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What is the Prevalence of Social Anxiety Disorder Among Adolescents in Ireland? How Does it Impact their Lives and How Do Schools Address it?

Social Anxiety Disorder (SAD) is the most common anxiety disorder encountered in adolescence. 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 supports are in place in schools to address it. The findings suggest that social anxiety is highly prevalent among adolescents who participated in this study and it has a significant impact on both their academic and personal lives. It also found that most teachers who participated are not confident in identifying or supporting students with social anxiety.

Key Words: *Social Anxiety Disorder (SAD), Adolescence, Prevalence, School Refusal Behaviour, School Interventions*

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INTRODUCTION

Research suggests that anxiety disorders are the most prevalent mental health issue facing adolescents today, yet they are largely undertreated (Siegel and Dickstein, 2011; Cartwright-Hattohasn et al., 2004). Most Irish studies focus on Generalised Anxiety Disorder (GAD), and do not look specifically at SAD (IPPN report, 2017; Dooley and Fitzgerald, 2012; Harvey, 2008; Martin, Carr, Burke, Carroll and Byrne, 2006). 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 can be as high as 13% (Sweeney et al., 2015; Brook and Schmidt, 2008). International research has stated that SAD can affect a person's quality of life, both at work and in school and their

relationships with others (Brook and Schmidt). It can have long lasting effects, potentially leading to depression and drug and alcohol misuse (Spence and Rapee, 2016). 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, 5th 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)*' (DSM-V, 2013).

SYMPTOMS

SAD exists on a continuum from mild to severe. Its symptoms 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 - giving a presentation, reading in class, asking/answering questions in class, participating in group exercises - leading them to stop attending certain classes or even refusing to attend school altogether (Nelemans, 2017; Blote et al., 2015). Kearney and Albano (2004) 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. Adolescents with severe SAD also engage in safety behaviours such as saying little and avoiding eye contact, in an attempt to reduce the likelihood of humiliating themselves (Kley et al., 2012). They attribute any

social successes to these safety behaviours thus maintaining the behaviour which in turn reinforces the anxiety and so the cycle continues (Spence and Rapee, 2016; Ranta et al., 2012).

SAD OR SHYNESS?

In some instances, SAD is mistaken for shyness (Masia-Warner et al., 2005). Heiser et al. (2009) outlined the difference between those who have SAD and those who are shy. In their study, the SAD group reported a significantly greater number of social fears than the shy group such as avoidance of social situations, negative thoughts, and somatic symptoms, such as blushing, shaking or sweating. 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 pre-requisite for SAD. 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 and increases the likelihood of depression during early adulthood (Spence and Rapee, 2016). Therefore, training teachers in how to identify SAD is essential.

WHY DOES SAD SPIKE IN ADOLESCENCE?

Research findings across many studies suggest that there is a spike in SAD symptoms in mid-adolescence (Nelemans et al, 2017; Ranta et al., 2012; Warren and Sroufe, 2004; Westenberg, et al., 2004). Developmental theory suggests that this is due to heightened self-consciousness and increased fear of negative social evaluation (Westenberg et al.). Erikson's (Baker-Smith, and Moore, 2015) theory of psychosocial development suggests that during the developmental stage that occurs between 12-18 years adolescents search for a sense of self while also wanting to fit in. Failure to establish a personal sense of identity within society may lead to establishing a negative personal sense of identity. Feelings of inferiority and negative self-images are common symptoms of SAD (Nelemans et al., 2017; Spence and Rapee, 2016; Ranta et al, 2012).

RISK FACTORS/CAUSES

Bronfenbrenner and Ceci's model of human development presents a transactional-ecological system of bi-directional influences that impact on development; varying

from proximal influences such as child temperamental vulnerability to more distal ones like family, school and community (Bronfenbrenner, 1994). International research has also found that there is a complex interplay between eight risk factors, which must be considered in the etiology of SAD:

- Biology and the structure of the brain (Caouette and Guyer, 2014)
- Behaviourally inhibited temperament (Rapee, 2014; Clauss and Blackford, 2012; Rapee and Spence, 2004)
- Cognitive factors; negative self-images/expectations (Spence and Rapee, 2016; Schreiber and Steil, 2012; Kley, Tuschen-Caffier, and Heinrichs, 2011)
- Social skills deficits and difficulty interacting (Spence and Rapee, 2016; Miers, Blote, and Westenberg, 2010; Masia-Warner et al., 2005)
- Peers and not belonging to a peer group (Poston, 2009; Ranta et al., 2009; Blote, Kint, and Westenberg, 2007; Greco and Morris, 2005)
- Gender (Ranta et al., 2012; Brook and Schmidt, 2008)
- Social Media (Lin et al., 2016; Prizant-Passal, Shechner, and Aderka, 2016; Shaw et al., 2015; Kittinger, Correia, and Irons, 2012)
- Culture with Asian countries reporting lower rates of SAD. This may be because shyness is not viewed negatively in these cultures (Spence and Rapee, 2016).

When we look at the risk factors for SAD it is important to consider equifinality (multiple developmental pathways); SAD may arise for any number of reasons such as an individual feeling they do not fit in with their peer group or because they have difficulty interacting. In the case of multifinality where the same risk factor has different outcomes, because an individual is shy does not mean they will develop SAD (Spence and Rapee, 2016). The combination of timing and circumstances surrounding the various risk factors is important as different factors may be more or less influential at different ages (Ollendick and Hirshfeld-Becker, 2002). Risk factors can be transactional and reciprocal, as young people influence their social environment, which, in turn impacts upon them (Spence and Rapee). One theory links biological, psychological and environmental factors into a diathesis-stress paradigm (Brook and 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 toward SAD for example, the less stress required to trigger it. This emphasizes the relationship between risk and protective factors in developing individuals (Brook and Schmidt).

METHODOLOGY

An instrumental case study was carried out to answer the research question. In instrumental case research the case, (i.e. a group of Irish adolescents in secondary school), facilitates understanding of something else, (i.e. prevalence of social anxiety (SA) among adolescents) (Mills, Durepos and Wiebe, 2010). The purpose of a case study is to show what it is like to be in a particular situation, to capture another person's reality, their lived experiences and their thoughts and feelings about a particular situation or topic making it ideal for this study (Cohen et al., 2011).

The research was carried out in two secondary schools in the west of Ireland; an urban girls' school and a rural boys' school. Questionnaires were administered to junior (JC) and leaving certificate (LC) classes in the two schools to determine if SAD was prevalent in one age group over another or in one gender over another. Questionnaires were also administered to teachers and Guidance Counsellors (GCs). Participants numbered 238; 154 girls, 65 boys, 17 teachers and one GC from each school. This research was carried out ethically with respect shown for all participants (BERA, 2011). All participants volunteered to take part and signed an informed consent form before completing the questionnaire. Those under the age of 18 years also needed parental consent.

A mixed methods approach was used, including questionnaires and semi-structured interviews. Questionnaires were chosen as the main research tool because they guaranteed anonymity and large amounts of information could be collected from a large number of people in a short period of time (Newby, 2014). The student questionnaire included 13 questions and the Leibowitz Social Anxiety Scale (LSAS). This added another 24 questions; 13 concerning performance anxiety and 11 examining social situations. The 24 items are first rated on a Likert Scale in terms of fear felt during the situation and avoidance of the situation. The total scores for the Fear and Avoidance sections are combined to provide an overall score. The maximum score is 144 points. Scores in the 0-54 range indicate little or no SAD, 55-65 Moderate, 66-80 Marked, 81-95 Severe and >95 Very Severe. The LSAS is one of the most commonly used clinician-administered scales for the assessment of SA and many studies have confirmed the reliability, validity and treatment sensitivity of this scale (Baker, Heinrichs, Kim and Hofmann, 2002; Heimberg et al., 1999). Social Anxiety Ireland also provides access to this scale on their website (www.socialanxietyireland.com). The semi-structured interview with the GC from each school provided a broader picture of what was happening at the school, whether many students were seeking help on this issue and what type of training, school policies and supports were in place.

While the results of such a focussed study cannot be generalised to the whole population, it may provide unexpected results which may lead to research taking new directions. It may also provide valuable information for the schools in question; to inform teaching practices and students self-development.

FINDINGS

1. What is the Prevalence of SAD among adolescents in two secondary schools in the West of Ireland?

Table 1. The Number of Students who claim to experience SAD

	LC	JC
Girls	54 (67.5%)	43 (58%)
Boys	4 (13.8%)	5 (13.8%)

Table 2. Results of LSAS

<table>
<tr><th>Cut-off scores</th><th></th><th>Little/No SAD (0-54)</th><th>Moderate (55-65)</th><th>Marked (65-80)</th><th>Severe (80-95)</th><th>Very Severe (>95)</th><th>Incom-plete</th></tr>
<tr><td rowspan="2">JC Students</td><td>Girls</td><td>39*</td><td>6</td><td>12</td><td>12</td><td>5</td><td>o</td></tr>
<tr><td>Boys</td><td>20*</td><td>6</td><td>0</td><td>0</td><td>2</td><td>6</td></tr>
<tr><td rowspan="2">LC Students</td><td>Girls</td><td>26*</td><td>8</td><td>11</td><td>9</td><td>15</td><td>0</td></tr>
<tr><td>Boys</td><td>7*</td><td>2</td><td>1</td><td>1</td><td>1</td><td>4</td></tr>
</table>

*A number of students scored close to the cut-off point. Even though they do not meet the cut-off score for diagnosis, they still experience significant social anxiety in specific situations, highlighting the need for a universal approach to treatment.

The findings of this study suggest that SAD is highly prevalent among the participants and more so in females (see Table 1 and 2). In this study at least one in two girls and approximately one in four boys met criteria for SAD on the LSAS.

More severe SAD among senior girls

The results of the LSAS showed that three times as many senior girls than junior girls had severe SAD and twice as many had co-morbid conditions such as panic

attacks and depression. This may indicate that the longer you have SAD, the more severe it gets and the greater the likelihood of co-morbid conditions. A longitudinal study would be necessary to confirm how SAD develops over time.

2. 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 triangulation among participants. The symptoms cited as having the biggest impact on school performance were fear of participating in class and avoiding school.

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. A sample of the symptoms and personal experience of SAD cited by LC and JC girls and boys are presented in Tables 3, 4, 5 and 6 below.

Table 3. Symptoms of SAD cited by LC Girls

Symptoms	**Frequency**
'Nervous in groups or crowds or social situations'	77
Physical symptoms such as *'Sweaty palms' 'Tight chest' 'rapid breathing' 'fidgeting' 'Sweating' 'shakey' 'feeling sick'*	72
'Dread participating in class'	52
'fear of communication or talking to others'	43
'feeling awkward', 'Self-conscious'	24
'avoiding situations' or 'withdrawing'	22
'feeling panicky', 'panic attacks'	22
'very scared' and 'worried'	18
'skipping school', 'difficult to come to school'	12
'Difficulty making friends'	9
'Low self-esteem' 'lacking confidence'	8

Table 4. Symptoms of SAD cited by LC Boys

Symptoms	Frequency
'Anxiety in social situations, school or parties', 'Feeling very nervous in public', 'feeling nervous/awkward/uncomfortable in front of other people'	22
'Feeling nervous to talk', 'stressed about communicating with friends or teachers'	17
'afraid to speak out in class', 'unable to respond to or ask questions'	14
Physical symptoms such as: *Nausea, hyperventilation, sweating, stuttering, going red in public, headaches, emotional fits, panic attacks, loss of breath, difficulty speaking, sleep deprivation, fidgety, stressed out, nervousness*	10
Absenteeism 'May not go to school'	8
'Feel stupid', 'Lack confidence', 'self-conscious'	7
'Shut yourself off', 'Isolate yourself', 'feel they have no one to talk to'	7
'quiet'	7

There was significant overlap between the LC boys and girls with the top nine symptoms being identical for both groups.

Table 5. Symptoms of SAD cited by JC Girls

Symptoms	Frequency
Physical symptoms such as '*Heart racing', 'Fidgeting', 'Biting my nails', 'shaking', 'sweating', 'tight chest' 'shortness of breath', 'blushing' 'feeling sick'*	45
'Fear of talking or communicating'	40
'fear of participating in class'	51
'nervous in social situations'	30
'Skip school', 'Stay at home'	22
'*Feeling awkward', 'self-conscious'*	15
'Avoid social situations', 'withdraw'	14
'Scared', 'worrying'	12
'Low self-esteem', 'low confidence'	8
'Crying', 'upset'	6
'Hard to make friends'	5

Table 6. Symptoms of SAD cited by JC Boys

Symptoms	Frequency
'Nervous and uncomfortable in social situations', 'Don't want to be around other students'	19
'can't talk to people in groups of one to one', 'scared to talk to teachers'	18
'Afraid to read out loud', 'afraid to ask questions', 'feel sick when asked to speak'	14
'don't go to school', 'isolated and withdrawn', 'lose friends'	11
'Anxiety', 'stress', 'fear', 'panic attacks'	10
'Distracted', 'overthinking'	8
'Fear of being judged', 'fear of being center of attention', 'fear of being laughed at'	6
'Feel stupid', 'low confidence'	4

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

These symptoms are typical of SAD (Rapee and Spence, 2012) with one symptom possibly causing another. For example, poor social skills may lead to peer rejection, which can cause feelings of isolation and of being misunderstood which in turn reinforces the SAD (Spence and 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 programmes could be delivered as part of the school programme to address this issue.

Social Media

The students did not place much focus on social media as a cause of SAD, while half the teachers and one GC cited it as a main cause. While there was no specific question in the study about social media this information was volunteered in a question about what causes SAD. Studies have suggested that social media can have some negative effects on a person's mental health (Schurgin O'Keeffe and Clarke-Pearson, 2011). However, there is still no evidence to suggest it causes SAD (Lin et al., 2016; Kittinger, Correia and Irons, 2012). Research suggests that

there are multiple pathways to SAD (Spence and Rapee, 2016). Therefore, the causes of SAD are not pre-determined.

3. How do schools address SAD?

Table 7. Current support in the two participating schools

Supports/Protective Factors	LC		JC	
	Yes	No	Yes	No
Do you receive talks/classes on social and emotional wellbeing?	(G) 43	37	40	30
	(B) 10	19	14	17
Do you get talks on looking after your mental health?	(G) 55	24	38	32
	(B) 11	18	17	17
Do you receive information on how to access support for anxiety?	(G) 20	59	27	45
	(B) 12	15	11	21

There is a discrepancy in the figures presented in Table 7 above. Several of the female LC students said the talks on social and emotional well-being '*are rare*', or '*are not effective*' and are '*out of touch with what students are really going through*'. This was supported by the female JC students who felt they '*don't cover social and emotional wellbeing or mental health issues enough*'. In addition to this, many female LC students said they '*don't get talks often*' on looking after their mental health, stating their most recent talks were in the Junior cycle, Transition Year and a general talk on mental health in 5th year. The majority of the boys also stated that they did not receive talks. Over half of the female LC (48) and JC (45) students cited a variety of people that they could go to for support, such as, the guidance counsellor, a helpful teacher, SNAs and the chaplain. Nonetheless, there were still many girls who felt there were very few supports in place or didn't know what supports were available. The boys did not elaborate on these questions and simply answered yes or no. In contrast to this, 12 out of 13 teachers/SNAs in the girls' school and 4 out of 6 in the boys' school said there were supports in place.

The majority of students agreed that talking and listening were essential to support those who suffer with SAD and educating others and raising awareness of the condition was paramount. Given the high prevalence of SAD that this research has uncovered, 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 and 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 throughout the school year to maintain awareness.

BARRIERS TO SUPPORTS

The main barriers to supports, consistent with the literature, were lack of time, shame, stigma around mental health issues, teacher training and parental acceptance (Shevlin et al., 2013; Ryan and Masia-Warner, 2012; HoganBruen et al., 2003; Olfson et al., 2000). In this study only six out of thirteen teachers in the girls' school felt confident supporting these students and nine teachers felt more should be done for these students. Four out of six teachers in the boys' school said there were supports in place but only three of the six felt confident supporting these students with five of the six saying more should be done to support them. This would suggest that training for teachers is essential. Shevlin et al. found that teachers in Ireland do not have confidence in their skills to manage the emotional needs of their students. With students hiding their symptoms, it becomes more difficult for teachers to identify and so the students continue to suffer in silence.

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.

DISCUSSION

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 many schools are unaware that they will visit schools and provide workshops (https://www.stepoutireland.com). In addition to this, schools could introduce evidence-based Social Skills Training (SST) programmes that have been shown to have much success addressing SAD (Beidel et al., 2014). Skills for Academic and Social Success (SASS) and Social Effectiveness Therapy for Children (SET-C) use a combination of exposure therapy, peer generalisation and group social skills training (Beidel et al., 2014; Beidel, Turner and Young, 2006; Masia-Warner et al., 2005). 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 program can use outgoing students to practice social skills (Masia-Warner et al.).

If SAD is as prevalent as the findings from this study suggest (one in two girls and one in four boys), it is vital that schools allocate time to address it. It is worth noting that less than half of the junior cycle boys knew what SAD was and it is also possible that boys feel they cannot admit experiencing SAD due to gender stereotyping (Brook and 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. More than half the teachers surveyed and both GCs underestimated how prevalent SAD was and only half of the teachers were confident identifying it. Furthermore, almost half of 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 would be helpful for teachers in Irish post-primary schools. The findings from this study 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 would be very beneficial for the senior cycle also.

Schools provide unique access to adolescents (Adelman and Taylor, 1999) and school interventions reduce financial barriers to treatment. Furthermore, by offering support in familiar settings like schools, it 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. found that the benefits of school-based interventions equalled clinic-based treatments 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: the prevalence of SAD among adolescents in two secondary schools in the West of Ireland; its impact on students' lives; and the supports 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 include the 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. Raising awareness, training teachers and students and providing workshops, ensures that as many protective factors as possible are in place. A whole school, multi-level approach to education, prevention and intervention is paramount to sustain long-term change (Winett, 1998).

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