SOCIAL ANXIETY

BEHAVIORAL DEFINITIONS

1. Overall pattern of social anxiety, shyness, or timidity that presents itself in most social situations.
2. Hypersensitivity to the criticism or disapproval of others.
3. No close friends or confidants outside of first-degree relatives.
4. Avoidance of situations that require a degree of interpersonal contact.
5. Reluctant involvement in social situations out of fear of saying or doing something foolish or of becoming emotional in front of others.
6. Debilitating performance anxiety and/or avoidance of required social performance demands.
7. Increased heart rate, sweating, dry mouth, muscle tension, and shakiness in social situations.

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LONG-TERM GOALS

1. Interact socially without undue fear or anxiety.
2. Participate in social performance requirements without undue fear or anxiety.
3. Develop the essential social skills that will enhance the quality of relationship life.
4. Develop the ability to form relationships that will enhance recovery support system.

5. Reach a personal balance between solitary time and interpersonal interaction with others.

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SHORT-TERM OBJECTIVES

1. Describe the history and nature of social fears and avoidance. (1, 2)
2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of social anxiety. (4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the client's history of social anxiety and avoidance including frequency, intensity, and duration of anxiety symptoms, triggers, and the nature and extent of avoidance (e.g., *The Anxiety Disorders Interview Schedule–Adult Version*).
3. Administer a measure of social anxiety to further assess the depth and breadth of social fears and avoidance (e.g., the *Liebowitz Social Anxiety Scale; Social Interaction Anxiety Scale; Social Phobia Inventory*); readminister as indicated to assess treatment progress.
4. Arrange for a substance abuse evaluation and refer the client for treatment for if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as

well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with an evaluation by a physician for psychotropic medication. (9)
6. Take prescribed psychotropic medications consistently. (10)
7. Participate in a small group therapy for social anxiety. (11)
8. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance. (12, 13)

9. Arrange for the client to have an evaluation for a prescription of psychotropic medications.
10. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.
11. Enroll client in a small (closed enrollment) cognitive-behavioral group therapy for social anxiety (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Social Anxiety Disorder* by Turk, Heimberg, and Magee).
12. Discuss how social anxiety derives from cognitive biases that overestimate negative evaluation by others, undervalue the self, distress, and often lead to unnecessary avoidance.
13. Assign the client to read psychoeducational chapters of books or treatment manuals on social anxiety that explain the cycle of social anxiety and avoidance and the rationale for cognitive behavioral treatment (e.g., *Overcoming Social Anxiety and Shyness* by Butler; *The Shyness and Social Anxiety Workbook* by Antony and Swinson; *Managing Social Anxiety* by Hope, Heimberg, and Turk).

9. Verbalize an understanding of the rationale for cognitive-behavioral treatment of social anxiety. (14)

10. Learn and implement calming and coping strategies to manage anxiety symptoms during moments of social anxiety and lead to a more relaxed state in general. (15)

11. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk. (16, 17)

14. Discuss how therapy based on cognitive-behavioral principles targets fear and avoidance to desensitize learned fear, build social skills, reality-test anxious thoughts, and increase confidence and social effectiveness.

15. Teach and ask the client to practice relaxation and attentional focusing skills (e.g., staying focused externally and on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety) for managing social anxiety symptoms and maintaining a more relaxed approach to life; review, reinforce successes; provide corrective feedback toward effective use.

16. Explore the client's and self-talk and underlying beliefs that mediate his/her social fears, challenge the biases (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); assist him/her in generating appraisals that correct for the biases and build confidence.

17. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; test fear-based predictions against alternatives using behavioral experiments; review; reinforce success, problem-solve obstacles toward accomplishing objective (see "Restoring Socialization Comfort" in the *Adult*

Psychotherapy Homework Planner by Jongsma; *The Shyness and Social Anxiety Workbook* by Antony and Swinson).

12. Participate in gradual repeated exposure to feared social situations within and outside of therapy. (18, 19, 20)

18. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with the phobic response.

19. Select initial in vivo or role-played exposures that have a high likelihood of being a successful experience for the client; do cognitive restructuring within and after the exposure, use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate progress through the hierarchy (see *Cognitive-Behavioral Group Therapy for Social Phobia* by Heimberg and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk).

20. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (or assign "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma; also see *The Shyness and Social Anxiety Workbook* by Antony and Swinson; review and reinforce success, providing corrective feedback toward improvement.

13. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (21, 22)

21. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (*Cognitive Behavioral Group Therapy for Social Phobia* by Heimberg

	and Becker; *Managing Social Anxiety* by Hope, Heimberg, and Turk).
	22. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., *Your Perfect Right* by Alberti and Emmons; *Conversationally Speaking* by Garner).
14. Implement relapse prevention strategies for managing possible future anxiety symptoms. (23, 24, 25, 26)	23. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.
	24. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.
	25. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, and exposure) while building social interactions and relationships.
	26. Develop a "coping card" on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," and "It will go away") are recorded for the client's later use.
15. Participate in Acceptance and Commitment Therapy (ACT) for social anxiety. (27, 28, 29, 30)	27. Use an ACT approach to help the client accept and openly experience anxious thoughts and feelings without being overly impacted by them, and committing his/her time and

efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

28. Teach mindfulness meditation to help the client recognize the negative thought processes associated with social anxiety and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
29. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into in everyday life.
30. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert).

16. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (31)

31. Conduct Interpersonal Therapy (apply *Comprehensive Guide to Interpersonal Psychotherapy* by Weissman, Markowitz, and Klerman) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships; develop a case formulation linking social anxiety grief, interpersonal role disputes, role transitions, and/or interpersonal deficits).

17. Verbalize and demonstrate an understanding and resolution of current interpersonal problems. (32, 33, 34, 35)

32. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.

33. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

34. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role, and taking steps to gain mastery over the new role.

35. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

18. Explore past experiences that may be the source of low self-esteem and social anxiety currently. (36, 37)

36. Probe childhood experiences of criticism, abandonment, or abuse that would foster low self-esteem and shame; process these.

37. Assign the client to read the books *Healing the Shame That Binds You* by Bradshaw and *Facing Shame* by Fossum and Mason, and process key ideas.

19. Work through developmental conflicts that may be influencing current struggles with fear and

38. Use an insight-oriented approach to explore how psychodynamic conflicts

avoidance and take appropriate actions. (38)

(e.g., separation/autonomy; anger recognition, management, and coping) may be manifesting as social fear and avoidance; address transference; work through separation and anger themes during therapy and upon termination toward developing a new ability to manage separations and autonomy.

20. Verbally describe the defense mechanisms used to avoid close relationships. (39)

39. Assist the client in identifying defense mechanisms that keep others at a distance and prevent him/her from developing trusting relationships; identify ways to minimize defensiveness.

21. Return for a follow-up session to track progress, reinforce gains, and problem-solve barriers. (40)

40. Schedule a follow-up or "booster session" for the client for 1 to 3 months after therapy ends to track progress.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	300.23	Social Phobia
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder
	300.7	Body Dysmorphic Disorder
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	_____	_____

Axis II:	301.82	Avoidant Personality Disorder
	301.0	Paranoid Personality Disorder
	310.22	Schizotypal Personality Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.4	F34.1	Persistent Depressive Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.7	F45.22	Body Dysmorphic Disorder
301.82	F60.6	Avoidant Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
310.22	F21	Schizotypal Personality Disorder
301.20	F60.1	Schizoid Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.