



Social anxiety disorder and quality of life: How fears of negative and positive evaluation relate to specific domains of life satisfaction



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ABSTRACT

Individuals with social anxiety disorder (SAD) experience functional impairment in social, educational, and occupational arenas, contributing to poor quality of life. Previous research using the Quality of Life Inventory (QOLI) has identified four distinct domains of quality of life among individuals with SAD: Achievement, Personal Growth, Social Functioning, and Surroundings. The present study was designed to investigate how fear of negative evaluation (FNE) and fear of positive evaluation (FPE) relate to the four QOLI domains among individuals with SAD. We also examined the relationships of FNE and FPE to Satisfaction and Importance ratings on the QOLI. Individuals with SAD ($N = 129$) completed a battery of questionnaires prior to initiating treatment. FNE and FPE showed distinct relationships with the four QOLI domains, even after controlling for demographic characteristics and comorbid depression. Both FNE and FPE were associated with ratings of Satisfaction with the QOLI domains, but neither was associated with ratings of Importance. Our findings highlight the differential impacts of FNE and FPE on SAD. Treatment implications are discussed.

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1. Introduction

Social anxiety disorder (SAD) is the fourth most common mental disorder, with an estimated lifetime prevalence of 12.1% (Kessler et al., 2005). Individuals with SAD experience intense fear and avoidance of social situations, and most treatments for SAD are designed to address and reduce these symptoms (Heimberg, Brozovich, & Rapee, 2014). Although the symptoms of SAD produce distress in and of themselves, social anxiety is also associated with significant functional impairment in social, occupational, and personal domains (Ruscio et al., 2008; Stein and Kean, 2000). For instance, individuals with SAD have more difficulty with dating and forming friendships, experience more impairment in social functioning (e.g., social and leisure activities), and are more likely to be single and living alone, even when compared to individuals with other anxiety disorders (Lochner et al., 2003; Norton et al., 1996; Rapaport, Clary, Fayyad, & Endicott, 2005). Socially anxious individuals are also more likely to fail a grade and more likely to drop out of high school than individuals without SAD (Simon et al., 2002;

Stein and Kean, 2000). Furthermore, individuals with SAD experience higher rates of unemployment, more missed hours of work, and reduced work performance relative to individuals without SAD (Wittchen, Fuetsch, Sonntag, Müller, & Liebowitz, 2000).

Given the association between social anxiety and functional impairment, it is unsurprising that individuals with SAD also endorse poorer quality of life and well-being than do individuals without SAD (Eng, Coles, Heimberg, & Safren, 2005; Mendlowicz & Stein, 2000; Olatunji, Cisler, & Tolin, 2007; Stein and Kean, 2000). Broadly defined, quality of life refers to the subjective evaluation of the aspects of life that make life fulfilling and worthwhile (Frisch, Cornell, Villanueva, & Retzlaff, 1992). Some researchers have emphasized the importance of distinguishing between disability, which represents an objectively measurable level of functional impairment (e.g., days missed at work, academic achievement), and quality of life, which reflects a more personal and subjective assessment of life satisfaction (Eng et al., 2005; Frisch et al., 1992; Hambrick, Turk, Heimberg, Schneier, & Liebowitz, 2003). Disability and quality of life appear to be related but independent constructs, with disability accounting for only 25% of the variance in quality of life in SAD (Hambrick et al., 2003). Symptom severity also appears to be distinct from quality of life, accounting for only 4% of the variance in quality of life in SAD (Rapaport et al., 2005). Thus, quality of life represents a subjective appraisal of life conditions and should

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be considered distinct from symptom severity and disability for individuals with SAD.

Research has largely concluded that individuals with SAD endorse lower levels of quality of life than do individuals without SAD, expressing dissatisfaction in areas as widespread as occupation, income, friendships, family life, and leisure activities (Eng et al., 2005; Mendlowicz & Stein, 2000; Olatunji et al., 2007; Safren, Heimberg, Brown, & Holle, 1996; Stein and Kean, 2000). Overall quality of life appears to be comparable for individuals with SAD versus other anxiety disorders (Barrera & Norton, 2009; Lochner et al., 2003; Olatunji et al., 2007; Rapaport et al., 2005), although some researchers have found that quality of life relative to interpersonal relationships and educational attainment is more significantly impaired in SAD (Lochner et al., 2003; Norton et al., 1996; Rapaport et al., 2005). The majority of studies conclude that SAD with comorbid disorders – particularly depression – results in lower reported levels of quality of life than does SAD alone (Barrera & Norton, 2009; Lochner et al., 2003; Rapaport et al., 2005; Wittchen et al., 2000).

Quality of life has also been identified as an important outcome measure in research on treatment of SAD. By incorporating patients' subjective views of their life circumstances, quality of life goes beyond symptom severity and provides a non-pathology-oriented assessment of well-being. Treatment research has demonstrated that self-reported quality of life improves significantly over the course of cognitive-behavioral treatment (CBT) for SAD (Eng, Coles, Heimberg, & Safren, 2001; Eng et al., 2005; Safren et al., 1996; Watanabe et al., 2010). However, despite these improvements, post-treatment quality of life ratings often remain considerably lower for patients than similar ratings provided by healthy controls (e.g., Eng et al., 2001; Safren et al., 1996). Treatment serves to improve life satisfaction and subjective well-being for individuals with SAD, but symptom reduction does not necessarily equate to normative levels of quality of life. Consequently, developing a more nuanced understanding of the quality of life deficits associated with SAD is essential to enhancing treatment outcomes beyond symptom reduction.

In an effort to better understand how quality of life differs across different domains for individuals with SAD, Eng et al. (2005) conducted an exploratory factor analysis of the Quality of Life Inventory (QOLI; Frisch, 1994). They identified four distinct domains of quality of life among individuals with SAD: Achievement, Social Functioning, Surroundings, and Personal Growth. Treatment-seeking individuals with SAD indicated dissatisfaction in Achievement and Social Functioning but not Personal Growth and Surroundings. Following treatment, quality of life in the Achievement and Social Functioning domains improved significantly, whereas quality of life in the Personal Growth domain improved marginally, and no improvement was seen in the Surroundings domain. As in other treatment studies, post-treatment quality of life remained low relative to normative samples (Eng et al., 2005). Nonetheless, these findings highlight the importance of examining specific domains of quality of life, as using a single global factor may obscure more nuanced distinctions in quality of life for individuals with SAD.

The present study was designed to replicate and extend the study by Eng et al. (2005) in two ways. For one, we wanted to further explore the aspects of quality of life that are most influential for individuals with SAD. Frisch et al. (1992) have argued that quality of life reflects fulfillment of an individual's most important needs, goals, and wishes. In determining quality of life, dissatisfaction matters less if the area of life is not particularly important to the individual (Frisch et al., 1992). To that end, the researchers developed the QOLI to incorporate not only satisfaction with a given facet of life (e.g., health, self-esteem, friends, home) but also importance of that facet of life for an individual. On the QOLI, individuals are asked to rate the importance of and their satisfaction with 16

different facets of life. The product of the Importance and Satisfaction ratings is computed to provide a weighted rating for each facet, and the weighted ratings are then averaged to create a weighted total score. Previous research has utilized the QOLI weighted total score (Eng et al., 2001; Hambrick et al., 2003; Safren et al., 1996) and the QOLI weighted domain scores (Barrera & Norton, 2009; Eng et al., 2005) to investigate quality of life in SAD samples, but no published research has examined the Importance and Satisfaction ratings separately. We know that individuals with SAD report poorer quality of life in Social Functioning than in Surroundings, but is this just because their community involvement is less important to them than their interpersonal relationships? Understanding whether Satisfaction and Importance ratings differentially contribute to quality of life ratings among individuals with SAD may provide important information for developing more targeted and effective treatments for SAD.

Additionally, the present study was designed to examine the relationship between quality of life and specific components of social anxiety. Research provides strong evidence that lower quality of life is associated with greater SAD symptom severity and that quality of life improves in parallel with symptom reduction during treatment for SAD. However, just as using a global quality of life index may blur subtle distinctions, previous studies have been limited in their reliance on a global index of social anxiety severity. We know little about the relationship between quality of life and specific components of SAD that are separate from overall symptom severity. Eng et al. (2005) suggested that the domains of quality of life that improve most following treatment (i.e., Social Functioning and Achievement) are those that are specifically addressed during treatment. Along similar lines, understanding which specific components of SAD most affect a patient's subjective experience of life satisfaction will be essential to conducting a more fine-grained analysis of the impact of CBT, improving treatment outcomes, and enhancing quality of life.

Fears of evaluation have been identified as key components of SAD and may uniquely contribute to subjective ratings of quality of life. Individuals with SAD experience both fear of negative evaluation (FNE) and fear of positive evaluation (FPE; Weeks, Heimberg, & Rodebaugh, 2008). FNE refers to distress about receiving negative feedback and concern about social rejection (Watson & Friend, 1969). Individuals with high levels of FNE experience fear and apprehension about being judged unfavorably by others, and the exaggerated levels of FNE commonly endorsed by individuals with SAD contribute to a heightened sensitivity to cues of potential social threat (e.g., Stopa & Clark, 2000; Winton, Clark, & Edelmann, 1995). FPE, on the other hand, is related to distress about receiving positive social feedback and concerns about social reprisal due to that positive feedback (Weeks, Heimberg, & Rodebaugh, 2008; Weeks, Menatti, & Howell, 2015). Individuals with high levels of FPE endorse feelings of discomfort and distress regarding performing well in front of others and receiving positive social feedback (Weeks, Heimberg, Rodebaugh, & Norton, 2008). FNE and FPE have both exhibit a strong positive relationship with SAD, and FPE has been shown to contribute unique variance to the prediction of social anxiety above and beyond that predicted by FNE (Weeks, Heimberg, & Rodebaugh, 2008; Weeks & Howell, 2012). Additionally, longitudinal assessments of fears of evaluation revealed FNE and FPE to be related but distinct constructs over time (Rodebaugh, Weeks, Gordon, Langer, & Heimberg, 2012).

The current study was designed to extend our understanding of quality of life deficits in SAD by examining specific components of SAD (i.e., FNE and FPE) and specific components of the quality of life (i.e., Importance and Satisfaction ratings) in a treatment-seeking population. Our first aim was to evaluate the relationships of FNE and FPE to the QOLI weighted total score and QOLI weighted domain scores. Higher levels of both FPE and FNE have been

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