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Advances in the Research of Social Anxiety and Its Disorder (Special Section)

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Editorial

Humans are social creatures. We have a strong need to be liked, valued, and approved of by others. As a result, we create sophisticated social structures and hierarchies that determine the individual's value. Ostracism from the social group negatively impacts a variety of health-related variables, including one's self-esteem and sense of belonging (Baumeister & Leary, 1995). Similarly, restricting social relationships is viewed as a punishment. For example, severe violations of social norms can lead to imprisonment, which limits the individual's social contacts. Moreover, a violation of prison rules can lead to a further restriction of social contacts and even solitary confinement. Due to the importance of social relationships, humans naturally fear negative evaluation by their peers.

The maladaptive expression of this evolutionarily adaptive concern is social anxiety disorder (SAD). The epidemiological literature reports lifetime prevalence rates of SAD in Western countries ranging between 7% and 12% of the population (Furmark, 2002; Kessler, Berglund, Demler, Jin, & Walters, 2005). SAD affects men and women relatively equally, with the average gender ratio (female:male) ranging between 1:1 (Moutier & Stein, 1999) and 3:2 (Kessler et al., 2005) in community studies. SAD often begins in the mid-teens, but can also occur in early childhood. During childhood, SAD is often associated with shyness, behavioral inhibition, overanxious disorder, mutism, school refusal, and separation anxiety. If the problem is left untreated, it typically follows a chronic, unremitting course and leads to substantial impairments in vocational and social functioning (Stein & Kean, 2001).

There is a considerable degree of variance among individuals with SAD in the number and type of situations they fear. Examples of social interactions that are associated with social anxiety include performance situations, such as speaking, eating or writing in public, initiating or maintaining conversations, going to parties, dating, meeting strangers, or interacting with authority figures (for a review, see Hofmann, Heinrichs, & Moscovitch, 2004). This high degree of heterogeneity of feared situations introduces a challenge for diagnosing SAD. In addition, excessive fear is not the only emotion that is experienced by individuals with this disorder. Shyness, embarrassment, self-consciousness, and even anger are other affective states that are often reported by people with social anxiety and SAD. This poses complicated nosological problems.

When SAD was first introduced as a diagnostic category in the DSM (American Psychiatric Association, 1980), it was conceptualized similarly to specific phobia. Specifically, the DSM-III stated that "both Social and Simple Phobias generally involve a circumscribed stimulus... When more than one type is present, multiple diagnoses should be made" (p. 225). The DSM-III did not recognize the fact that most individuals with SAD fear multiple social situations

when it stated: “generally an individual has only one Social Phobia” (p. 227). Furthermore, the diagnosis of SAD was ruled out if the individual met diagnostic criteria for avoidant personality disorder (APD). These diagnostic criteria underwent significant changes with the publication of the DSM-III-R (American Psychiatric Association, 1987) and then later the DSM-IV (American Psychiatric Association, 1994). Specifically, the diagnostic specifier “generalized subtype” was introduced to describe individuals who fear “most or all” social situations (p. 417). Furthermore, the diagnosis of SAD was no longer ruled out if the person also met criteria for APD. These diagnostic criteria are likely to undergo further changes with the next publication of the DSM. As one of the advisors to the DSM-V Task Force, I have experienced first-hand the lively controversies and disagreements with regards to SAD among my colleagues.

Contemporary treatment protocols for SAD include cognitive therapy (CT), behavior therapy, social skills training, and more recently, interpersonal psychotherapy. Of those interventions, CT and behavioral therapy—usually subsumed under the general term cognitive behavioral therapy (CBT)—are the most validated approaches (for a review, see Hofmann & Otto, 2008). CBT was initially developed based on Beck and Emery’s (1985) cognitive therapy for anxiety disorders. Although well-controlled clinical trials suggest that the original formulation of CBT for SAD is statistically more effective than no treatment or a placebo-control condition, a significant subset of patients fail to achieve optimal benefit from this treatment (Heimberg et al., 1998). Newer CBT approaches focus on modifying safety behaviors and self-focused attention, among other cognitive strategies (Clark et al., 2006; Hofmann, 2007). These strategies seem to be associated with greater treatment efficacy than the earlier CBT approaches (e.g., Clark et al., 2006). However, a replication of these promising findings is needed. Moreover, a number of other maintaining factors have been identified but have not yet been incorporated into CBT protocols. Finally, it is worthwhile to examine the efficacy of other treatment approaches and to explore the mechanism of treatment change. Considering these variables might further enhance the efficacy of treatment for this severe and prevalent disorder.

The current issue will present a number of exciting new developments in social anxiety and SAD. The articles include new research on the development, psychopathology, and treatment of social anxiety and SAD. The first article by Majdandžić, Vente, and Bögels examined rearing histories of individuals with and without social anxiety who become first-time parents. The results of this study showed that women who rated their mother lower on encouragement of autonomy and higher on rejection were more likely to have SAD. However, no association between rearing history and social anxiety or SAD was observed in men. Furthermore, fathers did not seem to have an influence on the development of SAD. Thus, the results of this study suggest that perceived maternal rejection is specifically related to social anxiety disorder in women who become first-time mothers.

Kashdan and Collins present an innovative method for studying social anxiety, using an ecological momentary assessment approach. This approach is based on recent research showing that social anxiety is associated with diminished positive affect and elevated anger. Results demonstrated that social anxiety was associated with more time spent feeling angry and less time spent feeling happy and relaxed throughout the day. Furthermore, people with high social anxiety reported fewer and less intense positive emotions and greater anger episodes across social and nonsocial situations. This fascinating study not only points to an exciting new method for studying social anxiety, but also highlights the importance of anger and low positive affect for social anxiety. Anger and low positive affect have been all but ignored in the social anxiety literature. Kashdan and Collins’s research opens up new and creative ways for studying and treating SAD.

The study by Bitran and Hofmann examined the effect of affect on social cost bias, a particular cognitive bias that occupies a central role in contemporary CBT models. Using an experimental manipulation, the authors showed that affect manipulation resulted in changes in estimated social cost. However, this effect was not specific to individuals with social anxiety disorder. Furthermore, individuals who received a positive affect instruction had the highest social cost estimates after a social challenge task. These results suggest that the social cost bias is influenced by the affective state in socially anxious and non-anxious individuals. This effect could lead to more effective treatment strategies through manipulating the person's affective state in the therapeutic setting.

The study by Stangier, Von Consbruch, Schramm, and Heidenreich explored the common factors that might underlie CBT and interpersonal therapy (IPT). Using patients' and therapists' ratings, the results showed that the treatment conditions differed significantly on several subscales of therapists' ratings. As expected, CT was rated as focusing more on the mastery of problems. Moreover, and unexpectedly, therapists also reported using resource activation and motivational clarification more in CT than in IPT. Furthermore, outcome was predicted by resource activation and problem activation. This study highlights the importance of exploring the mechanism of treatment change by comparing two active psychological treatments. The results demonstrate that common factors are important variables that need to be considered. The authors provide an excellent template for studying these factors, which have been notoriously difficult to study.

The final article by Chaker, Hofmann, and Hoyer examined the efficacy of a one-weekend group therapy for the fear of blushing, a specific syndrome that is usually subsumed under the diagnostic category of SAD. The intensive treatment, which consisted of a combination of attention training and behavioral therapy, was well accepted and significantly reduced the fear of blushing. This open-label study is promising and calls for further investigation.

It should be noted that all manuscripts underwent the standard peer-review process. Aleksandra Luszczynska served as the action editor of the article by Bitran and Hofmann, and Joachim Stoeber served as action editor of the article by Chaker, Hofmann, and Hoyer. I hope the readers share our excitement about the recent studies and future developments of research on social anxiety and SAD.

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