Social Phobia in an Arab Culture: The Impact of Sociocultural Factors

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A relatively high frequency of cases presenting with social phobia has been observed among Saudi patients seeking psychiatric help. In this study an attempt was made to assess the possible role of some sociocultural factors in explaining this phenomenon. Two aspects were explored:

1- The possible impact of social change in terms of upward social mobility, urbanization, and change of family structure.

2- The possible impact of the cultural patterns (cultural norms, traditions and customs) as reflected in the types of social contexts provoking social anxiety.

The study was conducted on a group of social phobic patients (N=53). A control group of other neurotic disorders (N=26) was utilized to assess the impact of social change. The results seem to provide evidence for a highly possible role of sociocultural factors in explaining the phenomenon of social phobia as observed in this culture. Implications related to the psychopathology of phobic disorders are discussed.

(Egypt.J. Psychiat.,1992,15:102-113).

Introduction

This study is part of a research project that was stimulated by our observation of a relatively high frequency of cases presenting with social phobia among Saudi patients attending a psychiatric outpatient clinic in Ryiadh. In a previous study (Arafa and Al-khani, 1988) a preliminary assessment of the prevalence of the disorder among patients attending the clinic confirmed these impressions. Cases diagnosed as social phobia comprised about 80% of phobic disorders, 20% of neurotic disorders and 9% of all psychiatric disorders seen over a period of one year. Similar observations were reported by another Saudi study in which social phobia comprised about 13% of neurotic disorders encountered in an outpatient clinic (Chaleby, 1987). These findings contrast with reports from the West which indicate that agoraphobia is clinically the most common phobic disorder and comprises about 60% of all phobic disorders. Taking into consideration that phobic disorders are estimated to account for less than 5% of all neurotic disorders in patients over 18 years of age, it may be assumed that social phobia does not exceed 2% of all neurotic disorders diagnosed clinicaly, (Nemiah, 1985). Though clinically appearing less common than agoraphobia, simple phobias are thought to be the most common phobic form epidemiologically (American Psychiatric Association,

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1987). This has been confirmed by some recent epidemiological reports indicating that simple phobias are more common than agoraphobia in the general population. As indicated in the same reports, however, social phobia was the least common phobic disorder (Freeman, 1988). In our attempt to explain this phenomenon, the possibility that certain sociocultural factors contribute to this high frequency of social phobia among Saudi patients was raised and hypothetically discussed in the first study (Arafa and Al- khani, 1988).

Sociocultural factors may influence mental disorders in different ways. Cultural patterns may have a bearing on the type or frequency of mental disorder. Child rearing practices and the socialization process are among the means mediating such impact. On the other hand, specific social situations or processes such as the social class and processes of social change may be related to high or low incidence of mental disorder or specific types of mental disorder. Generally speaking, sociocultural factors are thought to have both an aetiological role and a symptom molding effects (Dunham, 1976; Favazza and Oman, 1978). Social change has been particularly suggested as a significant agent related to an increased rate of some mental disorders or a specific aetiological factor in relation to others. Such effects are more likely to occur with sudden or rapid change (Kiev, 1972; Dunham, 1976). The extent to which sociocultural factors can influence mental illness is still highly debatable. Nevertheless, there seems to be some agreement that it is largely with the milder mental disturbances; the psychoneuroses and some character disorders, that one can make a case of the impact of such factors. In relation to psychotic disorders which are thought to be more influenced by early formative factors (e.g. biological vulnerability) the effects may be more limited (Dunham, 1976).

In relation to social phobia some authors have pointed to the possible role of sociocultural factors. According to Trower, et al., (1978), people undergoing upward social mobility are more liable to difficulties in coping with the new social milieu. Among these difficulties social anxiety is an understandable problem. Amies et al., (1983) have demonstrated a rather direct evidence in this respect. They found that, compared to patients with agoraphobia, patients with social phobia had significantly more often changed social class in an upward direction. This, together with some other factors, has led them to conclude that "social phobia evolves from normal social anxieties made worse by the need to face new social expectations".

As regards Saudi Arabia in which this research project was conducted there are sufficient reasons to suggest a significant role for sociocultural factors in relation to mental disorders including social phobia. As an Arab society its cultural patterns, including child rearing practices, have special characteristics which may influence different aspects related to psychiatric disorders (El-Islam, 1982, 1984). On the other hand, the Saudi society is currently undergoing a vast and rapid process of socioeconomic development and change. Urbanization and upward social mobility are two major aspects of this process. Large sectors of the population have moved from Bedouin (nomadic) and rural areas to the highly expanded or newly constructed modern urban centers. In addition, major economic and social developments touching all aspects of life including occupational activities and education have led to marked upward social mobility for a major bulk of the population (Al-Said, 1982)

In the present study an attempt is made to test the hypothesis that certain sociocultural factors may be related to the phenomenon of social phobia as observed in the Saudi society. Two main aspects are explored;

1- The possible impact of social change in terms of upward social mobility, urbanization and change in family structure.

2- The possible impact of cultural patterns (cultural norms, traditions and customs) as reflected in the types of social contexts or situations provoking social anxiety.

Subjects and Method

This study was conducted on 53 consecutive patients diagnosed as social phobia in a psychiatric outpatient clinic in Ryiadh and a control group of 26 patients attending the same clinic but presenting with other neurotic disorders. The diagnoses included generalized anxiety disorder (4 patients), panic disorder (6 patients), agoraphobia (3 patients), obsessive compulsive disorder (5 patients) and dysthymic disorder or depressive neurosis (8 patients). The diagnosis of social phobia and other neurotic disorders was established according to the criteria of the DSM-III-R (American Psychiatric Association, 1987)

In addition to the initial full psychobiogram, both the social phobia and control group patients were subjected to a structured interview eliciting precise information as regards three main indices of social change including:

1- Levels of occupation and education of patients of the two groups compared to those of their fathers.

2- Urbanization, i.e. movement from Bedouin (nomadic) or rural areas to an urban center (big city) during childhood or early youth.

3- The state of family - life - structure whether extended, nuclear or otherwise.

Choosing occupation and education, as indicators for social mobility instead of the usual social class stratifications, was decided for practical purposes including the fact that the structure of the traditional Saudi society may not conform with the conventional categories of such stratifications originally developed in the West. However, the chosen indicators are reasonably accepted, particularly occupation which has always been the main and most commonly used indicator for social classifications (Lipset and Zetterbery, 1966; Jones, 1988). On the other hand comparing the father's position, particularly occupational position, with that of his son is considered a conventional operational method for ascertaining social mobility (Lipset and Zetterberg, 1966).

To assess the possible role of cultural patterns in anxiety provoking social situations patients with social phobia were subjected to a special rating scale. On a 4-point scale (o=none,1=mild,2= moderate and 3= severe) each patient was required to evaluate the intensity of his anxiety in relation to 8 possible social contexts or situations. These were selected to represent the common variety of possible contexts for social encounter in the society. At the same time they also represent possible variable degrees of demand for conformity to norms and rules of behaviour dictated by the traditional cultural patterns.

Interviews with all patients were conducted by the same senior psychiatrist. Statistically, chi-square analysis was used to test the significance of differences on categorical data while the t-test was used to evaluate differences on continuous data. The student-Newman-Keuls test was used to evaluate the differences among mean scores for different social contexts on the rating scale.

Results

The social phobia and the control group were comparable as regards age, sex, marital status as well as occupational and educational levels. Mean age of the social phobics was 28.2 while it was 29.6 for the control group (t-test: difference not significant). In the social phobia group 48 (90.6%) of the patients were males and 5 (9.4%) were females compared to 20 (76.9%) and 6 (23.1%)

Table 1

Levels of Education and Occupation in Patients and Fathers of the Two Groups Compared

	Social Phobia (N = 53)		Control Group (N = 26	
	Patients No (%)	Fathers No (%)	Patients No (%)	Fathers No (%)
Education				
1- Illiterate	—	32 (60.4)	—	10 (38.5)
2- Reads & writes	—	10 (18.9)	—	8 (30.8)
3- Primary school	10 (18.9)	9 (16.9)	—	1 (3.8)
4- Middle school	13 (24.5)	2 (3.8)	8 (30.8)	4 (15.4)
5- Secondary school	17 (32.1)	—	11 (42.3)	1 (3.8)
6- Higher (education)	13 (24.5)	—	7 (27)	2 (7.7)
Occupation				
- Nomadic & rural (Semi-skilled & unskilled labour)	—	20 (37.7)	—	6 (23.1)
2- Skilled labour	3 (5.6)	5 (9.5)	—	1 (3.8)
3- Trading (small business)	2 (3.8)	14 (26.4)	1 (3.8)	10 (38.5)
4-Semiprofessional & clerical	30 (56.6)	14 (26.4)	11 (42.3)	6 (23.1)
5- Professional	11 (20.8)	—	7 (27)	3 (11.5)
6- Students	4 (11.3)	—	4 (15.4)	—
7- Other :Housewife	1 (1.9)	—	3 (11.5)	—

in the control group respectively. As regards marital status, 23 (60.4%) were married and 21 (39.6) were single in the social phobia group, while in the control group the respective figures were 18 (69.2%) and 8 (30.8%). Data on educational level and occupation are indicated within table (I). Statistical evaluation (chi-square analysis) revealed no significant differences between the two groups on all of the above criteria.

A) Indices of social change.

1- Upward social mobility

Table (I) illustrates levels of education and occupation of patients compared to their fathers. While the majority of fathers of social phobic patients are illiterate (about 60%) or can merely read and write (about 20% more) with none receiving any secondary school or higher education, most of the patients (about 80%) had at least finished middle school and a good percentage (about 25%) had received a higher education. A similar trend can be noticed in the control group though the fathers' level of education was relatively higher than that of the fathers of the social phobic group (illiterates about 40% and about 10% had received a secondary school or some higher education). As regards occupation, the major percentage of fathers of patients with social phobia (about 74%) had lower level occupations such as unskilled or semiskilled nomadic or rural activities (e.g. activities related to sheep and camel raising or some simple agricultural forms), some skilled labour or trading (small business), while the minor percentage (about 26%) had semiprofessional (including clerical) occupations. The sons, on the other hand, show a majority of higher level occupations belonging to the semiprofessional (about 57%) and professional (about 21%) categories, with none falling in the category of the low skilled nomadic or rural activities. Here also, a similar trend is noticed in the control group but again the fathers in

Table 2

Results of the Chi-Square test (P of x^2) Comparing the Levels of Education and Occupation Among Patients and Fathers of the Two Groups

	Education	Occupation
P1 Vs. F1	P < .0001	P < .0001
P2 Vs. F2	P <. 0001	P < .001
P1 Vs. P2	N.S.	N.S.
F1 Vs F2	P < .05	N.S.

P_1 = Patients with social phobia

P_2 = Patients of control group

F_1 = Fathers of social phobia patients

F_2 = Fathers of control group.

this group show a relatively higher level of occupations (less in the nomadic or rural category and about 12% in the professional category). These observations are reflected in the statistical evaluation of differences among patients and fathers of the two groups. Significant differences in the levels of education and occupation were encountered between patients and their fathers in the two groups. No statistically significant difference was found between patients of the two groups but the comparison between fathers shows a significant difference ($p<.05$) in relation to education alone. If we roughly try to express these findings in terms of the traditional social class classification (Jones, 1988), it may be globally concluded that while most patients can be allocated to classes I and II, most of their fathers belonged to classes III, IV and V. This clearly indicates a significant upward social mobility in both groups.

2- Urbanization

Social change in terms of migration from Bedouin (nomadic) or rural areas to an urban center is illustrated in table (3). It can be noticed that most patients with social phobia (about 64%) had moved from some Bedouin-rural area to a big city (mostly Ryiadh) during childhood or early youth. The rest (about 36%) showed no movement and were either stable city (32%) or Bedouin-rural (4%) inhabitants.

Table 3

Social Change in Terms of Movement from Bedouin - Rural to Urban Areas (Urbanization) in the Two Groups Compared.

	Social phobia (N = .53) No (%)	Control group (N = 53) No (%)
1- No movement		
a- Bedouin-rural inhabitants	2 (3.8)	1 (3.8)
b- Urban inhabitants	17 (32.0)	19 (73.1)
Total	19 (35.8)	20 (76.9)
2- Movement from Bedouin - rural area to urban center during childhood or early youth	34 (64.2)	6 (23.1)

* P <0.01 (Chi-Squre test)

In the control group, the situation is clearly reversed with most patients (about 77%) being stable inhabitants, either of the city (73%) or some Bedouin-rural area (4%), while movers comprise about 23% only. The difference between the two groups was statistically significant (chi-square: $p < .01$).

3- Family structure

Data of the present state of family-life-structure (table 4) indicate that most of the social phobia group either still maintain the extended family pattern (about 49%) or are living alone or with mates (15%) which probably reflects a transitional stage related to migration to the city for educa-

Table 4

Present State of the Family-Structure in the Two Groups Compared.

	Social phobia (N = 53)	Control gronp (N = 26)
	No (%)	No (%)
1- Extended Family	26 (49.1)	7 (27)
2- Nuclear Family	19 (35. 8)	18 (69.2)
3- Other:living alone or with mates	8 (15)	1 (3.8)

* P <0 . 05 (Chi-Square test).

work. On the other hand most of the control group (about 69%) have already shifted to the more urbanized nuclear pattern. The difference between the two groups was statistically significant (chi-square: P< .05).

B) Degree of social anxiety in relation to social contexts

Table (5) illustrates the mean scores of social anxiety as well as the percentage of scores rated "severe" in relation to different social contexts or situations commonly encountered in the Saudi culture. The highest means were exhibited in relation to contexts of gatherings of some official or formal social character such as ceremonies, weddings, parties .. etc. (2.6 and about 72% rated severe), contexts involving remote relatives, i.e. different degrees of kinship within the big family or tribe (2.5 and 66% rated severe) and contexts involving encounter with superiors or authority figures (2.4 and about 53% rated severe). Statistically, no significant differences were detected between these means but they were significantly higher than means related to all other contexts.

Table 5

Degree of Social Anxiety in Relation to Different Social Situations or Contexts as Rated by the Patients (N = 53)

Social context	Mean score (±SD)		Scores rated severe	
			No.	%
1- With direct family (father, mother & siblings)	0.6 (± 0.7)	**	–	–
2- With close relatives (uncles, aunts, cousins)	1.8 (± 0.8)		8	15
3- With remote relatives (Kinship within big family or tribe).	2.5 (± 0.8)	*	35	66
4- with colleagues or peers at work	1..8 (± 1)		16	30.2
5- With superiors or authority figures	2.4 (± 0.8)	*	28	52.8
6- With close personal friends	1.3 (± 1)		6	11.3
7- Big gatherings of some formal social character (ceremonies, weddings, parties ...)	2.6 (± 0.7)	*	38	71.7
8- Out of country and/ or with foreigners from other cultures	0.7 (±1)	**	2	3.8

According to the Student-Newman-Keuls procedure:

* No significant differences between situations 3,5 & 7 but they are significantly higher than all other situations (P<. 05).

** No significant differences between situations 1 & 8 but they are significantly lower than all other situations (P<. 05).

On the other hand, the lowest degrees of anxiety were rated in relation to contexts involving direct family members (mean 0.6 and none rated severe) as well as contexts involving only foreigners from other cultures encountered within the country or on travelling abroad (Mean 0.7 and about 4% rated severe). Their mean scores are not significantly different statistically but are significantly lower than means related to all other contexts. Other social contexts or situations (i.e. those involving close relatives, close personal friends or colleagues or peers at work) occupy an intermediate position.

Discussion

The results of this study seem to provide evidence for a highly possible impact of sociocultural factors in relation to social phobia as observed in Saudi patients.

A) Indices of social change

Indices of social change examined in this study generally indicate that social phobic patients have undergone relatively sharper and more dramatic changes and have accordingly been subjected to higher sociocultural stresses compared to the control group of other neurotic disorders. This fact is rather clear in relation to urbanization. Significantly more social phobic patients than other neurotic patients had moved from Bedouin or rural areas to urban centers during childhood or early youth. However, it is less conspicuous in relation to upward social mobility. Assessment of this index indicates that both the social phobia and the control group had undergone a significant upward mobility compared to their fathers but in this respect there was no significant statistical difference between the two groups. However, subtle differences in the fathers' levels of education and occupation imply that the social phobic patients may have been subjected to somewhat sharper or more dramatic change. This result is not as positive as that demonstrated in the study of Amies et al., (1983) in which social phobic patients had significantly more often changed social class in an upward direction compared to another group of agoraphobic patients. However, this may be explained by the fact that the process of socioeconomic change and upward mobility in the Saudi society has involved almost all the population (Al-Said, 1982). Thus, it has become a common factor whose differential effects on different groups would require more refined investigation. In our opinion this result does not necessarily negate the understandable impact of upward mobility in relation to social phobia. It may simply be a demonstration of the fact that it is rather a common factor that may influence different groups differently depending on their degree of predisposition. An alternative or additional explanation may be that the major or the differential stressful impact of social change for the Saudi social phobic patients is not related to upward social mobility as much as it is related to the shift from Bedouin to urban life and being in a stressful transition between the traditional sociocultural patterns and roles and the different patterns and roles demanded by the new milieu. This explanation is probably supported by the results as regards changes in family structure. Significantly more social phobic patients than control group patients were still living in extended families while the majority of the control group had already shifted to the relatively more independent nuclear family pattern. This implies that social phobic patients were subjected to a more stressful conflict situation, being still under strong influence from traditional cultural patterns while facing the demands of a new urban milieu. The fact that a substantial percentage of the social phobic patients (15%) were living alone or with mates probably also reflects a transitional stressful stage after migration for work or education in the big city.

As widely suggested in literature, people undergoing social changes similar to those demonstrated in this study are liable to high stresses in the process of adapting to new sociocultural environments, a fact that is particularly warranted if the process of change is sharp or rapid. Such stresses may lead to increased rate of some psychiatric disorders (Kiev, 1972; Dunham, 1976). Increased social anxiety or phobia is one of the possible disturbances. Individuals going through such changes are more liable to difficulties in coping with social situations. In an unfamiliar environment they become unsure how to behave and feel that their customary behaviour is inappropriate (Trower et al., 1978). Amies et al., (1983) go as far as suggesting that social phobia actually evolves from normal social anxieties made worse by the stresses of facing such new social expectations.

B) Impact of the cultural patterns of the society

As suggested in this study, the impact of cultural patterns of the society is probably reflected in the types of social contexts provoking different degrees of social anxiety. As seen in the results, the highest degrees of anxiety are experienced in contexts of some formal or conventional social character such as social or religious ceremonies, weddings, big parties, meetings involving remote relatives within the big family or tribe and encounters with superiors or authority figures. On the other hand, the contexts showing the lowest degrees are those involving immediate family members. Other contexts showing intermediate degrees are apparently related to the degree of intimacy (close relatives or personal friends) which clearly dilutes the formality and demands on performance. These findings may be interpreted by the simple fact that social anxiety generally increases with the degree of formality of the situation (Amies et al., 1983). However, it is equally true that such formal or semiformal contexts are loaded with the highest demands for conformity to cultural conventions and rules for behaviour and social interaction and that the degree of anxiety is related to the degree of demand to meet the expectations of these culturally determined patterns. This is clearly validated by the interesting finding that contexts taking place out of the country or generally involving foreigners from other cultures show a relatively very low degree of anxiety comparable with that reported with immediate family members. The clear reasonable explanation is that such contexts are highly free from the demands of the cultural social conventions.

As indicated by Hebding and Glick (1981) much human behaviour is guided by the cultural patterns of a society. Traditions, customs and cultural norms guide individuals and groups of people in their social interacting. There is a demand to meet the expectations of others in conforming to such sociocultural conventions. In the Saudi culture this demand seems to be quite high. The culture is heavily disciplined with moral codes and highly valued customs and rituals. The collective attitude towards these conventions is strict and inflexible. Even small deviations from the norms are unacceptable and individuals who do not conform are liable to harsh open criticism and may be quickly outcast. As noted by Chaleby (1987) the strong demand for conformity applies not only to general values and rules but extends to minor social rituals such as the manner of greeting somebody, how to make a conversation, attitudes of standing or sitting according to social status and age of those present at a gathering... etc. Through child rearing practices, these cultural patterns are heavily transmitted and secured by the family which still maintains much of the traditional hierarchical and highly influential extended pattern. As noted by El-Islam (1982) this socialization process is characterized by the cultivation of shame rather than guilt and the enhancement of conformity and fear of other's criticism rather than

individuality and self-criticism. Such sociocultural influences are likely to produce a personality structure characterized by being particularly sensitive to disapproval and criticism and having inflexible ideas about social conventions which cause individuals to expect criticism unnecessarily. As suggested by Nichols (1974) such features are characteristic of individuals who are vulnerable to the development of social anxiety or phobia. This vulnerability may also be explained in psychodynamic terms. The element of shame which is a leading theme in social phobia implies the involvement of superego anxiety; a form of anxiety which arises in response to behaviour that flouts one's moral codes or system of norms prescribed by social custom and traditions (Nemiah, 1985). The above portrayed cultural patterns indicate a particularly powerful, strict, inflexible, conformity-demanding and highly critical superego system. This system, operating collectively and reflected individually in the child rearing practices, is likely to produce a vulnerability that favors the development of a superego anxiety together with its possible pathological consequences including social phobia.

In conclusion, what is suggested here is that the traditional cultural patterns of the Saudi society have a strong impact that may contribute to the genesis of a personality structure that is predisposed or vulnerable to the development of social anxiety. In this study this impact is reflected and can be implied, though indirectly, from the types of social contexts producing high or low degrees of social anxiety depending on the degree to which they are loaded with the influences and demands of the traditional cultural patterns. This impact can probably also be implied from the indices of social change as regards family structure and urbanization. More social phobic patients still live in extended families and most of them had migrated from the traditional Bedouin. They are loaded with the influences and demands of the traditional cultural patterns. This impact can probably also be implied from the indices of social change as regards family structure and urbanization. The fact that significantly more social phobic patients still live in extended families and that most of them had migrated from the traditional Bedouin or rural milieu to the city during childhood or early youth implies that they have been under higher influences from the traditional cultural patterns compared to patients of the control group who have mostly shifted to the nuclear family pattern and have mostly been urban inhabitants since birth.

Conclusions and psychopatholgical implications

In the light of the previous discussions it may be reasonably suggested that the relatively high frequency of social phobia observed in the Saudi culture is possibly related to the combined, summated or interplay impact of two major sociocultural factors. The impact of the traditional cultural patterns seems to produce predisposed or vulnerable personality structures to which are added the high psychosocial stresses and demands created by the rapid and multifaceted social change processes ultimately leading to a situation that is highly favourable for the genesis of this disorder at a relatively high rate. However, it is important to stress the fact that these conclusions should not be understood as an overemphasis of the aetiological role of sociocultural factors in explaining social phobia. Like other psychiatric disorders, which are universal phenomena, phobic disorders can only be explained in terms of a complex model of causality (that is non- linear and non-mechanistic) which acknowledges the complex interplay of various biological, psychological and sociocultural factors in the aetiology of any disorder. What is suggested here is that these sociocultural factors, in their interaction with other factors, play a significant role that is substantially related to the currently observed higher frequency of the disorder in this culture.

In addition, however, these results may provide implications at another level of psychopathology i.e. the level of understanding structures and dynamics which underlie the genesis of pathological manifestations or what Jaspers (1963) calls the level of "interpretation" (rather than "causal explanation") of phenomena.. At this level many hypotheses have been introduced to interpret phobic disorders. Among these, a reasonable model is provided through an evolutionary or developmental perspective. The hypothesis is that humans have innate tendencies to form fearful links with some objects or situations because of their earlier advantages for the survival of the individual and the species and that for some reasons these anxieties become pathologically reactivated and exaggerated in the form of phobias (Freeman, 1988; Solyom et al., 1986). According to this model different phobic disorders are thought to have different underlying mechanisms or origins related to earlier phases of human development. Simple phobias were related to primitive or early fears of objects or situations that represent potential threats to human survival (snakes, various animals, heights, darkness .. etc). On the other hand agoraphobia was related to separation anxiety while social phobia was related to fear of strangers; both being common fears in childhood that usually disappear by the age of four (Solyom et al., 1986)

What we would like to suggest here, however, is different as regards Social Phobia. The anxiety experienced in social phobia is probably of a higher order than that experienced in other phobic disorders. Phenomenologically speaking the cognitive components of anxiety in social phobia mainly revolve around danger or threat to self- esteem in an interpersonal context (fears of acting in a way that may be inadequate, embarrassing or humiliating in interaction with others) This represents a more differentiated and higher order of anxiety compared to the other two forms of phobia in which cognitions revolve around some material harm or danger related to certain concrete objects or situations. As explained by Arieti (1976) emotions including anxiety, undergo an evolution (both ontogenetic and phylogenetic) from primitive undifferentiated feeling states into more differentiated affective states which involve higher cognitive processes. In primitive forms of anxiety the cognitive components are largely centered around concrete threats to physical existence or integrity while in its higher forms the cognitive components are mainly centered around concepts and values related to esteem and integrity of the self in the interpersonal world.

On the other hand, the development of self-esteem involves the internalization of an ideal self-image; a process that is highly related to socialization i.e. the acquisition of sociocultural norms and moral standards of attitude and behaviour through the family and other social institutions influencing the developing child. Actually, the ideal self image is highly dependent on culture (Murphy, 1977). This developmental stage is clearly higher than the stages assumed for separation anxiety (related to agoraphobia) or other primitive or early phobic fears (related to simple phobias), and takes place at a time when the child is more liable and vulnerable to sociocultural influences.

In other words, what is hypothesized here is that, from an evolutionary or developmental perspective, phobic disorders may not be a single entity but rather a hierarchy of disorders with different psychopathological mechanisms related to different stages of development. While agoraphobia and simple phobias are probably related to earlier and more primitive needs and drives (e.g. separation anxiety and survival anxiety), social phobia seems to belong to a higher order of anxiety revolving around esteem and fulfillment of self-image (or superego) ideal demands. Its genesis is related to a later stage that is highly influenced by the socialization process.

This, in turn, may help explaining why sociocultural factors possibly play a more significant role in its genesis and prevalence as demonstrated in this study.

However we are aware that at this stage of work in this area, such conclusions are largely speculative and require further verification and elaboration.

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La Phobie Sociale chez les Patients Seoudiens: l'Influence de Facteurs Socioculturels

Une fréquence relativement élevée de cas de phobie sociale a été observé parmi les patients Seoudiens en consultation. Dans cette étude nous avons tenté d'évaluer le rôle probable de quelques facteurs socioculturels qui pourraient expliquer ce phénomène.

Deux aspects ont été explorés:

1- L'influence des changements sociaux dans le sens d'un mouvement social ascendant, l'urbanisation et le changement de la structure familiale.

2- L'influence de l'aspect culturel (normes, traditions et habitudes) tel que reflété dans les différents contexts sociaux provoquant l'anxiété.

Les résultats semblent soutenir le rôle important que pourraient jouer les facteurs socioculturels dans la genèse des phobies sociales. Les implications concernant la psycho-pathologie des troubles phobiques sont discutées.

تأثير بعض العوامل الثقافية- الإجتماعية على اضطراب الرهاب الإجتماعى فى ثقافة عربية

لوحظ أن حالات الرهاب (الخوف) الإجتماعى متواترة بصورة عالية نسبيا لدى المرضى السعوديين المترددين على عيادات الطب النفسى. وتمثل هذه الدراسة محاولة لتقويم الدور المحتمل لبعض العوامل الثقافية - الإجتماعية فى تفسير هذه الظاهرة من خلال :

١- التأثير المحتمل لعمليات التغير الإجتماعى والتغيرات فى بنية الأسرة.

٢- التأثير المحتمل للأنماط الثقافية (بنية القيم والمعايير والعادات والتقاليد) وذلك من خلال إنعكاسها على مختلف أنواع المواقف الإجتماعية التى تستثير الخوف الإجتماعى. وقد أجريت الدراسة على مجموعة من مرضى الرهاب الإجتماعى (٥٣ مريضا) بالإضافة إلى مجموعة ضابطة من مرضى باضطرابات عصابية أخرى (٢٦ مريضا) وتشير النتائج إلى أن بعض العوامل الثقافية - الإجتماعية يمكن أن يكون لها دور ملحوظ فى تفسير هذه الظاهرة. وقد جرت مناقشة دلالات هذه النتائج إكلينكيا وسيكوباثولوجيا.