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The Validity of the Social Avoidance and Distress Scale and the Fear of Negative Evaluation Scale with Social Phobic Patients

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Abstract
Turner, McCanna and Beidel's (1987) recent evaluation of the Social Avoidance and Distress Scale (SADS) and the Fear of Negative Evaluation Scale (FNE) with anxiety disordered patients concluded that the SADS and FNE lacked discriminant validity and may be inappropriate for subject selection or outcome evaluation in studies of social phobia . This paper raises some concerns with the interpretation of the data presented by Turner et al. (1987) and presents additional data from studies in our laboratories that may qualify their conclusions. It is asserted that (a) the SADS and FNE are not appropriate for diagnostic screening of social phobic patients, (b) Turner et al.'s findings may have been the result of clinically meaningful social anxiety in several of the anxiety disorders, (c) significant differences among the anxiety disorders may have been hidden by heterogeneity among patients who receive the diagnosis of social phobia. and (d) the distribution of FNE scores in Turner et al.'s sample may have been unusually depressed.

The Social Avoidance and Distress Scale (SADS) and the Fear of Negative Evaluation Scale (FNE) were developed by Watson and Friend (1969) for the assessment of social anxiety and associated concerns regarding social-evaluative threat. These scales are among the

most frequently used scales in studies of social anxiety and social phobia, and the SADS is frequently used for subject selection in studies of social anxiety in college populations (Heimberg, in press). Watson and Friend (1969) reported normative, reliability, and validity data for both scales, and scores of additional studies have built upon this initial database. However, until recently, no effort at examining the validity of these scales with a clinical population had been reported.

Turner, McCanna and Beidel (1987) recently reported an evaluation of the SADS and FNE in a sample of 206 anxiety disordered patients. Patients who had received a diagnosis of Agoraphobia (with or without panic attacks), Social Phobia, Simple Phobia, Panic Disorder, Generalized Anxiety Disorder, or Obsessive-Compulsive Disorder completed the SADS, the FNE, and additional scales assessing anxiety, depression, or general emotional distress. These additional scales included the State-Trait Anxiety Inventory (Spielberger, Gorsuch and Lushene, 1970), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock and Erbaugh, 1961), and the revised 90-item version of the Symptom Checklist (Derogatis, 1983).

Turner et al. (1987) reported that simple phobics scored significantly lower on the SADS and FNE than patients in any other anxiety disorder category. However, social phobics did not achieve higher scores than patients with agoraphobia, panic disorder, generalized anxiety disorder, or obsessive-compulsive disorder. Furthermore, SADS and FNE scores were significantly correlated with scores on the additional inventories (rs = 0.42–0.63, Ps < 0.0001). On the basis of these data, several conclusions were drawn: (a) that the SADS and FNE should not be used as sole selection devices in studies of social phobia, (b) that the SADS and FNE do not have particular relevance for social phobia or social anxiety, and (c) that the SADS and FNE indicate only level of general distress rather than social anxiety per se. These conclusions warrant further examination.

We agree with Turner et al. (1987) that the SADS or FNE should not be used as a sole selection device in studies of social phobia. In fact, it strikes us as curious that any investigator might choose to do so in a study of social phobic patients. The SADS and FNE are simply not constructed to provide information on the specific diagnostic criteria for social phobia. DSM-III-R (American Psychiatric Association, 1987) defines social phobia as the persistent fear of one or more situations in which the individual is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. DSM-III-R further specifies that a social phobia may be manifested as general social apprehension or as fear in a number of specific situations in which the person might be observed by others. These may include, among others, fears of public speaking, eating in public, drinking in public, using public restrooms, or writing while under the observation of others. Additional diagnostic criteria include that the fear is unrelated to other Axis I or Axis III disorders, that exposure to the specific phobic stimulus almost invariably provokes an anxiety response, that the phobic situation is avoided or endured with intense anxiety, that the avoidant behavior (if present) interferes with social or occupational functioning or that there is marked distress about having the fear, and that the person recognizes that the fear is excessive or unreasonable. While the SADS (or FNE) may help a clinician determine the magnitude of avoidance and distress about social interaction, it cannot speak to the other diagnostic criteria, nor can it help in the diagnosis of

the more specific varieties of social phobia. Therefore, it seems a great deal more prudent to utilize a structured diagnostic interview, such as the Anxiety Disorders Interview Schedule–Revised (Barlow, 1985; DiNardo, O'Brien, Barlow, Waddell and Blanchard, 1983) or the Structured Clinical Interview for DSM-III-R (Spitzer, Williams and Gibbon, 1987), for the diagnosis or differential diagnosis of social phobia and to rely on scales like the SADS or FNE as supplementary measures.

Since social phobics did not differ on the SADS or FNE from most of the other anxiety patients in the Turner et al. study, it was asserted that the scales do not have specific relevance for social anxiety or phobia. This question appears to revolve around the conceptualization of the role of social anxiety in the anxiety disorders, in general, and social phobia, in particular. Turner et al. seem to imply that social anxiety is the sole province of social phobia, and therefore social phobics should score a great deal higher than the other groups on the SADS or FNE. However, this may not be the case. Rather, social anxiety may appear in greater or lesser degrees in all the anxiety disorders. In a recent study by one of us (Rapee, Sanderson and Barlow, 1987), social phobics, agoraphobics, simple phobics, and patients with panic disorder or generalized anxiety disorder were interviewed with the Anxiety Disorders Interview Schedule–Revised. As part of that interview, each patient was asked the following three questions: (a) In social situations where you might be observed or evaluated by others, do you feel fearful? (b) Are your overly concerned that you may say and/or do something that might embarrass or humiliate yourself in front of others, or that others might think badly of you? and (c) Do you try to avoid these situations altogether? Patients were also read a series of 9 social situations and asked to rate on a 5-point scale the degree to which they feared and/or avoided each situation due to concern over scrutiny or embarrassment. A subset of patients from each group also completed the Marks and Mathews (1979) Fear Questionnaire. A higher percentage of social phobics responded affirmatively to each of the three questions. They also reported fear and avoidance of a greater number of situations and greater disruption of their lives due to their phobic concerns. However, the most important finding of this study appears to be the high degree of social anxiety reported by the other anxious groups. For instance. while 94.3% of social phobics reported fear of observation by others, so did 75% of generalized anxiety patients and 48.6% of agoraphobics and panickers. A recent study of co-morbidity among anxiety disordered patients (Barlow, DiNardo, Vermilyea, Vermilyea and Blanchard, 1986) also suggests that social anxiety may be common across diagnostic groups. In that study, which suspended DSM-III's (American Psychiatric Association, 1980) hierarchical diagnostic scheme, an additional diagnosis of social phobia was given to 35% of panic disorder patients, 33% of generalized anxiety disorder patients, 17% of agoraphobics, and 29% of simple phobics. These studies suggest rather strongly that social anxiety occurs across the anxiety disorders and that social phobics may be discriminated from other anxious patients only on the degree of social fear they experience and the amount of disruption it causes. Thus, it remains a possibility that the SADS and FNE have considerable relevance for social anxiety but not only for social phobia.

Turner et al.'s (1987) third point, that the SADS and FNE indicate level of general distress among anxious patients rather than social anxiety per se, is based on the results of their correlational analysis. summarized above. However, it is based on a unidirectional

interpretation of their correlational findings. While it is not possible to rule out this conclusion, others are equally tenable. First, the other inventories may have a meaningful component of social anxiety. The correlations among scales may be the result of shared social anxiety item content. A review of items on each of these scales suggests that this alternative hypothesis possesses a reasonable degree of face validity. Second, social anxiety may itself be a meaningful component of trait anxiety, depression, or distress. While all these constructs may have been reliably and validly assessed, they may also be correlated in real life. Since correlational statistics are not directional, Turner et al.'s conclusion cannot be preferred over the others.

Another study from our laboratory (Heimberg, Dodge, Hope and Becker, 1987) suggests an additional reason for Turner et al.'s failure to find differences between social phobics and several of the other anxiety groups on the SADS and FNE. As noted earlier, social phobia is a heterogeneous category which includes individuals with both generalized or specific fears. In this study, patients who reported generalized fears of social interaction were compared to patients who reported only public speaking fears on a number of measures, including the SADS and FNE. While both groups reported high levels of fear of negative evaluation, generally socially fearful patients scored significantly higher on the SADS than public-speaking phobics. The two groups also differed on a large number of other measures including clinicians' ratings of phobic severity and the pattern of cardiac arousal displayed during an individualized behavioral test. Thus it is possible that a finer division or social phobic patients might result in a cleaner pattern of findings on scales that measure general social distress.

Finally, our examination or the FNE scores achieved by Turner's social phobic patients suggest that they are lower than previously reported for other samples or social phobics. If this is correct, for whatever reason, then the analysis of FNE scores in their study is open to question. For example, in a treatment study conducted in our laboratory (Heimberg, Becker, Goldfinger and Vermilyea, 1985), social phobic patients achieved a mean pretreatment score of 24.57 (SD = 7.19). In another recently completed study (Heimberg, Dodge, Hope, Kennedy, Zollo and Becker, 1987), samples of social phobic patients achieved pretreatment means of 24.73 (SD = 5.23) and 25.11 (SD = 5.67). Mattick, Peters, and Clarke (1987) recently reported a mean FNE score of 23.5 in another sample of social phobics. Turner et al.'s patients achieved a mean FNE score of only 17.8 (SD = 9.3), not far above the mean scores reported for college students by Watson and Friend (1969).

Our analysis suggests that the SADS and FNE do have a useful role in the assessment of social anxiety or as outcome measures in studies of social phobia. It also suggests that more work remains to be done in the evaluation of these measures with clinically anxious patients and in the examination of the role or social anxiety in social phobia and the other anxiety disorders.

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