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Clinical predictors of diagnostic status in individuals with social anxiety disorder

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Abstract

Objective: In psychiatric patients, comorbidity tends to be the rule, rather than the exception. This is especially true for patients with social anxiety disorder (SAD), but research on the implications of diagnostic status has been limited. This study aimed to examine the frequency of SAD as: (1) the only diagnosis, (2) a principal diagnosis with comorbid conditions, or (3) a comorbid condition when another diagnosis is principal in a treatment-seeking population. The study also sought to identify clinical features that distinguish people in these diagnostic groups.

Method: Our sample included 684 adult participants presenting for treatment in a specialty clinic for anxiety disorders. We established diagnoses with semistructured clinical interviews, and participants completed self-report measures of social anxiety, associated transdiagnostic symptoms, general distress, and impairment due to psychological difficulties. We analyzed group differences and investigated predictors of principal SAD diagnosis.

Results: Over half of participants reported symptoms that met criteria for a SAD diagnosis (51.8%). Of these, 8.8% had SAD only (no comorbid psychiatric diagnoses), 48.6% had multiple conditions with SAD as the principal diagnosis, and 42.7% had multiple conditions with SAD as an additional diagnosis. SAD-only was associated with less severe impairment and transdiagnostic symptoms. Among participants with comorbid conditions, greater fear of negative evaluation, behavioral avoidance, and coping with substances predicted a principal SAD diagnosis, whereas SAD as an additional diagnosis was more likely when participants presented with greater anxiety sensitivity, intolerance of uncertainty, and thought avoidance.

Conclusions: Our findings suggest that principal diagnosis of SAD is common in a treatment-seeking population and is associated with more severe disorder-specific symptoms and less severe transdiagnostic features related to anxiety. Implications for assessment and treatment planning in clinical practice are discussed.

1. Introduction

Social anxiety disorder (SAD) is the persistent, disproportionate fear of social or performance situations in which a person may be scrutinized or evaluated [1]. After major depressive disorder (MDD), alcohol dependence, and specific phobia, this condition is the fourth most prevalent psychiatric disorder, occurring in approximately 12.1% of people in their lifetimes [2]. However, this disorder very frequently co-occurs with other psychiatric conditions, and researchers are just beginning to understand reasons for this co-occurrence and implications of comorbidity for the presentation of symptoms, treatment response, and prognosis.

Epidemiological studies estimate about 80% [3–5] of people with SAD also experience a comorbid psychiatric condition, most commonly other anxiety disorders and MDD. In fact, in a sample of people seeking treatment in an outpatient psychiatric setting, researchers found that SAD was the

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principal diagnosis for only 4% of the 640 participants with a diagnosis of SAD in the sample [6]. Notably, this study defined principal diagnosis as the primary reason for the individual seeking treatment. This finding suggests that despite the symptoms of SAD being significantly impairing, few people with SAD actually describe it as their chief complaint. A number of retrospective and prospective studies have suggested that SAD typically precedes the development of other psychiatric conditions, like depression [e.g., 7–10]. Yet, we know little about differences among people for whom SAD is the most severe and impairing disorder and people who have a more severe psychiatric condition with SAD as an additional diagnosis.

Although a number of studies have investigated the frequency of comorbid conditions in SAD, only a few have examined clinical correlates of SAD with comorbid conditions compared to SAD only. People who have multiple psychiatric disorders usually report more severe symptoms, as well as greater distress and impairment compared to those who have SAD only [11,12]. This may be in part because those with co-occurring conditions may remain undiagnosed and thus untreated longer, leading to greater distress and impairment from social fears [13]. Additionally, people with SAD and another psychiatric condition are more likely to seek help and take medications to control their symptoms [14]. However, a study examining primary care setting interactions found people with SAD to mostly seek help for their comorbid psychiatric conditions, particularly depression [10]. Only 5.6% of people with SAD and without depression even mentioned psychological symptoms to their providers. Overall, psychiatric comorbidity has important implications for treatment seeking and provision of clinical care.

Given that the vast majority of people with SAD present for treatment with other psychiatric conditions, it is surprising that we know little about the clinical presentation of SAD when not the principal diagnosis. Several studies have examined differences in people for whom SAD precedes or follows another diagnosis temporally [e.g., 9,15]. However, precedence does not necessarily suggest greater severity or impairment. We sought to address this important gap in our knowledge of whether and how clinical features vary across cases where SAD is one of several diagnoses versus the principal diagnosis.

The present categorical diagnostic system described in the *Diagnostic and Statistical Manual of Mental Disorders* [1,16] has been criticized due to the significant overlap in symptoms, particularly across the anxiety and mood disorders [17,18]. Researchers have proposed hybrid models of disorders that propose disorders to have shared symptom dimensions as well as disorder-specific symptoms. The hybrid model of SAD [19,20] suggests that this condition shares some symptoms with other anxiety and depressive disorders (e.g., avoidance of unpleasant thoughts, anhedonia, using substances for coping, and functional impairment) but the severity of SAD would be determined by relatively unique features (e.g., behavioral avoidance of situations, fear of negative evaluation). According to this model, which has been replicated across analog and clinical samples [19,20], patients with SAD and comorbid diagnoses should present with high levels of nonspecific symptoms, whereas patients with a principal diagnosis of SAD should present with the highest levels of disorder-specific symptoms.

The aim of the present study was to compare symptom characteristics and demographic features of adults with (1) SAD only (no comorbid psychiatric diagnoses), (2) SAD as a principal diagnosis with co-occurring psychological conditions, and (3) SAD as an additional diagnosis when another disorder is principal. In particular, we sought to examine how diagnostic status relates to self-reported symptom dimensions related to SAD, symptoms associated with frequently comorbid conditions (e.g., depression), and transdiagnostic symptoms that are closely associated with other anxiety disorders. Specifically, we assessed for anxiety sensitivity, the tendency for people to misinterpret physiological symptoms of anxiety as dangerous; this construct is closely related to panic disorder [21]. We also measured intolerance of uncertainty, a discomfort with lack of certainty about future events; this construct is closely related to worry and generalized anxiety [22,23]. Based on available literature and clinical experience, we hypothesized that participants with comorbid conditions would exhibit greater levels of nonspecific psychological symptoms and impairment than those with only SAD. We also expected that participants with principal SAD would have higher levels of SAD-specific symptoms compared to those with SAD as an additional diagnosis.

2. Method

2.1. Participants and procedure

Participants included 684 psychiatric outpatients presenting for treatment in a Canadian university hospital clinic specializing in the assessment and treatment of anxiety disorders. The sample consisted of 263 men (38.5%) and 420 women (61.5%), ranging in age from 15 to 74 years (M = 36.30, SD = 12.71). Most participants self-identified as White (60.6%), followed by Asian (34.9%), Native-Canadian (1.8%), Black (0.7%), Hispanic (0.4%), and other ethnicities (1.6%). The marital status of the participants was primarily single (44.9%), followed by married (36.8%), cohabitating (9.7%), divorced (4.9%), separated (3.1%), and other (0.7%). The education status of the sample was as follows: less than high school degree (14.7%); high school degree or equivalent (40.5%); college degree (37.4%); at least some graduate or professional education (7.4%). Notably, several participants were missing demographic data about sex (n = 1), ethnicity (n = 7), education status (n = 8), and marital status (n = 4).