

Anxiety: Social Anxiety Disorder Assessment (Behavioral Health) - CE

ALERT

Social anxiety disorder (SAD) can significantly impact a patient's ability to function both socially and in his or her work setting.

OVERVIEW

SAD, also known as social phobia, is a condition that involves the experience of intense fear of social situations or interactions (e.g., giving a speech, meeting unfamiliar people). It is one of the most prevalent psychiatric disorders.¹²

In most cases, SAD is chronic. The fear and anxiety experienced in the disorder relates to the anticipated observation or scrutiny of others and the assumption that their judgment will be negative and cause humiliation or embarrassment. The fear is out of proportion with the actual threat and causes significant distress or impairment in certain areas of function, including social and occupational. The fear or avoidance is persistent, typically lasting for 6 or more months, and is not related to another condition, such as an adverse reaction to a medication or a panic disorder.¹ If the fear is restricted to performing in public, the social anxiety should be specified as performance anxiety only.¹²

When assessing patients for SAD, taking cultural factors into consideration is important. Cultural differences may lead to differences in symptoms. An example of the difference is found in *taijin kyofusho*, a culture-specific syndrome in Asian populations that involves the patient's experience of fear of offending or making others uncomfortable, rather than the fear of being made to feel extremely uncomfortable or embarrassed. This difference can be interpreted in the context of the difference between social norms and values of Asian cultures versus Western cultures.⁸

Women are more likely than men to experience SAD; however, the course of the disorder seems similar in men and women related to functional impairment.²

Almost one-third of patients with SAD also experience comorbid depression.⁹ In addition, generalized anxiety disorder is frequently a comorbid condition in children with SAD.⁷ For adolescents and adults, alcohol use disorder is associated with SAD. A national survey indicated that almost half of adults with SAD also had alcohol use disorder.³

The two most common periods of onset of social phobia are during mid-adolescence and early childhood.^{5,7} Early onset of SAD is associated with greater severity of signs and symptoms, including more significant functional impairment.

Standardized tools can be used to screen patients and assess the severity of symptoms of the anxiety disorders. These scales include the Social Interaction Anxiety Scale (SIAS) or the Social Phobia Scale (SPS). Scales use self-report or observed data.¹⁸ For older adults, the Older Adult Social Evaluative Scale (OASES) has demonstrated validity, as has the Geriatric Anxiety Scale (GAS).¹¹

SAD treatment includes cognitive behavioral therapy, social skills training, and psychoeducation and exposure therapy.¹⁴ Medications used to treat SAD include antidepressants, benzodiazepines, anticonvulsants, and beta blockers.¹²

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EDUCATION

- Establish a rapport with the patient, family, and designated support person that encourages questions. Answer them as they arise.
- Consider the patient's, family's, and designated support person's values and goals in the decision-making process.
- Assist the patient, family, and designated support person to recognize signs and symptoms of acute exacerbation of the illness.
- Explain the manifestations of the illness and expected progression of symptoms if the patient experiences a relapse. Describe what the family and designated support person are likely to see, hear, and experience (e.g., fear or embarrassment in social situations, excessive shyness, and avoidance of unfamiliar activities).¹² Advise the patient, family, and designated support person of steps to take if relapse occurs.
- Explain to the patient, family, and designated support person that the main goal is to provide a safe, secure place to receive treatment.
- Explain how the behavioral health unit may be different than other settings. Interaction is promoted between patients and staff, and group meetings are encouraged. To ensure patients' safety, they are checked on frequently throughout the day.
- Educate the family and designated support person regarding the nature of the psychiatric illness and expected signs and symptoms of SAD (e.g., social isolation, excessive fear embarrassment in social situations, impaired school and work performance).¹²
- Educate the patient, family, and support person about positive coping strategies such as cognitive reappraisal, problem-solving, and acceptance.^{6,16}
- Assist the patient, family, and designated support person to engage and participate as drivers of the plan of care.
- Explain the importance of following the medication regimen as ordered. The patient should not alter the dosage or stop taking the medication even if symptoms have subsided and he or she is feeling better.

ASSESSMENT

1. Perform hand hygiene.
2. Introduce yourself to the patient, family, and designated support person.
3. Verify the correct patient using two identifiers.
4. Assess the patient's mental status and ability to understand information and participate in decisions. Include the patient as much as possible in all decisions.
5. Consider that extreme states of anxiety may negatively impact the patient's ability to accurately hear and understand information.
6. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm.
7. Assess the patient for signs and symptoms of SAD, including physical signs and symptoms related to arousal, tachycardia, blushing, trembling, and sweating; behavioral signs and symptoms, including avoidance, refusing to eat meals with others, avoiding eye contact or participation in groups; and cognitive signs and symptoms, including negative thoughts, embarrassment, and shame.¹³
8. Assess the patient for comorbid disorders, such as substance use or alcohol use disorder, generalized anxiety disorder, or depression. Assess the patient for use of alcohol or drugs as a way to reduce anxiety and mask signs and symptoms in social situations.³
9. Assess the patient's use of coping strategies and consider whether they are adaptive (e.g., cognitive reappraisal, problem-solving, acceptance) or maladaptive (e.g., avoidance,

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suppression, rumination); determine how successful these coping strategies are in helping the patient reduce symptoms of anxiety.^{6,16}

10. Evaluate the patient's, family's, and designated support person's understanding of the patient's illness.
11. Assess for a possible family history of SAD. Genetic factors may play a role in the development of the disorder.¹²
12. Assess and discuss the patient's goal for treatment.
13. Collaborate with the patient, family, and designated support person to develop a plan of care.
14. Identify the patient's psychiatric advance directives, if available.
15. Determine the patient's desire for the family or designated support person to be kept informed and involved in treatment.
16. Determine the family's or designated support person's ability to support the patient during treatment.

STRATEGIES

1. Perform hand hygiene.
2. Verify the correct patient using two identifiers.
3. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm, and if present, implement appropriate precautions based on the patient's status.
4. Explain the strategies to the patient, family, and designated support person and ensure that they agree to treatment.
5. Allow the patient adequate time to answer questions.

Rationale: Pressuring the patient to answer questions or appearing to rush the assessment process can create more discomfort for him or her and should be avoided.

6. Maintain a calm, collaborative communication approach, avoiding the use of coercion.
7. Create an environment of trust that allows the development of a therapeutic relationship.
8. Orient the patient to the unit. Include discussion of unit routines, guidelines, patients' rights and expectations, and schedules. Inform the patient that he or she will be checked on frequently throughout the stay.
9. Create an environment that advocates for the patient's needs using an interdisciplinary team. Engage the team in collaborative assessment and treatment planning with the patient.
10. Engage the patient in treatment, including participation in therapeutic groups and individual sessions. Understand that the patient may not be comfortable participating in groups when first admitted, and that he or she may need to work with health care team members to gain a level of comfort to integrate into a group program.
11. Administer psychiatric medications as ordered and monitor the patient's response to the medications.
12. Monitor the patient's responses and social interactions in the milieu; reinforce appropriate social skills.
13. Identify issues related to the patient's SAD and his or her ability to interact in the milieu and in groups.

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Rationale: Patients who experience signs and symptoms of social anxiety may be too uncomfortable to participate in group activities or express themselves openly to others for fear of being judged.

14. Identify comorbid disorders that may impact the patient's ability to participate in treatment.

Rationale: Patients who are experiencing depression may lack the motivation to participate in treatment. In addition, patients who are substance or alcohol users may experience withdrawal when admitted and must be monitored for signs and symptoms of withdrawal.

15. Identify safety behaviors the patient uses to safeguard against feared outcomes. Safety behaviors may include keeping his or her hands in pockets to hide shaking, wearing heavy makeup to cover blushing, pretending not to see someone or to be disinterested, avoiding eye contact or sitting in an inconspicuous seat, being a passive spectator, walking with the head down or laughing to hide nervousness.¹⁰

16. Consider using a standardized scale to assess the patient's use of safety behaviors, such as the Social Phobia Safety Behaviours Scale (SPSBS).¹⁰

Rationale: Use of safety behaviors may, at times, be maladaptive and prevent the patient from addressing the issues related to social anxiety. Safety behaviors may also have negative interpersonal effects.

17. Consider using a standardized assessment tool to measure social anxiety, such as the SIAS or the SPS.¹⁸

18. Implement appropriate precautions based on the patient's status.

19. Respond to crisis in a calm, therapeutic, and nonthreatening manner. Use the least restrictive interventions to prevent harm to patients or staff.

20. Collaborate with the patient, family, designated support person, and team in planning for patient discharge and follow-up care.

21. Provide the appropriate education related to medications, crisis management, and follow-up care to the patient, family, and designated support person at the time of discharge.

22. Explain to the patient, family, and designated support person that ongoing treatment is vital to continuing recovery. Making and keeping follow-up appointments is critical.

23. Perform hand hygiene.

24. Document the strategies in the patient's record.

REASSESSMENT

1. Reassess the patient's pain status and provide appropriate pain management (e.g., medication, relaxation, mindfulness skills).

2. Reassess the patient for an increase in signs and symptoms of anxiety or use of safety behaviors.

EXPECTED OUTCOMES

- Patient experiences a reduction in signs and symptoms of SAD and is able to collaborate with the health care team member in the full assessment process.

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UNEXPECTED OUTCOMES

- Patient is too anxious to participate in the assessment process.

DOCUMENTATION

- Patient, family, and support person education
- Patient's behaviors and response to interventions
- Patient's progress toward goals
- Assessment of pain, treatment if necessary, and reassessment

ADOLESCENT CONSIDERATIONS

- Paranoia and social anxiety are closely related. Adolescents with SAD experience paranoid thoughts more frequently and intensely than the general population.¹⁵ A lack of understanding of this consideration may lead to inaccurate diagnoses in adolescents.¹⁵

OLDER ADULT CONSIDERATIONS

- Although anxiety disorders are prevalent among older adults, SAD is not among the most common ones. Older adults more commonly experience generalized anxiety disorder or specific phobias.⁴

SPECIAL CONSIDERATIONS

- SAD rates are significantly higher among all age groups of patients with comorbid autism spectrum disorder than among the general population.¹⁷

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- Level II - At least one well-designed randomized controlled trial
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- Level V - Descriptive or qualitative studies
- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

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