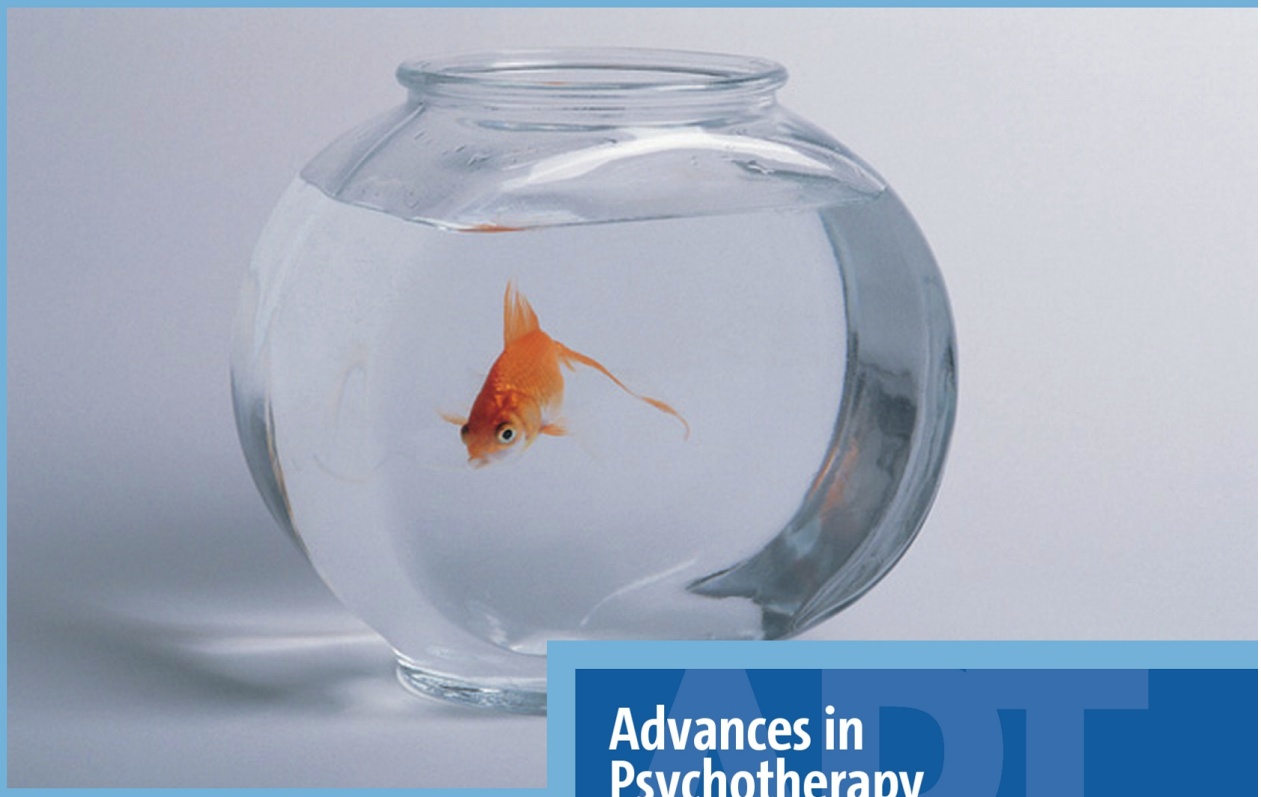
Martin M. Antony · Karen Rowa

Social Anxiety Disorder



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Social Anxiety Disorder

About the Authors

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Preface

Social anxiety disorder (SAD; also called *social phobia*) is one of the most common psychological disorders which, left untreated, can lead to significant impairment in a person's life and significant societal costs. Fortunately, there are effective treatments for SAD, including pharmacological and psychological interventions. This book describes the components of an empirically supported psychological therapy for SAD, namely cognitive behavioral therapy (CBT). CBT includes exposure techniques, cognitive techniques, and social skills training, and all of these treatment components are described in detail in this book. This book is intended for a variety of mental health professionals who see individuals with SAD in their practices, including psychologists, psychiatrists, social workers, family physicians, other mental health professionals, and trainees in all of these disciplines.

This book is divided into six chapters. The first two chapters are designed to provide a theoretical and descriptive overview of SAD. Chapter 1 reviews topics such as prevalence, comorbidity, and differential diagnosis. SAD has features that overlap with other psychological disorders, and a clear diagnostic picture is necessary for treatment purposes. We outline some of the most common differential diagnoses one should consider when assessing and diagnosing SAD. In Chapter 2, we review the leading theoretical models and research on the development and maintenance of SAD, including both cognitive behavioral models as well as genetic and developmental theories. Chapter 3 provides an overview of the key domains of assessment one should consider when seeing someone with SAD. It is not enough to simply establish a diagnosis of SAD; to effectively plan treatment interventions one needs to assess a number of important domains of symptoms, avoidance, etc. In Chapter 4, CBT techniques for SAD are described. Practical strategies are outlined for clinicians, and the empirical support for these strategies is reviewed. Although clinical illustrations are interspersed throughout this book, Chapter 5 is dedicated to two clinical vignettes where treatment is described from start to finish. Finally, Chapter 6 includes suggestions for further reading for the interested individual and useful forms are included in the Appendix.

Empirical support for cognitive behavioral treatment for SAD is encouraging. However, not all clinicians have access to training and supervision in this type of treatment. We hope that books such as this can help to bridge the divide between empirically supported treatments and day-to-day practice. Ideally, a book such as this would be used as one of several tools in learning the application of cognitive behavioral techniques to anxiety-related problems such as social anxiety, in conjunction with other readings, continuing education workshops and courses, case discussion and consultation with colleagues, and opportunities for supervision.

Our understanding of the nature and treatment of SAD has been influenced by the work of numerous experts, including Aaron T. Beck, Deborah Beidel, David M. Clark, Edna Foa, Richard Heimberg, Ron Rapee, Samuel Turner,

Adrian Wells, and many others. Our clinical examples and experiences have been mainly gathered through working with clients at the Anxiety Treatment and Research Centre (ATRC) at St. Joseph's Healthcare in Hamilton, Ontario. It has been immensely rewarding to watch so many individuals reclaim their lives and learn to manage their symptoms of anxiety though the implementation of CBT techniques. We are also grateful to the staff at the ATRC for supporting and participating in all the clinical and research endeavors that have helped us advance our clinical and theoretical knowledge of SAD.

We would like to thank Dr. Danny Wedding, as well as Robert Dimbleby of Hogrefe and Huber Publishers for inviting us to participate in what we believe is a timely and important series on empirically supported therapies for a range of psychological, psychiatric, and physical conditions. We appreciate their flexibility, patience, and guidance in the writing of this book. Finally, we would like to thank our families for their continued encouragement and support.

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Toronto, ON, Canada

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Dedication

For my granddaughter, Parker
MMA

For my parents, Ellen and Doug Rowa
KR

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Description

1.1 Terminology

People with SAD fear and avoid situations due to anxiety over the possibility of being embarrassed or judged by others

Social anxiety disorder (SAD; also called *social phobia)* is characterized by an intense fear of social or performance situations. In these situations, people with SAD are worried about embarrassment, humiliation, or scrutiny by others. Although many people are nervous or shy in social or performance situations (e.g., some studies suggest that 40% of individuals consider themselves to be chronically shy; Henderson & Zimbardo, 1998), SAD is diagnosed when this anxiety becomes so intense and pervasive that it causes significant distress for a person or it impairs the person's ability to function (e.g., at work or school, in relationships, etc.). Some situations that people with SAD often fear include:

- Conversations
- Meeting new people
- Calling acquaintances or strangers on the telephone
- Parties
- Talking to authority figures
- Expressing a controversial opinion or disagreement
- Being assertive
- Speaking in front of a group
- Participating in meetings
- Entering a crowded room
- Being the center of attention
- Eating or drinking in front of others
- Writing in front of others
- Making mistakes in front of others

The number of situations feared by people with SAD varies from person to person. Some people report concerns about a few situations, or even just one particular situation (e.g., public speaking) whereas others indicate fear across a broad range of social and performance situations.

1.2 Definition

The major classification scheme that provides a definition of and criteria for diagnosing SAD is the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). The DSM-IV-TR views SAD categorically, meaning that

criteria for the disorder are either met or not met. Of course, even though the diagnostic criteria are categorical, social anxiety exists on a continuum from mild shyness to severe symptoms. In severe cases of social anxiety, criteria for avoidant personality disorder (APD) may also be met. In fact, some authors have argued that there is such substantial overlap between severe SAD and APD that it may not be useful to consider them as distinct conditions. Indeed, there are few cases in which an individual is diagnosed with APD *without* a corresponding diagnosis of SAD. Studies suggest no differences between the disorders with respect to parental history of social anxiety, with both disorders showing a two to three-fold increase in risk of social anxiety if family history was positive for social anxiety (Tillfors, Furmark, Ekselius, & Fredrikson, 2001). However, a number of studies have found that there are other significant differences between individuals with just SAD versus those with both SAD and APD, suggesting that there is more that separates these groups than simply their level of social anxiety (Hofmann & Barlow, 2002). Further, authors have argued that these syndromes should remain distinct because SAD is a treatable disorder while outcomes for APD are less optimistic (Wittchen & Fehm, 2003). Statistical procedures, such as structural equation modeling, also support the conceptual distinction of these constructs (Strunk, Huppert, Foa, & Davidson, 2003). Clinically, it can be difficult to disentangle these syndromes, leaving a clinician unsure whether a client has both disorders, versus simply one or the other. Later in this chapter, we outline strategies that clinicians can use to differentiate between SAD and APD.

In DSM-IV-TR, SAD is defined as a marked and persistent fear of one or more social situations that often leads to avoidance of the feared situations. The individual fears being humiliated, scrutinized, or embarrassed. This fear must occur upon most exposures to social situations (i.e., it cannot be a transient fear), and the person must recognize that the fear is excessive. Some individuals may experience cued panic attacks in social situations (e.g., either when they are in the situation or when they are anticipating an upcoming stressful situation). Symptoms of social anxiety must lead to significant distress for the individual, or impairment in the person's life. Examples of ways that SAD may cause functional impairment for sufferers include social or marital problems (e.g., few friends, marital tension due to one's inability to attend social events, inability to date), employment or academic activities (e.g., inability to get a job due to fears of interviews, lack of advancement in one's current job due to anxiety, missed days of work, or missed classes), and day-to-day functioning (e.g., inability to make important phone calls, avoidance of public places). Impairment in SAD can be severe. Indeed, individuals with SAD report greater functional impairment than individuals with a variety of medical conditions including end-state renal failure (Antony, Roth, Swinson, Huta, & Devins, 1998) and genital herpes (Wittchen & Beloch, 1996). Functional impairment can lead to serious consequences. For example, one of our clients with SAD was not collecting disability payments he was entitled to because of fears of being criticized by others if he applied, as well as strong anxiety about making phone calls to "strangers" to request an application. Due to this inability to override his anxiety and apply for support, he found himself falling into significant debt.

In severe cases, people with SAD may be unable to work and may have no close friends

According to DSM-IV-TR, the term "generalized" should be used to describe cases of SAD in which an individual reports fear in *most* social or

performance situations. Although no specific rules are provided for how many situations constitute "most" social situations, this subtype appears to be a reliable and valid way of distinguishing between individuals with more pervasive SAD versus those whose fear is limited to a small number of situations (e.g., public speaking).

1.3 Epidemiology

SAD appears to be one of the most common psychological disorders, though prevalence rates in the literature vary across studies. For example, lifetime prevalence estimates for SAD based on large community samples in the United States range from 3 to 13% (Antony & Swinson, 2000; Kessler et al., 2005; Somers, Goldner, Waraich, & Hsu, 2006). One factor that may account for the variability across studies is the diagnostic instrument used to assess SAD. For example, older studies based on DSM-III criteria (e.g., Eaton, Dryman, & Weissman, 1991), tended to assess fear in a relatively small number of social situations, compared to newer studies based on DSM-III-R (Kessler et al., 1994) or DSM-IV (Kessler et al., 2005) criteria. When a greater number of social situations are provided as prompts for individuals, prevalence rates tend to be higher. Prevalence rates also vary depending on ways in which distress and impairment are measured in SAD, the age composition of the sample, and the cultural composition of the sample (Wittchen & Fehm, 2003).

SAD tends to begin in adolescence (i.e., mid to late teens), but can also occur earlier in childhood. In fact, significant numbers of adults report that they have had problems with social anxiety for their entire lives or as long as they can remember. A large-scale study of individuals presenting at an anxiety clinic found a mean age of onset of 15.7 years, a number that was younger than the age of onset of the other anxiety disorders (Brown, Campbell, Lehman, Grisham, & Mancill, 2001). Studies suggest that SAD is associated with similar or related problems in childhood, including selective mutism, school refusal, separation anxiety, and shyness (Albano & Detweiler, 2001). Since most studies employ retrospective data from adults, it is unclear whether SAD, per se, would have been diagnosed in childhood for these individuals or whether individuals believe that they had SAD in childhood because they were dealing with a host of related problems that later developed into SAD. Nevertheless, SAD is routinely diagnosed in specialty anxiety clinics for children, validating the fact that this disorder commonly begins in childhood or adolescence. Cases of SAD beginning in later adulthood are rare and may actually be social anxiety secondary to another mental disorder (e.g., social withdrawal in depression, avoidance of eating in public in an eating disorder).

Epidemiological studies suggest that SAD is slightly more common in women than in men (Fehm, Pelissolo, Furmark, & Wittchen, 2005), though these differences appear especially small when compared to gender differences for other anxiety disorders where women are commonly overrepresented (e.g., panic disorder, specific phobias, generalized anxiety disorder). Gender differences in clinical samples are negligible, and some evidence even suggests that men may be more likely to present for treatment (Hofmann & Barlow, 2002).

SAD is slightly more prevalent in women than men

There are some gender differences in the presentation of SAD. For example, men and women differ in their most feared social situations. Turk et al. (1998) found that women were more fearful than men of talking to people in authority, performing in front of an audience, working while being observed, entering a room where others are already seated, being the center of attention, speaking at meetings, expressing disagreement, giving a report to a group, and throwing a party. In contrast, men were more fearful than women of returning goods to a store and urinating in a public bathroom.

SAD is a broad cultural phenomenon, appearing in such diverse cultures as Japan, Korea, Australia, Sweden, Saudi Arabia, and other East Asian countries. Although the general presentation of SAD is fairly consistent across cultures, there are some interesting cultural differences. For example, the types of situations that produce anxiety differ across cultures. One study compared people with SAD from Sweden, Australia, and the United States (Heimberg, Makris, Juster, Öst, & Rapee, 1997). Results suggested that Swedish individuals were more fearful of situations involving public observation (e.g., writing in public, eating or drinking in public, and public speaking). Individuals from Australia were more fearful of dating and starting conversations. Another study comparing individuals with SAD from the United States, Canada, Puerto Rico, and Korea found that fears of speaking to strangers were more pronounced in the Korean sample than in the other groups (Weissman et al., 1996). Another cultural difference is that SAD appears to be less prevalent in the Far East than in Western countries (e.g., Hwu, Yeh, & Chang, 1989). It is possible that socially reserved and introverted behaviors are more socially acceptable in Eastern countries that focus on "collectivism" rather than individualistic pursuits. It is also possible that Eastern cultures have more reserved attitudes about revealing personal information in interview situations.

In Japan and Korea, individuals may suffer from *taijin kyofusho syndrome* (TKS), which is similar to SAD except that individuals with TKS are concerned about doing something that may offend or embarrass *others* rather than themselves. For example, an individual with TKS may worry that he will offend others by emitting an unpleasant odor, by staring at others, or by making an improper facial expression. It has been suggested that TKS is an East Asian form of SAD that emerges from the societal emphasis on collectivism (Kirmayer, 1991). In other words, culture is seen to affect the form in which social anxiety symptoms present. Thus, it is not enough to simply identify a person's feared situations when assessing SAD, but it is also imperative to understand the *focus* of a person's fear, particularly when working with clients of Asian descent.

Most studies of SAD have been based in Western countries, though there are a few studies that have examined cross-cultural differences

1.4 Course and Prognosis

Left untreated, SAD appears to have a chronic, unremitting course and it often precedes the development of other psychological disorders, such as depression and substance use (Stein et al., 2001). One study followed individuals with SAD for 65 weeks and found that very few individuals achieved remission from their disorder during this time frame. The subtypes of generalized

versus nongeneralized did not differ in this regard (Reich, Goldenberg, Vasile, Goisman, & Keller, 1994). Furthermore, the severity of SAD did not affect its course. In other words, individuals with severe SAD experienced the same low level of remission as those with mild SAD. Other studies echo these findings, suggesting that the chance of achieving remission in SAD is less than the likelihood of recovery for other anxiety disorders (Yonkers, Bruce, Dyck, & Keller, 2003). Additionally, the presence of a comorbid personality disorder (e.g., avoidant personality disorder) leads to even lower rates of remission for individuals with SAD (Massion et al., 2002). Unfortunately, there are consequences of the unremitting course of SAD, including greater lifetime disability and a higher risk of suicide attempts for individuals with SAD (20% risk of suicide attempts) compared to those without SAD (8%; Keller, 2003).

Fortunately, there are a number of successful interventions that can affect the course and outcome of SAD. Cognitive behavioral therapy (CBT) has been identified as an empirically-supported psychological treatment for SAD. Studies suggest that individuals who receive CBT experience significant improvements in both symptoms as well as the level of functional impairment caused by SAD. Chapter 4 includes more detailed information on the efficacy of CBT for SAD. Further, there are a number of pharmacological agents that have demonstrated success in treating SAD. Therapeutic intervention can dramatically alter an otherwise pessimistic course for SAD.

1.5 Differential Diagnosis

Anxiety in social situations is a feature of many different psychological disorders in addition to SAD

There are a number of disorders with overlapping or similar features to SAD, making diagnosing this disorder difficult at times. The following section aims to highlight both the similarities and differences between SAD and the following disorders: panic disorder with agoraphobia (PDA), generalized anxiety disorder (GAD), particular specific phobias (i.e., crowds, enclosed places), depression, avoidant personality disorder, and schizoid personality disorder.

1.5.1 Panic Disorder with Agoraphobia

There are a number of similarities between PDA and SAD. Both disorders are characterized by avoidance, and the situations avoided are often similar across these disorders; For example, both disorders may be associated with avoidance of situations like crowds, parties, or public places. To distinguish between these disorders, it is important to examine the underlying reasons for avoidance. In prototypic cases, people with PDA avoid situations for fear of having a panic attack or panic like symptoms, whereas people with SAD often avoid situations for fear of being humiliated or criticized for reasons unrelated to panic (e.g., being seen as incompetent, boring, unattractive, overly nervous, weak, stupid, etc.). Differential diagnosis is complicated, however, because some people with PD are concerned about embarrassing themselves if they have a panic attack in front of others, and some people with SAD are fearful of experiencing panic attacks or panic-like symptoms. To disentangle panic-

related concerns from SAD, it is helpful to consider the following information: (a) Does the person experience panic attacks and panic-like symptoms outside of social situations (e.g., when alone), or out of the blue? Uncued panic attacks and panic attacks cued by nonsocial situations are common in PDA, but in SAD panic attacks and panic-like symptoms are triggered only by being in or thinking about being in social situations. (b) Does the individual have panic related concerns that are unrelated to being embarrassed or humiliated (e.g., a fear of dying or going crazy)? This is often the case in PDA, but not in SAD. (c) Does the person have social anxiety concerns that are unrelated to a fear of having panic attacks (e.g., fear of saying something stupid or looking unattractive to others)? This is often the case in SAD, but not in PDA. Of course, individuals who have uncued panic attacks outside of social situations, as well as extreme fears of criticism and embarrassment that are unrelated to panic may receive diagnoses of both PDA and SAD.

Panic attacks cued by social situations are common among individuals with SAD

Another similarity between PDA and SAD involves elevated anxiety sensitivity, which refers to anxiety over experiencing sensations of physical arousal, such as a racing heart, dizziness, and breathlessness. Although anxiety sensitivity is seen as a hallmark feature of PDA, studies suggest that these concerns are often elevated in SAD, though typically not as high as in PDA (Taylor, Koch, & McNally, 1992). A commonly used questionnaire for anxiety sensitivity is the Anxiety Sensitivity Index (Peterson and Reiss, 1993), and there are several variations of this scale available as well (e.g., Taylor & Cox, 1998; Taylor et al., 2007). In our experience, people with SAD are most likely to fear sensations that might be noticed by others (e.g., blushing, sweating, shaking), and they are most fearful of experiencing physical arousal sensations when they are around other people. In contrast, people with PDA are more likely to fear a range of sensations, even when alone (and for some people, *especially* when alone).

1.5.2 Generalized Anxiety Disorder

SAD and GAD may both share heightened or excessive worry about social situations, performance situations, and relationships. For example, people with GAD often worry about friendships, whether their relationships will work out, and how they appear to others. Further, people with both SAD and GAD may avoid these situations due to elevated levels of anxiety. As in SAD, people with GAD may experience panic attacks when worrying about anxiety provoking situations. The main difference between the disorders is that concern about social or performance situations is the main focus in SAD, whereas social or performance concerns are only one of many worries that people with GAD may exhibit. Indeed, the diagnostic criteria for GAD stipulate that individuals worry excessively about a number of life domains, which may include work, school, finances, minor matters, appearance, the future, and world affairs. When making this differential diagnosis, ask these questions (a) Does the person report excessive worry about a number of life domains that are unrelated to social or performance concerns (necessary for a diagnosis of GAD)? (b) If social concerns are one of several excessive worries, are they a large enough problem to stand on their own, regardless of whether criteria for GAD

are met)? If the answer to these questions is *yes*, it is possible that the person may have enough symptoms to meet criteria for both disorders. On the other hand, if social concerns are milder, are not accompanied by significant phobic avoidance, and are part of a larger picture of chronic and excessive worry, a diagnosis of GAD may be the most appropriate diagnosis.

Another distinction between these two disorders is that a diagnosis of GAD requires the presence of several physical symptoms including trouble sleeping, muscle tension, and feelings of restlessness. These symptoms are often present in any anxious client, but are not necessary for a diagnosis of SAD.

1.5.3 Specific Phobia

SAD may be confused with certain specific phobias, including fears of crowded or closed-in places (claustrophobia), like a crowded elevator or movie theater, since both of these phobia types may include avoidance of certain public places. To distinguish between SAD and claustrophobia, it is important to ask about the underlying beliefs that are associated with the person's fear. In claustrophobia, the focus of the fear is often focused on the possibility of being unable to breathe or to escape from the situation. In SAD, the focus of the fear is typically on being observed by others, being embarrassed, or humiliated. As with PDA, someone with claustrophobia may report that part of his fear concerns embarrassment about leaving or passing out in front of others. Again, it is important to look at the spectrum of symptoms reported (a broader range of social concerns would be expected in SAD) as well as the proportion of fear attributed to embarrassment versus a physical catastrophe (which would likely be a stronger fear in claustrophobia).

1.5.4 Depression

There are two forms of depression that often have overlapping features with SAD. Major depressive disorder (MDD) is characterized by depressed mood or loss of interest in activities for at least two weeks, accompanied by other symptoms of depression including appetite changes, sleep changes, feelings of worthlessness, low energy, difficulty concentrating, and suicidal ideation or attempts. Dysthymic disorder has many similar symptoms as MDD, but the symptoms are not as severe and are typically more chronic (lasting a minimum of two years). Both forms of depression and SAD may involve withdrawal and avoidance of situations such as going out with friends, socializing, or attending work or school. However, this avoidance is fear-based in SAD and is more often fuelled by low energy and low motivation in depression. In addition, people who experience social withdrawal related to depression typically report feeling comfortable in social situations when they are not feeling depressed.

Another characteristic in common between these disorders is feelings of low self-worth, inadequacy, or even worthlessness. It is not uncommon for individuals with either disorder to report automatic thoughts such as "I can't do this" or "I'll mess up" and also to report beliefs like "I'm inadequate" or "I'm

no good." However, depression is more likely than SAD to include thoughts clustering around themes of hopelessness, worthlessness, and helplessness.

Both disorders may involve difficulties concentrating or sleeping. To properly distinguish them, it is important to ask individuals for the reasons behind the presence of these symptoms. For example, why is a person having trouble concentrating or falling asleep? In a depressed presentation, the person might report that she is ruminating about past failures or is feeling guilty about little unimportant omissions. If the presentation is SAD, the individual might be more inclined to report worry about a previous or upcoming social event when trying to sleep.

As is the case for other anxiety disorders, SAD and depression are highly comorbid. Thus, it is likely that both disorders may be present for a given client.

1.5.5 Avoidant Personality Disorder

SAD and avoidant personality disorder share many features, and may actually reflect the same underlying problem

As mentioned earlier, there is significant overlap between SAD and APD, so much so that some have proposed that APD is a severe form of SAD or that both disorders are different ways of labeling a single underlying dimension. DSM-IV-TR defines APD as a pattern of social inhibition and sensitivity to negative evaluation. Both disorders are characterized by this fear of negative evaluation, which leads to significant anxiety and avoidance of social situations. Even though fear and avoidance are present in both disorders, individuals desire social contact and interaction. Both disorders have onsets early in life. Generalized SAD is even harder to distinguish from APD as compared to nongeneralized SAD due to the pervasive nature of symptoms.

Research suggests that individuals with APD may be more interpersonally sensitive than those with SAD and may have poorer social skills (Turner, Beidel, Dancu, & Keys, 1986). Indeed, the degree of interpersonal sensitivity may be a useful way to distinguish these disorders. Whereas individuals with SAD are often sensitive about and fearful of being criticized, this quality appears to be more pervasive and marked in APD. The DSM-IV-TR suggests that people with APD are "preoccupied" with their concern of being criticized. Further, criteria can still be met for SAD even if concerns about being criticized are minimal. Some individuals present with concerns about embarrassing themselves or showing signs of anxiety rather than being criticized by others.

1.5.6 Schizoid Personality Disorder

Schizoid personality disorder is characterized by detachment from and disinterest in social relationships, disinterest in sexual relationships, and few friends or relationships. Individuals with this disorder prefer to be alone and are virtually indifferent to praise or criticism from others. Schizoid personality disorder can appear similar to SAD because of the avoidance of social situations and the lack of close relationships (e.g., both conditions are often associated with avoidance of family gatherings, a lack of intimate relationships, and a tendency to be unmarried). However, there are a number of important distinc-

tions between these disorders. The main distinction to bear in mind is that people with schizoid personality disorder are typically disinterested in social or intimate relationships, whereas people with SAD are often very interested in these relationships, but are simply too anxious to be able to have them. Further, although many people with SAD have small social circles and are not in intimate relationships, a sizeable proportion of them *are* in intimate relationships and report satisfaction with these relationships. Individuals with schizoid personality disorder are rarely involved in these relationships. Another distinction is the range of emotions experienced by individuals. Whereas individuals with schizoid personality disorder have more flat or constrained affect, individuals with SAD have an abundance of anxiety and nervous energy. This difference in affect is often very noticeable during a clinical interview.

1.6 Comorbidity

Most people with SAD will experience one or more other psychological disorders in their lifetimes

SAD is associated with an increased risk of a client having another Axis I disorder, including a mood disorder or another anxiety disorder. Brown et al. (2001) found that 46% of people with SAD had another current psychological disorder and that 72% of people with SAD had another psychological disorder in his or her lifetime. More specifically, people with SAD appear to have an increased risk of comorbid panic disorder, specific phobias, and depression. In fact, SAD and posttraumatic stress disorder had the highest rates of comorbid depression out of all the anxiety disorders. A large Canadian study also found that SAD was associated with a moderate level of comorbidity with substance abuse disorders (Chartier, Walker, & Stein, 2003). These higher rates of comorbidity can have an impact on severity of SAD as well as treatment outcome. Clients with SAD who also had an additional diagnosis of depression were found to have a longer duration of SAD symptoms and more severe impairment both before and after treatment than those with a sole diagnosis of SAD (Erwin, Heimberg, Juster, & Mindlin, 2002). In this study, clients with SAD and a comorbid anxiety disorder diagnosis were more similar to those with just SAD on measures of impairment (compared to those with SAD and depression), suggesting that having comorbid depression is more problematic than having a comorbid anxiety disorder. On the other hand, in a different study of individuals with SAD and an additional diagnosis of GAD demonstrated greater symptom severity and impairment than those without GAD (Mennin, Heimberg, & MacAndrew, 2000). It seems likely that the presence of any comorbid disorder can have at least some negative implications for the severity and prognosis of SAD.

1.7 Diagnostic Procedures and Documentation

Accurate diagnosis of SAD is important for selecting an appropriate treatment. In addition, it is useful to assess the severity of an individual's presentation, the presence of particular features, and the extent to which symptoms changes

as a result of treatment. A host of measures exist for assessing these domains, including interviewer administered scales, self-report questionnaires, and behavioral assessments. This section includes an overview of the most commonly used tools for assessing SAD. For a more thorough review of assessment measures, see Antony, Orsillo, and Roemer (2001).

1.7.1 Interviewer Administered Measures

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Di Nardo, Brown, & Barlow, 1994). The ADIS-IV is a clinician-administered semi-structured interview that provides both diagnostic information and dimensional information (e.g., symptom severity ratings) for a range of psychological problems, including anxiety disorders, mood disorders, somatoform disorders, and substance use disorders. Clinicians require extensive training in the administration of this interview, which can be lengthy (e.g., several hours). Despite these drawbacks for everyday practice, the ADIS-IV has the benefit of providing clear criteria to help determine the presence or absence of SAD (as well as common comorbid disorders) as well as assessing useful information such as the degree of fear and avoidance in a variety of social settings. The ADIS-IV has demonstrated good reliability and validity (e.g., Brown, Di Nardo, Lehman, & Campbell, 2001; Rodebaugh, Heimberg, Woods, Liebowitz, & Schneier, 2006).

The SCID is a semistructured interview often used to diagnose anxiety disorders (discussed in Chapter 3)

Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987). The LSAS is a 24-item clinician-rated scale designed to assess the severity of a range of social and performance concerns. Respondents are asked about both fear and avoidance of a series of situations over the past week, yielding total fear and avoidance scores as well as a number of subscale scores (fear of social interaction, fear of performance, total fear, avoidance of social interaction, avoidance of performance, and total avoidance). Although only a few studies have examined the psychometric properties of the LSAS, it appears to be a reliable and valid measure with good treatment sensitivity (Heimberg et al., 1999). This measure is useful to include in a pre and posttreatment assessment battery as it only takes about 20 minutes to complete and provides a helpful addition to self-reported symptom measures.

Brief Social Phobia Scale (BSPS; Davidson et al., 1991). The BSPS is an 18-item interviewer-rated scale designed to assess the severity of symptoms of SAD. Similar to the LSAS, respondents are asked to rate both fear and avoidance of a number of social situations over the past week. These measures differ in that the BSPS inquires about fewer situations (seven) than the LSAS, but also asks about physiological symptoms that may occur in social situations. The situations assessed include speaking in front of others, talking to people in authority, talking to strangers, being embarrassed or humiliated, being criticized, social gatherings, and doing something while being watched. It is a briefer measure than the LSAS and the ADIS-IV, only taking 5 to 15 minutes to administer, but its authors suggest using it in conjunction with another interview-based measure for thoroughness. Internal consistency for this interview is adequate, and it has demonstrated good validity and treatment sensitivity. It appears that the fear and avoidance subscales of this measure are psychometrically stronger

than the physiological subscale, suggesting that these may be the subscales to focus on when assessing treatment outcome (Davidson et al., 1997).

1.7.2 Self-Report Severity Measures

Social Phobia Inventory (SPIN; Connor et al., 2000). This is a 17-item self-report measure assessing how much a series of symptoms of social anxiety bother the respondent. Items fall into three subscales including fear, avoidance, and physiological arousal. Individuals complete the SPIN based on the previous week, making this a useful measure to assess week-to-week progress during treatment for SAD. Another appealing characteristic of the SPIN is its brevity. It takes several minutes to complete, allowing the client to quickly complete it at the beginning of a treatment session. The psychometric properties of the SPIN are very good (Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006; Connor et al., 2000). The total score demonstrates excellent internal consistency, and correlations with interviewer measures of SAD suggest it has good convergent validity. The authors of the SPIN suggest that a cutoff score of 19 (out of a possible 68) is useful in discriminating those with SAD and those without at an accuracy rate of 79%. The SPIN is reproduced in the appendix of this book.

A brief version of SPIN has also been developed

Social Phobia Scale (SPS; Mattick & Clarke, 1998). This is a 20-item self-report scale focusing on anxiety while being observed by others. Respondents rate how much each situation would bother them on a scale from *not at all* to *extremely true of me.* Situations include activities such as using public toilets, entering rooms where others are seated, fainting or being ill in front of others, and eating or drinking in front of others. This is also a brief measure, taking only minutes to complete. This feature makes the SPS a popular measure to use in treatment studies or to monitor weekly progress in treatment. The SPS demonstrates excellent reliability. Even though there are items on the SPS that seem related to agoraphobic concerns (i.e., fears of being ill in front of others), individuals with SAD score higher on this scale than do those with agoraphobia. The SPS has been well-studied and appears to demonstrate strong psychometric properties including treatment sensitivity (see Orsillo, 2001, for a review).

Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998). This self-report measure was designed in conjunction with the SPS and assesses fears of interacting with others. Sample items include concerns about talking with others, mixing at parties, and saying something embarrassing when talking. It contains 19 items and therefore is brief and easy for clients to complete. As with the SPS, it also demonstrates strong psychometric properties and studies suggest that the two measures, though related, are assessing different constructs (Orsillo, 2001).

1.7.3 Behavioral Approach Tests (BATs)

A BAT involves instructing a client to enter a feared situation or engage in a feared activity and monitoring his or her responses (e.g., subjective fear

ratings, escape or avoidance, safety behaviors, anxious thoughts, physical sensations, response to changing particular aspects of the situation, etc.). Using behavioral assessment strategies can provide important information not provided by interviews or self-report alone. For example, a client with a tendency to minimize his fears may report little or no avoidance of a particular situation, but then may freeze when in the actual situation. BATs can also be used to assess treatment outcome. A change in performance on a behavioral task provides real-world information about the effectiveness of treatment.

A commonly used BAT for SAD involves asking a client to give a speech in front of another person, a small audience, or a video camera. This situation is often used because public speaking is one of the most common fears that adults report, suggesting that it is likely to be anxiety-provoking for most individuals, especially those with a diagnosis of SAD. Other examples of BATs include having the individual engage in a spontaneous conversation or talk about himself to others. Although it is sometimes useful to have all participants engage in a consistent BAT for the purpose of research, it is typically more appropriate to use individually tailored BATs in clinical practice, selecting situations that are most relevant to the individual's phobia and treatment goals.

When designing a BAT, the clinician and client should identify a highly feared situation (ideally, one of the most feared situations) and then have the client enter that situation both before and after treatment (and perhaps several times during the course of treatment). During the BAT, clients should provide subjective fear ratings to communicate their distress, using a scale ranging from 0 (*no fear at all*) to 100 (*as much fear as can be imagined*). Other scales (e.g., 0 to 10) are fine as well. In addition to subjective fear ratings, other indicators of fear can be useful as well, including whether the client can complete the BAT, how long he or she spends in the situation, and objective signs of anxiety (e.g., shaking, trouble concentrating on questions, etc.).

1.7.4 Assessing Suitability for Treatment

As clinicians, we often assume that people are ready to engage in whatever treatment we have to offer when they present in a clinical setting. We also know that CBT is an effective treatment for SAD, so we may assume that this approach is always a good match for a client who presents to us with this problem. However, full benefit from a treatment like CBT depends on the active participation of clients. Clients have to be willing to "buy into" the cognitive behavioral model of social anxiety and practice the CBT techniques. Homework is a crucial part of successful outcome in CBT, requiring the client to not only attend appointments, but also to practice using techniques and completing exercises between sessions. However, many clients are not fully ready to commit to CBT, or may be ambivalent about engaging in treatment. It is helpful to know which clients are ready to begin active treatment, which clients are almost ready, and which clients are not likely to benefit from treatment at the current time. Knowing this information is useful not only for the clinician (i.e., it reduces the amount of time spent with clients who are not ready, it reduces the likelihood of frustration from working with a "resistant" client), but also for the client who might feel frustrated or hopeless about trying and