

Fear and avoidance of eye contact in social anxiety disorder

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Abstract

Background: Excessive fear of scrutiny is a defining feature of social anxiety disorder. Eye contact may trigger feelings of being scrutinized, and although eye contact is commonly feared in persons with social anxiety disorder, it has been studied little. The purpose of this study was to characterize fear and avoidance of eye contact in patients with social anxiety disorder and in nonpatient samples.

Methods: Gaze fears and avoidance, social anxiety, and depression were assessed in 44 patients with generalized social anxiety disorder, 17 matched healthy comparison subjects, and 79 undergraduates. Patients were reassessed after 8 to 12 weeks of treatment with paroxetine. A new self-report instrument, the Gaze Anxiety Rating Scale (GARS), was used to assess fear and avoidance of eye contact, and its psychometric properties were analyzed.

Results: Patients with generalized social anxiety disorder, in comparison with healthy control participants, reported significantly increased levels of fear and avoidance of eye contact, which decreased significantly after 8 to 12 weeks of treatment with paroxetine. Fear and avoidance of eye contact were significantly associated with severity of social anxiety in all 3 samples. The GARS demonstrated excellent internal consistency within each sample.

Conclusions: Self-reported fear and avoidance of eye contact are associated with social anxiety in both nonpatient and social anxiety disorder samples. Preliminary psychometric analyses suggest that the GARS has utility in the assessment of gaze anxiety.

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Social anxiety disorder (SAD) is one of the most common psychiatric disorders, with a lifetime prevalence of 5% to 13% [1,2], and it frequently causes severe distress and impairment [3]. In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, SAD is defined by a persistent fear of “social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others,” and its generalized subtype (GSAD) involves fear of *most* social situations. Common measures of severity of social anxiety quantify fear and avoidance across a variety of social or public situations (eg, Liebowitz Social Anxiety Scale (LSAS) [4] or focus on severity of anxious states and interference with functioning in social interactions (eg, Social Interaction Anxiety Scale [SIAS]) [5]. Relatively little attention has been paid, however, to assessment of fear of eye contact, a fundamental form of scrutiny fears.

Available data suggest that fear and avoidance of eye contact may be an important feature of SAD. In factor

analyses performed in 3 SAD patient samples, the single “fear of eye contact” item of the 24-item LSAS loaded on the factor accounting for the most variance, consistent with an association with core features of the disorder [6–8]. Persons with SAD make less eye contact during social conversations, as observed by independent raters in laboratory studies [9]. In eye tracking studies, SAD subjects show less gaze fixations on the eyes of faces presented for 10-second periods [10–12]. This avoidance of gaze appears to have functional relevance in SAD, as it leads to loss of social information that might otherwise counter the disorder’s common biases that others will be critical and rejecting. Others may misinterpret gaze avoidance by the person with SAD as a sign of disinterest, diminishing opportunity for positive social interaction.

Gaze behavior also holds potential as a link to the underlying neurobiology of SAD because it can be measured objectively and studied across primate species. Fear and avoidance of gaze have been noted to be elements of submissive behavior seen across group-living species [13]. Human social anxiety has been suggested to relate to such submissive behaviors as part of an evolved defensive system [14,15].

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Despite a growing body of data on objective assessment of gaze behavior, little is known about the subjective experience of gaze aversion in patients with SAD and whether it differs from that of the general population. In nonpsychiatric samples, the gaze aversion that occurs while engaging in difficult cognitive tasks has been reported to be primarily related to decreasing the distracting cognitive load associated with the processing of visual environmental information, and social-emotional causes have appeared to be of secondary importance [16]. In persons with SAD, however, gaze aversion appears to be primarily related to regulation of social anxiety, but this relationship has not been systematically studied. In addition, it is not known whether social anxiety is the only social-emotional symptom associated with gaze aversion or whether other symptoms, such as depression, are also associated.

To begin to identify clinical correlates of fear and avoidance of eye contact, we developed the Gaze Anxiety Rating Scale (GARS), a self-report instrument. The purpose of this study was to characterize self-reported fear and avoidance of eye contact in nonanxious persons and in patients with GSAD, before and after treatment, and to assess the psychometric properties of the GARS. We hypothesized that patients with GSAD, compared with matched control participants, would report more fear and avoidance of eye contact and that this would decrease with treatment of GSAD. We also hypothesized that within GSAD and nonpatient samples, the GARS would demonstrate internal consistency, convergent validity with measures of social anxiety and submissive behavior, and divergent validity with measures of depression.

1. Methods

1.1. Participants

Participants consisted of 3 samples: GSAD patients, matched healthy comparison (HC) subjects with no psychiatric disorder (“supernormals”), and a student sample of undergraduates which provided complementary data that were more representative of young adults in the community. The student sample included 79 undergraduates who completed the GARS and other measures for credit or extra credit in psychology classes. This student sample has been reported on previously (eg, Rodebaugh and Heimberg [17]), but not in regard to the GARS. All student participants gave written informed consent and the protocols were approved by Washington University’s Institutional Review Board. The student sample was predominantly female ($n = 52$, 66%), with a racial distribution of 54 (69%) whites, 9 (12%) Asians, 5 (6%) blacks, 3 (4%) Hispanics, and 7 (9%) “other,” with a mean (SD) age of 19.3 (1.1) years.

The GSAD sample consisted of 44 patients pooled from participants who were entering either a clinical trial ($n = 26$) or a functional magnetic resonance imaging (fMRI) study ($n = 18$) that used the same entry criteria.

The HC participants ($n = 17$) had no lifetime psychiatric disorders and were matched by age and sex to the fMRI study patients. Diagnoses in GSAD patients and HC participants were made using the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [18]. All patients had a principal diagnosis of GSAD, without current major depressive disorder, substance use disorders, or lifetime bipolar or psychotic disorders, and they were free of psychoactive medications. Other current diagnoses were permitted if they were of secondary clinical severity to GSAD: 4 patients had comorbid generalized anxiety disorder, 2 had dysthymia, and 1 each had panic disorder and bulimia nervosa. Patients were reassessed after open label treatment (for 12 weeks in the clinical trial or 8 weeks in the fMRI study) with the serotonin reuptake inhibitor paroxetine, a Food and Drug Administration–approved treatment for SAD, and a randomly selected subset of 8 HC participants were reassessed after a time interval of 8 weeks. All of the GSAD patients and HC participants gave written informed consent, and the protocols were approved by the New York State Psychiatric Institute’s Institutional Review Board.

The GSAD patients and HC participants did not differ significantly in mean (SD) age (32.0 [11.2] vs 31.4 [10.8] years; $df = 59$, $t = 0.20$, $P = .84$), sex (52% vs 41% male; $\chi^2 = 0.64$, $df = 59$, $P = .62$), marital status (20% vs 12% married; $df = 59$, $P = .49$), or mean (SD) years of education (15.9 [2.3] vs 16.6 [2.1] years; $df = 57$, $t = 1.1$, $P = .27$). Racial distribution differed significantly between groups (Fisher exact test, $P = .011$). The GSAD patients included 26 (59%) whites, 3 (7%) blacks, 7 (16%) Hispanics, 6 (14%) Asians, and 2 (5%) “others,” whereas the HC participants included 13 (76%) whites, 0 (0%) blacks, 2 (12%) Hispanics, 1 (6%) Asians, and 1 (6%) “other.”

1.2. Assessments

Student participants completed the GARS and the SIAS, among other measures, in a single session lasting an hour or less. The GSAD patients and HC participants completed the GARS and a different battery of clinician-rated and self-rated assessments of social anxiety, depression, and submissive behavior, and the GSAD patients repeated the same assessments after 8 to 12 weeks of paroxetine treatment.

1.2.1. Gaze Anxiety Rating Scale (see Appendix)

This self-report scale was developed based on unstructured interviews with GSAD patients that were used to generate a list of 17 situations in which eye contact was frequently feared and/or avoided. Fear and avoidance of making eye contact in each situation are rated on a 0–3–point Likert-type scale (none, mild, moderate, severe), and scores are summed over the 17 situations to yield a fear subtotal, avoidance subtotal, and overall total scores. In this study, additional questions assessing associated cognitions and life course of gaze anxiety were administered only in the GSAD

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