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SHORT COMMUNICATION

Social Anxiety Disorder and Agoraphobia in Dermatology Patients; Two Cases and a Review of the Literature

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Social anxiety disorder is an overwhelming sense of anxiety of social events where the individual feels they may be criticized. Agoraphobia is an overwhelming sense of anxiety triggered by actual exposure to or anticipation of a diverse range of situations (see Table I, criteria A). These conditions are often exacerbated by preoccupation with a perceived body 'defect' which is either a normal physiological variation, imagined or objectively trivial, i.e. body dysmorphic disorder (BDD).

Patients often develop behavioural rituals due to their distorted body image; severe psycho-social comorbidities such as a poor quality of life through isolation, unemployment, social avoidance, relationship difficulties, depression and suicide (1).

CASE REPORTS

Patient 1. Male, aged 28, first diagnosed with acne aged 17, had tried several topical and oral antibiotics and a course of isotretinoin. At the age of 20 he developed acne excoriee and was referred to his local community mental health team (CMHT). A Consultant Psychiatrist diagnosed sociophobia with prominent dysmorphophobia. He refused primary care psychology and at the age of 23 was referred back to his local dermatologist, who referred him to psychodermatology. He received UVB and was referred to local CMHT for cognitive behavioural therapy (CBT). He was subsequently lost to follow-up to be re-referred back to our psychodermatology service 5 years later, unable to leave his parents' house attributing this to his skin problem. On examination he had mild (Leeds grade 1) acne affecting his face, was not on medication and was diagnosed with severe BDD, agoraphobia and sociophobia. He was at this point prescribed citalopram and an oral antibiotic for his acne and referred again to his CMHT for CBT.

Patient 2. Male, aged 40, first presented to his local dermatology department aged 29 with facial vitiligo. Medical history included anxiety and depression as a teenager and panic disorder from the age of 21. He was prescribed mometasone ointment, advised to wear sunblock and referred to the camouflage clinic. Aged 32 he requested skin grafts of pigmented cells. He was living with his father and sister and denied leaving the house, fearing criticism. He would never go out without camouflage make-up and a baseball cap to cover his face. He was referred to psychodermatology. On examination he had a long fringe covering his forehead. He was prescribed topical tacrolimus ointment and his GP was advised to refer him to the local CMHT, his dosulepin (for depression) was tapered down to stop and he was commenced on citalopram. He remains under review by the psychodermatology service. On his last visit he was noted to be wearing camouflage make-up and when this was removed, no vitiligo was present. The patient is now on olanzapine, diazepam and citalopram and we have requested the GP to re-refer the patient to CMHT for CBT.

DISCUSSION

Both cases present patients with severe social anxiety disorder and agoraphobia. These conditions have been exacerbated as a result of their dermatological conditions, and have functionally impaired their lives. The onset of their mild anxiety disorder was before their

Table I. *DSM–V diagnostic criteria for agoraphobia (2)*

	Diagnostic criteria
A	Marked fear or anxiety about two (or more) of the following 5 situations: 1. Using public transportation (e.g., automobiles, buses, trains, ships, planes). 2. Being in open spaces (e.g., parking lots, marketplaces, bridges). 3. Being in enclosed places (e.g., shops, theatres, cinemas). 4. Standing in line or being in a crowd. 5. Being outside of the home alone.
B	The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).
C	The agoraphobic situations almost always provoke fear or anxiety.
D	The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
E	The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the socio-cultural context.
F	The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G	The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H	If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.
I	The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder – for example, the symptoms are not confined to social phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in obsessive–compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

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first symptoms of dermatological disease. Both patients found it difficult to retain jobs and were unable to establish relationships. In both instances the patients were referred to the psychodermatology clinic after being seen by GP's, general dermatologist and psychologists for prolonged periods of time.

Social anxiety disorder and agoraphobia are grouped in DSM-V under the section Anxiety Disorders. Agoraphobia incidence peaks in late adolescence and early adulthood. Females are more likely to present with the condition with an incidence of 2:1 (2). Social anxiety disorder has a prevalence of 2.3% in Europe. The prevalence rates are comparable in children and adolescents but decrease with age (2).

When social anxiety disorder and agoraphobia are compared with BDD, similarities can be seen in both prevalence rates and gender differences. A large BDD population study showed a higher prevalence amongst women (3), and prevalence in the general population is estimated to be 2.4% in the United States, and 1.7–1.8% elsewhere (2). Dermatologists are one of the specialities most often sought by patients with this condition, with a reported prevalence of 6.7% in general dermatology clinics and 14% in cosmetic dermatology clinics (4).

Sometimes it is difficult clinically to differentiate a primary social phobia from social anxiety secondary to BDD. A third of patients with BDD have had panic attacks triggered primarily by BDD-related situations. Social phobias normally precede the onset of BDD in patients, as the onset of social phobias is during early childhood and adolescence (5), whereas the mean age of BDD diagnosis is 16.4 years (6). In the majority of cases the major depressive episodes, which are often seen in patients with severe BDD, are due to BDD itself.

National guidance for the identification of social anxiety disorder includes the 3-item Mini-Social Phobia Inventory (Mini-SPIN) and the use of the following two questions:

– *Do you find yourself avoiding social situations or activities?*

– *Are you fearful or embarrassed in social situations (7)?*

There is no specific screening questionnaire for agoraphobia, however you can screen for agoraphobia using the DSM-V diagnostic criteria (see Table I) and clinical acumen.

Screening questionnaires for BDD include the Body Dysmorphic Disorder Questionnaire (BDDQ) (8), which has been validated in both dermatology and psychiatric settings and also the Cosmetic Procedure Screening Questionnaire (COPS) (9), used in cosmetic or dermatology settings.

Both social anxiety disorders and BDD exhibit similar cognitive maintenance factors. Psychological treatments for individuals with primarily social anxiety disorders has been shown to improve BDD (10). National guidance for treatment of social anxiety disorder, generalised anxiety disorder with agoraphobia and BDD includes CBT or an SSRI in moderate functional impairment and both in severe (7, 11, 12).

Social anxiety disorder and agoraphobia are underreported in dermatology patients, and yet both are common, as patients believe their problem to be a cosmetic one and they seek out dermatologists or plastic surgeons. Hence dermatologists need to be aware of social anxiety disorder and agoraphobia and should be able to diagnose and initially manage this condition safely. As these conditions are exacerbated by BDD prompt referral to specialist psychodermatology services, can prevent patients being subject to unnecessary investigations and treatment which they are often dissatisfied with.

The authors declare no conflicts of interest.

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