

Course Objectives

The purpose of this program is to inform nurses of the symptoms, treatment, and nursing implications of social anxiety disorder. After studying the information presented here, you will be able to —

- Discuss the prevalence of social anxiety disorder.
 - List two physical and two cognitive symptoms of social anxiety disorder.
 - List two implications of social anxiety disorder for nursing practice.
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Diana, a nurse at a diabetes clinic, is becoming concerned about one of her patients. Mr. Stevens has missed his last two appointments. During each follow-up call, he reassured Diana that he knew the date and time of the appointment and that he would be there. Diana wonders why he could be missing his appointments when he seemed concerned about his diabetes and acknowledged the importance of follow-up. This is especially important for Mr. Stevens since he is newly diagnosed with Type 2 diabetes and has begun a new weight loss program. What could be wrong? Mr. Stevens has social anxiety disorder.*

Social anxiety disorder, also called social phobia, is a relatively common condition that creates significant distress for those affected. It's triggered by certain types of social or performance situations. The person often attempts to deal with the anxiety by avoiding all situations that trigger it.¹

Social anxiety disorder is treatable. The main barrier is often the patient's and caregiver's lack of awareness of the problem and of the potential for treatment. In everyday life, social anxiety disorder is often misinterpreted as shyness. People with the disorder are frequently misperceived as being aloof or uncaring. In the healthcare setting, social anxiety disorder can masquerade as nonadherence. "No-shows" are common among people with this disorder, and the patient may be misjudged as being irresponsible.²

With knowledge about this common but often hidden disorder, nurses can help by asking pertinent and sensitive questions that may bring the patient closer to diagnosis and treatment. Uncovering social phobia as the cause of seemingly incomprehensible patient behavior may be the turning point for improved medical disease management, more comprehensive nursing management, and an increase in the patient's overall well-being.

Social anxiety disorder is the most common of the anxiety disorders.³ Estimates of its lifetime prevalence in the general population is 12%. It's considered to be the third most common mental disorder in the United States.⁴

Social anxiety disorder generally begins in childhood or early adolescence. It's more common in women than in men and is considered a chronic disorder.^{5,6}

Symptoms can be generalized or nongeneralized. In generalized social anxiety disorder, a person feels fearful or anxious in most or all social situations, such as going to class or waiting to check out at the supermarket. In nongeneralized social disorder, a person feels fearful or anxious about a specific situation, such as speaking in public. While many people fear speaking in public, the fear is seldom overwhelming and is generally accompanied by only mild symptoms of anxiety, such as sweaty palms or "butterflies" in the stomach. But when the fear is overwhelming and accompanied by physical symptoms (such as trembling, rapid breathing, and dizziness) and a cognitive symptom (such as "the mind going blank"), it's nongeneralized social anxiety disorder. The nongeneralized form of social anxiety disorder is sometimes called discrete anxiety or performance anxiety.³

Far-reaching effects

Anxiety disorders in general have a serious impact on the economy and the healthcare system. The economic impact is significant. People with social anxiety disorder have lower educational levels, often failing to complete high school. They are frequently unemployed or underemployed. Among the employed, people with social anxiety have higher rate of absenteeism than similar people without social anxiety disorder. People with social anxiety disorder are more likely not to marry or to divorce if they do marry.^{6,7,8}

Social anxiety disorder is often a secondary diagnosis or comorbid with other mental disorders. Depression and substance abuse

often occur with social anxiety disorder. People seldom seek help for social anxiety disorder; they are embarrassed by their anxiety and prefer to just put up with it.⁸ The symptoms of depression and substance abuse are often what make a person seek help. However, the social anxiety disorder may underlie or precede the depression or substance abuse. Depressive symptoms may stem from the social isolation and underachievement that the person with social anxiety disorder often experiences. When depression and social anxiety disorder co-occur, an increased risk of suicide or suicidal thinking exists. Substance abuse may begin as self-medication to “relax” before a social event. Gradually, the need for the substance increases as tolerance develops. In a circular fashion, the social phobia may get in the way of substance abuse treatment. Group interactions, such as participation in Alcoholics Anonymous, are difficult or impossible for people with social phobia, and social phobia may be a barrier to effective treatment.^{5,6,9}

Anxiety to the max

Anxiety is common in daily life. But anxiety becomes a mental disorder when symptoms interfere significantly with a person’s life and either occur frequently or are out of proportion to the stressor.¹

The hallmark of social anxiety disorder is a fear of negative evaluation and embarrassment. While this feeling is quite common in the general population, for the person with generalized social phobia the fear becomes paralyzing and almost the total focus of day-to-day life. Adults with social phobia often recognize that their fears are unreasonable.^{1,3} They are embarrassed to have them but powerless to overcome them. Instead of using time and energy to accomplish tasks or achieve goals, the person spends time and energy avoiding anxiety. Rather than focusing on how to get through an unpleasant event, the person focuses on “what ifs”: What will happen, and, more importantly, What will people think of me? What if I go to class and drop my books? People will think I’m clumsy and laugh. If I have to stand in the checkout line, people will begin to look at me and wonder why I’m so slow. It’s better to avoid the anxiety-provoking situation than risk evaluation and embarrassment.⁶

The physical symptoms of social anxiety disorder range from mild to severe, from those that cannot be seen by others to those that cannot be hidden. Muscle tension or increased respiratory and heart rates are examples of symptoms that cannot be seen by others. Visible symptoms that might be hidden may include blushing, increased perspiration, tremors, and vomiting or diarrhea. Panic attacks, on the other hand, can seldom be hidden. They occur quickly, and physical symptoms may include dizziness or fainting, chest discomfort, very rapid heart and respiratory rates, sensations of choking or being unable to breathe, and tingling sensations. Differentiating between the attacks of panic disorder and the panic attacks of social phobia may be difficult. However, it helps to remember that in social phobia the attacks are not random and occur when the person is expecting to be seen or evaluated in some way by others.¹

A heightened awareness

The cognitive symptoms of social anxiety disorder fall into two general categories: event symptoms that happen during the feared event and intervening symptoms that occur between events. During an event, the person has a heightened sense of awareness and an increased sensitivity to social cues. If the person is able to make face-to-face contact, he or she scrutinizes others’ expressions for critical thoughts and feelings. The person evaluates each word for negative feedback. Generally, people with social phobia misinterpret both facial expressions and oral exchanges. They perceive threats and criticism in every exchange. This heightened awareness and focus on evaluation make listening to the content of conversations and instructions difficult. All of the person’s energy is focused on how the other person is reacting. Sometimes “mind reading” is a part of this. The person with social phobia “knows” that the other person is laughing inside or making harsh judgments. Everything in the sufferer’s awareness is secondary to his or her fear of evaluation and humiliation.³

When a person with social anxiety disorder is not actually experiencing a feared event but is expecting one in the future, thoughts about the upcoming event occur frequently throughout the day. The thoughts tend to be ruminative and negative. The person imagines that every eye will be focused on him or her. The continued ruminations are full of negative self-statements and worse-case scenarios during which the person fails miserably at something or does something socially inappropriate. The person is then judged negatively by others and is embarrassed. Each incidence of rumination results in ever-increasing emotional pain. Rather than seeing these scenarios as only possibilities, the person believes that they are the only possible outcomes of the upcoming event. These ruminations result in anticipatory anxiety. Furthermore, some evidence exists that rumination tends to reinforce negative beliefs and negative affect.¹⁰ The person is caught in a cycle of negative thoughts increasing anxiety and anxiety increasing the negative thoughts.

A circle of avoidance

People with social anxiety disorder often try to avoid anxiety by interacting less and less with others. The ruminations and negative self-statements become more reinforcing as opportunities to prove them wrong grow fewer and fewer. Caught in a circle of avoidance and self-recrimination, the person may lose friends and job opportunities and not participate in positive life events. This encourages further negative self-statements and recrimination. This continued attack on self-esteem can result in depression. The person may then simply withdraw from social interaction. People who do not have the option of withdrawing may self-medicate to cope with the anxiety caused by real and imagined interpersonal encounters. Having an alcoholic drink or using

another mood-altering substance before an appointment or class may escalate to substance abuse.¹¹

The cause of social anxiety disorder is complicated and not completely understood. Research suggests that the etiology is a combination of genetic predisposition, neurochemical imbalances, and the influences of the social environment.

People often say that a personality trait “runs in the family.” Social anxiety is one of those traits, and when it “runs in the family,” it can range from shyness to severe generalized social phobia. Numerous studies of twins and families support the theory that social phobia is familial. The studies also offer a glimpse into the possible biological difference between generalized and nongeneralized social anxiety disorder.^{5,12,13}

The neurochemical imbalances involved in social phobia appear to involve the neurotransmitters serotonin, dopamine, and gamma-aminobutyric acid (GABA). Neurotransmitters facilitate the movement of electrically charged ions across neuronal synapses. Serotonin and dopamine play a role in CNS regulation. An inadequate amount of dopamine or serotonin is thought to result in depression.¹ GABA, which also plays a role in CNS regulation, is connected to the facilitation and inhibition of anxiety. Continued advances in neuroimaging may eventually pinpoint the chemical imbalances and dysfunctions involved in social anxiety symptoms.¹

Investigations into the environmental causes of social phobia focus on the social, primarily parental, factors that may encourage and maintain the symptoms of social phobia in children and adolescents. An over-protecting parenting style, especially if it's combined with rejection, is possibly associated with social anxiety disorder, especially generalized social anxiety. Other parental environmental influences could include a parent who has social phobia, another anxiety disorder, or depression. Genetics may play a part, as well.¹³ As is often the case with mental disorders, etiology is difficult to determine exactly.

The two standard treatments for social anxiety disorder are cognitive-behavioral therapy (CBT) and pharmacotherapy. Maximum benefits are seen when both therapies are used, though CBT alone is somewhat more effective than pharmacotherapy alone.^{5,14}

CBT is a combination of cognitive therapy and behavioral therapy. Cognitive therapy focuses on changing cognitions, or thoughts, that are negative and self-defeating. Behavioral therapy focuses on changing behavior that is contributing to and helping to maintain symptoms.¹⁵ CBT is an “active” therapy that keeps both the therapist and the patient engaged in finding the thoughts underlying negative emotions. These thoughts are then replaced with healthier, more positive thoughts. The therapist and the patient work together to formulate an individualized treatment plan. This plan centers on facilitating awareness of negative thoughts that trigger distressing emotions and contribute to maladaptive behaviors. The patient learns to challenge these negative thoughts and change old behaviors. The new behaviors are rehearsed, both in the office and in real-life situations, and eventually the new behaviors replace the old behaviors. The new thoughts and behaviors are designed to reinforce each other. The eventual outcome is less anticipatory anxiety and more frequent anxiety-free social events.

CBT can be offered individually or in a group and is often combined with exposure to the feared social situations. Recent research indicates that individual therapy, when combined with repeated exposure to feared situations, is superior to group CBT with repeated exposure.¹⁶

The pharmacological treatment of social anxiety disorder makes primary use of three types of drugs: selective serotonin reuptake inhibitors (SSRIs), benzodiazepines, and beta-blockers.⁵

For generalized social anxiety disorder, pharmacological treatment requires a daily maintenance dose of medication for six to 12 months because the symptoms are not limited to a discrete stressor. SSRIs, such as paroxetine (Paxil) and sertraline (Zoloft), have emerged as first-line drugs. One serotonin-norepinephrine reuptake inhibitor, venlafaxine (Effexor), has also become a “first-line” drug and requires similar administration.^{5,8} Benzodiazepines, such as clonazepam (Klonopin), are not generally prescribed for more than two weeks because of the possibility of dependence. They are often discontinued once the patient is stabilized on an SSRI. This may take up to six weeks. Benzodiazepines must be taken daily in divided doses.^{5,8}

For nongeneralized social anxiety disorder, both beta-blockers and benzodiazepines are prescribed. Beta-blockers are most often associated with the treatment of hypertension and heart disease. However, it's precisely because of their effect on the cardiovascular system that they are prescribed for nongeneralized social anxiety disorder. Beta-blockers, such as propranolol (Inderal), work by minimizing the physical symptoms of social phobia, such as increased heart and respiratory rates. This allows the person to perform the necessary task or get through the feared event. The beta-blocker is administered about 60 minutes before the anxiety-provoking event or task.⁵ People may continue to use the beta-blocker in this way. However, people often learn that the event does not actually result in the feared consequences and are then able to forgo medication.³ Benzodiazepines, on the other hand, have a generalized sedative effect. Because of this, they are somewhat less useful for a performance event.^{5,8}

Exposure to feared events adds to the beneficial effects of both CBT and pharmacotherapy.^{14,16} Because exposure therapy should be attempted only by a therapist who has been trained in this modality, it's limited in its usefulness because of time and

possible financial constraints. But virtual reality (VR) exposure, while still requiring a trained therapist, may prove to be as useful as real-life exposure. VR therapy eliminates the need for potentially expensive travel for patient and therapist and can be scheduled at convenient times. In VR therapy, a client dons goggles and earphones that provide realistic sights and sounds of an anxiety-producing situation, such as an audience assembled to listen to a speech or, in the case of a fear of flying, an airplane's interior. Combined with pharmacotherapy, VR therapy may become a potent modality in the treatment of social phobia.^{14,17}

Cognitive enhancers, a new pharmacological intervention under study, may also prove useful in the future. A cognitive enhancer is a type of medication used to improve memory. Several cognitive enhancers, donepezil (Aricept), for example, are used to treat dementia. Cognitive enhancers in the research stage, such as D-cycloserine, work on neural pathways to facilitate learning and extinguish fear responses.¹⁸ When combined with CBT or exposure therapy, cognitive enhancers may work to reduce social phobia symptoms.¹⁴

Hidden health impact

Social anxiety disorder can be devastating and disabling. Often only the sufferer is aware of the emotionally painful symptoms, and social phobia becomes a hidden disorder. It can affect all aspects of a person's life, including health.

Health care is one of the least private aspects of modern life. Numerous safeguards for a patient's healthcare information exist, but there are fewer safeguards for the patient's privacy while receiving health care. In a busy clinic, for instance, time and space are at a premium, and meeting the needs for patient privacy and education can be challenging. Most of us deal with this lack of privacy as "just one of those things." But the person with social anxiety disorder cannot.

The person with social anxiety disorder may have fears about a healthcare visit. Everyone dislikes undergoing unpleasant diagnostic tests or receiving bad news. But for the person with social phobia, the biggest fear is being embarrassed and evaluated. Perhaps the person didn't meet that that weight loss goal, didn't make an appointment at the smoking clinic, or didn't fill a prescription. Maybe it's impossible to "give a specimen" and bring it to the nurse or technician. Receiving health-related instructions in a small alcove off the main hallway may trigger embarrassment and anxiety so severe that learning cannot take place. Even a phone call to cancel an appointment would be risking embarrassment. So instead, the appointment becomes a no-show.

When patients fail to understand what we are explaining, they may actually be experiencing symptoms of a social anxiety disorder so severe that it interferes with the ability to understand instructions. This was the case with Mr. Stevens in the introduction. Because the cognitive symptoms of social phobia are not visible and because admitting to not understanding would increase embarrassment, the patient says nothing. The patient may agree with what is said and may even seem enthusiastic about the instructions. However, the patient will never carry them out, because he or she never really heard them. The patient's enthusiasm and agreement are a frantic effort to escape a situation loaded with the potential for judgment and embarrassment.

No place to hide

Lack of privacy in facilities providing bedside nursing can seriously affect the person with social anxiety disorder. A stay in a hospital or skilled nursing facility may become a nightmare of anxiety. Urinating on a bedpan or even in a semiprivate bathroom may be impossible. Being evaluated for mobility training in a large room under the eye of one or more therapists may bring on a panic attack. How much better to avoid it all together and simply not have the illness treated.

Nurses are in a unique position to assess the meaning behind nonadherence or no-shows. Asking questions to explore the possibility of social phobia may uncover anxiety that has been hidden for years. Sharing online resources dealing with anxiety may help the patient understand that anxiety is common and, more importantly, treatable. Dealing sensitively with the patient's anxiety and embarrassment is central to helping the patient. Knowing that the nurse understands and doesn't criticize may encourage the patient to seek help. Feeling accepted rather than embarrassed may be the experience that changes the patient's life.

*The case study in this module is fictitious.

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