A Review Article on Social Phobia

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Abstract— Background: Social phobia also known as social anxiety disorder (SAD) is one of the most common anxiety disorders which are characterized by marked and persistent fear of social situations in which embarrassment may occur.
Objectives: The objectives of this review are to define social anxiety disorder; to demonstrate the prevalence worldwide and in Saudi Arabia and to identify causes, risk factors, manifestations and effects of social phobia.
Literature of review: Social phobia represents the third largest mental health care problem in the world today. In Saudi Arabia, it has been under-studied, poorly recognized and often not diagnosed; however, it constitutes approximately 13% of all neurotic disorder seen in psychiatric clinics. Different risk factor combinations may have role in development of SAD with various manifestations and effects on their quality of life.
Conclusions: The global prevalence of social phobia ranges from 8 to 12% with multifactorial causes involving genetics, neurobiology, the fetal environment, and the postnatal environment. The reported risk factors in patients with social phobia are family history of anxiety or mood disorder; heritability, female gender, middle age, being single, separated, or widowed, low socioeconomic status or low income, stressful life event or trauma as maltreatment or sexual abuse, physical punishment in childhood, overprotective or harsh parenting style in childhood. Individuals with social phobia experience higher rates of unemployment, more missed hours of work, and reduced work performance relative to individuals without social phobia.

Index Terms— Anxiety, Causes of social phobia, Disorder, Epidemiology of social phobia, Manifestations of social phobia, Phobia, Social, social anxiety disorder, Social phobia.

1 Introduction

Phobic disorder or phobia is a dominant form of anxiety disorder, and is described by persistent, marked, and unreasonable fears of an object or situation. People with a phobia avoid specific situations or objects that induce these types of fears. One of the most famous types of phobia is "social anxiety disorder (SAD)", which is usually defined as social phobia, which involves an excessive fear of embarrassment in social situations and avoidance of such situations (1).
Social experiences are an integral part of normative development for youth while social functioning difficulties may place them at risk for maladjustment (2) with significant impairment in almost all aspects of daily life as work, studies and relationships (3).
Anxiety disorders as a group are the most common class of mental disorders. In a recent systematic review conducted by Craske and Stein, 2016, anxiety disorders global prevalence was estimated to be 7.3% with one every 14 people around the world at any given time has an anxiety disorder (4).
Social phobia is one of the prevalent types of anxiety disorders, with estimated prevalence (8-12%) among general population and is more obvious in women than men (5).
The causes of social anxiety are multifactorial, involving genetics, neurobiology, the fetal environment, and the postnatal environment (6).
In addition, there are non-specific causes reported in individuals with anxiety disorders as family history; being female gender, middle age, single, separated, or widowed, heritability rate of 30%-50% also documented, low social class, stressful life event as or sexual harassment or maltreatment, physical punishment in childhood, and harsh parenting behavior in childhood.
Moreover, behavioral inhibition trait identifiable in early childhood appears to increase risk of social phobia among children and adults (7).
Persons with social phobia vary in the type and number of social situations that they provoke fear and in the number and range of their feared consequences (8).

I decided to start this research because of the following:

- "Social Anxiety Disorder (SAD) also termed as social phobia" is increasingly being recognized as a prevalent, unremitting, and highly comorbid disorder (9).
- There is an obvious increasing trend of social phobia particularly in developing countries with little or even neglected attention towards its associated factors (10).

The aim of this review article is to give an overview on the Social Anxiety Disorder (also termed 'social phobia') in order to increase awareness towards this problem with the following objectives.

- To define "social anxiety disorder (social phobia)".
- To demonstrate the prevalence of social anxiety disorder worldwide and in Saudi Arabia.
- To identify causes, risk factors, manifestations and effects of social anxiety disorder.

2 Literature of Review

2.1 History and concept of social phobia:

Social phobia entered the dictionary of psychiatry half century ago, as "an isolated disorder discrete from specific phobias and agoraphobia as reported by Marks and Gelder, 1966" (11).
After that, the concept of social phobia changed from being a comparatively neglected condition to be recognized as a highly prevalent disorder across the world (12) – and is now

termed as "social anxiety disorder or SAD" (13).
"According to the Diagnostic and Statistical Manual of Mental Disorders DSM-V; American Psychiatric Association, 2013, social anxiety disorder is defined as marked or intense fear of social or performance-based situations where scrutiny or evaluation by others may occur" (14).

2.2 Epidemiology of social phobia:

"Social Anxiety Disorder (social phobia)" was documented as the third most common mental health care problem in the globe recently figure (1) (15) with prevalence rates extending from 8-12% among the global general population. It is more common in females than males figure (2), (16) and increased rates have been recorded in developed countries (6.1%) versus developing countries (2.1%). SAD has an early age of onset, commonly during adolescence (mean 12 years old), and tends to have a chronic and persistent course(5).

2.2.a. Worldwide

Collected data on SAD epidemiology from countries with high income in the West showed obvious differences in prevalence across countries(12).
Data demonstrated by "World Mental Health (WMH) survey" showed the most conclusive picture of the universal epidemiology of SAD to date. The prevalence ratios are maximal in Western areas and minimal in Africa and the Eastern Mediterranean regions. Across all countries, SAD is a prevalent disorder Table 1 (12).
For instance, In USA, it has been documented that the lifetime prevalence of SAD is at 12% and nearly half of cases are concerned about panic or avoidance to be in different social positions (17).
In Germany (Munich), Beesdo, et al. (18) conducted a study to estimate the cumulative range of SAD among adolescents and young adults (from 14 to 24 years old). The overall cumulative range for SAD was 11% for the participants (18).
In India, a study conducted on 380 undergraduate university students, revealed that social phobia was found in 19.5% of the studied students (19).
A study from Malaysia on medical students showed that 56% of medical students had symptoms of social phobia (20).
Iranian study showed the prevalence of 58.5% between medical students (21).
A recent study conducted in Ethiopia in 2017, documented 27.5% overall prevalence rate of social phobia among school adolescents (9).

2.2.b. Saudi Arabia and Arab countries

In Saudi Arabia, it has been realized that such social condition is a field which is often poorly recognized and understudied, usually not diagnosed in case of people who are suffering from such disorder (22), however, it forms about 13% of all neurological disorders shown in psychiatric clinics, (23) particularly among adolescents and early adulthood individuals as documented by Jarallah H, et al., in 2017(24).
A study conducted by Momani and Jaradat in 2011 among university students, showed that the total prevalence rate of social phobia among students was 17.7% (25).
In addition, a previous study conducted by El-Tantawy, et al., in 2010 at the Burydah mental hospital showed that the percentage of SAD among the patients in the outpatient clinic was 5.63% and the quality of life among these individuals was relatively lower when compare it to the controlled group which has been used in their inquiry (26).
A similar study conducted in Morocco in 2007, to determine the prevalence and comorbidity of anxiety disorders in Moroccan individuals showed that 25.5% from 800 individuals met criteria of at least one anxiety disorder while SAD constitutes around 3.4%(27).
Furthermore, several studies conducted on school students in Egypt, Saudi Arabia, and United Arab Emirates showed 13%, 9.8%, and 7.8%, prevalence of social phobia respectively(28).

2.3 Causes and risk factors of social phobia:

Concerning the etiological mechanisms, various multifactorial risk factor (e.g. genetics, neurobiology) might result in development of SAD but importantly any given risk factor may be correlates with other disorders Figure (3)(29). This latter concept is at the center of diagnostic models of psychopathology (30).
For instance, past study showed that excessive controlling parenting is participating to suppressed children's temperament - and so risk for the disorder - however, these parenting styles are not noted exclusive for increasing risk of social phobia(29).
In fact, parental behaviors may share (or be a response) to a more general trait anxiety in early childhood as conducted by Negreiros and Miller in 2014 (31). Moreover, a study demonstrated by Spence and Rapee, (2016) (29) further illustrated that stress, adverse life events and trauma elevate the risk for developing SAD. However, these factors lack specificity to the condition.
It is hence progressively obvious that the field require novel approaches to illustrate the differing influences of transdiagnostic versus disorder-specific etiological factors. Lahey et al., (2017) (32) submitted an evidence of psychopathology depend on shared unique causal factors across differing first-order dimensions (i.e. latent constructs defined by correlations amongst manifestations).
Different models illustrate that both specific and non-specific genetic and environmental factors could participate to the psychopathology of social phobia, which has important implications for whether SAD can continue to be conceptualized as discrete condition or not (32).
There is an evidence of environmental impacts such as attitudes of the parents, lack of warmth and over-protection that enhance anxiety in children which are probably to be serious(24).
Child position in the family could have a role in occurrence of SAD as several studies have documented increased prevalence of social anxiety among the children who born first. while,

other studies showed it among children born later(24).
However, other researchers have demonstrated that children who born first are less susceptible to SAD than their siblings who born later and that increasing adult anxiety associated with increasing the birth order (24).
To date, reports on birth-order are indecisive. In a recent study, the results demonstrated that rate of SAD were not significantly correlates with birth disorder. Parents are postulated to affect the potentiality of SAD in their young by either (a) a genetic predisposition or (b) familial environments that are rejecting, emotionally distant, or overprotective and possessive(24).
Evidences demonstrated that "social phobia" was correlates with 20% of cases of adult depression and 17% of cases of alcohol and drug dependence. Low level of education, unemployment, low socioeconomic status, and low social support and being unmarried were identified also as a risk factor for social phobia(9).
Moreover, society's conduct towards shyness and avoidance as a sign of politeness is also another significant factor correlates with students' ability to establish social interactions(9).

2.4 Manifestations of social phobia:

Since 2004, there have been only minor changes to diagnostic classification systems for SAD, with the key components of both "International Classification of Disease (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria" remaining relatively consistent(14).
According to "DSM-5", the core defining features of SAD include anxiety or fear in social situations in which the person is exposed to possible concentration and focusing by other people and a fear of behaving in a way that will be negatively evaluated by others. These features are either resulting from anxiety symptoms as blushing, sweating or trembling or from the individual's own behavior(14).
In another words, the social conditions are either faced with massive anxiety or are avoided. "DSM-5" furthermore determines that the fear must be out of proportion to the real threat and has persisted for duration longer than 6-months, is not due to medical condition, physiological effects of a substance or mental disorder, and that it leads to clinically critical distress or dysfunction in significant areas of life. Social phobia may be manifested by crying, freezing, headache, shrinking, clinging, stammer or failing to speak in social situations (29).
Although the onset of SAD usually occurs during adolescence, several studies have shown a childhood onset correlates with greater severity(33).
Typically, children may experience anxiety from social situations include meeting new people, speaking in front of the class, joining in conversations, asking a teacher a question, performing in front of others, eating in public, going to parties or social events where peers are present and asking for help in shops or at school (29).
The somatic symptoms of social phobia including massive sweating, blushing, slurred speech, palpitations, tremor and nausea (21). Individuals who suffer social phobia have a significantly lower quality of life, negative impact on social relationships and impairments in work performance (34) also they have lower self-esteem than those who don't have social phobia (34). As many of those who had this disorder may lose their educational and occupational opportunities and they may stay at home for long period of time (21).
A study conducted by Linardon et al., (2017) (35) , showed that SAD can lead to eating disorders.
Another study demonstrated by Ashlen S and Maree J (2016)(36), reported that negative self-imagery maintain social fears despite repeated exposure to normal social situations.
Furthermore, a study conducted by Justin W et al., (2013) (37), illustrated a relationship between gaze avoidance and social anxiety disorder (SAD). Findings of the study highlight increased gaze avoidance as a behavioral marker of social anxiety.

2.5 Effects of social phobia:

Social phobia is the most chronic and prevalent type of anxiety disorders worldwide and it affects social, educational and occupational affairs of the individual (9).
Patients with SAD are also suffering from the reduced quality of life because of their fears. Furthermore, SAD can lead to other troubles such as substance abuse and alcohol, depression, and other problems which are related to anxiety (24).
In addition, the results of a previous study have shown that individuals with social anxiety disorder had reduced level of life satisfaction. SAD impacts the quality of life of an individual roughly and thus makes him or her unstable both psychologically and physically (24).
A study conducted in Saudi Arabia in 2014 to demonstrate social anxiety disorder among adolescents and its relation to quality of life established correlation between SAD and reduced quality of life and physical performance (38).
Moreover, people with SAD experience higher rates of unemployment, reduced work performance and more missed hours of work relative to individuals without SAD(39).
Literature showed that people with SAD have more difficulty with forming friendships, dating and experience more impairment in social functioning (e.g., leisure and social activities), and are more likely to be single and living alone, even when compared to individuals with other anxiety disorders. Moreover, individuals with SAD are more likely to fail a grade and more probably to drop out of high school than individuals without SAD(39).
There is a strong support to the concept that early identification and interference with socially anxious individuals might decrease risk for depressive disorders in young adulthood and adolescence (24).
However, reducing the prevalence of depression is obstructed by the fact that a small number of individuals with SAD receive suitable management and treatment, despite overall increased mental health care awareness (24).

3 CONCLUSIONS:

The global prevalence of social phobia ranges from 8 to 12% with multifactorial causes involving genetics, neurobiology, the fetal environment, and the postnatal environment. The reported risk factors in patients with social phobia are family history of anxiety or mood disorder; heritability, female gender, middle age, being single, separated, or widowed, low socioeconomic status or low income, stressful life event or trauma as maltreatment or sexual abuse, physical punishment in childhood, overprotective or harsh parenting style in childhood. Individuals with social phobia experience higher rates of unemployment, more missed hours of work, and reduced work performance relative to individuals without social phobia.

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6 ANEXXES:

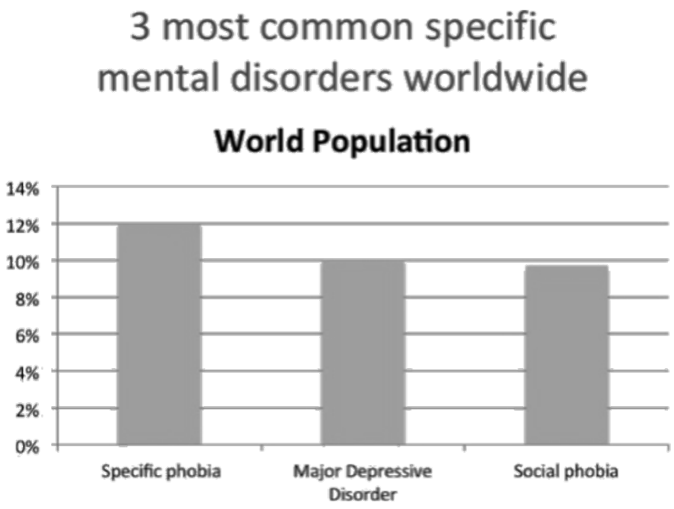

Figure (1): The 3 most common mental disorders worldwide(15).

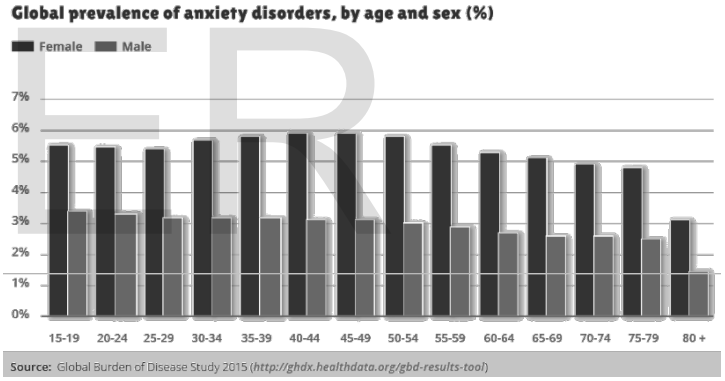

Figure (2): Global prevalence of anxiety disorder, by age and sex (%) in 2015(16).

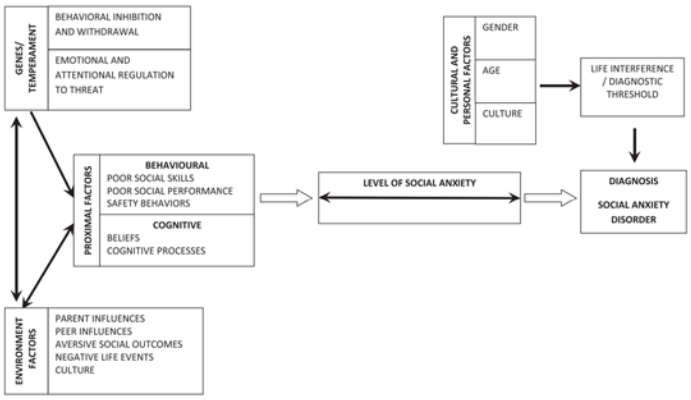

Figure (3): Risk Factors of social anxiety disorder(29).

Table 1: Worldwide of lifetime prevalence of SAD(12).

Country	Ages at selected percentiles								Lifetime prevalence of SAD		Projected risk at age 75	
	5	10	25	50	75	90	95	99	%	SE	%	SE
Iraq	7	9	13	14	18	23	36	36	0.8	0.2	0.8	0.2
Brazil	5	7	11	14	17	29	41	54	5.6	0.4	6.1	0.4
Colombia (Medellin)[a]	5	5	8	13	16	21	31	41	4.6	0.5	4.7	0.5
Lebanon	6	7	11	14	18	20	26	30	1.9	0.4	2.0	0.4
Mexico	6	7	11	15	19	26	40	54	2.9	0.2	3.2	0.3
South Africa	11	13	16	26	49	67	67	67	2.8	0.4	4.7	1.2
Australia	5	6	9	14	20	37	46	68	8.5	0.4	9.6	0.5
Belgium	5	5	7	13	17	25	36	36	2.0	0.4	2.2	0.4
France	7	8	11	14	20	31	45	57	4.3	0.5	4.9	0.5
Germany	7	9	11	14	35	50	62	62	2.5	0.3	3.0	0.5
Italy	5	7	13	15	20	28	36	56	1.9	0.2	2.0	0.3
New Zealand	5	6	8	13	17	27	38	57	9.5	0.3	10.4	0.4
Portugal	5	5	9	14	18	29	43	61	4.7	0.5	5.2	0.5
Spain	5	5	9	13	19	22	48	48	1.2	0.2	1.3	0.2
USA	5	6	8	13	15	23	32	51	12.1	0.4	13.0	0.5