Published in final edited form as:

Compr Psychiatry. 2008 ; 49(4): 399–406. doi:10.1016/j.comppsy.2008.01.009.

Screening for Social Fears and Social Anxiety Disorder in Psychiatric Outpatients

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Abstract

The ability of a diagnostic interview to identify all individuals with a particular psychiatric disorder depends, in part, on the performance of the interview's initial screening questions. The Structured Clinical Interview for *DSM-IV* (SCID) is the most widely used research diagnostic interview, yet little research has examined the performance of the SCID screening questions. Because Social Anxiety Disorder (SAD) is one of the most frequent psychiatric disorders, we examined the performance of the SCID screening question in the SAD module to detect social fears and SAD. The incremental validity of a more comprehensive list of social fears was examined by determining how many patients were diagnosed with SAD in those who were originally missed by the SCID screening question. Five percent of those originally missed by the SCID screening question subsequently received a lifetime diagnosis of SAD, and there was a significant increase in the prevalence of social fears after patients were cued by the social fears list. The most commonly reported fears missed by the SCID screening question included speaking in a group, with sexually attractive others, and with authority figures. Results suggest that perhaps these fears could be added to the SCID screening question in order to capture individuals missed by the SCID screening question and to provide more comprehensive information for treatment purposes.

Keywords

Social Anxiety Disorder; social fears; assessment; SCID

Social Anxiety Disorder (SAD) is an excessive fear of social or performance situations in which embarrassment or humiliation may occur (1). It is typically characterized by avoidance of these situations, and often is associated with marked impairment in several areas, including work, social life, and family life (2,3). Epidemiological studies indicate that SAD is the fourth most common psychiatric disorder, following major depression, alcohol abuse, and specific phobia, with a lifetime prevalence rate of 12.1% (4).

Although prevalence rates of SAD are high in epidemiological samples, studies utilizing treatment-seeking samples have shown that SAD is often under-recognized in routine clinical practice (5-8). For example, Zimmerman and Mattia (8) found that the prevalence of SAD was

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nearly 9 times higher in patients given a semi-structured diagnostic interview compared to those assessed with an unstructured clinical interview (28.6% versus 3.2%, respectively).

Most screening questions in structured and semi-structured interviews assess only a few possible social concerns. For example, the National Comorbidity Survey (NCS) used the Composite International Diagnostic Interview (CIDI; 9) to examine the prevalence of six social fears in a representative general population epidemiological study of adults aged 18 to 55 (10). Public speaking was the most frequently reported anxiety-provoking situation (30%). "Talking to others" had a prevalence rate of 13%, writing in front of others, a rate of 6%, and eating/drinking in front of others, a rate of 3%. One limitation of this study was the use of a brief list of social fears, and only one of the six social fears assessed interactional fear ("fear of talking to people because you might have nothing to say or might sound foolish").

The Structured Clinical Interview for *DSM-IV* (SCID; 11) is one of the most widely used diagnostic interviews. Therefore, it is important to know how well it assesses social fears and lifetime history of SAD. The SCID screening question for the SAD module states: "Was there ever anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?" If an individual responds negatively to this question, then the SAD module is discontinued. One potential limitation of the SCID screening question is that it assesses fears such as eating or writing in front of others, which previous research using self-report measures (e.g., 12) and a more recent study from the NCS-R (3) have shown are the least frequently reported or severe social fears. In addition, individuals with SAD may not fear performance situations, such as public speaking, but may significantly fear interactional social situations, such as having conversations with strangers. Therefore, the SCID screening question may not be adequately assessing social fears common to those with SAD, and as a result, diagnoses of SAD may be underestimated. However, no known published studies to date have examined whether the SCID screening question sufficiently identifies the presence of social fears and SAD diagnoses.

Although more time consuming, it may be important to inquire for SAD using a more comprehensive list of social situations than the typical 3 situations included in the SCID screening question because this may reduce the number of missed diagnoses and provide additional clinical information. In fact, the *DSM-IV-TR* recommends: "Because individuals with Social Phobia often do not spontaneously report the full range of their social fears, it is useful for the clinician to review a list of social and performance situations with the individual" (1, p.413). We are not aware of any published studies that have examined the performance of the SCID screening question compared to a more comprehensive list of social fears in identifying individuals with SAD. In addition to reducing under-diagnosis, it may be helpful to gather a more comprehensive list of social fears while using a semi-structured interview, such as the SCID, to determine specific fears that should be addressed in treatment.

The aims of the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project were: 1) to examine the performance of the SCID screening question in identifying social fears and lifetime history of SAD in psychiatric outpatients; and 2) to examine the incremental validity of a more comprehensive list of social fears, by calculating the number of individuals who responded negatively to the SCID screening question but who endorsed at least one social fear and subsequently met full criteria for SAD. Based on previous studies suggesting that eating and writing in public are not the most frequently reported fears in patients with SAD, we hypothesized that utilizing a more comprehensive list of social fears after the SCID screening question would result in a significant increase in the number of patients meeting criteria for SAD. Finally, exploratory analyses were conducted to examine differences in clinical presentation between those who were and were not missed by the SCID screening question.

Method

Participants

Participants included psychiatric outpatients presenting for treatment at the outpatient practice of the Rhode Island Hospital Department of Psychiatry. Five percent of patients approached for the study declined participation, with a resulting sample size of 1,800. The sample consisted of 1,106 females (61.4%) and 694 males (38.6%), ranging in age from 18 to 80 ($M = 37.7$, $SD = 12.6$). The majority of the sample was Caucasian ($n = 1,571$; 87.3%), followed by African American ($n = 73$; 4.1%), Portuguese ($n = 65$; 3.6%), Hispanic ($n = 48$; 2.7%), other ethnicities ($n = 29$; 1.6%), and Asian ($n = 14$; 0.8%). The marital status of participants was as follows: married ($n = 735$; 40.8%), never married ($n = 558$; 31.0%), divorced ($n = 250$; 13.9%), separated ($n = 119$; 6.6%), living with their partner ($n = 106$; 5.9%), and widowed ($n = 32$; 1.8%). Over half of the sample ($n = 1,136$; 63.1%) had a high school degree or equivalency, 10.8% ($n = 194$) had less than a high school degree, 18.6% ($n = 335$) received a 4-year college degree, and 7.5% ($n = 135$) received a graduate/professional degree. The most frequent current Axis I *DSM-IV* diagnoses (other than SAD) were major depression (46.0%), generalized anxiety disorder (17.7%), panic disorder with agoraphobia (14.3%), posttraumatic stress disorder (12.4%), specific phobia (10.5%), obsessive-compulsive disorder (7.9%), alcohol abuse (7.9%), and dysthymia (7.0%).

Measures

Individuals presenting for an intake appointment were asked to participate in a diagnostic evaluation prior to meeting with their treating clinician. Patients provided informed, voluntary, written consent, and all procedures were approved by the Institutional Review Board at Rhode Island Hospital. The Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID; 11) was used for the diagnostic evaluation. All patients were evaluated with the full SCID. Diagnosticians were research assistants with bachelor's degrees in social or biological sciences, as well as doctoral-level clinical psychologists. They were trained for a period of 3 months, which included reviewing written cases, discussing item-by-item administration with the principal investigator (M.Z.), observing at least 5 interviews, and administering 15 to 20 interviews while being observed and supervised. Diagnosticians were then required to demonstrate exact or near-exact inter-rater reliability with a senior diagnostician for 5 consecutive interviews. They also received ongoing supervision of interviews via a weekly case conference.

Inter-rater reliability information was collected over the course of the entire project. From the 48 joint-interview reliability evaluations, the reliability of SCID-based diagnoses of mood and anxiety disorders was excellent (MDD $\kappa = 0.95$; dysthymia $\kappa = 0.88$; panic disorder $\kappa = 1.0$; SAD $\kappa = 0.84$; obsessive-compulsive disorder $\kappa = 1.0$; specific phobia $\kappa = 0.91$; generalized anxiety disorder $\kappa = 0.93$; posttraumatic stress disorder $\kappa = 0.91$).

The SAD module of the SCID begins with a standard screening question: "Was there ever anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?" If the screening question is answered in the affirmative, then the remaining SAD criteria are evaluated. The SAD module was modified for the current study by adding a list of social fears to cue the participants. All patients were administered the social fears list after the screening question, regardless of whether they provided a negative or affirmative response to the screening question (see Figure 1). A list of 13 possible social fears were added to the SAD module, based on the Liebowitz Social Anxiety Scale (LSAS; 13), a review of the literature, and clinical experience. The list was read to patients, and they were asked whether they felt more fearful, anxious, or nervous than most people in any of those situations. If a patient answered "no" to the screening question and all of the social fears, then

the module was terminated. However, if they answered “yes” to at least one of the social fears, diagnosticians continued with the module. Therefore, all patients meeting criteria for SAD endorsed at least one social fear. The list included the following social fears: eating in front of others, writing in front of others, public speaking, saying something in a group of people, asking a question in a group of people, using public restrooms, business meetings, using the telephone or other job-related equipment, one-on-one conversations with strangers, conversations with sexually attractive others, conversations with authority figures, returning something to a store, and walking around a mall with no specific plan. The fear of returning something to a store was added after the first 400 participants had been evaluated.

Analyses

First, we determined the prevalence of SAD and social fears according to each assessment method (i.e., SCID screening question alone and SCID screening question plus social fears list). The prevalence rates of social fears and SAD were calculated, and we also examined the change in prevalence rates (i.e., before and after the social fears list was administered with the SCID screening question) for social fears and lifetime history of SAD. McNemar tests were conducted to determine whether the change in prevalence after administering the social fears list was significant. Sensitivity, specificity, positive predictive power (PPP) and negative predictive power (NPP) were calculated to examine the ability of the SCID screening question and social fears list to identify individuals with and without the disorder (14).

Although diagnosticians did not originally differentiate between the generalized and specific subtypes of SAD, this was estimated based on the list of 13 social fears. Based on a definition used by other researchers (e.g., 15-17), we defined the generalized subtype as endorsing 3 or more social fears on the list. Those endorsing one or two social fears were classified as the specific subtype. Sensitivity, specificity, PPP, and NPP were calculated separately for each of the subtypes.

Finally, preliminary analyses were conducted to examine differences in social functioning and desire for treatment of SAD between patients who were identified by the screening question and met criteria for SAD, and patients who were originally missed by the screening question but who endorsed at least one social fear and subsequently met criteria for SAD. Current social functioning was rated by diagnosticians using an item from the Schedule for Affective Disorders and Schizophrenia (SADS; 18). It was rated on a 7-point Likert scale, ranging from 1 (superior) to 7 (grossly inadequate). An independent samples t-test was conducted to compare current social functioning scores between the two groups. Regarding desire for treatment, participants were asked at the end of the SAD module whether or not they wanted treatment for SAD. A chi square test was conducted to compare those who were originally identified and originally missed by the SCID screening question on desire for treatment of SAD.

Results

Prevalence of SAD and Social Fears

Three participants had missing data and were therefore excluded from the analyses, yielding a sample size of 1,797. Nearly one-third of participants were diagnosed with a lifetime history of SAD ($n = 576$; 32.1%). The disorder was current in a majority of cases ($n = 519$; 90.1%). In 12 (2.1%) patients SAD was in partial remission, and in 45 (7.8%) it was in full remission. Of those with a current diagnosis, 499 (96.1%) were not presenting for treatment primarily for their SAD symptoms but were seeking treatment for another Axis I disorder, most often major depression ($n = 211$; 42.3%) or another anxiety disorder ($n = 135$; 27.1%). The mean age of onset of SAD was 11.6 years ($SD = 7.9$).

The prevalence rate of SAD was 29.3% ($n = 527$) when using the SCID screening question alone, and was 32.1% ($n = 576$) after administering the social fears list. In other words, 8.5% (49/576) of the patients diagnosed with SAD would have been missed if we had limited the assessment to the SCID screening question alone.

Within the total sample, the most frequently endorsed situations were public speaking ($n = 774$; 43.0%), saying something in a group of people ($n = 560$; 31.2%), asking a question in a group of people ($n = 555$; 30.9%), speaking with authority figures ($n = 370$; 20.6%), and speaking with sexually attractive others ($n = 345$; 19.2%). The prevalence rate of having at least one social fear based on the SCID screening question alone was 50.3% ($n = 905$), and 57.3% ($n = 1032$) after administering the social fears list. See Table 1 for descriptive statistics on all social fears.

Using the social fears list to determine SAD subtype, 82.1% ($n = 473$) of patients with a lifetime diagnosis of SAD were identified as having the generalized subtype, and the remaining 17.9% ($n = 103$) as having the specific subtype. Of all of the patients endorsing at least one social fear regardless of whether or not they eventually met criteria for SAD ($n = 986$), 64.0% ($n = 631$) endorsed 3 or more social fears.

Sensitivity of the Screening Question

Eight hundred ninety-two (49.6%) participants responded “no” to the SCID screening question. A significantly greater percentage of females ($n = 587$; 64.9%) compared to males ($n = 318$; 35.1%) responded “yes” to the screening question ($\chi^2 = 8.75, p < .01$). Of the 892 patients who responded negatively to the screening question, 127 (14.2%) endorsed at least one social fear when cued by the social fears list. The data in Table 1 show that among this sub-sample of patients, the most frequently endorsed social fears were public speaking ($n = 52$; 40.9%), saying something in a group ($n = 50$; 39.4%), asking a question in a group ($n = 48$; 37.8%), speaking with sexually attractive others ($n = 39$; 30.7%), and speaking with authority figures ($n = 32$; 25.2%). Among those who responded negatively to the screener, there was no significant gender difference between those who did versus did not endorse at least one social fear ($p > .05$).

Within the 127 participants who responded negatively to the SCID screening question but subsequently endorsed at least one social fear, 49 (38.6%) met criteria for a lifetime diagnosis of SAD. Forty-three of the 49 (87.8%) had a current diagnosis, while 2 (4.1%) were diagnosed with SAD in partial remission, and 4 (8.2%) were in full remission. There was no significant gender difference between those who responded negatively to the screening question and subsequently did versus did not meet criteria for SAD ($p > .05$). Therefore, of the original 892 who responded negatively to the screening question, 5.5% received a lifetime diagnosis of SAD after cued by the social fears list. In addition, had we relied on the SCID screening question alone and not further inquired about specific social fears, the prevalence of any social fear would have been 50.3%, compared to a rate of 57.3% after using a more thorough assessment of social fears (resulting in a change of 7.0% in prevalence). This difference was statistically significant (McNemar test, $p < .01$). However, the increased rate of SAD diagnoses between the screening question alone and the screening question plus the list of social fears was not significant (32.1% versus 29.3%; McNemar test, $p = .15$). See Figure 1 for the frequencies of patients’ responses to the screening question and social fears list.

The data in Table 2 show that for detecting presence of social fears, the SCID screening question had a sensitivity of 87.1% (859/986), specificity of 94.3% (765/811), PPP of 94.9% (859/905), and NPP of 85.8% (765/892). For detecting a lifetime history of SAD, the SCID screening question had sensitivity of 91.5% (527/576), specificity of 69.0% (843/1221), PPP of 58.2% (527/905), and NPP of 94.5% (843/892).

The performance of the social fears list in detecting lifetime history of SAD was compared to that of the SCID screening question in order to assess its incremental validity. The specificity decreased by 2.6% (to 66.4%), and the PPP remained the same when using the social fears list. However, the sensitivity and NPP of the social fears list were 8.5% and 5.5% higher than those of the SCID screening question (100% for both; see Table 2).

The data in Table 2 show that sensitivity of the SCID screening question in detecting the presence of social fears was much higher for those patients who endorsed 3 or more fears compared to those who endorsed one or two, while specificity was the same for both groups. In addition, PPP and NPP were higher for those with more social fears. The sensitivity of the SCID screening question in detecting a diagnosis of SAD was higher for patients endorsing 3 or more fears compared to patients endorsing one or two fears, while specificity was slightly higher for those endorsing 3 or more fears. PPP was much higher for patients with 3 or more fears, while NPP was comparable. Finally, sensitivity for detecting a SAD diagnosis based on the social fears list was the same for both groups, but specificity was higher for patients endorsing 3 or more fears compared to patients endorsing one or two fears. PPP was much higher for patients with 3 or more fears, and NPP was the same for both groups.

With respect to the incremental validity of the social fears list, sensitivity and specificity to detect a SAD diagnosis increased when using the social fears list in addition to the SCID screening question within the group of patients who endorsed 3 or more social fears. However, within the group of patients who endorsed one or two fears, sensitivity increased but specificity decreased slightly. PPP and NPP also increased slightly when using the social fears list for both subgroups of patients (see Table 2).

Social Functioning and Desire for Treatment

Preliminary analyses were conducted between those patients with SAD who were identified originally by the SCID screening question ($n = 527$) and those who were not identified originally by the SCID screening question (i.e., responded negatively but endorsed at least one social fear and subsequently were diagnosed with SAD; $n = 49$) on current social functioning and desire for treatment. Of those who were not identified originally by the screening question, 88.6% desired treatment for SAD, compared to 79.7% of those who were identified originally by the SCID screening question. This difference was not significant ($\chi^2 = .72, p > .05$). In addition, no difference was found between the two groups on current social functioning (not originally identified: $M = 3.35, SD = 1.36$; originally identified: $M = 3.47, SD = 1.26$; $t_{566} = -.62, p > .05$).

Discussion

The aim of the current study was to examine the performance of the SCID screening question in identifying prevalence of social fears and lifetime history of SAD. First, the prevalence of SAD and social fears was examined in the total sample. In a large study of psychiatric outpatients evaluated with a semi-structured interview, we found a prevalence rate of 32% for SAD, similar to other studies of treatment-seeking samples utilizing a semi-structured interview (e.g., 19). The majority of patients meeting criteria for SAD were classified as having the generalized subtype, and a majority of patients, regardless of diagnosis of SAD, endorsed 3 or more social fears. The rate of the generalized subtype in the current study is higher than the rate found in epidemiological studies, but comparable to other treatment-seeking samples (e.g., 20). This is most likely because individuals with the generalized subtype are more likely to present for treatment compared to those with the specific subtype (21).

It also was found that the most frequently reported social fears were public speaking, saying or asking something in a group of people, speaking with sexually attractive others, and speaking

with authority figures, rather than eating or writing in public. This is consistent with other studies examining the prevalence of social fears in clinical and epidemiological samples, which found eating and writing in public to be among the least frequent and/or least distressing (12; 3). Despite the lower prevalence rates of public eating and writing fears, they are often components of screening questions for SAD, rather than other fears that are much more frequently reported among individuals with SAD. Because of this, the prevalence of social fears and SAD may have been previously underestimated.

When we examined the performance of the SCID screening question in identifying social fears and lifetime history of SAD before and after administering a more comprehensive list of social fears, the prevalence rates were modestly different. The prevalence of social fears increased by 7.0% after using the social fears list, and the prevalence rate of lifetime history of SAD increased by only 2.8%. Thus, while the prevalence of social fears significantly increased and therefore would have been underestimated, the SCID screening question appeared to identify most individuals with a lifetime history of SAD.

When examining results by subtype (i.e., comparing those patients who endorsed 3 or more social fears to patients who endorsed one or two social fears), a similar pattern of results emerged with respect to the performance of the social fears list in addition to the SCID screening question. In other words, the addition of the social fears list improved the detection of a SAD diagnosis compared to the SCID screening question in both subtype groups. However, it was found that the SCID screening question and social fears list are better at identifying cases of SAD in people who endorsed 3 or more social fears compared to one or two fears. One potential explanation for this finding is that in people who endorse several social fears, there is a higher probability of “getting a hit” with a screening measure because the individual has a broad enough range of fears. Therefore, although the screening question does not cover all possible social fears, it may cover a broad enough range of social fears such that someone with SAD (especially the generalized subtype) would endorse at least one of those fears.

Nonetheless, results from the total sample showed decreased specificity and increased sensitivity after using the social fears list in identifying patients with a lifetime diagnosis of SAD. From a clinical perspective, it is most important for a screening question to have higher sensitivity even at the expense of lower specificity (14). Although this may result in a greater number of false positives, it is particularly important for a screening question to err on the side of false positives because the screening question determines whether the full module should be administered, and the full module in turn determines if an individual has the disorder. If the screening question is not sensitive enough, the full module will not be administered, the disorder subsequently will not be adequately identified, and the patient will not be treated for this problem. This is an especially relevant problem for patients with SAD, given its chronic and unrelenting course without treatment (2).

As no published studies have been conducted on the performance of the SCID screening question in identifying social fears and lifetime history of SAD, preliminary analyses also were conducted to examine differences in clinical presentation (i.e., social functioning and desire for treatment) between the patients who were and were not identified originally by the SCID screening question. Results showed that the patients who were missed by the SCID screening question but endorsed at least one social fear and subsequently met criteria for SAD were no less severe than those who were identified originally by the SCID screening question, based on current social functioning. In addition, those patients missed by the SCID screening question were no less interested in receiving treatment for SAD than those originally identified by the SCID screening question. This highlights the importance of using a screening question with adequate sensitivity so that the full module will be conducted. In other words, the patients who were missed by the screening question would not have been administered the rest of the SAD

module, and therefore the disorder would not have been identified. As a result, they may not have had the opportunity to receive treatment for SAD even though their social functioning was no less impaired and they were no less interested in treatment compared to the patients who were identified originally by the screening question.

It was found that a greater percentage of females compared to males responded affirmatively to the SCID screening question. Although the prevalence rate of SAD for women is higher than for men in community samples (15.5% versus 11.1%, respectively; 22), roughly equal proportions of men and women present for treatment of SAD (23). Therefore, perhaps the screening question captures fewer men than women with SAD because of the types of fears listed in the screening question. Prior research examining gender differences using the LSAS found that men reported more severe fear than women when urinating in public and returning goods to a store (12), yet these items are not included in the screening question. However, the authors also concluded that men and women appeared to share similar social fears. Gender differences in the types of social fears reported should continue to be examined, as this may affect how SAD is screened in males versus females.

Potential limitations exist that should be considered when interpreting the results. Although only 4% of individuals diagnosed with SAD were seeking treatment for it and had it as their primary diagnosis, many participants were seeking treatment for comorbid conditions; therefore, results may not be generalizable to samples of patients with primary SAD. There may exist several reasons for why only 4% of patients were seeking treatment primarily for SAD. For example, an individual may perceive his/her SAD symptoms to be less severe than symptoms of another comorbid condition. In addition, patients may be less aware of the treatment options for SAD compared to other conditions that are discussed more often in the media, such as depression (24). It is important to note that, when asked, the majority of patients desired treatment for SAD in addition to their primary condition.

The generalizability of sample demographic characteristics also should be considered, as the majority was Caucasian and educated. However, the composition of this sample is consistent with other treatment-seeking samples (15,16,25). The use of a treatment seeking sample also constitutes a potential limitation, such that these samples may over-report psychopathology in general (26). As a result, findings may not be generalizable to non-treatment seeking samples.

Another limitation is that this study did not directly compare the utility of the SCID screening question and the social fears list. Rather, the purpose of this study was to examine whether detection of lifetime history of SAD and social fears improved after using a more comprehensive social fears list. Future studies should conduct a head-to-head comparison of these two assessment methods. In addition, the current study relied primarily on interview-based data, rather than also including other modes of assessment such as self-report and behavioral methods. Therefore, method effects cannot be ruled out. Future research on the utility of the SCID screening question should include these other modes of assessment, in order to determine if patients negatively versus affirmatively responding to the screening question differentially report severity of symptoms and respond to social challenges.

Finally, social fears were measured by their presence or absence, rather than level of severity. Therefore, even if a particular social fear was reported to be present by more patients, it may not be more severe than another fear that fewer patients reported to be present. However, one purpose of this study was to determine what types of fears were reported by those who responded negatively to the SCID screening question, in order to determine how screening questions could be improved. Future studies should examine types of fears reported, as well as the severity of each of these fears.

In summary, the SCID screening question failed to capture 5.5% of individuals who eventually went on to meet criteria for SAD. Although the increase in prevalence of SAD after administering the list of social fears was not statistically significant, the increase in prevalence of social fears was significant. Results on the types of social fears reported in this study, particularly by those who were missed by the SCID screening question, suggest that perhaps screening questions could be modified to more accurately capture these individuals and to better identify social fears to be targeted in treatment. In particular, results suggest that the SCID screening question could be modified to include such fears as saying something in a group, speaking with authority figures, and speaking with sexually attractive others, as these fears were among the most prevalent in individuals with SAD missed by the SCID screening question. Modifying the SCID screening question in this way would be particularly helpful if the purpose of the evaluation is to gather more detailed information related to treatment, such as types of social fears to be targeted in treatment, rather than if the purpose is solely to provide a diagnosis. Although it may be more time consuming to administer a more comprehensive social fears list during a diagnostic interview such as the SCID, such an assessment could be obtained using brief, evidenced-based self-report measures such as the Brief Social Phobia Scale (27) or the Social Phobia Inventory (28).

As this was the only known study to examine performance of the SCID screening question for the SAD module, it should be replicated not only with the SCID but also with other commonly used semi-structured interviews. Based on the results of our ongoing, large clinical epidemiological study, we have modified the SCID screening question for SAD to read as follows: “Was there ever anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, writing, saying something in a group of people, conversing with sexually attractive others, or with authority figures?” Future research is needed to determine whether this revision of the screening question performs differently from the original version.

Acknowledgements

This research was supported in part by grants MH48732 and MH56404 from the National Institute of Mental Health.

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Figure 1.
Frequency of Responses to the SCID Screening Question for Social Anxiety Disorder, the Social Fears List, and Frequency of Diagnoses

Table 1

Prevalence of Social Fears in the Total Sample and Those Who Responded Negatively to the SCID Screening Question

Social Fear	Total Sample (<i>n</i> = 1797)	Said "No" to SCID Screen but Endorsed at Least One Fear (<i>n</i> = 127)
Eating in front of others *	217 (12.1)	8 (6.3)
Writing in front of others *	160 (8.9)	5 (3.9)
Public speaking *	774 (43.0)	52 (40.9)
Saying something in a group	560 (31.2)	50 (39.4)
Asking something in a group	555 (30.9)	48 (37.8)
Public restrooms	79 (4.4)	5 (3.9)
Business meetings	269 (15.0)	21 (16.5)
Using telephone/job-related equipment	133 (7.4)	2 (1.6)
One-on-one conversations with strangers	244 (13.6)	16 (12.6)
Conversations with sexually attractive others	345 (19.2)	39 (30.7)
Authority figures	370 (20.6)	32 (25.2)
Returning something to a store	130 (9.3)	11 (8.7)
Walking around the mall with no specific plan	112 (6.3)	7 (5.5)

Note. SCID = Structured Clinical Interview for *DSM-IV* (First et al., 1997). Fear of returning goods to a store was added to the social fears list after the first 400 participants.

* Social fears included in the SCID screening question.

Performance of the SCID Screening Question Compared to the Social Fears List in Identifying History of Social Fears and Social Anxiety Disorder

Table 2

Variable	SCID Screening Question				Social Fears List			
	Sens.	Spec.	PPP	NPP	Sens.	Spec.	PPP	NPP
Social Fears: Total Sample	87.1	94.3	94.9	85.8	--	--	--	--
Social Fears: 3 or more fears	93.3	94.3	92.8	94.8	--	--	--	--
Social Fears: 1 or 2 fears	76.1	94.3	85.4	90.0	--	--	--	--
SAD diagnosis: Total Sample	91.5	69.0	58.2	94.5	100.0	66.4	58.2	100.0
SAD diagnosis: 3 or more fears	94.3	80.4	70.1	96.7	100.0	83.6	74.8	100.0
SAD diagnosis: 1 or 2 fears	78.8	78.0	25.9	97.4	100.0	76.3	29.2	100.0

Note. SCID = Structured Clinical Interview for DSM-IV (First et al., 1997); SAD = Social Anxiety Disorder; Sens. = sensitivity; Spec. = specificity; PPP = positive predictive power; NPP = negative predictive power.