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Quality of life impairments among adults with social phobia: The impact of subtype

Nina Wong*, Dustin E. Sarver, Deborah C. Beidel

Department of Psychology, University of Central Florida, 4000 Central Florida Blvd, Orlando, FL 32816, USA

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ABSTRACT

Social phobia is characterized by extreme fear in social or performance situations in which the individual may be exposed to embarrassment or scrutiny by others, which creates occupational, social and academic impairment. To date, there are few data examining the relationship of social phobia impairments to quality of life. In this investigation, we examined how demographic characteristics, comorbidity, and social competence are related to quality of life among patients with social phobia and normal controls. In addition, we examined the impact of social phobia subtype. Results indicated that individuals with generalized social phobia had significantly impaired quality of life when compared to individuals with no disorder or individuals with nongeneralized social phobia. Comorbid disorders decreased quality of life only for patients with nongeneralized social phobia. Hierarchical linear regression revealed that a diagnosis of social phobia and observer ratings of social effectiveness exerted strong and independent effects on quality of life scores. Results are discussed in terms of the role of social anxiety, social competence, and comorbidity on the quality of life for adults with social phobia.

Contemporary theoretical (Wakefield, 1992) and nosological conceptualizations (Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision; DSM-IV-TR: APA, 2000) of psychological disorders require not only the presence of an extreme emotional or behavioral state but also the existence of functional impairment as a result of the clinical symptoms. In turn, functional impairment leads to decreases in overall quality of life (QOL), defined as the subjective experience of well-being, health status, life satisfaction, social relationships, economic status, and external life situations (Mendlowicz & Stein, 2000; Rapaport, Clary, Fayyad, & Endicott, 2005). QOL impairments have been documented among adults with various types of anxiety disorders (Mendlowicz & Stein, 2000; Mogotsi, Kaminer, & Stein, 2000; Quilty, Ameringen, Mancini, Oakman, & Farvolden, 2003).

One prevalent anxiety disorder, social phobia (SP), is a debilitating condition characterized by marked and persistent fear in social or performance situations in which the individual may be exposed to embarrassment or scrutiny by others. Adults with SP may experience functional impairment across occupational, social, and academic domains (DSM-IV-TR: APA, 2000). Initial investigations were descriptive in nature, indicating that SP is negatively related to education and income, and the disorder is significantly more common among never-married people, students, people who are neither working nor studying, and those who live with their parents (Kessler et al., 1994). Approximately half of people with SP report at least one significant functional limitation at some time in their lives (e.g., significant role impairment, professional help seeking, or use of medication). SP is also associated with low social support (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996), poor social networking, and impaired dating or romantic relationships (Schneier et al., 1994; Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 2000). When compared to adults with no disorder, people with SP report lower occupational attainment and income, restricted social relationships, greater marital discord and an increased risk for substance abuse (Bruch, Fallon, & Heimberg, 2003; Katzelnick et al., 2001; Keller, 2003; Kessler, 2003). Consistent with these initial descriptions, people with SP rate their QOL lower relative to standardization sample norms on QOL measures (Safren, Heimberg, Brown, & Holle, 1996/1997). Furthermore, subjective QOL ratings are significantly correlated with clinician ratings of functional impairment (Safren et al., 1996/1997). In addition, a recent meta-analysis indicates that SP is associated with significant impairments in QOL (Olatunji, Cisler, & Tolin, 2007), particularly in social functioning domains.

The above studies documented the existence of QOL impairments within a diagnostic group, representing an important initial step for understanding the impact of SP. A second set of studies examined QOL among individuals with SP relative to other anxiety disorders. Barrera and Norton (2009) found that individuals

* Corresponding author. Tel.: +1 407 823 3910; fax: +1 407 823 5862.
E-mail addresses: nwong@knights.ucf.edu, ms.ninawong@gmail.com (N. Wong), Dustin.Sarver@knights.ucf.edu (D.E. Sarver), Deborah.Beidel@ucf.edu (D.C. Beidel).

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with generalized anxiety disorder, SP, or panic disorder were all significantly less satisfied with their QOL relative to non-anxious adults, but there were no differences based on diagnostic groups. Lochner et al. (2003) also compared QOL among individuals with different anxiety disorders. Overall QOL impairments, based on self-report questionnaires, were similar across individuals with obsessive compulsive disorder, panic disorder, or SP. However, domain specific differences emerged among diagnostic groups. Individuals with obsessive compulsive disorder had greater impairment in family life and daily living; individuals with SP had greater impairment in social and leisure activities; and individuals with panic reported greater difficulty refraining from prescription drug use (Lochner et al., 2003). In addition to group differences in these specific areas, the proportion of patients with clinically significant QOL impairments (>2 *SD* below community norms) varied by diagnoses (Rapaport et al., 2005), suggesting that some diagnostic groups may be more or less impaired than others. Using the criteria of clinical significance, QOL impairments affected between 20% and 59% of people in the anxiety disorders group, including 21% of individuals with SP. SP was particularly associated with QOL impairments related to social and family relationships as well as leisure activities. Thus, although overall mean scores suggested functional impairment, this impairment is likely clinically significant for only a particular subset of individuals with SP.

The fact that people with SP have scores on QOL measures that are significantly lower than individuals with no disorder (Olatunji et al., 2007) but only a subset fall outside the range of scores for community groups may be reconciled by a closer examination of research design approaches and subject selection strategies. First, lower scores on self-report measures may represent statistical, but not necessarily clinical, significance. Depending on sample size, small numerical differences may be statistically significant but clinically meaningless. Second, normative data based on a community sample may skew the outcome. Community samples may contain individuals who suffer from psychological disorders, particularly when the disorder is as prevalent as SP (12% of the population; Kessler et al., 2005). In such instances, community samples may include people with clinical impairments and potential group differences may be obfuscated, with the magnitude of any existing effects minimized.

A third challenge complicating the ability to examine QOL among patients with SP is the existence of subtypes. The DSM-IV-TR distinguishes two SP subtypes: a generalized subtype (GSP) defined by widespread social interaction fears and behavioral avoidance, and a nongeneralized subtype (NGSP) where fears are limited to performance situations (e.g., public speaking). Although both GSP and NGSP subtypes have significant deficits in social skill relative to non-psychiatric controls, adults with GSP tend to demonstrate even greater deficits in skill and higher levels of anxiety in analogue social situations than adults with NGSP (Beidel, Rao, Scharfstein, Wong, & Alfano, 2010). Mounting evidence suggest that the deficits of the GSP subtype are more pronounced than the delimited NGSP subtype (Beidel & Turner, 2007; Beidel et al., 2010; Heimberg, Hope, Dodge, & Becker, 1990; Herbert, Hope, & Bellack, 1992; Kessler, Stein, & Berglund, 1998; Stemberger, Turner, Beidel, & Calhoun, 1995; Turner, Beidel, Borden, Stanley, & Jacob, 1991).

However, only two studies to date have examined QOL impairments between the GSP and NGSP subtypes (Pallanti et al., 2008; Safren et al., 1996/1997) and both of these studies have limitations. Compared to adult blood donors, adults with generalized SP experienced a lower QOL across a variety of domains (e.g., physical health, feelings, work, school/course work, leisure time activities, social relations, and general activities; Pallanti et al., 2008). Individuals with the performance-based subtype differed from controls only in the areas of physical health and leisure time. Direct comparison between the two subtypes, however, revealed significantly poorer QOL in the domain of feelings, a category that was ill defined. Furthermore, the use of blood donors as a control group represents a community sample but not a rigorously diagnosed group. In other words, it is unclear whether people with psychological disorders were included in this community group. The second study examining QOL in SP subtypes (Safren et al., 1996/1997) did not find significant differences in a sample of treatment seeking adults, although individuals with comorbid generalized SP and avoidant personality disorder reported lower QOL than individuals with nongeneralized SP. Neither of the two studies included a normal control comparison group nor examined differences in clinical significance.

An important element neglected to date in this research is that although there appears to be a relationship between SP severity and functional impairment (Eng, Coles, Heimberg, & Safren, 2005; Safren et al., 1996/1997; Simon et al., 2002; Stein, Torgrud, & Walker, 2000; Wittchen et al., 2000), symptom severity explained only 4% of the variance in QOL scores in one sample (Rapaport et al., 2005). This suggests that the impact of SP on QOL is not solely or even largely related to symptom severity, and may be a function of other clinically relevant variables including age of onset (which can lead to a more severe impairment if SP occurred very early in life), social circumstances (i.e., having a job which is not demanding in term of social performance), maladaptive coping mechanisms (i.e., avoidance of social performances/situations) and the presence of other comorbid diagnoses. Yet the impact of these factors on QOL for individuals with SP have not been determined.

In summary, despite the extant literature on functional impairment, significant gaps remain in our understanding of QOL among individuals with SP. First, there is a need to examine these variables using rigorously diagnosed participant groups (NGSP, GSP, and no disorder). Second, there is a need to understand the clinical impact of the disorder on QOL, not only statistically significant differences on self-report measures. Third, it is likely that poor QOL is not simply the result of clinical symptoms or symptom severity. Thus, this investigation examines the additive influence of demographic variables (i.e., age, gender, marital status, number of children, and racial background), behavioral observations of social performance, and clinical diagnosis of SP in predicting QOL in a sample of adults. Unlike previous studies, this investigation directly compares QOL among individuals with GSP versus NGSP subtype and normal controls (NC).

1. Method

1.1. Participants

Participants were recruited for a study to examine social behavior among people with either the GSP or NGSP subtype in comparison to NCs (Beidel et al., 2010). All potential participants completed a brief telephone screen to determine initial eligibility. Individuals who met the screening criteria completed an in person comprehensive assessment. Participants were interviewed by doctoral level psychologists or doctoral students in clinical psychology using the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1997) and the Structured Clinical Interview for DSM-IV Axis II (SCID-II; First, Gibbon, Spitzer, & Williams, 1997). Participants in the NC group did not meet criteria for any current or lifetime Axis I disorder. For the SP groups, the SP diagnosis had to be the primary diagnosis. Twenty percent of the diagnostic interviews were audio-taped and rated by a second clinician for the purposes of calculating inter-rater reliability. For the diagnosis of SP, inter-rater agreement was excellent ($k = .92$).