Social Phobia In Saudi Patients: A Preliminary Assessment of Prevalence and Demographic Characteristics.

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ABSTRACT

A considerable frequency of cases presenting with social phobia has been observed among Saudi patients seeking psychiatric help. In this study a preliminary attempt was made to assess the prevalence of this disorder among patients attending a psychiatric outpatient clinic in Riyadh over a period of one year. The demographic characteristics of patients presenting with the disorder were also examined. The results do confirm our earlier impressions. Cases diagnosed as social phobia comprised 79. 8% of phobic disorders, 20. 3% of neurotic disorders and 9. 2% of all psychiatric disorders diagnosed over the period of one year. Mean age of patients was 28. 3 and the great majority (97. 2%) were males. The higher percentage of patients (56. 3%) were married. Data as regards educational level and occupation indicate good or above average levels of achievement and status. Explanations for findings were discussed particularly in relation to the possible role of sociocultural factors.

INTRODUCTION

Phobic neurosis has traditionally been identified as a single global disorder characterised by a persistent irrational anxiety or fear in relation to a specific stimulus resulting in a compelling desire to avoid that stimulus. Over the last two decades, however, there has been a rising interest in differentiating and delineating distinctive subtypes of phobic disorder. While the traditional conception is still reflected in the ICD - 9 (W. H. O. , 1979) which

recognizes only one phobic syndrome, the late DSM III (American Psychiatric Association, 1980) explicitly differentiates three distinctive phobic disorders; agoraphobia, social phobia and simple phobia. This differentiation has been validated by evidence from studies comparing different phenomenological and clinical aspects of these disorders (Marks, 1969, Amies et al, 1983, Solyom et al, 1986). The differentiation has also extended into suggesting different psychopathological mechanisms and dynamics in relation to the three respective disorders (Nemiah, 1985, Solyom et al. , 1986). Among these disorders, the distinction of social phobia has lately received a particular concern in some studies (Amies et al. 1983, Solyom et al, 1986). Though anxiety related to social and interpersonal situations is involved in several forms of psychiatric disturbance, it has also been recognised to present as the main or only disorder with characteristics typical of phobia and to an extent justifying its categorization as such (Hall & Goldberg, 1977). Probably the clearest present delineation of this category is that provided by the DSM III (American Psychiatric Association, 1980) in which social phobia is identified as persistent irrational fear of, and compelling desire to avoid situations in which the individual may be exposed to scrutiny by others, the fear or anxiety being largely centered around acting in a way that may be embarrassing, humiliating or shameful. It is a phobia related to performance or function (Nemiah, 1985).

Reports of the prevalence of phobic disorders indicate that they affect less than 1% of a given population and comprise about 5% of all neurotic disorders seen in outpatient clinics (Nemiah, 1985). According to Marks (1969), phobic disorders are found in 2 - 3% of all neurotic patients in psychiatric practice in North America and England. As regards the prevalence of different types it is believed that simple phobia may be the most common type in the general population but it is not clinically documented as individuals rarely seek treatment (American Psychiatric Association, 1980). Clinically, however, western studies indicate that agoraphobia is the most common type and comprises more than 50% of all phobic disorders seeking treatment (Marks, 1969;Torgersen, 1979). Less information is

available about social phobia, but according to DSM III (American Psychiatric Association, 1980), it is "apparently relatively rare"

Reports as regards demographic characteristics of phobic patients indicate that social phobia is characteristically associated with adolescence while agoraphobia usually starts in the late teens or early twenties. On the other hand, simple phobias mostly start during childhood. As regards the sex, agoraphobia and simple phobia are more frequently diagnosed in women while the sex ratio of social phobia is not known (American Psychiatric Association, 1980; Nemiah, 1985). In some late studies, however, social phobia was found to be more frequent in males. Compared to agoraphobics, patients with social phobia presented at a younger age, were more frequently single and showed a higher level of education and occupational status (Amies et al, 1983, Solyom et al, 1986).

The aetiology of phobic disorders is unclear, but there is much to recommend a pluralistic view taking into consideration the interplay of several factors (Parker, 1979). Marks (1969) considered that phylogenetic influences, age, sex, personality, physiological variables, trauma and stress, modelling experiences and cultural influences inside and outside the family may all contribute. From the psychodynamic perspective explanations of the anxiety of phobics have developed beyond classical psychoanalysis, and it is now viewed as having a variety of sources and colourings. While in agoraphobia separation anxiety seems to play the leading role, the element of shame in social phobia implies the involvement of superego anxiety (Nemiah, 1985). From a behavioural perspective distinctive mechanisms for the three types of phobic disorder have also been suggested by Solyom et al. (1986).

This study was stimulated by our observations of a considerable frequency of cases presenting with social phobia among Saudi patients attending a psychiatric outpatient clinic in Riyadh. An attempt is made for a preliminary assessment of the phenomenon in terms of prevalence and associated demographic features as encountered among the clinic's patient population.

MATERIAL AND METHOD

Records of Saudi patients attending a psychiatric out-patient clinic in Riyadh were examined for the frequency of different psychiatric disorders diagnosed over a period of one year starting 1 - 8- 1406 through 30 - 7 - 1407 hejira (1986 - 1987 Gregorian). Non - Saudi patients were excluded. The obtained figures were utilized for assessing the frequency of cases diagnosed as "social phobia" compared to other phobic disorders, other neurotic disorders and generally the whole spectrum of psychiatric disorders diagnosed during the studied period. As part of the clinic's system the diagnoses had been established by the working senior psychiatrists mainly in accordance with the ICD- -9 classification of psychiatric disorders, (WHO, 1979). However, as the ICD - 9 does not include specified criteria for "Social phobia" the diagnosis of this disorder was guided by criteria described in other sources, particularly the DSM- III (American Psychiatric Association, 1980). Psychobiograms of patients diagnosed as social phobia were further examined for demographic data including age, sex, marital status, educational level, and occupation and the results were assessed for possible characteristic trends.

RESULTS

Over a period of one year, 89 Saudi patients were diagnosed as having "phobia disorders". Of these patients, 71 (79. 8%) were diagnosed as "social phobia". 16 (18%) showed "simple phobias" while only 2 patients (2. 20%) suffered from agoraphobia.

Table I which compares the frequency of different neurotic disorders during the studied period shows that while phobic disorders comprise 25. 5% of all neurotic disorders, social phobia alone comprises 20. 3% of these disorders. It can be seen that the frequency of social phobia alone ranks third among neurotic disorders and is only preceded by neurotic depression (37. 8%) and anxiety states (27%).

Table II shows the frequencies of the whole spectrum of psychiatric disorders diagnosed over the year. Phobic disorders comprise 11. 9% of the diagnoses while social phobia alone comprises 9. 5%. Again, its frequency ranks third among all diagnoses, being preceded by neurotic depression (17.

5%) and anxiety states (12. 5%) while the fourth and fifth ranks are occupied by schizophrenia (7. 9%), and affective psychoses (6%) respectively.

Table I Frequency of social phobia compared to other neurotic disorders diagnosed over one year.

Neurotic Disorders	N	%
1 - Phobic states		
- Social phobia	71	20. 3
- Simple phobias	16	4. 6
- Agoraphobia	2	0. 6
Total	89	25. 5
2 - Anxiety states	94	27. 0
3 - Neurotic depression	132	37. 8
4 - Hysteria	14	4. 0
5 - Obsessive - Compulsive disorders	13	3. 7
6 - Hypochondriasis	4	1. 1
7 - Neurasthenia	3	0. 9
Total neurotic disorders	349	100. 0

Table II Frequency of social phobia compared to all other psychiatric diagnoses over one year

Diagnosis	N	%
Neurotic disorders		
- Phobic states	89	11. 9
- Social phobia	71	9. 0
- Other phobias	18	2. 4
- Anxiety states	94	12. 2
- Neurotic depression	132	17. 5
- Hysteria	14	1. 9
- Obsessive - Compulsive disorders	13	1. 7
- Hypochondriasis	4	0. 5
- Neurasthenia	3	0. 4
Total	349	46. 5
Psychotic disorders		
- Schizophrenic psychosis	59	7. 9
- Affective Psychosis	45	6. 0
- Paranoid states	13	1. 7
- Other non - organic psychoses	4	0. 5
Total	121	16. 1
Adjustment reactions	45	6. 0
Personality disorders	16	2. 1
Sexual deviations and disorders	31	4. 1
Organic psychotic conditions	18	2. 4
Drug dependence	16	2. 1
Physiological malfunction arising from mental factors	4	0. 5
Childhood disorders (including M. R)	39	5. 2
Specific symptoms or syndromes not elsewhere specified	43	5. 7
Epilepsy	46	6. 1
Others (diagnosis not defined)	32	4. 3
Total	750	100. 0

Table III Demographic characteristics of patients with social phobia (N - 71)

Data	N	%
Age		
15 - 19	3	4. 2
20 - 24	15	21. 1
25 - 29	15	39. 4
30 - 34	17	23. 9
35 - 39	2	2. 8
40 - 44	5	7. 0
45 - 49	1	1. 7
Sex		
- Male	96	97. 2
- Female	2	2. 8
Marital status		
- Single	28	39. 4
- Married	40	56. 3
- Divorced	3	4. 2
Educational level		
- Primary school	6	8. 5
- Preparatory school	15	21. 1
- Secondary school	17	23. 9
- Higher Education	21	29. 6
- Post graduate degree	5	7. 0
- Not defined	7	9. 9
Occupation		
- Student	10	14. 1
- Skilled labour	4	5. 6
- Military and Policemen	9	12. 6
- Employees (clerks)	19	26. 8
- Professionals	20	28. 2
- Tradesmen	3	4. 2
- Not defined	6	8. 5

Table III illustrates relevant demographic characteristics of the social phobic patients. The mean age was 28. 3 years with a SD of 6. 2. The majority of patients (60. 5%) fall within the age range of 20 to 30 years and

84. 5% are under 35 years of age. 69 of the patients (97. 2%) were males while only 2 patients (2. 8%) were females. Married patients (56. 3%) were relatively more than single patients (39. 4%), while a minor percentage (4. 2%) were divorced.

Data on education generally indicated a good level of education among the patients. Most of the sample (81. 6%) had at least finished preparatory school. Those with middle level (Preparatory and secondary) comprise 45% of the patients while those with high and postgraduate levels amount to 36. 6% of the sample. Data on occupation also indicated a good level of achievement and social status. Most patients were either professionals (28. 2%), clerical or administrative employees (26. 8%), students (14%) or military and policemen (12. 6%).

DISCUSSION

The results do indicate a considerably high frequency of social phobia which comprises 79. 8% of phobic disorders. 20. 3% of neurotic disorders and 9. 2% of all psychiatric disorders diagnosed among Saudi patients over the period of one year. As reviewed in the introduction reports from the West indicate that agoraphobia is the most common phobic disorder and comprises about 60% of clinically diagnosed phobic conditions (Torgersen, 1979), while social phobia is reported to be relatively rare (American Psychiatric Association, 1980). On the other hand, phobic disorders as a whole comprise 2 - 3% of all neurotic disorders encountered (Marks, 1969). Findings of this study not only indicate a reversal of the ratio (with social phobia comprising 79. 8% and agoraphobia comprising 2.2% among the studied Saudi patients, but it also indicates that the frequency of social phobia is so high that it alone comprises 20. 3% of all neurotic disorders and thus raises the overall frequency of phobic disorders to 25. 5% of the diagnosed neuroses. It is admitted that this preliminary study, with its limitations, cannot claim an accurate representation of the prevalence of this disorder in the society as a whole and more extensive epidemiological investigation is required to confirm the above findings. However, we believe that these findings may not be overrepresentative. Actually, they do not fully reflect the phenomenon of

social anxiety as encountered among Saudi psychiatric patients . The findings only document patients diagnosed as social phobic disorders, i. e. patients in whom social phobic anxiety is the main or only complaint and accordingly the primary diagnosis. In our experience, however, social phobic manifestations are also encountered as part of the symptomatology of many patients with other main diagnoses including different neurotic disorders, personality disorders and even some psychotic disorders. In other words, it is our impression that social anxiety of phobia among Saudi psychiatric patients may be a meaningful phenomenon that calls for appropriate consideration and explanation.

As reviewed in the introduction, it is cogently believed that phobic disorders, like other psychiatric disorders, are products of the complex interplay of several constitutional and environmental factors (Marks, 1969). However, we believe that the observed dimensions of the above phenomenon may be particularly related to sociocultural factors. Sociocultural factors may significantly influence the frequency and presentation of psychiatric disorders (Kiev, 1972). The Arab culture, particularly in the Arab peninsula, is characterised by a deeply rooted and highly valued traditional set of social values, attitudes and customs of behaviour. The collective attitude as regards such conventions is rather strict and inflexible. The major role in transmitting and securing conformity to these conventions is played by the traditional extended family which is the basic and most influential social system. As pointed out by El - Islam (1984) the extended family exerts a powerful influence in shaping and controlling the life of individuals through its hierarchical and highly authoritarian structure. It offers security to its members in return for behaviour that is harmonious with the cultural code and conventions. It follows that rejection and shame are the highly painful price paid for deviation from these conventions. In this social context, as El - Islam (1982) also notes, affiliative behaviour is favoured at the expense of differentiating behaviour. Traditional child rearing instills behaviour oriented towards accommodation, conformity and interdependence rather than individuality and independence. Such rearing orientation has been blamed for certain defects in the psychological development of Arab children including a

disturbed superego development as a result of the cultivation of shame rather than guilt and the enhancement of conformity and fear of others criticism rather their own self - criticism. Such sociocultural background probably provides a rather fertile land for the development of a disturbance like social anxiety or phobia in susceptible individuals. As viewed by Nichols (1974), social anxiety (or phobia) seems to arise in people who are unduly sensitive to disapproval and criticism and who have inflexible ideas about social conventions which cause them to expect criticism unnecessarily. The likelihood of developing such predisposition is probably higher within the described sociocultural context. Speaking in psychodynamic terms, the element of shame, which seems to be a leading theme in social phobia, implies a major role of superego anxiety in the genesis of this disorder (Nemiah, 1975). Again, the portrayed sociocultural influences including the powerful, strict, critical and conformity demanding superego system would apparently favour the development of such superego anxiety and its possible consequences including social phobia.

A second important contributing sociocultural factor may be related to significant social changes currently taking place in the Saudi society. Over the past two decades or so Arab Gulf countries including Saudi Arabia have undergone an admirably vast and accelerated process of socioeconomic development. Urbanization is clearly a major aspect of this developmental process. People started to migrate from the nomadic settlements and the countryside to work in the civil service or the oil industry. The existing urban areas have greatly expanded and new centers of population have come into being. Thus urban areas are in the process of accommodating the major bulk of the population, while the nomadic population is progressively decreasing (Al - Khani, 1983). Such socioeconomic changes are obviously associated with significant social mobility for large sectors of the population. People undergoing such process of upward social mobility are liable to difficulties in coping with the new social milieu. Among these difficulties social anxiety is an understandable problem. As reported by Trower et al (1978), studies conducted in the West have indicated that people undergoing similar upward social mobility are significantly more liable to difficulties in coping with

social situations. Being in an unfamiliar social environment, they would be unsure how to behave and would feel that their customary behaviour is inappropriate. A more specific evidence for the impact of such social change in relation to social phobia has also been provided by the study of Amies et al (1983). Compared to patients with agoraphobia, patients with social phobia had significantly more often changed social class in an upward direction. This finding, as the authors suggest, supports the idea that social phobia evolves from normal social anxieties made worse by the need to face new social expectations.

Sociocultural factors probably also contribute to some of the demographic findings encountered in this study. The higher frequency of males in this study is principally consistent with the results of other studies by Hall & Golderg (1977). Amies et al (1983) and Solyom et al (1986) in which males comprised about 2/3, 60% and 53% of their social phobic patients respectively. However sociocultural factors most likely contribute to the extremely high ratio of males in this study (97. 2%). A cultural attitude against females presenting for psychiatric management has been observed in this culture and apparently contributes to their under representation in psychiatric epidemiological evaluations in general (El- Islam, 1982). Also, in relation to social phobia the boundaries of their social role and their lesser liability to face evocative social situations makes their motivation for help seeking less urgent. For males, on the other hand, their greater social roles and responsibilities and their unavoidable exposure to social situations make them more motivated to seek the specialized help. Also, their being more educated than females probably makes them more perceptive of their mental symptoms and more accepting for the idea of seeing a psychiatrist.

In relation to marital status, the relatively higher percentage of married patients (56. 3%) probably also reflects cultural trends. In Saudi Arabia young marriage is common and is generally encouraged by the culture. Girls marry at an average age of 15 - 19 and men at an average age of 19 - 24 (Al - Khani, 1983).

Findings as regards age (mean age 28. 3 and 60% within 20 - 30 years range) are more or less consistent with other reported studies. In the studies of

Amies et al (1983) and Solyom et al (1986) the mean age for social phobic patients was 30. 7 and 30. 5 respectively, while in the study of Hall & Golderg about 83% of patients were within the age rage of 20 - 30 years. Such results probably do not contradict the assumption that this disorder usually starts during adolescent years since reports of most patients in our study do confirm this fact. Patients apparently do not resort to psychiatric help until difficulties become more prominent and continuous as they proceed in their adult practical and social life. A similar observation was made by Solyom et al (1986) who tried to differentiate between the age of first symptoms (usually during adolescence) and the age of onset of illness as continuous symptoms (mostly during early adult life).

Data as regards the educational level and occupation generally indicate a good or above average level of achievement and status among our patients. This is also consistent with the findings of Solyom et al (1986) who reported that, compared to agoraphobic patients, patients with social phobia showed a higher educational and occupational status. On one hand, this might be related to personality potentials of patients liable to such disorder. On the other hand, however, this may simply be an indication that patients with better educational and occupational status are more likely to be motivated to present for psychiatric help.

REFERENCES

1. Al - Khani, M. A. (1983) The impact of life events and the onset of schizophrenia within the cultural context of Najd region of Saudi Arabia. Ph. D. Thesis. Guys Hospital School - London.

2. American Psychiatric Association (1980) Diagnostic and Statistical Manual of Mental Disorders - Third Edition (DSM III). American Psychiatric Association. Washington DC.

3. Amies, P. L. , Gelder, M. G. and Shaw, P. M. (1983) Social Phobia : A comparative clinical study. British Journal of Psychiatry, 142, 174 - 179.

4. El - Islam, M. F. (1982) Arabic Cultural Psychiatry. Transcultural Psychiatry Research Review, 195 - 21

5. El - Islam, M. , F. 91984) Cultural change and intergenerational relationship in Arab families. International Journal of Family Psychiatry, 44, 55 - 63.

6. Hall, R. & Golderg, D. (1977). The role of social anxiety in social interaction difficulties. British Journal of Psychiatry, 131, 610 - 615.

7. Kiev, A. (1972) Transcultural Psychiatry. The Free Press, New York.

8. Marks, I. (1969) Fears and phobias. London : Heinemann.

9. Nemiah, J. C. (1985). Phobic disorders. In Kaplan, H & Sadock, B. (Eds.). Comprehensive Textbook of Psychiatry. Fourth Edition. Baltimore : Williams and Wilkins.

10. Nichols, K. A. (1974) Severe social anxiety. British Journal of Medical Psychology, 47, 301 - 306.

11. Parker, G. (1979) Reported parental characteristics of agoraphobics and social phobics. British Journal of Psychiatry, 135, 555 - 560.

12. Solyom, L. , Ledwidge, B. and Solyom, C. (1986) Delineating social phobia. British Journal of Psychiatry, 149, 464 - 470.

13. Torgersen, S. (1979) The nature and origin of common phobic fears. British Journal of Psychiatry, 134, 343 - 351.

14. Trower, P. , Bryant, B. and Argyle, M. (1978) Social Skills and Mental Health. Methuen and Co. Ltd. , London.

15. World Health Organization (1979) International Classification of Diseases - Ninth Revision (ICD - 9). W. H. O. ;Geneva.

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PHOBIE DE SOCIÉTÉ CHEZ DES PATIENTS SÉOUDIENS UNE EVALUATION PRÉLIMINAIRE DE LA PRÉVALENCE ET DES CHARACTÉRISTIQUES DÉMOGRAPHIQUES.

ABSTRAIT

Un nombre considérable de cas souffrant de phobie de société a été observé parmi les patients Séoudins demandant l'aide psychiatrique. Dans cette étude une tentative préléminaire a été faite, pour évaluer la prévalence de ces troubles parmi les malades présentant à la clinique psychiatrique á Riad, pendant une durée d'une année. Les charactéristiques démographiques de ces malades ont été ainsi éxaminés. Les résultats ont confirmé nos impréssions préalables. Les patients diagnostiqués comme souffrants de phobie de société comprenaient 79,8% des troubles phobiques, 20,3% des troubles névrotiques, et 9,2% de tous les troubles psychiatriques diagnostiqués sur une période d'un an. L'âge moyen des malades était 28. 3 ans, et la grande majorité (97,2%) était de sexe masculin, et 56,3% étaient mariés. Les patients appartenaient á un niveau professionnel et intellectuel moyen ou plus élevé. Ces résultats sont discutés surtout en ce qui concerne le role probable des facteurs socioculturels.

الموجز

الرهاب الاجتماعي لدي المرضي السعوديين دراسة مبدئية لانتشار الاضطراب والخصائص الديموجرافية

لوحظ من خلال الممارسة الاكلينيكية أن هناك نسبة مرتفعة من الحالات التى تشكو من الرهاب الاجتماعى ضمن المرضي السعوديين المترددين للعلاج النفسى وهذة الدراسة تمثل محاولة مبدئية لتقدير مدي انتشار هذا الاضطراب ضمن المترددين على عيادة خارجية للطب النفسي بالرياض خلال فترة عام كامل بالاضافة الي تقويم الخصائص الديموجرافية لهؤلاء المرضي.

وقد أكدت النتائج الاولية حيث بلغت نسبة الحالات التي تحمل تشخيص الرهاب الاجتماعي ٧٩,٨٪ من الاضطرابات الرهابية كما كانت تمثل ٢٠,٣٪ من الاضطرابات العصابية و ٩,٢٪ من كافة الاضطرابات النفسية التى تم تشخيصها خلال العام.

وقد بينت الخصائص الديموجرافية أن متوسط عمر هؤلاء المرضى هو ٢٨,٣ سنة وأن غالبيتهم العظمي (٩٧,٢٪) من الذكور كما أن النسبة الاعلي منهم (٥٦,٣٪) متزوجين بالاضافة الي ذلك تشير البيانات الخاصة بمستوي التعليم ونوع العمل الي مستوي جيد أو فوق المتوسط من التعليم والمكانة الاجتماعية .

وقد تمت مناقشة النتائج وخاصة فيما يتعلق بالدور المحتمل للعوامل الاجتماعية - الثقافية في تفسير هذة الظاهرة .