

An illustration on a dark blue background. In the center is a person with a dark skin tone, wearing a light pink long-sleeved shirt and white pants. Their hair is represented by a dense, chaotic mass of white scribbles. They are sitting with their hands clasped in their lap. Surrounding the person are five hands of different skin tones (light brown, dark brown, and black) reaching in from the edges, all pointing their index fingers towards the person. The overall mood is one of social scrutiny or anxiety.

Social Anxiety

Individual Differences: Theory and Practice



What is social anxiety?

The fear, nervousness and apprehension most people experience in their relationships with other people.

It strikes people when they think that they might do something that will be humiliating or embarrassing.

It makes you think that other people are judging you, and doing so in a negative way, because of something you said or did.

Seeing things this way makes it hard to interact naturally with people, and difficult to talk, listen or make friends.

Socially anxious people tend to assume that their interactions with others will be painfully revealing: that others will notice their weaknesses or awkwardness; that they will be dismissed, ignored, criticized or rejected for not behaving more acceptably

Social anxiety
is normal.

Everybody
feels it
sometimes.

Often it leads to isolation and loneliness, prevents them becoming intimate with other people, or finding a partner with whom to share their lives.

They may have a sense of fun, be energetic and generous, kind and understanding, serious, amusing, quiet or lively, and they spontaneously behave in these ways when they feel at ease.

But feeling at ease in company is so hard for them, and makes them so anxious, that these qualities are often hidden from view.

The anxiety interferes with their expression.



Social anxiety disorder (SAD)

A persistent fear of one or more social situations where embarrassment may occur and the fear or anxiety is out of proportion to the actual threat posed by the social situation as determined by the person's cultural norms.

Typical social situations - meeting people including strangers, talking in meetings or in groups, starting conversations, talking to authority figures, working, eating or drinking while being observed, going to school, shopping, being seen in public, using public toilets and public performance including speaking.

People can worry excessively about them and can do so for weeks in advance of an anticipated social situation.

Fear that they will say or do (involuntarily or otherwise) something that they think will be humiliating or embarrassing (such as blushing, sweating, shaking, looking anxious, or appearing boring, stupid or incompetent).

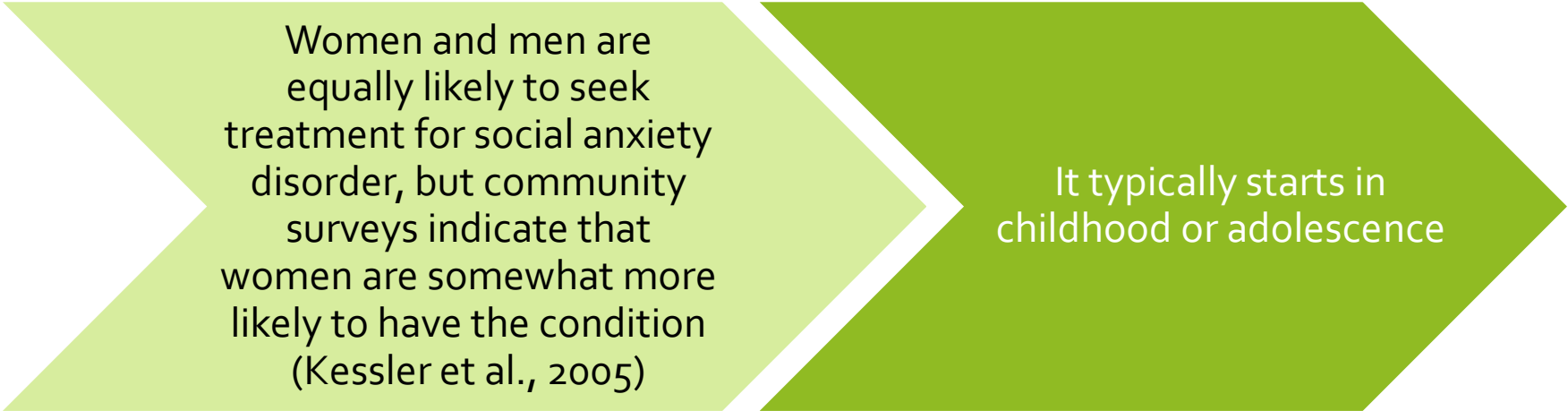
Whenever possible, people will attempt to avoid their most feared situations.

However, this is not always feasible, and they will then endure the situation, often with feelings of intense distress.

Usually the condition will cause significant impairment in social, occupational or other areas of functioning.

There are no UK epidemiological surveys that specifically report data on SAD in adults

How common is social anxiety disorder?



SAD is one of the most common of all the anxiety disorders.

Data from the National Comorbidity Survey reveals it is the third most common psychiatric condition after major depression and alcohol dependence (Kessler et al., 2005)



Lifetime prevalence rates of up to 12% have been reported (Kessler et al., 2005) compared with lifetime prevalence estimates for other anxiety disorders of 6% for generalised anxiety disorder, 5% for panic disorder, 7% for post-traumatic stress disorder (PTSD) and 2% for obsessive-compulsive disorder (OCD).

Educational achievement can be undermined, with individuals having a heightened risk of leaving school early and obtaining poorer qualifications (Van Ameringen et al., 2003).

How does it interfere with people's lives?

Less likely to marry,
More likely to divorce
Less likely to have children
(Wittchen et al., 1999)

Social life is impaired.
Fewer friends and have more difficulty getting on with friends
(Whisman et al., 2000).

Social fears can also interfere with visiting shops, buying clothes, having a haircut and using the telephone.

Employed- but report taking more days off work and being less productive because of their symptoms (Stein et al., 1999). People may avoid or leave jobs that involve giving presentations or performances.

Katzelnick et al. (2001) - associated with outpatient medical visits.



An interaction between several different biopsychosocial factors (Tillfors, 2004)

What do we know about the causes of social anxiety disorder?

Genes seem to play a part, but may influence the probability of developing any anxiety disorder rather than developing social anxiety in particular.

Twin studies. Kendler et al (1992; 1999) - found that if one twin is affected, the chance of the other twin being affected is higher if the twins are genetically identical (monozygotic) than if they only share 50% of their genes (dizygotic).

Higher rates of social anxiety disorder are reported in relatives of people with the condition than in relatives of people without the condition

However, heritability estimates are only 25 to 50%, indicating that environmental factors also have an important role in the development of the condition

What do we know about the causes of social anxiety disorder?

Stressful social events in early life (for example, being bullied, familial abuse, public embarrassment or one's mind going blank during a public performance) (Erwin et al., 2006).

Neuroimaging studies - different activation of specific parts of the brain (the amygdalae, the insulae and the dorsal anterior cingulate – all structures that are involved in the regulation of anxiety) when threatening stimuli are presented compared with healthy volunteers.

Parental modelling of fear and avoidance in social situations plus an overprotective parenting style (Lieb et al., 2000)

The success of SSRIs, SNRI and MAOIs in treating it suggests that dysregulation of the serotonin and dopamine neurotransmitter system may also play a role.

Shyness

Discomfort and/or inhibition in interpersonal situations that interferes with pursuing one's interpersonal or professional goals.

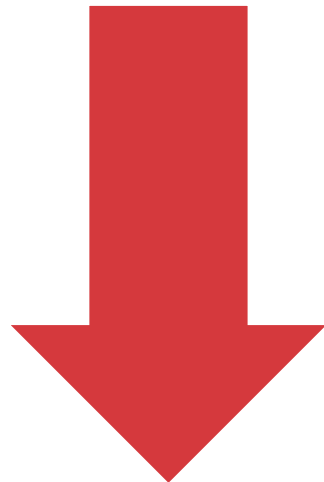
Henderson and Zimbardo (1998)

Zimbardo and Henderson

It is a form of excessive self-focus, a preoccupation with one's thoughts, feelings and physical reactions.



It may vary from mild social awkwardness to totally inhibiting social phobia.



Shyness may be chronic and dispositional, serving as a personality trait that is central in a person's self definition.

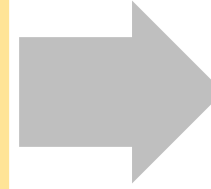
Situational shyness involves experiencing the symptoms of shyness in specific social performance situations but not incorporating it into one's self-concept.

Shyness reactions can occur at any or all of the following levels: cognitive, affective, physiological and behavioural and may be triggered by a wide variety of arousal cues.

Behaviour	Physiological	Cognitive	Affective
Inhibition and passivity	Accelerated heart rate	Negative thoughts about the self, the situation, and others	Embarrassment and painful self-consciousness
Gaze aversion	Dry mouth	Fear of negative evaluation and looking foolish to others	Shame
Avoidance of feared situations	Trembling or shaking	Worry and rumination, perfectionism	Low self-esteem
Low speaking voice	Sweating	Self-blaming attributions, particularly after social interactions	Dejection and sadness
Little body movement or expression or Excessive nodding or smiling	Feeling faint or dizzy, butterflies in stomach or nausea	Negative beliefs about the self (weak) and others (powerful), often out of awareness	Loneliness
Speech dysfluencies	Experiencing the situation or oneself as unreal or removed	Negative biases in the self-concept, e.g., "I am socially inadequate, unlovable, unattractive."	Depression
Nervous behaviors, such as touching one's hair or face	Fear of losing control, going crazy, or having a heart attack	A belief that there is a "correct" protocol that the shy person must guess, rather than mutual definitions of social situations	Anxiety

Zimbardo Stanford Shyness Survey

A large- scale survey first with open-ended questions, then a self-report checklist which was administered to more than a thousand people.



Also -hundreds of in-depth interviews, case studies, experimental-behavioural research, and cross-cultural research on shyness for more than 20 years, culminating in the creation of a treatment program for shy adults.

In addition to the 40% of respondents who reported being chronically shy; another 40% indicated that they had considered themselves as shy previously but no longer, 15% more as being shy in some situations, and only about 5% believed they were never shy.

Shyness is distinct from introversion. Introverts feel energized by time alone; shy people often desperately want to connect with others, but don't know how or cannot tolerate the anxiety that comes with human interaction.

The consequences of shyness

Don't take advantage of social situations, date less, are less expressive verbally and nonverbally, and show less interest in other people than non-shys.

Painfully self-conscious, and report more negative thoughts about themselves and others in social interactions, seeing themselves as inhibited, awkward, unfriendly and incompetent, particularly with people to whom they are sexually attracted.

They also see themselves as less physically attractive, although research indicates that shyness is not related with observers' ratings of attractiveness.

Ten to twenty percent of shy individuals may also lack basic social skills. This may mean not knowing what to say or do (content), how to do so (style), and when best to respond (timing).

Objective ratings have shown that some shy individuals talk less, initiate fewer topics of conversation, avert their gazes more often, touch themselves nervously, and show fewer facial expressions.

Their lowered likelihood of enacting social behaviours appears to be related to their lowered confidence in their ability to carry out the required behaviours, to their lack of self efficacy beliefs.

State vs. Trait Shyness

situational
vs. dispositional

State

- Immediate emotional and cognitive experiences of shyness
- Heightened self-consciousness in response to a social threat
- Experienced by anyone – strangers and new situations



Trait

- Long-lasting or permanent
- Heightened self-consciousness in response to many different and frequent situations
- Experience shyness in response to much lower levels of social threat than are usually needed to experience state shyness.
- A personality trait that remains stable over time and across situations



Kagan Behavioural inhibition (BI)



Kagan looked at individual differences in temperament in babies

He observed variations in the emotional responses

He called this temperamental behavioural inhibition (BI)

BI - wariness in regards to novel people, objects, or situations (Kagan, Snidman, Kahn, & Towsley, 2007).

Individuals can be inhibited toward the unfamiliar and also be inhibited as a result of social-evaluative concerns based on the fear of being rejected or neglected by others (Asendorpf, Denissen, & van Aken, 2008).



Kagan Behavioural inhibition (BI)



Whereas inhibition refers to both social and non-social situations, shyness is a narrower construct that is described as wariness when confronted with novel social situations and/or self-conscious behaviour in perceived social-evaluative settings (Rubin, Coplan, & Bowker, 2009).

Therefore, as with inhibition, shyness is elicited by both novel and familiar social situations.

Children's lack of social interaction can result from either active isolation, a process where peers reject and/or exclude children from social situations, or social withdrawal whereby the child himself or herself elects not to engage in social interaction (Rubin et al., 2009).

While the experience of shyness in moderation is considered typical, excessive childhood inhibition can foreshadow adjustment problems.



Shyness



While shyness and clinical symptoms of anxiety are related, they are by no means synonymous.

They are not components of a single underlying construct (Rapee, 2010).

Only exhibit moderate levels of shyness.

Family factors

Mothers who have difficulty with stress and anxiety are more likely to have shy or anxious children (Hastings, Nuselovici, Rubin, & Cheah, 2010), regardless of whether the transmission is genetic, experiential, or interactive.



While some of this risk can be explained by genetic influences, shyness or anxiety is also more likely because of the uncertain environment created by an anxious parent for the child.

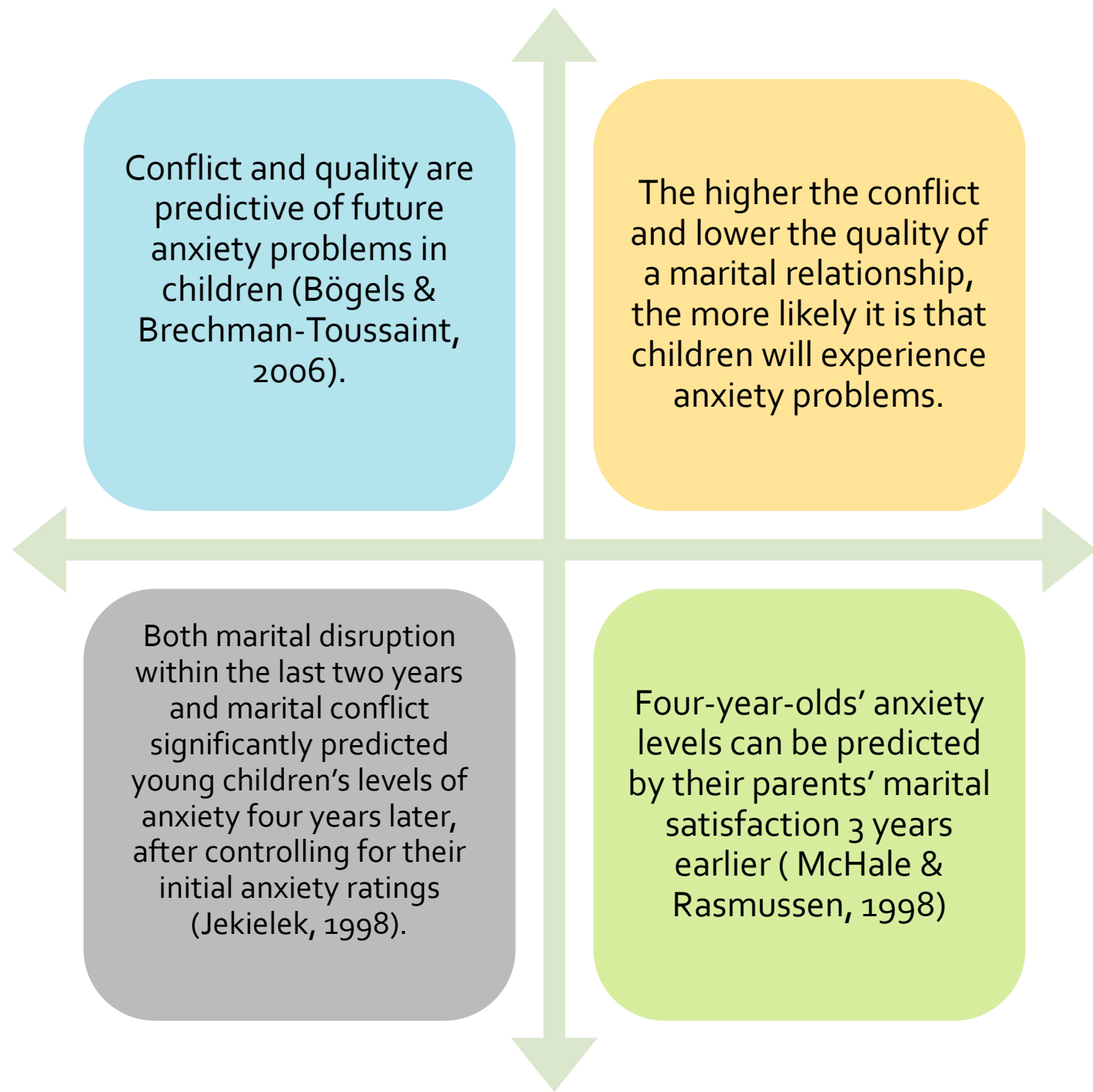
In a sample of genetically identical (monozygotic) twin pairs, internalizing problem behaviours were predicted by discordant parental feelings coupled with a chaotic home environment (Asbury, Dunn, Pike, & Plomin, 2003).

A chaotic home moderated the relationship between parents' differential feelings toward each twin and anxiety symptoms.

It is important to note, however, that children of anxious parents may appear more inhibited themselves because these parents may over-report their children's anxiety symptoms.

When emotionally distressed parents are reporting on their own children's internalizing, their ratings are likely to be inflated, especially for daughters (Krain & Kendall, 2000).

The marital relationship



Family's socioeconomic status



Adults with low social capital and socioeconomic status are at a greater risk for mental health problems (Phongsavan, Chey, Bauman, Brooks, & Silove, 2006).



Children are at an increased risk for the development of internalizing behaviour problems if they are living in households with low socioeconomic status (Cicchetti & Toth, 1998; Turner & Butler, 2003).



Experiencing poverty within the first five years of life is associated with higher maternal reported depression and anxiety scores (Spence, Najman, Bor, O'Callaghan, & Williams, 2002).

Treatments



Prescription
medications



Cognitive-behavior
therapy



Acceptance and
commitment therapy



Psychoanalysis

Treatments

Both medication and therapy have been shown effective in treating social anxiety disorder.

Social anxiety that occurs in all situations responds best to a combination of medication and therapy, while therapy alone is often sufficient for people with anxiety specific to one type of performance or social situation.

Prescription Medications

A systematic review of the effectiveness of medication in SAD treatment showed a small to medium-sized effect—with all of the following categories of medications showing improvements (Williams et al., 2017)

Benzodiazepines
Selective Serotonin Reuptake Inhibitors (SSRIs)
Monoamine Oxidase Inhibitors (MAOIs)
Beta Blockers
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)



Psychological Therapies

CBT is the first-line psychotherapeutic treatment for SAD. It is a form of psychotherapy designed to modify your thoughts and behaviours in order to positively influence your emotions.

Acceptance and
commitment
therapy (ACT)

Psychoanalysis
and
psychodynamic
therapy

Cognitive-Behavioural Therapy (CBT)



Exposure



Cognitive
restructuring



Social skills training

Summary

Social anxiety is normal. Everybody feels it sometimes (so everyone knows to some degree what it is like), and it would be absurd for any of us to suppose that we would never feel socially anxious again.

We have discussed the prevalence, aetiology and effects of social anxiety and explored how this differs from shyness.

We discussed Kagan's behavioural inhibition and familial factors involved in shyness.

We ended with some of the treatments for SAD

TASK

In pairs or on your own:

- Locate ONE journal paper that evaluates the usefulness of a therapy or range of therapies for social anxiety
- Describe the therapies and discuss the findings/conclusions

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