*Psychiatria Danubina, 2012; Vol. 24, Suppl. 1, pp 125–127* *Conference paper*


# IMPACT OF FAMILY AND SCHOOL ENVIRONMENT ON THE DEVELOPMENT OF SOCIAL ANXIETY DISORDER: A QUESTIONNAIRE STUDY

**Joanna Bracik, Krzysztof Krysta & Adam Zaczek**

*Department of Psychiatry and Psychotherapy, Medical University of Silesia Katowice, Poland*

## *SUMMARY*

***Background:*** *Social anxiety disorder (SAD) is a very common condition, although its prevalence is believed to be underestimated. The affected subjects often have trouble to search for support. The onset occurs mainly in early adolescence. The aim of this paper was to evaluate the impact of school and family background on the development of SAD.*

***Subjects and methods:*** *Our survey, available on a popular social network site, was divided into 4 parts: 1) demographic data (gender, age, site of residence), 2) genetic and organic background (comorbid mental disorders, addictions), 3) situation at school and in the family environment during adolescence, 4) the part designed to define the group that may suffer from SAD with the use of the Mini-Social Phobia Inventory (Mini-SPIN).*

***Results:*** *226 people were recruited. The age range was 16-61, with the average of 25,8. 71% of the respondents lived in cities with a population of more than 100 000. Male to female ratio was 3:1. According to Mini-SPIN 26,5% of the interviewees might suffer from SAD (28.2% of women and 21.4% of men). Our study showed, that both family and school environment factors have an influence on the development of SAD. It was shown that the especially important risk factors are bad relations with peers and being an object of derision at school.*

***Conclusion:*** *The percentage of network community users that are likely to suffer from SAD, significantly exceeds the clinical data. Both family and school environment factors were shown to be risk factors for the development of this disorder.*

***Key words:*** *social anxiety disorder - risk factors - family background - school environment*

* * * * *

## INTRODUCTION

According to DSM-IV criteria (1994) generalized SAD manifests with marked and persistent fear of social situations, in which the person may be judged by others. Anticipation of embarrassment and humiliation due to revealing symptoms of stress (blushing, sweating, trembling and also difficulties in speaking and making eye contact) on these occasions, enhance those symptoms. The person avoids social situations or endures them with considerable distress and anxiety, even though one is aware, that this fear is excessive and unreasonable. This leads to a significant reduction of the quality of life.

This condition is one of the most common manifestations among neurotic disorders (Furmark 2000) affecting 7% of the European population (Lecrubier et al. 2000). Lifetime prevalence rate reaches 13.3% (Timothy & Saeed 1999). This figures are discussed and by some authors and are considered as inaccurate. On the one hand diagnostic criteria are considered to be not restrictive enough, and on the other hand people affected with SAD tend to have trouble with reaching out for help (Wakefield et al. 2004).

According to the report of the National Institute of Mental Health (2009) the onset of symptoms occurs mainly in early adolescence. Substance abuse (alcohol, drugs, benzodiazepines) and genetic background increase the risk of the development of SAD (Book & Randall 2006, Kendler et al. 1999). The situation is similar when it comes to negative experiences in childhood. The influence of education and family background is still considered to be unclear (Brook & Schmidt 2008).

The aim of our study was to investigate this vague impact of the above-mentioned major life conditions on the development of SAD. Also the form of the internet survey was used to assess the prevalence, as it seems to be the most comfortable for people potentially affected with this condition.

## SUBJECTS AND METHODS

### Subjects

Our survey, being available on a popular social network site from 16.03.- 15.04.2012, consisted of 12 questions divided into 4 sections. The first one concerned the demography, identifying gender, age, and site of residence (village or city, depending on the number of inhabitants). The second one was designed to investigate genetic and organic background. It contained questions about close and distant relatives affected with SAD and occurrence of it, and other often comorbid diseases, (depression, dysthymia, panic attacks) in interviewees. We could also find out if respondents were addicted to alcohol, drugs or benzodiazepines. The third section dealt with the situation at school and the family environment during adolescence. It included questions about having been raised by parents (both/ mother/ father), other persons or institutions, and if they had had

too high demands. We also wanted to know if the surveyed were victims of abusive behaviours and could not have received proper support. When it comes to educational factors, relationships with teachers and peers were investigated. We also asked if the respondents were objects of derision caused by schoolmates. Another question concerned the preference of team sports. In the last section, we have placed Mini-SPIN, to define the group that may suffer from SAD.

Filling out our anonymous questionnaire was an equivalent of consent to the processing of derived data.

### Methods

Mini-SPIN is a compact screening instrument for SAD. It is composed of three questions to be answered, using Likert scale (0-4 points for replies from "not at all" to "extremely"). Those questions are constructed to measure the level of fear, embarrassment and avoidance in the context of social situations. With a cutoff of 6 or more points, its sensitivity and specificity reaches 88.7% and 90.0% respectively (Connor et al. 2001). We used it to identify respondents that might be affected with SAD. The next step was to calculate their percentage in groups, that gave the same response to particular questions.

## RESULTS

226 people were recruited. Age range was 16-61, with average age of 25.8. 71% of respondents were from cities with a population of more than 100 000. Male to female ratio was 3:1. According to Mini-SPIN, 26.5% of the interviewees might have suffered from SAD (28.2% of women and 21.4% of men).

Analysing family factors (Table 1) we can see that following percentage of respondents in groups, that gave the same answers, meet the criteria for SAD. 30.6% in the group not raised by both parents and 25.8% of subjects raised in a complete family. 38% of those who at least sometimes experienced unrealistically high demands, and 21.3% of those, who hardly ever experience them. 34.7% of interviewees, whose carers were at least sometimes abusive, and 20% of those without such experience. When it comes to the support of elders, the percentage was 30.4%, in case of those, who could not have always counted on it, and respectively 20.4% in case of those, who could.

Applying the same pattern to educational factors (Table 2), we can observe the proportion of respondents, who received a score of 6 or more points in Mini-SPIN and had not had good relations with peers (62.2%) and of those, who had (19.6%). In this subgroup the proportion was 30% in the case of those, who used to have bad relations with teachers and 26.4% of those, who used to have good relations with teachers. The percentage 51.1% referred to the interviewees who had been object of derision and 20.4% to those, who had not. And, by comparison, 28.6% to those without a preference of team sports and 20.7% to the respondents who declared it.

**Table 1.** Results of the analysis of family environment factors

| Question | Reply | Total number of respondents | Respondents affected with SAD | Percentage of respondents affected with SAD (%) |
|---|---|---|---|---|
| Both parents present during adolescence | + | 190 | 49 | 25.8 |
| | - | 36 | 11 | 30.6 |
| Parents - always supporting | + | 88 | 18 | 20.4 |
| | - | 138 | 42 | 30.4 |
| Parents - never abusive | + | 125 | 25 | 20.0 |
| | - | 101 | 35 | 34.7 |
| Too high demands - never or rarely | + | 155 | 33 | 21.3 |
| | - | 71 | 27 | 38.0 |

**Table 2.** Results of the analysis school environment factors

| Question | Reply | Total number of respondents | Respondents affected with SAD | Percentage of respondents affected with SAD (%) |
|---|---|---|---|---|
| Good relations with teachers | + | 216 | 57 | 26.4 |
| | - | 10 | 3 | 30.0 |
| Good relations with peers | + | 189 | 37 | 19.6 |
| | - | 37 | 23 | 62,2 |
| Being not an object of derision | + | 181 | 37 | 20.4 |
| | - | 45 | 23 | 51.1 |
| Preference of team sports | + | 58 | 12 | 20.7 |
| | - | 168 | 48 | 28.6 |

## DISCUSSION

According to the above results, over one fourth of the examined participants are likely to suffer from SAD. This percentage significantly exceeds the data derived from other studies (Heimberg et al. 2000). We should note at this point, that people with a particular distress are probably more inclined to fill in the questionnaire respecting their condition. Nevertheless, this form appears to be the most comfortable research tool for them, which may also decrease the results, in studies performed in another way. The family background seems to have a remarkable influence on the development of SAD, although the data from the literature are sometimes inconsistent (Merikangas et al. 2003). Especially, such agents as being raised by people with abusive behaviours and too high expectations toward protégés. It occurs that the lack of support in childhood also plays an important role in this matter. By comparison, these types of factors have been already discussed in other anxiety disorders, such as GAD (Gosselin & Laberge 2003). We have a similar situation, when it comes to educational factors. Of particular note are bad relationships with peers. This seems to be the element of prominent significance, in the context of developing SAD, as opposed to bad relationships with teachers, which did not reveal this level of interdependence. Another substantial result concerns being an object of derision in childhood. As in the case of bad relationships with peers, over one half of the examined group, that dealt with such situation, meets the criteria for SAD. These findings show the importance of the development of preventive programmes at schools, which has been advocated by other authors (Essau et al. 2012).

## CONCLUSION

SAD is a frequent disorder of a possibly underestimated prevalence. Both family background and educational factors have an impact on its development. Bad relationships with peers and being an object of derision in childhood, play an explicit role in this process.

***Acknowledgements:*** None.

***Conflict of interest:*** None to declare.

*Correspondence:*

*Krzysztof Krysta*
*Department of Psychiatry and Psychotherapy,*
*Medical University of Silesia*
*ul. Ziołowa 45/47, 40-635 Katowice, Poland*
*E-mail: krysta@mp.pl*

## REFERENCES

1. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). APA, Washington, DC, 1994.*
2. *Book SW & Randall CL: Social anxiety disorder and alcohol use. National Institute of Alcohol Abuse and Alcoholism 2006.*
3. *Brook CA & Schmidt LA: Social anxiety disorder: A review of environmental risk factors. Neuropsychiatr Dis Treat 2008, 4:123–43.*
4. *Connor KM, Kobak KA, Churchill LE, Katzelnick D & Davidson JR: Mini-SPIN: a brief screening assessment for generalized social anxiety disorder. Depress Anxiety 2001; 14:137-40.*
5. *Essau CA, Conradt J, Sasagawa S & Ollendick TH: Prevention of anxiety symptoms in children: results from a universal school-based trial. Behav Ther 2012; 43:450-64.*
6. *Furmark T: Social Phobia. From Epidemiology to Brain Function. Acta Universitatis Upsaliensis 2000; 97:8.*
7. *Gosselin P, Laberge B: Etiological factors of generalized anxiety disorder. Encephale 2003; 29:351-61.*
8. *Heimberg RG, Stein MB, Hiripi E & Kessler RC: Trends in the prevalence of social phobia in the United States: a synthetic cohort analysis of changes over four decades. Eur Psychiatry 2000; 15:29-37.*
9. *Hudson JL & Rapee RM: The Origins of Social Phobia. Behav Modif 2000; 24:102-29.*
10. *Kendler KS, Karkowski LM & Prescott CA: Fears and phobias: reliability and heritability. Psychological Medicine, 1999; 29:539-53.*
11. *Lecrubier Y, Wittchen HU, Faravelli C, Bobes J, Patel A & Knapp M: A European perspective on social anxiety disorder. Eur Psychiatry. 2000; 15:5-16.*
12. *Merikangas KR, Lieb R, Wittchen HU & Avenevoli S: Family and high-risk studies of social anxiety disorder. Acta Psychiatr Scand Suppl 2003; 417:28-37.*
13. *National Institute of Mental Health: The numbers count: Mental disorders in America. NIMH, 2009.*
14. *Seeley-Wait E, Abbott MJ & Rapee RM: Psychometric Properties of the Mini-Social Phobia Inventory. Prim Care Companion J Clin Psychiatry. 2009; 11:231–36.*
15. *Stein MB & Gorman JM: Unmasking social anxiety disorder. J Psychiatry Neurosci 2001; 26:185–89.*
16. *Stein MB & Stein DJ: Social anxiety disorder. Lancet 2008; 371:1115-25.*
17. *Timothy JB & Saeed SA: Social Anxiety Disorder: A Common, Underrecognized Mental Disorder. Am Fam Physician 1999; 60:2311-20.*
18. *Wakefield JC, Horwitz AV & Schmitz MF: Are We Overpathologizing the Socially Anxious? Social Phobia From a Harmful Dysfunction Perspective. Can J Psychiatry 2004; 49:736-42.*