

About Social Anxiety and Schools

Social anxiety involves more than shyness. It is about being extremely anxious in social situations, and often is called social phobia. With the publication of fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), social phobia is now formally diagnosed as Social Anxiety Disorder (SAD). This resource highlights causes and effects and explores how school-based interventions can help address the problem.

What is Social Anxiety Disorder?

When anxiety is disruptive, it is associated with a host of cognitive, behavioral, and emotional problems. When the problems are pervasive and severe, they may be diagnosed as anxiety disorders. However, caution is warranted since most students who have problems and appear or indicate that they are anxious are not disordered and should not be treated as having a psychopathological condition. And, as in so many instances with young children, it is difficult to determine causality and so diagnosis relies on correlates that are seen as symptoms.

A diagnosis of Social Anxiety Disorder is meant to denote a condition that is highly disruptive of the daily functioning and that requires significant intervention. The diagnosis is intended for those for whom social interactions consistently provoke distress and whose fear or anxiety is out of proportion (in frequency and duration) to the situations they are experiencing. An individual's distress or impairment must be significant; symptoms must be present for at least six months.

Criteria also include that social interactions are either avoided or painfully and reluctantly endured and that the individual's problems often are specific to social settings where the person feels concern about being noticed, observed, judged, embarrassed. In such settings, the individual fears displaying anxiety and experiencing social rejection. The anxiety and fear usually is accompanied by autonomic arousal (e.g., blushing, sweating, trembling, tachycardia, even nausea).

The symptoms may arise in reaction to strangers or acquaintances. In children, the behavior must be age appropriate and occur in settings with peers rather than in interactions with adults. For example, young children may display extreme clinging; severe, prolonged crying or tantrums; become physically immobilized or shrink away from others; be unable to speak in social situations.

Diagnosticians are cautioned that the various symptoms can arise from a medical disorder, adverse medication effects, or other anxiety disorders, depression and substance abuse disorders, and other conditions which cause the individual to be excessively self conscious. Moreover, care must be taken not to see shyness and introversion that are within normal limits as an anxiety disorder.

A few examples of how social anxiety might be experienced by a student

"I wanted to ask the teacher a question, but I was are afraid I would sound stupid."
"I dread reading out loud because I might pronounce something wrong or skip a word."
"I walked in and saw some friends whispering and laughing. I felt they were laughing at me. Even when they promised they weren't, I couldn't help worrying."
"I agonized over a paper I was writing because I was afraid it would judged as 'bad.'"

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As noted by the National Institute of Mental Health (2014):

Occasional anxiety is a normal part of life. You might feel anxious when faced with a problem at work, before taking a test, or making an important decision. But anxiety disorders involve more than temporary worry or fear. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships. ...

So, while students often feel anxiety about some activities at school, those with a social anxiety disorder usually are terrified. They frequently behave in ways that lead others to avoid and even reject them. The lack of normal interactions with peers can negatively affect social and emotional and other areas of development. In turn, this can exacerbate an individual's social anxiety. In addition, problems tend to generate other problems. Social anxiety can lead to loneliness and isolation, and the lack of social contacts can lead to depression and to substance abuse.

Onset and Prevalence

Social phobia usually starts during youth. According to best estimates as reported in the DSM-5:

- The median age of onset of social anxiety disorder in the US is age 13, with 75% of those with social anxiety disorder experiencing the onset at a range of ages 8-15. The onset can either be insidious, or sudden onset triggered by a specific event.
- The annual prevalence of social anxiety disorder is 7%, in both children and adults in the United States.

Causes and Correlates

While there is considerable agreement about the symptoms of social anxiety, causes remain speculative. Some theories focus on inborn temperamental qualities; others focus on child rearing experiences; still others focus on school and peer factors. For example, Brook and Schmidt (2008) highlight as correlates of social anxiety (a) family environment (e.g., parental overcontrol and rejection), (b) economic status (e.g., poverty in developing countries), and (c) gender and gender roles (e.g., females have higher rates of SAD than males at a ratio of 3:2). Brain researchers are exploring several areas related to fear and anxiety, and considerable research focuses on how stress and environmental factors play a role.

Schools, of course, are sources of interpersonal stressors and thus can contribute to the development of a range of learning, behavior, and emotional problems, including social anxiety. Students experience pressures to both conform and change (e.g., as a result of enforcement of rules, norms, and standards by peers, family, school staff). Daily interpersonal interactions with teachers and other staff and peers are especially difficult for some students. Differences in background, appearance, language, social and emotional development, all can affect whether a student fits in or not. Not fitting in can lead to being isolated, rejected, and even bullied and coming to school each day fearful and anxious.

Do you ever get stage fright?



No, I'm not afraid of the stage.
It's the audience that scares me.

A Few Bits from the Research Literature

Research suggests that some social anxiety stems from misreading others' behavior. For example, think about times you have perceived people as staring or frowning at you and then found out they were not. Other research points at weak social skills. For instance, students with weak social skills may feel discouraged after interacting with others and may worry about future contacts. Children and adolescents also may create a distorted image of themselves (e.g., with respect to their appearance and social skills). Those with social anxiety do this excessively, and this produces anxiety related symptoms. Additionally, those with social anxiety tend to perceive their audience as having higher expectations for them than the individuals have for themselves and overestimate how visible their social anxiety symptoms may appear. Socially anxious children and adolescents also tend to report more anxiety symptoms in formal situations and opposite sex interactions (Rapee & Barlow, 2002).

Gresham, Vance, Chenier, and Hunter (2013) review research suggesting that students with social anxiety are more likely to miss school and experience "a myriad of difficulties that leave them unfit for a successful life."

A study by Terlecki and Buckner (2015) found that a sample of adolescent students with clinically elevated social anxiety developed drinking related problems. They concluded that the heavy situational drinking could be jointly attributed to desire to cope with negative affect and to avoid social scrutiny. That is, socially anxious students seemed to drink more to cope with negative affect and avoid negative evaluation and ridicule from alcohol-using peers and also to cope with their social anxiety and to reduce it.

Masia Warner and colleagues developed a program that drew from "empirically supported techniques and could be feasibly implemented in schools. The school-based program, *Skills for Social and Academic Success* (SASS), was derived from Social Effectiveness Therapy for Children (SET-C), an empirically supported, clinic-based treatment that consists of 12 individual sessions of behavioral exposures, 12 group sessions of social skills training, and unstructured peer generalization exercises in which socially anxious children practice socializing with nonanxious peers. The emphasis of SET-C on using peers to assist with generalization fits well with the natural availability of same-age peers in the school environment. Clinical trials have demonstrated the efficacy of SASS for adolescents compared with a waiting list³² and even a credible attention control." As reported in Ryan & Masia Warner (2012). For more on this and other school-based intervention, see Masia Warner, Colognori, Brice, & Sanchez (2015).

Interventions

Clinically, social anxiety disorders generally are treated with psychotherapy, medication, or both. Over the years, research has found that Cognitive Behavioral Therapy (CBT) with an emphasis on exposure can reduce symptoms of social phobia. (Exposure involves gradually placing oneself in anxiety provoking situations and associating the feared stimulus with a response of relaxation or indifference). This is also known as systematic desensitization. CBT aims at changing the way students perceive their situations, while simultaneously providing healthy coping mechanisms (e.g., learning and practicing social skills).

Medication often is used -- sometimes alone and often in conjunction with behavioral therapies. For example, selective serotonin reuptake inhibitors (SSRIs) often are prescribed to reduce anxiety symptoms. (See Appendix A for more on medications used and concerns about side effects.)

As with all learning, behavior, and emotional problems, schools must think strategically about how best to play a role in watching for and addressing such problems. Since many students experiencing problems don't seek help, schools need a proactive system in place.

A well-developed system of student and learning supports is unified, comprehensive, and equitable. It helps to personalize instruction and provide special assistance (including accommodations) as needed. Such a system not only can provide a better instructional fit, it facilitates student transitions by providing academic and social supports and quickly addresses school adjustment problems. And it enhances home involvement and engagement in the student's schooling. For effective implementation, the system must be fully embedded into school improvement policy and practice and include a continuing education facet for all school staff.

Key in all this, from a psychological perspective, is minimizing threats to and maximizing strategies that enhance feelings of (a) competence, (b) self-determination, and (c) connections to significant others. At schools, a daily focus on these matters is essential, and schools need to work with students' families to enhance their understanding of how such a focus can help ameliorate problems.

Schools also need to communicate and work collaboratively with primary providers who are treating such youngsters. As with all youngsters experiencing significant learning, behavior, and emotional problems, some special assistance (including accommodations) will be necessary. Primary providers and family members can provide information about what the school might do, and the school can provide information back based on the student's responses to school interventions.

School's Might Help with Exposure Intervention

For example, a student support staff member might work with a student to develop a fear hierarchy that rank orders the anxiety-provoking situations, beginning with the least-feared situation. Guided exposures at school provide a realistic context, a variety of settings, and can be personalized. Some common exposures for socially anxious students include accompanying a student to the cafeteria to initiate conversations with peers or to purchase and return food, ask questions of the librarian, visit the main office and speak to administrative staff, or seek out assistance from a teacher. With support, the student might join a club that matches her/his interests. Beside pursuing exposure techniques, student support staff can help a student evaluate the evidence for specific fears (e.g., about being treated badly by peers) and can help connect them with a peer buddy who is prepared to help. Peer buddies can assist with exposures and skill practice and attend social events with their socially anxious peer.

For more on what schools can do, see Appendix B.

Concluding Comments

Remember that occasional anxiety is a normal part of life. It becomes a significant mental health concern when the anxiety does not go away and interferes with daily activity and relationships. As with all mental health concerns, schools must be prepared to play a role in addressing anxiety problems. This is essential not only for improving the lives of students but is in the spirit of the recently passed *Every Student Succeeds Act*.

At the same time, schools must not pursue each problem that is named as a special program or initiative. Over the years, we have seen many folks advocate for special initiatives at schools to address mental health education and almost every mental disorder (e.g., depression, suicide, social anxiety), substance abuse, etc. While addressing specific problems in schools may be well-intentioned, the tendency to implement new initiatives in a piecemeal manner increases what is an already highly fragmented approach to tackling problems at school, home, and in the community. Even worse, this type of systemic tinkering contributes to the ongoing marginalization of efforts to develop a unified, comprehensive, systemic, and equitable approach to addressing a full range of overlapping learning, behavior, and emotional concerns.

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*Many related resources are included in the Center's online clearinghouse Quick Finds. See, for example, the Quick Find on *Anxiety* – <http://smhp.psych.ucla.edu/qf/anxiety.htm> .

Appendix A

About Medication

From: National Institute of Mental Health

<http://www.nimh.nih.gov/health/publications/social-phobia-social-anxiety-disorder-always-embarrassed/index.shtml>

... The most commonly prescribed medications for social phobia are anti-anxiety medications and antidepressants. Anti-anxiety medications are powerful and there are different types. ... they generally should not be taken for long periods.

Antidepressants are used to treat depression, but they are also [used] for social phobia. They are probably more commonly prescribed for social phobia than anti-anxiety medications. Antidepressants may take several weeks to start working. Some may cause side effects such as headache, nausea, or difficulty sleeping.
...

A type of antidepressant called monoamine oxidase inhibitors (MAOIs) are [used] in treating social phobia. However, they are rarely used as a first line of treatment because when MAOIs are combined with certain foods or other medicines, dangerous side effects can occur.

It's important to know that although antidepressants can be safe and effective for many people, they may be risky for some, especially children, teens, and young adults. A "black box" — the most serious type of warning that a prescription drug can have — has been added to the labels of antidepressant medications. These labels warn people that antidepressants may cause some people to have suicidal thoughts or make suicide attempts. Anyone taking antidepressants should be monitored closely, especially when they first start treatment.

Another type of medication called beta-blockers can help control some of the physical symptoms of social phobia such as excessive sweating, shaking, or a racing heart. They are most commonly prescribed when the symptoms of social phobia occur in specific situations, such as "stage fright."

Appendix B

Students in Distress

Here are six immediate strategies for teachers to consider:

- (1) Be alert to students in distress, but don't rush to diagnose and label their problems.
- (2) Talk with the students (individually or, as feasible, in small groups) and try to determine if the source of the problems are related to experiences at school. Find out what the students like and dislike about school and why. Encourage full expression of concerns.
- (3) If you haven't the time or feel uncomfortable talking with students about such matters, ask a member of the school's student support staff (e.g., the school's counselor, psychologist, social worker) to come to the class and find natural opportunities to observe, interact, and talk with the students about experiences at school and elsewhere.
- (4) Based on what is learned from and about any student, a decision must be made about whether the noted distress is so *severe* that an immediate conference with the family is needed to discuss the problem and what to do. Ask a member of the school's student support staff to participate and add their expertise at the conference.
- (5) If the problem is not deemed a crisis, work with the student to improve school experiences. For example, plan and implement classroom changes to build on the student's interests and strengths and address needs by minimizing negative experiences and increasing academic, social, and emotional supports and accommodations.
- (6) If the student continues to appear distressed, schedule another problem solving conference with the family to explore what additional student and learning support options are available at school and in the community. Again ask a member of the school's student support staff to participate.

Three General Matters for Schools to Consider in Helping Teachers Address Students in Distress

Bringing Support into the Classroom. Identification of students who are troubled and troubling occurs each day at schools. Given that most teachers and student support staff are painfully aware of such students, it seems ironic that there is a push for schools to formally screen mental health concerns such as depression and suicide. The big problem for schools is not identification of students in need; the first problem is effectively providing these students with added supports in the classroom. Schools need to revamp student and learning supports so that student support staff are teamed with teachers and are available to do some of their work directly in classrooms to assist teachers in strengthening the support for students of concern. As described above, this will help in deciding the nature and scope of the problem and what to do immediately.

Connecting with out-of classroom and community supports. After enhancing student and learning supports in the classroom, the school's must be prepared to connect students who need more help to schoolwide, district, and community student and learning supports. With this in mind, see *Rebuilding for Learning: Addressing Barriers to Learning and Teaching and Re-engaging Students* – <http://smhp.psych.ucla.edu/rebuild/RebuidlingV11RD28.pdf>

Enhancing Professional Development. Currently, the focus of most school improvement and thus professional development for teachers and other school professionals tends to marginalize efforts to enhance understanding and action related to addressing the many barriers to student learning. This is especially a problem in schools in economically downtrodden neighborhoods where many students experience a high and constant level of traumatic stress. A good place to start identifying relevant staff development resources is our Online Clearinghouse Quick Finds – <http://smhp.psych.ucla.edu/quicksearch.htm>. Each covers a great many topics related to students' emotional, behavioral, and learning problems.