Chapter 1

Conceptualizing and Describing Social Anxiety and Its Disorders

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INTRODUCTION

Social anxieties and fears exist along continua of intensity, ranging from the helpful and adaptive (e.g., keeping one on one's "social toes" in uncertain social situations) to the disabling and impairing (e.g., being unable to develop or maintain close relationships in spite of loneliness). Unpleasant emotional states and maladaptive behaviors associated with social situations can be significant, life-affecting problems for many people. Given the social nature of human beings, and the functional nature of social relationships (e.g., social support), discomfort associated with interacting with others is particularly difficult, as socialization cannot easily be avoided on a consistent basis. In other phobias or phobic-like disorders, avoidance often can be effective in the short term, to prevent or reduce anxiety, albeit temporarily in many situations.

Social anxieties and fears were described by Hippocrates and were systematically delineated with other phobias beginning in the 1870s (Marks, 1970, 1985). Over the past 40 years, the social psychological focus on shyness (e.g., Zimbardo, 1977), the work of Marks and others in the 1960s and 1970s, and the identification of social phobia as a distinct disorder in the Diagnostic and Statistical Manual–III (e.g., American Psychiatric Association [APA], 1980) and subsequent revisions, including the new Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; APA, 2013), have been part of a massive growth in the related scientific and self-help literatures.

This general arena of problems includes several somewhat overlapping constructs; the scientific language has many different terms that apply or relate, including: shyness, social anxiety, social withdrawal, social phobia, social anxiety disorder, behavioral inhibition, communication apprehension, and introversion. In both everyday and scientific language, these states have been described in a myriad of ways. Leitenberg (1990), in introducing his book in the area, states:

> *Social anxiety has been studied in various guises. Shyness, performance anxiety, social phobia, avoidant personality disorder, social withdrawal, social isolation,*

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> *public speaking anxiety, speech anxiety, communication apprehension, fear of interpersonal rejection, dating anxiety, separation anxiety, stage fright, fear of strangers, shame, embarrassment, social inhibition, social timidity – all of these and more fall under the umbrella of social anxiety. (p. 2)*

Other anxiety-related syndromes, such as test anxiety and selective mutism, also likely have a strong social component, and may be instantiations of social anxiety disorder (SAD) (Bögels et al., 2010). Body dysmorphic disorder, highly comorbid with SAD, similarly is socially determined, at least in part, in that the perception of others regarding (imagined) defects may be an underlying feature.

There also are a variety of terms that suggest, at least somewhat, deficient social skills, such as *nerd, geek*, and *wall flower*. Masia and Morris (1998) identify terms related to social distress in children across areas of psychology: developmental (i.e., peer neglect, social withdrawal), personality (i.e., shyness), and clinical (i.e., social phobia, avoidant personality disorder [APD]). Stranger anxiety and separation anxiety likely are related constructs as well (Thompson & Limber, 1990). Masia and Morris note that this varying "psychological language" (p. 212) creates problems in investigating phenomena (e.g., parental behavior and its relation to child social anxiety) that span across subdisciplines in psychology, and presumably across related disciplines (e.g., psychiatry).

It should be noted that comparative psychology has contributions to this area as well. Social anxieties are not solely human phenomena; such social/emotional problems are shared by other primates (Mineka & Zinbarg, 1995; Suomi, Chaffin, & Higley, 2011), and lower animals. Social dominance and submissiveness hierarchies have been suggested as important determinants of socially anxious behavior across species of primates, including humans (Schneier & Welkowitz, 1996; Trower & Gilbert, 1989). Facial expressions, for example, provide important social interactional cues in humans and other primates, including both aggression and appeasement related to anxiety (Mogg & Bradley, 2002; Öhman, 1986). Early learning history, particularly mother-offspring interaction, also has been suggested as an important determinant of socially anxious behavior in primates (e.g., Schino, Speranza & Troisi, 2001).

One of the issues that continues to be an albatross for the field is the everyday language basis of the most frequently used terms: shyness, stage fright, and social anxiety. Some years ago, Harris (1984) detailed a number of problems inherent in using the lay language of "shyness" in scientific discourse, a problem that still exists today. Clinically-oriented scientists may try to "distance" SAD from shyness, perhaps to emphasize that individuals who meet criteria for the disorder suffer with impairment in social and occupational functioning that can be quite terrible, leading to chronic suffering. Issues related to the terminology used to describe social fears and anxieties can obfuscate the already complex and sometimes controversial task of understanding and defining SAD (Dalrymple, 2012). Adding further complexity, some degree of social anxiety can be adaptive (Schneier & Welkowitz, 1996). Moreover, the social consequences of

some socially anxious behaviors are quite positive. One example is a "bashful" child who hides his or her face by planting it directly in a part of his or her parent's body, resulting in adult laughter and encouragement to socialize. A further example is a distant, detached person who is regarded as "coy," "interesting," or even "mysterious," relating to his or her lack of social initiation or response.

Defining social anxieties and fears, and specifying what types or degrees of behavior are most appropriately classified as pathological or a "disorder," is an involved and often perplexing undertaking. The definitions we create are informed by research and clinical experience, and indeed inform future research and clinical intervention. The National Institute of Mental Health (NIMH) recently initiated the Research Domain Criteria project (RDoC) in an effort to "develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures" (NIMH, 2013). Research that transcends standard diagnosing and steps away from strict definitions of mental illness based on diagnostic criteria, such as those presented in the DSM-5, now is preferred by the NIMH. This effort represents an understanding that the task of defining any psychological disorder indeed is complex. SAD is no exception. Research in the area of SAD that considers definitional issues and acknowledges the limits of even new diagnostic criteria allows for a more comprehensive understanding of its psychopathology and more appropriate translation of research findings to clinical work.

This chapter provides a perspective on conceptual, definitional, and diagnostic nosology issues for the field, including a focus on the DSM-5. It is proposed that social anxieties and fears, like other phobic disorders, exist along a continuum across the general population, as explicated later in this chapter, and as shown in Figure 1.1. The range of social anxieties/fears along this continuum is from no anxiety/fear, to "normal" levels, to psychopathological extremes. The debate (e.g., Campbell-Sills & Stein, 2005; Wakefield, Horowitz, & Schmitz, 2005a; Wakefield, Horowitz, & Schmitz, 2005b) on "overpathologizing" socially anxious people then may be somewhat addressed by a conceptualization that acknowledges both "normal" social anxieties that are mildly

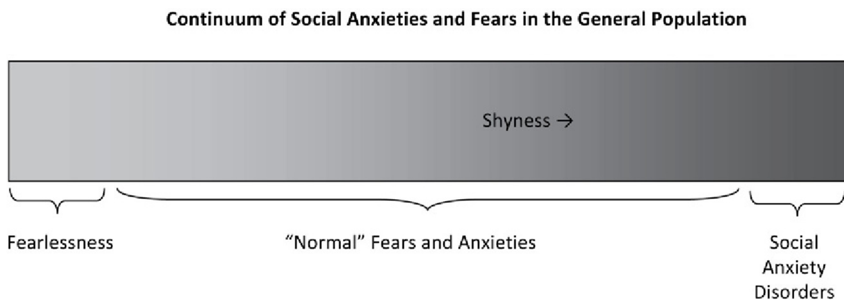

FIGURE 1.1 Model of the continuum of social anxieties and fears across the general population.

to moderately intense, or transient, and their potential connectedness to SAD, depending on potentially contributing environmental and individual factors.

This chapter also reviews the evolution of constructs important to the area. Finally, it reemphasizes the need for a multidisciplinary approach to studying and understanding distress and dysfunction related to social situations. This chapter, similar to other work (Masia & Morris, 1998), uses the term “social anxiety” in an attempt to broadly encompass the various constructs emanating from the various disciplines and subdisciplines. Given the recognized differences between anxiety and fear states generally (Bouton, Mineka, & Barlow, 2001; McNeil, Vargovich, Turk, & Ries, 2012), the term “social fear” is incorporated into this lexicon, and will be further elaborated on in this chapter. Consistent with the current literature (APA, 2013; Bögels et al., 2010), the term *Social Anxiety Disorder*, abbreviated here as SAD, is used to describe psychopathological levels of such anxieties or fears, although “social phobia” is used when describing historical designations.

OVERLAPPING AND CONTRASTING EMOTIONAL STATES

Anxiety and fear are not “lumps” (Lang, 1968) and are not, in and of themselves, disease states. Rather, they exist along continua across the population. At the extreme, high levels of social fears and anxiety are psychopathological, and can be classified as clinical syndromes such as SAD. Studies addressing whether the principal components of SAD correspond to a latent category or dimension suggest that SAD is continuous with milder phenomena such as social anxiety and shyness, providing support for a dimensional approach to conceptualizing SAD (e.g., Ruscio, 2010). This dimensional understanding of the disorder informed revisions of the diagnostic criteria outlined in the DSM-5, as described later (APA, 2013). Depending on the type of anxiety or fear, as well as other factors such as gender (Craske, 2003; Kessler et al., 2012), the distributions of individuals along the continua vary.

Figure 1.2 illustrates the distributions of general social anxiety based on Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969) scores of 477 male ($n = 214$) and female ($n = 263$) university undergraduates. The mean age of the sample was 19.9 ($SD = 3.1$). Score distributions also are provided for specific public speaking fear using the Personal Report of Confidence as a Speaker scale (PRCS; Paul, 1966) for these same individuals. The SADS distribution is positively skewed toward lower scores, which are associated with less anxiety, but kurtosis is unremarkable (skewness and kurtosis coefficients are 0.79 and −0.39, respectively). In contrast, the PRCS is more normally distributed, but has a rectangular distribution, in which each score has the same frequency of occurrence (skewness and kurtosis coefficients are −0.04 and −1.1, respectively).

Given the size of the present sample, substantively small differences (i.e., less than 2 points on 28- and 30-item scales) were statistically significant. The varying directionality of the sex differences, however, is interesting. For general

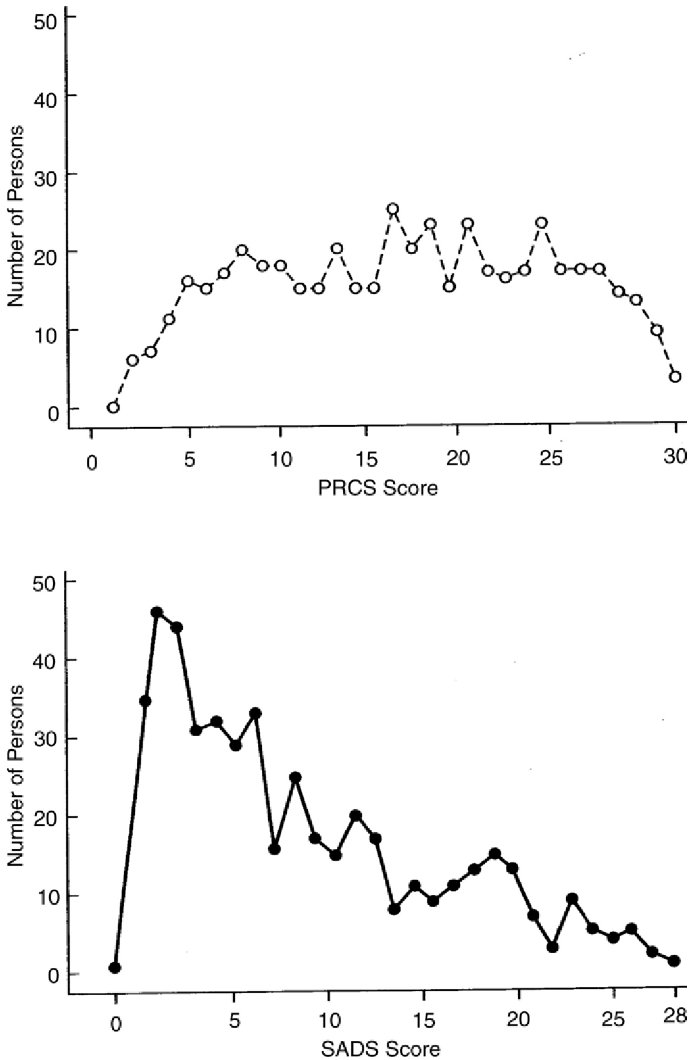

FIGURE 1.2 The number of individuals having each total score, reflecting general social anxiety using the Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969; bottom panel), and public speaking fear based on the Personal Report of Confidence as a Speaker Scale (PRCS; Paul, 1966; top panel). The possible range of scores is 0–28 for the SADS and 0–30 for the PRCS. Higher scores for both instruments are indicative of greater anxiety. The total sample consists of 477 male and female undergraduates.

social anxiety measured by the SADS, males ($M = 9.9$, $SD = 7.3$) had higher scores, indicating more anxiety, than females ($M = 8.4$, $SD = 6.3$), $t(475) = 2.40$, $p < 0.05$. Conversely, for specific public speaking fear on the PRCS, females ($M = 16.2$, $SD = 7.7$) indicated more anxiety than males ($M = 14.8$, $SD = 7.6$), $t(475) = 1.97$, $p < 0.05$. These differences provide suggestive evidence of

the differences between general social anxieties and specific public speaking fears. While there may be differences in SADS and PRCS total scores between the sexes, the shape of the distributions were relatively consistent, except for kurtosis on the SADS, as evidenced by coefficients for skewness (SADS: males = 0.60 and females = 0.95; PRCS: males = −0.02 and females = −0.06) and kurtosis (SADS: males = −0.79 and females = 0.06; PRCS: males = −1.1 and females = −1.0). That clear differences between general social anxiety and a specific public speaking fear exist, and that the two are related but distinctly constructed, has been demonstrated elsewhere (Boone et al., 1999; see Blöte, Kint, Miers, & Westenberg, 2009 for a review).

The unique features of public speaking fear as measured by the PRCS, relative to general social anxieties, are consistent with prior research (Klorman, Weerts, Hastings, Melamed, & Lang, 1974) that compared it to other specific-fear questionnaires, although not a general social anxiety instrument. The different distributions for the SADS and PRCS are interesting, particularly as general social anxiety and public speaking fear seem intrinsically related. Regardless of the distribution shapes, these data clearly demonstrate that both general social anxiety and public speaking fear exist along continua, albeit different ones, in a general population. The more normally distributed public speaking fear scores, with a greater number of individuals at the right tail of the distribution (associated with higher scores and greater anxiety), is consistent with reports of their high prevalence in the general population, relative to general social anxiety (Kessler, Stein, & Berglund, 1998; Pollard & Henderson, 1988; Stein, Torgrud, & Walker, 2000).

In the USA, the lifetime prevalence of SAD is 11.2% and 6.2%, respectively, for females and males between the ages of 13 and 17, a significant difference between genders (Kessler et al., 2012). The lifetime prevalence of SAD for American adults between the ages of 18 and 64 is 14.2% and 11.8% for males and females, respectively, with the difference between genders significant (Kessler et al., 2012); relative prevalence of SAD across nations and cultures is discussed later in this chapter. These prevalence estimates are for those individuals who meet DSM-IV-TR criteria for SAD; however, social anxieties and fears exist continuously across the general population. Moreover, significant features of social anxiety are present across various psychological disorders, including but not limited to anxiety disorders in addition to SAD. The comorbidity of anxiety disorders with one another is well documented (Barlow, 2002) and argues for a dimensional classification scheme. High levels of social anxiety, and perhaps other anxieties, also exist across clinical syndromes such as schizophrenic disorders, affective disorders, and substance use disorders (Hall & Goldberg, 1977).

DEFINITIONS

In 1966, Marks and Gelder described patients with "social anxieties" as having "phobias of social situations, expressed variably as shyness, fears of blushing in public, of eating meals in restaurants, of meeting men or women, of going

to dances or parties, or of shaking when the center of attention" (p. 218). A few years later, Marks (1970) further elucidated the classification of "social phobias," distinguishing them from animal phobias and agoraphobia. He noted that the social phobia group of patients had "fears of eating, drinking, shaking, blushing, speaking, writing or vomiting in the presence of other people" (p. 383). Even at that point, however, Marks noted that: "We need to know more about social phobics before definitely classifying them on their own" (p. 383). From these early scientific descriptions has grown a myriad of definitions; the evolution of our understanding of SAD continues with the recently updated DSM–5 (APA, 2013).

Most researchers in the USA and some other Western nations adopt the most current Diagnostic and Statistical Manual (DSM) definition of SAD (e.g., DSM-5; APA, 2013). Presently, that definition describes individuals who are "fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized" (p. 190; APA, 2013). Aside from this designation, there is little consensus in the area, either about the definitions themselves or the underlying constructs. Across scientific and clinical disciplines, different terminology and different labels, describing slightly different constructs, are used, with correspondingly different definitions. All of these groups focus on socially anxious and fearful behaviors, including thoughts and emotions, yet regard their own area as unique and somehow separate from others.

DIAGNOSTIC NOSOLOGY CLASSIFICATIONS

Social phobia first was recognized as a separate diagnostic entity in the DSM system with the advent of DSM-III (APA, 1980). DSM-II (APA, 1968), for example, did not even specifically mention social phobias under the Phobic Neurosis category; nor was APD specifically detailed in that DSM version. In DSM-III, however, there were two fairly simple sets of criteria for social phobia, and an exclusionary category. Both fear and a desire to avoid were required in the first set of criteria. Significant distress and recognition of the excess or unreasonableness of the fear both were necessary for the second criteria set. DSM-III descriptions implied that Social Phobia had discrete manifestations in one of four areas: public speaking/performing, using public bathrooms, eating in public, and writing in front of others. APD was one of the exclusionary criteria for Social Phobia, so patients might meet criteria for both disorders, but could only be diagnosed with APD, thus making it the predominant categorization. Children and adolescents with psychopathological social anxiety typically would be diagnosed with Avoidant Disorder of Childhood or Adolescence, which was in the DSM categorization of Disorders Usually First Evident in Infancy, Childhood, or Adolescence. There were, however, no stated criteria that would specifically prohibit diagnosing a child or adolescent with Social Phobia. Conversely to adult classification, if the patient was under 18 years old, Avoidant Disorder of Childhood or Adolescence was an exclusionary criterion for APD, and so took precedence over it.

The publication of DSM-III-R (APA, 1987) represented a significant shift in the conceptualization of Social Phobia as a syndrome. In addition to a greater number of separate diagnostic criteria, and more specificity in these criteria, a generalized type of social phobia was allowed as a specifier, "if the phobic situation includes most social situations" (p. 243), although it was noted that the disorder could be circumscribed. Also, APD was allowed as a comorbid diagnosis with Social Phobia. Avoidant Disorder of Childhood or Adolescence was a formal exclusionary diagnosis for Social Phobia in individuals under age 18.

In DSM-IV (APA, 1994), the Social Phobia diagnosis was slightly changed once again. For the first time, the term *Social Anxiety Disorder* was parenthetically listed along with *Social Phobia*, apparently representing a conceptual shift to differentiate it from other phobic disorders, and perhaps also to discriminate the extreme of psychopathological behaviors from "normal" social anxieties that affect most people in certain situations. In DSM-IV, Avoidant Disorder of Childhood or Adolescence was subsumed into the Social Phobia diagnosis. The text revision of the DSM-IV (i.e., DSM-IV-TR; APA, 2000) of course retained the same criteria as the DSM-IV, and incorporated relatively minor wording changes and additions (e.g., noting that SAD may be associated with suicidal ideation).

The DSM-5 incorporates a number of notable changes to the definition and diagnostic criteria for SAD (APA, 2013). First, the term *Social Anxiety Disorder* (SAD) has replaced *Social Phobia* as the predominant wording, with the latter term in parentheses secondary to the former term. This change in terminology represents a shift in the conceptualization of the disorder wherein the condition is more broadly understood to exist in a variety of social situations. Second, the "generalized" specifier for SAD has been dropped and replaced with a "performance only" specifier, which is assigned "if the fear is restricted to speaking or performing in public" (APA, 2013, p. 203). Third, a six-month duration for which symptoms must be present in order to diagnose SAD, which applied only to children in DSM-IV-TR (APA, 2000), now is listed as a diagnostic criterion for all individuals. Fourth, in DSM-5, judgment of whether the socially anxious response is excessive or unreasonable is made by the clinician, a shift from DSM-IV-TR, which required recognition of the anxious response as excessive or unreasonable by the individual with SAD. According to DSM-5, the clinician determines whether the social anxiety or fear "is out of proportion to the actual threat posed by the social situation and to the sociocultural context," with mention of culture being added directly to the diagnostic criteria in the updated DSM (APA, 2013, p. 203). Lastly, two behaviors have been added to the list of ways in which children, specifically, may manifest anxiety or fear provoked by social situations: "clinging" and "failing to speak in social situations" (APA, 2013, p. 202). Each of these changes represents a new and broader conceptualization of SAD and provides additional definitional clarity.

This evolution of criteria for SAD and APD, while representing advances in some ways, also has hampered the literature in terms of historical comparisons.

A group of individuals diagnosed with DSM-defined social phobia in 1985, for example, would differ from an analogous group so classified in 1995, and both likely would differ from a group classified in 2013, making comparisons across these studies of limited and uncertain value.

While virtually all clinically-based SAD research in the USA presently uses the DSM system, lest we fall victim to national imperialism, it should be remembered that there is an International Classification of Diseases (ICD) diagnostic nomenclature (e.g., World Health Organization, 2007), which exists in its most current instantiation as ICD-X (Version for 2007); there are other methodologies for classifying and understanding psychopathology as well. The ICD and DSM systems are different, and SAD/Social Phobia provides an important example. In the ICD-X "social phobias" classification, the criteria are more general, and structured differently than the seven inclusionary criteria in DSM-5. There is no generalized type or subtype in the ICD-X, although there is mention of the possibility of "more pervasive social phobias." Perhaps most importantly, relative to DSM-5, the ICD-X has considerable focus on physiologically-related symptoms regarded as being unique to social phobia (i.e., blushing, hand tremor, nausea, and urgency of micturition). The ICD-X also suggests that symptoms of social phobia may evolve into panic attacks. Individuals classified with Social Phobia by one of these systems may well not be diagnosed in the same category by the other system. The diagnostic concordance rate between these two systems may only range between 39% and 66%, which certainly is troubling (Andrews, Slade, Peters, & Beard, 1998). Finally, it is important to note that social anxiety exists cross-culturally, albeit in varying forms (Hong & Woody, 2007; Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997; McNeil, Porter, Zvolensky, Chaney, & Kee, 2000), as discussed later in this chapter, so an international classification or descriptive system is imperative. The ICD-XI is expected to replace the ICD-X as the international classification system in 2015; an initial draft of the ICD-XI was made available for comment in May 2012, and there are no major differences between the definitions of Social Phobia presented in the ICD-X and the proposed update (World Health Organization, 2012).

The DSM system dominates the field and its utilization in both research and clinical settings in the USA is almost universal. While immensely helpful in a variety of ways, the DSM is limiting in terms of discouraging cross-disciplinary work with non-service-delivery disciplines. Also, the focus on categorical diagnoses is artificial, given the comorbidity across anxiety disorders. Individualized, functional analyses of behavior, followed by theory-driven therapy, seem almost antithetical to the DSM system (Eifert, 1996). Nevertheless, there are attempts to move the field away from syndromal to functional classification (Hayes, Wilson, Strosahl, Gifford, & Follette, 1996), or to classification focused on observable behaviors and neurobiological indices (NIMH, 2013). In the case of SAD, for example, analysis of function (e.g., of poor social skills) is of great importance because the same behavior across individuals may have widely

different antecedents (e.g., lack of knowledge about appropriate social responses versus inhibited display of social behaviors due to anxiety).

RELATION OF PERFORMANCE DEFICITS AND SOCIAL ANXIETY

Because of the strong contribution of performance-related issues in some social anxieties, social skill and social anxiety in the past often were (inaccurately) viewed as always being one and the same problem, or as inextricably intertwined issues. Making public speeches is one prominent example, in which a high degree of anxiety displayed by the speaker may negatively affect skill level, or vice versa, in which poor public speaking skills may be one antecedent to anxiety in speech situations. Sometimes, however, performance anxieties have been considered separately, as in the cases of males experiencing sexual dysfunction (e.g., Bruce & Barlow, 1990), musical performance (e.g., Clark & Agras, 1991), and athletes in competitive sport situations (e.g., Smith & Smoll, 1990). Nevertheless, the relation of social skill and social anxiety is complex and inconsistently addressed in the literature (Hopko, McNeil, Zvolensky, & Eifert, 2001). Intersecting relations between social skill and anxiety have been suggested (Lewin, McNeil, & Lipson, 1996). Such a conceptualization may help to explain the finding that not all individuals who meet criteria for SAD suffer from social skills deficits when compared to individuals without the disorder (Beidel, Rao, Scharfstein, Wong, & Alfano, 2010). This conceptualization also may help to explain the curious (but relatively common) cases of clinical patients who have a sophisticated set of social skills, but are extremely anxious nonetheless and who evaluate their performance negatively. The literature suggests individuals with SAD regard their own social performance harshly, more than less anxious persons do, and more so than independent observers (Hofmann & Barlow, 2002). Alternatively, it has been suggested that performance problems in generalized social anxiety might best be thought of as inhibitions rather than deficits (Rapee, 1995). Clearly, in this area particularly, more research is needed to clarify the relations between these constructs. From a clinical perspective, it is important to know whether a problem with social performance has a primary deficit (i.e., the ability was never learned), a secondary deficit (i.e., anxiety disrupts performance, in spite of the ability being present), or a tertiary deficit (i.e., the ability is absent, and there is anxiety about performing the skill as well) (Hopko et al., 2001). Relative to earlier conceptualizations, there is greater understanding now that social skill and social anxiety/fear can be independent.

FORMS OF SAD

The diagnostic conceptualization of SAD and its specific manifestations has changed considerably over time, continuing through the most recent evolution in DSM-5. Whether there are unique distinctions of the disorder, how those distinctions are best characterized, and whether they should be referred to as

"types" or "subtypes" has been the subject of much controversy and change (Bögels et al., 2010). The literature on subtypes and types of SAD is considerable (Bögels et al., 2010; Hofmann, Heinrichs, & Moscovitch, 2004). Over two decades, significant progress has been made in understanding and conceptualizing SAD, as well as treating it, but some fundamental questions remain. Current data strongly suggest there are unique variations of SAD, and that the DSM- and ICD-designated disorders are not homogenous ones.

The semantic issue is actually quite important: Is there one major type of SAD, with some slight variants, or are there several SADs? At this point in the field, the idea that the disorder varies along a severity continuum enjoys considerable support (Aderka, Nickerson, & Hofmann, 2012; Bögels et al., 2010; McNeil, 2001). The conception of "subtypes" (e.g., Kessler et al., 1998) remains viable, with strong evidence for the existence of predominantly performance-based instantiations of the disorder (Bögels et al., 2010). The most common of the performance subtypes involves public speaking (e.g., Boone et al., 1999). There are performance fears in other areas as earlier identified in DSM-III-R (APA, 1980): public eating, writing, and use of lavatories. The circumscribed public speaking fears have even been suggested as being equally like Specific Phobias relative to other Social Phobias (Boone et al., 1999). Individuals with more generalized fears certainly often have strong public speaking fears as part of the constellation of distressing social situations, but there is a separate group having social fears exclusively or almost so in this one domain. These latter persons are not often seen in behavioral health facilities, particularly in major health care centers, because public speaking fears are not viewed as "mental health" problems but rather are perceived as "normal" even when at high levels (Booth-Butterfield & Cottone, 1991; McCroskey, 2009; West, 1988). Distress about public speaking situations may most appropriately be regarded as fear rather than anxiety given the high degree of situation specificity, robust psychophysiological response, prevalence of avoidance behavior, and prevalence of traumatic conditioning histories in individuals who have circumscribed concerns about public speaking (Boone et al., 1999).

Test anxiety is in many ways similar to other social anxieties, and may in fact best be considered a form of evaluation anxiety (Bögels et al., 2010). Similarly, test anxiety in its extreme forms may be phobic in nature, although lesser forms are more typical and considered "normal" based on situational demands. In psychopathological extremes, these problems are phobic in nature, and thus may be functionally more similar to Specific Phobias rather than other SADs (Boone et al., 1999), but in some cases also may best be categorized as manifestations of other anxiety disorders such as Generalzied Anxiety Disorder or Obsessive-Compulsive Disorder (Bögels et al., 2010).

In the DSM-IV-TR (APA, 2000), there was a "generalized" specifier that designated individuals who fear "most social situations." Nevertheless, there was a lack of a clear, generally accepted operational definition of this generalized type of SAD, which has hampered progress in the literature. Given the

idea of a continuum of severity for SAD, the generalized specifier did not appear to add much to the demarcation of the disorder (Bögels et al., 2010). The "generalized" specifier was removed in the updated DSM-5 (APA, 2013). While a "nongeneralized" social phobia designation was once suggested (Heimberg, Holt, Schneier, Spitzer, & Liebowitz, 1993), studies found that generalized and nongeneralized forms did not differ qualitatively, and that "the two diagnostic subtypes of SAD belong to the same population of origin" (Aderka et al., 2012, p. 752).

Rather than focusing on generalization in SAD, the DSM-5 includes a specifier that denotes "performance only" fears (APA, 2013, p. 203), such as public speaking. Individuals with the performance only type of SAD typically are most impaired in professional work and do not experience fear in or avoid social situations not involving performance. Identifying other core fears within SAD, such as social interaction, being observed, and displaying anxiety symptoms (particularly blushing) has been of some interest (Bögels et al., 2010). Methods for understanding idiographic core fears and individual differences in symptom presentation within SAD have been proposed (e.g., Moscovitch, 2009) and are part of a conceptual approach to SAD that clarifies the definition and nature of the disorder. Additionally, this conceptual approach seems to have particular heuristic value for future dimensional classifications, which might assess, among other points, the functional aspects of social situations that engender anxiety.

The interaction of Social Phobia and APD has been the subject of great interest; the relation of these states has had more focus in the APD literature than any other (Mendlowicz, Braga, Cabizuca, Land, & Figueira, 2006). The criteria for APD outlined in the DSM-5 are identical to those in DSM-IV-TR. Of the seven criteria for APD in the DSM-5 (APA, 2013), six describe a social interactional component. In addition to these criteria, the DSM-5 includes a proposed research model for diagnosis and conceptualization of personality disorders. Under this alternative system, the diagnostic criteria for APD are organized differently than in the DSM-IV-TR; however, the very strong focus on social interaction is retained. Indeed, the criteria for APD in the new model require pathological personality traits in the negative affectivity domain for a diagnosis, specifically anxiousness often in relation to social situations (APA, 2013). While comorbidity rates for SAD and APD vary (Alden, Laposa, Taylor, & Rider, 2002; Bögels et al., 2010; Heimberg et al., 1993), they are generally substantial (Cox, Pagura, Stein, Sareen, 2009; Friborg, Martinussen, Kaiser, Øvergård, & Jan, 2013). It should not be expected, however, that a high percentage of individuals with SAD also would be classified with APD, given the likelihood of a continuum of severity in SAD. Only some minor percentage of those individuals with (severe) instantiations of SAD also would meet criteria for APD. While most studies find substantial overlap between SAD and APD (e.g., Hofmann, Newman, Becker, Taylor, & Roth, 1995), including an early collection of three studies and an overview devoted specifically to the topic

(Herbert, Hope, & Bellack, 1992; Holt, Heimberg, & Hope, 1992; Turner, Beidel, & Townsley, 1992; Widiger, 1992), as well as a review (Alden et al., 2002), there are some inconsistencies (Tran & Chambless, 1995).

Overall, there is little support for the idea that APD describes a disorder that is qualitatively different from SAD (e.g., Boone et al., 1999; Hofmann et al., 2004). Data suggesting that a diagnosis of APD adds significant clinically relevant information for individuals with SAD, over and above the SAD diagnosis, is minimal (Marques et al., 2012). APD primarily seems to describe a distinction that is quantitative in nature (Alden et al., 2002), as noted in the DSM-5. Individuals who also meet criteria for APD in addition to SAD are more severely affected by social fears and anxieties. Nevertheless, that conception may not paint a complete picture, in that other qualities, even features of the schizophrenia spectrum disorders (Bögels et al., 2010), may demarcate APD. Additionally, other distinguishing features of APD may be the likelihood of using avoidance as a coping strategy (Taylor, Laposa, & Alden, 2004), personality patterns such as degree of rigidity, and ambivalence about the positive aspects of interpersonal interactions. The approach–avoidance gradient in social anxieties and fears may be a particularly important one, given that it is much more difficult to avoid entirely certain core aspects of social anxieties and fears, primarily interactional fears and secondarily, observational fears. (Performance-based fearful situations may be somewhat easier to avoid, in general.) It is the perseverative avoidance, in spite of social costs (e.g., lack of social support and even outright rejection) and at the same time the difficulty or impossibility of completely avoiding the target of social anxiety and fear, that distinguishes SAD from other DSM Phobic Disorders, and which may distinguish the severity of APD from other SAD(s).

Understanding the forms of SAD and their relation to one another depends in part upon a broader conceptualization of both nonpathological and psychopathological forms of such behavior in social anxiety. Hofmann et al. (2004) introduce important dimensions to consider in conceptualizing SAD, including fearfulness and anxiousness, shyness and self-consciousness, as well as submissiveness and anger. Figure 1.1, as noted earlier, presents a proposed model of a continuum of social anxieties and fears across the population. Related constructs such as shyness span across "normal" to high "normal" to psychopathological levels of social anxiety, with the assumption that there is overlap across a gradient (cf. Turner, Beidel, & Townsley, 1990). The most extreme types of these behaviors are labeled as SADs, which broadly affect social functioning, or specifically affect social performance, such as public speaking.

CULTURAL AND DEVELOPMENTAL CONSIDERATIONS

Cross-national and cross-cultural differences in the conceptions, manifestations, and societal responses to social anxieties and fears highlight the need to understand the connectedness of intensity levels of such concerns across continua.

Which behaviors are considered "typical" and which ones are regarded as "abnormal" or "pathological" differ across groups. Social anxieties and fears, as well as SAD, exist internationally (Hofmann, Asnaani, & Hinton, 2010; Hong & Woody, 2007), across cultures, broadly defined. While there are many similarities across groups, there are disparate aspects as well, including unique, culturally-specific manifestations of social anxiety that go beyond DSM and other Western society conceptualizations. The Māori of New Zealand, for example, have the concept of *whakamā*, which involves shyness, embarrassment, and feelings of inadequacy, but also feelings of shame and being unsettled (Metge & Kinloch, 1978; Sachdev, 1990). A severe variant of this condition involves *whakapeke*, which is running away and hiding (Metge & Kinloch, 1978); this latter response may be akin to avoidant behavior observed in SAD in other cultural groups.

Epidemiological investigations have focused on factors such as nationality, culture, race/ethnicity, sex and gender, age, socioeconomic status, and urban–rural distinctions, both in terms of social anxieties and related disorders. This area of research is beset with a lack of clarity, however, regarding whether social anxiety is being evaluated (typically through self-reports), or whether impairment and life disruption due to social anxiety is being assessed (to diagnose a SAD). The heterogeneity of social anxieties, changing definitions of social phobia and SAD over time, inconsistency in assessment instruments across studies, and the lack of attention as to whether investigations focus on social anxiety in general or SAD in particular, all contribute to inconsistencies in the current epidemiological knowledge base.

Social anxieties, at both typical and pathological levels, are socially conceived, experienced, and expressed differently across nations and cultures (Caballo et al., 2008; Lewis-Fernández et al., 2010). There appears to be consistency in the conclusion that social anxieties are more frequently indicated on self-report scales in East Asia relative to the USA and Europe (e.g., Okazaki, Liu, Longworth, & Minn, 2002). Collectivist cultural orientations in East Asia (versus individualism in the latter areas) may help explain the functions of nonpathological social anxiety in these cultures in promoting sensitivity to others and awareness of one's social impact. These differences in reported social anxiety appear to be mediated by unique social values and views of the self across Eastern and Western cultures (Hong & Woody, 2007). Conversely, the rate of SAD in East Asian cultures is markedly lower than in certain other countries (e.g., Brazil, Chile, Russia, USA) (Hofmann et al., 2010; Lewis-Fernández et al., 2010). SAD also may be diagnosed more often in distinct cultural groups (e.g, Native Americans in the USA, Udmurts in the Russian Federation) than the other constituent groups in some nations or regions (Hofmann et al., 2010; Lewis-Fernández et al., 2010). The differences in SAD prevalence may be related to unique social pressures on these cultural minority groups, or more likely to bias in measurement or inapplicability of the diagnostic criteria to those groups (Lewis-Fernández et al., 2010).

Allocentric anxieties, focused on one's social effect on others, are observed in *taijin kyofusho* (TKS, from the Japanese) among East Asian cultural groups (Hofmann et al., 2010; Lewis-Fernández et al., 2010). It is described as a Cultural Syndrome in DSM-5. TKS has been of great interest in the SAD literature, given its similarities to and general consistency with DSM and ICD classifications. TKS appears to be of two subtypes, one of which partially overlaps with SAD, but which also has more allocentric qualities. In the other variant, the offensive subtype (Choy et al., 2008), there is anxiety about offending or embarrassing another person by one's appearance or behavior, including physiologically based bodily functions such as emitting intestinal gas. An associated olfactory response syndrome has been specifically identified, in which there is concern about emanating noxious body odor (Lewis-Fernández et al., 2010).

In terms of other epidemiological considerations, there are data to suggest that people in rural areas report more social anxiety than their urban counterparts (Grant et al., 2005; Pakriev, Vasar, Aluoja, & Shlik, 2000) which may be testimony to learned responses (see Chapter 15 on basic behavioral mechanisms and processes), perhaps through social skill development on the basis of experience, through exposure that reduces anxiety, or other mechanisms. Greater and lesser population density may impact opportunities for such social learning to occur. Additionally, lifetime prevalence of social fears or anxieties appear to be similar between developed and developing countries (Stein et al., 2010). Consistent with the previous discussion of the reports of social anxieties *vis a vis* SAD diagnoses, the diagnostic prevalence of SAD is significantly higher in developed countries, compared to developing countries (Stein et al., 2010).

In considering sex and gender, the distinctions and different prevalence rates across self-reported social anxieties and diagnosed SAD (or related disorders) are further complicated by potentially different rates of treatment-seeking behavior. Areas to be considered between the sexes, then, are the prevalence of: (a) self-reported social anxiety and fear, (b) diagnosed SAD across population groups, and (c) patients reporting for and/or receiving treatment for SAD. Some earlier literature suggested males and females were more similar in prevalence of reported social anxieties and social phobia/SAD, relative to other types of anxieties and disorders. In fact, it was suggested in the past that more males than females may evidence clinically significant social anxieties (e.g., a higher prevalence of a social skill deficit type of social phobia; Marks, 1985), although the literature was equivocal in this regard.

More recently, there are a variety of data (e.g., Caballo et al., 2008; Stein, Walker, & Forde, 1994) indicating that, relative to males, females report greater intensity of social anxieties and a broader range of distressing social situations, although males indicate more anxiety than females in certain situations, and in other situations there are no differences. The literature has become directed toward a finer grain analysis of sex differences, beyond that of simply assessing overall social anxiety intensity levels, and focusing on specific types of social situations (e.g., asking for directions), as they may be experienced differently

by males and females, based on social role and other factors (Turk et al., 1998). Sex differences in social anxieties and fears exist in many nations and cultures internationally, including Hispanic groups, and may be more pronounced in younger age groups (Caballo et al., 2008). Similarly, more females than males are diagnosed with SAD in the USA (Xu et al., 2012); this difference also has been demonstrated in some international groups (e.g., Europeans [Wittchen & Jacobi, 2005] and specific Russian groups [Pakriev et al., 2000]). Lifetime prevalence estimates of SAD in the USA indicate that more women than men are afflicted with this disorder (Kessler et al., 2012). This sex difference appears to exist regardless of type of social phobia (Kessler et al., 1998), and may be greater in younger cohorts (Hofmann et al., 2010; Kessler et al., 2012). Interestingly, the available data from specialty anxiety clinics in the USA suggest that there is an equal representation of male and female patients receiving treatment for SAD (Turk et al., 2008). Given the greater preponderance of social anxieties and fears, as well as diagnosed SAD among women, the female:male distribution in the SAD patient population in the USA is all the more noteworthy. Nevertheless, international data are not uniform in this regard, suggesting the possibility of cross-national, and likely cultural, differences in the distribution of females:males in SAD clinical populations (de Menezes, Fontenelle, & Versiani, 2006).

In spite of a number of differences across the sexes, social fears and anxieties and SAD are unique in that females and males typically differ less, in comparison to many other types of anxiety and fear, in which the female to male ratio is much higher. The evidence suggesting equal representation of males and females in specialized anxiety clinic samples, therefore is interesting, and deserving of further scientific scrutiny. Studying sex and gender differences in social anxiety and SAD, gender role, gender role identification, and sexual orientation all are important to consider (Hofmann et al., 2010), as are social role, expectations, and status associated with each sex.

In relation to age, socially-based anxieties and fears (e.g., separation anxiety) are experienced very early in life, continue throughout the lifespan, and may vary across adulthood as well (Ciliberti, Gould, Smith, Chorney, & Edelstein, 2011). Thus, extreme manifestations of such anxieties, in the form of SAD, often begin in the mid-teens or even early childhood (Hofmann & Barlow, 2002). The diagnosis of SAD likely can be reliably rendered as early as age six (Bögels et al., 2010). As explicated in the DSM-5, childhood and adolescence may be particular developmental periods in which transient social anxieties appear. Nevertheless, social anxieties can appear at various points in the developmental course of life, as in the case of older adults in the USA (and presumably in other Western cultures), whose social anxieties may be related to appearing socially competent, successfully navigating health care visits, being noticed as having a good memory or as being forgetful, and asking for help from others (Gould, Gerolimatos, Ciliberti, Edelstein, & Smith, 2012).

COVERAGE ACROSS DISCIPLINES AND SUBDISCIPLINES

Hope, Gansler, and Heimberg (1989), focusing on social phobia, noted that the high degree of specialization in psychology and related areas deters "cross fertilization" (p. 49) across disciplines and subdisciplines. Contributions from personality psychology and social psychology are obvious, even when their terms (e.g., *shyness)* differ from those popular in clinical and counseling psychology arenas. Psychiatry certainly brings important perspectives, particularly the emphases on biological antecedents and approaches. Other areas, such as *communication apprehension* in the communications arena, are less often considered, but still deal with much of the same subject matter (e.g., Booth-Butterfield & Cottone, 1991; McCroskey, 2009; Richmond & McCroskey, 1998). Other behavioral/mental health disciplines such as social work and counseling also figure importantly in terms of the treatment of individuals with social anxiety that is of problematic proportions. Moreover, evolutionary biology and ethology have contributed immensely to this area, focusing on dominance/submission behavioral patterns, defensive systems, and gaze. These constructs have been extremely provocative in terms of understanding present-day human social behavior (Mineka & Zinbarg, 1995; Suomi et al., 2011; Trower, Gilbert, & Sherling, 1990). Finally, anthropology, sociology, and cultural studies can bring an important perspective in terms of the behavior of groups, which has obvious implications for understanding social anxieties in individuals. The knowledge base, theoretical perspectives, and methods for acquiring information from each of these fields, when considered together, offer a tremendous opportunity for a comprehensive conceptualization and understanding of social anxieties and fears, broadly defined. There are strong arguments, therefore, supporting multidisciplinary approaches, and a cross-disciplinary nomenclature, in the area of social anxieties and fears, as well as their psychopathological disorders.

SUMMARY AND CONCLUSIONS

The future understanding of the continua of social anxieties and fears, and their related disorders, will best be served by a dimensional analysis. This approach should be based on the concept that social anxieties and fears exist along a continuum that includes pathological extremes in SADs. Work with problem levels of social anxiety and fear invites an RDoC analysis (NIMH, 2013); the social nature of SAD allows analysis of observable behaviors, with substantial opportunities to study neurobiological measures. Understanding the distinctive nature, and similarities, of social fears and social anxieties may provide one basis for understanding SAD dimensionally (McNeil, Vrana, Melamed, Cuthbert, & Lang, 1993).

Social anxieties, fears, and their disorders have many faces. Since the early writings of Marks (e.g., 1970; Marks & Gelder, 1966), behavioral and health scientists have studied the varied dimensions of these problems, which can be debilitating and severely limiting in the extreme. Conversely, situationally restricted and mild to moderate levels of social anxiety can be highly transient,

may prompt social sensitivity in uncertain situations, and can even be stimulating in a positive way, such as when one is about to give a speech in accepting an award or when a young person telephones to ask for a date with someone he or she finds attractive. These gradients of social anxieties also give us glimpses of what it is that makes us uniquely human.

This area of investigation is, in many respects, fully mature. It long ago arrived as a *bona fide*, accepted, and independent area of study. Now, there is a risk of future stagnation, unless there are new approaches, such as the RDoC initiative, and new areas of investigation. SAD once was dubbed the "neglected" anxiety disorder (Liebowitz, Gorman, Fyer, & Klein, 1985), and the relative coverage was considered less than some other problems with anxiety. While it was no longer considered "neglected" about 25 years ago, (Heimberg, 1989), significant work remains in regard to classifying SAD, recognizing the relation between typical social anxieties and SAD, and the link between SAD diagnosis and SAD type with treatment.

Revisions to the SAD definition and diagnostic criteria incorporated in the DSM-5 indeed represent a shift toward more concretely defining the disorder based on available data. For instance, the "performance only" designator acknowledges the existence of "circumscribed" SAD in describing public speaking phobia and other specific Social Phobias. Still, additional changes are needed in the DSM and ICD diagnostic systems, particularly so that dimensional analyses are more the norm than categorical diagnoses. Much work lies ahead in this regard. The relation between SAD and APD was not resolved with the DSM-5. Clarifying the conceptualizations of these disorders is a necessary, even critical next step; perhaps APD is unnecessary as a categorization (Hofmann et al., 2004). Avoidant behaviors of all kinds are of great importance; such manifestations should be investigated in their own right, independent of the personality disorder designation (Hayes et al., 1996).

Volumes such as this one help to organize, synthesize, and advance the state of knowledge about social anxieties, social fears, and SAD(s). The accumulated knowledge base in the social anxieties and fears area over 40 or more years is considerable. It clearly is past time, therefore, for the evolution of a common nomenclature (Gray, 1991) that can be used across disciplines and theoretical and other orientations, as well as a dimensional classification scheme for SAD. While the DSM diagnostic nomenclature likely has been enhanced with the new DSM-5, further conceptual work on the dimensional aspects of SAD still are necessary. Multinational, multicultural, and transdisciplinary approaches are needed, prompting greater sharing of knowledge throughout related fields, and more collaborative work across disciplines.

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