Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis

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INTRODUCTION

Social anxiety disorder (SAD), also known as social phobia, is a common disorder characterized by excessive fears of scrutiny, embarrassment, and humiliation in social or performance situations, leading to significant distress or impairment in functioning.

SAD is a prevalent condition, estimated to affect between 3 and 7 percent of the adult United States population over a 12-month period. SAD typically begins in childhood or adolescence and, untreated, can be associated with the subsequent development of major depression, substance use disorder, and other mental health problems. The disorder can be associated with extensive functional impairment and reduced quality of life [1].

This topic addresses the epidemiology, pathogenesis, clinical manifestations, and diagnosis of SAD. Psychotherapy for SAD and overview of treatment for SAD, including SAD performance only are discussed elsewhere. Topics related to anxiety in children and adolescents are also found elsewhere.

- (See "Social anxiety disorder in adults: Psychotherapy".)
- (See "Approach to treating social anxiety disorder in adults".)
- (See "Anxiety disorders in children and adolescents: Assessment and diagnosis".)
- (See "Pharmacotherapy for anxiety disorders in children and adolescents".)

DEFINITIONS

Behavioral inhibition — A childhood temperament that has been operationally defined by researchers to refer to young children who manifest fear and withdrawal behavior when introduced to novel situations or unfamiliar persons.

Avoidant personality disorder — An avoidant personality disorder is described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) as a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interaction [2].

Shyness — A nontechnical term referring to feelings of apprehension or awkwardness, and inhibited behavior when in proximity to other people. It does not generally imply psychopathology, but it is common among individuals with social anxiety disorder (SAD).

Performance anxiety — Anxiety related to performing an activity in the presence of one or more other persons. Most commonly refers to public speaking or stage performance, but can affect a range of other activities, from taking a test to having sex. The anxiety commonly includes fears of scrutiny or negative evaluation and/or physical symptoms and may interfere with performance. Performance anxiety does not generally imply psychopathology, but it is common among individuals with SAD, and it is the predominant feature of the performance-only subtype of SAD in DSM-5-TR [2].

EPIDEMIOLOGY

Prevalence — Social anxiety disorder (SAD) is one of the most common psychiatric disorders. The lifetime prevalence in the United States is estimated to be 5 to 12 percent. One-year prevalence in the United States is 3 to 7 percent [3,4]. Internationally, prevalence has been found to be similar in other developed countries but tends to be lower in resource-limited countries [5].

Risk factors for SAD include female sex, family history of SAD, and early childhood shyness or behaviorally inhibited temperament [3,4,6,7]. (See 'Behavioral inhibition' above and 'Differential diagnosis' below.)

Comorbidities

Psychiatric disorders — Psychiatric disorders, particularly mood disorders, other anxiety disorders, and personality disorders, occur at higher rates in individuals with SAD than in those

without SAD. For example, in a national epidemiological survey of adults in the United States, the lifetime prevalence of any mood disorder was 56 percent in individuals with SAD versus 18 percent in those without SAD [3,4]. Other anxiety disorders (eg, panic disorder, specific phobia, and generalized anxiety disorder) were found in 54 versus 13 percent; and any personality disorder, 55 versus 13 percent. Additionally higher rates of alcohol use disorder and any drug use disorder were higher in individuals with SAD than in those without SAD [3,4]. These comorbid disorders may be a consequence of SAD, an earlier disorder giving rise to SAD, or a co-occurring disorder sharing a common predisposition with SAD as outlined by the following examples:

- **Substance use** – Studies suggest SAD is a risk factor for the subsequent development of substance use or substance use disorder [8,9]. As an example, some individuals with SAD report experiencing a reduction in anxiety with alcohol or cannabis use, and subsequently develop symptoms of dependence. (See "Risky drinking and alcohol use disorder: Epidemiology, clinical features, adverse consequences, screening, and assessment" and "Cannabis use disorder: Clinical features, screening, diagnosis, and treatment" and "Unipolar depression in adults: Assessment and diagnosis".)

- **Other anxiety disorders** – Other anxiety disorders, in particular other phobic disorders, panic disorder, and generalized anxiety disorder, have the highest rates of comorbidity with SAD. This reflects shared diagnostic features and possibly shared higher-order traits, such as harm avoidance, anxiety sensitivity, or neuroticism. (See "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis" and "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis" and "Specific phobia in adults: Epidemiology, clinical manifestations, course, and diagnosis".)

- **Avoidant personality disorder** – In patients with severe SAD, symptoms are pervasive and overlap with those of avoidant personality disorder. Common clinical manifestations include a widespread avoidance of essential activities (including school avoidance and work absenteeism), pervasive low self-esteem, and a relatively isolated existence. In a study of 45 individuals with SAD, over 50 percent of persons generalized subtype met criteria for avoidant personality disorder [10].

- **Selective mutism** – Descriptive studies of selective mutism (a childhood disorder characterized by persistent failure to speak in social situations despite the ability to speak) have found that the majority of cases are comorbid with SAD. In a meta-analysis of 22 studies (n = 837), 69 percent of children with selective mutism were also diagnosed with SAD [11].

- **Autism spectrum disorder** – More than a quarter of individuals with autism spectrum disorders may have SAD [12], but individuals with SAD alone lack the pervasive impairment in social development and social relatedness that characterizes the autism spectrum disorders [13]. (See "Autism spectrum disorder in children and adolescents: Clinical features", section on 'Impaired social communication and interaction' and "Autism spectrum disorder in children and adolescents: Terminology, epidemiology, and pathogenesis", section on 'Associated conditions and syndromes'.)

- SAD has been found to be a comorbid disorder in approximately 15 percent of outpatients with schizophrenia [14]. However, the presence of SAD appears to be unrelated to rates of positive or negative symptoms of schizophrenia. (See "Schizophrenia in adults: Clinical features, assessment, and diagnosis" and "Anxiety in schizophrenia".)

Medical comorbidity — A variety of medical conditions that are characterized by symptoms that attract unwanted scrutiny have a high comorbidity with SAD. These include symptoms of tremor in Parkinson disease, essential tremor, spasmodic torticollis, stuttering, facial disfigurement, and hyperhidrosis. Individuals with a subsyndromal propensity for social anxiety may develop significant impairment after a secondary medical condition draws unwanted attention to a new physical or behavioral defect [15,16].

PATHOGENESIS

Both heredity and environment are implicated in the development of social anxiety disorder (SAD) [17], although findings for the influence of specific genes have not been consistently replicated. Studies of the pathogenesis of SAD have focused on a variety of interacting neurohormonal and neurotransmitter systems, and on functional neurocircuitry involving the amygdala, insula and prefrontal cortex. Psychosocial factors include early childhood adversity, parental and peer influences.

- **Autonomic nervous system** – Some early studies of SAD focused on the pathogenesis of symptoms of autonomic arousal, including increased heart rate and trembling that are common responses to performance situations, such as public speaking. Their findings suggest that individuals with circumscribed SAD, limited to performance situations, may have exaggerated autonomic nervous system responses to performance situations while those with more generalized SAD have autonomic responses similar to individuals without SAD [18].

- **Central nervous system neurotransmitters and neuropeptides** – A number of neurotransmitter systems have been implicated in SAD:
  - Selective serotonin reuptake inhibitors have been shown to reduce SAD symptoms, and experimental depletion of serotonin has been shown to reverse the benefit of these medications and to increase autonomic responses to fear [19,20].
  - Dopamine mediates incentive and reward function, which has been hypothesized to be abnormal in SAD. However, findings of dopamine system dysfunction in SAD have been inconsistent [19,20].
  - Glutamate levels have been reported to be increased in the anterior cingulate cortex in patients with SAD compared with controls and appeared to correlate with the intensity of social anxiety symptoms [21].
  - The neuropeptide oxytocin has been shown to modulate social cognition. Peripheral oxytocin levels and oxytocin receptor regulation may be associated with severity of social anxiety [22,23].
- **Hypothalamic-pituitary axis dysfunction** – Hypothalamic-pituitary axis reactivity to social stressors has been shown to be associated with degree of avoidance in SAD [24]. Reactivity appears to be specifically elevated in those individuals with SAD who also have a history of early childhood abuse [25].
- **Brain circuitry** – As a whole, the most consistent brain imaging findings demonstrate hyperactivity of limbic and paralimbic fear circuitry in response to social threat stimuli in individuals with SAD. Positron emission tomography (PET) and functional magnetic resonance imaging (fMRI) studies have demonstrated that individuals with SAD, as a group, show hyperactivation of the amygdala and insula when engaging in public speaking [26], or when viewing socially threatening images, such as emotional faces, but not when viewing nonsocial threatening images [27]. Other studies have found dysfunction in medial prefrontal cortex and medial parietal and occipital cortical regions associated with the default mode network, involved in self-reference and emotion regulation [28,29].
- **Temperament** – Approximately 15 percent of toddlers manifest a behaviorally inhibited temperament, characterized by a pattern of withdrawal, crying, and increased cortisol response when exposed in a laboratory setting to unfamiliar objects and people. This behavior is heritable and associated with amygdala hyperactivity in adulthood. The temperament of behavioral inhibition identifies a more severe subset of all children who

might be considered shy, yet it does not of itself define a disorder. Prospective studies of these children have found that by teenage years, SAD is the most common psychiatric disorder to emerge in individuals with this temperament, with a meta-analysis of seven studies (n = 877) finding that behavioral inhibition increased the risk for SAD by seven-fold [30]. It also supports the clinical observation that SAD often arises out of pre-existing nonpathological shyness [7,31]. Adults with SAD manifest temperamental tendencies for low levels of approach behavior and high avoidance [32].

- **The influence of parenting and peers** – Most patients with SAD are unable to identify a specific environmental precipitant of their difficulties, but a prospective study found that maternal stress (eg, mother's report of frequent anger at the child) is associated with the development of SAD [31]. Retrospective studies have reported that childhood maltreatment, including physical, sexual, and emotional abuse and neglect, is associated with a greater severity of SAD symptoms and impairment in functioning [33]. Other retrospective studies have identified hypercritical and overprotective parenting, and history of childhood teasing and other manifestations of childhood adversity to be associated with the disorder, although it is difficult to rule out the effects of recall bias in these studies [34-36].

- **Cognitive-behavioral factors** – A cognitive-behavioral perspective has informed understanding of psychosocial factors in the development and maintenance of SAD [37]. Individuals with SAD have biased, negative cognitions about their own social performance, others' perceptions of them, and the consequences of those perceptions. They show vigilance for signs of negative evaluation by others and tend to dwell on negative stimuli such as threatening faces [38]. They also tend to experience even objectively neutral responses as threatening rejection and indicating criticism. Individuals with SAD also avoid social situations, or they attend but remain self-focused and not fully engaged in social interactions, which interferes with the development of their social skills and results in missed opportunities to disconfirm their excessive fears of being evaluated. Thus the social fears are reinforced in a vicious cycle.

Potential mechanisms for development of these cognitive biases include teaching by socially anxious parents/caregivers, vicarious learning from observation, and conditioned learning, in which a previously neutral situation becomes associated with threat. In support of a conditioning mechanism, some patients do identify a socially traumatic incident as a precipitant of their disorder. Fear conditioning occurs when an originally neutral stimulus (ie, speaking in class) becomes an aversive experience through its pairing with an aversive unconditioned experience (ie, being criticized). In the laboratory, individuals with SAD show a propensity to be

more easily conditioned to develop fears of socially relevant stimuli, such as faces with neutral expressions, when they are paired with an aversive stimulus, such as critical faces [39].

CLINICAL MANIFESTATIONS

The hallmarks of social anxiety disorder (SAD) are excessive fears of scrutiny, embarrassment, and humiliation, although patients often manifest broader fears of social inadequacy and fears of criticism and negative evaluation by others [40].

- Individuals with SAD often present with shy behavior in a diagnostic interview, appearing ill at ease, making little eye contact, and offering only brief answers to questions. Some may be reluctant to disclose symptoms of social anxiety, extending to the clinician their fears of embarrassment, being judged as irrational, or not taken seriously. An empathic clinical approach can help the socially anxious patient feel comfortable discussing their symptoms.

- Individuals with SAD often fear that others will notice that they are irrationally anxious. They often experience anticipatory anxiety, worrying for hours or days prior to a feared event.

- Individuals with SAD may present with social fears that extend across most interpersonal and performance situations. They may completely avoid some or most social activities. However, at times, they may participate despite experiencing intense anxiety. They may show subtle avoidance behaviors, such as limiting eye contact or initiation of conversations. Upon leaving a social situation, individuals with SAD often focus on their perceived shortcomings, berate themselves, and feel depressed.

- In social or performance situations, individuals with SAD may experience physical manifestations of anxiety, which include blushing, sweating, trembling, and palpitations, and these sometimes take the form of a full panic attack. Additionally, individuals may feel scrutinized and self-conscious in other situations, such as eating or drinking in public, or using a public urinal.

- SAD can present with social fears that are confined to performance situations (indicated using the performance-only specifier) [41]. However, evidence that this is a discrete condition is mixed [42]. Most studies have found that the number of situations feared by individuals with SAD lies on a continuum rather than falling into a clear dichotomy [1].

- Individuals with SAD experience low levels of positive emotions. This interferes with social connectedness [43].

Other clinical manifestations in patients with SAD may be features of psychiatric or medical comorbidities. (See 'Comorbidities' above.)

COURSE

Social anxiety disorder (SAD) has a mean age of onset in the mid-teens, although it can occur as early as age five years [3,4]. It often arises as an intensification of pre-existing nonimpairing shyness, although some patients will identify an unusually stressful social experience as a precipitant. New onset of SAD after age 30 is uncommon, and such late-onset cases often emerge in the context of new social demands (ie, promotion to a job that requires public speaking).

Some individuals with SAD will spontaneously improve as they gain experience with novel social challenges (ie, a new school environment) or when social demands decrease (ie, a person with fear of dating enters a secure relationship). Patients seeking treatment typically report that their symptoms have been present and consistent for many years.

Between half and two-thirds of patients respond to efficacious treatments for SAD in clinical trials [44]. About half of these “responders” achieve full remission and no longer meet criteria for the disorder. Continuing medication treatment for 6 to 12 months has been shown to decrease the likelihood of relapse [45]. Cognitive behavioral therapy has shown evidence of persistent benefits for as long as five years after treatment [46] although some patients require longer term treatment or subsequent “booster” sessions to maintain gains. A naturalistic study of patients 10 years after treatment for SAD found only one in three had experienced recovery, suggesting that the outcome of patients in community-based treatment lags behind findings from clinical trials [47]. (See "Approach to treating social anxiety disorder in adults".)

SAD can be associated with significant disability, with impairments in school and work functioning. As an example, in a population-based cohort study in Sweden that included over 15,000 participants, SAD was associated with impaired academic performance [48]. Individuals with SAD were less likely to finish secondary education (adjusted odds ratio 0.19) or start or obtain a university degree than individuals without SAD (adjusted odds ratio 0.47 and 0.35, respectively).

Avoidance behavior tends to be the most impairing feature of SAD, so it is particularly important to investigate its scope and severity and follow its response to treatment over time.

In individuals with major depression combined with SAD there is a higher rate of suicide attempts than in individuals with major depression alone [49-51]. (See "Suicidal ideation and behavior in adults".)

ASSESSMENT

To meet the diagnostic criteria for social anxiety disorder (SAD), the syndrome must cause impairment in functioning or marked distress and is not attributable to the direct physiological effects of a substance or a general medical condition.

Screening — We ask patients presenting for mental health problems if they have problems with feeling shy or self-conscious. Patients may present for treatment of a condition comorbid with SAD (eg, major depression or substance use disorder), but not disclose the social anxiety. (See 'Psychiatric disorders' above.)

Among tested screening instruments, the three-question Mini-Social Phobia Inventory appears useful for SAD. It has been found to have a high sensitivity (89 percent) and specificity (90 percent) for the generalized type of SAD [52,53]. The questions ask, on a scale from 0 (not at all) to 4 (extremely), how much the following problems have bothered you during the past week:

- Fear of embarrassment causes me to avoid doing things or speaking to people.
- I avoid activities in which I am the center of attention.
- Being embarrassed or looking stupid are among my worst fears.

Once a diagnosis of SAD has been made, we work with the patient to clarify the scope of social fears by systematically inquiring into fear and avoidance of common school, work, and social situations. Conversely, it can also be helpful to identify the range of situations in which they do feel comfortable. Most individuals with SAD have a social comfort zone, often including immediate family, perhaps a few close friends, or more. The prospect of treatment can be presented to the patient in the context of expanding this comfort zone to encompass a broader range of encounters and situations.

Monitoring — We use the Liebowitz Social Anxiety Scale (LSAS) to monitor response to treatment over time [54]. The LSAS is the most commonly used assessment instrument for SAD. The 24-item instrument assesses fear and anxiety in numerous common social and performance situations. The scale has good psychometric properties [55]. It can be used for clinician assessment and for patient self-report.

DIAGNOSIS

Patients can be diagnosed with social anxiety disorder (SAD) if they present with a marked, persistent fear of one or more social or performance situations involving exposure to unfamiliar people or possible scrutiny by others. Exposure typically provokes anxiety. The patient usually recognizes that their anxiety or fear is excessive (though young patients or those with longstanding and/or severe symptoms may feel that their anxiety is reasonable given how aversive they find these situations, and judgment of the clinician is required to make this assessment). The patient tends to avoid feared situations or to endure them with distress.

Diagnostic criteria for SAD are described below [2].

- "A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (eg, having a conversation, meeting unfamiliar people), being observed (eg, eating or drinking), and performing in front of others (eg, giving a speech).

  Note: In children, the anxiety must occur in peer settings and not just during interaction with adults.

- B. The individual fears that they will act in a way or show anxiety symptoms that will be negatively evaluated (ie, will be humiliating or embarrassing; will lead to rejection or offend others).

- C. The social situations almost always provoke fear or anxiety.

  Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

- D. The social situations are avoided or endured with intense fear or anxiety.

- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

- F. The fear, anxiety, or avoidance is persistent, typically lasting for six months or more.

- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication) or another medical condition.

- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

- J. If another medical condition (eg, Parkinson disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specifier: Specify if performance only – if the fear is restricted to speaking or performing in public."

DIFFERENTIAL DIAGNOSIS

We differentiate social anxiety from the following disorders that may present with similar symptoms:

- **Nonpathological shyness and performance anxiety** – SAD differs from nonpathological shyness and performance anxiety in its greater severity, pervasiveness, and resultant distress and impairment [56].

- **Unipolar depression** – After the clinician identifies that the patient has an impairing social fear or avoidance, the next important point of diagnostic differentiation is the patient's underlying reasoning for the fear or behavior. Individuals with primary depression may lose interest in social activities, or experience social anxiety only when in a depressive episode, while individuals with primary SAD usually maintain desire for social activities and report depressed moods secondary to their perceived social failures [57]. (See "Unipolar depression in adults: Assessment and diagnosis".)

- **Panic disorder, obsessive compulsive disorder** – In panic disorder or obsessive-compulsive disorder, patients may experience social anxiety due to concerns that a panic attack or compulsive behaviors will be observed by others, leading to embarrassment. In SAD, the fear of being observed is primary, and anxiety is limited to the performance or encounter, or anticipating them. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis" and "Panic disorder in adults: Epidemiology, clinical manifestations, and diagnosis".)

- **Agoraphobia** – Patients with agoraphobia may avoid public situations due to fear of developing anxiety spontaneously and having difficulty fleeing the situation, rather than due to primary fears of scrutiny and embarrassment. Thus, a person with agoraphobia would be likely to feel more anxious on an empty bus, which lacks someone to provide

assistance in the event of an anxiety episode, while a person with SAD would typically feel more anxious in the presence of other bus riders. (See "Agoraphobia in adults: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

- **Autism spectrum disorder** – Individuals with milder forms of autism spectrum disorders, such as Asperger syndrome, may experience social anxiety secondary to difficulty learning social skills and their awareness that their social skills are poor. Social skill knowledge is usually intact in SAD, although anxiety may interfere with the person's utilization of social skills [13]. (See "Autism spectrum disorder in children and adolescents: Clinical features", section on 'Impaired social communication and interaction'.)

- **Attention deficit hyperactivity disorder** – Some individuals with attention deficit hyperactivity disorder experience social anxiety due to fears that their inattention will interfere with social communication. (See "Attention deficit hyperactivity disorder in adults: Epidemiology, clinical features, assessment, and diagnosis" and "Attention deficit hyperactivity disorder in children and adolescents: Clinical features and diagnosis".)

- **Psychosis** – Individuals with psychotic disorders may avoid social situations due to delusional fears of harm, while individuals with SAD generally fear embarrassment and recognize that their fears are excessive [58]. (See "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation".)

- **Body dysmorphic disorder** – Individuals with body dysmorphic disorder maintain a fixed belief, as in SAD, but limited to ideas that certain bodily features are abnormal or ugly. They may additionally experience social anxiety due to fear of others judging their appearance negatively [59].

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Anxiety and anxiety disorders in adults".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given

condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topic (see "Patient education: Social anxiety disorder (The Basics)")

SUMMARY AND RECOMMENDATIONS

- **Introduction** – Social anxiety disorder (SAD), also known as social phobia, is characterized by excessive fears of scrutiny, embarrassment, and humiliation in social or performance situations, leading to significant distress and/or impairment in functioning. (See 'Introduction' above.)

  Performance anxiety that causes significant distress or affects functioning may be a part of SAD. When limited to public speaking or performance, this is considered a specifier for SAD.

- **Epidemiology** – SAD is one of the most common psychiatric disorders with a lifetime prevalence in the United States estimated to be 5 to 12 percent. Its prevalence may be lower in resource-limited countries. (See 'Epidemiology' above.)

- **Comorbid disorders** – SAD co-occurs with many other psychiatric disorders, including avoidant personality disorder, major depression, alcohol dependence, schizophrenia, eating disorders, and other anxiety disorders. (See 'Comorbidities' above.)

- **Pathogenesis** – Research studies suggest that both genetic and environmental factors contribute to the development of SAD. Studies have not consistently identified specific genes. Psychosocial factors include early childhood adversity and parental and peer influences. (See 'Pathogenesis' above.)

- **Course** – SAD has a mean age of onset in the mid-teens, although it can occur as early as age five years. New onset of SAD after age 30 is uncommon but can occur in the context of new social demands (eg, promotion to a job that requires public speaking). (See 'Course' above.)

- **Screening** – We ask patients presenting for mental health problems if they have feelings of shyness or self-conscious. Individuals with SAD may be reluctant to disclose them to an evaluating clinician. This is consistent with the interpersonal fear and avoidance characteristics of the disorder. We often use the Mini-Social Phobia Inventory as a screening instrument. (See 'Screening' above.)

- **Monitoring** – We use the Liebowitz Social Anxiety Scale (LSAS) to monitor response to treatment over time. The scale can be used as a clinician assessment tool or a self-report tool. (See 'Monitoring' above.)

- **Differential diagnosis** – We differentiate social anxiety from the following disorders that may present with similar symptoms. These include unipolar depression, panic disorder, obsessive compulsive disorder, autism spectrum disorder, psychosis, attention-deficit hyperactivity disorder, and body dysmorphic disorder. (See 'Differential diagnosis' above.)

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