Original Research Article

A cross-sectional study on perceived social functioning in patients with anxiety disorders

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Abstract

Background and Aim: Anxiety symptoms are associated with poor social skills and more social problems. Only limited evidence establishing associations between anxiety diagnoses and SF are available. In this study, we have aimed at assessing the perceived social functioning in patients with anxiety disorders.

Materials and methods: This was a cross-sectional study which was conducted on 52 subjects with anxiety disorders diagnosed with ICD-10 criteria. Severity of anxiety was assessed using Hamilton Anxiety Scale and perceived social functioning was assessed using Social functioning questionnaire.

Results: Among the samples, 29 subjects had SFQ score of more than 10, indicative of poor social functioning. 20% of subjects with mild anxiety, 65.22% with mild to moderate anxiety, 12.5% with moderate to severe and 81.81% with severe anxiety had poor functioning.

Conclusion: In our study, anxiety disorders had a significant association with poor social functioning with severity of anxiety symptoms correlating with level of social functioning. Clinically many patients with anxiety report with poor social skills and various social problems but the literature

support to show the association between anxiety disorders and social functioning is limited. Reduced social functioning can independently contribute to or worsen anxiety disorder and it can impair response to treatment.

Key words

Anxiety disorders, Perceived social functioning, Social functioning.

Introduction

Anxiety is a pathological state that is characterized by feeling of dread and apprehension caused by an ill-defined threat or danger that is not realistically based. Anxiety disorders usually present with psychological symptoms like fear, worries, difficulty in concentrating and a constant feeling of being overwhelmed and physical symptoms like palpitations, tachycardia, tremors, sweating indicating a hyperactive autonomic nervous system. Pooled 1-year and lifetime prevalence rates for anxiety disorders were found to be 10.6% and 16.6%. Women have higher prevalence rates compared to women [1]. A meta-analysis of 13 studies, including a sample size of 33, 572 subjects, to estimate prevalence rates of mental and behavioral disorders in India found that neurotic disorders have estimated prevalence rates between 18.7% and 22.7% [2].

Social functioning refers to individual's interaction and role in family, work, and society. Adequate social functioning is very essential for well-being and survival of human beings. Social dysfunction can lead on to severe negative outcomes with respect to mental and physical health. Social functioning as a risk factor for premature mortality is believed to be higher than that of smoking, alcohol consumption, or obesity [3]. Social Functioning is one of the important areas to be significantly affected in psychiatric disorders. Social functioning has been assessed in various manners, and little consensus is available on how to describe it in the best way. 'Behavioral' and 'Affective' indicators of social functioning are the usual measures used to describe social functioning. Behavioral indicators of social functioning include objective and quantitative measures like frequency of social support, social activities etc and affective indicators include subjective and evaluative measures of social functioning like perceived ability to enjoy life, loneliness, work, relationships etc.

Social functioning when compared among anxiety disorders were found to be unambiguous. A study showed that among anxiety disorders Generalized Anxiety Disorders and Panic disorders were found to be more significantly associated with Social dysfunction than Social phobia and other Phobic disorders [4].

Patients with anxiety disorders usually have a lower quality of life in various areas of life especially in social interactions, subjective wellbeing etc when compared with healthy controls. Anxiety symptoms are associated with poor social skills and more social problems. Social dysfunction is very pervading and debilitating and it prevails for a long time even after remission. It can also interfere in the treatment process and can worsen the disease process. Many a times, this aspect of functioning is not much looked upon by clinicians and also only limited evidence establishing associations between anxiety diagnoses and SF are available, thereby calling for extensive research in this area.

In this study we have aimed at assessing the level of social functioning among subjects of anxiety disorders and the association of clinical characteristics like type of disorder, age of onset, duration, severity of anxiety disorders etc with the level of social functioning.

Materials and methods

Study design and duration

The study was approved by the Institutional Human Ethical Committee, Chettinad Academy of Research and Education (Approval No. 582/IHEC/11-19). This was a cross-sectional observational study done to estimate the level of social functioning among patients of anxiety disorders. This study was done for a period of 6 months among the patients attending the Department of Psychiatry, at a tertiary health care centre in Tamil Nadu.

Study sample

All inpatients and outpatients, between ages 18-65 years, diagnosed with anxiety disorders according to ICD-10 criteria (F40, F41), willing to give informed consent, were included in the study. All subjects with other co-morbid psychiatric disorders, medical co-morbidities and on treatment with psychotropics were excluded from the study.

Measurements

All samples with anxiety disorders were diagnosed according to the International classification of diseases (ICD) DCR – 10^{th} edition (F40, F41). A semi-structured questionnaire was used for assessing the socio-demographic, clinical and treatment variables. WHO Schedules for Clinical Assessment in Neuropsychiatry (WHO-SCAN) version 2.1 was used to rule out other psychiatric disorders. The severity of anxiety disorders was assessed using the Hamilton Anxiety rating scale. Each item was scored on a scale of 0 (indicates not present) to 4 (indicates severe). It has a total score range of 0–56, where <17 indicates mild, 18–24 indicates mild to moderate and 25–30 indicates moderate to severe.

Social Functioning Questionnaire (SFQ) was used to assess the perceived social functioning in the samples. It had 8 items, to be self- reported and is scored on a four-point scale (0-3) and had a total possible score of 24. Data obtained from all studies suggested that a score of 10 or more is indicative poor social functioning [5].

Study procedure

All the participants were interviewed and rapport was established. They were ensured adequate privacy during the interview and about confidentiality regarding the data to be collected. Semi-structured proforma was used to collect information about socio-demographic, clinical and treatment variables. A senior psychiatrist assessed the participants and diagnosed anxiety disorder using ICD-10 and severity was evaluated by Hamilton anxiety rating scale (HAM-A). Other psychiatric disorders were ruled out using WHO Schedules for Clinical Assessment in Neuropsychiatry (WHO-SCAN) version 2.1. Perceived social functioning was assessed using Social Functioning Questionnaire (SFQ).

Statistical analysis

Collected data was subjected to descriptive statistics using frequencies, and percentages of different variables were calculated. Fisher's Exact Test was used to compare the severity of anxiety disorders and levels of perceived social functioning. ANOVA test was used to compare the socio-demographic details with severity of anxiety disorders and perceived social functioning. P value of <0.05 was considered statistically significant. Statistical Package for the Social Sciences (SPSS) software was applied to analyze the data.

Results

The mean age of the study population (n=52) was 35.94± 11.40. Majority were Men (82.7%), had pursued at least high school education (75%), skilled workers/ professionals, lived in nuclear families(65.4%), married(67.3%) and middle socioeconomic status(67.3%) (**Table – 1**).

Among the study population, 10 (19.2%) subjects had mild anxiety levels, 23 (44.2%) had Mild to Moderate levels of anxiety, 8 (15.4%) had Moderate to Severe levels and 11 (21.2%) had Severe levels of anxiety when assessed with Hamilton Anxiety Rating scale.

Table - 1: Socio-demographic details of study population.

Socio-demographic variable	Frequency (n=52)
Age (years)	35.94± 11.40
Gender	
Male	43(82.7%)
Female	9(17.3%)
Education	
Primary School	1(1.9%)
Middle School	12(23.1%)
High School	9(17.3%)
Intermediate/diploma	17(32.7%)
Graduate	6(11.5%)
Professional degree	7(13.5%)
Occupation	
Unemployed	4(7.7%)
Unskilled worker	1(1.9%)
Semiskilled worker	2(3.8%)
Skilled worker	18(34.6%)
Clerical/Farm/Shop	1(1.9%)
Semiprofessional	7(13.5%)
Professional	19(36.5%)
Family type	
Nuclear	34(65.4%)
Joint	13(25.0%)
Broken	4(9.6%)
Marital status	
Married	35(67.3%)
Unmarried	13(25.0%)
Separated/Widowed	4(7.7%)
SES	
Upper lower	17(32.7%)
Lower middle	21(40.4%)
Upper middle	14(26.9%)

48.1% subjects had good social functioning (SFQ scores <9) and 51.9% had poor social functioning (SFQ scores >/= 10).On assessing the relationship between anxiety severity and perceived social functioning in study population, it was found that 2 subjects with mild anxiety (n=10), 12 subjects with mild to moderate anxiety (n=23), 1 subject with moderate to severe anxiety (n=8) and 9 subjects with severe anxiety (n=11) had poor social functioning. Assessment of relationship between anxiety severity and perceived social functioning showed statistical significance (0.002).

Relationship between Anxiety severity and perceived social functioning in study population were assessed using Fisher's Exact Test and it showed significance (p value= 0.002); indicating probable association between anxiety severity and level of social functioning.

Table - 2: Relationship between Socio-demographic factors and Anxiety disorders.

Socio-demographic variable	Frequency (n=52)	p-value
Age (years)	35.94± 11.40	0.231
Gender		0.325
Male	43(82.7%)	
Female	9(17.3%)	
Education		0.377
Primary School	1(1.9%)	
Middle School	12(23.1%)	
High School	9(17.3%)	
Intermediate/diploma	17(32.7%)	
Graduate	6(11.5%)	
Professional degree	7(13.5%)	
Occupation		0.738
Unemployed	4(7.7%)	
Unskilled worker	1(1.9%)	
Semiskilled worker	2(3.8%)	
Skilled worker	18(34.6%)	
Clerical/Farm/Shop	1(1.9%)	
Semiprofession	7(13.5%)	
Professional	19(36.5%)	
Family type		0.005
Nuclear	34(65.4%)	
Joint	13(25.0%)	
Broken	4(9.6%)	
Marital status		0.009
Married	35(67.3%)	
Unmarried	13(25.0%)	
Separated/Widowed	4(7.7%)	
SES		0.278
Lower middle	21(40.4%)	
Upper lower	17(32.7%)	
Upper middle	14(26.9%)	

One-way ANOVA test used.
p-value <0.05 was considered to be significant.

Table - 3: Relationship between Socio-demographic factors and Perceived social functioning.

Socio-demographic variable	Frequency (n=52)	p-value
Age (years)	35.94± 11.40	0.082
Gender		0.228
Male	43(82.7%)	
Female	9(17.3%)	
Education		0.048
Primary School	1(1.9%)	
Middle School	12(23.1%)	
High School	9(17.3%)	
Intermediate/diploma	17(32.7%)	
Graduate	6(11.5%)	
Professional degree	7(13.5%)	
Occupation		0.377
Unemployed	4(7.7%)	
Unskilled worker	1(1.9%)	
Semiskilled worker	2(3.8%)	
Skilled worker	18(34.6%)	
Clerical/Farm/Shop	1(1.9%)	
Semiprofession	7(13.5%)	
Professional	19(36.5%)	
Family type		0.981
Nuclear	34(65.4%)	
Joint	13(25.0%)	
Broken	4(9.6%)	
Marital status		0.697
Married	35(67.3%)	
Unmarried	13(25.0%)	
Separated/Widowed	4(7.7%)	
SES		0.020
Lower middle	21(40.4%)	
Upper lower	17(32.7%)	
Upper middle	14(26.9%)	

One-way ANOVA test used.
p-value <0.05 was considered to be significant.

On assessing the relationship between socio-demographic variables and anxiety disorders, significance was found with respect to family type (p=0.005) and marital status (p=0.009). Other variables did not have significance (**Table – 2**).

On assessing the relationship between socio-demographic variables and social functioning, significance was found with respect to education status (p=0.048) and marital status (p=0.020). Other variables did not have significance (**Table – 3**).

Discussion

Though used very commonly, the term 'social functioning', has only limited consensus about its clear definition. It is used interchangeably with a varied similar and overlapping concepts, like 'social performance', 'social dysfunction', 'social adjustment', 'social competence', 'social adaptation' etc. [6]. Social functioning refers to "level at which a person will function in his or her social context, such function ranging between self-preservation and basic living skills to the relationship with others in society [7].

Social functioning is known to be affected to be in a variety of psychiatric disorders. Its impact is well studied and proven to be significantly impaired in psychotic disorders like schizophrenia, affective states like depression etc. But it is often understudied with respect to anxiety disorders. Anxiety symptoms are often associated with poor social skills and various social problems. Clinically many patients with anxiety report with poor social skills and various social problems but the literature support to show the association between anxiety disorders and social functioning is limited. Reduced social functioning can independently contribute to or worsen anxiety disorder and it can impair response to treatment. The studies available on assessment of social functioning were more on disorders like Schizophrenia, Depression etc and in others, anxiety disorders co-morbid with other disorders like ADHD, Alcohol Use Disorder etc were assessed for social functioning. Some studies have focused on functioning in social anxiety disorders whereas other anxiety disorders were understudied [8-13].

In this study we have focused on assessing the levels of perceived social functioning among

individuals with anxiety disorders without any known psychiatric or medical co-morbidities. Among the 52 samples, majority were Male (82.7%), with at least high school education (75%), most were skilled workers/ professionals, living in nuclear families (65.4%), married (67.3%) and belonging to middle class socioeconomic status (67.3%).

48.1% subjects had good social functioning (SFQ scores <9) and 51.9% had poor social functioning (SFQ scores >/= 10). 20% (n=10) of subjects with mild anxiety, 65.22% (n=23) with mild to moderate anxiety, 12.5% (n=8) with moderate to severe and 81.81% (n=11) with severe anxiety had poor functioning.

Among socio-demographic variables, family type (p=0.005) and marital status (p=0.009) had significance with anxiety severity; education status (p=0.048) and marital status (p=0.020) had significance with social functioning. Other variables did not have significance.

In our study, relationship between Anxiety severity and perceived social functioning when assessed, showed significance (p value= 0.002); indicating probable association between anxiety severity and level of social functioning.

However, our study had few limitations. This study is limited by a small sample size, hence results cannot be generalized. Also, gender variation could not be assessed due to predominant male study population. Since it is a cross-sectional study, causal inferences cannot be made.

Future studies, including large sample size, follow-up studies with extensive exploration of social functions and its domains can provide for greater understanding for social functioning in anxiety disorders. Also, future research on exploration of mechanisms underpinning social functioning abilities in anxiety disorders is also important.

Conclusion

Social functioning is an important domain to be assessed for in anxiety disorders. It can be considerably affected in anxiety disorders. In our study, relationship between anxiety disorders and social functioning had significance; indicating probable association between anxiety disorders and social functioning. So, clinicians should look out for social functioning domain in anxiety disorders and address the issue appropriately.

Data availability statement

The datasets used and/or analyzed during the current study are available from the corresponding author on request.

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