

# Prevalence of Social Anxiety Symptoms Among a Sample of Egyptian Adolescents

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**Background:** Social anxiety disorder, also Known as social phobia is one of the most prevalent anxiety disorders affecting 7-13% in the community at some time in their lives and it may be reached up to 18.75%. Despite the prevalence of social phobia and the disability it causes, it remains under diagnosed and thus under treated by the clinicians. The aim of this work was to determine the prevalence of social phobia symptoms and disorder among a community sample of Egyptian university students. The sample (1000 students), their age ranged between 17-22 years was selected using a multistage stratified random sample of Al Azhar university students. The tools used in this study included the General health questionnaire (GHQ) for screening of psychiatric morbidity, Fear questionnaire to determine the profile of phobic symptoms, Liebowitz Social Anxiety Scale (LSAS) to evaluate the degree of fear and avoidance in common social situations, the DSM IV research criteria for diagnosis of social phobia disorder and Brief fear of negative evaluation scale to evaluate the severity of social phobia.

**Subjects&Methods:** subjects and 38.5% among the total sample. SAS were

more prevalent among female students, among age group 19-21 years and among rural students. Giving a report to a group, speaking up at meetings, acting performance in front of an audience, working while being observed, urinating in a public bathroom, participating in a small group and telephone in public were the commonest social phobia disorder symptoms. 32.4% of subjects with SAS fulfilled DSM IV criteria for social phobia and the majority of cases were rated as mild to moderate degree severity according to Brief FNE. Psychiatric comorbidity was very common and the most frequent psychiatric comorbidity was; other anxiety disorders especially panic attacks, depression, avoidant personality disorder and somatiform disorder.

**Results:** the prevalence of psychiatric morbidity among the total sample was 56.4%, whilst that the prevalence of social phobia symptoms was 68.2% among GHQ positive.

**Conclusion:** social anxiety symptoms and disorder are the most common anxiety disorders, causing marked social and educational disabilities, the disability and grievous outcome can now be prevented through early recognition and treatment.

**Keywords:** Social Anxiety Symptoms, Social Anxiety disorder, Prevalence, Epidemiology, Adolescents.

## Abbreviations:

GHQ: General Health Questionnaire

LSAS: Liebowitz Social Anxiety Scale

SAS: Social Anxiety Scale

MDD: Major depressive disorder

SAD: Social Anxiety disorder

FQ: Fear questionnaire

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## INTRODUCTION

Social anxiety disorder is a common psychiatric illness that imposes persistent functional impairment and disability on persons who have the disorder.

The essential feature of social anxiety disorder (Social phobia) is fear of scrutiny by other people in social or performance situation (Westenberg, 1998).

Epidemiological studies have shown a high prevalence of the condition in the general population (Lepine and pelissolo, 2000). It is the most prevalent of anxiety disorders and is the third most common psychiatric disorder after depression and alcohol abuse (Pollack, 2006). The life time prevalence ranges from 2.8 to 13.3% in epidemiological studies (Cottraux, 2005).

13.3% prevalence rate makes it the third most common psychiatric disorder (Manfro, et al. 2003). Although social phobia also known as social anxiety disorder is a very common and is a severely disabling disorder, it is all still not clearly understood, under diagnosed and under-treated in health care setting (Kaminer and Stein, 2003). With onset commonly occurring during childhood or adolescence, SAD may disrupt normal patterns of development of social personal relationships. Often having long term impact on emotional stability in social or working life. If left untreated, the course of social anxiety disorder is frequently complicated with comorbid conditions, particularly major depressive disorder (MDD) or substance abuse (Wittchen, et al. 1999).

Moreover, the presence of comorbid social anxiety disorder (SAD) in adolescents who are already depressed is associated with more malignant course, a worse prognosis and character of subsequent depressive illness (Stein, et al. 2002). Social anxiety disorder is associated with Substantial impairment. Patients exhibit a wide range of educational, occupational and social disabilities. This is a disorder of lost opportunities; individuals make major life choices to accommodate their illness. For example, they drop out of school early because of their fears of speaking in front of groups, or they take jobs that permit them to avoid interacting with other, and many become lonely and isolated, the disability and grievous outcome can now be prevented through early recognition and treatment (Van Ameringen, et al. 2004).

## SUBJECTS AND METHODS

### *Selection of the Subjects:*

Four faculties from Al Azhar University were randomly chosen to be the site of this research (Faculties of Medicine for boys and for girls and faculties of translation and language for boys and for girls). The total sample size was 1000; 250 students from each faculty, the age of the sample ranged between 17 and 22 years.

### *Procedures:*

All the sample were subjected to the (GHQ) for detection of any psychiatric morbidity, all students who scored above the cutting score (9) at the GHQ. Those were subjected to the following: Detection of the phobic symptoms and associated psychiatric symptoms resulting from phobia by using fear questionnaire (FQ). Students with phobic symptoms at the fear questionnaire was further subjected to (LSAS) to evaluate type, degree of fear and avoidance in common social situations.

Psychiatric interview by using DSM IV criteria for detection of the social anxiety disorder. Those individuals who met DSMIV criteria were subjected to (Brief-FNE) to evaluate severity of social phobia.

### *Tools:*

- The fear questionnaire: developed by IM Marks and AM Matthews is a 24-items self-rated scale that is used mainly for the assessment symptoms of phobias.
  - The Liebowitz: Social Anxiety scale (Liebowitz, 1987) evaluates fear and avoidance of 11 social (e.g. calling to people in authority) and 13 performance (e.g. working while being observed) situations.
  - The LSAS contains 4 subscales: performance fear, performance avoidance. Social fear and social avoidance. Total fear and total avoidance subscale scores can also be derived.
1. A score of 51 or below indicates mild social phobia.

2. A score of 52 to 81 indicates moderate social phobia.
  3. A score of 82 or more indicates severe social phobia.
- Brief version of negative evaluation the scale (Leary, 1983) was been used in the assessment of social anxiety. The BFNE contains 12 items, uses a 5-point Liker-type format (1=not at all characteristic of me; 5=extremely characteristic of me), and correlates highly with the original scale ( $r=0.96$ ) (Leary, 1983).

### *Statistical analysis:*

The data collected was introduced to personal computer, statistical analysis was conducted with SPSS statistical software (V, B.2, Echo soft Corp, USD).

## RESULTS

Five hundred and sixty four students (56.4%) scored above the cut off point of 9 on the GHQ had psychiatric morbidity, this group was further assessed for SAS and SAD by using social subscale of the fear questionnaire 68.2% from this group had SAS (34.2% were boys and 65.8% were girls)—Students of faculties of medicine had a higher prevalence of SAS (70%) than students of faculties of language and translations (66.1%) with significant statistical correlation. Students with age group II (19-21 years) were more prevalent to had SAS than others. A positive family history of psychiatric illness was found in 27.5% of the cases. According to (LSAS) social fear subscale, there was a significant relation in the social fear between boys and girls regarding to; talking to people in authority, being the center of attention, meeting strangers, going to a party, looking at people you don't know very well in eye, giving a party, calling someone you don't know very well, returning goods to a store. According to LSAS social avoidance subs scale, there was a significant relation regarding to, talking to people in authority, being the center of attention, meeting strangers, going to a party, looking at people you don't know very well in the eye, giving a party, resisting high pressure sale person, calling someone you don't know very well. Performance fear subscale showed significant relation regarding speaking up at meetings, giving a report to a group, eating in a public place, working while being observed, trying to pick up some one, taking a test, telephone in public, writing while being observed, drinking with others in public places, entering room when other is already seated, urinating in a public bathroom. Performance fear sub scale showed significant relation regarding to, speaking up at meetings, giving a report to a group, eating in a public place, trying to pick up some one, taking a test, telephone in public, drinking with others in public places, entering room when other is already seated, urinating in public bathrooms. Social anxiety disorder was diagnosed according to DSMIV criteria in 32.4% of students with positive SAS symptoms with statistical significant relation as regard

to gender difference. The majority of patients were rated as mild to moderate severity for social phobia disorder according to Brief-FNE. Psychiatric comorbidity was very common the most common psychiatric disorder associated with social phobia were anxiety disorder (Especially panic attack), depression, personality disorder (Especially avoidant personality disorder) and somatoform disorders.

**Table 1:** Prevalence of minimal Psychiatric Morbidity:

|                          | GHQ      | NO.  | %     |
|--------------------------|----------|------|-------|
| The total studied sample | <9 score | 436  | 43.6% |
|                          | ≥9 score | 564  | 56.4% |
|                          |          | 1000 | 100%  |

**Table 2:** Prevalence of Social anxiety Symptoms according to (F.Q):

| Total sample | Student with +ve GHQ | Student with phobic symptoms |                    |
|--------------|----------------------|------------------------------|--------------------|
| 1000         | 564                  | % from the total sample      | % from the +ve GHQ |
| 1000         | 56.4%                | 38.5%                        | 68.2%              |

**Table 3:** SAS as regard to Sex:

| The variable | Social phobic symptoms     |      |          |      |
|--------------|----------------------------|------|----------|------|
|              | Negative                   |      | Positive |      |
|              | No                         | %    | No       | %    |
| Boys         | 85                         | 47.4 | 131      | 34.1 |
| Girls        | 94                         | 52.6 | 254      | 65.8 |
| <b>Total</b> | 179                        | 100  | 385      | 100  |
|              | $\chi^2 = 9.37$ $p < 0.01$ |      |          |      |

**Table 4:** SAS as regard to age:

| Age distribution     | Boys |      | Girls |      | Total |      |
|----------------------|------|------|-------|------|-------|------|
|                      | No.  | %    | No.   | %    | No.   | %    |
| Group I < 19 years   | 32   | 8.4  | 65    | 16.8 | 97    | 25.2 |
| Group II 19-21 years | 57   | 14.8 | 103   | 26.8 | 160   | 41.6 |
| Group II >21 years   | 42   | 10.9 | 86    | 22.3 | 128   | 33.2 |
| <b>Total</b>         | 131  | 43.1 | 254   | 65.9 | 385   | 100  |

**Table 7:** Social Fear according to LSAS as regard to sex:

| Social Fear  | (Boys) |      | (Girls) |      | $\chi^2$ | p       |
|--|--------|------|---------|------|----------|---------|
|  | No.    | %    | No.     | %    |          |         |
| Talking to people in authority                               | 112    | 85.4 | 247     | 96.5 | 18.0     | <0.0001 |
| Going to a party   | 92     | 70.2 | 222     | 87.4 | 16.95    | <0.0001 |
| Calling someone you don't Know very well                     | 65     | 49.6 | 193     | 75.9 | 27.18    | <0.0001 |
| Meeting strangers  | 99     | 75.5 | 218     | 85.8 | 6.25     | <0.01   |
| Being the center of attention                                | 109    | 83.2 | 152     | 59.8 | 21.16    | <0.001  |
| Expressing a disagreement to people you don't know very well | 105    | 80.1 | 206     | 206  | 0.05     | >0.05   |
| Looking at people you don't know very well in the eye        | 86     | 65.6 | 103     | 103  | 21.78    | <0.0001 |
| Returning goods to a store                                   | 58     | 44.2 | 83      | 83   | 5.01     | <0.05   |
| Giving a party   | 69     | 52.7 | 191     | 191  | 20       | <0.0001 |
| Talking people you don't know very well                      | 108    | 82.4 | 200     | 200  | 0.74     | >0.05   |
| Resisting a high pressure sale person                        | 83     | 63.3 | 178     | 178  | 1.79     | >0.05   |

**Table 5:** Profile of Social fear symptoms according to LSAS:

| Fear Performance Symptoms                   | Males | Females |
|---|-------|---------|
| Giving a report to a group                  | 78.6% | 91.3%   |
| Speaking up at meeting                      | 77.8% |         |
| Acting performing in front of an audience   | 73.3% | 79.9%   |
| Writing while being observed                | 71.8% | 59.1%   |
| Urinating in a public bathroom              | 77.1% | 31.1%   |
| Participating in small group                | 76.3% | 75.6%   |
| Talking a test                              | 67.2% | 42.9%   |
| Telephone in public                         | 64.1% | 42.5%   |
| Trying to pick up some one                  | 63.4% | 43.3%   |
| Writing while being observed                | 61.8% | 36.2%   |
| Entering room when other are already seated | 57.3% | 33.5%   |
| Drinking with others in public places       | 51.9% | 35.8%   |
| ng in public place                          | 44.3% | 73.6%   |

**Table 6:** Profile of performance fear symptoms according to LSAS:

| Social avoidance   | Males | Females |
|--|-------|---------|
| Calling someone you don't Know very well                     | 93.5% | 75.2%   |
| Talking to people in authority                               | 77.8% | 94.9%   |
| Expressing a disagreement to people you don't know very well | 76.3% | 81.1%   |
| Being the center of attention                                | 74.8% | 78.7%   |
| Talking with people you don't know very well                 | 72.5% | 29.1%   |
| Meeting strangers  | 68.7% | 83.1%   |
| Going to a party   | 63.4% | 83.5%   |
| Looking at people you don't know very well in the eye        | 58.8% | 42.5%   |
| Resisting a high pressure sale person                        | 52.7% | 67.7%   |
| Giving a party   | 47.3% | 74.8%   |
| Returning goods to a store                                   | 32.8% | 30.1%   |

**Table 8:** Social avoidance according to LSAS as regard to sex:

| Social avoidance   | (Boys) |      | (Girls) |      | x <sup>2</sup> | p       |
|--|--------|------|---------|------|----------------|---------|
|  | No.    | %    | No.     | %    |                |         |
| Talking to people in authority                               | 102    | 77.8 | 241     | 94.9 | 25.76          | <0.0001 |
| Going to a party   | 83     | 63.4 | 212     | 83.5 | 19.5           | <0.0001 |
| Calling someone you don't know very well                     | 57     | 93.5 | 191     | 75.2 | 37.85          | <0.0001 |
| Meeting strangers  | 90     | 68.7 | 211     | 83.1 | 10.46          | <0.01   |
| Being the center of attention                                | 98     | 74.8 | 150     | 29.1 | 9.36           | <0.01   |
| Expressing a disagreement to people you don't know very well | 100    | 76.3 | 206     | 81.1 | 1.2            | >0.051  |
| Looking at people you don't know very well in the eye        | 77     | 58.8 | 93      | 36.6 | 17.22          | <0.0001 |
| Returning goods to a store                                   | 43     | 32.8 | 78      | 30.1 | 0.18           | >0.05   |
| Giving a party   | 62     | 47.3 | 190     | 74.8 | 28.85          | <0.0001 |
| Talking people you don't know very well                      | 95     | 72.5 | 200     | 78.7 | 1.87           | >0.05   |
| Resisting a high pressure sale person                        | 69     | 52.7 | 172     | 67.7 | 8.36           | <0.01   |

**Table 9:** Performance fear according to LSAS as regard to sex:

| Performance fear                             | (Boys) |      | (Girls) |      | x <sup>2</sup> | p       |
|--|--------|------|---------|------|----------------|---------|
|  | No.    | %    | No.     | %    |                |         |
| Telephone in public                          | 84     | 64.1 | 108     | 42.5 | 16.13          | <0.001  |
| Participating in small group                 | 100    | 76.3 | 192     | 75.6 | 0.03           | >0.05   |
| Eating in public places                      | 58     | 44.3 | 187     | 73.6 | 32.17          | <0.0001 |
| Drinking with others in public places        | 68     | 51.9 | 91      | 35.8 | 9.2            | <0.01   |
| Acting performing in front of an audience    | 96     | 73.3 | 203     | 79.9 | 2.2            | >0.05   |
| Working while being observed                 | 94     | 71.8 | 150     | 59.1 | 6.01           | <0.01   |
| Writing while being observed                 | 81     | 61.8 | 92      | 36.2 | 22.9           | <0.0001 |
| Urinating in a public bathroom               | 101    | 77.1 | 79      | 31.1 | 73.5           | <0.001  |
| Speaking up at meeting                       | 102    | 77.8 | 232     | 91.3 | 13.7           | <0.01   |
| Giving a report to a group                   | 103    | 78.6 | 228     | 89.8 | 8.89           | <0.01   |
| Trying to pick up some one                   | 83     | 63.4 | 110     | 43.3 | 13.9           | <0.001  |
| Talking with people you don't know very well | 75     | 57.3 | 85      | 33.5 | 20.1           | <0.0001 |
| Resisting a high pressure sale person        | 88     | 67.2 | 109     | 42.9 | 20.4           | <0.001  |

**Table 10:** Performance avoidance according to LSAS as regard to Sex:

| Performance avoidance                        | (Boys) |      | (Girls) |      | x <sup>2</sup> | p       |
|--|--------|------|---------|------|----------------|---------|
|  | No.    | %    | No.     | %    |                |         |
| Telephone in public                          | 76     | 58   | 100     | 39.4 | 12.1           | <0.001  |
| Participating in small group                 | 97     | 74   | 192     | 75.6 | 0.11           | >0.05   |
| Eating in public places                      | 50     | 38.2 | 175     | 68.9 | 33.6           | <0.01   |
| Drinking with others in public places        | 62     | 47.3 | 86      | 33.9 | 6.63           | <0.01   |
| Acting performing in front of an audience    | 95     | 72.5 | 200     | 78.7 | 1.87           | >0.05   |
| Working while being observed                 | 83     | 63.4 | 141     | 55.5 | 2.19           | >0.05   |
| Writing while being observed                 | 72     | 54.9 | 79      | 31.1 | 20.6           | <0.0001 |
| Urinating in a public bathroom               | 94     | 71.8 | 60      | 23.6 | 83.4           | <0.0001 |
| Speaking up at meeting                       | 102    | 77.8 | 232     | 91.3 | 13.7           | <0.001  |
| Giving a report to a group                   | 99     | 75.6 | 223     | 87.8 | 9.94           | <0.001  |
| Trying to pick up some one                   | 71     | 54.2 | 95      | 37.4 | 9.94           | <0.01   |
| Talking with people you don't know very well | 66     | 50.4 | 81      | 31.9 | 12.5           | <0.001  |
| Resisting a high pressure sale person        | 81     | 61.8 | 100     | 39.4 | 17.5           | <0.0001 |

**Table 11:** Prevalence of Social Anxiety disorder:

| Meeting criteria of social anxiety disorder               | Adolescents gender |      |       |      |
|---|--------------------|------|-------|------|
|   | Boys               |      | Girls |      |
|   | No.                | %    | No.   | %    |
| Social anxiety symptoms with social anxiety disorders.    | 42                 | 10.9 | 83    | 21.5 |
| Social anxiety symptoms without social anxiety disorders. | 89                 | 23.1 | 171   | 44.4 |
| <b>Total</b>  | 131                | 34.1 | 254   | 65.9 |
| Chi-square $\chi^2$                                       | 0.21               |      |       |      |
| P value   | >0.05              |      |       |      |

**Table 12:** Severity of SAD according to Brief – FNE:

| Brief-FNE    | Boys |      | Girls |      | Total |      |
|--------------|------|------|-------|------|-------|------|
|              | No.  | %    | No.   | %    | No.   | %    |
| Non          | 9    | 2.3  | 3     | 0.8  | 12    | 3.1  |
| Mild         | 31   | 8.1  | 16    | 4.2  | 47    | 12.2 |
| Moderate     | 27   | 0.7  | 13    | 3.4  | 40    | 10.3 |
| Severe       | 16   | 4.2  | 8     | 2.1  | 26    | 6.7  |
| Extreme      | 0    | 0.0  | 2     | 0.5  | 2     | 0.5  |
| <b>Total</b> | 83   | 21.6 | 42    | 10.9 | 125   | 32.5 |

## DISCUSSION

It is normal for a child or adolescent to be anxious in new or relatively challenging social or evaluative situations (e.g. the first oral report, athletic or musical performances, and changing schools, tasking tests). Social anxiety symptoms during these situations may include physiological response such as increased heart rate and respiration, blushing and sweaty palms. In addition to behavioral symptoms such as stuttering and avoiding eye contact. Mild to moderate level of these symptoms are considered normal and consistent with developmental expectations. Excessive reactions involving panic attacks behavioral freezing, crying, tantrum, or excessive somatic complaints considered inconsistent with developmental expectations are evidence of the clinical state of social phobia (Langone and Glickman, 2000).

The evidence suggests that social anxiety is a normal, species typical, designed response to specific triggering situations, one that is roughly normally distributed in temperamental intensity (Schneier, et al. 2002).

This raises the question: Is temperamentally high but non disordered social anxiety being mislabeled a disorder? They argue that many, perhaps most people whom the DSM-IV potentially classifies as suffering from social phobia are probably not disordered (Wakefield, et al. 2005). So, clinical scientists identify three broad factors to consider in delineating normal social fears from social phobia in youth:

- the magnitude of the social fears in the context of developmental expectations.

- the persistence of the anxiety reaction over time, despite repeated opportunities for contact with the anxiety provoking cue.
- the degree of interference in functioning across a variety of domains. (Langone and Glickman, 2000).

This work presents data from a field study among adolescents in the university students with ages ranging between 17-22 years. The prevalence of probable minor psychiatric morbidity was 56.4%. this high prevalence could be explained by many biological and social factors that are associated with adolescence and early adulthood, especially in a country like Egypt, where the socioeconomic situation prolongs the duration of dependence on family and where attempts at independent living are met with major challenges, foremost economic ones. Although several studies allover the world in varying populations have been carried out of estimate the prevalence of SAD, yet there are still faraway from being truly representative. This can be linked to methodological problems or to difference in sociodemographic variables or because social anxiety disorder was though to be a relatively rare disorder and the patients with social anxiety disorder in the community seldom seek or receive psychiatric care leading to a gross under estimation of the prevalence of the disorder.

According to social phobia subscale, the prevalence of social phobia symptoms was 40%. This is nearly equal with the world wide recognition of high prevalence of social phobia in epidemiological studies. A community survey in USA, (Stein, et al. 2002) found that 39.6% had social phobia symptoms.

Ragahb, et al. (2005) found that the prevalence of social phobia among An Egyptian students was 30.9%. (Haggag and El Sheikh, 2003) found that the frequency of social phobia among a sample of Egyptian collage students was 45.5% also, (Bassiony, et al. 2001) discovered that 78% of his sample of patients had generalized social phobia.

Differences in estimation rates of the actual prevalence of social phobia in epidemiological studies were attributed by stein, et al. (2002) whether the tools used for surveys covered a narrow or a wider range of social situations and depends also on where the diagnostic threshold is set. The high frequency of social phobia symptoms in this study can be viewed from the same perspective.

Also, the high frequency of social anxiety symptoms could be explained by expectations of employment difficulties after graduation with its impact on all life domains. The typical adolescents is confronted with



social evaluative situation on a daily basis, this may cause transient increased social anxiety symptoms which is considered a normal developmental experience; they cause relative little interference in functioning, but some of them may truly developed social anxiety disorder (Langone and Glickman, 2000). In the general population the gender ratio is approximately 1.5 to 2 females to 1 male (Wells, et al. 1994), but in clinical samples there is a more even gender distribution (Degonda and Angst, 1993). In the present study sex difference was found in the prevalence of SAS, it was (65.8%) for girls and (34.2%) for boys. The same result was found by Ibrahim, (2006) in their study of social phobia symptoms in children. Most of the girls of our sample were originally from rural areas (49.8%) where the culture plays an important role in the appearance and presentation of symptoms. The parent behavior and family environment act as modeling of avoidant responses and restricted exposure to social situations, and they are likely to have moderate effect on the development of social phobia.

SAS was more prevalent among group II; age ranged between 19-21 years. Also it may be due to educational relocation from secondary schools at rural and small villages areas to university at Cairo; a huge modernized city where there is complete environmental variations and variations in traditions and attitude, therefore the conflict arising between following their tradition and culture and their efforts to adjust properly to their new modernized environmental life style, might have frustrated their adaptation skills and have provoked or increased their social anxiety symptoms.

Langone and Glickman, (2000) mentioned that classic social phobia typically has an onset in early adolescence (Age 12-13) yet many youngsters report a history of social inhibition or shyness much earlier. With increasing age, adolescents develop more sophisticated social cognitive skills which enable them to compare themselves with others and to examine and interpret situations from another perspective. In most cases, the onset is prior to the end of adolescence. There are reports of onset in early adolescence and even in childhood, the epidemiological study of Haggag and El Sheikh, (2003) found that the mean age at onset for college students in Egypt is 20 years. But, Bassiony, et al. (2001) found that the mean age at onset is in late adolescents (17 years). In another study done he found that the mean age at onset is 19.5 years. While, (Allsopp, et al. 1984) found that mean age of patients with social phobia (27.7 years).

Talking to people in authority, going to a party, meeting strangers, talking people you don't know very well, expressing a disagreement to people you don't know very well were the most frequent social fear symptoms in girls according to LSAS. Talking to people in authority, being the center of

attention, talking with people you don't know very well, expressing a disagreement to people you don't know very well were the most frequent social fear in boys according to LSAS. Giving a report to a group, participating in small group, eating in public places, were the most frequent performance fear symptoms in girls according to LSAS. Giving a report to a group, speaking up at meeting, urinating in a public bathroom, were the most frequent performance fear symptoms in boys according to LSAS.

Wittchen, et al. (1999) had found that the most commonly SAS among adolescents were fears of performance situation (31.1%), public speaking (19.7%), talking to others (9.2%), eating or drinking in public (8.3%) and writing while someone is watching (2.9%).

According to Liebowitz social anxiety scale as regard to social fear, there was a significant statistical relation between boys and girls regarding talking to people in authority, being the center of attention, meeting strangers, going to a party, looking at people you don't know very well in the eye, giving a party, calling someone you don't know very well, returning goods to a store.

As regard to social avoidance, there was a significant relation between boys and girls regarding talking to people in authority, being the center of attention, meeting strangers, going to a party, looking at people you don't know very well in the eye, giving a party, resisting high pressure sale person, calling someone you don't know very well. As regard to performance fear, there was a significant relation between boys and girls regarding speaking up at meetings, giving a report to a group, eating in a public place, working while being observed, trying to pick up some one, taking a test, telephone in public, writing while being observed, drinking with others in public places, entering room when other are already seated, urinating in a public bathroom. As regard to performance avoidance, there was a significant relation regarding, speaking up at meetings, giving a report to a group, eating in a public place, trying to pick up some one, taking a test, telephone in public, drinking with others in public places, entering room when other are already seated, urinating in a public bathroom. Psychiatric comorbidity was found in about 50% of cases, the most prevalent psychiatric comorbidity were; other anxiety disorder especially panic disorder, depressive disorder, personality disorders especially avoidant personality disorder and substance misuse.

Stein, et al. (2002), found that 35% of a group of socially phobic patients had a lifetime histories of at least one major depressive episode. Jansen, et al. (1994) had pointed out that at least one personality disorder is present in 50% of socially phobic patients. The most prevailing one is avoidant personality disorder.

Our results showed that SAD was diagnosed according to DSMIV criteria in 32.4% of students with positive SAS symptoms. This high prevalence of SAD can be explained by the fact that they were subjects from those who have SAS and not the prevalence in the general population. However these were also non-consulting subjects, which poses a challenge to the health-care system to identify them.

SAS was mostly in the mild range of severity in both cases, which is an expected finding considering that the study sample were all non consulting subjects, who did not seek help for their symptoms. Further more it seems that the cultural background provides some reference for rationalizing the symptoms as intruding into their lives or severely obstructing their capacity to function.

Defining optimal cutoff points for distinguishing between psychiatric disorder and SAS that are common in the general population therefore remain a challenge. Hence school and university health systems are recommended to put forward strategies for the early detection of such cases. It could well be recommended to introduce a screening system for SAS symptoms among school and university students in order to reduce its deleterious effect on the student's psychological health, academic performance, maturation of personality, interpersonal relationship, difficulties in adaptation, apart from subjective suffering. This in addition to routine psychological assessment of school and management. Recognition of those symptoms by primary care practitioners can help demystify the phenomenon and ensure subjects with SAS who may sometimes be embarrassed by their symptoms and may at others have a great fear of going "Insane".

Furthermore, public awareness campaigns targeting parents, school and religious leader may work to alter patterns of upbringing that may predispose to the development of SAS and possibly SAD.

## CONCLUSION

Social anxiety symptoms and disorder are the most common anxiety disorders, causing marked social and educational disabilities, the disability and grievous outcome can now be prevented through early recognition and treatment.

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## الملخص العربي

### دراسة معدل انتشار أعراض القلق الاجتماعي لدى عينة من المصريين المراهقين

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كان معدل الرهاب الاجتماعي أكثر في الإناث عن الذكور. كان اضطراب الرهاب الاجتماعي 32.4% من هؤلاء الذين لديهم أعراض رهابية.

بلغ معدل الاضطرابات النفسية المصاحبة 50% وكان أكثرها اضطرابات القلق الأخرى وأكثرها الهلع، ثم اضطراب الإكتئاب فالاضطرابات الشخصية.

هذا البحث يبرز أهمية زيادة وعي المتخصصين بهذا النوع من الاضطراب النفسي وذلك لأهمية الاكتشاف المبكر للإصابة به ومن ثم علاجه لتقليل أثاره السلبية اجتماعيًا ونفسيًا. كما نبهت نتائج هذا البحث إلى توقع حدوث الرهاب الاجتماعي مع اضطرابات القلق الأخرى والإكتئاب وأكدت أهمية تقييم نوع الشخصية لمرضى الرهاب الاجتماعي ووضعها في الاعتبار ضمن خطة العلاج.

رغم سعة إنتشار الرهاب الاجتماعي حسب الدراسات الوبائية الحديثة فإنه لا يزال يشخص بمعدل أقل ومن ثم لا يحصل معظم المصابين به على العلاج اللازم. يهدف هذا البحث إلى دراسة معدل حدوث الرهاب الاجتماعي لدى عينة من الطلبة المصريين.

إشتملت العينة على 1000 طالب وطالبة 500 طالب و500 طالبة من جامعة الأزهر. تتراوح أعمارهم من 17-24 سنة بمتوسط 18-21 سنة.

#### خضعت العينة للاختبارات الآتية:-

استبيان الصحة العام - استبيان الخوف المستنبط من استبيان الخوف لايزاك ماركس - مقياس ليبوتز للرهاب الاجتماعي، مقياس التقدير السلبي للخوف.

بلغ معدل وجود أعراض نفسية خفيفة غير ذهانية 56.4% - بلغ معدل أعراض الرهاب الاجتماعي 38.5% من العينة الكلية، 68.2% من الذين لديهم أعراض نفسية خفيفة.