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

ALERT

Social anxiety disorder (SAD), also known as social phobia, can significantly impact a patient's ability to function both socially and in their 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 common disorders in Western societies.[4]

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. If the fear is restricted to performing in public, the social anxiety should be specified as performance anxiety only.[11]

Almost one-third of patients with SAD also experience comorbid depression.[10] In addition, generalized anxiety disorder is frequently a comorbid condition in children with SAD.[9] 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.[2]

Early onset of the disorder is associated with greater severity of symptoms, including more significant functional impairment.[5,9]

Psychotherapy is an effective treatment for SAD. Cognitive behavioral therapy (CBT) is the traditional form of psychotherapy used and focuses on changing thoughts to reduce negative responses. It uses patient education to increase awareness of the faulty thinking and the problematic responses that ensue. It aims to help patients correct the distorted thinking, improve problem-solving, reduce avoidance behaviors, and restructure their cognitive responses. Another component of therapy is repeated exposure to the feared situation to desensitize and thus eliminate the fear. Mindfulness-based therapies, which sensitize patients to faulty thinking and increase awareness of positive responses, have also demonstrated effectiveness in the treatment of SAD.[1] Use of social skills training has also been effective in the treatment of SAD in adolescent patients. The training helps the patient develop appropriate social interactions.[16]

Current expert consensus is that both pharmacotherapy and psychotherapy are instrumental in the management of this disorder.[20]

The medications that have demonstrated effectiveness in the treatment of SAD include selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), reversible inhibitors of monoamine oxidase A (RIMAs), and benzodiazepines, as well as the anticonvulsants gabapentin and pregabalin.[20] SSRIs are the only medications that demonstrated effectiveness in reducing relapse.[20] SSRIs; the serotonin and norepinephrine reuptake inhibitor (SNRI) venlafaxine; MAOIs; RIMAs; benzodiazepines; the antipsychotic olanzapine; and the noradrenergic and specific serotonergic antidepressant (NaSSA) mirtazapine demonstrated effectiveness in reducing SAD symptoms' severity.[20] Although SSRIs and RIMAs have demonstrated effectiveness in reducing depression symptoms, SSRIs were shown to improve patient function.[20]

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Use of social skills training improves treatment response for adolescent patients with SAD. In addition, psychoeducation and exposure therapy may be used to treat SAD.[16]

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, avoidance of unfamiliar activities).[11] 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 psychiatric illness and expected signs and symptoms (e.g., social isolation, excessive fear and embarrassment in social situations, impaired school and work performance).[11]
- 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.[2]
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,

suppression, rumination); determine how successful these coping strategies are in helping the patient reduce symptoms of anxiety.[7,18]
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.[11]
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 ask questions and discuss concerns.

> Rationale: Pressuring the patient to answer questions or appearing to rush the interview 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. Understand that anxiety can be contagious; therefore, be aware of responses to the patient who is manifesting signs and symptoms of anxiety.[6,19]
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. Advise the patient that health care team members will work closely with him or her to foster the ability to participate in group activities.

> Rationale: Patients with SAD may experience increased anxiety in anticipation of participating in activities and be reluctant to engage in treatment because of fears of what others might think or say about them.[8]

11. Provide CBT to help the patient alter unhealthy thinking patterns.

Rationale: CBT is the gold standard therapy to treat SAD and works to shift self-critical thinking and reduce fears of negative evaluations to diminish social avoidance.[15]

12. Identify the patient's coping strategies and assist him or her with developing adaptive strategies.

Rationale: Patients may use maladaptive coping strategies such as avoidance, suppression, or rumination to reduce symptoms of anxiety.[7,18]

13. Administer psychiatric medications as ordered and monitor the patient's response to the medications.
14. Monitor the patient's responses and social interactions in the milieu; reinforce appropriate social skills.
15. Implement appropriate precautions based on the patient's status.
16. Respond to crisis in a calm, therapeutic, and nonthreatening manner. Use the least restrictive interventions to prevent harm to patients or staff.
17. Collaborate with the patient, family, designated support person, and team in planning for patient discharge and follow-up care.
18. 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.
19. 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.

Rationale: A majority of patients with SAD do not participate in treatment due to the barriers that their signs and symptoms create.[8]

20. Perform hand hygiene.
21. 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's level of anxiety and success or failure of interventions.

EXPECTED OUTCOMES

- Patient experiences a reduction in signs and symptoms of SAD, participates in treatment, and experiences improved ability to interact socially.

UNEXPECTED OUTCOMES

- Patient experiences an increase in signs and symptoms of SAD and becomes more isolated and fearful.
- Patient experiences suicidal ideation.

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

- SAD may have a more devastating effect on adolescent boys' social and academic functioning than on the social and academic functioning of adolescent girls experiencing SAD.[17]

OLDER ADULT CONSIDERATIONS

- SAD has a negative impact on the experience of happiness in older adults. It is underrecognized in this population and not addressed in treatment. Efforts at greater recognition and improved treatment of SAD in older adult patients can have a positive influence on their experience of happiness.[12]

SPECIAL CONSIDERATIONS

- Adults, adolescents, and children who experience gender dysphoria have higher rates of SAD than the general population.[3,14]

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