What is the prevalence of Social Anxiety Disorder among adolescents in Ireland?

How does it impact their lives and how do schools address it?

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ABSTRACT

Social Anxiety Disorder (SAD) is the most common anxiety disorder encountered in adolescence; however, there is little research in this area in Ireland. The purpose of this study was to determine the prevalence of SAD among adolescents in Ireland, how it impacts on their lives and to examine what support is in place in schools to address it. The findings suggest that social anxiety is highly prevalent among the adolescents who participated in this study and it has a huge impact on both their academic and personal lives. It also found that most teachers who participated are not confident identifying or supporting students with social anxiety. The findings promote training for teachers and the use of school-based interventions to enable access to treatment and support for socially anxious adolescents.

KEYWORDS

Social Anxiety Disorder (SAD)

Adolescence

Guidance Counsellor (GC)

Prevalence

School Refusal Behaviour

School Interventions

INTRODUCTION

Research suggests that anxiety disorders are the most prevalent mental health issue facing adolescents today, yet they are largely undertreated (Cartwright-Hattohasn et al., 2004; Siegel & Dickstein, 2012). Most Irish studies focus on Generalised Anxiety Disorder (GAD), and do not look specifically at Social Anxiety Disorder (SAD) (Martin et al., 2006; Harvey, 2008; Dooley & Fitzgerald, 2012; IPPN, 2016). According to international research, SAD, also known as social phobia, is the most common anxiety disorder encountered in adolescence (Tassin et al., 2014), with a prevalence rate of 9.1% but which can be as high as 13% (Brook & Schmidt, 2008; Sweeney et al., 2015). According to ***Social Anxiety Ireland***, 16.8% of Irish adults suffer from SAD at any given time (www.socialanxietyireland.com). However, this research did not uncover any studies on Irish adolescents and SAD. Therefore, the aim of this study was to examine the prevalence of SAD among adolescents in Ireland.

WHAT IS SAD?

The Diagnostic and Statistical Manual of the American Psychiatric Association, fifth edition, defines SAD as:

> *'a marked fear or anxiety in one or more social or performance situations in which the person is exposed to possible scrutiny by others. They fear that they will act in a way (or show anxiety symptoms) that will be humiliating, embarrassing, or they will be rejected by others. Exposure to the feared social situation almost invariably provokes anxiety. The fear or anxiety is out of proportion to the actual threat of the situation. Feared social or performance situations are either avoided or endured with intense anxiety or distress. The fear or avoidance interferes significantly with the person's normal routine, occupational functioning, relationships, or social activities. The diagnosis can be further specified as "performance only" if the anxiety is focused specifically on public speaking or performing in public to a degree that there is marked functional impairment (e.g. interfering with ability to work)'.* (APA, 2013)

SYMPTOMS

SAD exists on a continuum from mild to severe. The symptoms of SAD are associated with a wide range of psychosocial difficulties such as lower peer acceptance and lower quality of friendships. In the school context, socially anxious adolescents encounter many distressing situations (e.g. giving a presentation, reading in class, asking/answering questions in class, participating in group exercises), which may lead them to stop attending certain classes or even refuse to attend school altogether (Blöte et al., 2015; Nelemans et al., 2017). Kearney suggests that between 5% and 28% of children and adolescents engage in some type of school refusal behaviours and as many as 7.7% of clinical samples of school refusers have a diagnosis of SAD (Kearney & Albano, 2004). Adolescents with severe SAD also engage in safety behaviours (i.e. saying little, avoiding eye contact) in an attempt to reduce the likelihood of humiliating themselves (Kley et al., 2012). They attribute any social successes to the safety behaviours. This maintains the safety behaviour which in turn enhances the anxiety and so the cycle continues (Ranta et al., 2012; Spence & Rapee, 2016,).

SAD OR SHYNESS?

In some instances, SAD is being mistaken for shyness (Masia-Warner et al., 2005). Many people who are shy do not have the negative emotions and feelings that accompany SAD, and while many people with SAD are shy, shyness is not a prerequisite for SAD (Heiser et al., 2009). When SAD is mistaken for shyness, it is expected that these young people will grow out of their anxiety (Hoganbruen et al., 2003). However, studies indicate that SAD during childhood and adolescence tends to endure if it is not addressed, resulting in lower achievements in important aspects of their lives. This ultimately causes poor quality of life and an increased risk of depression and alcohol/drug misuse (Brook & Schmidt, 2008; Buckner et al., 2008; Black et al., 2015; Spence & Rapee, 2016).

WHY DOES SAD SPIKE IN ADOLESCENCE?

Research findings across many studies suggest that there is a spike in SAD symptoms in mid-adolescence (Westenberget al., 2004; Warren & Sroufe, 2004; Ranta et al., 2012; Nelemans et al., 2017). Developmental theory suggests that this is due to heightened self-consciousness and increased fear of negative social evaluation (Westenberg et al., 2004). Erikson's (1959) theory of psychosocial development assumes that a psychosocial crisis occurs at each stage of development, whereby the psychological needs of the individual are conflicting with the needs of society (Baker-Smith & Moore, 2015). The developmental stage that occurs between 12 and 18 years is where adolescents search for a sense of self but they also want to fit in. Failure to establish a personal sense of identity within society may lead them to establish a negative identity. Feelings of inferiority and negative self-images are common symptoms of SAD (Ranta et al., 2012; Spence & Rapee, 2016; Nelemans et al., 2017). Bandura's (1994) concept of self-efficacy complements Erikson's (1959) theory. Self-efficacy implies confidence in our own ability to exercise control over our own behaviour and social environment. Bandura (1988) stated that perceived self-efficacy to exercise control over potential threats plays a central role in anxiety arousal. An individual with SAD does not feel in control in social situations.

RISK FACTORS/ CAUSES

Bronfenbrenner & Ceci (1994) present a transactional–ecological system of bidirectional influences that affect development; varying from proximal (e.g. child temperamental vulnerability) to more distal (e.g. family, school, community). There is a complex interplay between eight risk factors, all of which must be considered in the etiology of SAD:

- *Biology and the structure of the brain (Caouette & Guyer, 2013)*
- *Temperament i.e. behaviourally inhibited temperament (Rapee & Spence, 2004; Clauss & Blackford, 2012; Rapee, 2014)*
- *Cognitive factors i.e. negative self-images/expectations (Kley et al., 2012; Schreiber and Steil, 2012)*
- *Social skills deficits, i.e, difficulty interacting (Masia-Waner et al., 2005; Miers et al., 2010)*
- *Peers, i.e. not belonging to a peer group (Greco & Morris, 2005; Blöte et al., 2007; Poston, 2009; Ranta et al., 2009)*
- *Gender (Brook & Schmidt, 2008; Ranta et al., 2012;)*
- *Social media (Kittinger et al., 2012; Shaw et al., 2015; Lin et al., 2016; Prizant-Passal et al., 2016)*
- *Culture, i.e. Asian countries report lower rates of SAD. This may be because shyness is not viewed negatively in these cultures.*

When we look at the risk factors for SAD, it is important to consider the principles of equifinality (i.e. multiple developmental pathways) and multifinality (i.e. same risk factor, different outcomes) (Spence & Rapee, 2016). The combination of timing and circumstances surrounding the various risk factors is important as different risk factors may be more or less influential at different ages (Ollendick & Hirshfeld-Becker, 2002). Risk factors can be transactional and reciprocal, as young people influence their social environment, which, in turn, impacts upon them (Spence & Rapee, 2016). One theory links biological, psychological and environmental factors into a diathesis–stress paradigm (Brook & Schmidt, 2008). This implies a two-way effect between a predisposition towards a disorder (diathesis) and environmental disturbances (stress). Therefore, the greater the underlying vulnerability to SAD for example, the less stress required to trigger it. This emphasises the relationship between risk and protective factors in a developing individual (Brook & Schmidt, 2008).

METHODOLOGY

An instrumental case study was carried out to answer the research question. A mixed methods approach was used, a combination of quantitative (questionnaires) and qualitative (semi-structured interviews) methods. Questionnaires were administered to junior and leaving cert classes in two schools, a boys school and a girls school (to determine if it was prevalent in one age group over another or in one gender over another), teachers and guidance counsellors (GCs). The total number of participants was 238:154 girls, 65 boys and 19 teachers. Semi-structured interviews were also carried out with each GC. The Leibowitz Social Anxiety Scale (LSAS) was attached to the student's questionnaire. The LSAS is one of the most commonly used clinician-administered scales for the assessment of SAD.

FINDINGS

What is the prevalence of SAD among adolescents in Ireland?

The findings of this study suggest that SAD is highly prevalent among the participants and more so in females. In this study, more than one in two girls and approximately one in four boys met criteria for SAD on the LSAS. It is worth noting that less than half of the junior boys knew what SAD was and it is also possible that boys feel they cannot admit experiencing SAD due to gender stereotyping (Brook & Schmidt, 2008). This makes it all the more important that we raise awareness of SAD in schools and inform students how common it is across both genders.

Prevalence: teachers in this study were not aware of how prevalent it is.

More than half the teachers surveyed and both GCs believed SAD was not that prevalent among students or underestimated how prevalent it was, and only half of the teachers were confident identifying it. Furthermore, almost half the teachers believed SAD was more prevalent in the junior cycle while the results of this study indicate that it is consistently prevalent across both age groups with a slight majority among senior girls and junior boys. This supports the literature that teachers and GCs are not an optimal means for identifying students with SAD (Sweeney et al., 2015) and indicates that training in identifying SAD is essential for teachers in Irish secondary schools.

Prevalence: more severe SAD among senior girls.

The results of the LSAS showed that three times as many senior girls versus junior girls had severe SAD and twice as many had co-morbid conditions. SAD tends to persist if left untreated (Beesdo-Baum et al., 2012). This may indicate that the longer you have SAD, the more severe it gets and the greater the likelihood of co-morbid conditions, such as panic or depression. A longitudinal study would be necessary to confirm how SAD develops over time. These findings highlight the need for early assessment and identification so that supports can be put in place to reduce the risk of severe SAD and maladaptive safety behaviours. The Department of Education in Ireland is currently rolling out a wellbeing programme in the junior cycle which commenced in September 2017 (NCCA, 2017). However, there is no such programme for the senior cycle. Results from this study would indicate that wellbeing programmes and, in particular, workshops on managing SAD would be very beneficial for the senior cycle also.

What impact does SAD have on school performance and relationships?

The analysis showed a huge overlap in symptoms cited by the girls, the boys and teachers, demonstrating great triangulation among participants. The symptoms cited as having the biggest impact on school performance were fear of participating in class, and avoiding school. According to Brook & Schmidt (2008), it is common for people with SAD to avoid going to or participating in school and this can have major ramifications on their academic, occupational and personal life. These are not just symptoms but also safety behaviours, which as mentioned previously only serve to heighten social anxiety in the long term (Ranta et al., 2012; Spence & Rapee, 2016). Only four teachers mentioned absenteeism as a symptom, which suggests that teachers may not be linking absenteeism to SAD. It is essential that teachers are made aware of how far-reaching and debilitating the symptoms can be. Knowledge of these symptoms could inform decision making around interventions and support plans. Future studies could also take a more in-depth look at the impact of avoidance behaviours on academic outcomes.

The symptoms cited as having the biggest impact on relationships were fear of speaking/communicating, difficulty making or maintaining friends, feelings of isolation and feeling misunderstood.

These symptoms are typical of SAD, and one symptom may be causing the other, i.e. poor social skills may lead to peer rejection, which can cause feelings of isolation and of being misunderstood which in turn enhance the SAD (Spence & Rapee, 2016). According to Maslow's hierarchy of needs (Poston, 2009), a level of belonging must be established by individuals because of its effect on one's self-esteem. Maslow also suggested that if the level of belonging is low, or an individual is viewed negatively by peers in that group, he or she may develop SAD. Social Skills Training (SST) programmes could be delivered as part of the school programme to address this issue.

The results suggest that bullying/'slagging' was the main cause of SAD according to the boys. Bullying was also cited most frequently by the girls; however, the girls attributed their symptoms to a greater mix of causes such as being forced to speak, stress/pressure, family issues and fear of being judged/not fitting in. Neither group placed much focus on social media, while half the teachers and one GC cited social media as a main cause. Studies have suggested that social media can have some negative effects on a person's mental health (Schurgin O'Keeffe et al., 2011); however, there is still no evidence to suggest it causes SAD (Kittinger et al., 2012; Lin et al., 2016). Research also suggests that there are multiple pathways to SAD, not just one, and any risk factor can lead to different outcomes, i.e. social media may be a positive experience for some but a negative experience for others (Spence & Rapee, 2016). This would suggest that the causes of SAD are not predetermined. It is worth bearing in mind the diathesis–stress paradigm, which suggests that causes of SAD are multi-factored; biological, psychological and environmental. This concept suggests that certain individuals may be vulnerable to SAD and, depending on the risk or protective factors present, they may succumb to it or not (Brook & Schmidt, 2008). Therefore, raising awareness, training teachers and students and providing workshops ensures that as many protective factors as possible are in place.

The majority of students agreed that talking and listening were essential to support those who suffer with SAD and raising awareness of the condition was paramount. Given the high prevalence of SAD that this research has demonstrated, talks that specifically aim to address SAD may be more effective than those that focus on general factors that are common across all anxiety disorders (Spence & Rapee, 2016). It is also important to make all students aware of what supports are available, not just those who seek help, and it may be necessary to deliver this message more than once a year to maintain awareness.

Barriers to support

The main barriers to support were consistent with the literature, i.e. lack of time, shame, stigma around mental health issues, training and parental acceptance (Olfson et al., 2000; Hoganbruen et al., 2003; Shevlin et al., 2013). In addition to this, many of the teachers do not feel confident identifying or supporting students with SAD. Shevlin et al. (2013) found that teachers in Ireland do not have confidence in their skills to manage the emotional needs of their students. Students hiding their symptoms makes the issue even more difficult for teachers to identify and so the students continue to suffer in silence. Schools need to be proactive in order to address these barriers, through workshops for staff, universal psychoeducational programmes for students, SST programmes and information sessions for parents.

A further barrier is the lack of protection for the role of GCs. In Ireland, it is up to the principal of each school to decide if they have enough resources to accommodate a GC. The current Minister for Education is reviewing this process (Dooley, 2018). It is important that this role is protected to ensure that there is a balance between academic and emotional guidance and support.

Suggestions going forward

Based on responses to this study, there are questions that should be added to any future studies: for example, a question that directly asks if the students avoid school or class due to their SAD, to determine if there is a direct link between absenteeism and SAD. Many teachers believe social media is a causal factor, therefore it would be prudent to ask the students if they believe it plays a role. Finally, it would be useful to get more feedback about safety behaviours by asking the students how they manage their social anxiety. This data could be used in teacher training.

Based on the findings from this study it is apparent that there is a need to raise awareness about SAD. Charity organisations such as Step Out Ireland have compiled their own modules to specifically address SAD and will visit schools and provide workshops (https://www.stepoutireland.com), which many schools are not aware of. In addition to this, schools could introduce evidence-based SST programmes that have been shown to have much success addressing SAD (Beidel et al., 2014), such as SASS (Skills for Academic and Social Success) and SET-C (Social Effectiveness Therapy for children) which use a combination of exposure therapy, peer generalisation and group social skills training (Masia-Warner et al., 2005; Beidel et al., 2006, 2014). Using these in the school environment makes generalisation easier; teachers can help students overcome classroom fears, parents learn techniques to reduce absenteeism and promote skills generalisation, and the programme can use outgoing students to practise social skills (Masia-Warner et al., 2005).

If SAD is as prevalent as the findings from this study indicate (one in two girls and one in four boys), it is vital that schools allocate time to address it. Schools provide unique access to adolescents (Adelman & Taylor, 1999). School interventions reduce financial barriers to treatment. Furthermore, offering support in familiar

settings like schools may make treatment more acceptable and break down barriers such as mental health stigma and shame (Masia-Warner et al., 2005). Masia-Warner et al. (2005) found that the benefits of school-based interventions are as good as clinic-based treatments. This is because schools provide an unparalleled opportunity to address instances that trigger SAD such as social situations and speaking in class.

CONCLUSION

The purpose of this study was to determine three things: What is the prevalence of SAD among adolescents in Ireland? How does it impact their lives? And what supports are in place to address it? As mentioned, international studies suggest that SAD is the most common anxiety disorder encountered in adolescence. However, there has been little research into SAD in Ireland. This study indicates that one in two female and one in four male Irish adolescents struggle with this disorder. The long-term impact of SAD can be life-altering, e.g. increased risk of depression and drug or alcohol misuse, which can affect an individual's academic, occupational and personal life. For these reasons it is important to invest in education for students and teachers during a phase where SAD is most prevalent. In addition to a whole school approach, families must also be included. This multi-level approach to education, prevention and intervention is paramount to sustain long-term change (Winett, 1998). ■

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