Anxiety Doesn't Work:
Treatment Options for SAD

by

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Introduction

The purpose of this class activity is twofold. First, you will read a story about a person with a psychological disorder so that you can gain some understanding as to how this particular problem—social anxiety disorder—may affect an individual. Second, you will learn about a variety of possible treatments for social anxiety disorder and discover the pros and cons of those different treatment options. In this way, you will gain knowledge about how complicated it can be to choose an appropriate treatment, what sorts of decisions individuals must make when choosing treatments, and why it is necessary for individuals to consult a mental health professional to help with this decision making. (*Important Note:* The treatments discussed are not the only possible treatments for social anxiety disorder.)

Class Structure

First, you will be assigned to a "home team." Each home team will consist of about five people. For this activity we will be using what is called a "jigsaw classroom." It's called this because every student on a home team will be responsible for gathering one piece of information and they will then teach their teammates the information. Then the entire home team will, in effect, put the pieces of the puzzle together (like a jigsaw puzzle) and come to some decisions about the different treatments.

Each home team member will be responsible for gathering information from one specific treatment location. There will be five separate treatment locations in the classroom (A, B, C, D, and E) and each location will have its own resources. Each home team will have one representative who goes to only one of the five treatment locations to gather information. For example, the student from each home team who is responsible for gathering information from treatment location A will go to that location and then take notes using a provided handout. (At the end of the class activity, student handouts may be collected, so please put your name on this form.) After every home team member gathers information from their respective treatment locations, they will return to their home team and teach their teammates the information they gathered.

A jigsaw classroom involves not only active learning, but also students teaching other students (i.e., peer teaching). Active learning and peer teaching are both excellent ways to learn and remember class material. You will also get to discuss all the information both with your teammates and with the entire class, so we'll all be able to express our ideas as well as help each other understand the material.

Procedure

The steps and time allocations for the class activity are the following:

Step 1—Meeting your Home Team (5 minutes)

Members of each home team will meet with each other in small circles (move your desks around, please). Make sure you know everyone's name. Each member of the team should have their own copy of the case handout to read. After every person in your home team has finished reading the case, you will determine among yourselves (by going in alphabetical order based on the first letter of your last name) which team member will gather information from which treatment location. If you have more than five in your team, a pair of you will visit the treatment location instead of just one of you.

Step 2—Gathering Information from Your treatment location (10 to 15 minutes)

At each of the five treatment locations (i.e., A, B, C, D, and E) the representatives from each home team will read the resources, take notes on the handout that will be provided (titled Treatment Notes) and clear up any confusion about what you have read by asking the instructor, and each other, questions. Also, be certain that you understand the strengths and weaknesses (i.e., pros and cons) of the treatment. Please put your name on the handout; they may be collected at the end of the class period.

In order to be certain that the information you plan to take back to your home team is accurate and thorough, you will need to receive approval. To signal that your treatment location group is ready for review of your notes, all members of the group will raise their hands. Once all teams' notes have been reviewed (or once 15 minutes has elapsed), everyone will go back to their home team.

Step 3—Teaching Your Teammates and Discussing Options (20–25 minutes total; 3–4 minutes per person, 5–10 minutes for group discussion)

Once you return to your home team, it's time to teach your teammates the information you gathered. The representative who gathered information from treatment location A should go first and then all other representatives should take turns in alphabetical order. All team members must take notes on what your teammates teach you. If anything is unclear, be sure to ask your teammates (or instructor) for clarification.

After all the treatment location information has been presented in each home team, it is time for home team members to decide, based on the notes you took about the pros and cons of each treatment, what treatment you, personally, would first recommend to Mo and why. You'll also decide the rankings of the four other treatment possibilities. Your answers will be recorded on the handout titled Team Member's Treatment Recommendations. These completed forms may be collected; therefore, be sure to put your name on the handout.

After all of you have made your own personal rankings of the treatments, it is time to discuss with your teammates the pros and cons of each treatment, which treatment you believe Mo should try first, and why you believe that treatment should be his choice. Your team should try to reach a consensus concerning your top recommendation for Mo's treatment. The discussion should also result in each team ranking the other four treatments (i.e., giving your second, third, fourth, and fifth choices), writing those rankings (and your reasons for them) on the handout you will be provided (called home team's Treatment Recommendations), and turning in the handouts to me. Be sure all team members' names are on this handout.

In addition, your team needs to pick a representative who will explain to the entire class what first treatment your home team picked and why.

Step 4—Recommendations Shared with Entire Class and Additional Questions Asked (20–30 minutes)

After team recommendations have been turned in, all home team representatives will give their team's first treatment recommendation (and the reasons for this choice) to the entire class. We'll see if teams are in agreement or if there are differing opinions among home teams. We'll also discuss experts' recommendations regarding the optimal treatments for social anxiety.

We may also raise some additional questions in order for you to explore whether your answers to these additional questions affect what you think Mo should do regarding treatment for his social anxiety disorder. If so, you will receive additional handouts on which to write your own personal responses, as well as your entire team's responses.

Mo's Story

Part I – Time at Work

"All right, team, nice work. Now, get those reports to me by Friday morning. And see you all at the fundraiser!"

The conference room, filled with men and women in gray, black, and the occasional navy business attire, erupted in mumbling and snippets of conversation as everyone lazily got up from their chairs. Mo remained seated in the back corner of the conference table, observing the office chatter buzzing around him:

"You going to that fundraiser?" ... "Yeah! You?" ... "Yes, I'm bringing my husband with me, so you'll finally get to meet him!" ... "You're married?" ...

Mo looked out the window, away from everyone. He started to feel a bit uneasy, as though he didn't belong there. He wanted to go home, hide, and sleep. He was so tired and the last thing he wanted to do was to sit at work doing something he hated. He watched a pigeon with muted colors speckled across its wings fly off from a nearby roof and he found himself yearning to be that bird. He yearned to be so free. He blinked and took a deep breath in.

"Mo, are you going to the fundraiser?" Celine, a young intern, asked earnestly.

His thoughts were interrupted. He turned his head slowly, keeping his eyes averted.

"Umn…no," he mumbled. He started to tremble and felt his cheeks get red.

"Huh?" asked Celine.

"UmmIhavetogo," Mo said, cramming his response into one syllable. He slowly got up from the conference table, making sure he kept his eyes on the ground. Celine scuttled out of the way as Mo made his way to the door in a panic.

Mo didn't remember the car ride home, but that didn't matter. He opened the door to his two-bedroom loft and collapsed onto his chair. He was exhausted, mildly sweaty, and felt that he was going to vomit at any minute.

Am I having a heart attack? he thought, as he struggled to catch his breath.

Mo's heart started to pump faster and he felt that the room was getting hotter and hotter by the second. He got up, opened a window, and stuck his head outside in an attempt to get a little bit of the cool breeze that had been caressing the warm weather all day.

After a few minutes he regained some of his composure and brought his head back inside. He sat solemnly on his couch.

"I can't do this anymore," he said out loud.

"Anymore what?" replied Ray, his brother, exiting from his bedroom.

"Nothing. Work. I just can't go in…I can't do this job anymore."

"Wait, what? Why?"

"It's hard to explain. But every time I'm there, I feel like I'm going to pass out from being nervous. I hate sitting in meetings. I've avoided three presentations now and I don't even know why."

"Why are you nervous? And how long have you been feeling this way?"

"I don't know. And I don't know how long. Months maybe? All I know is that every time someone looks at me, or talks to me, my mind goes blank, you know? I just stop thinking. My body goes into like overdrive, and I find myself just wanting to hide. And they're probably seeing all this happen and laughing."

"No, they're probably not laughing at you."

"Yes they are. I'd bet on it. They're probably making fun of how much I sweat, shake or stutter. They probably think I'm some idiot who doesn't know how to do this job. Chances are I'm going to get fired soon anyway because of all

this, so why don't I just quit? I'm gonna quit. The thought of even going in tomorrow makes me want to hide. I just can't, Ray. I just can't."

Mo put his head in the palm of his hands and sighed. He had made up his mind: he was going to send in his letter of resignation the first thing tomorrow morning. He couldn't bear to walk into work one last time and tell his boss in person. The thought of that made him feel dizzy and sick all over again.

"Before you call it quits, Mo, why don't you go to a doctor and see if they can help?"

"Um. Maybe. Ok. I guess..."

"Cool. I'll see if my doc can fit you this week."

"This week? That's so soon!"

"If you're this stressed out, why would you wait? I'm going to call first thing tomorrow."

Part II – A Visit to the Doctor

Before Mo knew it, he was sitting in a tan and oak room, which Mo found slightly mismatched. He tapped his fingers on the arm of his chair, breathing heavily, his heart punishing his chest.

"Mo?" A petite nurse called his name. "Hi Mo. C'mon back. You're going to be in this room, right here."

Mo followed the instructions silently and then sat quietly as the nurse made small talk. He responded aloofly and curtly. Then the nurse left the room. Mo felt so nervous; he felt as though he was getting tunnel vision. Everything was becoming farther away. He felt so detached.

After a few minutes, the doctor walked in. He was about 50 years old and had brown hair peppered with gray. His eyes looked as if he had read too many books in the dark and his mouth naturally curved downward, as though he had given too many people bad news. Mo's anxiety increased.

"Hi, Mo. I'm Dr. Abbot. Could you verify your age for me?"

"I'm 28."

"Thanks. So, what brings you in today?"

"Well, um, I just, I just, get these feelings of…of anxiety? It happens every time I'm around people, or am expected to give presentations, or do anything social," Mo said exasperatedly.

"What exactly do these feelings of anxiety feel like to you?"

"My heart rate speeds up, I start sweating, and I just feel like I'm gonna faint."

"And how long has this been going on?"

"I don't know. Maybe like, maybe, um, … eight months?"

"Sounds like you've been dealing with this for quite some time…."

"I just need this to stop. I really do. But I don't want to be seen as crazy. I'm not crazy!"

"Let me assure you that you aren't crazy, Mo. Your symptoms are more common than you think. One of my colleagues, Dr. Tolgin, specializes in anxiety problems, so I'd like to refer you to her so she can make an accurate diagnosis and then get you the help you need. Does that sound okay to you?"

"Okay, as long as I'm not crazy. Yeah, I definitely want to get this figured out before it completely ruins my entire life. I just can't go on like this, Doctor."

Over the next few weeks, Mo schedules several appointments with Dr. Tolgin. During the clinical interview they discuss Mo's background, experiences, thoughts, and feelings. Mo is also given a complete physical exam to determine if there are medical issues causing his symptoms. In addition, Dr. Tolgin gives Mo several psychological tests.

Based on the physical exam, psychological test results, and interview information, Dr. Tolgin is able to make a diagnosis. Several weeks after their initial meeting, she and Mo have an appointment to discuss the diagnosis and possible treatments.

"Good to see you again, Mo," says Dr. Tolgin.

"You, too, Doctor," replies Mo. "So, am I crazy?"

"No, of course not, Mo. I want to assure you again that many people have the symptoms you're having, so you're not alone. You have what's called social anxiety disorder, which is actually the most common type of anxiety disorder. The good news is that there are effective ways to reduce these symptoms so that you can lead a life with much, much less anxiety. Today I'd like to talk with you about different forms of treatment. How does that sound to you?"

"It sounds good. I just can't let this anxiety continue to ruin my life."

"I really like that you're open-minded about getting treatment, Mo. That's a very good sign. It's also a good sign that your answers on one of the surveys indicate that you don't appear to have clinical depression. Anxiety and severe, debilitating depression often occur together, but for you the issue is social anxiety, not depression. That'll likely make it easier to treat your anxiety. So, let's talk about some treatment options."

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Social Anxiety Disorder

Social Anxiety Disorder (SAD) is one of the most common anxiety disorders. In the United States, it is estimated that 5% to 12% of individuals have experienced SAD sometime during their lifetime (Stein & Stein, 2008). SAD generally begins in childhood or early adolescence and is more common in females than in males (Stein & Stein, 2008). According to *The Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (*DSM-5;* American Psychiatric Association, 2013), SAD is characterized by disproportional anxiety centering on social situations (e.g., talking to other people, giving presentations, going to parties). People with SAD fear that engaging in a social situation will either directly lead to negative evaluations from others (e.g., they are seen as weird, stupid, boring, different, untrustworthy) or that their anxiety symptoms will be highly obvious and therefore will elicit negative evaluations from others. Due to their anxious feelings about social situations and fear of embarrassment or humiliation, people with SAD tend to avoid social situations. Some individuals with SAD only avoid or feel excessive anxiety in specific situations (e.g., public speaking, talking to authority figures), whereas others have more generalized social anxiety in which most or all social situations produce distress (Brunello et al., 2000). To be diagnosed with SAD, people typically have to show symptoms for at least six months. It is important to note that being "shy" is not the same as having SAD. Shyness typically does not cause extreme distress and negatively impact a person's social, occupational, educational, and/or daily functioning, whereas SAD does. In addition, individuals with SAD often also have depression. Thus, without proper treatment SAD can greatly reduce a person's wellbeing and quality of life.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: American Psychiatric Association.

Brunello, N., Den Boer, J. A., Judd, L. L., Kasper, S., Kelsey, J. E., Lader, M., Y Lecrubierh, Y., Lepinej, J. P., Lydiardk, R. B., Mendlewiczl, J., Montgomery, S. A., Racagnia, G., Steino, M. B., Wittchenp H. U. (2000). Social phobia: Diagnosis and epidemiology, neurobiology and pharmacology, comorbidity and treatment. *Journal of Affective Disorders*, 60, 61–74. doi: 10.1016/S0165-0327(99)00140-8

Stein, M. B., & Stein, D. J. (2008). Social anxiety disorder. *The Lancet*, 371, 1115–1125. doi: 10.1016/S0140-6736(08)60488-2.

Efficacy vs. Effectiveness

Efficacy and effectiveness are terms with different meanings (Flay et al., 2005). For a therapy or medication to be efficacious it has to show, in controlled experimental studies, some desired effect(s) on the dependent variable. In this case, the dependent variable is the social anxiety symptoms and the desired effect is a reduction in those symptoms. That is, for a treatment to show efficacy it has to show that it can produce desired effects under optimal conditions and after multiple variables have been controlled. Efficacy studies use experimental designs, most often with some sort of control group, such as individuals on a waitlist, those receiving "treatment as usual," or participants randomly assigned to receive a placebo or no treatment (Flay et al., 2005).

For a therapy or medication to show effectiveness, it has to show some desired effects under everyday conditions. That is, for a treatment to be effective it has to show that it can produce desired effects when everyday factors and challenges occur and thus confounding variables are not controlled (Flay et al., 2005). For example, a study investigating a social anxiety treatment may be implemented in a community outpatient clinic, without controlling for confounding variables, in order to see if the treatment helps clients. If it does, that shows its effectiveness.

The best treatments are both efficacious and effective.

There are various factors that can affect the efficacy and effectiveness of treatments. First, clients are more likely to stay in treatment if they perceive that it aligns with their beliefs, goals, values, and needs (Castro, Barrera, & Steiker, 2010). Second, in terms of therapy, if the therapist is highly skilled, clients respond better to therapy (Hoffman, 2013; Shaw et al., 1999; Woody & Adessky, 2003). Third, clients receiving medication must be motivated to take the medication as prescribed and clients in therapy must be motivated to learn, try new things, and follow the therapist's suggestions. Fourth, for clients receiving therapy the therapeutic alliance (i.e., the relationship between the therapist and the client) is important, in that strong rapport has been shown to positively affect the effectiveness of therapy. In fact, it is regarded as one of the most important factors a therapist needs to consider when conducting therapy (Addis, 2000; Martin, Garske, & Davis, 2000; Raue, Goldfried, & Barkham, 1997).

References

Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology: Science and Practice,* 6, 430-441. doi: 10.1093/clipsy.6.4.430.

Castro, F. G., Barrera, M., & Steiker, L. K. H. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology,* 6, 213–239. doi: 10.1146/annurev-clinpsy-033109-132032 (open access at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4262835/>).

Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., Mościcki E., Schinke, S., Valentine, J., & Ji, P. (2005). Standards of evidence: Criteria for efficacy, effectiveness and dissemination. *Prevention Science*, 6, 151–175. doi: 10.1007/s11121-005-5553-y Accessed July 2016 from <https://www.researchgate.net/publication/7404567_Standards_of_Evidence_Criteria_for_Efficacy_Effectiveness_and_Dissemination>.

Hofmann, S. G. (2013). Bridging the theory-practice gap by getting even bolder with the Boulder Model. *Behavior Therapy*, 44(4), 603–608. doi: 10.1016/j.beth.2013.04.006 (open access at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4007058/>).

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology,* 68, 438–450. doi: http://dx.doi.org/10.1037/0022-006X.68.3.438.

Raue, P. J., Goldfried, M. R., & Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology,* 65, 582–587. doi: http://dx.doi.org/10.1037/0022-006X.65.4.582 Accessed August 2016 from <https://www.researchgate.net/publication/13962767_The_therapeutic_alliance_in_psychodynamic-interpersonal_and_cognitive-_behavioral_therapy>.

Shaw, B. F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T. M., Dobson, K. S., Lowery, A., Sotsky, S., Watkins, J., & Imber, S. D., (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology*, 67, 837–846. doi: http://dx.doi.org/10.1037/0022-006X.67.6.837

Woody, S. R., & Adessky, R. S. (2003). Therapeutic alliance, group cohesion, and homework compliance during cognitive-behavioral group treatment of social phobia. *Behavior Therapy*, 33, 5-27. doi: 10.1016/S0005-7894(02)80003-X.