being watched doing something
Crowds	Being teased
Open spaces	Eating at home with acquaintances
Small shops	Eating at home with family
.....	Writing in front of others
Mice, rats, bats	Speaking in public
Snakes	
Flying insects	
Deep water	
Aeroplanes	
Blood, wounds	

Not significantly different between the two groups:
Drinking at coffee bar
Eating in an informal restaurant
Eating in a formal restaurant
Enclosed spaces
.....
Spiders, Worms, Crawling insects, Injections, Doctors } tended to be more severe in the agoraphobic group

TABLE III
Somatic symptom check list

Item	Social phobia per cent	Agoraphobia per cent	P less than*
Blushing	51	21	.001
Twitching of muscles	37	21	(.07)
Weakness in limbs	41	77	.001
Difficulty breathing	30	60	.001
Dizziness/faintness	39	68	.01
Actual fainting episode	10	25	.05
Buzzing/ringing in ears	13	30	.05
Palpitations	79	77	
Tense muscles	64	67	
Dry throat/mouth	61	65	
Sinking feeling in stomach	63	54	
Feeling sick	40	40	
Trembling	75	75	
Sweating	74	68	
Lump in throat	33	33	
Needing to pass water	30	39	
Fullness in stomach	13	30	
Blurring of vision	21	33	
Flatulence	16	12	
Feeling hot/cold	57	61	
Pressure in head/headaches	46	44	
Needing to open bowels	24	12	
Pins and needles	10	12	

* If no value is shown, the difference is not significant.

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constellation of unfamiliar places, streets and open places, shops, crowds and cinemas (especially when the patient is alone). It is noteworthy that the agoraphobia patients reported more simple phobias of various kinds (these are listed below the line in the table). Some situations were rated equally by the two groups: these included eating in restaurants and drinking in a coffee bar. Social phobia and agoraphobia patients also rated equally, attending (as opposed to speaking at) meetings.

Somatic symptoms (Table III)

A check list of 23 somatic symptoms was completed by referring to each patient's experience in the worse phobic situation. A significance level of $P < .01$ was used in comparing the groups. Blushing was more common in the patients complaining of social phobia and there was also a tendency for muscle twitching to be more common. Weakness in limbs, difficulty breathing and dizziness and faintness were reported more often by patients complaining of agoraphobia, and there was a tendency for fainting episodes and buzzing or ringing in the ears to be reported more often in this group.

Other symptoms

The groups did not differ on seven *anxiety symptoms* (poor concentration, noise intolerance, irritability, initial insomnia, restless sleep, increased vasomotor responses and tension). Nor did they differ on six *depressive symptoms* (depressed mood, loss of interest, early morning waking, loss of energy, pessimistic outlook and loss of confidence), these symptoms being present in about half of each group. *Obsessional symptoms* were also evenly distributed (about 20 per cent of each had obsessional fears and ruminations). *Depersonalization and derealization* were more frequent (51 per cent compared to 26 per cent; chi square $P < .05$) and more severe (0-2 scale; Mann Whitney U, $P < .05$) among the patients complaining of agoraphobia.

Use of alcohol and drugs and suicidal acts

Alcohol was taken in excess more commonly by the social phobia patients (20 per cent compared to 7 per cent; chi square $P < .07$), while drug dependence was found only in one of each group. Parasuicidal acts were reported more often by the social phobia patients (14 per cent compared to 2 per cent; chi square $P < .01$). They were rather more frequent among the women.

Personality

All patients completed the EPI (Eysenck and Eysenck, 1964). Extraversion scores were lower (t test $P < .001$) in the social phobia patients (mean 8.61) than in the agoraphobia patients (mean 13.32), whose scores were not significantly different from the normal population (mean 14.145). Neuroticism scores were similar (social phobia 16.48; agoraphobia 16.99) and comparable to the norms for anxious neurotic groups (mean 16.49), they were higher than the normal population (mean 10.52; t test $P < .001$).

Family history

Phobic disorders were reported in the near relatives of about 20 per cent of each group. Patients were asked how they assessed their relationship with their parents in adolescence. More social phobia patients said that their fathers were dominant and that they had an unsatisfactory relationship with their fathers ($P < .05$ for both). Relationships with mothers were not reported differently.

Past medical history

There was no difference between the groups on ratings of previous psychiatric history. There was a tendency for agoraphobia patients more often to report a past history of physical illness ($P < .06$).

Discussion

Our aim was to discover whether patients whose main complaint is the symptom of social phobia have associated symptoms sufficiently different from those of patients complaining of agoraphobia to justify the recognition of two distinct syndromes. Our patients were unselected, consecutive referrals from general practitioners who knew of the Department's interest in treating both the symptom of agoraphobia and that of social phobia. It is, therefore, necessary to ask whether the group is representative. The close correspondence of the findings in agoraphobia patients who were referred, with the published data concerning agoraphobia (Mathews *et al*, 1981) indicates that these patients were representative. There is less information about patients who complain of social phobia, but the age distribution resembles that of a previous series (Marks and Gelder, 1966). The only doubt about the representative nature of the sample arises from the greater number of social phobics that was recruited. This was against our expectations, though there is no reliable data about the frequency of the two conditions. It probably arose because Dr Shaw was known to be interested in social phobia. Nevertheless, there is no reason to believe that this led to the referral of atypical patients.

The patients who complained of social phobia differed from those who complained of agoraphobia in several ways. The former reported that their symptoms began at a younger age, a greater proportion were men and they were of higher social class. The anxiety

symptoms experienced in the phobic situation by the two groups also differed in several respects. Blushing and muscle twitching were more often experienced by patients with social phobia. Weakness in the limbs, difficulty breathing and dizziness or faintness were more often experienced by patients with agoraphobia. It is interesting that the symptoms more commonly associated with social phobia involve a change which can be seen by other people. The situations which the patients feared differed in the expected ways. It was, however, interesting that simple phobias were rather less often associated with social phobias, while depersonalization was both more common and more severe among the patients with agoraphobia. Both points were reported by Marks (1970). We conclude that the constellation of symptoms associated with social phobia is sufficiently different from that accompanying agoraphobia to require the separation of the two syndromes.

The groups were separated in the first place by the principal situations which caused anxiety and avoidance. It is of interest to discover whether particular situations characterize social phobia and separate it from agoraphobia or whether there is much overlap between them. The situations described more frequently by our agoraphobics were those commonly reported in the literature. Those described by the social phobia patients resemble those described by Marks (1970), namely eating, visiting or speaking in front of people, especially if this involved employers who might be expected to be critical. They share the common feature of being situations in which the individual feels that his appearance or his performance is being monitored. The aspect of watching seems particularly important but the use of the telephone was also associated with anxiety, though to a lesser extent. Marks reported that patients with social phobia often described anxiety when eating in crowded restaurants or canteens and these situations were reported often by our patients. However, this is not a feature that distinguishes social phobia from agoraphobia, for the same places cause anxiety to the latter as well. The accounts given by patients indicate that the fear arises for different reasons in the two groups; in the agoraphobics it relates to distances from home and crowded surroundings, in the social phobics it relates to being observed. Indeed a characteristic feature of social phobia is the patient's avoidance of situations in which they have to sit facing people, speak to an audience, or write where they can be seen.

Marks described anxiety and depression as part of the social phobic syndrome. These symptoms were present in our patients but they were equally common among the agoraphobics. Phobias are not especially common in the families of social phobics, a point which Marks also notes. However, we did not confirm his findings that a high proportion (one third) came from broken homes and that nearly half had a past history of depression.

Two other problems were reported more often by the socially phobic patients, namely habitual use of alcohol to reduce symptoms, and suicide attempts. Excessive use of alcohol was reported by Marks in 18 per cent of his group, a figure which is close to our finding of 20 per cent. These patients usually take alcohol to relieve both anticipatory anxiety and the anxiety expressed in the social situation. Agoraphobia patients experience anxiety in situations in which it is less socially acceptable to take alcohol, a point that may go some way towards explaining the difference. The rather frequent history of parasuicide acts among social phobics (14 per cent) is less easy to understand. We have insufficient information about the acts to comment further, but suggest that the apparent association is worthy of further study.

Although our data do not permit any definite conclusions about aetiology, attention can be drawn to four findings. First, onset was earlier in the social phobia group. It was most often in the second half of the teenage years when social embarrassment and lack of social confidence are common problems. Secondly, when compared with their parents, social phobics had more often than agoraphobics changed social class in an upward direction. This was usually the result of entry to higher education, but in a few women it followed marriage to a man of higher social class. Thirdly, social phobias generally began gradually, while agoraphobia more often started suddenly. Fourthly, the social phobias had few associated simple fears. All these features are consistent with the idea that social phobia evolves from normal social anxieties made worse by the need to face new social expectations. Such an account would be more plausible if we had reliable information about previous personality, but our method did not permit this, nor do we think it has been achieved by other authors. Thus Nichols (1974) suggested that social phobia (which he calls social anxiety) arises in people who are unduly sensitive to disapproval and criticism and who have inflexible ideas about social conventions which cause them to expect criticism unnecessarily. However, his assessment of personality was unsupported by any quantitative estimate of the frequency of the problems. Nichols also suggested that cognitive factors play a part in perpetuating social anxiety. He supposes that exaggerated awareness of certain autonomic symptoms, particularly blushing, increase the patient's self-conciousness. Our patients reported blushing frequently and did so significantly more often than the agoraphobics.

We conclude that the present findings lend further support to the recognition of a separate syndrome of social phobia. The next step in establishing the syndrome must be a follow-up investigation to test the clinical impression that the differences we have identified persist over the years.

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