

Social Anxiety Disorder: An Integrative Review

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ABSTRACT

Social anxiety disorder (SAD) is a persistent and impairing condition characterized by fear of negative evaluation, social avoidance, and distress in situations involving scrutiny. This integrative review examines the diagnostic features, etiology, course, assessment, and treatment of SAD across cognitive-behavioral, neurobiological, developmental, psychoanalytic, and existential perspectives. Current research indicates that attentional and interpretation biases, negative autobiographical memory, self-focused attention, and avoidance interact to reinforce symptoms over time. Neurobiological differences and developmental risk factors further contribute to the onset and persistence of the disorder. Psychoanalytic and existential perspectives expand this understanding by emphasizing internalized criticism, self-consciousness, and the meaning individuals assign to being evaluated by others. Although cognitive behavioral therapy, acceptance-based interventions, medication, and attention-based approaches can reduce symptoms, some individuals continue to experience negative self-perceptions and residual anxiety. These findings support a multilevel understanding of SAD and highlight the need for assessment and treatment approaches that address both observable symptoms and the individual's subjective experience of the self in social situations.

Keywords: Social Anxiety Disorder, Negative Evaluation, Self-Focused Attention, Cognitive Biases

Social Anxiety Disorder (SAD) is characterized by a marked and persistent fear of social situations in which a person may be exposed to scrutiny, embarrassment, rejection, or other forms of negative evaluation. Individuals with SAD often avoid these situations or endure them with intense distress, and the symptoms must be persistent and clinically impairing to meet the diagnostic threshold [1]. In clinical and academic settings, SAD matters because its effects extend beyond momentary discomfort. It can interfere with social functioning, academic participation, occupational development, and quality of life across time. In a large population-based cohort study, individuals with SAD had significantly lower odds of passing school subjects, completing upper secondary education, starting university, and obtaining a degree, suggesting a long-term functional burden of the disorder [2].

Although SAD is often introduced as a fear-based anxiety disorder centered on social scrutiny, the literature suggests a more layered clinical picture. Cognitive models have consistently emphasized self-focused attention, exaggerated estimates of social threat, distorted self-perception, safety behaviors, and post-event rumination as processes that help maintain the disorder over time [3]. Recent empirical work has extended this picture. Liu et al. found that greater social anxiety severity was associated

with attentional bias toward negative emotional information [4]. Martin et al. further showed that higher social anxiety and stronger negative self-schemas were linked to greater impact of negative social autobiographical memories, suggesting that socially anxious individuals may assign disproportionate meaning to experiences that reinforce negative beliefs about the self [5]. SAD is maintained through recurrent distortions in attention, memory, and self-appraisal.

A broader formulation is useful for understanding why social situations carry such weight for some individuals. From an existential perspective, SAD can be understood as involving a painful form of self-consciousness in which the person becomes preoccupied with how they appear to others and loses a sense of ease in social presence. From a psychoanalytic perspective, chronic shame, harsh self-evaluation, and internalized criticism may deepen the experience of anticipated judgment. These perspectives do not replace behavioral or cognitive accounts. They help interpret the subjective experience that accompanies them. SAD can be examined through multiple clinical lenses while remaining grounded in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) diagnostic criteria and empirical research.

Diagnostic Features and Clinical Presentation DSM-5-TR Criteria

SAD is defined by a persistent and marked fear of one or more

social situations in which the individual may be exposed to possible scrutiny by others. These situations commonly include social interactions, being observed, or performing in front of others. The central concern is that the individual will act in a way or display anxiety symptoms that will lead to negative evaluation, such as embarrassment, rejection, or offending others. The feared situations almost always provoke anxiety and are either avoided or endured with significant distress. The fear is out of proportion to the actual threat and must be persistent, typically lasting at least six months, and cause clinically significant impairment in social, occupational, or other important areas of functioning [1]. This diagnostic framework highlights that SAD is a pattern of fear, avoidance, and impairment that is stable over time. The emphasis on negative evaluation is particularly important, as it reflects a core feature consistently supported by empirical and theoretical models of the disorder.

Clinical Presentation

Individuals with SAD present with a combination of behavioral, cognitive, and physiological symptoms that interact to maintain the disorder over time. Behaviorally, avoidance is one of the most prominent features. Individuals may avoid conversations, public speaking, classroom participation, or social gatherings. When avoidance is not possible, they often rely on safety behaviors, such as mentally rehearsing sentences, avoiding eye contact, or minimizing participation. These strategies may reduce anxiety in the short term but tend to reinforce fear in the long term.

Cognitively, individuals with SAD experience persistent concerns about negative evaluations and often engage in heightened self-focused attention. Rather than attending to the external social environment, attention is directed inward toward perceived flaws in behavior or performance. This shift in attention contributes to distorted self-perception and increases anxiety during social interactions. Cognitive models describe this process as a cycle in which individuals overestimate the likelihood and consequences of a negative evaluation, while underestimating their ability to cope [3].

Empirical research supports the presence of these cognitive distortions. Individuals with SAD show a reduced tendency to interpret ambiguous social information in a benign manner and are more likely to endorse threatening interpretations of social situations [6]. Neurocognitive findings further suggest that these biases may occur at early stages of information processing, before conscious awareness, indicating that they are not entirely under voluntary control [7].

Physiologically, social situations often elicit symptoms such as increased heart rate, sweating, trembling, and muscle tension. These physical sensations can become additional sources of concern, as individuals may fear that their anxiety is visible to others, further reinforcing the cycle of self-monitoring and distress.

Differential Diagnosis

Accurate diagnosis of SAD requires careful differentiation from other conditions that may present with social difficulties. Avoidant Personality Disorder shares features such as social inhibition and fear of criticism, but is typically more pervasive and reflects a broader pattern of interpersonal avoidance and feelings of inadequacy. Autism Spectrum Disorder (ASD) may

involve social communication difficulties, but these are rooted in differences in social understanding rather than fear of evaluation. Panic Disorder can also involve avoidance of certain situations, but the primary concern is the occurrence of panic attacks rather than negative social judgment. These distinctions are important because they influence both case conceptualization and treatment planning. While overlapping symptoms may be present, the underlying mechanisms and maintaining factors differ across disorders, which reinforces the importance of a thorough assessment process.

It is also important to consider cultural context. Cultural expectations, social norms, and environmental demands can influence how symptoms are expressed and interpreted. Behaviors that appear avoidant in one setting may be more normative in another, which makes careful assessment essential.

Etiology

SAD is part of a broader group of anxiety conditions that share underlying features related to how threat is perceived and processed. Anxiety is typically described as a future-oriented state involving anticipation of possible harm, and fear reflects a more immediate response to perceived danger. Both involve activation of the same underlying defensive systems, but differ in how that activation unfolds over time [8]. In SAD, the perceived threat is the anticipation of negative evaluation.

Behavioral and Cognitive Mechanisms

A substantial body of research supports the role of cognitive and behavioral processes in the development and maintenance of SAD. One of the most consistently identified mechanisms is attentional bias toward negative social information. Individuals with higher levels of social anxiety tend to preferentially attend to threatening stimuli, such as negative facial expressions or socially evaluative cues. In an experimental study using dot-probe tasks, attentional bias toward negative emotional information was significantly associated with social anxiety severity, and modification of this bias was associated with reductions in anxiety symptoms [4].

In addition to attentional processes, interpretation bias plays a central role. Socially anxious individuals are more likely to interpret ambiguous social situations as threatening and are less likely to generate harmless interpretations. Amir et al. found that individuals with SAD demonstrated a reduced tendency to endorse interpretations of ambiguous scenarios, particularly at both automatic and reflective levels of processing [6]. This pattern suggests that cognitive distortions are not limited to conscious thought but may also occur at more automatic levels of processing.

Neurocognitive evidence further supports the presence of early-stage processing differences. Using event-related potentials, Moser et al. found that individuals with higher social anxiety did not show the same bias toward positive interpretations that was observed in low-anxiety individuals, indicating altered processing of ambiguous social information at early stages of neural response [7].

Memory processes also contribute to the persistence of social anxiety. Individuals with SAD tend to encode and retrieve social experiences in ways that reinforce negative self-beliefs. In an experimental study, Martin et al. found that individuals with stronger negative self-schemas and higher social anxiety rated

negative social autobiographical memories as more impactful than positive ones [5]. This finding suggests that memory appraisal processes may strengthen maladaptive beliefs about the self.

These findings point to a system in which attention, interpretation, and memory interact to maintain anxiety. Individuals attend to threat, interpret ambiguity negatively, and recall experiences in ways that confirm existing beliefs, creating a self-reinforcing cycle.

Neurobiological Factors

Beyond cognitive and behavioral processes, neurobiological research has identified structural and functional abnormalities associated with SAD. Neuroimaging studies suggest that the disorder involves disruptions in brain circuits. In a multimodal magnetic resonance imaging (MRI) study, individuals with SAD showed reduced gray matter volume in brain regions, along with altered functional connectivity across cortico-striato-thalamo-cerebellar circuitry [9].

These findings are consistent with models that emphasize dysregulation in neural systems involved in fear and evaluation. Altered connectivity patterns may contribute to heightened emotional reactivity and reduced top-down regulation, which in turn make it more difficult for individuals to disengage from perceived social threats. The study also found that functional connectivity differences partially mediated the relationship between structural abnormalities and SAD diagnosis, suggesting that these neural differences may contribute to the expression of the disorder [9].

Developmental Factors

Developmental research indicates that social anxiety symptoms emerge early and may follow different trajectories across childhood and adolescence. In a longitudinal study tracking individuals from early childhood through adolescence, approximately 10% of participants met criteria for an anxiety disorder at some point, with patterns of stability increasing in later developmental periods [10]. Early anxiety symptoms do not always predict later disorders, but symptoms that persist into middle childhood and adolescence are less likely to remit. This suggests that developmental timing plays a critical role in the course of anxiety disorders. The transition into adolescence, a period characterized by increased social evaluation and identity formation, may be particularly relevant for the consolidation of social anxiety symptoms.

Temperament and Risk Factors

Temperamental factors have been consistently linked to the development of SAD, particularly behavioral inhibition. Behavioral inhibition refers to a tendency to respond to unfamiliar people, situations, or environments with withdrawal or distress. Children who display this pattern early in life are more likely to develop anxiety disorders, especially when these tendencies are reinforced over time. Behavioral inhibition does not directly lead to SAD in all cases. Its impact appears to depend on how these early tendencies interact with environmental factors such as parenting style and peer experiences. For example, children who are consistently protected from social discomfort may have fewer opportunities to develop coping skills, which can, over time, strengthen avoidance patterns. In contrast, gradual exposure to social situations may reduce the likelihood that early inhibition develops into clinically significant anxiety.

These findings suggest that risk for SAD arises from the interaction between individual predispositions and environmental factors. This aligns with the broader pattern observed in the disorder, in which early tendencies become more stable when reinforced by avoidance and repeated negative experiences.

Psychoanalytic Perspective

From a psychoanalytic perspective, social anxiety can be understood in relation to internalized experiences. Individuals may develop a heightened sensitivity to evaluation based on early interpersonal experiences, leading to the internalization of a critical or judgmental self-representation. This internal dynamic may contribute to persistent fears of rejection and negative evaluation in social contexts. The experience of social anxiety reflects concern about external judgment and the activation of internalized evaluation processes. This perspective aligns with the observation that individuals with SAD often engage in harsh self-criticism and anticipate negative outcomes even in neutral situations.

Existential Perspective

An existential perspective offers a different lens by focusing on the individual's experience of self in relation to others. Social anxiety can be conceptualized as a heightened form of self-consciousness in which individuals become acutely aware of themselves as objects of evaluation. This shift in awareness may disrupt the ability to engage authentically in social interactions, leading to feelings of disconnection and inauthenticity. The fear experienced in SAD may extend beyond specific negative outcomes and reflect a deeper concern about being judged or found lacking in the presence of others. This perspective helps explain why social situations that are objectively low risk can still evoke intense anxiety. It also provides a framework for understanding the subjective distress that is not fully captured by symptom-based models.

Integrative Model

Each of these perspectives contributes to a more complete understanding of SAD. Cognitive and behavioral models explain how attention, interpretation, and memory processes maintain anxiety. Neurobiological research identifies underlying brain systems associated with these processes. Developmental studies highlight how symptoms emerge and stabilize over time. Psychoanalytic and existential perspectives provide insight into the disorder's internal and subjective experience. These approaches describe different levels of the same phenomenon. Together, they suggest that SAD is best understood as a multi-level condition involving cognitive biases, emotional processing, developmental influences, and disturbances in self-experience.

Social Evaluation as a Threat

A central feature of SAD is that evaluation is experienced as threatening. Within broader models of anxiety, threat is typically linked to potential harm, either physical or psychological [8]. In SAD, the threat is not physical danger but the possibility of negative evaluation and its perceived consequences. This raises the question of why evaluation carries such weight.

Cognitive models suggest that individuals with SAD overestimate both the likelihood and consequences of negative evaluation [3]. However, this does not fully explain why evaluation is experienced as inherently threatening. For many individuals, social evaluation

becomes tied to self-worth. As a result, feedback is processed as a reflection of personal inadequacy. This may help explain why neutral or mildly ambiguous social situations are interpreted negatively and why reassurance does not always reduce anxiety.

From an interpersonal perspective, evaluation is embedded within social relationships and expectations. The anticipation of being judged may reflect concerns about rejection or a sense of belonging being disrupted. This aligns with findings that socially anxious individuals report lower perceived social support and communication difficulties, even when objective social resources are available [11].

Understanding social anxiety in this way shifts the focus from isolated cognitive distortions to the meaning assigned to social evaluation. It suggests that the disorder's persistence is due to the significance evaluation holds for the individual's broader sense of self and relationships. This may also contribute to reluctance to seek treatment, as disclosing distress introduces another context in which evaluation is possible.

Course and Functional Impact

SAD often begins early, with symptoms emerging in childhood or adolescence and, for many individuals, continuing into adulthood. Longitudinal data suggest that anxiety symptoms can fluctuate over time, but once patterns of social avoidance and fear of evaluation become established, they tend to persist. In a community study following participants from preschool through adolescence, anxiety symptoms showed increasing stability with age, meaning that early symptoms were more likely to remain over time as children got older [10]. This pattern is clinically relevant because it suggests a narrowing window for natural remission. Early social fears may present as shyness or inhibition, but when they are reinforced through avoidance and negative experiences, they can develop into more rigid patterns that are harder to change. By adolescence, when peer evaluation becomes more central, these patterns often intensify rather than resolve.

The impact of SAD is visible across multiple areas of functioning. One of the most well-documented areas is education [2]. These outcomes are tied to specific patterns of avoidance and under-participation. Tasks that require speaking, presenting, or engaging in group work are often avoided or minimized. Over time, this can limit academic opportunities and reinforce beliefs about incompetence or inadequacy. In a study examining communication in higher education, students with higher social anxiety reported avoiding participation in class discussions, hesitating to ask questions, and limiting interactions with peers and instructors [12]. These behaviors reduce opportunities, which can compound the disorder's impact over time.

Social anxiety affects relationships and day-to-day interactions. Individuals may limit social engagement and avoid initiating conversations. These patterns can lead to smaller social networks and fewer opportunities for supportive relationships. The difficulty is not a lack of social interest. Many individuals with SAD want social connections but feel unable to engage in a way that feels manageable. This mismatch between desire and behavior can contribute to feelings of isolation and reinforce negative beliefs about the self.

The course of SAD is closely tied to cognitive and behavioral

processes. Avoidance reduces short-term anxiety, which makes it more likely to occur again. Avoidance also limits exposure to corrective experiences, thereby allowing beliefs about negative evaluation to remain unchallenged. Cognitive biases, such as selectively attending to threat or recalling negative interactions more strongly than positive ones, further reinforce these patterns. Over time, these processes create a feedback loop. The longer the pattern continues, the more stable it becomes, which helps explain why SAD often follows a chronic course without intervention.

Gender Differences and Social Functioning

Research suggests that the relationship between social anxiety and interpersonal functioning may vary based on gender, particularly in how individuals communicate and perceive social support. Social anxiety has been associated with lower perceived social support, but this relationship appears to be influenced by communication style. In a study examining these patterns, socially anxious individuals reported lower levels of perceived social support, with communication behaviors mediating this relationship [11]. These patterns differed between men and women. Among men, social anxiety was associated with lower perceived support through reduced clarity and organization in communication, suggesting difficulty expressing thoughts in a way that aligns with social expectations. Among women, social anxiety was associated with lower perceived support through lower expressiveness and higher emotional reactivity, which may affect how interactions are experienced and interpreted. These differences suggest that social anxiety does not present identically across individuals and that interpersonal consequences may depend on how anxiety shapes communication within different social contexts. These differences may also influence help-seeking behavior, as social expectations around emotional expression and vulnerability differ across genders.

Assessment and Measurement

Clinical Assessment

Assessment of SAD typically begins with a clinical interview focused on the presence, frequency, and impact of social fears. The DSM-5-TR criteria guide this process, with attention to situations involving scrutiny and the individual's response to them [1]. During assessment, it is important to clarify what specifically is feared. Some individuals are concerned about appearing anxious, while others are focused on being judged as incompetent or unlikable. The content of the fear often shapes avoidance patterns and can help differentiate SAD from other conditions. Clinicians also assess duration, onset, and whether the fear is consistent across situations or limited to performance contexts.

Standardized Measures

Standardized measures are commonly used to quantify symptom severity and track changes over time. Traditional tools such as the Liebowitz Social Anxiety Scale (LSAS) and the Social Phobia Inventory (SPIN) assess fear and avoidance across a range of social situations. These measures are useful for establishing baseline severity and monitoring treatment response.

More recent work has focused on improving the measurement of social anxiety. The Visual Social Anxiety Scale (VSAS) was developed as an alternative format that uses visual stimuli. In a validation study, the VSAS shows high internal consistency and strong ability to distinguish individuals with SAD from non-clinical controls [13]. This type of measure may capture aspects

of social anxiety that are harder to assess through traditional questionnaires, particularly for individuals who struggle to describe their internal experience in words.

Limitations of Assessment

Although current assessment tools are useful, they are largely focused on observable symptoms such as fear and avoidance. They do not always capture how individuals experience themselves in social situations. For example, measures may identify the presence of anxiety without fully reflecting the degree of self-monitoring or the meaning individuals assign to social interactions.

This gap becomes relevant when considering perspectives beyond symptom-based models. Cognitive measures capture distorted thinking patterns, but they may not fully address how individuals relate to themselves during social interactions. This can limit the depth of assessment, particularly when the distress is tied to identity, self-evaluation, or a sense of exposure in social contexts.

Clinical Challenges

Assessment of SAD can be complicated by the fact that individuals often minimize or avoid discussing their symptoms. Because the disorder centers on fear of evaluation, the assessment process itself may provoke anxiety, which can influence how individuals respond to questions or describe their experiences. Some individuals may underreport symptoms to avoid appearing vulnerable, while others may have difficulty articulating their internal experiences.

Another challenge involves distinguishing between normative social discomfort and clinically significant anxiety. Social anxiety exists on a continuum, and behaviors such as hesitation in social situations or discomfort during public speaking are common. The distinction lies in the level of impairment and the degree to which avoidance interferes with functioning. This requires careful clinical judgment.

There is also variability in how social anxiety presents across individuals. Some individuals experience anxiety primarily in performance situations, while others experience more generalized social fears. Standardized measures may not fully capture these differences, leading to an incomplete understanding of the individual's presentation.

Treatment

Cognitive Behavioral Therapy (CBT)

CBT is one of the most established treatments for SAD. It typically includes exposure to feared social situations along with cognitive work targeting beliefs. The goal is to help individuals engage in situations they would otherwise avoid. In a randomized controlled trial comparing CBT and Acceptance and Commitment therapy (ACT), both treatments led to significant improvement relative to a waitlist condition, with no meaningful difference between the two approaches on most outcome measures [14]. These findings support the effectiveness of CBT while also suggesting that different therapeutic approaches can lead to similar outcomes when they address avoidance and maladaptive beliefs.

One of the more consistent findings across CBT research is that avoidance plays a central role in maintaining symptoms. When individuals begin to approach rather than avoid social situations, anxiety often decreases over time. At the same time, changes in

belief do not always occur at the same pace as behavioral change, which may help explain why some individuals continue to experience residual symptoms even after treatment.

Pharmacological Treatment

Medication is often used as an additional or alternative intervention, particularly in moderate to severe cases. Selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed and have been shown to reduce symptoms of social anxiety. Other medications, including serotonin-norepinephrine reuptake inhibitors and beta-blockers, may be used depending on the presentation.

Medication can reduce physiological arousal and baseline anxiety levels, which may make it easier for individuals to engage in treatment or daily functioning. At the same time, medication alone does not directly address patterns of avoidance or the way individuals interpret social situations, which is why it is often combined with psychotherapy.

Attention-Based and Mechanism-Based Treatments

More recent interventions have focused on targeting specific cognitive mechanisms associated with social anxiety. One example is attention bias modification, which aims to shift attention away from threat-related stimuli. In an experimental study, participants who completed attentional bias modification training showed reductions in both attentional bias and social anxiety symptoms compared to a control condition [4]. These findings suggest that directly modifying underlying cognitive processes can have measurable effects on symptoms. However, the extent to which these changes generalize to real-world functioning is still being examined, and these approaches are often used alongside more established treatments.

Psychoanalytic and Relational Approaches

Psychodynamic approaches focus on patterns that show up across relationships, including expectations of criticism and sensitivity to perceived rejection. In treatment, attention is often given to how these patterns appear in current interactions, including the therapeutic relationship. This can make it easier to identify recurring expectations about how others will respond. Work in this area tends to move more slowly than structured behavioral approaches. The emphasis is less on immediate symptom reduction and more on how individuals understand themselves in relation to others. This can be useful in cases where social anxiety is closely tied to long-standing patterns of self-evaluation.

Existential Considerations

Some aspects of social anxiety are not fully addressed by reducing avoidance or changing specific beliefs. For some individuals, the difficulty is tied to how they experience themselves in social situations. Attention shifts inward, and interactions start to feel effortful or unnatural. Treatment can include helping individuals tolerate being seen without relying on strategies that reduce visibility or control impressions. This may overlap with exposure work, but the focus is slightly different. Instead of only reducing fear, the goal is to stay present in the interaction without constant self-monitoring.

Limitations of Treatment

Even with effective treatments, not all individuals experience full remission. Some continue to report anxiety in specific situations,

while others return to avoidance over time. Treatment outcomes can vary based on factors such as severity, comorbidity, and level of engagement. One limitation across approaches is that improvement in behavior does not always lead to changes in self-perception. Individuals may participate more in social situations but still hold the same beliefs about how they are viewed by others. This gap can contribute to ongoing distress even when functioning improves.

Barriers to Treatment Engagement

Despite the availability of effective treatments, many individuals with SAD do not seek or remain in treatment. One barrier is the nature of the disorder itself. Fear of negative evaluation can extend to the therapeutic setting, making it difficult for individuals to engage openly with a clinician or participate in interventions such as exposure.

Avoidance can also interfere with treatment adherence. Interventions that require participation in feared situations may feel overwhelming, particularly early in treatment. This can lead to dropout or partial engagement, which limits treatment effectiveness. Even when individuals remain in treatment, they may engage in subtle avoidance behaviors that reduce the impact of interventions.

Factors such as access to care and availability of clinicians can influence whether individuals receive treatment. These barriers highlight the gap between research findings and real-world application, where effective treatments are not always accessible or fully utilized.

Discussion

SAD is often described in terms of fear of negative evaluation, but findings suggest that this description is incomplete on its own. Research shows that individuals with SAD process social information in ways that consistently reinforce anxiety. Ambiguous situations are interpreted negatively, attention is drawn to perceived threats, past experiences are recalled in ways that support existing beliefs, and avoidance is used. These processes do not operate in isolation. They interact and repeat over time, which helps explain why symptoms persist even when individuals recognize that their fears may be exaggerated [4-6].

Neurobiological findings add another layer to this picture. Structural and functional differences in brain regions involved in emotion and evaluation suggest that these cognitive patterns are supported by underlying neural systems [9]. Developmental research shows that anxiety symptoms can become more stable as individuals move into adolescence, especially when early patterns are reinforced [10].

Looking at these findings together, it becomes difficult to locate a single cause. The disorder is better understood as a pattern that develops over time through repeated interactions between cognitive processes and behavior. Avoidance reduces immediate discomfort but increases the likelihood of recurrence. Reduced participation limits opportunities for corrective experiences. Over time, this pattern becomes more consistent and harder to shift.

At the same time, the experience of social anxiety is not fully captured by observable behaviors or cognitive distortions. Many individuals report feeling overly self-conscious during

interactions. This experience is not directly measured in most assessment tools, but it shows up indirectly in patterns such as self-focused attention and concern about how one is perceived. Cognitive models describe this in terms of attention and bias [3]. Other perspectives approach the same issue by focusing on how the individuals relate to themselves in social contexts, including expectations of criticism or difficulty feeling at ease when interacting with others.

Treatment findings reflect a similar pattern. Structured approaches such as CBT lead to measurable improvement, particularly when individuals begin to engage in situations they previously avoided [14]. Interventions targeting attention also show that modifying specific processes can reduce symptoms [4]. Even with these gains, some individuals continue to experience anxiety or return to avoidance over time. This suggests that changing behavior and attention does not fully change how individuals understand themselves in social situations.

Functional outcomes highlight the impact of these patterns over time. Individuals with SAD are less likely to complete higher levels of education, which reflects internal distress and reduced participation in environments that require social engagement [2]. More immediate effects can be seen in settings such as classrooms, where socially anxious individuals may avoid speaking or interacting even when they want to engage [12].

Future Directions

Future research may benefit from focusing on how different levels of explanation can be integrated more effectively. Current work often examines processes separately, yet the findings suggest they are closely connected. Research that examines how these levels interact over time may provide a more complete understanding of the disorder. There is also a need for assessment tools that better capture internal experience. Existing measures focus primarily on observable symptoms, but aspects such as self-focused attention and perceived visibility are central to how individuals experience social anxiety. Improving measurements in this area may lead to more targeted interventions.

In treatment, further work is needed to address the gap between symptom reduction and changes in self-perception. Some individuals continue to experience anxiety even after behavioral improvement, which suggests that additional approaches may be needed to address underlying patterns.

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