

Review

SOCIAL ANXIETY DISORDER IN DSM-5

Richard G. Heimberg, Ph.D.,^{1*} Stefan G. Hofmann, Ph.D.,² Michael R. Liebowitz, M.D.,³ Franklin R. Schneier, M.D.,⁴ Jasper A. J. Smits, Ph.D.,⁵ Murray B. Stein, M.D., M.P.H.,^{6,7} Devon E. Hinton, M.D., Ph.D.,⁸ and Michelle G. Craske, Ph.D.⁹

With the publication of DSM-5, the diagnostic criteria for social anxiety disorder (SAD, also known as social phobia) have undergone several changes, which have important conceptual and clinical implications. In this paper, we first provide a brief history of the diagnosis. We then review a number of these changes, including (1) the primary name of the disorder, (2) the increased emphasis on fear of negative evaluation, (3) the importance of sociocultural context in determining whether an anxious response to a social situation is out of proportion to the actual threat, (4) the diagnosis of SAD in the context of a medical condition, and (5) the way in which we think about variations in the presentation of SAD (the specifier issue). We then consider the clinical implications of changes in DSM-5 related to these issues. Depression and Anxiety 31:472–479, 2014. © 2014 Wiley Periodicals, Inc.

Key words: DSM-5; social anxiety disorder; social phobia; diagnostic criteria; diagnosis; classification; specifiers

¹Department of Psychology, Adult Anxiety Clinic, Temple University, Philadelphia, Pennsylvania

²Department of Psychology, Boston University, Boston, Massachusetts

³Department of Psychiatry, Columbia University College of Physicians and Surgeons and the Medical Research Network, New York, New York

⁴Anxiety Disorders Clinic, New York State Psychiatric Institute and Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, New York

⁵Department of Psychology and the Institute for Mental Health Research, University of Texas at Austin, Austin, Texas

⁶Department of Psychiatry, University of California at San Diego, La Jolla, California

⁷Department of Family & Preventive Medicine, University of California at San Diego, La Jolla, California

⁸Department of Psychiatry, Harvard University, Cambridge, Massachusetts

⁹Department of Psychology, University of California at Los Angeles, Los Angeles, California

*Correspondence to: Richard Heimberg, Adult Anxiety Clinic, Department of Psychology, Temple University, Weiss Hall, 1701 N. 13th St., Philadelphia, PA 19122. E-mail: heimberg@temple.edu
Received for publication 07 September 2013; Revised 09 November 2013; Accepted 28 November 2013

DOI 10.1002/da.22231

Published online 2 January 2014 in Wiley Online Library (wileyonlinelibrary.com).

With the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), there have been changes to the diagnostic criteria for several disorders, additions of new disorders, and deletion of some for which time has runs its course.^[1] The Anxiety Sub-Workgroup of the DSM-5 Anxiety, OC Spectrum, Posttraumatic, and Dissociative Disorders Workgroup devoted many long hours to consideration of the diagnostic criteria for, and even the name of, social anxiety disorder (SAD, the disorder previously known as social phobia). In this paper, after a brief history, several of us who have devoted considerable energy to the study of SAD examine the primary changes in the diagnostic criteria and the implications these may have for the recognition, assessment, and treatment of SAD. Keep in mind that any statements contained herein do not represent the views or opinions of the *American Psychiatric Association* and are purely those of the authors.

A BRIEF HISTORY OF SAD (SOCIAL PHOBIA)

Much of our thinking about the classification of phobic disorders derives from the 1966 work of Marks and Gelder.^[2] Citing distinctions in clinical features and family history, they divided the phobic disorders into three principal types—agoraphobia, specific phobias, and social phobia. They defined social phobia broadly as an exaggerated fear of scrutiny or evaluation by

others that led to distress and/or avoidance when engaging in performance or social interactions.

DSM-III^[3] defined social phobia in a way that, at first glance, did not seem to differ markedly from Marks and Gelder's typology. DSM-III required affected individuals to manifest "a persistent, irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others, and fears that he or she may act in a way that will be humiliating or embarrassing" [3, p. 228]. However, it limited the diagnosis in several ways, all without strong empirical support. Importantly, it excluded from the diagnosis of social phobia individuals whose symptoms were due to avoidant personality disorder (APD), a newly created category characterized by "hypersensitivity to potential rejection, humiliation, or shame; an unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance; social withdrawal in spite of a desire for affection and acceptance; and low self-esteem" [3, p. 323]. In practice, this excluded those individuals with widespread interpersonal fears, leaving the category to those with more discrete and specific concerns such as performance anxiety. This was reinforced in the text, which stated that an affected individual generally had only one social phobia. DSM-III also opined that social phobia was relatively rare and not typically the source of great disability.

Liebowitz and colleagues^[4] challenged the DSM-III view of social phobia on several grounds, arguing most strongly against the APD exclusion. They reasoned that individuals with widespread interpersonal fears often suffered from an anxiety (phobic) disorder amenable to cognitive-behavioral or medication approaches. Furthermore, regardless of the definition, social phobia did not appear to be rare or associated with only limited impairment and disability. DSM-III-R^[5] expanded the DSM-III definition of social phobia by creating a "generalized subtype" for individuals who feared most social situations. The APD exclusion was removed; individuals could meet criteria for both diagnoses. Interestingly, the generalized subtype has been the more common variant of social phobia in many clinical settings, and many clinicians have regarded the comorbid presentation of social phobia and APD as the most impaired presentation of social phobia rather than a true manifestation of two disorders. Although expanding the range of social phobia, DSM-III-R limited it in another way, namely, by creating an exclusion for individuals whose social or performance fears were related to an Axis III disorder, such as stuttering or a tremor due to Parkinson's disease.

DSM-IV^[6] added "SAD" as an alternative name, an issue discussed further below. The DSM-IV Anxiety Disorders Workgroup also recommended changes to the exclusion for individuals whose fears were related to an Axis III condition, but this recommendation was not accepted by the DSM-IV leadership group. This exclusion, which has been modified in DSM-5, is also described below.

The diagnosis of social anxiety in children also underwent considerable change across editions of the DSM.

In DSM-III and DSM-III-R, socially anxious children most commonly received a diagnosis of avoidant disorder of childhood or adolescence. This diagnostic category was eliminated in DSM-IV, reflecting the high degree of overlap with SAD. DSM-IV also restricted the diagnosis of SAD to children who are capable of age-appropriate peer relations who show anxiety in peer interactions rather than solely when interacting with adults. Further, DSM-IV stipulated that, unlike adults with SAD, children did not have to recognize that their fears were excessive or unreasonable.

THE DSM-5 ANXIETY SUB-WORKGROUP

The Anxiety Sub-Workgroup addressed a large number of issues related to the diagnosis of SAD over the course of its deliberations. In addition to consideration of each specific criterion, they focused on the name of the disorder, the advantages and disadvantages of the generalized specifier versus various alternative specifiers, the relationship between SAD and APD and whether the two should be retained as separate diagnostic entities in DSM-5, whether selective mutism (SM) and test anxiety should be considered variants of SAD, the minimum duration of the disorder, and whether the diagnosis is valid for children and adolescents and from what age. Many of these issues are discussed in their 2010 paper^[7].

Briefly, with respect to topics not covered further here, the Anxiety Sub-Workgroup concluded that there was insufficient evidence to recommend that SAD and APD be considered a single disorder, although they are highly overlapping. Of interest is recent research suggesting that APD may be part of a schizophrenia spectrum.^[8,9] Regarding SM, the Sub-Workgroup also concluded that it was not possible to state that SM is identical to SAD, although the two are strongly related. Continuing to classify SM as a separate disorder could allow for the diagnosis in a child who does not clearly appear to suffer from SAD, but the Sub-Workgroup acknowledged that the absence of social anxiety in children with SM is rare. Conversely, including SM as a young child's variant of SAD could lead to the use of more efficacious treatments for this behavior. In the end, although failing to speak in social situations was listed as one means by which children may express social anxiety in SAD, SM is classified as a distinct anxiety disorder in DSM-5. The Sub-Workgroup recommended that test anxiety be considered as an exemplar of SAD if fear of negative evaluation by others is the core issue, but it might be considered a manifestation of generalized anxiety disorder if worry about the nonsocial consequences of failing an examination is more prominent. The Sub-Workgroup also asserted that SAD is a proper diagnosis for children, that it can be reliably diagnosed in children as young as age 6, that the same diagnostic criteria can be used to identify cases across age groups, and that a minimum duration of 6 months, regardless of age, is appropriate. Few changes were made in the SAD criteria that

were specific to children. In the remainder of this paper, we examine (1) the name of the disorder, (2) the role of fear of negative evaluation in SAD, (3) whether the fear or anxiety is out of proportion to the actual threat and the importance of sociocultural context in making that determination, (4) diagnosis of SAD in the context of a medical condition, (5) and the specifier issue. We then consider the clinical implications of changes in DSM-5 related to these issues.

SOCIAL PHOBIA VERSUS SAD: WHAT IS IN A NAME?

SAD was an alternative name in DSM-IV, but it has become the primary name in DSM-5. Those of us involved with the DSM-IV Anxiety Disorders Workgroup were concerned that the label “social phobia” contributed to the mistaken impression held by many in mental health and primary care settings that the disorder was neither frequent nor impairing.^[10] Data were accumulating that social phobia was rarely brought up by patients, largely because they feared negative evaluation by providers^[11] and that it was just as rarely recognized by providers who apparently did not consider it sufficiently important unless accompanied by other problems such as depression or substance use.^[12–14] In 2000, we^[10] recommended making SAD the primary name because it more strongly conveys the sense of pervasiveness and impairment than does social phobia, it has no historical baggage to suggest that the disorder is unimportant, and it is better differentiated from specific phobia. The DSM-5 Anxiety Sub-Workgroup expressed similar sentiments in its 2010 paper.^[7] However, until recently, there were no data to empirically tip the scales in either direction.

In 2012, Bruce and colleagues conducted a study of whether the name of the disorder influenced perceived need for treatment in a sample of 806 community residents.^[15] Respondents heard a brief vignette describing a person who experiences discomfort in social situations and often avoids social events. These symptoms were labeled as either social phobia or SAD, and respondents indicated whether the person should seek treatment. The percentage of respondents recommending the person seek treatment was larger if the symptoms were labeled as SAD rather than social phobia. Of course, there is much room for further study of this issue, and it is especially needed in samples of mental health and primary care service providers.

THE ACKNOWLEDGED ROLE OF FEAR OF NEGATIVE EVALUATION IN SAD

In earlier editions of the DSM, the primary fear in SAD was that the person would act in a way or show anxiety symptoms that would be humiliating or embarrassing. In DSM-5, this criterion has been substantially

broadened: “The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others)” [1, p. 202]. This is a significant change. However, it is unclear whether it will lead to the identification of new cases of SAD or whether it will simply bring the criteria more in line with the understanding of SAD that has developed since the initial work of Marks and Gelder,^[2] as represented in several prominent models of SAD.^[16–19]

The focus on humiliation and embarrassment was simply too narrow. Clearly, humiliation and embarrassment are significant concerns for many persons with SAD, but not in every case. Fear of rejection, as well as fear of offending others, can be central concerns, leading to substantial distress and avoidance, and thus functional impairment, in the absence of humiliation and embarrassment. A few examples related to fear of negative evaluation or rejection may make the point (fear of offending others is discussed in the following section). What better way to invoke negative evaluation from others than to become highly angry toward them? Erwin and colleagues^[20] demonstrated that persons with SAD were angrier than nonanxious controls. They were also much more likely to suppress the expression of anger toward others, and anger suppression was correlated with fear of negative evaluation. In another study,^[21] participants high in social anxiety reported greater ambivalence about emotional expression and more negative beliefs about emotional expression than less anxious persons. Believing that emotional expression is a sign of weakness and will be met with social rejection partially mediated the association between social anxiety and emotional suppression. Being humiliated or embarrassed may be an important part of SAD, but it is not the only part.

FEAR OR ANXIETY IS OUT OF PROPORTION TO THE ACTUAL THREAT AND THE SOCIOCULTURAL CONTEXT

DSM-IV stated that the person must recognize that the fear is excessive or unreasonable. In DSM-5, the criterion is tied to the judgment of the clinician rather than that of the patient based on the well-replicated findings that socially anxious individuals underestimate the quality of their behavioral performance and overestimate the likelihood of negative outcomes in social situations.^[22–24] Because the judgment of the clinician rather than the patient is emphasized, the statement that children need not recognize their fears as excessive or unreasonable was removed. However, whether the fear or anxiety is, indeed, disproportionate to the actual risk may be difficult to determine. DSM-5 recommends that “the individual’s sociocultural context needs to be taken into account when this judgment is being made. For example, in certain cultures, behavior that might otherwise appear socially anxious may be considered appropriate in

certain social situations (e.g., might be a sign of respect)” [1, p. 204]. DSM-5 [1, p. 749] further states:

Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. Cultures are open, dynamic systems, that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their own identities and make sense of experience. These features of culture make it crucial not to overgeneralize cultural information or stereotype groups in terms of fixed cultural traits.

Culture differs from *race*, which distinguishes groups based on various superficial physical attributes, and *ethnicity*, which distinguishes groups based on shared characteristics, such as a common history, geography, language, or religion. DSM-5 describes *cultural syndromes* (clusters or groups of co-occurring and relatively invariant symptoms specific to a particular culture) as one example of how culture influences the presentation and course of DSM disorders (also see the work of Hinton and colleagues^[25] on how cultural syndromes specifically influence the anxiety disorders). DSM-5 discusses *taijin kyofusho* (TKS), believed to be particularly prevalent in Japanese and Korean cultures, as an example of a cultural syndrome [1, p. 205]. In contrast to SAD as typically expressed in Western cultures, which is characterized by fear of embarrassing *oneself*, a person with TKS is concerned about doing something, or presenting an appearance, that will offend or embarrass the *other person*.^[26–30] An example of this so-called *offensive subtype* of TKS may be a person who fears that he or she would offend others by emitting offensive odors, blushing, staring inappropriately, and presenting an improper facial expression or physical deformity.^[26] Some forms of TKS are more closely associated with delusional disorder and body dysmorphic disorder.^[1] However, characteristics of the offensive subtype of TKS are common among patients with SAD in the United States as well as those from East Asia,^[27] a finding which provided an important impetus for the inclusion of fear of offending others in the DSM-5 criteria for SAD.

Of particular relevance to TKS and other cultural syndromes described in DSM-5 is individualism/collectivism, which describes the relationship between members of social organizations. In collectivistic cultures, group harmony is the highest priority and individual gain is considered less important than improvement of the broader social group, whereas in individualistic societies, individual achievements, and success receive the greatest reward and social admiration.^[31,32] For example, in Asia, South America, the Pacific Islands, and southern European countries, strict social rules dictate what behavior is appropriate

in certain social situations.^[33] Individuals who deviate from social rules are threatened with sanctions, such as exclusion from the group. Therefore, it is important for individuals in such countries that their social behavior be evaluated as appropriate and positive.^[34] Thus, it is possible that the match between a person’s cultural orientation and cultural norms contributes to SAD and other emotional disorders.^[35]

Our review of sociocultural issues is of necessity brief, and TKS and individualism/collectivism are presented as examples only. However, it is important to emphasize that cultural differences might help explain the differences in prevalence and expression of social anxiety/SAD in different countries as well as within different cultural groups within the same country. Asian samples typically show the lowest rates, whereas Russian and United States samples show the highest rates, of SAD.^[35]

SAD IN THE CONTEXT OF A MEDICAL CONDITION

An important boundary issue involves how to distinguish SAD from social anxiety symptoms that are a consequence of a medical disorder. Medical disorders such as hyperhidrosis or essential tremor cause symptoms that are also common in SAD and may trigger fears of negative evaluation. Other medical conditions, such as obesity or facial disfigurement, may draw unwanted scrutiny from others and lead to embarrassment and social avoidance.

Prior criteria conservatively restricted the diagnosis of SAD to persons whose symptoms could not be attributed to another psychiatric or medical condition. Furthermore, the social fears were required to be unrelated to the other condition (e.g., not fear of tremor in Parkinson’s disease). The objective was to maintain a relatively homogeneous category of SAD, because social anxiety secondary to other conditions might differ in symptom profile, pathophysiology, demographics, course, and treatment outcome (personal communication, Robert Spitzer).

DSM-5 retains many of these comorbidity exclusions but allows the diagnosis of SAD in the presence of another medical condition when the social fear, anxiety, or avoidance is unrelated to the medical disorder or “is excessive” [1, p. 203]. The intention of this change is to recognize that social anxiety secondary to a medical condition, but with severity beyond the usual fear, anxiety, and avoidance experienced by most persons with the medical condition, deserves clinical and research attention and that persons with secondary social anxiety may benefit from treatments developed for SAD.^[7]

In an early study in a speech disorders clinic sample, Stein et al.^[56] found that social anxiety was not an inevitable consequence of stuttering and severity of social anxiety was unrelated to the severity of stuttering. Subsequent research, reviewed by Iverach and colleagues,^[37] has come to the consensus that, in a subset of persons

with stuttering, social anxiety is clinically significant and impairing, and in such cases, a specific focus on treating the social anxiety may be beneficial. Similar findings have been reported for Parkinson's disease,^[38] hyperhidrosis,^[39] hyperkinesias,^[40] obesity,^[41] essential tremors,^[42] and psoriasis.^[43]

SUBTYPE OR SPECIFIER: CHANGES IN THE WAY WE THINK ABOUT VARIATIONS IN SAD

DSM-5 includes a new specifier, *performance only*, applied if the fear is restricted to speaking or performing in public. It replaces the DSM-IV *generalized* specifier (also known as the generalized subtype). This change elicited more debate within the Anxiety Sub-Workgroup than any other change proposed for SAD. Central to the debate was whether or not the DSM-IV generalized specifier, which simply stated that the individual fears "most social situations," was adequately operationalized for use in research and clinical practice and whether a more precise specifier should be substituted.

The generalized specifier focuses on quantity rather than content (i.e., most social situations, as defined in DSM-IV). However, there was concern that different research groups were using different cutoffs for what constitutes "most" social situations. Furthermore, research in this area (see^[7] for a review; ^[44-46]) converges on the conclusion that a dimensional severity scale or a simple count of the number of situations feared captures the heterogeneity of subgroups of patients with SAD better than the categorical (generalized/nongeneralized) specifier, suggesting that the intent of the generalized specifier would be better operationalized by the use of a dimensional severity measure. It was also noted that some investigators made distinctions based on type of feared situation, such as anxiety limited to public speaking versus social interaction anxiety, which may have merit but which may also result in confusion in research. Consensus for an improved description or operationalization of the generalized specifier could not be reached, which led to the search for an alternative.

The majority of Sub-Workgroup members expressed the idea that it would be easier to reliably decide on what constitutes a more limited variant of SAD. The creation of the performance-only specifier is supported by evidence that patients who suffer exclusively from performance fears (e.g., certain musicians, individuals who speak publicly on the job or give presentations in classes or meetings) appear to be a distinct group. Epidemiological studies also indicate that some individuals who meet criteria for SAD report only performance fears.^[44,47,48] Other studies, however, question the existence of this subtype in clinical samples.^[49] Some studies suggest that individuals who report performance-only fears are more likely to display heightened physiological response (i.e., higher heart rate) when confronted with the feared

situation relative to other individuals with SAD,^[50-52] although this observation arises from a relatively small set of studies. Furthermore, compared to more pervasive social anxiety, performance-only social anxiety has not been shown to have a genetic basis, has a later age-of-onset, and is less strongly related to personality characteristics such as shyness or behavioral inhibition. Moreover, some patients with performance-only social fears respond to beta-adrenergic blocking agents, whereas patients with other types of SAD do not.^[7,53]

CLINICAL IMPLICATIONS

Although the DSM-5 does not provide specific treatment guidelines, there are clinical implications attached to the changes in the criteria for SAD. To begin, the move to the primary name SAD may raise awareness of the seriousness of the disorder among both patients and providers, making it easier for patients to discuss their concerns and more likely that providers will ask about it. The broader focus on fear of negative evaluation rather than the previous more narrow focus on humiliation and embarrassment may capture a larger group of patients who may benefit from evidence-based treatments for SAD.

The criterion shift away from patient recognition that the fear is excessive or unreasonable to the judgment of the clinician that the fear or anxiety is out of proportion to the actual threat can have a number of potentially positive consequences. Because patients tend to underestimate the quality of their social behavior and overestimate the likelihood and severity of negative social consequences, the clinician is better situated to make this judgment. However, the clinician should be informed by this shift that sole reliance on patients' report of how they performed or how others reacted to them in a social situation may be a poor choice and should be supplemented by other assessment methods. Utilization of informants if available or behavioral tests in which the specific behaviors in question can be sampled^[54] can contextualize patient report and help the clinician to determine whether a greater or lesser emphasis on shaping cognitions or behavior is indicated. It is worth noting, however, that the previous requirement that the patient judge his or her fear to be excessive or unreasonable was intended to discriminate between patients with SAD versus those with psychotic disorders such as paranoia. The DSM-5 Anxiety Sub-Workgroup concluded that it may not be necessary to make these disorders mutually exclusive because psychotic patients with a comorbid diagnosis of SAD may benefit from the treatment of their social anxiety.^[7] However, this might still make us wary of the paranoid patient who appears to the clinician to be overly anxious about others' opinions when the patient does not feel that way at all.

DSM-5 emphasizes that cultural and contextual factors must be considered when determining the degree to which an individual overestimates the threat of a stimulus, recognizing that social anxiety can be an

appropriate emotional response, that social reticence can be an appropriate behavioral response, and that neither automatically indicates a mental disorder or requires intervention. Most importantly, the clinical relevance of patterns of behavior, cognition, and emotion displayed by an individual person must be evaluated in context. An important corollary is that individuals who live in multiple cultures (e.g., immigrant persons who interact at some times within their local immigrant communities and at other times in the larger culturally different community) may have troubling symptoms of social anxiety in some circumstances but not in others.

An important change is the removal of the exclusion when the person's fears are related to a medical disorder, and this change will potentially result in the increased recognition of SAD as a treatment target. This impact may be most noticeable in nonpsychiatric medical settings (e.g., a movement disorders clinic). A challenge for clinicians working in these settings will be to determine when social anxiety symptoms are "excessive" for a given medical condition. In the absence of objective information, patient distress and impairment from social anxiety symptoms should be considered. Treatment of SAD should be considered particularly when the underlying condition cannot be adequately treated. Additional research will help clarify whether and how the underlying condition will alter the approach to the treatment of SAD for this population.

DSM-5 replaced the generalized specifier from DSM-IV with the performance-only specifier. Whether the performance-only specifier will be easier to operationally define and more helpful for treatment planning remains to be seen. Accumulating research indicates that this specifier is not highly prevalent in the general population, and particularly in the treatment-seeking population, thus calling its clinical utility into question.^[49,55,56] There is also little research as yet on the relative efficacy of different psychological and pharmacological interventions for SAD with and without the performance-only specifier,^[57] although it is likely that such research will be forthcoming and may ultimately tell us whether the new specifier is an improvement over prior efforts.

A minority of the Sub-Workgroup and advisors expressed significant concerns about the performance-only specifier, only some of which are noted here. Concerns were raised that changing specifiers would require clinicians to adapt to the changing labels, and this might lead to confusion about the proper medication for a particular patient. Also, it is not clear whether the patient group designated by the generalized specifier in DSM-IV is the same patient group who would not meet criteria for the DSM-5 performance-only specifier, which may accentuate confusion in referencing the extant treatment literature. Finally, concern was expressed that, in focusing on the new specifier, clinicians may overlook nonperformance (other) social fears in patients who present with predominantly performance fears. This is a serious concern as patients with SAD may present with performance

fears initially because of fear that telling the provider of more pervasive social fears will be judged negatively.

CONCLUDING COMMENTS

With the publication of DSM-5, a number of changes have been made to the way we define SAD. It is recognized that the typical person in clinical settings with SAD has multiple social fears and is broadly impaired, although there may be patients who fear only speaking or performing in public. It is acknowledged that SAD is not only about humiliation and embarrassment, but other social consequences, such as rejection by others, may be feared as well. The importance of cultural considerations has been emphasized, and this is particularly important since SAD and culture are essentially social phenomena. It is now recognized that social anxiety secondary to another medical condition can be very disabling in its own right, and affected persons may now receive the diagnosis. We believe that these changes have significant clinical implications, and we will see whether that is true in the months and years to come.

Conflict of interest. Dr. Schneier reports personal fees from GlaxoSmithKline, outside the submitted work; Dr. Craske reports grants from NIH, NIMH, other from Oxford University Press, other from APA Books, outside the submitted work; Dr. Hofmann reports grants from NIH, other from Journal and book publishers, outside the submitted work; Dr. Stein reports a patent use of 5HTTLPR genotyping to identify patients with social phobia likely to respond to SSRIs issued. None of the other authors have any specific disclosures to make.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual for Mental Disorders, 5th edition (DSM-5). Arlington, VA: American Psychiatric Publishing; 2013.
2. Marks IM, Gelder MG. Different ages of onset in varieties of social phobia. *Am J Psychiatry* 1966;123:218–221.
3. American Psychiatric Association. Diagnostic and statistical manual for mental disorders, 3rd edition (DSM-III). Washington, DC: American Psychiatric Press; 1980.
4. Liebowitz MR, Gorman JM, Fyer AJ, Klein DF. Social phobia: review of a neglected anxiety disorder. *Arch Gen Psychiatry* 1985;42:729–736.
5. American Psychiatric Association. Diagnostic and Statistical Manual for Mental Disorders, 3rd edition revised (DSM-III-R). Washington, DC: American Psychiatric Press; 1987.
6. American Psychiatric Association. Diagnostic and Statistical Manual for Mental Disorders, 4th edition (DSM-IV). Washington, DC: American Psychiatric Press; 1994.
7. Bögels SM, Alden L, Beidel DC, et al. Social anxiety disorder: questions and answers for the DSM-V. *Depress Anxiety* 2010;27:168–89.
8. Hans SL, Auerbach JG, Styr B, Marcus J. Offspring of parents with schizophrenia: mental disorders during childhood and adolescence. *Schizophrenia Bull* 2004;30:303–315.

9. Asarnow RF, Nuechterlein KH, Fogelson D, et al. Schizophrenia and schizophrenia-spectrum personality disorders in the 1st-degree relatives of children with schizophrenia: the UCLA family study. *Arch Gen Psychiatry* 2001;58:581–588.
10. Liebowitz MR, Heimberg RG, Fresco DM, et al. Social phobia or social anxiety disorder: what's in a name? *Arch Gen Psychiatry* 2000;57:191–192.
11. Olfson M, Guardino M, Struening E, et al. Barriers to treatment of social anxiety. *Am J Psychiatry* 2000;157:521–527.
12. Weiller E, Bisslerbe JC, Boyer P, et al. Social phobia in general health care: an unrecognized undertreated disabling disorder. *Br J Psychiatry* 1996;168:169–174.
13. Bisslerbe JC, Weiller E, Boyer P, et al. Social phobia in primary care: level of recognition and drug use. *Int Clin Psychopharmacol* 1996;11:25–28.
14. Wagner R, Silove D, Marnane C, Rouen D. Delays in referral of patients with social phobia, panic disorder, and generalized anxiety disorder attending a specialist anxiety clinic. *J Anxiety Disord* 2006;20:363–371.
15. Bruce LC, Heimberg RG, Coles ME. Social phobia versus social anxiety disorder: effect of disorder name on recommendation for treatment. *Am J Psychiatry* 2012;169:538.
16. Clark DM, Wells A. A cognitive model of social phobia. In: Heimberg RG, Liebowitz MR, Hope DA, Schneier FR, editors. *Social Phobia: Diagnosis, Assessment, and Treatment*. New York: Guilford Press; 1995:69–93.
17. Rapee RM, Heimberg RG. A cognitive-behavioral model of anxiety in social phobia. *Behav Res Ther* 1997;35:741–756.
18. Heimberg RG, Brozovich FA, Rapee RM. A cognitive behavioral model of social anxiety disorder: update and extension. In: Hofmann SG, DiBartolo PM, editors. *Social Anxiety: Clinical, Developmental, and Social Perspectives*. 2nd ed. New York: Academic Press; 2010:395–422.
19. Hofmann SG. Cognitive factors that maintain social anxiety disorder: a comprehensive model and its treatment implications. *Cognit Behav Ther* 2007;36:193–209.
20. Erwin BA, Heimberg RG, Schneier FR, Liebowitz MR. Anger experience and expression in social anxiety disorder: pretreatment profile and predictors of attrition and response to cognitive-behavioral treatment. *Behav Ther* 2003;34:331–350.
21. Spokas M, Luterek JA, Heimberg RG. Social anxiety and emotional inhibition: the mediating role of beliefs. *J Behav Ther Exp Psychiatry* 2009;40:283–291.
22. Rapee RM, Lim L. Discrepancy between self- and observer ratings of performance in social phobics. *J Abnorm Psychol* 1992;101:728–731.
23. Stopa L, Clark DM. Cognitive processes in social phobia. *Behav Res Ther* 1993;31:255–267.
24. Foa EB, Franklin ME, Perry KJ, Herbert JD. Cognitive biases in generalized social phobia. *J Abnorm Psychol* 1996;105:433–439.
25. Hinton DE, Park L, Hsia C, et al. Anxiety disorder presentations in Asian populations: a review. *CNS Neurosci Ther* 2009;15:295–303.
26. Kleinknecht RA, Dinnel DL, Kleinknecht EE, et al. Cultural factors in social anxiety: a comparison of social phobia symptoms and Taijin kyofusho. *J Anxiety Disord* 1997;11:157–177.
27. Choy Y, Schneier FR, Heimberg RG, et al. Features of the offensive subtype of Taijin-Kyofu-Sho in US and Korean patients with DSM-IV social anxiety disorder. *Depress Anxiety* 2008;25:230–240.
28. Takahashi T. Social phobia syndrome in Japan. *Comp Psychiatry* 1989;30:45–52.
29. Kirmayer L. The place of culture in psychiatric nosology: Taijin kyofusho and DSM-III-R. *J Nerv Ment Dis* 1991;179:19–28.
30. Suzuki K, Takei N, Kawai M, et al. Is Taijin Kyofusho a culture-bound syndrome? *Am J Psychiatry* 2003;160:1358.
31. Singelis TM. The measurement of independent and interdependent self-construals. *Pers Soc Psychol Bull* 1994;20:580–591.
32. Argyle M. Rules for social relationships in four cultures. *Aust J Psychol* 1986;38:309–318.
33. Triandis HC, Hui CH, Albert RD, et al. Individual models of social behavior. *J Pers Soc Psychol* 1984;46:1389–1404.
34. Suh E, Diener E, Oishi S, Triandis HC. The shifting basis of life satisfaction judgment across cultures: emotions versus norms. *J Pers Soc Psychol* 1998;74:482–493.
35. Hofmann SG, Asnaani A, Hinton DE. Cultural aspects in social anxiety and social anxiety disorder. *Depress Anxiety* 2010;27:1117–1127.
36. Stein MB, Baird A, Walker JR. Social phobia in adults with stuttering. *Am J Psychiatry* 1996;153:278–280.
37. Iverach L, Menzies RG, O'Brian S, et al. Anxiety and stuttering: continuing to explore a complex relationship. *Am J Speech Lang Pathol* 2011;20:221–232.
38. Kummer A, Cardoso F, Teixeira AL. Frequency of social phobia and psychometric properties of the Liebowitz Social Anxiety Scale in Parkinson's disease. *Mov Disorder* 2008;23:1739–1743.
39. Schneier FR, Heimberg RG, Liebowitz MR, et al. Social anxiety and functional impairment in patients seeking surgical evaluation for hyperhidrosis. *Comp Psychiatry* 2012;53:1181–1186.
40. Ozel-Kizil ET, Akbostanci MC, Ozguven HD, Atbasoglu EC. Secondary social anxiety in hyperkinesias. *Mov Disord* 2008;23:641–645.
41. Dalrymple KL, Galione J, Hrabosky J, et al. Diagnosing social anxiety disorder in the presence of obesity: implications for a proposed change in DSM-5. *Depress Anxiety* 2011;28:377–382.
42. Schneier FR, Barnes LF, Albert SM, Louis ED. Characteristics of social phobia among persons with essential tremor. *J Clin Psychiatry* 2001;62:367–372.
43. Schneider G, Heuft G, Hockmann J. Determinants of social anxiety and social avoidance in psoriasis outpatients. *J Eur Acad Dermatol Venereol* 2013;27:383–386.
44. Knappe S, Beesdo-Baum K, Fehm L, et al. Social fear and social phobia types among community youth: differential clinical features and vulnerability factors. *J Psychiatric Res* 2011;45:111–120.
45. Ruscio AM. The latent structure of social anxiety disorder: consequences of shifting to a dimensional diagnosis. *J Abnorm Psychol* 2010;119:662–671.
46. Vriends N, Becker ES, Meyer A, et al. Subtypes of social phobia: are they of any use? *J Anxiety Disord* 2007;21:59–75.
47. Stein MB, Walker JR, Forde DR. Public speaking fears in a community sample: prevalence, impact on functioning, and diagnostic classification. *Arch Gen Psychiatry* 1996;53:169–174.
48. Stein MB, Laine JT, Walker JR. Social phobia symptoms, subtypes, and severity: findings from a community survey. *Arch Gen Psychiatry* 2000;57:1046–1052.
49. Kerns CE, Comer JS, Pincus DB, Hofmann SG. Evaluation of the proposed social anxiety disorder specifier change for DSM-5 in a treatment-seeking sample of anxious youth. *Depress Anxiety* 2013;30:709–715.
50. Boone ML, McNeil DW, Masia CL, et al. Multimodal comparisons of social phobia subtypes and avoidant personality disorder. *J Anxiety Disord* 1999;13:271–292.
51. Heimberg RG, Hope DA, Dodge CS, Becker RE. DSM-III-R subtypes of social phobia: comparison of generalized social phobics and public speaking phobics. *J Nerv Ment Dis* 1990;176:172–179.

52. Levin AP, Saoud JB, Strauman TJ, et al. Responses of “generalized” and “discrete” social phobics during public speaking. *J Anxiety Disord* 1993;7:202–221.
53. Blöte AW, Kint MJW, Miers AC, Westenberg MP. The relation between public speaking anxiety and social anxiety: a review. *J Anxiety Disord* 2009;23:305–313.
54. Heimberg RG, Magee L. Social anxiety disorder. In: Barlow DH, editor. *Clinical Handbook of Psychological Disorders*. 5th ed. New York: Guilford Publications; in press.
55. Burstein M, He J-P, Kattan G, et al. Social phobia and subtypes in the National Comorbidity Survey-Adolescent Supplement: prevalence, correlates, and comorbidity. *J Am Acad Child Adol Psychiatry* 2011;50:870–880.
56. Merikangas KR, Ames M, Cui L, et al. The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Arch Gen Psychiatry* 2007;64:1180–1188.
57. Schneier FR. Pharmacotherapy of social anxiety disorder. *Expert Opin Pharmacother* 2011;12:615–625.