

Social Phobia in the Primary Care Medical Setting

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BACKGROUND. Social phobia (social anxiety disorder) is a common disorder that is receiving more attention as new treatments become available. Little is known about social phobia as it appears in the primary care setting. The purpose of our study was to determine the prevalence of social phobia in a primary care clinic, the rates of comorbidity with other anxiety and mood disorders, the extent of disability, and patterns of healthcare utilization.

METHODS. A total of 511 English-speaking adults presenting for routine medical care participated in a 2-stage screening consisting of the administration of a self-report measure for social phobia followed by a structured diagnostic interview. We determined current (1-month) prevalence of social phobia, current comorbid disorders, and we ascertained use of health care in the previous 6 months. We also administered brief functional impairment and disability indices.

RESULTS. A lower-bound estimate of 7.0% of primary care attendees suffered from social phobia as defined in the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition*. Comorbidity with major depression (58.3% of cases of social phobia) was extensive, somewhat less so with panic disorder (27.8%) and generalized anxiety disorder (30.6%). Social phobics reported significantly more impairment in all functional domains than primary care patients without mental disorders; this was most pronounced in patients with the generalized subtype of social phobia. Social phobics made greater use of health care resources than patients who were not mentally ill, yet few (<20%) were receiving appropriate psychotropic medications.

CONCLUSIONS. Patients with social phobia frequently present to primary care medical settings, and manifest impairment in multiple functional domains. But, on the basis of the low rate of psychotropic prescription, it seems that social phobia is either undiagnosed or felt by physicians to be unlikely to benefit from such treatments. Social phobia is highly comorbid with major depression and with other anxiety disorders in the primary care setting. Attention by family physicians to the presence of depression or panic attacks should signal the need to query patients about possible social phobia.

KEY WORDS. Social phobia; social anxiety disorder; major depression; primary care; health care utilization. (*J Fam Pract* 1999; 48:514-519)

Social phobia (also known as social anxiety disorder) is defined in the *Diagnostic and Statistical Manual for Mental Disorders—Fourth Edition (DSM-IV)* as the fear of being observed or evaluated by others. In social situations, persons with social phobia are fearful that they will embarrass themselves or fail to achieve some standard of performance, and that humiliation will result. Consequently, persons with social phobia often avoid situations where such scrutiny may take place; if not avoided, these situations are endured with intense distress. When social phobics fear and/or avoid a majority of social situations (eg, speaking in public, meeting new people, talking to people in authority, attending social

gatherings, and so forth), they are said to suffer from the generalized subtype of social phobia; persons who fear fewer situations are referred to as suffering from the nongeneralized subtype.

Social phobia is a prevalent, often disabling condition.^{1,7} Several recent community surveys have placed the one-year prevalence of social phobia in the range of 2% to 7% of adults, with lifetime prevalence as high as 13.0%.^{3,4,6} In these surveys, social phobics were noted to have rarely received mental health care interventions for their disorder.^{3,4} This raises the question of how often social phobics are encountered in the general medical health care system. Patients with other psychiatric disorders, such as depression, present more often in medical settings than in mental health clinics.⁸ If true of patients with social phobia, then their attendance in primary care might represent an opportunity for identification and intervention.

Several prior studies have demonstrated that anxiety disorders are highly prevalent among general medical clinic attendees.⁹⁻¹¹ Although social phobia was not a pri-

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mary focus of these studies, in one of these it was noted that social phobia was associated with meaningfully reduced role functioning and sense of well-being.¹¹ In the only in-depth study to date of social phobia in the general medical health care system, the investigators found a one-month prevalence of 4.9% in a French primary care clinic, but poor recognition of the disorder on the part of general practitioners.^{12,13}

We attempted to replicate and extend these findings by determining the prevalence of *DSM-IV* social phobia in a US primary care clinic, focusing on issues of comorbidity, impairment, disability, and health care utilization. Furthermore, given that various social phobia subtypes (ie, generalized versus nongeneralized)¹ manifest different levels of severity and associated impairment,^{1,14,16} we designed the study to enable us to ascertain subtype specificity and its relationship to functional and utilization variables.

METHODS

SUBJECTS AND PROCEDURES

We asked 668 consecutive English-speaking adults aged 18 and older at a community-based, University-affiliated primary care clinic in San Diego to participate in this study at the time of their visit to their family physician. Patients were approached by an undergraduate research assistant who invited them to participate in a study of "the relationship between physical and mental health." They were informed that the study consisted of 2 parts, the first being a short set of questionnaires and the second a phone interview of a subset of participants. Subjects gave informed written consent to participate in this study, which was approved by the University of California, San Diego, Faculty of Medicine Committee on the Use of Human Subjects in Research.

Those patients who consented to participate were administered a packet of questionnaires that assessed demographic variables and current psychiatric symptoms. The assessment took approximately 15 minutes to complete. The research assistant reviewed the information, then approached patients who met specified cut-offs and invited them to participate in a follow-up diagnostic interview. Patients who agreed were contacted by phone within 10 days of the screening assessment, and completed the diagnostic interview and disability and utilization questionnaires over the phone. Patients were paid \$20 for the follow-up interview.

A total of 157 subjects (23.6%) refused to participate, leaving a sample of 511 patients (170 men and 341 women) who completed the screening questionnaire. The mean age of the participants was 38.9 years (standard deviation [SD]= 13.5; range = 18 to 80). Ethnicities included African American (7.4%), Asian American (7.4%), Latino (7.0%), Filipino (14.5%), Native American (1.8%), white (55.2%), other (6.7%), with 0.6% of participants declining to state their ethnicity. Regarding edu-

cation, 4.0% of patients did not complete high school, 14.2% completed high school, 30.6% had some college or post-secondary education, 10.1% completed 3 years of college, and 41.2% had more than 3 years of college.

SOCIAL PHOBIA SCREENING MEASURE

We used a new self-reported screening instrument, the Social Phobia Questionnaire (SPQ), to identify possible cases of social phobia. This instrument (available from the authors upon request) begins with 2 yes or no questions: "When you are around other people do you often feel nervous, self-conscious or uncomfortable?" and "Do you often avoid situations where you could be the center of attention?" Patients who answer yes to either of those 2 questions are asked to complete the remainder of the questionnaire, which asks about anxiety (on a 4-point scale, where 0 = "wouldn't make me anxious at all," and 3 = "would make me extremely anxious") and avoidance (also on a 4-point scale, where 0 = "would never avoid," and 3 = "would always avoid if I could") in the following 10 social situations: speaking in front of a large group of people; speaking to a small group of people; eating in public; writing while being watched; using public toilets; being introduced to a stranger; going to a party; dealing with authority figures such as a teacher or boss; returning items to a store; looking someone you don't know well straight in the eyes. The SPQ result is considered positive for subjects who answer affirmatively to either of the 2 initial yes or no questions, and report extreme anxiety or extreme avoidance (ie, a score of 3) in any of the 10 social situations (with the exception of public speaking, where both extreme anxiety and avoidance are required to select only those subjects with abnormal levels of difficulty in what is a commonly-feared situation).¹⁷ One hundred sixty-nine (33.1%) of the 511 subjects who completed the screening measures had a positive test result on the SPQ.

PSYCHOMETRIC PROPERTIES OF THE SPQ

Factor analysis (principal components analysis with varimax rotation) of the SPQ administered to the first 435 patients in this study showed that the SPQ items load onto 2 factors: an observation factor consisting of 6 items that account for 41% of the variance, and a performing and interacting factor of 4 items that account for an additional 12% of the variance. The SPQ has good internal consistency (Cronbach's α = 0.91). The anxiety and avoidance subscale totals of the SPQ are highly correlated ($r = 0.81$; $df = 434$; $P < .0005$), which led us to drop the avoidance subscale in a subsequent revision to this instrument (SPQ-R).

Criterion validity of the SPQ was undertaken subsequent to this study in an independent sample (not included in the present report) of 143 consecutive primary care attendees. We interviewed 21 (14.7%) subjects who had a positive result on the SPQ, and a yoked sample (ie, selected immediately after a subject with a positive SPQ

test result) of 21 subjects whose results were negative on the SPQ using the modified Comprehensive International Diagnostic Interview (CIDI). Using the criteria described above for a positive response, the SPQ had a sensitivity for *DSM-IV* social phobia of 87.5% (7 of 8 subjects with social phobia were correctly classified as such by the SPQ) and a specificity of 58.8% (20 of 34 subjects without social phobia were correctly identified as such); the sensitivity and specificity for generalized social phobia were 100% and 58.3%, respectively. The first question on the SPQ ("When you are around other people do you often feel nervous, self-conscious or uncomfortable?") was 75% sensitive and 53% specific on its own for the diagnosis of social phobia; sensitivity and specificity for the generalized type were 83.3% and 61.5%, respectively.

COMPARISON SAMPLE

A sample of patients with no mental disorder was identified for comparison purposes; these subjects were among the 511 patients screened for this study. This sample consisted of 161 subjects (15 selected at random, 28 selected by convenience, and 118 who showed a positive test result on the SPQ or scored ≥ 15 on the Center for Epidemiologic Studies-Depression Scale [CES-D]^{18,19}) and were determined by interview not to meet *DSM-IV* diagnostic criteria for any of the disorders under consideration. It should be noted that although these subjects were below *DSM-IV* diagnostic standards, they may still have had mood or anxiety symptoms with potential clinical impact.²⁰ Their use as a comparison group with patients with social phobia in this study, then, should yield a conservative estimate of the impact of social phobia on the outcomes studied.

DIAGNOSTIC INTERVIEW

The diagnostic interview was an abbreviated version of the CIDI modified by Ronald C. Kessler, PhD, and colleagues at the University of Michigan (UM-CIDI Short Form). The UM-CIDI is the diagnostic instrument used in the National Comorbidity Survey, a large cross-national epidemiologic survey of mental disorders,²¹ and has been found to have acceptable reliability and procedural validity for the diagnosis of social phobia.²² The reliability of the UM-CIDI Short Form is comparable to that of the full-length version (Kessler RC, unpublished source documents, 1995). For this study, modules for major depressive disorder, panic disorder, social phobia, generalized anxiety disorder, and drug and alcohol abuse and dependence were included, as was a module to assess impairment (ie, days of work lost and days of work performed sub-optimally because of mental illness).

We determined the subtype of social phobia as follows: Patients who reported moderate to extreme anxiety in more than 5 of the 10 social situations were classified as having generalized social phobia. This, it should

be noted, is a fairly rigorous definition. All other social phobics were classified as nongeneralized.

Subjects were also questioned at the time of diagnostic interview about their healthcare (including medication) utilization in the previous 6 months using a standardized questionnaire (Katon W, unpublished). Finally, the Sheehan Disability Scale²³ was administered to a subset (approximately one half) of subjects (this instrument was added in the middle of the study).

DATA ANALYSIS

Given our complex sampling framework, it was not possible to derive a precise estimate of the actual rates of social phobia in this sample. Thus, we have elected to report the raw (ie, unadjusted for sampling framework) rates of social phobia as a lower bound estimate of the true rate, which is likely to be somewhat higher. For all subsequent analyses, only subjects who had received a confirmatory diagnostic interview were included. Given the high sensitivity (>0.85) of the SPQ, it is likely that we would have missed few cases of social phobia; furthermore, we have no reason to believe that the subjects who were included are nonrepresentative of the sample as a whole. We report also the proportion of subjects with various forms of comorbidity. We compare, using the Student's *t* test (or, as in the case of the health care utilization variables, where the data are skewed, the Mann-Whitney *U* test), impairment scores in patients with social phobia with patients without mental disorders. All tests are two-tailed, with *P* values $<.05$ considered statistically significant.

RESULTS

PREVALENCE OF SOCIAL PHOBIA

A total of 36 subjects (7.0% of the total sample of 511) were found to meet *DSM-IV* criteria for social phobia according to the diagnostic interview. Mean age of the social phobic patients was 37.4 (SD = 11.6) years. Twenty-seven (75%) of the social phobics were female.

SUBTYPES OF SOCIAL PHOBIA

Ten of the 36 patients with social phobia (27.8%) met criteria for the more severe generalized subtype of the disorder. Among the 26 nongeneralized social phobics 7 (19.4% of all social phobics) had fears limited to speaking-only situations (in large or small groups), and 19 (52.8% of all social phobics) had fears in at least one nonspeaking situation.

COMORBIDITY

Ten of the 36 patients with social phobia (27.8%) had comorbid panic disorder (4 with agoraphobia and 6 without), 11 (30.6%) had comorbid generalized anxiety disorder, and 21 (58.3%) had comorbid major depressive disorder. Nine patients (25%) had a substance use disorder within the previous 12 months: 4, alcohol abuse

alone, 1, alcohol dependence and drug abuse, 2, drug abuse alone, and 2, drug dependence alone.

FUNCTIONAL IMPAIRMENT

Two indices of impairment included in the UM-CIDI Short Form Interview were examined: (1) the number of work days lost in the past month because of "nerves or emotional problems," and (2) the number of days in the past month where productivity was reduced because of "nerves or emotional problems." Both of these were significantly increased among social phobic patients compared with primary care clinic patients without mental disorders (Table).

Social phobic patients were also significantly more impaired than primary care clinic patients without mental illness on all 3 subscales (work, family/home life, and social life) of the Sheehan Disability Scale (Table). Social phobics with concurrent major depression ($n = 10$) were not significantly more impaired than those without concurrent major depression ($n = 6$) on the work functioning subscale of the Sheehan Disability Scale (6.3, SD = 4.5 vs 3.3, SD = 4.1; $t = 1.31$; $P = ns$). They did, though, show a trend toward poorer social functioning (5.8, SD = 4.3 vs 1.7, SD = 3.1; $t = 2.03$; $P < .07$) and had significantly poorer family/home life functioning scores (5.8, SD = 4.1 vs 0.5, SD = 0.8; $t = 3.08$; $P < .003$).

HEALTH CARE UTILIZATION

Only one social phobic had been hospitalized (for a total of 4 days) for personal or emotional problems in the preceding 6 months. Emergency department visits in the preceding 6 months did differ significantly between social phobics and nonpsychiatrically ill primary care patients ($U = 1839$, $P < .05$), but the number of visits was low in both groups (0.47; SD = 0.97 vs 0.20; SD = 0.50, respectively). Social phobics made more than 2 times as many visits to their medical providers in the previous 6 months (7.58, SD = 7.91) than did primary care patients without mental illness (3.42; SD = 2.96; $U = 1141$; $P < .0006$). Social phobics also made many more visits in the previous 6 months to mental health providers (psy-

chiatrists, psychologists, social workers, psychiatric nurses, or counselors) than did primary care patients without mental illness ($U = 1136$; $P < .0003$), though, again, few such visits were made by either group (3.08, SD = 8.11 vs 0.32, SD = 2.29, respectively).

COMPARISON ACROSS SOCIAL PHOBIA SUBTYPES

When possible, we compared the impact of the generalized and nongeneralized subtypes of social phobia by comparing outcomes across groups. Although the number of days lost from work in the past 30 days because of mental health problems did not differ significantly between generalized (5.89, SD = 9.2) and nongeneralized social phobic patients (1.88; SD = 3.83; $U = 67.5$; $P < .08$), the former did report significantly more days with reduced productivity in the past 30 days because of mental health problems (8.29, SD = 7.11 vs 2.81, SD = 5.59). Too few subjects in each subgroup were given the Sheehan Disability Scale to allow for a meaningful comparison. There were no significant differences in health care utilization between generalized and nongeneralized social phobic patients.

MEDICATION PRESCRIPTION

Few patients with social phobia were prescribed psychotropic agents. Five patients were taking selective serotonin reuptake inhibitors, one was taking trazodone, and 2 were taking benzodiazepines. A total of only 6 patients (16% of the social phobics) — 3 of whom had the generalized subtype — were taking a psychotropic agent of any kind. All 6 patients had concurrent major depressive disorder, suggesting that this was probably the focus of treatment in those cases.

DISCUSSION

In our study, we found that social phobia was present in at least 7.0% of primary care patients. It is possible that social phobics were less willing to participate in this survey than patients without social phobia; thus the true rate may be even higher.

This prevalence rate is in the same range as that found by Weiller and colleagues¹² (1-month prevalence of 4.9%) in their study of general medicine clinic patients in France. The slightly higher rate in our study may be explained by an increased number of social phobic situations surveyed here (10, compared with 5 in the French study). We have previously demon-

TABLE

Functional Disability in Primary Care Medical Patients

Index of Disability	Social Phobic		Not Mentally Ill		U	P
	Mean (SD)	n	Mean (SD)	n		
Work days missed in past 30 because of emotional problems	2.97 (5.97)	33	0.23 (1.32)	108	992	<.0001
Work days cut down in past 30 because of emotional problems	3.97 (6.25)	33	0.65 (2.73)	116	1293	<.0001
Sheehan Disability Scale:						
Work	5.19 (4.49)	16	1.35 (1.97)	54	239	<.035
Family/home	3.81 (4.17)	16	1.57 (2.34)	60	336	<.045
Social	4.25 (4.33)	16	1.43 (2.45)	60	285	<.0055

SD denotes standard deviation.

strated that rates of social phobia in community surveys are highly dependent on the number of situational probes used.⁵ These minor differences notwithstanding, our data confirm the relatively high rate of social phobia in primary care patients.

We found high rates of comorbidity among social phobia and other mood and anxiety disorders in primary care patients as did Weiller and colleagues.¹² Current major depression was the most common comorbid disorder, present in more than 50% of social phobic patients. It appears likely, given findings from community surveys, that social phobics seldom seek medical attention for their disorder.^{3,4} The occurrence of major depression may drive health-seeking in these patients,²⁴ however, therein providing an opportunity for their social phobia to be recognized and treated. Accordingly, it seems reasonable to recommend to family physicians and other primary care clinicians that they inquire about possible social phobia when they encounter patients with major depression. If followed, this recommendation might lead to improvement over the currently low recognition rates for social phobia in the primary care setting.^{12,13} As noted by Nisenson and colleagues,²⁵ however, improved recognition of anxiety disorders may not necessarily lead to improved care and superior outcomes. This issue requires further study as it applies to social phobia.

Social phobics were found to make more frequent use of resources — both general medical and mental health care — than primary care patients without mental disorders. Our study was not intended to examine in detail what forms of medical illness tend to occur in patients with social phobia, a limitation that should be remedied in future studies. The fact that social phobics do attend the health care setting more frequently than do nonphobic patients, once again, suggests that the opportunity to identify and intervene does exist. Yet, despite relatively frequent visits to providers, we found that few (1 in 6) social phobics were prescribed psychotropic medications that may have proved beneficial.²⁶ This finding suggests 2 notions: social phobia is unrecognized by primary care physicians, or the physicians perceive these medications as not likely to be useful. Efforts aimed at educating primary care clinicians about social phobia may address this problem.

A key finding of this study was the extent to which social phobics were functionally impaired as a result of their illness. Whereas the French study demonstrated that social phobics self-rated their health as poor, that study did not focus on disability.¹² We found that social phobics in the general medical setting reported more impairment on multiple indices of daily functioning than patients without mental illness. These data, in concert with those finding reduced quality of life among social phobics in mental health^{15,27} and medical clinic settings¹¹ underscore the fact that social phobia can be a disabling problem with very negative consequences for the indi-

vidual. Moreover, given our finding that social phobics report more days of reduced work because of emotional problems than mentally well primary care patients, the economic consequences for society can be serious. In this regard, social phobia can be considered a serious public health problem.

Still, given the impressive comorbidity between major depression and social phobia in this and other studies,^{3,12} the relative contributions to disability of these 2 disorders remains to be determined. This is particularly true of the finding that generalized social phobics — who have the highest rates of depressive comorbidity among social phobics^{2,16} — exhibited the worst disability and the greatest loss in work productivity. It is plausible that this increased impairment might be primarily attributable to the presence of increased comorbidity with depression.²⁵ In our study, we did find some evidence of greater disability (on the Sheehan Disability Scale) in social phobics with comorbid depression than in those without. Interestingly, a recent study in a primary care group practice found that phobias were associated with increased disability, even when adjusted for the effects of comorbid disorders such as major depression.²⁸ That study did not mention whether this held true specifically for social phobia, which was the type of phobia diagnosed in approximately one third of their phobic patients. This should be examined in future studies that attempt to disentangle the sources of disability experienced by patients with social phobia in medical settings.

LIMITATIONS

Among the limitations of this study are our reliance on sampling from a single primary care clinic, and the relatively small sample size of slightly more than 500 screened patients. Both of these sampling choices limit our ability to generalize to other clinic settings and to comment confidently on rates of some of the more unusual health care utilization variables, such as hospitalization.

CONCLUSIONS

Our study supports the work of Weiller and colleagues,¹² who found that social phobia is prevalent among primary care patients and is highly comorbid with other mood and anxiety disorders. It also adds to the body of data that indicates that social phobia — particularly the generalized subtype — is frequently associated with significant disability and reduced work productivity. Although it seems to deserve more serious attention on the part of medical practitioners, social phobia remains underrecognized and undertreated in primary care. This should not be construed as a criticism of primary care medical providers. Faced with the need to fulfill multiple competing medical demands,^{29,30} primary care physicians will find it difficult to justify a routine screen for social phobia among their patients. The relatively low specificity of

the instrument we developed for this study will limit its usefulness in primary care settings, pointing to the need for a better social phobia screening instrument - particularly one with high positive predictive value for the more severe generalized subtype.

Armed with the knowledge that depression or panic disorder signify an increased likelihood of the presence of social phobia, family physicians may well find it feasible to screen for social phobia those patients who present with depressive symptoms or panic attacks. Given that screening can be accomplished with little additional effort (the single question "When you are around other people do you often feel nervous, self-conscious, or uncomfortable?" was sensitive to 75% of cases), this approach should have considerable appeal. It is anticipated that increased recognition of social phobia, in concert with increased awareness of available treatment modalities (eg, selective serotonin reuptake inhibitors),³¹ will lead to improved treatment of this condition in the primary care setting. This hypothesis, however, remains to be tested.

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REFERENCES

- Stein MB. How shy is too shy? *Lancet* 1996; 347:1131-2.
- Den Boer JA. Social phobia: epidemiology, recognition, and treatment. *Br Med J* 1997; 315:796-800.
- Magee WJ, Eaton WW, Wittchen HU, McGonagle KA, Kessler RC. Agoraphobia, simple phobia, and social phobia in the National Comorbidity Survey. *Arch Gen Psychiatry* 1996; 53:159-68.
- Lepine JP, Lellouch J. Classification and epidemiology of social phobia. *Eur Arch Psychiatry Clin Neurosci* 1995; 244:290-6.
- Stein MB, Walker JR, Forde DR. Setting diagnostic thresholds for social phobia: considerations from a community survey of social anxiety. *Am J Psychiatry* 1994; 151:408-12.
- Offord DR, Boyle MH, Campbell D, et al. One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. *Can J Psychiatry* 1996; 41:559-63.
- Schneier FR, Heckelman LR, Campeas R, et al. Functional impairment in social phobia. *J Clin Psychiatry* 1994; 55:322-31.
- Norquist GS, Regier DA. The epidemiology of psychiatric disorders and the de facto mental health care system. *Annu Rev Med* 1996; 47:473-9.
- Sherbourne CD, Jackson CA, Meredith LS, Camp P, Wells KB. Prevalence of comorbid anxiety disorders in primary care outpatients. *Arch Fam Med* 1996; 5:27-34.
- Fifer SK, Mathias SD, Patrick DL, Mazonson PD, Lubeck DP, Buesching DP. Untreated anxiety among adult primary care patients in a health maintenance organization. *Arch Gen Psychiatry* 1994; 51:740-50.
- Schonfeld WH, Verboncoeur CJ, Fifer SK, Lipschutz RC, Lubeck DP, Buesching DP. The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. *J Affective Disorders* 1997; 43:105-19.
- Weiller E, Bisslerbe JC, Boyer P, Lepine JP, Lecrubier Y. Social phobia in general health care: an unrecognized undertreated disabling disorder. *Br J Psychiatry* 1996; 168:169-74.
- Bisslerbe JC, Weiller E, Boyer P, Lepine JP, Lecrubier Y. Social phobia in primary care: level of recognition and drug use. *International Clinical Psychopharmacology* 1996; 11:25-8.
- Brown EJ, Heimberg RG, Juster HR. Social phobia subtype and avoidant personality disorder: Effect on severity of social phobia, impairment, and outcome of cognitive-behavioral treatment. *Behavior Therapy* 1995; 26:467-80.
- Safren SA, Heimberg RG, Brown EJ, Holle C. Quality of life in social phobia. *Depression Anxiety* 1997; 4:126-33.
- Kessler RC, Stein MB, Berglund PA. Social phobia subtypes in the National Comorbidity Survey. *Am J Psychiatry* 1998; 155:613-9.
- Stein MB, Walker JR, and Forde DR. Public speaking fears in a community sample: Prevalence, impact on functioning, and diagnostic classification. *Arch Gen Psychiatry* 1996; 53:169-74.
- Radloff LS. The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement* 1977; 1:385-401.
- Coyne JC, Fechner-Bates S, Schwenk TL. Prevalence, nature, and comorbidity of depressive disorders in primary care. *Gen Hosp Psychiatry* 1994; 16:267-76.
- Nease DE Jr, Volk RJ, Cass AR. Investigation of a severity-based classification of mood and anxiety symptoms in primary care patients. *J Am Board Fam Pract* 1999; 12:21-31.
- Kessler R, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Arch Gen Psychiatry* 1994; 51:8-19.
- Wittchen H-U, Zhao S, Abelson JM, Abelson JL, Kessler RC. Reliability and procedural validity of UM-CIDI DSM-III-R phobic disorders. *Psychol Med* 1996; 26:1169-1177.
- Leon AC, Shear MK, Portera L, Klerman GL. Assessing impairment in patients with panic disorder: the Sheehan Disability Scale. *Social Psychiatry and Psychiatric Epidemiology* 1992; 27:78-82.
- Von Korff M, Ormel J, Katon W, Lin EHB. Disability and depression among high utilizers of health care. *Arch Gen Psychiatry* 1992; 49:91-100.
- Nisenson LG, Pepper CM, Schwenk TL, Coyne JC. The nature and prevalence of anxiety disorders in primary care. *Gen Hosp Psychiatry* 1998; 20:21-8.
- Ballenger JC, Davidson JR, Lecrubier Y, et al. Consensus statement on social anxiety disorder from the International Consensus Group on Depression and Anxiety. *Br J Psychiatry* 1998; 59 (suppl 17): 54-60.
- Antony MM, Roth D, Swinson RP, Huta V, Devins GM. Illness intrusiveness in individuals with panic disorder, obsessive-compulsive disorder, or social phobia. *J Nerv Ment Dis* 1998; 186:311-5.
- Olfson M, Fireman B, Weissman MM, et al. Mental disorders and disability among patients in a primary care group practice. *Am J Psychiatry* 1997; 154:1734-40.
- Jaén CR, Stange KC, Nutting PA. Competing demands of primary care: a model for the delivery of clinical preventive services. *J Fam Pract* 1994; 38:166-71.
- Callahan EJ, Jaén CR, Crabtree BF, Zyzanski SJ, Goodwin MA, Stange KC. The impact of recent emotional distress and diagnosis of depression or anxiety on the physician-patient encounter in family practice. *J Fam Pract* 1998; 46:410-8.
- Stein MB, Liebowitz MR, Lydiard RB, Pitts CD, Bushnell W, Gergel I. Paroxetine treatment of generalized social phobia (social anxiety disorder): a randomized controlled trial. *JAMA* 1998; 280:708-13.