



Functional impairment in social anxiety disorder

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ABSTRACT

The present study examined functional impairment among treatment seekers with social anxiety disorder (SAD). We investigated the effects of diagnostic subtypes of SAD and comorbidity with mood and anxiety disorders on impairment. In addition, we used cluster analysis procedures to empirically identify subgroups of individuals with distinct patterns of impairment. Participants were 216 treatment-seeking individuals with SAD. Clinical interviews were undertaken to determine diagnoses of anxiety disorders and major depressive disorder, and a battery of self-report measures was administered to index symptoms of social anxiety, depression and extent of impairment. Results indicated that individuals with the generalized subtype of SAD had greater impairment in all three life domains compared to individuals with the nongeneralized subtype. Comorbidity with mood disorders was associated with greater impairment than SAD alone, but comorbidity with anxiety disorders was not. Four distinct impairment profiles emerged from the cluster analysis: primary work/studies impairment, primary social life impairment, both work/studies and social impairment, and impairment in all domains. Findings from this study suggest that SAD is associated with substantial impairment across multiple domains, and that individuals with SAD present diverse impairment profiles. These profiles may inform subtyping of the disorder as well as therapeutic interventions.

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Social anxiety disorder (SAD) is associated with significant disability, impairment and reduced quality of life (Alonso et al., 2004; Kessler, 2003; Mendlowicz & Stein, 2000; Schneier et al., 1994; Stein, Torgrud, & Walker, 2000). Individuals with SAD have been found to be more financially dependent (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992), underemployed (Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 2000), less productive at work (Wittchen et al., 2000), and underpaid (Stein et al., 2000), compared to those without the disorder. In addition, SAD is associated with educational impairment (Schneier et al., 1994), with individuals with SAD being more likely to fail a grade or drop out of school (Stein & Kean, 2000) compared to individuals without the disorder. Finally, individuals with SAD have been found to have impairment in close relationships (Davila & Beck, 2002), including romantic relations (Sparrevoth & Rapee, 2009), friendships (Davila & Beck, 2002; Schneier et al., 1994), and family relations (Schneier et al., 1994) compared to individuals without SAD. Even when

compared to other psychiatric disorders, the impairment caused by SAD is very high, with SAD being among the 5 most impairing psychiatric disorders (Alonso et al., 2004).

Whereas evidence suggests that SAD is associated with impairment across numerous areas of functioning, certain life domains may be more strongly impaired by SAD than others (Wittchen et al., 2000). Specifically, there is evidence that SAD impairs work, studies, and social life, more than family life (Wittchen et al., 2000).¹ Similar findings have emerged in studies comparing impairment across the anxiety disorders. For instance, SAD is associated with more educational and social life impairment and less family life impairment compared to other disorders (Lochner et al., 2003; Quilty, Ameringen, Mancini, Oakman, & Fervolden, 2003).

The reduced impairment in family life is consistent with cognitive models of SAD (Clark, 2005; Hofmann, 2007; Rapee & Heimberg, 1997) which identify conditional beliefs about consequences of social behavior as pivotal in maintaining the disorder

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¹ In the Wittchen et al. (2000) study, different facets of impairment were compared among individuals with SAD (within-subjects), so no comparison group was used.

(e.g., “If I disagree with someone, they will reject me”, “If people get to know me, they won’t like me”). In a family context, these beliefs may not be as prevalent as in other life domains and thus may not result in enhanced processing of the self as a social object. In addition, exposure to feared social situations reduces SAD symptoms (e.g., Clark, 2005) and one usually interacts with family members often, potentially leading to reduced symptoms and impairment in the family context.

Several factors have been found to affect functional impairment among individuals with SAD. There is evidence to suggest that individuals with the generalized subtype of SAD have greater impairment compared to individuals with the nongeneralized subtype² (Kessler, Stein, & Berglund, 1998; Stein & Kean, 2000; Stein et al., 2000; Wittchen, Stein, & Kessler, 1999). Specifically, individuals with the generalized subtype report greater dysfunction in work, other daily activities, interpersonal relationships, and school, compared to individuals with nongeneralized SAD (Stein & Kean, 2000). Other studies have suggested that the generalized subtype is associated more with fear of interpersonal situations, whereas the nongeneralized subtype is associated more with fear of performance situations (Cox, Clara, Sareen, & Stein, 2008; Stemberger, Turner, Beidel, & Calhoun, 1995). When considered in the context of impairment, these patterns of symptoms may suggest that social impairment may be more pronounced in the generalized subtype whereas work and academic impairment may be more pronounced in the nongeneralized subtype. In addition, several studies have found that comorbidity with major depressive disorder is associated with increased impairment among individuals with primary anxiety disorders (Barrera & Norton, 2009; Bourland et al., 2000; Lochner et al., 2003) but comorbidity with additional anxiety disorders is not (Norberg, Calamari, Cohen, & Riemann, 2008; Norberg, Diefenbach, & Tolin, 2008).

One potential explanation for increased impairment when SAD is comorbid with mood but not anxiety disorders, may be related to the structure of anxiety and depression. According to the tripartite model of anxiety and depression (Clark & Watson, 1991; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995), depression and anxiety have common factors (e.g., negative affect), but also unique factors (e.g., hyperarousal for anxiety and anhedonia for depression). Thus, the combination of anxiety and depression may include symptoms from all three factors, thus increasing the impairment, whereas comorbidity of anxiety disorders may include symptoms from only two of the factors (i.e., negative affect and hyperarousal). This may result in the increased impairment in comorbid anxiety and depression.

The present study builds on previous research by examining impairment associated with SAD in a treatment-seeking population. First, we investigated the phenomenology of impairment, as well as its relationship to diagnostic subtypes of SAD and comorbid conditions. Second, we used cluster analysis to identify empirically based and clinically meaningful groups of treatment seekers with differing impairment patterns. This can provide important information regarding the nature and extent of the impairment associated with SAD, and may inform the development of intervention strategies.

We hypothesized that (a) individuals with SAD would have higher levels of work/studies and social life impairment compared to family life impairment, (b) individuals with the generalized subtype of SAD would have greater overall impairment compared to individuals with the nongeneralized subtype, (c) individuals with the generalized subtype would have greater impairment in

social life compared to work/studies and family life, and individuals with the nongeneralized subtype would have greater impairment in work/studies compared to social life and family life and (d) comorbidity with mood (but not anxiety) disorders would be associated with higher impairment levels. Finally, we explored whether treatment-seekers could be divided into empirically supported groups with different impairment profiles.

1. Method

1.1. Participants

The sample included 216 individuals who sought treatment at the Anxiety Disorders Unit at Geha Mental Health Center in Israel over a four-year period. The unit is part of a psychiatric hospital which provides cognitive behavioral treatments for outpatients with anxiety disorders. All participants were diagnosed with primary SAD according to DSM-IV criteria, using the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). The mean age of participants was 35.26 years ($SD = 10.06$), and the mean age of onset of SAD was 12.42 ($SD = 7.19$). Thus, participants had SAD for an average of 22.84 years ($SD = 12.20$) prior to seeking treatment. Over half of the participants ($n = 120$; 55.56%) had a comorbid diagnosis in addition to primary SAD, with 88 (40.74%) having an anxiety disorder and 49 (22.69%) having a mood disorder. Of the total sample, 175 participants (81.02%) had the generalized subtype of SAD, and 41 (18.98%) had the nongeneralized subtype.

Participants were included in the present study if they were between 18 and 60 years of age, had sufficient knowledge of the Hebrew language, and did not have a current or past history of psychosis.

1.2. Procedure

To establish diagnoses, participants were interviewed using the MINI by Ph.D.-level clinical psychologists or experienced graduate psychology students. The sub-diagnosis of generalized social phobia was based on DSM-IV criteria. Participants were diagnosed as suffering from the generalized subtype if they demonstrated fears and avoidance in most social situations. Otherwise, they were diagnosed as suffering from the non-generalized subtype.³ The diagnoses made by graduate students in the clinic have been found to be reliable and valid in a pilot study comparing them to those of a senior psychologist and a senior psychiatrist ($\kappa = 0.92$; Marom, Gilboa-Schechtman, Aderka, Weizman, & Hermesh, 2009).

Following the interview, participants who met criteria for SAD were approached by a research assistant. The assistant provided information about the study and offered participants to take part. Participants signed informed consent forms to indicate their willingness to participate in the study. Participants then filled out a battery of self-report questionnaires.

1.3. Measures

The Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998). The MINI is a widely used structured diagnostic interview based on DSM-IV criteria. It has been validated in relation to the Structured Clinical Interview for DSM (SCID) and the Composite

² Generalized SAD is assigned when individuals demonstrate fears and avoidance in most social situations. Nongeneralized SAD is assigned when individuals demonstrate fears and avoidance in several circumscribed situations.

³ Because the definition of diagnostic subtypes in the DSM is not quantitative, we also used an established cutoff point on the LSAS (LSAS = 60) to assign generalized and nongeneralized specifiers. We chose 60 on the LSAS as it has been found to be the ideal cutoff point in two independent studies (Mennin et al., 2002; Rytwinski et al., 2009). Results using the quantitative cutoff were identical to those obtained with the DSM-based diagnosis. Therefore we only report results based on DSM criteria.

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