JORMA International Journal of Health and Social Sciences
Volume 2 No. 3 (2025) - Special Issue: Expert opinions in health and Social Sciences, p.7-13

JORMA IJHSS
ISSN: 2978-0942 (Online)
DOI: https://doi.org/10.64074/pspwa225

Diagnostic clarity: Re-evaluating a clinical case for social anxiety disorder diagnosis in comorbid presentations

Jesse Omoregie, PhD || Parvaneh Sara Pakshir, MSc || Etinosa Steven Omoregie, NHS SN.

[1]Department of Psychology, University of Greater Manchester, Bolton, United Kingdom.

[2]Oxford Brookes University, GBS Manchester, United Kingdom.

[3]School of Nursing
Nottingham Trent University,
Nottingham,
United Kingdom.

Correspondence:
Dr. Jesse Omoregie
https://orcid.org/0000-0003-0749-419X

Abstract

Diagnostic clarity plays a vital role in the effective treatment and recovery of individuals with anxiety disorders. Social Anxiety Disorder (SAD) and Generalised Anxiety Disorder (GAD) frequently co-occur, yet SAD often remains undiagnosed in individuals who are primarily identified with GAD. This oversight can exacerbate the symptoms of both disorders, thus complicating treatment and hindering recovery. This paper explores the impact of missed comorbid diagnoses through a case study of "Rex", an individual initially diagnosed with GAD. Using a qualitative method, this paper draws on personal narratives to examine Rex's experiences. Findings reveal that Rex's symptoms align closely with the diagnostic criteria for SAD as outlined in the DSM-5-TR, despite the absence of a formal SAD diagnosis. The analysis highlights how the unrecognised presence of SAD contributed to persistent social avoidance, and the heightening of the symptoms of both disorders, causing functional impairment and poorer treatment outcomes. This paper highlights the importance of comprehensive diagnostic assessments in anxiety disorders, particularly when symptoms of GAD and SAD overlap. It advocates for the implementation of treatment strategies that target social fears in SAD. Furthermore, it was recommended that periodical reassessments become an integral part of care plans to be sure that no evolving or missed symptoms are left uncaptured. By emphasising the significance of diagnostic precision and personalised care, this paper contributes to a more nuanced understanding of anxiety comorbidity and its implications for mental health practice.

Key Words: Social anxiety disorder || Generalised anxiety disorder || Diagnostic clarity || Comorbid anxiety.

Introduction

Diagnostic clarity plays a vital role in the effective treatment and recovery of individuals with anxiety disorders (Brady et al., 2013). Recovery is a profoundly personal, unique process of change, and flourishing in hope, life satisfaction, and functioning adequately regardless of health adversities. It is also a process of gaining new purpose and meaning in life (Anthony, 1993; Llewellyn-Beardsley et al., 2019). The knowledge of recovery is predominantly based on personal narratives from those with lived experiences of psychopathologies. For example, Patricia Deegan, a psychologist with a lived experience of mental health disorder, describe recovery as a journey rather than a destination (Deegan, 1988; Deegan, 1996). In addition, Robertson et al. (2020) presented that personal narrative, influenced by lived experiences can aid mental health recovery. On the other hand, early, accurate, and complete diagnoses are important in the recovery process, mostly while addressing comorbid disorders such as Social Anxiety Disorder (SAD) alongside Generalised Anxiety Disorder (GAD).

Social anxiety, also known as social anxiety disorder (SAD), is a mental health condition and a kind of psychological disorder that is characterised by an intense fear of social situations whereby the person has the perception of an exposure to judgement and scrutiny by other people, thus impacting adversely on their ability to function in their daily lives, consequently causing them to avoid social settings (Leichsenring & Leweke, 2017). In contrast, GAD involves excessive, uncontrollable worry about a wide range of everyday issues (such as work, finances, health, finances, family, etc.) not limited to social situations (Stein & Sareen, 2015; Rowa et al., 2017). Nevertheless, both disorders can coexist in a situation known as comorbidity, wherein an individual meets the diagnostic criteria for both disorders (e.g., Mennin, Heimberg, & Jack, 2000; Nutt et al., 2006; Bystritsky et al., 2013; Koyuncu et al., 2019).

Accurate and complete diagnosis of mental health disorders is essential in clinical practice for guiding effective treatment and improving patient outcomes. Especially in cases involving comorbid conditions, wherein overlapping symptoms can obscure the presence of specific disorders. With anxiety disorders, SAD and GAD often co-occur (e.g., Bystritsky et al., 2013; Fonzo et al., 2015), nonetheless, SAD is often underdiagnosed when GAD is already identified. Not identifying SAD in a comorbid presentation may cause treatment failure to address the specific social fears that underpin the patient's distress (Koyuncu et al., 2019).

GAD diagnosis can be challenging as some of its symptoms overlap with other conditions such as major depressive disorder, panic disorder, and SAD, making differential diagnosis difficult (e.g., Zbozinek et al., 2012; Stein, 2001). GAD is also highly comorbid with SAD, making treatment complicated as symptoms of one disorder may reinforce the other (e.g., Koyuncu et al., 2019) and may lead to maladaptive coping mechanisms such as substance use (Smith & Book, 2008; McHugh, 2015).

Ephemeral Context

Rex is a pseudonym given to the patient whose personal narrative was used for this paper; this is to protect his anonymity. Rex was born in the early nineties to a working class family in Great Britain. When Rex was ten years old, his father was convicted for grievous bodily harm (GBH) against her mother who was suspected of infidelity. Rex attended a pupil referral unit (PRU) school in a Greater London town where he was reported to have been bullied repetitively by his peers, and as a result, he was moved to another PRU school. He later attended a further education college in the midlands of England where he studied level 3 Building and Construction. Soon after completing college, Rex had difficulty getting into employment, and when he did, he could not maintain them. Since 2020, Rex has had eight episodes of suicidal attempts which led him to be detained under the Mental Health Act 1983. As at when this narrative was obtained, Rex was receiving treatments for generalised anxiety disorder and studying psychology at a university in the Northwest of England.

The problem

SAD can be mistaken for other conditions because of overlapping symptoms and behavioural outcomes. Rex, the clinical case used in this paper, is currently diagnosed with GAD, while his symptoms are consistent with a comorbid disorder.

Aim

The aim of this paper was to examine the importance of diagnostic clarity, using the clinical profile of a patient to demonstrate the challenges and consequences of missed or incomplete diagnoses.

Method

This paper used personal narratives of an individual diagnosed with GAD. Rex was a participant of a large scale anxiety research, approved by the Ethics Committee of the University of Bolton in Greater Manchester. Rex wrote a personal narrative of diagnosis and living with GAD. With this narrative, analyses were made using the DSM V (APA, 2022). To address the questions and capture relevant research literatures, databases were searched, including PsychINFO, ProQuest Central, and Google Scholar.

Analysis

Indicators of SAD

Although Rex has a diagnosis of GAD and has been receiving both pharmacological and psychological interventions, nevertheless, Rex's symptoms are also consistent with SAD. If diagnosed with SAD, Rex may benefit from targeted intervention(s) for SAD. For example, when compared, a major difference between GAD and SAD interventions is within the premise of the specific psychological techniques utilised, such as general techniques in reducing anxiety, e.g., stress management and mindfulness, and concentrating on social skills training and exposure to social situations respectively. Though cognitive behavioural therapy (CBT) may be used for both GAD and SAD; however, interventions for SAD are administered to address specific anxiety related to social interactions (Curtiss et al., 2021).

SAD is characterised by an intense fear of social situations whereby the person has the perception of an exposure to judgement and scrutiny by other people. Key indicators for SAD include persistent worry about being embarrassed, the fear of social interacting, and the avoidance of social settings. Rex's personal narrative was analysed using the DSM V (2022).

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 (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). (APA, 2022, p.230).

"I dread the idea of going out, meeting people, and having conversations. There are no words to explain it ……. My heart beats like the flash, my mind races, my head spins, I start to sweat heavily, my shirt becomes soaked in sweat, and my under arm begins to drip." (Rex).

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others). (APA, 2022, p.230).

"When I am in the midst of people such as in a group, meeting, or parties, even a job interview, or meeting strangers, I start to sweat heavily, my underarm noticeably drips sweat covering my shirt. I start to fidget and anyone near me could hear my heartbeat. I start to feel I am choking, I freeze, and become extremely ashamed." (Rex).

C. The social situations almost always provoke fear or anxiety. (APA, 2022, p.230).

"I went for a job interview last week. The interview did not hold because there was an incidence, yes an incidence about my anxiety. I froze and couldn't breathe. My chest was like it was being cooked, and I could feel my blood pumping through my veins. This is why I never like going out from my comfort zone." (Rex).

D. The social situations are avoided or endured with intense fear or anxiety. (APA, 2022, p.230).

"I tend to avoid place where there are people as in most cases, someone will refer to me, ask me questions, or expect me to say something. I would rather stay on my own instead of being humiliated or becoming an object of scrutiny". (Rex).

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context. (APA, 2022, p.230).

"My fear for social places is over the roof and I think that sometimes, I an over-reacting to all of these. All of these have made me become so lonely. Because who would even like to befriend someone like me? …. Last year, during a council electrician visit to my home, I nearly shit my pants when the electrician asked me questions about the electrical problems. I knew that I was not meant to be that scared or worried, but I was anyway." (Rex).

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more. (APA, 2022, p.231).

"Since I humiliated myself at a small Tesco outlet near me, I have avoided social situations consistently for 8 months going. I do like to meet people, but I can't." (Rex).

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (APA, 2022, p.231).

"I go to Church on a Sunday when everyone is gone, and I pray – when will be able function like a human being? When will I be able to do the things I love to do? ……. I have not been able to keep a job for some years, ……. I have suicidal ideations regularly and I can't help it. I have attempted to unalive myself several times, I guess I was unlucky or lucky, I don't know." (Rex).

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. (APA, 2022, p.231).

"Come to look at it – the origin of my problem is a cocktail of series of event. I am not trying to blame but saying what I believe to be true. I was a magnet to bullies. Anywhere I went, bullies bullied me. My dad's situation did not help, he used to batter my mum, people mocked me because my dad was convicted of GBH to the point that I became very timid and then started to avoid people. My mum and I did not have a very good relationship either……." (Rex).

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. (APA, 2022, p.231).

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive. (APA, 2022, p.231).

"I am taking any other medication for any other thing. I may have different mental health problems, but I have only been diagnosed with GAD." (Rex).

Discussion

The case for comorbidity

Rex is diagnosed with GAD; however, GAD is highly comorbid with other anxiety disorders such as SAD, thereby complicating treatment/intervention planning, because the symptoms of one may strengthen that of the other (e.g., Koyuncu et al., 2019). This can result to functional impairment and poorer treatment outcomes (Mennin, Heimberg, & Jack, 2000). This necessitates clinical practitioners to adopt treatment plans that address the overlapping characteristics and the marked attributes of each disorder.

It is clear that based on Rex's presenting symptoms, he may benefit from SAD diagnosis as his presenting symptoms are consistent with the DSM 5-TR diagnostic criteria for SAD. Rex finds social situations overwhelming, often avoiding eye contact and appearing noticeably withdrawn. He keeps to himself and has difficulty holding down a job due to the anxiety triggered by social interactions. His discomfort is often accompanied by physical symptoms such as a racing heart, excessive sweating under the arms, and constant fidgeting, all of which make his anxiety more visible.

Missed diagnosis in comorbid anxiety disorder

Rex's case highlights the critical implications of missed or incomplete diagnoses in individuals presenting with comorbid anxiety disorders. Accurate diagnosis is critical in the process of recovery (Bystritsky et al., 2013). It is important for Rex, especially given that his symptoms align closely with SAD and may co-occur with GAD, which he is already diagnosed with. Comorbidity can cause complexities in how symptoms manifest and in treatment outcomes, making it important to identify overlapping characteristics of disorders to develop an effective personalised treatment plan (Mennin, Heimberg, & Jack, 2000; Nutt et al., 2006; Bystritsky et al., 2013; Koyuncu et al., 2019). While GAD involves continuing, uncontrollable worry, Rex's pronounced fear of social situations evidenced by his withdrawal, avoidance of eye contact, and physical symptoms like excessive sweating and fidgeting suggests a strong SAD component (see APA, 2022). If this comorbidity is not recognised, treatment may only focus on generalised anxiety, while overlooking the specific social fears that causes impairment in Rex's daily functioning and the inability to maintain employment, thus becoming a case of incomplete treatment. Such oversight can cause persisted psychological distress, a decline in work-related and social encounters, as shown in Rex's case, and may also increase the reliance on maladaptive coping styles like substance use (Smith & Book, 2008; McHugh, 2015). Additionally, when undiagnosed and untreated, SAD can exacerbate the symptoms of GAD, thus reinforcing the general anxiety and avoidant behaviour, with increasing complexities (e.g., Mennin, Heimberg, & Jack, 2000). An accurate diagnosis of SAD as a comorbid disorder with GAD would allow patients like Rex to access targeted interventions, such as cognitive-behavioural therapy for social anxiety, which may facilitate recovery overall quality of life.

Recommendation

Rex's case highlights the need for a more comprehensive diagnostic assessments that differentiates between anxiety disorders and to consider the possibility of comorbidity, particularly when patients present with complex or overlapping symptoms. This would allow the implementation of treatment strategies that target social fears in SAD. Furthermore, through this paper, it is recommended that periodical reassessments become an integral part of care plans to be sure that no evolving or missed symptoms are left uncaptured. Through the prioritisation of diagnostic clarity and personalised care, mental health practitioners can provide a more effective support and enhance the long-term recovery trajectories for those with comorbid anxiety disorders like Rex.

Conflict of Interest

The authors declare no conflicts of interest.

Funding

This research did not receive any grant from funding agencies in the public, commercial, or not-for-profit sectors.

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