

Social Anxiety Disorder: Primary Care Overview



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Sommaire : Social anxiety disorder (SAD) is characterized by extreme fear of being judged and evaluated, which leads the individual to either avoid social interactions and situations, or to experience them with great distress. Social anxiety disorder causes significant problems with relationships and impairment at home, school and work. It manifests with various physical and emotional signs and symptoms, and often presents with other anxiety disorders and/or depressive disorders. SAD can be treated with counseling/therapy, or pharmacologically with SSRI's or SNRI's.

Case

- Arthur is a 12 year old male who lives with his parents and is in Grade 7.
 - Parents report he has always been shy and reserved.
 - He does not make friends easily, has trouble making eye contact, and mumbles when speaking to people outside of his immediate family.
 - Last month, Frank was unable to do a presentation in front of the class due to feeling physically ill, to the point where he was unable to attend school
 - Arthur's mother takes him to see his family physician
 - Mother: "I think he needs help."
 - Father: "He's just a bit shy... Besides, I was like that too when I was his age..."
- Dave is a 30-yo male who has always been excessively shy
 - His shyness has been so severe, that it has interfered with work and school
 - He recently turned down a promotion at work, due to worries that he would have to do presentations in his new role
 - He desperately wants to meet the right person and settle down, but he is so shy, that he has troubles meeting women
 - He spends his evenings and weekends playing online video games and connecting with people in the 'virtual world', but wishes that he could be able to connect with people in the 'real' world

Epidemiology

- 12-month prevalence: 7% in USA (DSM-5)
- Mean age of onset: 13-years, with 75% of individuals having age of onset between age 8-15 (DSM-5)
- 12-month prevalence: 6.8% in USA (DSM-4), with 30% of these being considered severe cases of social

phobia

- Similar prevalence found in a study of large primary-care based anxiety study (6.2%)

Etiology

- Predisposing
 - Genetic predisposition: There may be a family history of social anxiety and anxiety, as well as a 'highly sensitive' temperament.
 - Early childhood experiences: There may have been early experiences that the world is unsafe (e.g. abuse, neglect, parents being overwhelmed, or simply cases where there is temperamental mismatch between child and parent; negative experiences from peers/teachers such as bullying/teasing from peers)
- Precipitating
 - Symptoms may be triggered by life events where the patient is rejected, embarrassed or humiliated, e.g. breakups, bullying, teasing.
 - Protective factors
- Protective
 - Secure attachments to parents, siblings or others are protective.

Signs/Symptoms

Physical signs

- Autonomic arousal
 - Blushing
 - Sweating
 - Trembling
 - Fast heartbeat
 - Upset stomach
 - Nausea
 - Shaky voice
 - Muscle tension
 - Confusion
 - Diarrhea
 - Cold, clammy hands

Emotional and behavioural symptoms

- Intense fear of interacting with strangers
- Fear of situations in which the patient may be judged
- Worries about being embarrassed or humiliated
- Anxiety that disrupts daily routines, work, school or other activities
- Avoidance of activities or speaking to others out of fear of embarrassment
- Difficulty making eye contact
- Difficulty talking

History (Hx)

- With adult patients
 - Start with a general screen for anxiety symptoms
 - Clinician: "Do you have problems with anxiety?"
 - Clinician: "Would you say that you are a shy person?" "Does your shyness cause you

problems?"

- Clinician: (Normalizing statement) "Sometimes people get very scared when they have to do things with other people, especially people they don't know. They might worry about doing things with other people watching. They might get scared that they will do something silly or that people will make fun of them. They might not want to do these things or, if they have to do them, they might get very upset or cross."
- With a child/youth patient
 - Clinician: (to parent) "Does your child get scared about doing things with other people, like talking, eating, going to parties, or other things at school or with friends?"
 - 'Does your child find it difficult to do things when other people are watching, like playing sport, being in plays or concerts, asking or answering questions, reading aloud, or giving talks in class?'
 - 'Does your child ever feel that you can't do these things or try to get out of them?'
 - If the child/caregiver respond yes to one or more questions, consider a more comprehensive screen
- Collateral history
 - Involve a parent, carer or other adult known to the child who can provide information about current and past behaviour.

Dx by DSM-5

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

- Performance only: If the fear is restricted to speaking or performing in public.

Differences with DSM-IV and DSM-5

- Removal of the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. There is evidence that individuals with such disorders often overestimate the dangers in “phobic” situations.
- 6-month duration to diagnose SAD is now extended to all ages (previously limited to individuals under 18 years of age).

DDx

- Medical causes
 - Rule out medical induced anxiety disorders such as endocrine (hypothyroidism, hypoglycemia); cardiac (e.g. mitral valve prolapse)
- Medication-induced
 - Rule out stimulant induced anxiety such as from excess caffeine consumption, ephedrine, etc.
- Once medical causes are ruled out, consider psychiatric causes
 - Normal shyness
 - Shyness is normal trait in the population. Social anxiety disorder is distinguished from normal shyness in that it causes distress and dysfunction.
 - Agoraphobia
 - Patient fears and avoids social situations such as going to a movie not because of fear of evaluation by others, but rather of fear of being trapped.
 - Panic disorder
 - Patient avoids going to social situations not due to fear of evaluation by others, but rather due to fear of having a panic attack.
 - Generalized anxiety disorder
 - Patient has numerous worries, not just focused on social situations.
 - Separation anxiety disorder
 - Patient avoids social situations out of fear of being separated from caregiver, rather than out of fear of evaluation by others.
 - Specific phobia
 - Patient has fears in certain situations (e.g. having blood drawn) but it is not due to fears of evaluation by others
 - Selective mutism
 - Patient may be unable to speak due to fear of negative evaluation, but is not fearful of situations where speaking is not required (e.g. non-verbal play).
 - Body Dysmorphic Disorder
 - Patient with BDD may have social anxiety, out of fears that they have a marked bodily defect. However, their concerns are out of proportion to what others perceive as a problem. E.g. a patient believes their nose is grossly deformed, whereas others agree the patient doesn't have a perfect nose, but it is definitely within acceptable parameters of normal.
 - Depressive Disorders:
 - Patient may have social withdrawal, but it is due to anhedonia and lack of motivation seen in depressive disorders, rather than due to fear of evaluation by others.
 - Psychosis:
 - Patient may have social withdrawal due to paranoia, i.e. fears that others are out to harm him/her.
- Other mental disorders include, but are not limited to:
 - Autism spectrum disorder
 - ADHD: Untreated ADHD can lead patients to be in situations where they perform under their potential, leading them to feel inadequate, leading to feelings of self-consciousness and social anxiety

- Personality disorders: Ongoing controversy about whether or not social anxiety disorder is the same disorder as avoidant personality disorder

Comorbidity

- Patients with social anxiety disorder are at a higher risk of having other comorbid conditions
- Common comorbidities:
 - Other anxiety disorders
 - Depressive disorders such as Major depressive disorder / Dysthymic disorder
 - Substance abuse
 - Avoidant personality disorder
 - Neurodevelopment conditions such as ADHD, autism and learning disabilities
 - Speech and language problems
- SAD patients are often unaware of their condition and do not seek treatment unless they need help for the comorbidities.

Physical Exam (Px)

- Physical exam may be useful to rule out medical causes of anxiety, e.g. thyroid problems
- Physical exam may provide objective assessment of any perceived bodily defects; for example, in Body Dysmorphic Disorder, patients perceive a bodily defect (e.g. ugly nose), which may contribute to social anxiety symptoms
- Physical exam can be useful to assess the extent of the perceived bodily defect

Investigations

- Investigations may be useful to rule out physical causes

Management in Primary Care

- Non-medication
 - Reduce use of stimulants such as caffeine, nicotine. Patients may insist that nicotine is helpful; studies show that it is helpful in the short-term, but in the long run increases anxiety. If patients are resistant to reducing nicotine use, then try to ally with the patient by 1) agreeing to reconsider it in a few weeks if things aren't any better; and 2) even if it is decided to reduce nicotine, consider it as a trial
 - Regular aerobic exercise lasting at least 20 minutes a day (Reference: Petruzello, SJ, Landers, DM, Hatfield, BD, Kubitz, KA, Salazar, W. A meta-analysis on the anxiety-reducing effects of acute and chronic exercise. Sports Medicine 1991; 11(3): 143-182.)
 - Recommend a local anxiety support group, e.g. Anxiety Disorders Association of Canada (ADAC), or local provincial / city chapters.
- Counseling/therapy
 - For adults
 - 1st line
 - Offer individual CBT specifically developed to treat social anxiety disorder as first-line treatment for adults.
 - Do not offer group therapy (based on a systematic review).
 - For children/youth
 - 1st-line

- Consider individual or group CBT
- 2nd line
 - Use supported self-help as second-line treatment.
- 3rd line
 - Other types of psychotherapy, such as short-term psychodynamic psychotherapy specifically developed for social anxiety disorder
- Medications
 - For adults
 - IF CBT not effective or unavailable
 - Consider SSRI
 - FDA approved medications include
 - 1st line
 - Fluvoxamine (Luvox) 100-300 mg daily
 - Paroxetine (Paxil) 20-50 mg daily
 - Sertraline (Zoloft) 50-150 mg daily
 - Venlafaxine (Effexor XR) 75-225 mg daily
 - Other SSRI
 - Escitalopram (Cipralex) 10-20 mg daily
 - 2nd line
 - Clonazepam (longer-acting) is preferred over shorter acting medications (such as Alprazolam)
 - For non-generalized social anxiety (i.e. performance anxiety)
 - Beta blockers (such as propranolol, atenolol) can be used to relieve symptoms on a PRN (as needed) basis
 - For children and youth
 - Do not routinely offer medications for social anxiety in children and youth (NICE, 2013)

When to Refer

- When a patient has been unresponsive after two trials with first-line medications
- When the disorder is complicated by alcohol or substance abuse
- When the disorder substantially interferes with social and occupational functioning of a patient
- When secondary depression or suicidality occurs

Who to Refer to

- Local resources
- Professionals
- Psychologists for CBT
- Social workers
- CCC
- Other counseling/therapy services
- Toast Masters
- Anxiety Support Groups and Organizations

References

- Bandelow, B., Sher, L., Bunevicius, R., Hollander, E., Kasper, S., Zohar, J., & Möller, H. J. (2012). Guidelines for the pharmacological treatment of anxiety disorders, obsessive-compulsive disorder and posttraumatic stress disorder in primary care. *International journal of psychiatry in clinical practice*, 16(2), 77-84.

- Connor, K. M., Kobak, K. A., Churchill, L. E., Katzelnick, D., & Davidson, J. R. (2001). Mini-SPIN: A brief screening assessment for generalized social anxiety disorder. *Depression and Anxiety*, 14(2), 137-140.
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, 62(6), 617-627.
- Kroenke, K., Spitzer, R. L., Williams, J. B., Monahan, P. O., & Löwe, B. (2007). Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Annals of internal medicine*, 146(5), 317-325.
- NICE guidelines for Social Anxiety Disorder: <http://www.nice.org.uk/nicemedia/live/14168/63868/63868.pdf>
- Stuhldreher, N., Leibing, E., Leichsenring, F., Beutel, M. E., Herpertz, S., Hoyer, J., ... & König, H. H. (2014). The costs of social anxiety disorder: The role of symptom severity and comorbidities. *Journal of Affective Disorders*, 165, 87-94.

About this Document

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