Diagnosis and Treatment of Social Anxiety Disorder

Cynthia L. Turk, PhD

Anxiety Clinic

Washburn University

Presented at Stormont Vail

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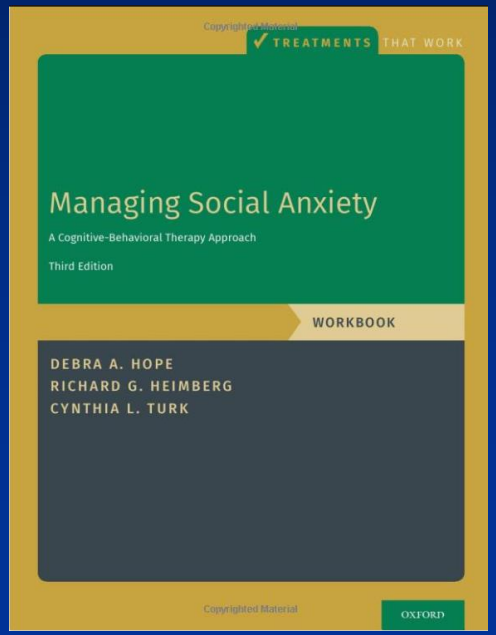
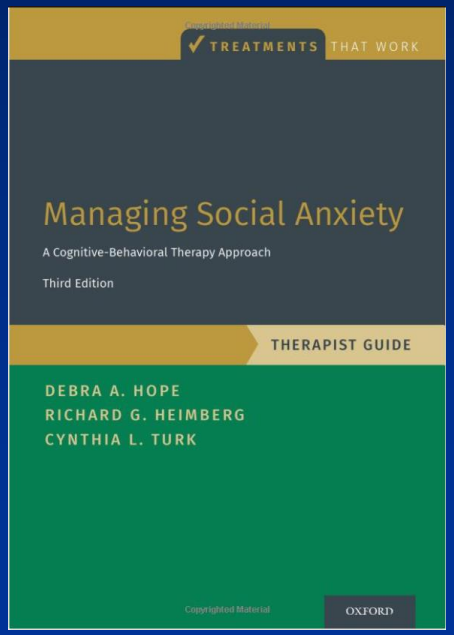
About Me

- PhD in clinical psychology OSU
- 6 Year Postdoctoral Fellowship at the Adult Anxiety Clinic at Temple University
- 3 Years at La Salle University
- 17 years at Washburn University

Hope, D. A., Heimberg, R. G., & Turk, C. L. (2019). ***Managing social anxiety: A cognitive-behavioral therapy approach (therapist manual), third edition.*** New York: Oxford University Press.

Hope, D. A., Heimberg, R. H., & Turk, C. L. (2019). ***Managing social anxiety: A cognitive-behavioral therapy approach (client workbook), third edition.*** New York: Oxford University Press.



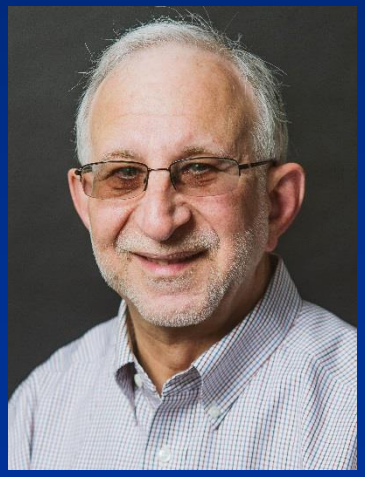


Free PDFs of Worksheets

https://academic.oup.com/book/28747/chapter/234412205

Acknowledgements

Debra Hope, PhD
University of Nebraska - Lincoln



Richard G. Heimberg, PhD
Temple University

Educational Objectives

At the end of the workshop, participants will be better able to:

1. Diagnose social anxiety disorder

2. Describe the prevalence and impairment associated with the disorder

3. Conceptualize the mechanisms of exposure

4. Implement exposure techniques

DSM-5 Definition Of Social Anxiety Disorder (Social Phobia)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others.

B. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be negatively evaluated.

DSM-5 Criteria for Social Anxiety Disorder

C. The social situations almost always provoke fear or anxiety

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

DSM-5 Criteria for Social Anxiety Disorder

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

H. Not due to the effects of a substance or another medical condition

I. Not better explained by another mental disorder

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

Specifier

- Individuals with the performance only type have performance fears that are typically most impairing in their professional lives or in roles that regularly require public speaking.

Social Anxiety Disorder: Cases of Paul and Kim

SAD is Under Recognized in Primary Care Settings

- Random sample of 7,165 HMO patients invited to participate in a study about illness and health-related quality of life from 2 large outpatient clinics in the Midwest
- 1,017 patients were assessed with the diagnostic interviews and outcome measures
- Prevalence rate of generalized SAD was 8.2%.
- .5% had an SAD diagnosis in the HMO database
- 31.4% had a visit with a mental health specialist in the past year

Katzelnick et al. 2001

Brief Social Phobia Inventory (Mini -SPIN)

(Davidson, 1999)

1. Fear of embarrassment causes me to avoid doing things or speaking to people.

2. I avoid activities in which I am the center of attention.

3. Being embarrassed or looking stupid are among my worst fears.

Scale: 0 = not at all to 4 = extremely true

Scoring: Sum all items; score of 6 or higher suggests the need for more assessment for SAD

Differential Diagnosis

- Normative Shyness
- Panic Disorder
- “Paranoia” or Paranoid Personality Disorder
- Schizoid Personality Disorder

Common Comorbidities

- Generalized Anxiety Disorder
- Depressive Disorder
- Substance Use Disorder

12-Month Prevalence of DSM-IV SAD in the National Comorbidity Survey Replication (Kessler, Chiu, et al., 2005)

- *N* = 9,282, Ages 18+
- 12-Month Prevalence 6.8%
- Second Most Prevalent 12-Month Mental Disorder
  - Specific Phobia 8.7%

Lifetime Prevalence of DSM-IV SAD in the National Comorbidity Survey Replication (Kessler, Berglund, et al., 2005)

- Lifetime Prevalence 12.1%
- Fourth Most Prevalent Lifetime Mental Disorder
  - Major Depressive Disorder 16.6%
  - Alcohol Abuse 13.2%
  - Specific Phobia 8.7%

SAD: Disability in Managed Care
(Katzelnick et al., 2001)

- 8.2% prevalence
- 10% lower probability of graduating college
- 10% lower wages
- 14% lower probability of professional, technical, or managerial position
- 39% more medical outpatient visits in the past year
- 17% higher likelihood of a suicide attempt in the past year

Impairment in Friendships

- More severe SAD symptoms in a community sample associated with (Falk Dahl & Dahl, 2010)
  - greater likelihood of living alone
  - fewer good friends
  - less involvement in clubs/organizations
  - feeling lonely
- SAD is also associated with the absence of friends (Whisman et al., 2010)
- Individuals with SAD perceive themselves as having low instrumental and emotional social support (Cramer et al., 2005; Furmark et al. 1999)
- Individuals with SAD evaluate their friendships as lacking in intimacy and quality but their friends disagree (Rodebaugh et al., 2014)

Impairment in Romantic Relationships

- Individuals with SAD are less likely to be cohabitating or married (Falk Dahl & Dahl, 2010)
- Individuals with SAD are less likely to marry, even compared to individuals with other anxiety disorders (Sanderson et al., 1990)
- Small negative correlation between social anxiety and romantic relationship satisfaction (Bar-Kalifa et al., 2015; Porter & Chambless, 2013).
- SAD individuals in a romantic relationship
  - experienced a decrease in social anxiety
  - increased comfort in interacting with others
  - overall improvement in their well-being (Gordon et al., 2012)
- They may become dependent on their partner in order to interact with others (Darcy et al., 2005; Gordon et al., 2012).

Evan's (2014) Meta-Analysis

- Included psychological and pharmacological treatment trials (published and unpublished) 1988 - 2013
- 101 trials (13,164 participants) of 41 interventions or control conditions, which were grouped into 17 classes
  - Controls: Waitlist, pill placebo, psychological placebo
  - Pharmacological Interventions: anticonvulsants, benzodiazepines, MAOIs, noradrenergic antidepressant (mirtzazapine), SSRIs/SNRIs
  - Psychological Interventions: Exercise promotion, exposure/social skills training, group CBT, Individual CBT, other psychotherapy (interpersonal, supportive, mindfulness), psychodynamic, self-help with support, self-help without support)
- Outcomes were validated measures of social anxiety

Evan et al.’s (2014) Meta-Analysis: Conclusions

- Individual CBT and SSRIs/SNRIs were the only classes of interventions that had greater effects on outcomes than appropriate placebo.
- Individual CBT also had a greater effect than psychodynamic psychotherapy and interpersonal psychotherapy, mindfulness, and supportive therapy.

Evan et al.'s (2014) Meta-Analysis: Conclusions

- Only 5 studies comparing combined treatment to monotherapies
  - Combined treatment conferred no advantage
- Individual CBT is associated with large effect sizes
  - Lower risk of side-effects than pharmacotherapy makes it recommended as a first line treatment
- Could not investigate whether immediate treatment effects persist.
  - Findings from studies that have addressed this issue suggest that most people who respond to a SSRI will relapse within a few months if the drug is discontinued
  - About 25% of people who respond to SSRI treatment and continue drug treatment will relapse within 6 months.

Treatment Responder

Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach

Treatment Structure

16 sessions over 20 week period
(does not include intake and assessment sessions)

Treatment Segments

- Psychoeducation (4 sessions max)
- Training in cognitive restructuring (3 sessions max)
- Exposure (4 sessions min; 6 sessions typical)
- Advanced cognitive restructuring (1 session min)
- Termination (1 session min)

Cognitive Restructuring

Exposures

In Session Exposures Combine Exposure and Cognitive Work – There is no substitute for these!

Homework Builds Upon In Session Exposures

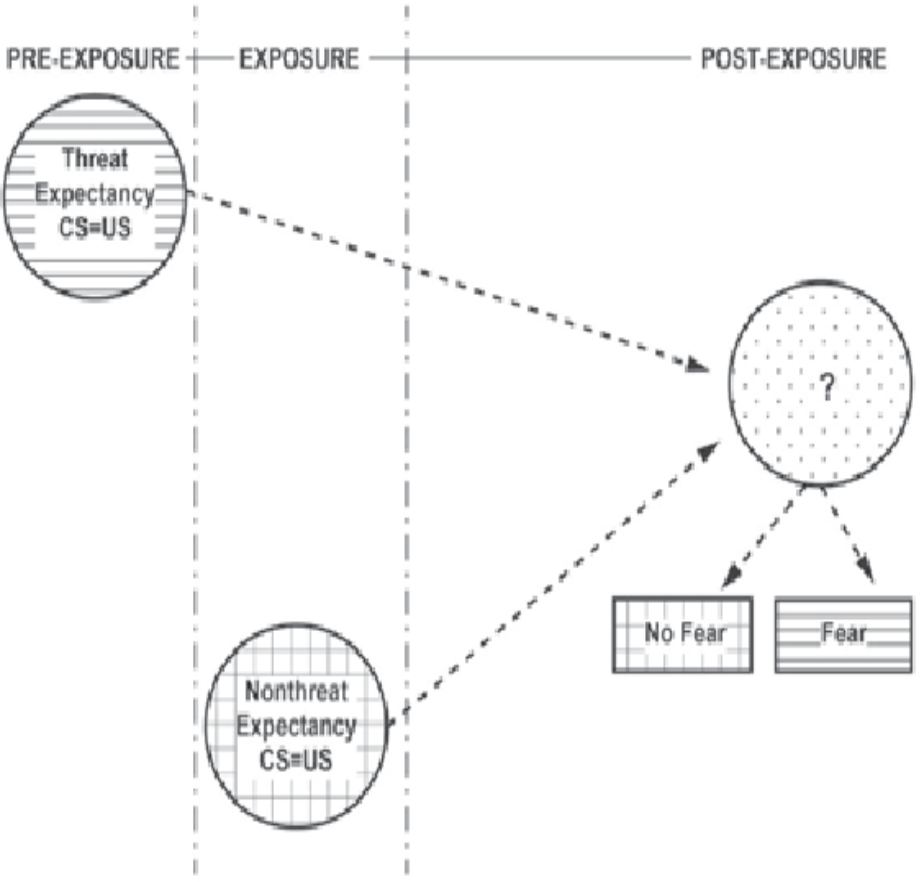
Examples of In-Session & *In Vivo* Exposures

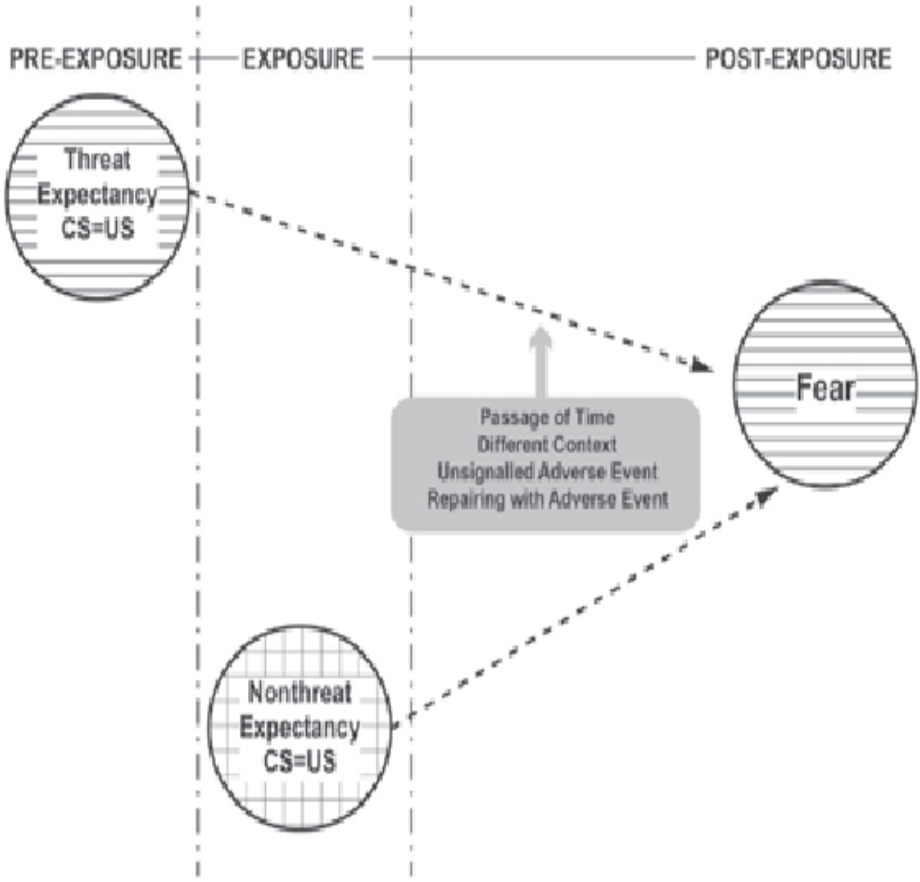
- Dyadic Conversation
- Meeting Someone for the First Time at a Party
- Joining in an Ongoing Conversation
- Making a Telephone Call to Someone You Like
- Make a Presentation in a Class or Seminar
- Speaking Up in a Group
- Presenting Your Views in a Meeting at Work
- Asking Someone for a Date
- Interviewing for a Job
- Chairing a Meeting of a Self-Help Group
- Demonstrating a Procedure to a New Employee
- Eating or Drinking While Having a Conversation
- Writing While Others Observe

Exposure

Inhibitory learning model Craske, 2015

- Avoidance prevents extinction of fear
- Inhibitory learning: the original CS-US association is not erased during extinction trials (exposure)
- Instead, it is learned that the CS no longer predicts the US.
- After extinction trials, the CS has two meanings – its original excitatory meaning and its inhibitory meaning


PRE-EXPOSURE
EXPOSURE
POST-EXPOSURE
Threat Expectancy CS=US
?
No Fear
Fear
Nonthreat Expectancy CS=US


PRE-EXPOSURE
EXPOSURE
POST-EXPOSURE
Threat Expectancy CS=US
Fear
Passage of Time
Different Context
Unsignalled Adverse Event
Repairing with Adverse Event
Nonthreat Expectancy CS=US

Craske, 2015

Marlene's Completed Fear and Avoidance Hierarchy

SITUATION	*SUDS*	*AVOIDANCE*
#1 most difficult situation is ***telling a parent their child is failing***	***100***	***25***
#2 most difficult situation is ***meeting husband's ex-girlfriend at high school reunion***	***100***	***100***
#3 most difficult situation is ***speaking in front of the congregation at church***	***90***	***90***
#4 most difficult situation is ***making small talk with husband's boss***	***80***	***40***
#5 most difficult situation is ***walking into a meeting late where everyone is already seated***	***75***	***90***
#6 most difficult situation is ***speaking in front of the Parent-Teacher Association meeting***	***75***	***50***
#7 most difficult situation is ***talking with students' parents***	***40***	***5***
#8 most difficult situation is ***returning something to a store***	***40***	***100***
#9 most difficult situation is ***eating dinner at someone's house that I do not know well***	***35***	***50***
#10 most difficult situation is ***making small talk with husband's co-workers***	***25***	***15***

Exposure

Strategy to Max Exposure	Description	Catch-Phrase
Expectancy violation	Design exposures to violate specific expectations	*Test it Out*
Deepened extinction	Present two cues during the same exposure after conducting initial extinction with at least one of them	*Combine It*
Reinforced extinction	Occasionally present the US during exposures	*Face Your Fear*
Variability	Vary stimuli and contexts	*Vary It Up*
Remove safety behaviors	Decrease the use of safety signals and behaviors	*Throw It Out*
Attentional focus	Maintain attention on the target CS during exposure	*Stay With It*
Affect labeling	Encourage the clients to describe their emotional experience during exposure	*Talk It Out*
Mental reinstatement/retrieval cues	Use a cue present during extinction or imaginally reinstate previous successful exposures	*Bring It Back*

Thank you for your interest!

Cynthia L Turk, PhD

Anxiety Clinic
Department of Psychology
Washburn University
Topeka, KS