SOCIAL ANXIETY

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This paper provides a brief overview of social anxiety and its treatment. There are several psychotherapeutic and psychopharmacological treatment options. Often, a combination of the two leads to superior results. Special emphasis is given to a communication-oriented approach. Since communication is the mechanism which is impaired, communication is also the instrument how the condition and the debilitating symptoms that come with it can be reversed.

Keywords: social anxiety, psychotherapy, psychiatry

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Introduction

Social anxiety disorder (SAD), also known as social phobia, is an anxiety disorder characterized by a significant amount of fear in one or more social situations causing considerable distress and impaired ability to function in at least some parts of daily life. [1] Social anxiety can impair important functions in life, such as finding a partner or a job or getting admitted to a college of one's choice. Social anxiety strikes where individuals interact with their environment to get their needs, values and aspirations met. Communication is thus the mechanism that is impaired the most, but it is also the instrument which can be used to successfully treat social anxiety (Haverkampf, 2010b, 2013, 2015, 2018a).

Social anxiety can be triggered by perceived or actual scrutiny from others. This reflects either maladaptive internal or maladaptive communication patterns, or both. Communication patterns are the structured ways win which individuals exchange meaningful messages with each other. For example, if an individual with social anxiety receives a message from the other which conflicts with other information a communication pattern may lead to limit any signals that could reflect that rather than asking for clarification. Especially when it comes to selecting, encoding and decoding messages, maladaptive communication patterns, can lead to the breakdown of communication. If such experiences, which are to an already socially anxious person often catastrophic, accumulate, the result can be a further increase in social anxiety and yet more withdrawal. Focus on communication patterns in therapy can break this vicious cycle and lead to a recovery from even sever cases of social anxiety.

According to ICD-10 guidelines, the main diagnostic criteria of social anxiety disorder are

- fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating
- avoidance and
- anxiety symptoms. [2]

Social anxiety is the most common anxiety disorder with up to 10% of people being affected at some point in their life. [3]

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Symptoms

While the symptoms of social anxiety disorder affect the external communication, their root is usually in maladaptive internal and external communication patterns which may have developed over time, be old communication patterns which were never reevaluated and adjusted or sudden new communication, for example, as a result of trauma.

The physical symptoms are the ones which are typical for anxiety. They are:

- excessive blushing
- excess sweating
- trembling
- palpitations
- nausea

While blushing can occur in many forms of anxiety, in the case of social anxiety there is an added vicious cycle as the person feels it is very visible to others, which causes even further anxiety and blushing.

Communication channels can be affected directly, such as the voice, which can lead to:

- stammering and
- rapid speech.

The Illness of Lost Opportunities

SAD is sometimes referred to as an "illness of lost opportunities" where "individuals make major life choices to accommodate their illness". [2][4] To this one may add that a person suffering from SAD is usually hyperaware of any lost opportunities. While it is quite normal, that interactions with other people may not lead to the wished-for result in many cases, to someone suffering from SAD this just highlights the own ‘deficiency’ and that there is something ‘wrong’ with oneself. This can induce the vicious cycle of depressed thought patterns, negative self-image and social anxiety even more.

Many people with social anxiety are overly conscious of themselves in social situations, which makes these situations less fulfilling and successful than they could otherwise be. They focus heavily on the effect of their behaviors on other people. Often, they assume that people think negatively about them (mind reading) without any concrete evidence. Embarrassment, shame and even guilt often are felt, leading to a sense of loneliness and disconnection from the world.

Distorted thoughts are often self-defeating and inaccurate. Those with social phobia tend to interpret neutral or ambiguous conversations with a negative outlook, and many studies suggest that socially anxious individuals remember more negative memories than those less distressed. [5]

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A previous negative social experience can be a trigger to social phobia. [6][7] perhaps particularly for individuals high in 'interpersonal sensitivity'. An example of an instance may be that of a man at a social event walking up to a woman. If he is unable to say something within the first few seconds he might become conscious of there being a problem, and then of himself. Even if she would like to help him, he may interpret her reaction of looking at him as indifference or even rejection for his inability to start a conversation. This cognitive thought propels further anxiety which compounds with further stuttering, sweating, and, potentially, a panic attack. The result is a negative memory of a social interaction which can then generalize into all interactions, and lead to social isolation and loneliness.

Physiological aspects

Physiological effects, similar to those in other anxiety disorders, are present in those with social anxiety. [8] Common mechanisms and symptoms underly all forms of anxiety. The reason is that the maladaptive internal and external communication patterns lead to communication failures which can, given particular memories and other information, trigger an anxiety reaction in the brain. (Haverkampf, 2018b) Since humans share basic biological structures for anxiety with each other and many animals, for example, in the form of the fight or flight response, the basic physiological responses are the same. Common symptoms can thus include:

- tears
- excessive sweating
- nausea
- difficulty breathing
- shaking
- palpitations

Walk disturbance may appear, especially when passing a group of people.

Blushing is commonly exhibited by individuals suffering from social phobia. [9] These visible symptoms further reinforce the anxiety in the presence of others.

Development

Social anxiety is a result of maladaptive internal and external communication patterns. Most of these communication patterns are not conscious. There may be various reasons and factors why the system cannot autoregulate itself. Some may be biological, but many are a result of inadequate information, such as a string of hurtful experiences and an individual’s withdrawal from the world or looking for information about the world and oneself in the wrong places.

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Studies suggest that genetics can play a part in combination with environmental factors. Generally, social anxiety begins at a specific point in an individual's life. As the individual tries hard to counter the social anxieties, they often become even stronger. Eventually, mild social awkwardness can develop into symptoms of social anxiety or phobia.

It is still not clear which proportion is inheritable, and which is learned. Studies of identical twins brought up (via adoption) in different families have indicated that, if one twin developed social anxiety disorder, then the other was between 30 percent and 50 percent more likely than average to also develop the disorder. [10] However, it may not social anxiety that is heritable, but rather anxiety or depression in general. [11] Social anxiety is a form of anxiety with the typical symptoms associated with anxiety, but at the same time it distinguishes itself from other forms of anxiety because it directly affects an individual's ability to communicate with the world, which then also has an effect on internal communication patterns. (Haverkampf, 2013)

There may be inheritable personality traits which can make a case of social anxiety more likely. Studies suggest that parents of those with social anxiety disorder tend to be more socially isolated themselves (Bruch and Heimberg, 1994; Caster et al., 1999), and shyness in adoptive parents is significantly correlated with shyness in adopted children (Daniels and Plomin, 1985). It has been shown that there is a two to threefold greater risk of having social phobia if a first-degree relative also has the disorder. However, learning and exposure to certain interaction patterns probably plays a very significant role. The presence of certain personality traits or other potentially predisposing factors does not mean one has to suffer from social anxiety disorder. An important variable consists of the communication patterns build and shape over time, beginning on the day they are born. These communication patterns need to be reassessed and changed over time so that they help an individual satisfy own needs, values and aspirations. However, if these adaptions do not happen or are inadequate, communication is becoming less helpful to the individual in satisfying needs and aspirations, which has an impact on well-being and quality of life.

Adolescents who were rated as having an insecure (anxious-ambivalent) attachment with their mother as infants were twice as likely to develop anxiety disorders by late adolescence, [12] including social phobia. Absent parents or an unpredictable parenting style can also contribute to problems in developing a healthy and complete self-image and security in human interactions. The mechanism is again in the communication patterns others and the person uses. Meaningful information leads to changes in communication patterns. So, depending on how a caretaker encodes and sends meaningful messages, and what these messages contain, the communication patterns the child uses can develop in more adaptive or maladaptive ways. Looking at the interaction between the caretaker and child over time, the dynamic that unfolds has an effect on both, but the impact on the developing communication patterns of the child will be greater as there are less past communication experiences. (Haverkampf, 2010a)

For around half of those diagnosed with social anxiety disorder, a specific traumatic or humiliating social event appears to be associated with the onset or worsening of the disorder. [13] Usually, these events have a significant objective or imagined interpersonal component and high expectations of how the individual is supposed to perform in the situation. It is easy

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to seer how a combination of internal and external communication contributes to the development and maintenance of social anxiety.

Shy adolescents or avoidant adults have emphasized unpleasant experiences with peers [14] or childhood bullying or harassment. In one study, popularity was found to be negatively correlated with social anxiety, and children who were neglected by their peers reported higher social anxiety and fear of negative evaluation than other categories of children. [15] Socially phobic children appear less likely to receive positive reactions from peers [16] and anxious or inhibited children may isolate themselves. [17]

People with social anxiety may not have lower social skills, but they often attach a greater importance to how the social interaction unfolds. It is actually quite often the case that an individual who is very sensitive to social cues may not be able to make this additional information work for himself or herself. Research has indicated the role negative beliefs play, which can be 'core' or 'unconditional' beliefs, such as "I am inept", or 'conditional' beliefs, such as "If I show myself, I will be rejected". Negative beliefs are thought to develop based on personality and adverse experiences and to be activated when the person feels under threat. [18] Social norms and expectations may play a role. For example, if extroversion is a desirable trait, being more introspective can put additional pressure on an individual.

One model [19] emphasizes the development of a distorted mental representation of the self and overestimates of the likelihood and consequences of negative evaluation, and of the performance standards that others have. Negatively biased memories of the past often seem to play a role, leading to anxiety before an interaction and unhelpful interpretations and ruminations after it.

Studies have highlighted the role of subtle avoidance and defensive factors and shown how attempts to avoid feared negative evaluations or use 'safety behaviors' (Clark & Wells, 1995) can make social interaction more difficult and the anxiety worse in the long run.

Neurobiology

The neural foundations of social anxiety disorder have been studied extensively. [20] [21] A 2006 study found that the area of the brain called the amygdala, part of the limbic system, is hyperactive when patients are shown threatening faces or confronted with frightening situations. They found that patients with more severe social phobia showed a correlation with the increased response in the amygdala. [22] The amygdala is part of the limbic system which is related to fear cognition and emotional learning. Individuals with social anxiety disorder have been found to have a hypersensitive amygdala; for example, in relation to social threat cues (e.g. perceived negative evaluation by another person), angry or hostile faces, and while waiting to give a speech. [23]

Sociability seems to be tied closely tied to dopamine neurotransmission. [24] and social anxiety disorder may involve reduced serotonin receptor binding. [25] A recent study reports

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increased serotonin transporter binding in psychotropic medication-naive patients with generalized social anxiety disorder. [26]

Recent research has also indicated that another area of the brain, the anterior cingulate cortex, which was already known to be involved in the experience of physical pain, also appears to be involved in the experience of 'social pain', for example perceiving group exclusion. [27] A 2007 meta-analysis also found that individuals with social anxiety had hyperactivation in the amygdala and insula areas which are frequently associated with fear and negative emotional processing. [28]

Therapy

Psychotherapy is the first line of treatment, but medication can be a valuable support.

Psychotherapy

What exactly has the positive effect in the case of psychotherapy may not be that clear after all. Many schools of therapy, including cognitive behavioral therapy (CBT), claim that their techniques are the most effective ones. In the end, it may be the interaction between therapist and client, the therapeutic relationship, which contributes significantly to the success of the therapy.

A significant proportion of social anxiety may be learned. A series of bad experiences or an isolated life in childhood can contribute significantly to social anxiety early on and for decades to come. The fundamental question is whether a child learns to see and use communication with others as a valuable tool to get one's needs and wants satisfied, or if communication is used by others to hurt and ostracize. CBT uses tools that can help to 're-learn' what social interactions can be in a step-by-step approach. One drawback of CBT as compared to the more individualized, insight and emotion oriented approaches is that the effect may not be as long lasting (Haverkampf, 2017a), making 'booster' sessions at intervals necessary. There is also the problem that by learning new ways of thinking and behavior they may not be integrated as fully into the person's concept of self and personality as when they are developed by him or her in a therapeutic interaction. The sense of ownership of the individual changes must be particularly low when manualized CBT therapies are used.

Psychodynamic psychotherapy (PPT) is more concerned with the reasons for the social anxiety in the first place. How one sees oneself determines how one sees others. Often, it can be observed that clients project their own expectations and fears into others and then interact with mirror images of their harshest critic, themselves. PPT is thus looking more at the underlying dynamics, while also paying attention to certain communication phenomena, such as transference, counter-transference and reflecting on how a patient talks about content. However, PPT does not focus directly on the communication patterns. It is more concerned

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with content. From a communication focused perspective, the causal sequence is seen differently as the content is a consequence of the communication patterns an individual uses.

Communication-Focused Therapy (CFT) was developed by the author for several mental health conditions (Haverkampf, 2017b, 2018a), such as anxiety and panic attacks (Haverkampf, 2017d), depression (Haverkampf, 2017f), ADHD (Haverkampf, 2017c), bipolar condition (Haverkampf, 2017e), psychosis (Haverkampf, 2017g), social anxiety (Haverkampf, 2017h), and more. It focuses on the internal and external communication patterns which cause and maintain the impairment. In the therapeutic setting, awareness is created for these communication patterns, they are observed, reflected on and experimented with. The result is to gain the insight needed to lower and eliminate the symptoms. It is extensively described by the author elsewhere. (Haverkampf, 2010b, 2017b, 2018a)

Serotonin Reuptake Inhibitors (SSRIs)

The serotonin reuptake inhibitors (SSRIs) have been helpful in the treatment of social anxiety in a number of cases. Paroxetine and sertraline are two SSRIs that have been confirmed by the FDA to treat social anxiety disorder. In a meta-analysis, Blanco et al. (2003) found phenelzine to produce the largest improvement in measures of social anxiety, with an overall controlled effect size (ES) of 1.02. However, phenelzine did not perform significantly better than other medications included in this investigation, including the high potently benzodiazepine clonazepam (ES=.97), the anti-convulsant gabapentin (ES=.78), the reversible inhibitor of monoamine oxidase-A brofaromine (ES=.66), and the SSRIs (ES=.65). Effect sizes for the SSRIs sertraline, fluvoxamine, and paroxetine ranging from .30 to 2.2 have been reported (Van der Linden et al., 2000). Well-tolerated, safer drugs like the SSRIs may be better first-line treatments for social anxiety disorder, reserving highly efficacious medications with some associated health risks, such as phenelzine, for use where other treatments have been ineffective (Blanco et al., 2003).

Psychotherapy vs Medication

Gould et al.’s (1997) meta-analysis examined effect sizes of 24 controlled trials that evaluated either cognitive-behavioral or pharmacological treatments for social anxiety disorder. Both pharmacological and cognitive-behavioral treatments were superior to control conditions. These two approaches, however, were not significantly different from each other. Furthermore, CBT and medication had nearly equivalent rates of attrition at post-treatment and follow-up.

Fedoroff and Taylor (2001) found pharmacotherapies to be more effective than cognitive-behavioral treatments. SSRIs and benzodiazepines yielded the largest effect sizes, both performing better than control conditions but not significantly different from one another. In fact, benzodiazepines were found to perform better than the MAOIs and CBT (i.e., cognitive restructuring, cognitive restructuring plus exposure, and social skills training). However, the

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SSRIs were not significantly better than these treatments, nor were the MAOIs more effective than CBT. Pharmacotherapies appear to be somewhat more effective than cognitive-behavioral interventions in the short-term (Fedoroff & Taylor, 2001). Liebowitz et al. (1999) assessed the long-term outcome of clients receiving either phenelzine or CBGT and who met responder criteria after 12 weeks of treatment in the Heimberg et al. (1998) study. After a 6-month maintenance phase and an additional 6-month follow-up phase, 50% of clients from the phenelzine group had relapsed, compared to only 17% of clients who had received CBGT.

Blomoff et al. (2001) tested sertraline versus pill placebo, each in conjunction with either physician assisted exposure or non-directive encouragement and support, in a 22 design. At week 8, clients receiving sertraline plus exposure showed significantly more improvement than clients receiving pill placebo and supportive care. At week 12, at which point the exposure therapy ended, all active treatments were superior to the placebo and non-directive encouragement condition, but there were no differences between active treatments. By week 24, sertraline was superior to pill placebo, and there was a trend for the exposure conditions to be superior to the support conditions. Exposure appeared to add somewhat to sertraline, at least in terms of efficiency (i.e., the combination treatment showed significant change earlier), but there were few significant differences between sertraline with and without exposure.

A 1-year follow-up of clients in this study reported by Haug et al. (2003) showed that those who received exposure and supportive treatment continued to improve, whereas clients in the other conditions, including the combination treatment, failed to do so. In fact, there was some indication that clients who received sertraline with or without exposure deteriorated during the follow-up period, although all active treatment conditions were superior to placebo interventions alone. It may be that sertraline actually impeded the effects of exposure in the long run, even though the combination appeared more beneficial in the short term.

Psychotherapy and Medication

In many cases psychotherapy alone can be sufficient, while in some cases the added support from medication is needed. Medication by itself without psychotherapy is usually an inferior option because practically all symptoms in psychiatry are due to issues around internal, and often external flows of information. Only a communication-based therapy, which includes most flavors of psychotherapy, can bring about change here. However, adding the support of medication can be helpful in many situations. Medication, if it is used correctly, should not put a lid on things, but more distance from getting overwhelmed by anxiety can help to address issues and try some forms of exposure which would not be possible otherwise. In the case of social anxiety, working on communication patterns, unresolved issues from past experiences and trying stepwise exposure can all be supported with anxiolytic antidepressant medication in cases of more severe anxiety. Most studies exist on the combined use of medication and CBT. In studies of placebo-controlled discontinuation with paroxetine (Stein, Veriani, Hair, & Kumar, 2002; Stein et al., 1996) and sertraline (Walker et al., 2000), and in an uncontrolled discontinuation study with phenelzine (Liebowitz et al., 1999), relapse rates varied between

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30% and 60%, but were consistently higher than relapse rates reported for group CBT (17%; Liebowitz et al., 1999).

Psychotherapy has traditionally been called the 'talking cure' because it uses interpersonal communication to achieve a positive effect in a patient. While it started out more or less as a one-way street from therapist to patient, particularly in early attempts with hypnosis. It is now seen as a process which affects both, the patient and the therapist. When both can reflect on its effect, this can translate into change in the patient. Communication is the exchange of meaningful information, and meaningful information, if it can be received, decoded, interpreted and translated into meaning within the information that is already there, is what directly induces change.

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