Social Anxiety Disorder (SAD) amongst Adolescents in Schools

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Contributor: Ireni Farag

Adolescence is a stage of development that is impacted by a number of factors including relationships with peers, parent and teachers. A condition such as Social Anxiety Disorder (SAD), which impedes those relationships due fear about social interactions, has detrimental impact on adolescent development. Through the review of recent studies, this paper will explore the use of Cognitive Behavioural Therapy (CBT) and the school-based program, Skills for Social and Academic Success (SASS), with adolescents experiencing SAD. A review of the assessment and diagnostic process for SAD is provided which explores the limitations and gaps within current assessment processes. Suggestions for more developmentally informed assessment processes are considered. The paper will also outline the role which schools can play in the detection and treatment of SAD amongst an adolescent population. Furthermore, the outcomes of those interventions are considered herein.

Keywords: Social Anxiety Disorder ; Youths ; Adolescents ; Psychology ; School ; Counselling ; CBT

1. Introduction

Social Anxiety Disorder (SAD) is a recognised, yet often overlooked mental health condition experienced by a large number of adolescents throughout the world. SAD is associated with thoughts, behaviours and emotional experiences of an individual who holds fears of social interactions, compounded by their belief that they are likely to be criticised by others. Schools have a unique opportunity to be able to identify adolescents at risk of, or are experiencing SAD since many do not seek assessment from mental health professionals. Furthermore, schools are able to provide opportunities for students to engage with interventions such as Skills for Social and Academic Success (SASS) specifically targeting SAD symptoms.

2. Characteristics of Social Anxiety Disorder in Adolescents

Social Anxiety Disorder (SAD) is generally described as the experiencing of extreme fear of social interactions, where an individual perceives that they are likely to be criticised by others . The Diagnostic and Statistical Manual-V [1] states that the individuals experiencing SAD are likely to avoid social engagements due to their fear of judgement or ridicule, which is generally disproportionate to the risk of that occurring. It also outlines that in order for an individual to be considered as experiencing SAD those symptoms needed to have been evident for the majority of the time for a period of at least six months and are unrelated to other psychical or psychological conditions.

It is important to note that SAD symptoms extend beyond shyness or anxiety related to one particular activity [2]. Fear or anxiety related to social interactions where SAD occurs in adolescence are likely to have detrimental impact on psychological development, academic performance, school attendance, social interactions and/or familial relationships [3] [4]. SAD in adolescents has been associated with paranoid thoughts, difficulty in forming and maintain friendships, negatively impacting problem solving skills and social isolation and withdrawal [5][6][7][8].

2.1 Prevalence of SAD in adolescents.

The average onset age of SAD is thirteen years [7], as such it is of particular concern for adolescents. In the National Survey of Mental Health and Wellbeing, carried out in 2007, it was found that 4.3% of individuals between the ages of 16 and 24 had experienced SAD in the year prior to the survey. Of those young people surveyed, 6.4% had experienced it at least once in their lifetime [9].

2.2 Causes of SAD in adolescents.

Studies have attempted to identify the causes of SAD in adolescents, with varying results. Several have considered the potential of genetic influence on the presentation of SAD. However, in a recent systematic study of thirty-one research articles, Moreno et al. [10] found that SAD heritability rates ranged between 13% and 76% across studies examined. Such findings indicate that although genetic factors may cause SAD, the extent to which this occurs is unclear. Furthermore, studies have been unable to identify a particular gene which is responsible for or is influential to SAD [11][12].

Other possible causes of SAD include environmental factors. One factor examined was the adolescent's parents metal health, particularly in relation to anxiety disorders. Researchers have found that adolescents with one parent who had social anxiety were at greater risk of developing SAD [13][11][14]. Of particular importance was that the parenting style and level of control of adolescents was found to be a major contributing factor in the onset and development of SAD. Parental over-control and unwarranted over-protection were found to exacerbate adolescent symptoms of SAD as they would reinforce the beliefs of the adolescent that they were unable to engage in social activities [4].

Other factors which have been considered with regard to the causes of SAD include temperament, specifically the behavioural inhibition of the adolescent in their infancy. Behavioural inhibition is associated with distress or fear in unfamiliar situations to an extent which is beyond that expected of an infant. Several studies have pointed to behavioural inhibition as being a precursor to SAD in adolescence [14].

Issues such as bullying and social rejection have also been found to be contributing factors to the development and presentation of SAD amongst adolescents [4].

2.3 Impact of SAD on Adolescent Development and Functioning

According to Erikson [15], the psychosocial development of the adolescent is dependent on their ability to form social relationships which ultimately aid in their identity formation and independence. SAD significantly hinders this developmental process. In fact, adolescents experiencing SAD may find that they are in an self-perpetuating cycle where they avoid social interactions, leading to decreased social skill development - a decline that they become aware of, and which they believe hinders them from engaging in social interactions [16]. Social withdrawal due to SAD in adolescence has also been linked to difficulties in forming intimate relationships in early adulthood, therefore having developmental impacts beyond its stage [16][17].

SAD impacts the adolescent development across all domains. From an emotional perspective, a recent study found that adolescents experiencing SAD were more likely exhibit maladaptive emotional regulation. They were found to resort to withdrawal and rumination rather than problem solving when experiencing distress [8].

Cognitive development is also impacted by SAD with adolescents focusing on negative thoughts limiting their ability to engage in abstract thinking which requires thinking about possible solutions to problems [3]. Furthermore, Piaget's cognitive development theory identifies adolescence as the time of development of metacognition, or the ability to observe one's thoughts. SAD results in thoughts which are consuming for the adolescent, thus hindering their ability to objectively assess or view their own maladaptive thinking patterns [18].

2.4 The impact of SAD on education, learning and presentation in the classroom.

SAD has the potential of having detrimental impacts on an adolescent's school performance and attendance, therefore ultimately also on their learning. Studies have indicated that individuals experiencing SAD have a higher risk of failing grades or dropping out of school [19]. Furthermore, due to the social withdrawal which is generally evident in adolescents with SAD, there is increased risk of school absence, and lack of participation [6]. Test and performance anxiety are also likely to impact academic performance [3].

These issues present challenges for teachers, support staff and parents as it can be difficult to ascertain an appropriate level of support and encouragement to help the adolescent engage in school whilst being aware of their experiencing of SAD. These challenges are further compounded by the fact that many adolescents experiencing SAD are unlikely to ask for help from teachers or support staff due to their fears of ridicule and embarrassment [20].

2.5 Cultural and other relevant considerations.

In one study which evaluated the presentation of SAD amongst Iranian communities, it was found that the underlying beliefs regarding poor evaluation of self, sense of inadequacy and unworthiness were present across all cultural groups considered [21]. However, how SAD presented differed from one culture to another, with individuals in Iran found to be more likely to experience physical symptoms of SAD such as blushing and sweating [21]. Individuals living in countries such as Japan or Korea were found to be more likely experience Taijin kyofusho (TKS) which is associated with a fear that an action may embarrass the other person [21].

It is important to recognise that SAD is related to and influenced by the cultural environment of the adolescent. Adolescents experiencing SAD are fearful of violating social norms, therefore what is considered acceptable and normal within a cultural group is likely influence how SAD is experienced and presents in adolescent groups. Overall, cultural issues such as gender roles, social constructs and individualism and collectivism are likely to impact adolescents experiencing SAD [18].

3. Diagnosis of SAD in adolescents.

It is important to firstly highlight that diagnosis of SAD cannot be undertaken by a school counsellor or social worker. Since SAD is a recognised disorder which is described within the DSM-V a clinical psychologist or psychiatrist's evaluation is required for its diagnosis.

For a diagnosis of SAD to occur the adolescent needs to have experienced symptoms for a period of six months or more [7]. This alone presents an issue for the adolescent and their family or school, since adolescents who may be experiencing SAD but have not had symptoms for more than six months may be misdiagnosed or not provided with the information they need to get appropriate supports.

Symptoms which are considered by the psychologist when assessing an adolescent include fear of social interactions, performance and/or the evaluation of others [7]. Those fears need to have reached a point where they are causing significant impact to the adolescent's daily functioning. Furthermore, they need to also not be by-products of other issues being experienced by the adolescent such as drug taking, other mental disorders, medication side-effects or that the fear only occurs with regard to social speaking [7].

Several assessment tools are available to psychologists to aid in the diagnosis of SAD amongst adolescents. The first of these is the Liebowitz Social Anxiety Scale (LSAS). The LSAS is a questionnaire which contains twenty-four scenarios which are said to be likely to elicit anxiety [22]. In its original format, several of the items on the LSAS are social situations likely to be experienced by adults rather than adolescents. Adaptation to the LSAS was developed by Masia-Warner et al. [23] for use with children and adolescents. The LSAS's 24 items have been reworded to include situations which are relevant to adolescents, such as questions relating to school settings. However, in a similar fashion to the adult version, the LSAS-CA relies on the honesty of the client in self-reporting their experiences of anxiety. Despite this reliance on the honesty of clients, it has been found to be effective in the assessment of adolescents experiencing SAD [24]. Other questionnaire style tools used to aid practitioners in the assessment of adolescent SAD include the Social Anxiety Scale for Adolescents (SAS-A), which has been adapted from a longer adult version. It has also been found to be effective for the assessment of SAD[25]. The Subtle Avoidance Frequency Examination (SAFE) is another tool which has been developed for the assessment and diagnosis of SAD. A recent study by Thomas et al. [26], SAFE was also found to be an effective tool for capturing information specifically about the adolescent's experiences of anxiety and subsequent avoidance.

In addition to questionnaire assessments clinicians also use observations, family interviews and school reports to assist in diagnosis of SAD in adolescence. Comorbidities are also evaluated during assessment for SAD, amongst adolescents, these tend to include major depressive disorder, alcohol abuse, genralised anxiety disorder, post-traumatic stress disorder and agoraphobia [9][27][7].

3.1 Evaluation of the process of assessment.

It has been found that the majority of adolescents with SAD are unlikely to seek professional help [20]. Avoiding discussing their social anxieties with mental health professionals such as their school counsellor hinders both the assessment and therapeutic processes. In addition to this, due to the intense fear of judgment and ridicule by others, adolescents experiencing SAD are likely to avoid situations where they are required to speak to an unknown person such as a psychologist or counsellor, particularly about their experiencing of SAD symptoms.

If the adolescent is able to engage with a therapist they then need to complete self-reporting questionnaires which rely on their own evaluation and re-telling of SAD symptoms. An accurate diagnosis of SAD requires that information provided is an accurate self evaluation and assessment of their experiences. This is often problematic for adolescents since, as noted earlier, the presence of intrusive thoughts can impact their ability to objectively evaluate their thought processes [3].

Assessment methods which incorporate an evaluation of risk and protective factors are likely to lead to more holistic treatment plans than those which rely solely on surveys and questionaires. One assessment approach may be to pursue a biopsychosocial model and case formulation [28]. This involves considering various aspects of the adolescent's life to formulate a case conceptualization and provide valuable information for the development of a treatment plan. The

biopsychosocial model considers the biological, social and psychological factors in the adolescent's life. It also assesses these in terms of their being protective, precipitating, predisposing and perpetuating factors. Gathering information about predisposing factors would involve consideration of genetic and hereditary influences in the adolescent's life. The precipitating factors may highlight a preceding event or series of events which impacted the development of SAD. The perpetuating factors may include such things as current parenting styles which may be placing pressure or being unnecessarily protective of the adolescent. Furthermore, an understanding of the protective factors will aid therapists to guide the adolescent to identify and leverage those to help in their treatment of SAD.

Pursuing a psychosocial assessment method also provides opportunity to consider all ecosystems impacting the adolescent's development [29]. The micro-system of their immediate family unit and its impact of the adolescent's SAD presentation is important to consider as it has been found that parenting relationships and adjustment in parenting style are influential to SAD [14]. Consideration of the adolescent's school attendance, relationships with teachers and peers also provides information regarding their microsystem. Adolescents experiencing SAD have also been found to be more likely to be subjected to bullying and peer victimisation online [4]. Therefore, consideration of social media usage and other elements within their exosystem such as relationships with extended family and mental health providers may also provide information about protective and risk factors in the adolescent's life. Finally, a consideration of the cultural environment of the adolescent will also provide therapists with information at a macro-level about expectations of the adolescent, their own understanding of their role and what they perceive as normal and acceptable behaviours [30], such information may then be used in treatment to address maladaptive or unhelpful thought patterns.

3.2 Evaluation of the identification and assessment of SAD in schools

It is important to note that only 20% of adolescents who are experiencing SAD are diagnosed [31], this places an important responsibility on schools where there may be a large number of undiagnosed, unassessed students experiencing SAD.

Identification of SAD in school settings may prove to be difficult as symptoms of SAD are commonly confused with other disorders, and are at times mistaken for normal adolescent behaviours relating to heightened social awareness [6][7]. One examples of this is shyness. Shyness is where students may be reluctant to engage in social activities, group work or speak in presentations. However, an awareness of the persistence and intensity of SAD symptoms may help educators and school mental health professionals identify students whose presenting issues extend beyond casual occurrences of withdrawal or shyness.

Schools have a unique opportunity to assist in the early identification and treatment of SAD. The recording of student attendance, participation and engagement in social and group activities within school settings may help identify patterns and lead to early intervention for adolescents experiencing SAD. In addition to this, schools also provide an environment which is ideal for the participation in group-based activities for the treatment of SAD. Provision of treatment in the natural setting of the adolescent has been argued to enhance treatment outcomes [31].

4. Evaluation of evidence-based practice interventions for SAD in adolescence.

Several psychotherapeutic interventions and modalities have been evaluated for the treatment of SAD in adolescents. Sportel et al. [32] conducted a study with 240 adolescents experiencing SAD. The adolescents were placed in groups, a school-based CBT group, an internet based cognitive bias modification (CBM) program and a control group which did not have any interventions. The CBT group was based on the Clark and Wells [33] model of social anxiety, the model aims to address the underlying beliefs of the adolescent experiencing SAD. The model is recommended as the most effective treatment model for SAD by the National Institute for Health and Care Excellence (NICE) in the USA [34]. The study found that adolescents who were in the CBT group displayed most improvement at six months, however the improvements were no longer present when evaluated at 12 months following treatment. These findings were echoed by Kerns et al. [35]. They found that children treated with CBT for SAD had less improvement at 7.4 year follow up compared to at 1 year post treatment. Both studies indicate that CBT may not be effective for the long-term treatment of SAD. Furthermore, these findings suggest that adolescents require ongoing treatment, rather than short term interventions [32].

Silk et al. [36] compared CBT with CCT (child centered therapy) for 133 anxious young people. The CBT group were guided to identify anxious arousal, negative self-talk, develop coping self-talk, learnt muscle relaxation, self-evaluation and self-reward. The CCT interventions included the provision of empathy, genuineness, unconditional positive regard and therapist attentiveness. Unlike the previous studies considered, it found that youth who were in the CBT group were more

likely to maintain a full recovery at 1 year post treatment [36]. This suggests that rather than CBT wholly being effective for the treatment of SAD, it is the specific interventions within a CBT framework, when tailored to the adolescent's needs which are most effective.

Other interventions have also been evaluated for the treatment of SAD in schools. One such program which has been demonstrated to be effective is the Skills for Social and Academic Success (SASS). This program was developed by Masia-Warner and her colleagues and was based on the Social Effectiveness Therapy for Children (SET-C) model [31]. It consists of 12 group therapy sessions which are carried out in a school setting. Interventions include psychoeducation, exposure, goal setting, social practice activities and relapse prevention. It also aims to involve parents and teachers within the program, therefore providing a more holistic, developmentally informed intervention approach. The program has been found to be effective across several studies [37], however there is a reservation that because it is a school-based, low-intensity intervention the findings may not be true for treatment of clinically diagnosed adolescents experiencing SAD [4].

4.1 Developmental issues/challenges addressed by strategies.

One reason each of the strategies considered are capable of achieving positive outcomes with adolescents is the neuroplasticity of the adolescent brain [38]. This provides a unique opportunity for therapists to work with cognitive processes which are still developing during adolescence. This can be achieved through the cognitive training utlised in CBT models, the psychoeducation of the SASS program [31].

Interventions such as the social skills practice included in the SASS program target the psychosocial developmental issues resulting from SAD in adolescence [37][31]. Through the use of a group settings, all interventions outlined aim to provide opportunity for adolescents to form social connections within a safe environment since this is an important aspect of both their psychosocial development and their overcoming SAD.

The Clark and Wells [33] model for the treatment of SAD aims to address unhelpful underlying thoughts which may lead to anxiety symptoms. However, Leigh and Clark [4] argue that developmental influences need to be considered when using the model with adolescents, specifically consideration of the roles of parent and peer relationships within this lifespan stage. Despite this, it can be used as an effective intervention for adolescents experiencing SAD due to its targeting of cognitive developmental tasks of problem solving, objective viewing of one's thoughts and considering the views of others.

4.2 Intervention strategy implementation – by whom, where, when and at what age.

CBT interventions outlined may be implemented within a school setting by a CBT trained school counsellor. Since adolescence covers a large range of developmental abilities, it is important that interventions implemented are adapted to suit the age of the adolescent and their individual circumstances [4].

The SASS intervention is led by group leaders, who are generally trained counsellors. It incorporates 12 weekly in-school group sessions, 2 follow-up sessions to address relapse issues and 2 individual student consultations with the group leader. The program also includes a 4 social weekend event to promote social interaction outside of the school setting. Groups are usually small in number consisting of 3 to 6 students of a similar age, in an aim to reduce the possibility of participants feeling overwhelmed within larger groups. One of the distinguishing features of the SASS intervention is that peers of participants are involved in the program. Generally, those peers are other students who may have experienced SAD and completed the program previously. Through the inclusion of peers, the program aims to address several issues concurrently – social avoidance, friendship formation and social skill development. The intervention also allows for meetings with teachers and parents in order to provide psychoeducation and support information [31].

4.3 Evidence and efficacy of strategies for SAD in adolescence in school settings

The SASS has been found to be effective across several studies [23][37]. Despite this, SASS has been criticised as an intervention which may not be relevant to the treatment of clinically diagnosed adolescents due to its lack of rigidity [4].

Warwick et al. [39] carried out a meta-analysis of CBT interventions for children and adolescents experiencing SAD. They found that it was difficult to ascertain the effectiveness of interventions due to the broad range of outcome measures used to assess this. Furthermore, it is important to note that CBT interventions do not appear to consider factors contributing to the onset or presentation of SAD in adolescents. Those include familial relationships, temperament, cultural practices, shyness as a personality trait or genetic influences [12]. Finally in the studies previously outlined it is evident that CBT has inconsistently provided long-term positive outcomes for adolescents experiencing SAD [36][32]. Further study, a more rigorous and streamlined measure of outcomes is needed in order to effectively evaluate outcomes and efficacy of strategies for SAD in adolescence in school settings [39].

5. Conclusion

SAD during adolescence can hinder the young person's normative social, emotional, physical and cognitive development. It is therefore imperative that school welfare, counselling and teaching staff have an understanding of the characteristics of SAD. Since many young people experiencing SAD are unlikely to be formally diagnosed or engage with mental health professionals, interventions such as SASS and CBT by school counsellors, delivered within a school setting, may provide young people the only opportunity to receive support in overcoming this condition. Although further research is needed in regards to the treatment of SAD, findings suggest that there are positive outcomes associated with the interventions outlined in this paper.

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