Look Closer . . . I Am Not "Just Shy"

Recognizing Social Anxiety Disorder: A Case Study

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Early recognition, assessment, and treatment of social anxiety disorder are criteria to prevent persistent functional impairment in educational and occupational settings and in relationships. Individuals who avoid social settings due to the fear of embarrassment miss out on activities, learning opportunities, and interactions with others. Those who work with children in schools or health care settings are in an ideal position to help those who often don't have a voice. The 2013 updated NICE guideline, Social Anxiety Disorder: Recognition, Assessment and Treatment, *has been critically reviewed and applied to a case study. The guideline is intended to provide evidence-based best practice advice for providers on how to recognize, complete assessments of, and treat social anxiety disorder.*

Keywords: social anxiety disorder; social phobia; social anxiety; school-age children

Introduction

Sarah has joined the ranks of the chronic visitors to the school health office. As Sarah opens the door and quietly takes a seat, her school nurse gives a deep inward sigh, thinking, "Sarah is so shy." The nurse knows that when she asks Sarah how she can help her, Sarah will shrug and quietly whisper, "My stomach hurts."

Sarah is one of the 6% to 11% of school-age children who suffer from social anxiety disorder (SAD) (Chiu et al., 2013). Early recognition and intervention of SAD are critical in preventing long-term complications. Health care providers in school health programs, primary care, and behavioral health settings need to be skilled to make accurate assessments for appropriate interventions. Those who work with children, such as school nurses, educators, and support staff, may have the opportunity to advocate for students with social anxiety. The focus of this article is to apply the most recent clinical guidelines produced in 2013 by the National Institute for Health and Care Excellence (NICE) and developed by the National Collaborating Centre for Mental Health (NCCMH). The objective of the evidence-based guideline is to offer best practice advice for those who care for people of all ages with SAD.

Case Study

Every day when Sarah arrives at her 3rd-grade classroom at school, her stomach is queasy, her legs are shaky, and her heart rate increases. She hangs her head as she makes her way to her desk, hoping that no one will notice her. Other kids in the class are talking with each other as they settle in for the day. Sarah does not talk to anyone, and her classmates have learned to ignore her, as she rarely engages in conversation. The teacher explains to the other kids, "That's Sarah. . . . She's just shy." She spends her entire day with butterflies in her stomach, with her eyes downward, and hoping that the teacher will not call on her. She asks to see the school nurse, especially during reading, and often misses part of her school day as she remains in the health office. She watches the clock and counts down the hours and minutes until she can go home.

Sarah is the youngest of three daughters of married parents. Her father is an accountant and her mother a homemaker. As a preschooler, Sarah was healthy and happy, meeting all developmental milestones, but she was quiet and would tend to stay by her mother. Her mother would introduce her to others, saying, "This is Sarah. . . . She's just shy." After starting kindergarten, Sarah began having stomachaches in the mornings. She was assessed by her

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primary care provider, who could not find a cause. As she got older, she began having stomachaches on school nights that continued into the morning. Her mother sometimes had to pull her out of the car in the mornings. She had begun to refuse to attend soccer practice and an art program she previously enjoyed. A complete physical revealed that her growth and development were typical for her age and laboratory tests indicated normal values. Gastrointestinal studies were negative. Medications for nausea and reflux were ineffective.

Background

The U.S. Centers for Disease Control and Prevention (CDC) reports 3% of the population as having social anxiety disorder, also known as social phobia (CDC, 2011). Anxiety disorders are the most common childhood psychiatric disorder. It is noteworthy that 32% of children with anxiety will continue having an anxiety disorder as an adult (Piacentini et al., 2014). The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*) (American Psychiatric Association [APA], 2013), lists school anxiety as a common cause of children refusing to attend school. The median age of the onset of SAD is 13 years, with 75% of those beginning to have symptoms between ages 8 and 15. Approximately 50% of individuals with SAD seek clinical help; however, it may be years or even decades after living with the disorder (APA, 2013).

The onset may follow a history of being shy or may begin after a stressful or humiliating event, such as being bullied or becoming ill in public. Various factors have been identified as possible causes for the disorder. Heritability estimates are between 25% and 50%. This suggests that environmental causes may also contribute to the development of anxiety, such as bullying, family abuse, or a public embarrassment of behaviors. Overprotective parenting or parental modeling of anxiety can influence the development of social anxiety (NICE, 2013).

Social anxiety disorder includes fear or anxiety regarding social interactions and situations. This may include places where the person can be observed and judged, including eating or drinking; performing in front of others; making a phone call; or reading out loud in the classroom. Those with SAD will go out of their way to avoid social settings and meeting unfamiliar people. They may feel embarrassed, humiliated, or rejected or may have a fear of offending others (APA, 2013). In children, the fear must occur in the school setting with peers, not just during interactions with adults. Social or classroom situations will almost always provoke fear or anxiety in persons with SAD that is out of proportion to the actual risk of what is perceived that could happen. To form a diagnosis, symptoms must be present for at least 6 months (APA, 2013).

A person with SAD may present with various characteristics. For example, blushing is a hallmark sign of SAD. Individuals with social anxiety may present with rigid postures, avoid eye contact, and speak with a quiet voice (APA, 2013). They will appear shy and not participate in general conversations or talk about themselves. Self-medication with alcohol or drugs can be common in adolescence with social anxiety, such as drinking to increase social skills before attending events. They might avoid engaging in significant relationships with others and live at home longer than others without social anxiety. Students may not choose occupation goals that they have an interest in or would otherwise enjoy (APA, 2013). This fear affects multiple life functions and social and peer interactions necessary for normal psychosocial development.

Guideline Appraisal

In May 2013, NICE updated the 2006 version of the national guideline *Social Anxiety Disorder: Recognition, Assessment and Treatment (CG159)*. This guideline for SAD offers practice advice for the care of children from school age to 17 years old and for adults 18 and older in the recognition, assessment, and evidence-based treatment of SAD.

The NICE guideline includes clear information with referenced data for recognizing social anxiety in various settings and recommended screening tools for accurate assessments. The guideline addresses expected outcomes in symptom improvement along with the economic impact of treatments. Contributors to the guideline included experts in the field as well as consumers who have the lived experience of having SAD.

Guideline Recommendations

Recognition. Early recognition and treatment of SAD is critical and can prevent the development of abnormal behavior patterns, which may later cause interference in education, occupations, and relationships. Furthermore, early recognition may prevent a comorbid diagnosis of depression or substance abuse from the results of having social anxiety. Primary care providers often recognize depressive symptoms but overlook the possibility of social anxiety. Likewise, school personnel often under-recognize this disorder, by attributing behaviors to shyness or personality (NICE, 2013).

School nurses and health care providers should complete a thorough history to determine if a student has anxiety and then probe further to delineate what type of anxiety. It should be noted that students may not be forthcoming about symptoms; therefore, accurate questions will lead to the correct diagnosis, which will then correlate with appropriate treatment.

Assessment. Formal assessments may be used with children who have symptoms of social anxiety. Although these are not diagnostic tools, the results may verify that the child should be referred for further assessment. Table 1 lists some of the assessment tools recommended in the NICE guideline, which are available online for school nurse use.

A quick two-question method of screening may also include asking, "Do you find yourself avoiding social situations or activities? Are you fearful or embarrassed in social situations?" (NICE, 2013, p. 16). If the answer is "yes" to either of these, further assessment is recommended by a primary care provider or a mental health professional. Assessments at baseline and ongoing

Table 1. Assessment Measures for Social Anxiety Disorder (SAD)

Assessment	Comments	Where to Find
Revised Child Anxiety and Depression Scale (RCADS)	Grades 3-12	http://www.childfirst.ucla.edu/Resources.html
	Identifies SAD and other types of anxiety	
	Youth self-report and parent report versions	
	Multiple languages	
The Spence Children's Anxiety Scale (SCAS)	School age	http://www.scaswebsite.com/1_1_.html
	Identifies SAD and other types of anxiety	
	Youth self-report	
	Preschool Parent version	
	Multiple languages	
Screen for Childhood Anxiety Related Emotional Disorders (SCARED)	Ages 8 and older	http://www.tn.gov/mental/policy/best_pract/Pages%20from%20CY_BPGs_445-453.pdf
	Identifies SAD and other types of anxiety	
	Youth self-report and parent report versions	
Mini-Social Phobia Inventory (Mini-SPIN)	Adolescents and adults	depression.acponline.org/content/all/tools/dcg_o15.pdf
	Three-question rating scale	

Source: National Institute for Health and Care Excellence (2013).

during treatment will provide outcome information for efficacy of treatment.

Treatment

Psychotherapy. In children with SAD, psychological interventions are first-line recommendations for treatment. Cognitive behavioral therapy (CBT) is recommended as the psychotherapy of choice. Other interventions can be systemic therapy that includes the family, parenting interventions, counseling, and psychodynamic therapy (NICE, 2013).

Pharmacology. Following refusal of psychotherapy or partial or non-response to psychotherapy, psychopharmacology is another option for the treatment of SAD. There are several classes of medications that have been recommended as effective pharmacological treatment in children with SAD, as indicated in Table 2 (NCCMH, 2013). When the recommended first-line pharmacological treatment does not produce a remission of symptoms, a second line of pharmacological treatment is recommended. Medications may also be utilized before stressful events, such as when giving a presentation, giving a speech in the classroom, or performing in a play (Baldwin et al., 2005; NCCMH, 2013).

Medications should be given for at least 12 weeks at maximum doses before any changes are made to the treatment plan. If a medication leads to significant reduction in symptoms, then maintenance treatment follows. Current recommendations include continuing treatment for at least 1 year, or longer, since this disorder can become chronic (NICE, 2013; Stein et al., 2010).

Review of Current Evidence

The Screen for Childhood Anxiety Related Emotional Disorders (SCARED) is a commonly used written self-report tool that can be completed by the child and/or parent and is recommended by the NICE guideline. The benefit of using this tool is that results will delineate SAD and symptoms related to school phobias, as well as generalized anxiety and separation and panic disorders. It takes about 10 minutes to administer and is easily completed in a health office. This test has good internal consistency, validity, and test-retest reliability and is sensitive to treatment response (California Evidence-Based Clearinghouse for Child Welfare, 2011).

A meta-analysis showed probable efficacy for the use of CBT for children with social phobia. This type of therapy can be varied with individual, group, or self-help deliveries. The extent of parental involvement depends on the type of psychotherapy utilized. In young

Table 2. Psychopharmacology for Social Anxiety Disorder in Children

Recommended First-Line Medications	Recommended Second-Line Medications	Other Recommended Medications
Selective serotonin reuptake inhibitors (SSRIs):	Serotonin norepinephrine reuptake inhibitors (SNRIs):	Other antidepressants
escitalopram	venlafaxine	Anticonvulsants
paroxetine		Beta-antagonists
sertraline		Antipsychotics
		Cognitive enhancers
		Herbal remedies

Source: National Institute for Health and Care Excellence (2013).

children, parent-delivered CBT may be helpful (NCCMH, 2013). Parental involvement during treatment sessions was equally as effective as non-parental involvement (Silverman, Pina, & Viswesvaran, 2008). Although psychotherapy interventions, especially CBT, have proven results, it is a challenge to find trained therapists, due to availability, or therapists adhering to pure delivery of CBT (Henry, Kisicki, & Varley, 2012).

Anxiety that develops in childhood can persist into adulthood. Those who have treatment to reduce anxiety during childhood have fewer anxiety-related disorders as an adult than those who do not receive treatment. Retrospective and longitudinal studies conducted on children who had anxiety as a teen showed that those who had effective CBT had fewer panic disorders and less alcohol dependence and drug abuse as adults (Benjamin, Harrison, Settipani, Brodman, & Kendall, 2013). The long-term benefit of learning lifelong skills to address anxiety is an important aspect for school nurses and health care providers to consider when making recommendations for psychotherapy treatment (NICE, 2013).

Despite known efficacy of psychopharmacology in reducing anxiety, barriers exist in the use of medications to treat SAD. The disorder may be undiagnosed if depression or other comorbid illnesses exist. Those with social anxiety may perceive taking medications as a sign of personal failure. There can be a lack of knowledge in some prescribers about the value of an optimal outcome using medications (NCCMH, 2013).

Some studies have found, in comparing psychotherapy and pharmacology, that each has equal efficacy, but using *both* psychotherapy and pharmacology as part of the treatment plan has superior results (Baldwin et al., 2005; Piacentini, 2014). Masi et al. (2012) studied school-age children using medication for SAD, with 66% of those also having psychotherapy and 34% using medication alone. In comparing positive responders in both groups, 72.8% of those were receiving both psychotherapy and medication compared to 50.8% being treated with medication only.

Alternate approaches to treatment that are new and innovative include Internet therapy or telehealth deliveries. Virtual reality therapy (VRT) can be done electronically or in a therapy-led session. This exposure provides individualized high anxiety scenarios and allows for behavior modifications without the usual feelings of being judged (Yuen et al., 2013), and it was found to be effective in treating social anxiety related to public speaking fears. The improvement was maintained up to 1 year and is equally as effective when delivered as group therapy (Anderson et al., 2013).

Case Study Treatment and Outcome

Sarah's school nurse completed a comprehensive mental health assessment to better understand Sarah's history of behavior. She administered the SCARED, and her score indicated that she may have SAD.

Sarah's school nurse made a referral for CBT, the first-line treatment recommendation according to the NICE guideline. Cognitive therapies strive to identify thoughts and feelings and consequent behaviors. Further, therapies provide interventions that change thoughts before maladaptive behaviors develop, such as avoiding learning or social activities required for normal development (Yuen et al., 2013).

After 10 weekly sessions of individual CBT, Sarah had reduced complaints of stomachaches and was no longer avoiding school. She had started to interact with her classmates and to participate in group projects. Her teacher recognized her progress, and she was moved up from a group requiring reading assistance to her grade level group of readers. The use of CBT has an additional benefit of a reduced risk of symptom relapse. Longevity studies show that the effects of treatment with CBT or other psychotherapies may last for years (Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Kerns, Read, Klugman, & Kendall, 2013; Piacentini et al., 2014).

While collaborating with Sarah and her parents, an individualized healthcare plan (IHP) was developed, and suggestions for classroom management of social anxiety were given to the classroom teacher and other adults working with Sarah.

During follow-up assessments done 1 year later, Sarah had made great strides in reducing her reaction to social situations through psychotherapy; however, she continued to feel anxious and purposefully avoided some social interactions. She was referred for an assessment for the use of psychopharmacology as treatment. She was started on escitalopram 10 mg daily in the morning. The NICE guideline recommends starting a selective serotonin reuptake inhibitor, like escitalopram, if therapy does not produce symptom remission (NICE, 2013).

By the time Sarah reached high school, she was no longer considered "just shy." She was secretary of her class, was a cheerleader, and participated in track competitions. By following the NICE guidelines on SAD, this school nurse contributed to Sarah's success with a positive prognosis. She was enabled to fully participate in the classroom to meet educational goals and learn lifelong skills to reduce anxiety in stressful situations. Sarah avoided the fate of those with unrecognized and untreated SAD, who have higher school dropout rates, with decreased quality of life, employment opportunities, workplace productivity, and socioeconomic status. They are also more likely to remain single or get divorced and to be childless. Social anxiety prevents many individuals from enjoying social and leisure activities (APA, 2013).

School Nurse Recommendations

A school nurse who understands the signs and symptoms of SAD should recognize students who demonstrate SAD behaviors and not make an assumption that this behavior is related to being a shy child. Children who present with frequent somatic complaints, combined with or without an appearance of anxiety, need further assessment. School nurses may advocate for students with SAD in the classroom by raising awareness with educators of common classroom indicators of social anxiety behaviors, as described in Table 3.

Table 3. Classroom Behaviors of Students With Social Anxiety Disorder

Somatic complaints	• Headaches, stomachaches, general discomfort • Frequent requests to see the nurse
Behaviors	• Blushing • Soft or barely audible voices • Crying • Avoiding eye contact • Tremors, increased heart or respiratory rate • Hypersensitive to criticism • May not eat or drink in front of others
Communication	• Non-response or a delay in response to questions • Avoids starting or participating in discussions • Avoids asking for help • Will not express difficulties with learning • Avoids speaking up if unhappy or scared • Selective mutism
Learning	• Speaking and writing difficulties • Avoids being the center of attention, reading out loud • Will not volunteer to answer questions • Social anxiety disorder interferes with processing, comprehension, memory • Classroom work grades may be lower than expected
Relationships	• Intimidated by authority • Avoids peer friendships • Avoids play interactions

Source: Massachusetts General Hospital (2010); National Institute for Health and Care Excellence (2013).

Educators may assume that a child does not have the capability or interest in learning, especially with behaviors such as a delay in responding to others due to the fear of speaking. Adults should understand that students with SAD are suffering, and it is a burden to have these feelings. Relationships with peers and adults may not progress due to excess worrying that others will discover that anxiety is present. Those with SAD fear that others will react with anger or ridicule or will not like them. The results of behavior related to social anxiety interfere with normal cognitive learning and psychosocial development.

Individualized healthcare plans for social anxiety may include interventions of teaching the student self-awareness of his or her anxiety regarding triggers or symptoms, self-calming coping skills, collaboration with parents and educators in recognizing symptoms, and providing social opportunities for the student to develop peer relationships.

School nurses can collaborate with advanced practice nurses (APNs) and other providers who play an important role in the diagnosis and treatment of children with SAD. Community resources may include primary care providers, community mental health centers, psychologists, and mental health counselors.

By looking closer at children who are frequent visitors to the health office, school nurses are in an optimal position to recognize and assess social anxiety and other anxiety disorders in children and adolescents and to make appropriate referrals. Early recognition and treatment is critical in order to ensure lifelong success for those with anxiety disorders.

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