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Social Anxiety Disorder – An Overview

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Abstract
Background: Social anxiety disorder (SAD), a type of anxiety disorder, is one of the most common psychiatric disorders. Early SAD symptoms often go undetected in the community. Thus, the disorder tends to run a chronic course.It is important to improve awareness about this disorder and to identify the socio-cultural factors which may affect health-seeking behaviors as well as coping skills in SAD. **Methods:** A detailed literature review was conducted with a focus on the worldwide prevalence, identification of SAD and how socio-cultural elements influence the health-seeking behavior of sufferers. Factors affecting treatment and current therapeutic methods as well as possible negative coping skills employed and their attendant implications were also identified.**Results:** SAD has a worldwide distribution. Prevalence rates vary slightly across and within countries. Socio-cultural dynamics significantly influence prevalence rates, health-seeking behaviour of patients and their care-givers as well as factors affecting treatment. **Conclusion:** There is an imperative need for socio-cultural adaptation of investigative tools used in epidemiological surveys. Clinicians need to be aware of the prevailing socio-cultural dynamics and how it affects clinical presentation, treatment approach and possible outcomes for SAD. This would facilitate the institution of appropriate interventions and enhance patient satisfaction.
Keywords: Social Anxiety Disorders, factors, Health-seeking behaviour, Implications, factors affecting therapy.

1. Introduction

Social Anxiety Disorder (SAD) is centered on the fear of situations that require socialization and public activities such as public speaking and eating in public places. This leads to the experience of feelings of discomfort, enough to cause distress to the individual which can amount to the avoidance of its inducers. More so, sufferers often display hypersensitivity to criticism, difficulty with being assertive, low self-esteem and inadequate social skills [1].

Early SAD symptoms could easily be overlooked as extreme shyness or anxious-avoidant personality trait. This could lead to poor recognition of disorder, delayed presentation, misdiagnosis and under-diagnosis of this disorder [2, 3].

SAD has been described as having an early onset in childhood, with majority of patients presenting in their thirties [1, 4, 5]. This shows a significant delay from time of onset to time of clinical presentation.

SAD has been reported to have higher lifetime prevalence rates in females than males [4, 6, 7], however, males tend to seek medical intervention where as in some societies females with such a challenge are accepted as part of normal gender behaviour. [5, 8, 9, 10, 11]. This shows a difference in the presenting gender.

School underachievement [10] and school drop-out [12] has been found to be more common in persons/sufferers with SAD. However, [8], patients with SAD who may seek medical intervention are more likely to be of higher level of education. This may be due to an increased awareness to the challenges they experience during social activities such as public speaking [13].

Therefore, there is a need for proper anticipation and an understanding of the larger epidemiological picture of sufferers with SAD.

2. Epidemiology

- **A.** There is a bimodal distribution with peaks at 5 yrs and between 11 to15 years. However, a majority of patients do not present until they are in their 30s [1, 4, 5].
- **B.** The disorder has a worldwide distribution varying across and within countries [13, 14, 15].
- **C.** Lifetime prevalence ranges from 2% to 16% [16]. However, a lifetime prevalence of 9.4% and 12 month prevalence of 8.5% was reported amongst University undergraduate students in Nigeria [13]. Another study in Nigeria showed a 12-month prevalence in the general population was 0.3%.
- **D.** Positive Family history especially in first-degree relatives is has been identified as a risk factor [1] [16].
- **E.** Onset has been reported to occur in adolescence, with a childhood history of shyness [1, 2].
- **F.** Although SAD is often chronic, however can remit or improve with time [1, 2, 11].

3. Aetiology

Studies have showed that both genetic and environmental factors play a role.

3.1 Genetic factor

Persons with SAD are reported to have a predisposition to over-react to certain situations [18]. It has been suggested that distinct neuronal circuits along with chemical molecules facilitate the manifestation of the disorder. More so [2], studies have explored molecules such as monoamine neurotransmitters and neuropeptides which mediate dominance or subordination and social interaction [19].

Behavioral inhibition has been linked to development of SAD. It has been described to be promoted by some neuro-anatomical (such as limbic and striatal pathways) and neuro-chemical (such as serotonergic and dopaminergic) pathways [2, 20, 21, 22, 23].

Furthermore, familial behavioral pattern has been identified as a risk factor. There is interplay of behavioral patterns and authority in the development and understanding of symptoms by the child [16, 24].

3.2 Environmental factor

This determines the extent to which the social anxiety will be expressed. This is usually based on the negative interpretation of the early inducing encounters that lead to the development of the disorder [18]. For example, an adolescent who is ridiculed on various occasions by a teacher or classmates when asking a question or making a comment in a classroom might perceive the class or school environment as hostile and experience fear or avoid speaking out in future occasions.

4. Diagnostic Criteria

Social Anxiety Disorder or Social Phobia according to ICD 10 Criteria [25], the following should have been present for 6 months or more;

A	These fears are manifested in social situations, such as eating or speaking in public; encountering known individuals in public; or entering or enduring small group situations, such as parties, meetings and classrooms: 1). Marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating. OR 2). Marked avoidance of being the focus of attention or situations in which there is fear of behaving in an embarrassing or humiliating way.
B	At least two symptoms of anxiety in the feared situation at some time since the onset of the disorder and one of which must have been from items (1) to (4) below • **Autonomic arousal symptoms:** - Palpitations or pounding heart, or accelerated heart rate - Sweating - Trembling or shaking. - Dry mouth (not due to medication or dehydration • **Symptoms concerning chest and** abdomen - Difficulty breathing - Feeling of choking - Chest pain or discomfort - Nausea or abdominal distress (e.g. churning in stomach) • **Symptoms concerning brain and mind** - Feeling dizzy, unsteady, faint or light-headed - Feelings that objects are unreal (de-realization), or that one's self is distant or "not really here" (depersonalization) - Fear of losing control, going crazy, or passing out - Fear of dying • **General symptoms:** - Hot flushes or cold chills - Numbness or tingling sensations • **In addition one of the following symptoms:** - Blushing - Fear of vomiting - Urgency or fear of micturition or defecation
C	Significant emotional distress due to the symptoms or to the avoidance
D	Recognition that the symptoms or the avoidance are excessive or unreasonable
E	Symptoms are restricted to or predominate in the feared situation or when thinking about it
F	Most commonly used exclusion criteria: Criteria A and B are not due to delusions, hallucinations, or other symptoms of disorders such as organic mental disorders, schizophrenia and related disorders, affective disorders or obsessive compulsive disorder and are not secondary to cultural beliefs.

5. Types of SAD

According to ICD 10[25];

5.1 Specific Social Phobia

Anxiety where the individual has to be the focus of attention while performing an activity in public. For example public speaking, musical performance, etcetera.

5.2 General Social Phobia

Applies to general situations that involving socialization. It is associated with earlier onset, greater severity, longer duration, and more disability. There is evidence that this subtype is more likely to have a familial component.

6. Socio-Cultural Factors Influencing The Health-Seeking Behavior Of Patients With Social Anxiety Disorder

There are several factors such as sex, age, family among others which have been reported to influence the health-seeking behaviour of sufferers with SAD.

6.1 ***Sex***

The gender difference in patients with SAD is more prominent among young adults [26]. The lifetime prevalence estimate of SAD was higher in females than in males [4, 6, 7]. However, in a Japan based study, Taijin Kyofusho (TKS) a culture-bound variant of SAD, is more prevalent in males than females [11, 27, 28]. This may be due to reasons such as societal expectations which permit social inhibition in females while it is does not in males, leading them to conceal or seek treatment for the condition [2, 9]. Most women were found to have to take permission from their partner/spouse to seek medical attention [29].

6.2 Age

The age gap (15 to 30+ years) between onset and possible presentation also incorporates a part of the reproductive period of women. Depression and anxiety are prevalent among women of reproductive age group [30]. This age margin also incorporates the age group of young adults such as students of tertiary institutions. Socialization is a daily experience that young adults face at school, home or work environment. This makes the disorder more obvious to its sufferers [13].

6.3 Family

Family acts as a preserver and propagator of socio-cultural values. A positive family history is a common factor to most persons with SAD [1, 16]. Many individuals have cited a positive family history of anxiety as having a crucial role in their perceptions of themselves as they began experiencing symptoms [16].More so, a parent's behavioral patterns were seen to be highly influential on the recognition and treatment of these disorders in their children. More so, children whose parents were open with them about their depression or anxiety were diagnosed at an earlier age than those whose parents kept their symptoms private. Also, notable parallel was noted between the symptomatic parent's experiences with pharmacotherapy and the beliefs of the child towards these treatment options [16].

6.4 Population Cluster

Specific population clusters such as students have been shown to have a higher lifetime and 12-month prevalence rate of SAD as compared to the general population. The condition was more easily identified due to the awareness of the difficulties experienced in discharging expected social obligations [13]. It is possible that members of such population clusters would seek help earlier than the general population due to the impact of the associated disabilities.

6.5 Social Support

Poor social support has been identified as a stressor for mental health problems such as anxiety [29]. Primary social support is expected from family members by patients and this plays a significant role as to the kind of help and when it would be sought.

6.6 *Beliefs*

A cross-cultural study [36] done by Olivia Bolt et al in different countries across some continents identified actions, bad karma, stress, spirits, magic and violence as perceived causes of SAD. This has been collaborated by other authors [31, 32, 33, 34].

6.7 Culture

Culture is dynamic. Culture can affect treatment in a variety of ways [3, 31, 33]. Culture affects the way people label illness, identify symptoms, seek help, decide whether someone is normal or abnormal, set expectations for therapists and clients, give themselves personal meaning, and understand morality and altered states of consciousness [31]. However, rapid globalization is forcing an integration of various systems including culture and this may have a significant impact on compliance to treatment methods especially where it is not culturally acceptable [3].

6.8 Societal Norms

Different societies have different expectations and uphold distinct values. In some, the distress of shyness is tolerated as a normal individual personality [2, 35]; therefore having less impairment in patient's working activities.

6.9 Language

The description of psychic distress varies in different languages. A patient may choose a group of words, sometimes in his or her native language, to describe a symptom to the therapist. For example, a person might report his or her experience of fear of speaking in public as ''my heart was cutting', 'my heart was beating fast'. Heart distress has been identified as a common idiom of distress [37, 38, 39].It is therefore important for the therapist to understand the true message of his or her patient's experience.

6.10 Level of Education

Exposure to various forms of adverts of drugs for psychiatric conditions has increased the number of mental health patients soliciting drug from their family doctors by 150% in the past decade [40]. Understanding the content of advertisement is facilitated by the level of education attained by the individual. Therefore, an individual with a low level of education may not seek medical help on time due ignorance or illiteracy.

6.11 Socio-economic status

The difference in socio-economic class within a culture are often more significant than differences between cultures [41]. A community-based study done in the United States of America by Schneier et al [4] identified low socio-economic status as a risk factor for SAD due to low social exposure and self-esteem, while in contrast, another community-based study also done in the United States of America by Kessler et al [7] identified low socio-economic status to be as a result of SAD [7], which could be due to the associated disabilities.

An individual's socio-economic status significant affect on the level of education, occupation, level of socialization which could be relevant to the feeling of independence, competence and high self-esteem, features not common in patients with SAD.

7. Coping Skills Employed By Patients With SAD And Attendant Implications

The following are possible adverse coping skills employed by patients with SAD and their attendant implications.

7.1 Avoidance

This is more common in patients with the full blown disorder [42]. It is possible that the apprehension and/or experience of the excessive response keeps patients with SAD anxious as well as avoidant of inducers of such experience, which may be linked to the development of Anxious-avoidant personality disorder later in adulthood.

7.2 Role Transfer

It is possible that due to the fear of embarrassing themselves or others, they could give up their roles in activities even when capable in an attempt to avoid the feared situation. The psychological distress could lead to reduced work productivity and feelings of dissatisfaction [5].

7.3 Substance Use

People with the sub-threshold forms of SAD were more at risk at developing alcohol related problems than those with full blown SAD [42]. This may be in an attempt to alter their state of conscious awareness as regards anticipation or during the experience of SAD symptoms. However, development of alcohol related problems has been linked to peer pressure and social media [43]. As a socially accepted practice, it could be easily mis-used and/or abused.

Another socially accepted practice that could be abused is cigarette smoking. This can lead to alcohol and other drug use induced disorder as well as possible medical complications in the future.

7.4 Self-harm/Suicide

The psychological distress of SAD has been associated with increased suicidal ideation and attempts amongst

patients [4].This is could stem from major depression requiring emergency psychiatric services.

7.5 *Behavioral Changes*
The potential of SAD symptoms to run a chronic course could reflect in a chronic change in patient's behavioral pattern which could be disturbing to others. For example exhibition of irritability as a way to 'let out frustrating emotions about the disability caused SAD symptoms'. Other behavioral changes could include withdrawal.

8. Possible Factors That May Affect Treatment

8.1 Patient's Related:

8.1.1 *Socio-cultural factors: Have been earlier discussed*
8.1.2 *Fear of a possible undiagnosed medical condition*
8.1.3 *Fear of therapy expenses*
8.1.4 *Fear of drugs and its adverse effects*

8.2 Therapist related:

8.2.1 *Cultural difference:* Culture-specific symptoms may lead to under-recognition or mis-identification of psychological distress [3].
8.2.2 *Linguistic Challenge:* 'Clinicians must learn to decode the meaning of somatic and dissociative symptoms, which are not simply indices of disease or disorder but part of a language of distress with interpersonal and wider social meanings' [3].
8.2.3 *Prevailing health practice:* Screening rates for SAD in Primary Care practices have been recorded to be low and majority of those who have this condition go untreated [5].
8.2.4 *Clinician's professional orientation* [3, 15, 36].
8.2.5 *Prioritization of symptoms manifestation:* For a patient who is presenting at an older age with co-morbities, there is need for thorough assessment to rule out the possibility of a background SAD. This would prevent under-diagnosis of the disorder, possibly reduce relapse rates and increase treatment in many parts of the world [5].
8.2.6 *Avoidance of patient discomfort:* Physicians, perhaps especially in Japan, may feel reluctant to refer patients to a psychiatrist or ask probing questions about social anxiety for fear of offending them [2].
8.2.7 *Diagnostic challenge:* Expression of SAD symptoms differs between places with attendant difficulties in the inadequate socio-cultural adaptation of internationally adopted diagnostic criteria and investigative tools [2] [3].
8.2.8 *Treatment Approach:* Where the viewed etiology and treatment is shared by both therapist and patient, compliance is encouraged [2] [3].

9. Management
Using The Bio-Psycho-Social Model approach:

*9.1 Biological Therapy***:** This involves the use of pharmacotherapy which involves;
9.1.1 Selective Serotonin Re-uptake Inhibitors (SSRIs) as the first line medication.
9.1.2 Benzodiazepines: in combination to SSRIs.
9.1.3 Mono-Amine Oxidase Inhibitors (MAOIs): Especially for generalized social phobia.
9.1.4 Beta blockers: At low doses prior to the anticipated stressor event.

9.2 Psychological Therapy (Psychotherapy):
This majorly involves the use of Cognitive/behavioral therapies (CBT) in combination with pharmacotherapy has proven effective and better in preventing relapses. Which component of CBT is most effective remains controversial, however combination of various components as it suits the patient's needs is recommended. CBT could be in group or individualized. Its components include;
9.2.1 Psycho-education
This could be in form of audiovisual materials. It focuses on teaching the patient and sometimes caregivers about the disorder. It includes information about possible treatments as well as empowerment of strategic coping and problem solving skills.
9.2.2 Cognitive retraining
Patients assess their thoughts about the feared event and justifications for the thoughts for them to realize the errors in a bid to make them consider a scientific-based alternative explanation.
9.2.3 Systematic Desensitization
This is a behavioral technique. The patient undergoes graded exposure to an object, event or place that triggers the anxiety, while simultaneously engaged in a type of relaxation in order to reduce the anxiety symptoms.

9.2.4 Relaxation Training
Patients are taught on how to control their anxiety during or in anticipation of the feared event.
9.2.5 Graded Exposure and Response Prevention
Patients are re-conditioned by gradually exposing them to the feared situation in a gradual pattern along with training them in various techniques in preventing the usual excessive response. Once, the patient can cope with lower level exposure, subsequent exposures are increased depending on the rate of patient's progress.

Exposure therapy has been suggested as a means of altering the temperament in families where there is poor accommodation of behavioral inhibition.

9.3 Social Therapy
9.3.1 Social skills training: This is based on the possibility of the presence of behavioral deficiencies in SAD patients.
9.3.2 Assertiveness Training
9.3.3 Family Involvement: Positive communicative skills and good social support are encouraged to facilitate remission and improvement in patient's condition.
9.3.4 Social Service Referrals: Patient and caregivers are referred to support groups that may help patient recovery and coping skills.

10. Course
SAD could persist till adulthood as a chronic psychiatric condition if treatment is not instituted. With combined therapeutic approach, response rates of up to 90% may be achieved. Therapeutic alliance is needed to facilitate treatment compliance to reduce relapse rate [2] [4].

11. Disability
SAD has been associated with lower grades and higher dropout rates from school, lower salaries, higher rates of unemployment, lower marriage rates ,dysfunctional intimate relationships, reduced work
Productivity, feelings of dissatisfaction with family life, leisure, and work activities [2] [4] [5] [44] [45].

12. Comorbidity
The co-morbidities that have been associated with SAD include other anxiety disorders such as depression, agoraphobia, panic disorder, generalized anxiety disorder, post-traumatic disorder, substance misuse and abuse (for example alcohol abuse) and specific phobias [4].

Depression is characterized by low mood, low energy, low self-esteem as core symptoms of at least two weeks [25]. One-third [5] and one-fourth [13] of patients with SAD have been found to have depression as a co-morbidity.

Agoraphobia is marked and consistent fear in or avoidance of situations such as crowds, public places, travelling alone or travelling away from home [25].

Specific Phobias is marked fear or avoidance of a specific object or situation not included in agoraphobia or social phobia [25].

Panic Disorder comprise of recurrent panic attacks that are not consistently associated with a specific situation or object, and often occurring spontaneously. The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations [25].

Generalized Anxiety Disorder is a disorder with a period of at least six months with prominent tension, worry and feelings of apprehension about every-day events and problems [25].

Post-Traumatic Disorder is the persistent remembering or avoidance (actual or preferred) of the circumstances resembling or associated with an inciter of a previous stressful event or situation (either short or long) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone [25].

13. Differential Diagnosis Of SAD
13.1 Substance-Induced Anxiety Disorder
13.2 Obsessive-Compulsive Disorder
13.3 Generalized Anxiety Disorder
13.4 Anxious/Avoidant Personality Traits/Disorder
13.5 Depressive Disorder
13.6 Psychotic Disorders (Secondary avoidance due to delusional ideas)
13.7 Specific Phobia, Hypochondriasis, Anorexia Nervosa
13.8 Anxiety Disorder Due to a General Medical Condition

14 Conclusion

Under-recognition of patients with Social Anxiety Disorder, delayed clinical presentation and diagnosis are significantly affected by socio-cultural factors. The associated co-morbidities and disabilities of this disorder contribute to its chronic potential. The disease burden on the patients and caregivers should attract concern given the micro and macro-economic dimensions of the disorder and its associated disabilities and co-morbidities. Policy makers, leaders and health workers need information about SAD and its consequences so that informed decisions can be made towards the factors that could lead to a delayed achievement of public health intervention strategies can be put in place.

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