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Assignment 5.3

Special Topics Paper

Social Anxiety Disorder

Social Anxiety Disorder (SAD) is characterized by an intense fear of social situations in which others may scrutinize the individual. The person has a strong fear of being negatively evaluated (i.e. being judged as anxious, weak, stupid, boring, or unlikable). "Social anxiety disorder is one of the most prevalent mental disorders with a lifetime prevalence of 13% and a 12 month prevalence of 8% among adults and similar prevalences among adolescents in the United States" (Solomon, 2017, p. 2255). Furthermore SAD is associated with an increased risk of depressive disorder, substance abuse disorders and cardiovascular disease. Social anxiety disorder not only has a high cost for the individual but systemically "more than 90% of persons with the disorder report psychosocial impairment (e.g. increased risk of dropping out of school, reduced workplace productivity, and reduced socioeconomic status and quality of life" (Solomon, 2017, p. 2256). Despite the high prevalence only about 35 % of persons with social anxiety disorder receive treatment specific for this disorder. "SAD in youth is comorbid with a significant number of mental health problems, particularly other anxiety disorders and depression, and with substance use in older adolescents" (Spence & Rapee, 2016, p. 51). This paper will review the etiology of SAD and literature on several treatment modalities for Social Anxiety Disorder including cognitive behavioral therapy, pharmacotherapy, mindfulness and acceptance based therapy, and emotion-focused

therapy. A case presentation will be provided on a first generation immigrant Latina adolescent who has diagnosed with SAD and cultural considerations and opportunities for advocacy will be highlighted.

Diagnostic and Background Information

Diagnostic criteria for Social Anxiety Disorder can be found in the DSM-5, criteria includes: marked fear or anxiety related to one or more social situations in which scrutiny by others ins anticipated, fear of acting in a way that will be negatively evaluated by others, fear or anxiety is almost always provoked by social situations, social situations are avoided or endured with intense fear or anxiety, fear or anxiety is out of proportion to actual threat, fear/anxiety/ avoidance is persistent (lasting for 6 months or more), fear/anxiety causes clinically significant distress or impairment in social occupational or other important areas of functioning, symptoms are not attributable to substance use or another medical condition, symptoms are not better explained by another mental disorder.

Although there are not exact indicators for who will develop social anxiety disorder it is know that the development is complex and there is interplay between intrinsic and environmental factors. Behavioral inhibition (BI) is " represents a tendency to respond with heightened sensitivity to novel auditory and visual stimuli and avoid unfamiliar situations and people" (Spence & Rapee, 2016, p. 53) and is one dimension of temperament that is strongly linked to the development of SAD. Patterns of BI can be identified from infancy onwards and are associated with specific physiological response patterns related to SAD. It is important to note that cultural factors are critical in determining impairment and there is evidence that temperamentally related behaviors are more socially accepted in some cultures than in others. Attachment style and parenting

style have moderating effects on BI (i.e. over-controlling parenting style and BI temperament and insecure attachment and BI temperament have been associated with subsequent social anxiety) as well.

Cognitive factors are a major contributor to the maintenance of social anxiety disorder, "socially anxious children expected that they would preform badly, which increased the focus of their attention upon their own behavior, negative thoughts, feelings, and physical symptoms. In turn, this self-focus was suggested to detract from accurate and valid monitoring of peer behavior, resulting in a perception that is aligned with their own negative thoughts and interpretations of their performance" (Spence & Rapee, 2017, p. 56). Adverse life and learning experiences, for those who are intrinsically vulnerable are also proposed to result in maladaptive schema and beliefs relating to the self and others. "Through their social experiences, young people come to believe that they are deficient stupid and unattractive, with little ability to control the outcomes of social situations" (Spence and Rapee, 2017, p. 62).

Several treatment modalities are used for management and amelioration of social anxiety disorder. The first line of treatment to date is cognitive behavioral therapy due to the fact that "individuals with social anxiety report having a negative self-view that is comprised of maladaptive thoughts and beliefs about the self and others" (Gregory & Peters, 2016, p. 3). Gregory and Peters review 41 studies measuring the impact of CBT on individuals with SAD "overall, pre- to post-treatment improvements in self-related negative thoughts and beliefs, implicit and explicit self-esteem, self-schema, self-focused attention, and self-evaluation was found" (Gregory & Peters, 2016, p. 9). The New England Journal of Medicine reports that " in high quality studies of CBT for the

treatment of social anxiety disorder response rates were between 50% and 65%" (Leichsenring & Leweke, 2017, p. 2258). Despite having higher than average response rates there are still several individuals who do not respond to cognitive behavioral interventions. Mindfulness and Acceptance Based Treatments (MABT) have been found to reduce state anxiety and increase positive thinking, "it is postulated that a mindful stance of nonjudgment, present –focused awareness may be an effective antidote to problematic self-focused attention, which is considered a key maintaining feature in all cognitive models of SAD" (Norton et al., 2015, p.284). However comparatively CBT "effect sizes are substantially stronger and more consistent than those yielded by equivalent length and when directly compared to MBSR, CBT was more effective in improving symptomology" (Norton et al., 2015, p. 297). Shahar makes an argument that Emotion-Focused Therapy is a well-suited alternative treatment for social anxiety because "social anxiety is based on psychopathological processes that are emotionally based; that EFT has been shown to be effective in treating self-criticism and unresolved feelings, two processes that are central in the development of social anxiety" (Shahar, 2013, p. 545). The last treatment option that I am going to cover is pharmacotherapy which appears to have a similar efficacy to CBT in short term treatment of social anxiety disorder with "available head to head comparisons suggesting that more immediate improvements are achieved with pharmacotherapy but that the effects of CBT are more enduring" (Leichsenring & Leweke, 2017, p. 2260). According to the review of the literature it is clear that CBT is the front line of treatment however there are many options for treatment in the event that a client is unresponsive to CBT interventions.

Case Conceptualization and Treatment Planning

Chelsea Estes is a 14-year-old Hispanic American female. The client has recently relocated to Sarasota, Florida with her mother, father, and younger brother. Chelsea has reported feeling intense anxiety when around family; particularly her younger brother who she reports is disrespectful. Chelsea reports not getting along with her father either because he often gets into verbal altercations with her. Chelsea states that she tries to appease her father but he does not believe what he says and becomes irritated with her. Chelsea reports getting along best with her mother but that she does not feel safe confiding in her about her anxiety because she calls her "abnormal" and says she needs to get over it and not care what others think". Chelsea's mother disclosed that Chelsea's father is currently taking medication for anxiety, which she states that he has "very badly". Chelsea reports having no friends that she feels comfortable confiding in about her anxiety or other problems because she is extremely fearful of being judged or not taken seriously. Chelsea reports having no support system with an individual that she can confide in other than our counseling sessions. The client appears to be intelligent and holds academia in high esteem. She appears to be withdrawn from communicating at a deeper level because she is "afraid what other people will think of her". Chelsea has mentioned some obsessive compulsive behaviors revolving around cleanliness and has reported that she wears gloves because she does not want to touch anything dirty, she also reports carrying hand sanitizer around to clean things before she comes into contact with them. Chelsea expresses desire to "understand people better" and "feel comfortable in the company of others" but has some ambivalence when

it comes to tackling those issues. Chelsea has several presenting issues including: reports of panic attacks, fear of being watched, reports of "hallucinations" and "paranoia", social anxiety and obsessive-compulsive tendencies. Her primary diagnosis given is for Social Anxiety Disorder (F40.10). She meets Criterion A, because she exhibits marked anxiety about one or more social situations in which she is exposed to possible scrutiny by others. She meets Criterion B, because she fears that she will act in a way or show anxiety symptoms that will be negatively evaluated. She meets Criterion C; the social situations almost always provoke fear or anxiety. She meets Criterion D; the social situations are avoided or endured with intense fear or anxiety. She meets Criterion E; the anxiety is out of proportion to the actual threat posed by the social situation and the sociocultural context. She meets Criterion F, because the anxiety is persistent and has lasted longer than six months. She meets Criterion G, because the anxiety causes clinically significant distress in social, occupational, or other areas of functioning. She meets Criterion H because the anxiety is not attributable to substance use. She meets Criterion I because the anxiety is not better explained by another mental disorder. The challenge for Chelsea to function more effectively is to feel more comfortable in the presence of other individuals. The goals of treatment will include minimizing self-defeating thoughts, changing maladaptive thoughts about emotions and opinions not mattering to others, and utilization of goal setting (e.g. meeting up with friends one time weekly). Cognitive Behavioral Therapy will focus on the reduction of misinterpretation of social judgment and perceptions of the self.

Additionally, social skills training in a group therapy setting focusing on assertive communication and relationship skills. Some obstacles to treatment can be anticipated. Given Chelsea's age, she relies on her mother solely for transportation to and from appointments. Given that Chelsea is anxious about being judged by others, resistance is likely. Supposing Chelsea is able to increase her relational skills, confidence, and social support outside of therapy her prognosis is good.

Chelsea's diagnosis is Social Anxiety Disorder. The objectives of her treatment include reduction of distorted cognitions to reduce anxiety in social situations, increase social supports through peer interaction to reduce isolation, and treatment of any co-occurring disorders. A complete medical examination is necessary as well as a Biopsychosocial examination, and self-report logs. Measuring symptoms and monitoring progress is useful in helping what the priorities of treatment should be, as well as assessing progress at various points in treatment. Desirable clinician characteristics include individuals who are patient supportive and encouraging; clinicians need to be directive and firm but also collaborative and comfortable with a range of mindfulness based relation, behavioral, and cognitive interventions. Given that Chelsea does not report any danger to herself or others I would recommend outpatient therapy. Interventions would include cognitive behavioral therapy techniques; one I would include is videofeedback so that Chelsea can see her negative self-representations and they can be modified. Social skills training would be beneficial for Chelsea in teaching her skills that promote harmonious and

productive interactions with others (as she indicated that her anxiety has negatively impacted her familial and peer relationships). Emphasis of treatment would be directive and supportive because the goal of treatment is to change behaviors and cognitions as well as enhance Chelsea's self-esteem. It would be my recommendation that Chelsea begin counseling individually and transition into group counseling to increase her social support network. Chelsea may benefit from family counseling as well if family problems are a presenting concern during treatment. I would advise that treatment consist of weekly individual sessions for duration of four months at which an assessment could be made of whether or not services need to be continued at that time. I would also advise that Chelsea does not begin group therapy until therapeutic alliance has been established with the individual practitioner and a gradual transition can occur when appropriate. Medication may be appropriate for Chelsea in order to be certain in would be advisable for her to have a full medical and psychiatric evaluation when being assessed for treatment. Adjunct services could include services from a personal trainer, as exercised is associated with reducing symptoms. Prognosis is good for symptom reduction although it can be challenging to obtain total remission.

Advocacy and Multicultural Considerations

"Currently, little is understood about social anxiety symptoms among Hispanic American adolescents, despite the fact that Hispanic Americans comprise the fastest growing segment of the U.S. population and are the least likely to use mental health services" (La Greca et al., 2015, p. 224). In light of this,

identification of culturally appropriate measures of social anxiety and treatment modalities for Hispanic America youth is an important area of focus.

Additionally cultural differences might affect they ways in which social anxiety is expressed and thresholds at which the clinical disorder, SAD, is diagnosed. Some cultures, particularly Asian demonstrate a significantly lower negative correlation between social anxiety and quality of life, in fact "research has show that Chinese youth who are often shy show very positive longer term outcomes which is in contrast to the often poor outcomes shown by shy youth from Western countries" (Spence & Rapee, 2016, p. 61). Advocacy opportunities exist in drawing attention to SAD as it is one of the most prevalent mental health disorders to date. It is especially important to create assessment tools that are designed specifically with various cultures in mind to get an accurate diagnosis.

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