

# Validation of the Social Interaction Anxiety Scale in scleroderma: a Scleroderma Patient-centered Intervention Network Cohort study

Shadi Gholizadeh<sup>1</sup>, Linda Kwakkenbos<sup>2,4</sup>, Marie-Eve Carrier<sup>2</sup>, Sarah D. Mills<sup>1</sup>, Rina S. Fox<sup>1</sup>, Lisa R. Jewett<sup>2,5</sup>, Karen Gottesman<sup>6</sup>, Scott Roesch<sup>1,7</sup>, Brett D. Thombs<sup>2,3,8</sup>, Vanessa L. Malcarne<sup>1,7</sup>, SPIN Investigators\*

<sup>1</sup> San Diego State University/University of California, San Diego Joint Doctoral Program in Clinical Psychology, San Diego, California - USA

<sup>2</sup> Lady Davis Institute for Medical Research, Jewish General Hospital, Montreal, Quebec - Canada

<sup>3</sup> Department of Psychiatry, McGill University, Montreal, Quebec - Canada

<sup>4</sup> Behavioral Science Institute, Clinical Psychology, Radboud University, Nijmegen - The Netherlands

<sup>5</sup> Department of Educational and Counselling Psychology, McGill University, Montreal, Quebec - Canada

<sup>6</sup> Scleroderma Foundation, Los Angeles, California - USA

<sup>7</sup> Department of Psychology, San Diego State University, San Diego, California - USA

<sup>8</sup> Departments of Biostatistics and Occupational Health, McGill University, Montreal, Quebec - Canada

\* The complete list of SPIN investigators is available in the Acknowledgements section.

## ABSTRACT

**Introduction:** Individuals with visible differences due to medical conditions, such as systemic sclerosis (SSc; scleroderma), have reported difficulty navigating social situations because of issues such as staring, invasive questions, and rude comments. Fears or anxiety linked to situations in which a person interacts with others is known as social interaction anxiety. However, there exists no validated measurement tool to examine social interaction anxiety in rheumatologic conditions.

**Methods:** The present study examines the reliability (internal consistency) and validity (structural and convergent) of the Social Interaction Anxiety Scale-6 (SIAS-6) in a sample of 802 individuals with SSc, and compares these psychometric properties across limited and diffuse subtypes of the disease. Multi-group confirmatory factor analysis was used to examine the factor structure of the SIAS-6 in patients with both limited and diffuse SSc.

**Results:** A one-factor structure was found to fit well for individuals with SSc with both limited and diffuse disease. The measure demonstrated strong internal consistency reliability and convergent validity with relevant measures in expected magnitudes and directions.

**Conclusions:** The SIAS-6 is a psychometrically robust measure that can confidently be used in SSc populations to examine social interaction anxiety. Moreover, scores can meaningfully be compared between patients with limited and diffuse disease.

**Keywords:** Psychometric, Psychosocial, Scleroderma, Social anxiety, Systemic sclerosis

## Introduction

The study of body image and associated constructs in a medical context has been called “one of the new frontiers” of body image research (p. 8) (1). Medical conditions that cause

changes in appearance can adversely impact many aspects of health-related quality of life, including social interactions (2). Individuals with visible differences have reported difficulty navigating social situations because of issues such as staring, invasive questions, and rude comments (2-4). Such experiences may result in anxiety that is specifically related to fears about interacting and mingling with others; this has been termed social interaction anxiety (5).

The Social Interaction Anxiety Scale (SIAS) is a self-report measure specifically developed to measure social interaction anxiety (5). The SIAS is a unidimensional measure that has demonstrated excellent internal consistency reliability in both clinical (e.g., social anxiety, agoraphobia) and non-clinical (e.g., undergraduate) samples ( $\alpha = 0.88-0.93$ ) (5, 6) as well as sensitivity to change following interventions targeting social

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### Corresponding author:

Vanessa L. Malcarne  
Doctoral Training Facility  
6363 Alvarado Court Suite 103  
San Diego, 92120-4913 CA, USA  
vmalcarne@mail.sdsu.edu

anxiety (5, 7). Peters and colleagues (8) developed a one-factor six-item short form of the SIAS, the SIAS-6. The SIAS-6 has demonstrated strong correlations with the original SIAS (ranging from  $r = 0.88$  to  $r = 0.92$ ) and related constructs (e.g., social appearance anxiety) in clinical and non-clinical samples (8). However, the factor structure and internal consistency reliability of the SIAS-6 have not been examined in the context of disfigurement from medical illness or injury.

Systemic sclerosis (SSc, or scleroderma) is a chronic and progressive autoimmune connective tissue disease with no known cure that is associated with marked appearance changes in visible and socially relevant areas of the body, including the hands and face (9-12). The disease's most common visible characteristic is skin thickening. Although SSc can have a heterogeneous presentation, it is typically divided into limited and diffuse subtypes, based on where skin thickening occurs. In limited disease, skin thickening is typically only present in the hands, arms, and face; in diffuse disease, skin involvement also includes the truncal region (13, 14). Appearance concerns are common in patients with both subtypes and can include a pinched appearance to the nose and eyes; contractures and amputations of the digits; loss of volume and flexibility of the lips; hypo- and hyper-pigmentation; and telangiectasias (11). Disease-related changes to appearance in SSc have been associated with appearance dissatisfaction and social discomfort (9, 15, 16). In a qualitative study, Joachim and Acorn (17) described SSc patients' concerns about calling attention to themselves in public and fears of stigmatization based on their appearance. For patients with SSc who struggle with unwanted appearance changes, there has been a call for increased research in order to inform assessments and interventions for body image distress and its social impacts (12, 18). To date, however, social interaction anxiety has not been studied in SSc.

The present study examines the reliability (internal consistency) and validity (structural and convergent) of the SIAS-6 in patients with SSc, and compares these psychometric properties across limited and diffuse subtypes of the disease. We hypothesized that a one-factor structure would provide the best fit for the data for both SSc disease subtypes and that internal consistency reliability would be high (Cronbach's  $\alpha \geq 0.80$ ). In previous research with the SIAS-6, moderate-to-large relationships have been demonstrated with measures of social anxiety ( $r = 0.54$ ), fear of negative evaluation ( $r = 0.42$ ), and depression ( $r = 0.48$ ) (8) and a moderate relationship between the full-length SIAS and a measure of appearance satisfaction ( $r = -0.46$ ) (19). Effect sizes for correlations have been described as small ( $|r| \leq 0.3$ ), moderate ( $0.3 < |r| < 0.5$ ), or large ( $|r| \geq 0.5$ ) (20). It was hypothesized that higher SIAS-6 scores would have moderate-to-large associations with measures of social appearance anxiety, social discomfort, and fear of negative evaluation, and smaller associations with measures of appearance dissatisfaction and symptoms of depression.

## Patients and methods

### Participants and procedures

The present study is a cross-sectional analysis of baseline data of patients enrolled in the Scleroderma Patient-centered

Intervention Network (SPIN) Cohort who completed the SIAS-6. To be eligible for the SPIN Cohort, patients must have a confirmed diagnosis of SSc according to the 2013 American College of Rheumatology/European League Against Rheumatism classification criteria (21), be aged  $\geq 18$ , be able to give informed consent, be fluent in English or French, and have the ability to respond to questionnaires via the Internet. The SPIN sample is a convenience sample. Eligible patients are invited by the attending physician or a supervised nurse coordinator to participate in the SPIN Cohort, and written informed consent is obtained. The local SPIN physician or supervised nurse coordinator then completes a medical data form that is submitted online to initiate patient registration in the SPIN Cohort. After completion of online registration, an automated welcoming email is sent to participants with instructions on how to activate their SPIN online account and how to complete the SPIN Cohort patient measures online. SPIN Cohort patients should complete outcome measures via the Internet upon enrollment and subsequently every three months. The SPIN Cohort study was approved by the Research Ethics Committee of the Jewish General Hospital, Montreal, Canada and by the Institutional Reviews Boards of each participating center. Patients included in the present study were enrolled at 27 SPIN centers in Canada, the USA, and the UK. Only data from the baseline assessments of English-speaking participants completed from April 2014 to February 2017 were analyzed.

### Measures

**SIAS-6 (8).** The SIAS-6 is a six-item measure of anxiety associated with initiating and maintaining social interactions, which was developed from the 20-item SIAS (5). Response options range from 0 (*not at all characteristic or true of me*) to 4 (*extremely characteristic or true of me*). A total score is computed by summing all items, with scores ranging from 0 to 24. Higher scores correspond to greater social interaction anxiety.

**Social Appearance Anxiety Scale (SAAS) (19).** The SAAS is a 16-item measure of anxiety about being negatively evaluated by others because of one's appearance. Items are scored on a five-point scale ranging from 1 (*not at all*) to 5 (*extremely*). Total scores range from 16 to 80, with higher scores indicating greater anxiety. A psychometric analysis supported the structural validity, convergent validity, and internal consistency of the SAAS in SSc (16). Internal consistency reliability in the present sample was excellent ( $\alpha = 0.96$ ).

**Brief Fear of Negative Evaluation Scale – Revised (BFNE-II) (22).** The BFNE-II assesses fears of being negatively evaluated by others. Items are scored on a five-point scale ranging from 1 (*not at all characteristic of me*) to 5 (*extremely characteristic of me*). Total scores range from 12 to 60, with higher scores indicating greater fear of negative evaluation. The BFNE-II has demonstrated strong internal consistency in non-SSc populations (22, 23). Internal consistency reliability in the present sample was excellent ( $\alpha = 0.98$ ).

**Brief Satisfaction with Appearance Scale (Brief-SWAP) (15).** The Brief-SWAP is a six-item measure of body image dissatisfaction, adapted from the full SWAP (24) with the following two subscales: Dissatisfaction with Appearance and Social Discomfort. Respondents report appearance-related

concerns on a seven-point scale ranging from 0 (*strongly disagree*) to 6 (*strongly agree*). Subscale scores range from 0 to 18, with higher scores indicating greater appearance-related discomfort and dissatisfaction. The structural validity, convergent validity, and internal consistency of the measure have been supported with SSc patients (16, 25). Internal consistency reliability in the present sample for the Dissatisfaction with Appearance and Social Discomfort subscales was excellent ( $\alpha = 0.83$  and  $\alpha = 0.88$ , respectively).

**Patient Health Questionnaire (PHQ-8)** (26). The PHQ-8 items measure depressive symptoms over the last two weeks on a four-point scale, ranging from 0 (*not at all*) to 3 (*nearly every day*). A total score is obtained by summing item scores, with higher scores indicating more depressive symptoms. The PHQ-8 performs equivalently to the PHQ-9 (27), which is a valid measure of depressive symptoms in patients with SSc (28). Internal consistency reliability in the present sample was excellent ( $\alpha = 0.89$ ).

**Sociodemographic and Medical Variables.** Patients self-reported sociodemographic data. SPIN physicians reported medical information, including modified Rodnan skin scores (mRss) (29, 30) a measure of skin thickening with scores ranging from 0 to 51, with higher scores reflecting greater thickening and disease involvement, and disease subtype.

### Data analysis

Descriptive statistics for sociodemographic and medical variables were calculated for the sample with SPSS, version 22.0. Confirmatory factor analysis (CFA) was conducted to confirm the single-factor structure of the SIAS-6 using Mplus version 7.12. MLR estimation, which provides maximum likelihood parameter estimates with standard errors and a chi-square statistic that is robust to non-normality, and non-independence of observations, was used in the present analysis. Modification indices were also requested to examine whether freeing parameters would improve model fit. After establishing structural validity, multiple group CFA was used, as described by Dimitrov (31), to evaluate the comparability of the factor structures, also referred to as measurement invariance, of the SIAS-6 for patients with limited and diffuse SSc via the following, iteratively restrictive models: (i) configural invariance; (ii) metric invariance; and (iii) scalar invariance. Briefly, this approach [recommended by Vandenberg and Lance (32)] first examines the baseline fit of the measurement model in both groups by constraining the number of factors and the items contributing to each factor to establish configural invariance, which demonstrates that the same factor structure exists for both groups. Next, a more restrictive model is run, such that the loading of each item onto the factor is constrained to equivalence between the groups to establish metric invariance, which suggests that the same factor loadings exist for both groups. If both the previous models demonstrate good fit, a third, even more restrictive, model is run to establish scalar invariance, to demonstrate that, in addition to factor loadings, the same item intercepts also exist for both groups.

Overall model fit was determined using the recommendations of Bentler (33). Three indicators of model fit were utilized, including: (a) the root-mean-square error of approximation

(RMSEA) (34), with values  $<0.08$  indicating acceptable fit and values  $<0.05$  indicating good fit; (b) the standardized root-mean residual (SRMR) (35), an index of overall model fit with values  $<0.08$  indicating acceptable fit and values  $<0.05$  indicating good fit; and (c) the comparative fit index (CFI) (33), with values  $>0.95$  indicating good model fit and values  $>0.90$  indicating acceptable model fit. The Satorra and Bentler (36) scaling factors were used for the chi-square value, given statistically significant multivariate skewness and kurtosis in the present data (all  $p < 0.05$ ). Because the likelihood-ratio chi-square ( $\chi^2$ ) is influenced by sample size, it was not the sole indicator of model fit (37). Per previously established criteria (37, 38) the Satorra-Bentler Scaled chi-square ( $S-B\chi^2$ ) (39) difference test and the CFI values were used to compare the increasingly restrictive multiple-group CFA models such that a non-statistically significant ( $p > 0.05$ ) change in  $S-B\chi^2$  or a change in CFI of  $\leq 0.01$  indicated no difference between the nested models; in other words, adding more restrictions would not significantly compromise good model fit (40).

Internal consistency reliability for the SIAS-6 items was calculated using Cronbach's coefficient alpha. Convergent validity was examined via Spearman correlations of the SIAS-6 with the SAAS, BFNE-II, Brief-SWAP, and PHQ-8. The aforementioned hypotheses regarding the direction and magnitude of the relationships were established *a priori*, based on prior research with the SIAS-6. Scores between the two groups were compared using Independent Samples t-tests.

A minimum sample size estimation for a one-factor CFA with six items, assuming factor loadings between 0.50 and 0.80, is between 60 and 190 participants (41). Regarding minimum sample size for the proposed correlation analyses, a correlation that can be assessed with 95% confidence and precision of 0.10 would require a minimum sample size of 403 for a small correlation ( $r = 0.30$ ) and at least 275 for a large correlation ( $r = 0.50$ ) (42). Thus, the present sample size exceeded the minimum sample size requirements.

### Results

Sample statistics are reported in Table I. Three participants who left the second item of the SIAS-6 blank were removed from the analysis. Participants ( $n = 802$ ) were predominantly female (87%), married (74%), and had a mean age of 55.5 years ( $SD = 12.0$ ).

#### Confirmatory factor analysis

CFA confirmed the one-factor model of the SIAS-6 [ $S-B\chi^2$  (9) = 30.2,  $p < 0.01$ ; CFI = 0.99, RMSEA = 0.05, SRMR = 0.02]. Individual item factor loadings are provided in Table II. The modification indices were examined; however, no parameters were freed, given that the one-factor model fit well without modification.

#### Multiple-group confirmatory factor analysis models

The one-factor model fit the data well for limited and diffuse disease groups (see Tab. II). Additionally, the factor loadings were statistically significant for all items in both groups (see Tab. III). The metric invariance model fit the data well

**TABLE I** - Sociodemographic, disease, and psychosocial variables for sample (n = 802)

Sociodemographic variables	
Age (mean, SD)	55.55 (12.0) <sup>a</sup>
Female (n, %)	697 (86.9)
White (n, %)	686 (85.6)
Years of formal education (mean, SD)	15.40 (3.2)
Employed full or part-time (n, %)	326 (64.4) <sup>b</sup>
Married or living as married (n, %)	595 (74.2)
Disease variables	
Diffuse scleroderma (n, %)	350 (43.6)
Disease duration (time since first non-Raynaud's symptom) in years (mean, SD)	11.61 (8.8) <sup>c</sup>
Modified Rodnan skin score (mean, SD)	8.22 (9.0) <sup>d</sup>
Psychosocial measures (mean, SD) <sup>e</sup>	
SIAS-6	2.43 (3.8)
Limited	2.06 (3.1)
Diffuse	2.91 (4.5)
Brief-SWAP-dissatisfaction with Appearance	9.28 (5.21) <sup>f</sup>
Brief-SWAP-social discomfort	5.34 (5.22) <sup>g</sup>
PHQ-8	6.03 (5.4) <sup>h</sup>
SAAS	28.09 (13.0) <sup>i</sup>
BFNE-II	24.80 (12.2) <sup>j</sup>

Due to missing values: <sup>a</sup>n = 799; <sup>b</sup>n = 801; <sup>c</sup>n = 744; <sup>d</sup>n = 639; <sup>e</sup>SAAS = Social Appearance Anxiety Scale; SWAP = Satisfaction with Appearance Scale; PHQ-8 = Patient Health Questionnaire-8; SIAS-6 = Social Interaction Anxiety Scale; BFNE-II = Brief Fear of Negative Evaluation Scale-Revised.  
Due to missing values; <sup>f</sup>n = 795; <sup>g</sup>n = 794; <sup>h</sup>n = 792; <sup>i</sup>n = 794; <sup>j</sup>n = 7.

descriptively (CFI = 1.00, RMSEA: 0.00, SRMR: 0.04; see Tab. II). Comparing the less restrictive configural invariance model to the more constrained metric invariance model, the results suggested that the metric model did not worsen fit statistically ( $\Delta S-B\chi^2 = 5.84$   $df = 5$ ,  $p = 0.32$ ) or descriptively ( $\Delta CFI \leq 0.01$ ). The scalar model also demonstrated good fit (CFI = 1.00, RMSEA: 0.00, SRMR: 0.04; see Tab. II). When compared to the less restrictive metric invariance model, fit was not compromised ( $\Delta S-B\chi^2 = 5.71$   $df = 5$ ,  $p = 0.33$ ,  $\Delta CFI \leq 0.01$ ).

### Descriptive statistics for the SIAS-6

The total score for the SIAS-6 in the full sample was 2.43 ( $SD = 3.8$ ; range: 0-24). The limited group mean was 2.06 ( $SD = 3.1$ ; range 0-18), whereas the diffuse group mean was 2.91 ( $SD = 4.5$ ; range 0-24). Internal consistency reliability was excellent for the total sample ( $\alpha = 0.89$ ) as well as for limited ( $\alpha = 0.86$ ) and diffuse subgroups ( $\alpha = 0.90$ ). Comparing group means, the scores were significantly different between groups ( $p < 0.01$ ; 95% CI: -1.39, -0.29). Thus, patients with diffuse disease reported significantly greater social interaction anxiety than patients with limited disease.

### Convergent validity

Consistent with the relationships hypothesized, SIAS-6 scores had positive, large correlations with measures of social appearance anxiety ( $r_s = 0.50$ ,  $p < 0.01$ ) and fear of negative evaluation ( $r_s = 0.60$ ,  $p < 0.01$ ), a moderate, positive correlation with a measure of social discomfort ( $r_s = 0.43$ ,  $p < 0.01$ ), and a small, positive correlation with appearance dissatisfaction ( $r_s = 0.23$ ,  $p < 0.01$ ). Contrary to the authors' expectations, there was a moderate rather than small correlation with symptoms of depression ( $r_s = .41$ ,  $p < 0.01$ ; see Tab. IV).

### Discussion

The results of the present study suggest that the SIAS-6 is a reliable and valid one-factor measure of social interaction anxiety for patients with SSc. Moreover, the multi-group confirmatory factor analysis provided support for the scalar invariance model, suggesting that scores can be meaningfully compared between limited and diffuse disease groups (40, 43). Internal consistency reliability was strong, and convergent validity was supported via significant correlations with relevant measures in the expected magnitudes and directions, except for the correlation with depressive symptomatology via the PHQ-8, which was larger than expected.

Given a possible range for total scores of 0 to 24, average scores for SSc patients in the range of 2 to 3 represent a low level of social interaction anxiety. In previous research, scores have been consistently higher among individuals receiving treatment for social anxiety [e.g., mean = 13.2;  $SD = 4.9$  (8);

**TABLE II** - Fit statistics for configural invariance, metric invariance, and scalar invariance models of the Social Interaction Anxiety Scale-6 (SIAS-6)

Model	S-B $\chi^2$	p	CFI <sup>a</sup>	SRMR <sup>b</sup>	RMSEA <sup>b</sup>	Reference model #	$\Delta S-B\chi^2$	$\Delta df$	$\Delta p$	$\Delta CFI$
1. Configural										
Limited	8.77	0.46	1.00	0.02	0.00					
Diffuse	7.34	0.60	1.00	0.02	0.09					
2. Metric	21.98	0.52	1.00	0.04	0.00	1	5.84	5	0.32	<0.01
3. Scalar	27.17	0.51	1.00	0.04	0.00	2	5.71	5	0.33	<0.01

<sup>a</sup>Plausible fit  $\geq 0.90$ , good fit  $> 0.95$ .

<sup>b</sup>Plausible fit  $\leq 0.08$ , good fit  $\leq 0.05$ .

CFI = robust comparative fit index; RMSEA = root-mean-square error of approximation; SRMR = standardized root-mean-square residual.

**TABLE III** - Standardized factor loadings from the confirmatory factor analysis (CFA) for the total sample and the multiple-group CFA baseline models for the Social Interaction Anxiety Scale-6 (SIAS-6)

SIAS-6 item	Factor loadings		
	Total sample (n = 802)	Limited (n = 452)	Diffuse (n = 350)
1. I have difficulty making eye contact with others	0.73	0.73	0.74
2. I find it difficult mixing comfortably with the people I work with	0.80	0.77	0.82
3. I tense up if I meet an acquaintance on the street	0.80	0.74	0.83
4. I feel tense if I am alone with just one person	0.81	0.72	0.86
5. I have difficulty talking with other people	0.84	0.80	0.86
6. I find it difficult to disagree with another's point of view	0.60	0.56	0.64

For all factor loadings  $p < 0.05$ .

**TABLE IV** - Correlation of variables with the Social Interaction Anxiety Scale-6 (SIAS-6)

	Spearman's correlations <sup>e</sup>
Brief-SWAP – dissatisfaction with appearance <sup>a</sup>	0.22
PHQ-8 <sup>b</sup>	0.41
Brief-SWAP – social discomfort	0.43
SAAS <sup>c</sup>	0.50
BFNE-II <sup>d</sup>	0.60

BFNE-II = Brief Fear of Negative Evaluation Scale-II; Brief-SWAP = Brief Satisfaction with Appearance Scale; PHQ-8 = 8-item Patient Health Questionnaire; SAAS = Social Appearance Anxiety Scale.

Due to missing values: <sup>a</sup>n = 794; <sup>b</sup>n = 792; <sup>c</sup>n = 789; <sup>d</sup>n = 787; <sup>e</sup>magnitude of correlations was defined as small =  $|r| \leq 0.3$ , moderate =  $0.3 < |r| < 0.5$ , and large =  $|r| \geq 0.5$ . All correlations were significant at  $p < 0.001$ .

mean = 12.52; SD = 5.14 (44)] and among sexual minorities [e.g., mean = 4.7; SD = 4.8 (45)]. However, scores from community-dwelling adults without clinically significant anxiety symptoms have been lower [e.g., mean = 1.5; SD = 2.25 (44)], and similar to the scores found for SSc patients in the present study. To the authors' knowledge, the SIAS-6 has not been used previously in any samples with medical disfigurement, though a study using the full-length SIAS in a sample of patients with spasmodic torticollis (ST), a neurological condition causing involuntary neck contortions, found that ST patients had significantly higher SIAS scores as compared to non-affected controls (46). The SIAS-6 has not yet been used in other rheumatologic conditions, limiting comparisons to other diseases. Given the good psychometric properties of the SIAS-6 in SSc, researchers interested in interactional anxiety among patients with other conditions, may consider including the SIAS-6 as a measure of social interaction anxiety.

The results of the present study should be interpreted in the context of limitations. The SPIN Cohort is a convenience sample of patients receiving treatment at SPIN recruiting centers who complete study questionnaires online, potentially limiting generalizability. Additionally, the cross-sectional design of the present study precluded evaluations of sensitivity to change or

test-retest reliability. A potential limitation of the measure is that all six items are positively worded. Most of the psychometric literature examining the role of negatively worded and reverse-scored items in minimizing response-bias has identified that negatively worded items can contribute to problems with internal consistency and factor structure (47). Barnette (47) examined the role of stem direction, item response direction, and Cronbach's alpha and identified that the best psychometric properties were achieved for measures with all directly worded stems and a mixture of directionality for response options. Future researchers who conduct psychometric work on this measure may consider testing the use of such alternative response options. Additionally, this study identified a disparity in scores such that patients with diffuse disease had higher scores than patients with limited disease. The present study was not powered to examine the role of various disease subtype-related variables (e.g., skin score, lung disease) or other medical characteristics (e.g., disease duration) in SIAS-6 scores. It may be interesting to identify the disease subtype-related variables associated with SIAS-6 scores in future research as the study sample grows. Additionally, exploring disease characteristics that can impact body image (e.g., facial involvement, location of telangiectasias, hand involvement) or participant characteristics (e.g., race/ethnicity, gender, marital status) may also be an interesting aim in future research that can inform interventions for social problems. Examining correlates of group membership in quartiles or identifying cut-off scores may be warranted in future research endeavors. Finally, it is conceivable that a disease-specific measure of social interaction anxiety that captures challenges of social interactions unique to SSc populations (e.g., fears about shaking hands) may better assess social interaction anxiety in individuals with SSc. Despite these limitations, the results of the present study provide important psychometric support for the use of the SIAS-6 to measure social interaction anxiety among patients with SSc.

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### List of SPIN Investigators

Murray Baron, McGill University, Montréal, Québec, Canada; Susan J. Bartlett, McGill University, Montréal, Québec, Canada; Dan Furst, University of California, Los Angeles, California, USA; Frank van den Hoogen, Radboud University Medical Center and Sint Maartenskliniek, Nijmegen, The Netherlands; Maureen D. Mayes, University of Texas McGovern School of Medicine, Houston, Texas, USA; Luc Mouthon, Université Paris Descartes, Paris, France; Warren R. Nielson, St. Joseph's Health Care, London, Ontario, Canada; Serge Poiraudou, Université Paris Descartes, Paris, France; Robert Riggs, Scleroderma Foundation, Danvers, Massachusetts, USA; Maureen Sauve, Scleroderma Society of Ontario, Hamilton, Ontario; Fredrick Wigley, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA; Shervin Assassi, University of Texas McGovern School of Medicine, Houston, Texas, USA; Isabelle Boutron, Université Paris Descartes, and Assistance Publique-Hôpitaux de Paris, Paris, France; Angela Costa Maia, University of Minho, Braga, Portugal; Ghassan El-Baalbaki, Université du Québec à Montréal, Montréal, Québec, Canada; Carolyn Ells, McGill University, Montréal, Québec, Canada; Cornelia van den Ende, Sint Maartenskliniek, Nijmegen, The Netherlands; Kim Fligelstone, Scleroderma Society, London, UK; Catherine Fortune, Scleroderma Society of Ontario, Hamilton, Ontario, Canada; Tracy Frech, University of Utah, Salt Lake City, Utah, USA; Dominique Godard, Association des Sclérodermiques de France, Sorel-Moussel, France; Daphna Harel, New York University, New York, New York, USA; Marie Hudson, McGill University, Montréal, Québec, Canada; Ann Impens, Midwestern University, Downers Grove, Illinois, USA; Yeona Jang, McGill University, Montréal, Québec, Canada; Sindhu R. Johnson, Toronto Scleroderma Program, Mount Sinai Hospital, Toronto Western Hospital, and University of Toronto, Toronto, Ontario, Canada; Ann Tyrell Kennedy, Federation of European Scleroderma Associations, Dublin, Ireland; Maggie Larche, McMaster University, Hamilton, Ontario, Canada; Catarina Leite, University of Minho, Braga, Portugal; Carlo Marra, Memorial University, St. John's, Newfoundland, Canada; Karen Nielsen, Scleroderma Society of Ontario, Hamilton, Ontario, Canada; Janet Pope, University of Western Ontario, London, Ontario, Canada; Alexandra Portales, Asociación Española de Esclerodermia, Madrid, Spain; Tatiana Sofía Rodríguez Reyna, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Mexico City, Mexico; Anne A. Schouffoer, Leiden University Medical Center, Leiden, The Netherlands; Russell J. Steele, Jewish General Hospital and McGill University, Montréal, Québec, Canada; Maria E. Suarez-Almazor, University of Texas MD Anderson Cancer Center, Houston, Texas, USA; Joep Wellington, NVLE Dutch patient organization for systemic autoimmune diseases, Utrecht, The Netherlands; Durhane Wong-Rieger, Canadian Organization for Rare Disorders, Toronto, Ontario, Canada; Alexandra Albert, Université Laval, Québec, Québec, Canada; Guylaine Arsenault, Sherbrooke University, Sherbrooke, Québec, Canada; Lyne Bissonnette, Sherbrooke University, Sherbrooke, Québec, Canada; Gilles Boire, Sherbrooke University, Sherbrooke, Québec, Canada; Alessandra Bruns, Sherbrooke University, Sherbrooke, Québec, Canada; Patricia Carreira, Servicio de Reumatología del Hospital 12 de Octubre, Madrid, Spain; Lorinda Chung, Stanford University, Stanford, California, USA; Pierre Dagenais, Sherbrooke University,

Sherbrooke, Québec, Canada; Christopher Denton, Royal Free London Hospital, London, UK; Robyn Domsic, University of Pittsburgh, Pittsburgh, Pennsylvania, USA; James V. Dunne, St. Paul's Hospital and University of British Columbia, Vancouver, British Columbia, Canada; Paul Fortin, Université Laval, Québec, Québec, Canada; Anna Gill, Royal Free London Hospital, London, UK; Jessica Gordon, Hospital for Special Surgery, New York City, New York, USA; Genevieve Gyger, Jewish General Hospital and McGill University, Montréal, Québec, Canada; Ariane L Herrick, University of Manchester, Salford Royal NHS Foundation Trust, Manchester, UK; Monique Hinchcliff, Northwestern University, Chicago, Illinois, USA; Alena Ikic, Université Laval, Québec, Québec, Canada; Niall Jones, University of Alberta, Edmonton, Alberta, Canada; Artur Jose de B. Fernandes, Sherbrooke University, Sherbrooke, Québec, Canada; Suzanne Kafaja, University of California, Los Angeles, California, USA; Nader Khalidi, McMaster University, Hamilton, Ontario, Canada; Benjamin Korman, Northwestern University, Chicago, Illinois, USA; Patrick Liang, Sherbrooke University, Sherbrooke, Québec, Canada; Joanne Manning, Salford Royal NHS Foundation Trust, Salford, UK; Ariel Masetto, Sherbrooke University, Sherbrooke, Québec, Canada; David Robinson, University of Manitoba, Winnipeg, Manitoba, Canada; Sophie Roux, Sherbrooke University, Sherbrooke, Québec, Canada; Doug Smith, University of Ottawa, Ottawa, Ontario, Canada; Robert Spiera, Hospital for Special Surgery, New York, New York, USA; Virginia Steen, Georgetown University, Washington, DC, USA; Evelyn Sutton, Dalhousie University, Halifax, Nova Scotia, Canada; Carter Thorne, Southlake Regional Health Centre, Newmarket, Ontario, Canada; John Varga, Northwestern University, Chicago, Illinois, USA; Pearce Wilcox, St. Paul's Hospital and University of British Columbia, Vancouver, British Columbia, Canada; Vanessa C. Delisle, Jewish General Hospital and McGill University, Montréal, Québec, Canada; Claire Fedoruk, Jewish General Hospital, Montréal, Québec, Canada; Brooke Levis, Jewish General Hospital and McGill University, Montréal, Québec, Canada; Mia R. Pepin, Jewish General Hospital, Montréal, Québec, Canada; Jennifer Persmann, Université du Québec à Montréal, Montréal, Québec, Canada.

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