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Screening for social fears and social anxiety disorder in psychiatric outpatients

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Abstract

The ability of a diagnostic interview to identify all individuals with a particular psychiatric disorder depends, in part, on the performance of the interview's initial screening questions. The Structured Clinical Interview for the *Diagnostic and Statistical Manual, Fourth Edition* (SCID) is the most widely used research diagnostic interview, yet little research has examined the performance of the SCID screening questions. Because social anxiety disorder (SAD) is one of the most frequent psychiatric disorders, we examined the performance of the SCID screening question in the SAD module to detect social fears and SAD. The incremental validity of a more comprehensive list of social fears was examined by determining how many patients were diagnosed with SAD in those who were originally missed by the SCID screening question. Five percent of those originally missed by the SCID screening question subsequently received a lifetime diagnosis of SAD, and there was a significant increase in the prevalence of social fears after patients were cued by the social fears list. The most commonly reported fears missed by the SCID screening question included speaking in a group, with sexually attractive others, and with authority figures. Results suggest that perhaps these fears could be added to the SCID screening question to capture individuals missed by the SCID screening question and to provide more comprehensive information for treatment purposes.

1. Introduction

Social anxiety disorder (SAD) is an excessive fear of social or performance situations in which embarrassment or humiliation may occur [1]. It is typically characterized by avoidance of these situations and is often associated with marked impairment in several areas, including work, social life, and family life [2,3]. Epidemiological studies indicate that SAD is the fourth most common psychiatric disorder, after major depression, alcohol abuse, and specific phobia, with a lifetime prevalence rate of 12.1% [4].

Although prevalence rates of SAD are high in epidemiological samples, studies using treatment-seeking samples have shown that SAD is often underrecognized in routine clinical practice [5-8]. For example, Zimmerman and Mattia [8] found that the prevalence of SAD was nearly 9 times higher in patients given a semistructured diagnostic interview compared with those assessed with an unstructured clinical interview (28.6% vs 3.2%, respectively).

Most screening questions in structured and semistructured interviews assess only a few possible social concerns. For example, the National Comorbidity Survey used the Composite International Diagnostic Interview [9] to examine the prevalence of 6 social fears in a representative general population epidemiological study of adults aged 18 to 55 years [10]. Public speaking was the most frequently reported anxiety-provoking situation (30%). "Talking to others" had a prevalence rate of 13%; writing in front of others, a rate of 6%; and eating/drinking in front of others, a rate of 3%. One limitation of this study was the use of a brief list of social fears, and only 1 of the 6 social fears assessed interactional fear ("fear of talking to people because you might have nothing to say or might sound foolish").

The Structured Clinical Interview for the *Diagnostic and Statistical Manual, Fourth Edition* (SCID) [11] is one of the most widely used diagnostic interviews. Therefore, it is important to know how well it assesses social fears and lifetime history of SAD. The SCID screening question for

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the SAD module states: "Was there ever anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?" If an individual responds negatively to this question, then the SAD module is discontinued. One potential limitation of the SCID screening question is that it assesses fears such as eating or writing in front of others, which previous research using self-report measures (eg, Turk et al [12]) and a more recent study from the National Comorbidity Survey Replication [3] have shown are the least frequently reported or severe social fears. In addition, individuals with SAD may not fear performance situations, such as public speaking, but may significantly fear interactional social situations, such as having conversations with strangers. Therefore, the SCID screening question may not be adequately assessing social fears common to those with SAD, and as a result, diagnoses of SAD may be underestimated. However, no known published studies to date have examined whether the SCID screening question sufficiently identifies the presence of social fears and SAD diagnoses.

Although more time consuming, it may be important to inquire for SAD using a more comprehensive list of social situations than the typical 3 situations included in the SCID screening question because this may reduce the number of missed diagnoses and provide additional clinical information. In fact, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* recommends: "Because individuals with Social Phobia often do not spontaneously report the full range of their social fears, it is useful for the clinician to review a list of social and performance situations with the individual" [1] (p. 413). We are not aware of any published studies that have examined the performance of the SCID screening question compared with a more comprehensive list of social fears in identifying individuals with SAD. In addition to reducing underdiagnosis, it may be helpful to gather a more comprehensive list of social fears while using a semistructured interview, such as the SCID, to determine specific fears that should be addressed in treatment.

The aims of the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services project were to: (1) examine the performance of the SCID screening question in identifying social fears and lifetime history of SAD in psychiatric outpatients; and (2) examine the incremental validity of a more comprehensive list of social fears, by calculating the number of individuals who responded negatively to the SCID screening question but who endorsed at least 1 social fear and subsequently met full criteria for SAD. On the basis of previous studies suggesting that eating and writing in public are not the most frequently reported fears in patients with SAD, we hypothesized that using a more comprehensive list of social fears after the SCID screening question would result in a significant increase in the number of patients meeting criteria for SAD. Finally, exploratory analyses were conducted to examine differences in clinical presentation between those who were and were not missed by the SCID screening question.

2. Method

2.1. Participants

Participants included psychiatric outpatients presenting for treatment at the outpatient practice of the Rhode Island Hospital Department of Psychiatry. Five percent of patients approached for the study declined participation, with a resulting sample size of 1800. The sample consisted of 1106 (61.4%) women and 694 (38.6%) men, ranging in age from 18 to 80 years (mean = 37.7 years, SD = 12.6 years). Most of the sample was white (n = 1571; 87.3%), followed by African American (n = 73; 4.1%), Portuguese (n = 65; 3.6%), Hispanic (n = 48; 2.7%), other ethnicities (n = 29; 1.6%), and Asian (n = 14; 0.8%). The marital status of the participants was as follows: married (n = 735; 40.8%), never married (n = 558; 31.0%), divorced (n = 250; 13.9%), separated (n = 119; 6.6%), living with their partner (n = 106; 5.9%), and widowed (n = 32; 1.8%). More than half of the sample (n = 1136; 63.1%) had a high school degree or equivalency, 10.8% (n = 194) had less than a high school degree, 18.6% (n = 335) received a 4-year college degree, and 7.5% (n = 135) received a graduate/professional degree. The most frequent current *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* Axis I diagnoses (other than SAD) were major depression (46.0%), generalized anxiety disorder (17.7%), panic disorder with agoraphobia (14.3%), posttraumatic stress disorder (12.4%), specific phobia (10.5%), obsessive-compulsive disorder (7.9%), alcohol abuse (7.9%), and dysthymia (7.0%).

2.2. Measures

Individuals presenting for an intake appointment were asked to participate in a diagnostic evaluation before meeting with their treating clinician. Patients provided informed, voluntary, written consent, and all procedures were approved by the institutional review board at Rhode Island Hospital. The SCID [11] was used for the diagnostic evaluation. All patients were evaluated with the full SCID. Diagnosticians were research assistants with bachelor's degrees in social or biological sciences, as well as doctoral-level clinical psychologists. They were trained for a period of 3 months, which included reviewing written cases, discussing item-by-item administration with the principal investigator (M.Z.), observing at least 5 interviews, and administering 15 to 20 interviews while being observed and supervised. Diagnosticians were then required to demonstrate exact or near-exact interrater reliability with a senior diagnostician for 5 consecutive interviews. They also received ongoing supervision of interviews via a weekly case conference.

Interrater reliability information was collected over the course of the entire project. From the 48 joint-interview reliability evaluations, the reliability of SCID-based