CHAPTER 1

What Is Social Anxiety Disorder?

Jacquie's Story

Jacquie, a single 22-year-old woman, described herself as having been a quiet and "bookish" child who enjoyed her own company. Her parents were both loving and supportive, and they had high expectations for her academic and social performance. Her mother always encouraged her to "put her best foot forward" and seemed disappointed with her shyness in social situations. Jacquie's father was more sympathetic and also seemed to prefer to stay at home with the family rather than socialize with others. When she was old enough, he would often allow Jacquie to stay home if the family was going to visit family or friends.

Jacquie attended a small local primary school before moving to a large high school when she was 13 years old, which she remembered as being a particularly difficult experience. She found it hard to make friends, and she remembered having to give formal presentations in front of the class for the first time, which she found terrifying. Jacquie tried to avoid these presentations by pretending to be sick, but her parents were both teachers and would always send her to school anyway.

Jacquie remembered one particularly traumatic presentation when she was 15 years old. She had dreaded speaking in front of the class for weeks beforehand as she had vivid images of herself stammering and then being paralyzed by fear. She knew that she blushed when she was embarrassed, so she imagined all her classmates laughing at her bright red cheeks. In her mind's eye, her peers could clearly see how awkward and incompetent she was, and she feared that the few friends she had managed to make would ridicule and reject her. On the day of the presentation Jacquie awoke feeling unwell and anxious. She recalled having a headache and feeling too nauseous to eat breakfast. Just

before her presentation her heart and thoughts were racing, her palms were sweaty, and she had a strong urge to escape.

Jacquie doesn't recall much about the actual speech itself other than the overwhelming sense of shame she felt about her performance. She had written her speech word for word so that she didn't forget anything, and so she could look down at the paper rather than see the weird looks she thought her classmates must have been giving her. She remembered stumbling over her words, having her mind go blank, and being on the brink of tears. She was sure that her voice was trembling and quiet. She sat down without making eye contact with anyone and felt humiliated.

Unfortunately for Jacquie the trauma didn't end when the presentation was over. She continued to ruminate about her poor performance in the hours, days, and weeks afterwards. She repeatedly criticized herself, asking herself why she was so stupid. In the years that followed, negative thoughts and images of how she must have looked during the presentation came to mind every time Jacquie thought she was the focus of attention (e.g., when eating or drinking in public, or even walking down the street). Jacquie believed this image warned her of imminent humiliation and occasionally caused her anxiety to escalate to the point where she would have a panic attack.

Jacquie decided that she would start to protect herself from criticism and rejection by rarely speaking in social situations, and in fact she became an expert in avoiding social situations altogether by making excuses that she was unwell or had other plans. Jacquie's social anxiety became so severe at times that she was unable to walk down the street in case she saw someone she knew, or a stranger attempted to speak to her. When she did go out in public she would walk down the most isolated streets, avoid any eye contact with other people, and would cross the road to avoid passing another person. When Jacquie could not avoid social situations, she learned to ask questions so people talked about themselves and she did not need to disclose anything about herself.

After high school Jacquie studied to become a librarian because she loved books and it meant that she would not be expected to interact with people very often. Unfortunately, as Jacquie isolated herself more and more, even brief interactions she had with other staff and patrons began causing her significant anxiety. Jacquie knows she is introverted and does not necessarily want to change this, but she recognizes that her anxiety is more severe and debilitating than it need be. Jacquie presented for treatment because she would like a family one day, but she feels depressed because she does not believe this is possible for her.

Max's Story

Max is a 27-year-old actor who needs to attend auditions regularly. He has been experiencing panic attacks with increasing frequency, particularly when he is anticipating auditions or having to interact with colleagues. Max presented as a sociable and bright individual who is eager to please but nonetheless

reported having been shy for his whole life. When he was young he remembers hiding behind his parents when other people were around. Max reports having had some friends at school, but he would often listen from the periphery of the group rather than actively contribute to the discussions. He figured that if he was quiet he would avoid saying something stupid or boring, and people would tolerate him. As a consequence he usually felt disconnected from others, and he had few close friends. Max believes his love of acting came from his curiosity about people, but he also enjoys the fact that he has a clear script to work from. Max reported that he thrives onstage where he can play a character and his lines are written for him. However, whenever he has to interact as himself he "falls to pieces." Max's social anxiety increased when he left school and he had to meet new people in college, and again when he left college to become a professional actor. He noticed that over time he started to feel apprehensive in more and more social situations, to the point where he even felt anxious with his family. He began drinking alcohol to "settle his nerves" in the evenings and on weekends, and he recently started to carry around a hip flask of whiskey so that he could have a sip before having to meet other actors or directors.

As time has gone on Max has become more and more self-conscious about his anxiety. He scrutinizes the warmth in his cheeks and the sweatiness of his palms before interacting with others. He also closely studies his colleagues' facial expressions for any sign that they can see just how anxious he is. Although no one ever says anything to him directly, he believes he can read their minds from the expressions on their faces. Max notices that his thoughts are dominated by expectations of failure and negative evaluation from others before, during, and after social situations. In his mind's eye, he repeatedly sees an image of his colleagues looking at him strangely, which just confirms that he has failed and no longer enjoys their respect. He even interprets positive feedback as a sign of "pity," and he has started to find auditions intolerable. Max has also recently started avoiding seeing his friends and family by making excuses that he is too busy to see them. Max presented for treatment because alcohol is no longer working, and his increasing panic attacks mean that he can no longer concentrate on his acting career. It took Max a while to realize that he has significant social anxiety because he has always been able to bluff his way through social events with the use of alcohol. Max had also thought it was impossible for him to have social anxiety, given that he could comfortably perform onstage in front of a large audience. However, Max now recognizes his anxiety is excessive and wants to do something about it.

Jacquie and Max present just two of the many faces of social anxiety disorder (SAD). This book is designed to equip clinicians with new ways of integrating imagery- and verbally based strategies when working with clients like Jacquie and Max who suffer from SAD. The first part of the book provides clinicians with key information on SAD, including the unique aspects and advantages of imagery-enhanced cognitive-behavioral therapy (CBT) and the model that guides the treatment.

The second part of the book describes the components of imagery-enhanced CBT in sufficient detail so that they can be easily applied clinically. We provide sample scripts that can be used with clients, detailed step-by-step descriptions of each treatment strategy, suggested questions to optimize clients' learning, and sample dialogues. We also provide some clinical anecdotes that we hope will help therapists appreciate how the various strategies have been used with our clients. Throughout the book we describe potential difficulties that have arisen in our clinical work and suggest how these can be managed. At the end of the book we provide client-friendly handouts that describe the rationale for each treatment component, as well as worksheets that can be used as a framework to guide the application of specific treatment strategies and record clients' examples.

We have used this treatment in both group and individual formats with success. In Chapter 3 we provide a suggested structure for group treatment, which we have used in our treatment evaluation trials (McEvoy, Erceg-Hurn, Saulsman, & Thibodeau, 2015; McEvoy & Saulsman, 2014). To maximize the flexibility with which the treatment can be used in individual therapy, we have not written the book in a session-by-session structure. Instead, in Part II, we have devoted one chapter to each key maintaining factor in the model that guides the treatment: (1) negative thoughts and images, (2) avoidance and safety behaviors, (3) negative self-image, (4) attention biases, and (5) core beliefs. Some clients might require more or fewer sessions targeting each of these maintaining factors, and clinicians should be guided by their case formulation and experience when determining the appropriate "dose" of each component. In the final chapter of the book we discuss relapse prevention. Although this book is designed to enable clinicians to "hit the ground running," where possible it is highly recommended that relatively inexperienced clinicians receive supervision by therapists who are accredited and experienced in cognitive-behavioral approaches.

In the rest of this chapter we provide clinicians with a working knowledge of SAD, including its symptoms, common comorbidities, and how to distinguish it from other disorders. It is also helpful to have an understanding of the epidemiology and causes of SAD because clients are often surprised (and very reassured) by just how common the disorder is, and they are interested in the factors that may have contributed to their problem.

What Is SAD?

The core characteristic of people with SAD is excessive worry about or fear of other people thinking badly of them in some way. The particular fears or worries vary slightly from person to person—some people worry that others will think they are odd or weird, that they are "uncool," incompetent, unlikable, weak, rude, and so on. But in all cases, there is a basic concern that others will evaluate them negatively. As a result, people with SAD find any situation where there is a possibility for scrutiny by another person to be highly anxiety provoking. They avoid a wide range of situations where they might be observed or might have to interact with others. Again, the specific situations will vary

from person to person, but some of the common ones include meeting new people, being the center of attention, work meetings, social functions, using public toilets, or eating, drinking, or writing in front of others.

When working with socially anxious people, it is probably not critically important whether they meet the full diagnostic criteria for SAD. However, there are times when a formal diagnosis is needed, and most research on treatments for SAD has been conducted on people who meet formal diagnostic criteria. Therefore having an appreciation of SAD diagnostic criteria (e.g., the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5; American Psychiatric Association, 2013]) and using diagnostic information to assist treatment planning is advisable.

Jacquie and Max report long-standing and severe shyness, inhibition, and social avoidance across a variety of social situations because they anticipate being judged and rejected for failing to meet others' standards. When these social situations cannot be avoided they report suffering from extreme anxiety symptoms and panic attacks, which Max has tried to self-medicate with alcohol. As is the case for other emotional disorders, a diagnosis of SAD can only be given after other psychological or physiological causes or medical conditions have been ruled out as better explanations. For instance, if a client reports that he only loses his confidence and worries about negative evaluation when he is in the middle of a depressive episode, then a diagnosis of major depressive disorder rather than SAD should be considered. For both Jacquie and Max their social anxiety is chronic, persistent, pervasive, and not due to another condition. It is also important to consider sociocultural context when deciding whether anxiety is out of proportion to the actual threat because there are cross-cultural variations in the prevalence, nature, and meaning of social anxiety (Furmark, 2002). As with any mental disorder, the key issue is life impairment. Many people report being shy or quiet in some situations, but a diagnosis is only appropriate when that shyness impacts significantly on one's life. Max and Jacquie both acknowledge that their social fears are excessive, and their social and occupational functioning has clearly been chronically and severely affected by their social anxiety.

Epidemiology and Impact of SAD

SAD is one of the most common anxiety disorders. Lifetime rates of SAD vary depending on the assessment method, but it appears to be most common in Western countries such as the United States (18.2%), Australia (8.4%), and the nations of Europe (5.8–12%), and less common in Africa (e.g., 3.3% in Nigeria) and Asia (2.4–5.3%; Demyttenaere et al., 2004; McEvoy, Grove, & Slade, 2011). SAD typically begins in early adolescence (around 10 to 13 years of age), which is several years earlier than other anxiety and affective disorders except specific phobias (Kessler et al., 2005; McEvoy et al., 2011). New cases of SAD are uncommon after age 25, and people who report experiencing SAD from an earlier age tend to be more severely affected (Grant et al., 2005).

A range of factors increases the chances of having SAD. There are mixed findings on gender differences in children or adolescents, with some studies finding no difference

in rates between boys and girls (Beidel, Turner, & Morris, 1999; Wittchen, Stein, & Kessler, 1999) and others finding higher rates in girls (Kessler et al., 2012). A consistent finding is that more women than men in the general population have SAD (Asher, Asnaani, & Aderka, 2017; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Wittchen et al., 1999), so we might expect more women than men to seek treatment. Interestingly, however, this is not the case. Within clinical samples the ratio of women to men is relatively even (Rapee, 1995). Cultural expectations for men to be more dominant and assertive may result in greater impairments in social and occupational functioning for men than women with SAD, and therefore higher rates of treatment seeking (Asher et al., 2017).

Some important cross-cultural differences in the expression of SAD have been documented (Furmark, 2002; Rapee & Spence, 2004). *Taijin kyofusho* ("interpersonal fear disorder" in Japanese) is a culturally specific expression of social anxiety where the fear is of acting in ways that are inadequate or offensive *to* others, rather than fear of negative evaluation *by* others in SAD. DSM-5 (American Psychiatric Association, 2013) lists a range of specific fears of offending others due to emitting an offensive body odor (olfactory reference syndrome), facial blushing (erythrophobia), too much or too little eye gaze, awkward body movements or expression (e.g., stiffening), or body deformity. Eastern collectivist cultures value introversion and humility, and prioritize "the other" over "the self," which may, at least in part, explain the higher prevalence of SAD in Western countries, which value individualism and extraversion (Cain, 2012). The higher value placed on individual achievement and performance in Western countries may then create the perception of a more evaluative environment, and thus higher rates of SAD, for more introverted individuals. In collectivist cultures, where the communal rather than individual good is prioritized, the documented prevalence of SAD is lowest. This literature highlights the need to understand mental disorders within an individual's sociocultural context.

SAD tends to be chronic without treatment. One study found that only 35% of a clinical sample with SAD experienced full remission over an 8-year period, with a rapidly diminishing rate of remission after the first 2 years (Yonkers, Dyck, & Keller, 2001). SAD has the lowest remission rate of all anxiety disorders, with a median length of illness of 25 years (deWit, Ogborne, Offord, & MacDonald, 1999). A recent review found that full remission rates in prospective studies of SAD varied between 36 and 66%, whereas partial remission rates (i.e., not fulfilling all of the diagnostic criteria but continuing to have some social fears) varied between 54 and 93% (Vriends, Bolt, & Kunz, 2014). These findings might suggest that a reasonably high proportion of individuals spontaneously remit over time, or alternatively that SAD follows a waxing and waning course (Vriends et al., 2014). A range of factors was associated with an increased likelihood of remission, including having a nongeneralized subtype of social anxiety, no panic attacks, less avoidance, higher age of onset, less severe impairment, no comorbid mental disorders, no alcohol use, being older than 65, being employed, being in a relationship, higher socioeconomic status, fewer critical life events, and no parental history of SAD or depression.

Due to its high prevalence SAD has been found to account for a similar degree of disability in the population as schizophrenia and bipolar affective disorder (Mathers, Vos, & Stevenson, 1999). Individuals with SAD are more likely to have poorer academic functioning, to be unemployed, and to be single (Davidson, Hughes, George, & Blazer, 1993; Kessler, Stein, & Berglund, 1998). SAD is therefore an early-onset, common, chronic, and debilitating anxiety disorder that does not tend to remit without treatment. Unfortunately some studies have suggested that as few as 5% of individuals seek treatment for social anxiety (Keller, 2003) and, for those that do, the mean age of presentation for treatment is around 30 years (Rapee, 1995). People with SAD tend to wait longer to seek treatment than other anxiety disorders, which leads to an extended period of disability. Given the interpersonal nature of the disorder, the fact that most activities humans do in life involve interpersonal interactions, and the substantial delay in treatment seeking, SAD can have a pervasive impact on people's lives.

What Causes SAD?

As a truism, the causes of SAD almost certainly include a combination of nature and nurture. Although individual studies show some variability in results, overall, evidence from twins points to a consistent inherited component for social anxiety (Scaini, Belotti, & Ogliari, 2014). It is interesting that the heritable component seems to be almost twice as strong for symptoms of social anxiousness than for the actual clinical diagnosis of SAD. This might suggest that whereas social anxiousness reflects more of a fundamental personality trait, whether a highly shy person develops the clinical syndrome (SAD) might depend more on environmental factors (Spence & Rapee, 2016). There is some evidence that SAD "breeds true" so that individuals with SAD are more likely to have offspring with SAD compared to individuals without mental disorders (Fyer, Mannuzza, Chapman, Martin, & Klein, 1995) and compared to individuals with a different disorder (Lieb et al., 2000). However, most of the genetic influence seems to increase vulnerability to emotional disorders in general rather than SAD in particular. In other words, what is inherited seems to mostly be a general tendency to be "emotional"—often referred to as neuroticism. Neuroticism refers to a general tendency to experience negative emotional states and sensitivity to stress (Watson, Gamez, & Simms, 2005) and is a common temperamental vulnerability factor for a range of emotional disorders.

Personality and temperamental factors can increase the risk of developing SAD. Children who display a general tendency to be submissive, anxious, socially avoidant, and behaviorally inhibited are more likely to develop SAD (Clauss & Blackford, 2012; Rapee, 2014). Other personality dimensions have also been associated with SAD, particularly the combination of high neuroticism and low extraversion, and the personality style of low effortful control. Thus SAD is likely to result from a complex interplay between temperamental factors.

A range of environmental factors has been associated with SAD, but most of the evidence is based on retrospective self-report and correlational designs. It is therefore

unclear if the relationships are causal, unidirectional, or reciprocal. Environmental risk factors also appear to be similar across mental disorders rather than specific to SAD (Kendler et al., 2011). Examples of social traumas that have been associated with anxiety disorders in general and SAD in particular include bullying by peers, abuse, and a dysfunctional family of origin (Spence & Rapee, 2016).

Insecure attachment styles have also been associated with an increased risk of SAD (Shamir-Essakow, Ungerer, & Rapee, 2005). Trust in caregivers promotes exploration of the social world, development of social skills, and self-efficacy, whereas an absence of a secure, trusting, and responsive caregiver may adversely impact social skills and confidence. Parents of sociable and socially competent children tend to be warm and supportive and set clear expectations. In contrast, parents of shy and socially withdrawn children tend to be more overcontrolling, overprotective, distant, insensitive, rejecting, less sociable, stress the importance of others' opinions, and use shame for discipline (McLeod, Wood, & Weisz, 2007; Wong & Rapee, 2016).

It is important to emphasize again that these associations have been weak and mostly based on correlations and retrospective recall. It is plausible that parents adopt these styles *in response to* their children's inhibition. For instance, a parent may take more control as a way of trying to encourage a shy child to engage more fully with her peers with the laudable aim of enhancing her social skills and confidence. Alternatively, sensitive to their shy child's discomfort, other parents might allow him to predominantly engage in solitary activities. "Overcontrolling" and ""overprotective" parenting may thus be a response to the child's fearfulness and distress in social situations. In turn, reciprocal relationships between a child's temperament and parenting styles may serve to reinforce threat expectations and avoidant coping strategies (Spence & Rapee, 2016; Wong & Rapee, 2016).

In summary, the development of SAD probably involves a complex and reciprocal interaction among a range of genetic, temperamental, and environmental factors. Genetic and temperamental factors can elicit responses from the environment that reinforce or strengthen tendencies toward behavioral inhibition, and environmental factors may act upon preexisting temperamental characteristics to reduce or increase the risk for SAD. Each individual may be influenced by these factors to differing degrees, and a wide range of idiosyncratic experiences are also likely to complicate the picture. On an individual basis, when you meet a client with SAD, it is impossible to know exactly what factors led to his presenting problems. For this reason, treatment is not aimed at the "causes" of the disorder but rather at the current processes that maintain the problem. We discuss these processes in a later section.

Comorbidity

SAD rarely occurs in isolation. In fact SAD frequently co-occurs with other mental disorders, especially depression, other anxiety disorders, substance use disorders, and personality disorders (Grant et al., 2005). At least half the people presenting for treatment

with SAD will have a comorbid disorder (McEvoy et al., 2015), so it is important for assessing clinicians to be "on the lookout" for additional problems. Mood disorders are the most common co-occurring disorders, followed by other anxiety disorders (Grant et al., 2005). SAD is one of the earliest-onset mental disorders, so most clients' comorbid disorders will have started after their SAD.

Concurrent conditions can interfere with treatment progress (Lincoln et al., 2003, 2005; McEvoy, 2007), so treating clinicians need to carefully consider how they might need to feature in their case formulations and treatment plans. For instance, if major depression is the most debilitating problem when the client presents for treatment, this might need to be prioritized even if the depression started after the SAD. If left untreated, depression symptoms such as lethargy, avolition, and profound hopelessness may interfere with treatment engagement. Substance dependence may also interfere with progress by causing anxiety symptoms (especially during short-term withdrawal), which can reduce the effectiveness of the treatment strategies and ultimately reduce clients' confidence in the SAD treatment. However, it may be difficult for the client to reduce her substance use if the social anxiety is not addressed. In these cases an integrative approach to treating social anxiety and substance abuse is indicated, where both problems are treated simultaneously by the same or complementary services (Stapinski et al., 2015).

It can sometimes be difficult to determine which problem should be treated first, and this will typically be a decision that is made collaboratively with the client. We will often have an open discussion with clients about the treatment options and the pros and cons of each approach. In our experience, clients are usually well equipped to decide whether, for instance, their depressed mood is likely to interfere with their ability to regularly attend treatment sessions and apply treatment strategies for their SAD. If the client is suffering from severe depression and agrees that this needs to be addressed first, we will prescribe psychological and/or pharmacological treatments for depression before targeting his SAD. Once a collaborative decision has been made on the preferred treatment focus, the clinician can monitor comorbid problems and shift focus if it becomes clear that they are interfering with treatment. Group treatment is less flexible in this regard, so at times it might be necessary to remove a client from a SAD group if it becomes clear that comorbid problems are inhibiting treatment progress. After the comorbid issue is addressed she can then recommence treatment for SAD.

Differential Diagnoses

Some psychological disorders can present in similar ways to SAD, but the differences can have important treatment implications. Recurrent panic attacks can occur in SAD but are not diagnosed as panic disorder unless uncued (unexpected) panic attacks that are unrelated to social triggers are present (American Psychiatric Association, 2013). The core negative cognitions differ between SAD and panic disorder, with the former revolving around themes of evaluation and the latter around themes of catastrophic consequences of somatic symptoms (e.g., heart attack). Individuals with panic disorder

may fear some social consequences of having a panic attack, but their panic attacks are not invariably triggered by social cues, and the primary fear is of having a panic attack or the consequences of a panic attack rather than of negative evaluation. Agoraphobic avoidance may also resemble avoidance in SAD, but the function of avoidance in agoraphobia is to prevent fear and panic attacks, whereas the function of avoidance in SAD is to prevent social evaluation.

Body dysmorphic disorder (BDD) is another mental disorder that shares features with SAD. People with BDD believe they have an abhorrent and unacceptable physical flaw in their appearance (American Psychiatric Association, 2013). Individuals with BDD and SAD can present with some similar affective, physiological, interpersonal, and behavioral symptoms. Individuals with both disorders may report feeling anxiety, shame, and humiliation, and they might appear behaviorally inhibited, avoid social contact, and fear attention from others. Both disorders may also be associated with fear of negative evaluation based on appearance, which may result in mirror gazing, camouflaging, and excessive grooming behaviors. However, with BDD the cognitions tend to be more focused on rejection as a consequence of a specific perceived or exaggerated physical flaw (e.g., skin defects, nose size), and sufferers may have low insight into the discrepancy between their perception and reality. Individuals with SAD tend to have more general fears of rejection as a consequence of their social performance not meeting others' standards, which may extend to and include aspects of physical appearance. It is important to do a careful assessment for the presence of comorbid BDD because elements of treatment for SAD can be particularly grueling for these individuals (e.g., video feedback, see Chapter 7). When BDD is associated with very poor insight and is of almost delusional intensity, differential diagnosis is critical and relatively straightforward. However, in milder cases there is substantial overlap, and the concerns about aspects of physical appearance can be missed without careful assessment.

Avoidant personality disorder (PD) is characterized by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation (American Psychiatric Association, 2013) and reflects a more severe variant of SAD. Individuals with an avoidant personality will present as being more chronic, comorbid (e.g., depression, substance abuse), and debilitated by their social anxiety. Negative core beliefs about the self being inadequate, unlikable, and inferior, and of others being hostile, judgmental, and superior, are likely to be "stickier" than for those without avoidant PD. Avoidance behaviors will also be more pervasive, long-standing, and rigid. These individuals can be effectively treated using similar interventions as for SAD but may require a larger dose of therapy to achieve comparable outcomes to clients without avoidant PD. Research has found similar rates of improvement between those with and without comorbid avoidant personality, but fewer individuals with avoidant PD achieve full remission (Cox, Turnbull, Robinson, Grant, & Stein, 2011).

Occasionally individuals with schizoid PD are referred for treatment of SAD. Schizoid PD is characterized by a lack of interest in close interpersonal relationships and, like avoidant PD and SAD, is associated with high neuroticism and low extraversion

(Saulsman & Page, 2004). One 19-year-old man referred to our clinic was accompanied by his very concerned father, who reported that his son had always been uninterested in engaging with his peers and family unless it was necessary. A detailed assessment revealed that the son simply did not find social interactions rewarding, and so he preferred solitary activities. He described apathy rather than anxiety in social situations, and he did not meet criteria for major depression or dysthymia. Clearly this client was not a good candidate for treatment of SAD, as he did not experience the primary feature of this disorder, fear of negative evaluation.

SAD and depression often co-occur and have overlapping features. Like SAD, depression is often associated with social withdrawal, inactivity, low self-esteem, negative beliefs and perceptions about the self and others, and negative ruminations about social interactions. Given its earlier average age of onset, it is more common for SAD to precede rather than follow depression, suggesting that social anxiety and associated withdrawal can lead to depression. Many clients will report this pattern when asked what they recall first, feeling anxious in social situations or feeling depressed. For other clients it will be more difficult to tease these symptoms apart. If clients deny feeling socially anxious in between depressive episodes, this suggests that the primary disorder is depression, and if this is successfully treated the social anxiety should resolve. If the client reports that depression typically follows a period of social anxiety, then depression may be masking an underlying SAD. In these cases, it may still be important to treat the depression before the social anxiety, but we will often make this decision based on client preference and whether the depression is so severe that it is likely to interfere with engagement in SAD treatment.

A final issue we discuss here is a recognition that some clients referred for SAD may genuinely elicit frequent rejection or interpersonal disputes. Individuals with SAD fear negative evaluation, but almost invariably this is *perceived* evaluation. Friends or family members might express some frustration at their inhibited behavior, or the individual might avoid establishing social contact with others, but it is rare that someone with SAD *is* overtly rejected by others. Clients who present with clear evidence of negative evaluation and rejection may require a different form of treatment from what we describe in this book, such as social skills training, anger management, interpersonal psychotherapy, or dialectical behavior therapy. It is noteworthy that while there is evidence that children with SAD demonstrate social skills deficits, most adults with SAD have perfectly adequate social skills (Rapee & Spence, 2004). The problem is that they don't *think* they have adequate social skills. One of the most important goals of treatment is for clients to learn that there is a large discrepancy between their *perceived* and *actual* social skills. Avoidant behaviors (e.g., not making eye contact, staying quiet) may masquerade as social skills deficits, but as these fall away during treatment one of the great pleasures of treating clients with SAD is observing their natural social skills flourish. Many SAD clients feel relatively comfortable with clinicians, so some of these skills are often apparent in the initial assessment. Individuals with SAD desire relationships with others, they are sensitive to others' opinions and needs, and they are caring (albeit too much).

Social Anxiety: Dimension versus Subtypes

Normal shyness is typically considered to be a relatively mild social awkwardness that does not significantly interfere with functioning. Up to 40% of nonclinical samples report having felt shy at some point in their lives (Rapee, 1995), suggesting that it is a common and normal experience. We have all probably had the experience of feeling awkward within social situations. Perhaps you can recall an experience when everyone else appeared to be engaged in conversations while you were standing alone in the corner of the room with an hors d'oeuvre in your hand? Suddenly, the food or an item of furniture became extremely fascinating as you attempted to appear preoccupied by choice (rather than just appearing to be awkward and a loner). Perhaps you pretended to look busy with your cell phone as you considered excuses for making a hasty exit (perhaps you were Googling "how to make a hasty but subtle exit from a party")? We have all also had the experience of engaging in a pretty dull conversation or putting our "foot in our mouth." These are normal experiences that are very specific to particular situations (e.g., when we don't know anyone) and mercifully quite rare, and the awkwardness generally passes quickly. Even if these fleeting experiences occur relatively frequently and we identify as being a shy person, we might not let them overly affect our life. On the other hand, if we start to notice that these experiences are occurring frequently, are associated with significant anxiety in anticipation of social situations, start to promote avoidant behavior, and are having a negative impact on our life, then we have moved beyond "normal" shyness into SAD territory.

Previous editions of the DSM (American Psychiatric Association, 1987, 1994, 2000) distinguished between circumscribed (specific) and generalized social phobia. Specific social phobia was diagnosed when clinically significant social anxiety was triggered by one or two situations, whereas generalized social phobia was diagnosed when the client experienced social anxiety in most social situations. The validity of this subtyping was controversial, with researchers questioning whether the distinctions were more quantitative (different severities) than qualitative (different forms of the disorder) (see Skocic, Jackson, & Hulbert, 2015). Compared to specific social phobia, generalized social phobia tends to be associated with an earlier onset, greater chronicity, more severe anxiety, more avoidance and impairment, and more suicidal behavior (Furmark, Tillfors, Stattin, Ekselius, & Fredrikson, 2000; Hook & Valentiner, 2001; Stein, Torgrud, & Walker, 2000). Avoidant PD is even more severe on each of these variables.

DSM-5 (American Psychiatric Association, 2013) removed the specific and generalized specifiers and instead introduced a "performance only" subtype. The performance subtype is given when a client's fear of being observed or scrutinized is limited to situations such as presentations, job interviews, and when eating or drinking in public, but they do not fear interacting with people (Hofmann, Newman, Ehlers, & Roth, 1995; Stein & Deutsch, 2003). Epidemiological research suggests that the performance subtype of SAD is quite rare (Burstein et al., 2011). Apart from the specific subtype, and public speaking fears in particular, SAD may best be considered along a continuum based

on the number of feared situations and the associated degree of distress and disability (Skocic et al., 2015). Avoidant PD remained as a separate disorder in DSM-5 despite evidence that it is a more severe variant of SAD.

Summary

Jacquie and Max, our clinical cases at the start of this chapter, are typical examples of what the diagnostic criteria and research tell us about SAD. They report long-standing shyness and behavioral inhibition, and in Jacquie's case there is some suggestion that her father was introverted and her mother had high expectations of social performance. Although they are young adults, they have already suffered for a number of years with their social anxiety, and they have presented for treatment at a time when they are highly debilitated by their symptoms. Throughout this book we provide case examples of individuals we have worked with who have undertaken the challenging but ultimately rewarding journey through treatment. The aim of treatment is for our clients to feel that they can make genuine choices in their lives without their social anxiety dictating what they can and cannot do. Both Jacquie and Max have aspirations for a relationship, career, and family. The ultimate marker of treatment success is when clients believe that they can pursue their aspirations and lead fulfilling lives. Unfortunately, many individuals like Jacquie and Max suffer through every facet of life in silence, either indefinitely or for many years before seeking help.

In the next chapter we review cognitive-behavioral models that describe factors that maintain SAD and therefore inform the treatment described in Part II of this book. It is important for clinicians to have a working understanding of these models because they provide an understanding of why SAD persists and underpin the treatment rationale.

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