

PSYCHOLOGICAL MECHANISMS OF SOCIAL ANXIETY AND SOCIAL ANXIETY DISORDER (SAD) IN ADOLESCENTS

*Samoylova Vera Vladimirovna, student of the Department of Clinical Psychology, Altai State University, Барнаул, Россия
e-mail: samoylovavera@mail.ru*

*Sagalakova Olga Anatolievna, Ph.D., associate professor of the Department of Clinical Psychology of the Altai State University, Барнаул, Россия
e-mail: olgasagalakova@mail.ru*

Abstract: The cognitive model of social anxiety disorder is considered. Cognitive factors and linguistic features of the disorder are distinguished. The interconnections of such indicators as the quality of sleep, social behavior in everyday social situations, behavioral indices of social skills in social and performing tasks and physiological reactivity in adolescents are considered. It is shown that an accumulation of symptoms of social anxiety in the family leads to a disadaptive way of regulating the emotions of children.

Keywords: social anxiety disorder, social anxiety, adolescents, cognitive factors, linguistic correlates, emotion regulation, physiological reactivity, family influence.

ПСИХОЛОГИЧЕСКИЕ МЕХАНИЗМЫ СОЦИАЛЬНОЙ ТРЕВОГИ И СОЦИАЛЬНОГО ТРЕВОЖНОГО РАССТРОЙСТВА (СТР) У ПОДРОСТКОВ

*Самойлова Вера Владимировна, студентка кафедры клинической психологии Алтайского государственного университета, Барнаул, Россия
e-mail: samoylovavera@mail.ru*

*Сагалакова Ольга Анатольевна, к.п.н, доцент кафедры клинической психологии Алтайского государственного университета, Барнаул, Россия
e-mail: olgasagalakova@mail.ru*

Аннотация. Рассмотрена когнитивная модель социального тревожного расстройства. Выделены когнитивные факторы и лингвистические особенности этого расстройства. Рассмотрена связь таких показателей у подростков, как качество сна, социальное поведение в повседневных социальных ситуациях, поведенческие показатели социальных навыков в социальных и исполнительских задачах и физиологическая реактивность. Накопление симптомов социальной тревоги в семье приводит к дезадаптивному способу регулирования эмоций детей.

Ключевые слова: социальное тревожное расстройство, социальная тревога, подростки, когнитивные факторы, лингвистические корреляты, эмоциональная регуляция, физиологическая реактивность, семейное влияние.

In 1980, the term "social phobia" first appeared in the DSM-III, and the dispute is still going on. Where is the difference between "normal" shyness and pathological shyness within the SAD? What is the primary factor in the both cases? And, the most importantly: can a "normal" shyness go into a pathological one. The topic of social anxiety and SAD remains the most relevant all over the world. Millions of scientists conduct a lot of research, studying and discovering all the new aspects of this issue. (The terms social anxiety and SAD will be used as synonyms in this report because of the generality of psychological mechanisms).

The usual notion of "shyness" and the term "social anxiety" are different today. Shyness is understood as a personality trait without causing negative emotions and experiences. It doesn't prevent a person from fully functioning and flexibly adapting to changing social conditions. While a person with a social anxiety can't adapt successful, because psychological mechanisms, becoming pathological. At the same time shyness isn't the only and sufficient condition for the emergence of social anxiety.

There is a small refinement change in the DSM-V: "Fear, anxiety, or avoidance is persistent, typically lasting 6 or more months". This change connects with ambiguity in the application of these notions in practice and the subsequent increase in the percentage of the total population suffering from symptoms of SAD. This fear of embarrassment or humiliation can be based both on experience actually experienced, and on an imaginary hypothetical result. And this clearly affects the behavior. In order to reduce the level of fear / anxiety, the individual often resorts to avoiding such stressful situations for him. Even if the motive for this activity had already forming, and it was significant. [2]

What are the cognitive factors supporting SAD? Stefan G. Hoffman tried to answer this question. He presents the broadest and the most generalized cognitive model of SAD in his article. The bases for the model are four psychopathological

processes that form inadequate beliefs, of Clark and Wells (1995). The first is a constant monitoring of the threat. The attention of the individual to the processing of the situation and the behavior of other people is shifted to introceptive information, which inevitably creates a negative image of oneself in the eyes of others. The second process is the tendency to avoid stressful situations. This behavior prevents an individual from critically comprehending the situation and supports his dysfunctional beliefs. The third is a low sense of self-efficacy. The fourth process is the "mental chewing gum". The individual with the SAD is inclined to think about the social situation in detail (sometimes within a few weeks after the incident), focusing on past failures, creating a negative image of himself, predicting low self-efficacy in the future and the inevitable rejection of society.

Anxiety or fear also arises to the fact of wish to achieve success, but individuals with SAD doubt that they are able to do it. Partly because they are unable to define goals and choose feasible behavioral strategies.

The research by Hiemisch and his colleagues (2002) showed that people with social anxiety have a deficit in analytical and synthetic activities in particular planning defining strategies for achieving the goal and implementing them. This leads to increase self-focusing and catastrophic outcome.

Studies by Hofmann and Heinrichs (2003) showed that people with SAD in social situations see themselves as "the eyes of others" compared to less disturbing. Also they pay close attention to their inner experiences. The anxiety and influence of negative beliefs decreased, when they were asked to focus on aspects of the external situation. Furthermore, people with social anxiety tend to skip positive external signals from others, noticing only negative ones or interpreting them in this way.

People with SAD perceive all social standards through the prism of their self-esteem and subjective social anxiety. Because of this, they misjudge the real level of their abilities and exaggerate the level of the standard, minimizing their own. At the

same time they don't build their own ideas on how they see themselves, but on what, in their opinion, others give them assessments at the moment. Cognitive theories (Beck & Emery, 1985, Clark & Wells, 1995) postulate that this behavior based on warped beliefs about myself (for example, "I'm stupid"). They become prisms in which any incoming information is processed. Moreover, an individual with a social anxiety will ignore any information that contradicts this belief, regardless of the level of his competence or the degree of sheer friendliness of the interaction partner. The consequence is the conviction that they don't meet the expectations of others.

Leung & Heimberg (1996) showed that individuals with social anxiety don't have internal control. They believe that events can only be controlled by others, but not by them. Within this theory, avoidance of situations based on understanding of lack of the control over their emotional response and the high perceived risk that it will be noticed by others. [4]

Scientists are interested in the question: what other reliable markers of SAD exist besides cognitive distortions? Stefan G. Hofmann with colleagues study selected the linguistic correlates of the SAD. They studied the frequency of use in the speech of I- and We-sayings. Participants were 46 college undergraduates. They were predominantly female (65.2%), Caucasian (91.3%), and Christian (56.5%) with a mean age was 19 (range: 18-21, SD: .92). Based on an initial diagnostic interview, 24 out of the total 46 participants had SAD. Of these, 8 met criteria for a generalized subtype. The majority of SAD participants (n = 22) were primarily speech anxious. As part of the experiment, they were asked to give a speech on any topic of their choice for a total of 4 minutes. Participants performed for one audience member (the experimenter) and were recorded on a video camera that was placed directly in front of them on a conference table. Also they were informed that a panel of judges would conduct a post-rating of their speech in regards to poise, social self-confidence, and general presentation skills.

And the scientists came to the conclusion that people with SAD reduce the frequency of their use in active speech, so avoiding being in the center of attention. Besides, such people tend to use in their speech more words with a positive color, as a way to accommodate others and reduce the social threat on their part. At the same time, they use fewer words that cause negative emotions to more correspond to this social group and win it's favor. There were confirmed that individuals with a generalized subtype of SAD were the least likely to use I-sayings (self-focusing indicator) and words bearing negative emotions (an indicator of safe behavior), in contrast to the control group without this disorder. [5]

Scientists note that although most of SAD is diagnosed in adolescence, usually 15-16 years, few studies are devoted to the clinical manifestations and daily functional disorders of this disease in adolescents. Moreover, the clinical features of SAD adolescents are significantly different compared to younger children. SAD adolescents are associated with a lack of social skills such as: decreased face vision and increased latency response during social interactions. Even less is known about how the characteristics of the disorder (for example, low level of social activity and physiological reactivity in social situations) affect the daily level of stress and functioning in social situations of interactions in their spare time, at school or at work.

Franklin Mesa, Deborah C. Beidel and Brian E. Bunnell in their study (2014) tried to answer some of these questions. This study compared the characteristics of adolescents with and without SAD in open social behavior and physiological reactivity during the task of social interaction, such as performance (heart rate [HR] and electrodermal activity of the skin [EDA]). In addition, the objective and subjective qualities of sleep were considered.

Sixteen socially anxious adolescents aged 13 to 17 ($M=14.81$, $SD=1.47$) were included in the SAD group. Secondary diagnoses in the socially anxious group consisted of generalized anxiety disorder (18.75%), dysthymic disorder (12.5%),

major depressive disorder (12.5%), specific phobia (6.25%), and selective mutism (6.25%). Fourteen control adolescents ranging in age from 13 to 17 ($M=15.07$, $SD=1.54$) were included who didn't meet diagnostic criteria for any current Axis I diagnosis.

Social functioning was assessed using short speech and social interaction tasks, in which HR and EDA were measured. In addition, participants filled out a daily journal of social activity for 1 week, in which they noted a subjective assessment of anxiety in social situations. A multimodal approach was used to assess the quality of sleep: participants filled in subjective (for example, self-reports) and objective (for example, actigraph) measures of sleep quality.

In the course of the study, the researchers concluded that, compared with the control group, adolescents with SAD didn't experience constant difficulties with sleep. For about 1 week, adolescents with SAD reached 7 hours of sleep with an average efficiency of 94% per night. However, this group was exhibit impairments in social skill and more sympathetic activation during public appearances. The anxiety of adolescents wasn't permanent. It was caused by anxiety because of the expectation of a valuation situation. Therefore, for adolescents with SAD sleep disturbance didn't occur in the absence of a disturbing event.

During social interaction or the task of public speaking, adolescents with SAD experienced significantly more distress (anxiety) than NC. They were less engaged socially: they asked much less questions and they needed more confederate prompts to engage in the conversation. The speech of adolescents with SAD was much shorter in duration, despite the number of topics discussed with NC (normal choice). Teenagers with SAD didn't discuss topics in detail, but they were naming the topics. In addition, they often tried to avoid such situations of communication. This behavior makes difficulties to socialize in this sensitive period of development, when

communication and establishing a social network under various conditions are of paramount importance.

During both tasks of social interaction in adolescents with SAD, a high level of EDA was recorded, which is an indicator of sympathetic activation. While the increase in HR depends on the parasympathetic nervous system. Such divergent physiological reactions are explained by different activated vegetative systems. [3]

As already known, social anxiety is associated with a lack of regulation of emotion. But the interesting question is how the strategies of the mother's emotional response affect the level of social anxiety of their children. After all, from the point of view of development, emotional regulation arises as an interactive process between a parent and a child. Parents are largely involved in the formation of these strategies. This influence can be manifested directly by modeling strategies or indirectly through family climate, family influence.

So what is the relationship between the strategies for regulating the emotions of children with SAD and their parents? Find the answer tried Julia Asbrand and Jennifer Svaldi with colleagues (2016). They carried out a study in which children with SAD (aged 9 to 13 years) and without them, as well as their mothers, took part. It was found that children with SAD and their mothers had more non-adaptive strategies for regulating emotions than control groups. Moreover, non-adaptive strategies of the mother negatively influenced the adaptive strategy of the child, and this influence slowed the development of emotional regulation. The researchers concluded that disadaptive strategies of emotional regulation contribute to aggravation of social anxiety in both the mother and the child. Mothers with non-adaptive strategies can't support a child in a difficult social situation (because of lack their adaptive strategies) and it only increase in anxiety. [1]

In this way, we reviewed the main cognitive mechanisms of social anxiety and SAD, their linguistic correlates were examined. Four psychopathological processes

were identified that support this disorder, as well as features of speech characteristic for it. Also, the connection was considered of such indicators in adolescents as the quality of sleep, social behavior in everyday social situations, behavioral indices of social skills in social and performing tasks, and physiological reactivity. It was found out that the features of the regulation of the mother's emotions directly affect the strategies chosen by the child for regulating emotions.

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