Clinical Profile of Social Phobia in Saudi Patients

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This study was conducted with the aim of investigating characteristics of the clinical profile of Social phobia as encountered in Saudi patients. A sample of 54 patients diagnosed as social phobia according to DSM-III-R criteria were subjected to a thorough clinical assessment including: 1- a semistructured interview exploring key aspects related to history, symptomatology and associated manifestations, and 2- a psychometric evaluation of possible associated personality features. Results show that the disorder in our patients tends to be generalized in form and chronic and persistent in course with no significant episodic fluctuations. Among associated manifestations depression is particularly prominent. Other manifestations include generalized anxiety, obsessive features, paranoid ideas and substance abuse. Personality assessment indicates prominent neurotic and socially introverted features. Results were discussed in the light of findings in some parallel late studies conducted mostly in the West.

(Egypt.J. Psychiat.,1992,15:215-224).

Introduction

Though Marks (1969) assigned a separate category to social phobia the explicit delineation and recognition of the disorder had to wait for eleven more years to materialize in the DSM-III (American Psychiatric Association, 1980). While in the DSM-III a global social phobic disorder was described as being "apparently relatively rare" the DSM-III-R (American Psychiatric Association, 1987) differentiates between two forms; a generalized form involving generalized fear of most social situations that is common, and a circumscribed form involving only fears of certain performances like eating or writing in public that is relatively rare (with the exception of fear of speaking in public which is relatively common).

Some major studies (e.g. Amies et al., 1983 and Solyom et al., 1986) were concerned with the delineation and elaboration of the disorder in comparison with other phobic disorders. Other studies were concerned with certain aspects such as its relation to depression (Stein et al., 1990), or panic disorder (Stein et al., 1989), the evaluation of management strategies (Reich and Yates, 1988) or the impact of some possible aetiological factors such as parental rearing characteristics (Arrindell et al., 1989 Chaleby, 1990). However, one can notice that, compared to other areas of research, the literature on social phobia is apparently still limited. It has actually been described as a "neglected anxiety disorder" (Liebowitz et al., 1985) Moreover, with very few exceptions (e.g. Chaleby, 1987, 1990; Arafa and Al-Khani, 1988) almost all reported studies come from the West.

This study is the second in a research project that was planned to investigate different aspects of the social phobic dis-

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order as encountered in Saudi Arabia. It was stimulated by our observations of a relatively high frequency of this disorder among Saudi patients seeking psychiatric help. These observations were confirmed by the first study (Arafa and Al-Khani, 1988) in which a preliminary attempt was made to assess the prevalence and demographic characteristics of the disorder among Saudi patients attending a psychiatric outpatient clinic in Riyadh. Cases diagnosed as social phobia comprised about 80% of phobic disorders, 20% of neurotic disorders and 9% of all psychiatric disorders seen in that clinic over a period of one year. On the other hand, demographic features were comparable with those reported by other investigations around the world.

In the present work an attempt is made to investigate the possible characteristics of the clinical profile of this disorder as encountered in Saudi patients and discuss them in the light of findings in parallel studies conducted mostly in the West.

Subjects and Method

The sample of the study consisted of 54 consecutive Saudi patients receiving the diagnosis of social phobia in a psychiatric outpatient clinic in Riyadh. Diagnosis was established according to the criteria of DSM-III-R. Patients included were those in whom social phobia was the primary or main presenting complaint. Patients receiving other primary diagnoses in whom social phobia was a secondary associated condition were not included.

Besides the full initial psychobiogram patients were subjected to:

A) A semistructured interview eliciting information as regards certain specified clinical aspects including:

1- Social phobic symptoms (generalized or circumscribed).

2 Duration onset and course of illness

3- Physical anxiety symptoms associated with the phobic situation.

4- Other significant symptoms or manifestations associated with the condition (see table III). The presence or absence of these manifestations was guided by definitions and criteria from P. S. E. (Wing et al., 1974).

5- Past or family history of psychiatric disorder.

6- History of phobic fears in childhood.

7- Family size (number of siblings).

B) Psychometric evaluation including:

1- Minnesota Multiphasic Personality Inventory (M. M. P. I)*.

2- Middle sex Hospital Questionnaire (M.H.Q.)**.

All patients were interviewed by the same psychiatrist and all psychometric evaluations were conducted by the same clinical psychologist.

Results

Mean age of patients in our sample was 27.7 (±4.8). Males were 53 (98%) while there was only one female patient (2%). Married patients were 22 (41%) while 23 (59%) were unmarried. Except for one patient suffering from a circumscribed fear of eating in public all other patients (98%) complained of the generalized form of social phobia.

Table 1 illustrates some significant history variables. The following can be noticed:

1- Mean duration of illness was

* The used Arabic version was originally prepared by Melika *et al* (1974) and assessed in the Saudi culture by Al-Haj (1983).

** Arabic version

Table 1
History of Illness Variables (N= 54)

	No	(%)
Duration of illness (years)		
1—3	10	(19)
4—6	9	(17)
7—9	5	(9)
10—12	12	(22)
13—15	12	(22)
16—18	6	(11)
Onset		
- Gradual	52	(96)
- Sudden	2	(4)
Course		
- Persistent, constant	54	(100)
- Episodic variations or fluctuations	0	(0)
Family history		
1- Neurotic disorder	19	(35)
2- Psychotic disorder	9	(17)
3- Other (epilepsy)	2	(4)
Past history		
1- Neurotic disorder (other than S.P.)	7	(13)
2- Psychotic disorder	—	—
3- Other (epilepsy)	1	(2)
Phobic fears in childhood	6	(11)
Family size (No. of siblings)		
1—4	7	(13)
5—8	25	(46)
9—12	13	(24)
13—16	6	(11)
17—20	3	(6)

Mean (± SD) = 8.7 (± 7.2)

about 9 years. However, the distribution shows that the majority (55%) reported a duration of more than 10 years, while a smaller group (36%) reported a duration ranging between 1-6years.

2- Except for 2 patients (4%) who could identify a clear acute or sudden onset, all patients reported a gradual or ill defined onset.

3- All patients reported a more or less persistent course of illness and none of them could indicate any significant phasic or episodic fluctuations or variations.

4- As information provided by patients about past or family history of psychiatric disorder was not accurate or reliable enough for identifying definite diagnostic labels in most cases, data were globally assessed in terms of neurotic or psychotic disorder. It can be noticed that a substantial percentage (35%) showed a positive family history of neurotic disorders while psychotic disorders were much less (17%). Only 13% of the patients reported a past history of neurotic disorder other than social phobia and a closely similar number (11%) reported a history of simple phobic fears during childhood.

Table 2
Physical Anxiety Symptoms Associated with Social Phobia Rank Ordered According to Frequency (N=54)

	No	(%)
1- Tremors or trembling	42	(78)
2- Palpitation (heart pounding)	38	(70)
3- Sweating	28	(52)
4- Blushing	9	(17)
5- Shortness of breath	4	(7)
6- Dizziness	4	(7)
7- Dry mouth.	3	(6)

Table 3
Symptoms Associated with Social Phobia Rank Ordered According to Frequency (N = 54)

Symptoms	No	(%)
1- Depressed mood	49	(91)
2- Generalized anxiety	26	(48)
3- Obsessive features	22	(41)
4- Other phobic fears (simple phobias)	20	(37)
5- Psychosomatic.	15	(28)
6- Paranoid ideas	6	(11)
7- Substance abuse	6	(11)
8- Psychosexual dysfunction	6	(11)
9- Hypochondriasis	2	(4)
10- Panic attacks	2	(4)

5- Data on family size show that the patients come from relatively large families. Mean number of siblings is relatively high (about 9). Also, 31% of the patients had half-siblings i.e. their fathers had more than one wife.

Table* 2 indicates the physical (autonomic and somatic) symptoms reported in association with social phobic situations. Tremors, palpitation and sweating were the commonest symptoms while other symptoms, including blushing were much less reported.

Symptoms clinically presented in association with social phobia are shown in table 3. It can be seen that depression was the commonest associated feature (91%). Next in frequency come manifestations of generalized anxiety, obsessive-compulsive features (e.g. obsessive thoughts, compulsive checking or cleaning rituals.. etc.) and simple phobic fears (e.g. phobias of insects, blood, animals,

Table 4
Results of the M.M.P.I.

MMPI scale	Mean (± SD)	Percentage of T-Scores at Different Levels. ≥70	55-69	< 40
L	40.0 (± 5.8)	-----	-----	-----
F	56.6 (± 9.3)	-----	-----	-----
K	43.4 (± 10.9)	-----	-----	-----
(1) Hypochondriasis (HS)	53.0 (± 1.1)	3.7%	31.5%	64.8%
(2) Depression (D)	64.9 (± 13.7)	33.3%	37%	29.6%
(3) Hysteria (Hy)	58.5 (± 9.9)	14.8%	48.1%	37%
(4) Psychopathic deviate (Pd)	56.4 (± 11.5)	12.9%	48.1%	38.8%
(5)Masculinity-Femininity (Mf)	52.9 (± 5.4)	0%	38.9%	61.1%
(6) Paranoia (Pa)	60.9 (± 12.9)	27.7%	35.2%	37%
(7) Psychasthenia (Pt)	63.0 (± 8.3)	25.9%	55.6%	20.4%
(8) Schizophrenia (Sc)	60.0 (± 10.2)	16.6%	46.3%	35.2%
(9) Hypomania (Ma)	45.8 (± 10.9)	3.7%	16.7%	79.6%
(10) Social Introversion (Si)	70.9 (± 9.5)	64.8%	27.8%	7.4%

Table 5
Results of M.H.Q.

Scale	Mean score (± SD)
1- Anxiety (free floating)	9.6 (± 3.6)
2- Phobic anxiety	6.8 (± 2.7)
3- Obsessionality	9.5 (± 2.7)
4- Psychosomatic (somatic anxiety)	7.0 (± 3.1)
5- Depression	9.1 (± 2.2)
6- Hysteria	9.5 (± 3.1)

planes.. etc.) that were not severe or prominent enough to justify a concomitant diagnosis.

Results of the psychometric evaluations are presented in tables 4 and 5. On the MMPI (table 4) the only scale showing a mean score above 70 is that of social introversion. The next relatively height mean scores are those of depression (64.9), psychasthenia, i.e. obsessive-compulsive syndrome (63) and paranoia (60.9). As illustrated in the same table the sample also exhibits the following pattern of characteristic or prominent scales at different levels of T. scores:

1- Scales ranking highest in scoring 70 or more are the Si (64.8%) followed by the D (33.3%) scales.

2- Scale ranking highest in scoring between 55 and 69 include Pt (55.6%), Hy (48.1%), Pd (48.1%) and Sc (46.3%).

3- Scales ranking highest in scoring less than 40 include Ma (79.6%), Hs ((64.8%) and Mf (61.1%).

On the MHQ (table 5) mean scores on four of the scales fall between the usual norms for neurotic disorder (12 or more) and normal persons (8 or less) These were the scales of anxiety (9.6), obsessionality (9.5), hysteria (9.5) and depression (9.1).

Discussion

Most clinical characteristics encountered in our group of Saudi social phobic patients are comparable with the main trends reported in other studies conducted mostly in the West. However, certain variations could also be noticed.

History of Illness

Mean age of patients in this study (27.7 years) is comparable with that reported by Amies et al., (1983) and Solyom et al., (1986) (30.7 and 30.6 years respectively). The mean duration of illness in our study (8.9 years) is closer to that reported by Amies et al., (12 years) than that reported by Solyom et al., who tended to base the duration on the age of onset of first symptoms (16.6 years) rather than the onset of continuous symptoms. Age of onset of first symptoms was not systematically recorded in our study but most patients date their first experiences of symptoms to the early adolescent years. In most cases, however, the disorder did not take its full shape and continuity until late adolescence or early adulthood, probably in relation to increased social demands.

The course of the disorder, as reported by all our patients, was chronic and more or less persistent or constant with no significant episodic variations or fluctuations. This seems to contradict the findings of Solyom et al., (1986) who reported a fluctuating and phasic course in 46.1% of their socially phobic patients.

The fact that 98% of our patients suffered from the generalized or diffuse type of social phobia is in agreement with the information documented by the DSM-III-

R that this type is common while the specific or circumscribed type is rare.

Physical Anxiety Symptoms

The pattern of physical anxiety symptoms associated with the phobic situation reported in this study generally matches the pattern reported in other studies. In the study of Amies et al., (1983) the symptoms arranged according to their frequency included palpitation (79%), trembling (75%), sweating (74%), dry mouth (61%), blushing (51%), dizziness (39%) and difficulty breathing (30%). The pattern of prominent frequencies is more or less analogous to that in our study (table II). Differences in the actual frequency figures are probably related to method, since in our study information was obtained in response to an open question while in the study of Amies et al., (1983) a check list was utilized. Amies et al., noticed that physical symptoms more commonly associated with social phobia involve changes which can be seen by other people. The relatively prominent frequency of symptoms like trembling sweating and blushing in our study is probably in line with these observations. However, the question remains as to whether this reflects an actual higher frequency or a higher self-awareness (with possible subsequent reinforcement or perpetuation) of such symptoms on the part of social phobic patients.

Associated Manifestations

I- Depression and Anxiety

Among the manifestations associated with the social phobic clinical profile in this study depression was particularly conspicuous. Features of depression, mainly depressed mood, were clearly observed clinically in 91% of the patients. On the MMPI the depressive scale showed the second highest mean score with one third of the patients scoring over 70 while on the M.S.H.Q the mean score for depression ranked among the relatively elevated four scales. Generalized anxiety was the second highest associated clinical symptom (48%) and showed the highest mean score on the MSHQ.

These results lend strong support to similar observations reported in literature.

It has lately been recognized that depression frequently occurs in patients with phobic disorders (Stein et al., 1990). In the study comparing social and agoraphobic patients by Amies et al., (1983) depressive and anxiety symptoms were present in about 50% of each group.Similar findings were reported by Solyom et al., (1986). In Saudi socially phobic patients, Chaleby (1987) reported a 60% frequency of depressive symptoms. In a study exploring the relation between social phobia and major depression Stein et al., (1990) found that 35% of a group of socially phobic patients had a lifetime histories of at least one major depressive episode; of these 91% had their first depressive episode 13 years or more after the onset of social phobia. The risk for depression was similar in both generalized and discrete types of social phobia. However, a higher rate of major depressive episodes (63%) was found in a comparative group suffering from panic-agoraphobic syndrome.

As an explanation of the close relation observed between phobic anxiety and depression two main hypotheses have been suggested:

1- Patients with anxiety or phobic disorders develop depression as a direct consequence of the demoralization they experience as a result of living with chronic anxiety and phobic limitations. In social phobia the social isolation resulting from social avoidance may largely contribute to such demoralization (Stein et al., 1990).

2- Both disorders stem from a common psychopathological ground i.e. both aetiological and dynamic psychopathological factors may lead to a personality structure that is vulnerable to the development of both disorders. In relation to social phobia, Nichols (1974) sees that patients liable to severe social anxiety are characterized by a constellation of personality traits that include "low self-esteem, extreme self consciousness and a tendency toward negative self - evaluation". Persons with such a psychological profile are clearly at considerable risk for depression (Stein et al., 1989). Of course, there is a third possibility of a more complex explanation in which both the above possibilities interact to produce the observed association. Also, different mechanisms may lead to qualitatively different types of associated depression (i.e. major depression, or dysthymic (neurotic) depression rather than an associated homogeneous depressive syndrome. In this study all patients presented with dysthymic or neurotic depressive features. However this may be related to the inclusion criteria which would exclude patients with a more primary or salient diagnosis of major depression. On the whole much further work is definitely needed to explore and verify the possible explanations of this phenomenon.

2- Obsessive Symptoms

Obsessive features occupy the third order of frequency among clinically associated manifestations (41%). On the MMPI the psychasthenia (obsessive - compulsive syndrome) scale shows the third highest mean score while the obsessionality mean score on the MSHQ is the second highest. In the studies of Amies et al., and Solyom et al., clinically significant obsessive symptoms were detected in about 20% of both social phobic and agoraphobic patients. As reported by Solyom et al., (1986) the mean scores of both groups on the LOI fell between the norm for obsessive patients and normal persons. In the study of Chaleby (1987) obsessive compulsive disorder was associated in 11.4% of social phobic Saudi patients. As reviewed by Mellman and Uhde (1987) comparable rates of co-occurance of obsessive compulsive symptoms were demonstrated in different studies on agoraphobia and panic disorder. These rates of obsessive compulsive manifestations frequently reported with anxiety and phobic disorders apparently exceed their prevalence estimates in the general population. This together with other criteria (e.g. response to similar pharmacotherapies), probably indicates the presence of shared biological and psychological mechanisms among these disorders.

3- Other Phobic Manifestations

In this study other phobic fears were reported by 37% of the patients. However, they were all in the form of simple phobias while non of the patients presented with clinically significant agoraphobic fears. Simple phobias have been recognized to coexist "frequently" with social phobia (American Psychiatric Association, 1987).In the studies of Amies et al., (1983) and Solyom et al., (1986) simple phobic fears were significantly more frequent in agoraphobic than social phobic patients. However, in both studies a considerable percentage of socially phobic patients (25% and 30% respectively) reported anxiety in agoraphobic situations while anxiety in social phobic situations was reported by about double that percentage of agoraphobic patients. This has led the authors to conclude that although the two disorders are distinct there is some degree of overlap. The absence of agoraphobic symptoms in our patients is not in line with these findings. However, we tend to believe that the reported degree of overlap is

rather high. It may be related to methodological measures not giving sufficient attention to the content of phobic anxiety rather than its apparent stimulus situations. Though both social and agoraphobic patients are provoked by similar situations, i.e. crowded places the content of fear in agoraphobia is centered around the crowd and being away from home while in social phobia the concern is rather related to meeting someone known to the patient or generally performing in a way that may be embarrassing in front of others.

4- Other Symptoms

According to Stein et al., (1989) several studies have indicated that there may be a considerable overlap between panic disorder and social phobia. Both disorders, according to DSM-III-R, "frequently coexist". Such observations are also not confirmed in this study in which the frequency of associated panic attacks was rather low (4%).

Paranoid features encountered in this, study were mainly in terms of ideas of reference. Such ideas in this disorder are probably understandable in the light of the patients' oversensitivity and high self - consciousness in social situations. They are usually transient and often realized as being exaggerated (Hall and Goldberg, 1977; Freeman, 1988).

As a complication, socially phobic patients are known to be prone to episodic substance abuse. Alcohol was used by 20% of the British patients in the study of Amies et al., (1983) and 5.7% of patients in the study of Chaleby (1987). In our study, however, most of the patients reporting substance abuse (11%) tended to use stimulant drugs.

Personality Traits

On personality measures socially phobic patients usually score as neurotic and somewhat introverted (Freeman, 1988). In the study of Amies et al., (1988) all social and agoraphobic patients showed higher than normal neuroticism scores while the extroversion scores were significantly lower in social phobic patients than in the agoraphobic and the normal population. Similar findings were reported by Solyom et al., (1986) except that both social and agoraphobic patients showed lower than normal scores on extroversion. The results of our personality measures are generally in line with these findings. Our patients showed what may be considered moderate neurotic scores on most of the MHQ scales. On the MMPI the social introversion scale was the highest and most pathological.

Such finding, when added to other clinical aspects of social phobia, particularly the early onset and persistent course, contribute to a debated overlap between social phobia and personality disorder. (Hall and Goldberg, 1977). Some authors see that social phobia and avoidant personality disorder differ only in degree. It has also been suggested that the term social phobia should be restricted to the circumscribed or specific forms (e.g. phobias of speaking or eating in public) and not the generalized form which should be classified as avoidant personality disorder (Reich and Yates, 1988; Freeman, 1988).

However, such extreme view may not be widely accepted. As indicated from many clinical studies including the present study, social phobia (including its generalized form) cannot be ignored as a distinct anxiety disorder even if it is highly related to a certain personality disturbance or predisposition. These background or associated personality dimensions, however, should receive more attention and consideration as they definitely have important implications for a better understanding and management of the disorder.

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Aspect Clinique de la Phobie Sociale chez les Patients Seoudiens.

La phobie sociale a été récemment déliniée comme un trouble anxieux à part entière. Cette étude a été conduite dans le but de distinguer l'aspect clinique de ce trouble chez les patients Seoudiens. Nous avons fait passer à un échantillon de 54 patients, ayant le diagnostique de phobie sociale selon les critères du DSM III-R, un entretien semistructuré ainsi q'une évaluation psychométrique des trais de la personnalité. Les résultats ont montré que le trouble chez nos patients avait une forme plutôt diffuse et une évolution chronique sans fluctuations épisodique, la dépression se trouvait souvent associée ainsi que l'anxiété, les obsessions, les idées délirantes et l'abus de drogues. L'évaluation des traits de personnalité a indiqué de fortes tendences névrotiques ainsi que l'introversion sociale. Ces résultats ont été comparés avec des études récentes similaires faites en occident.

تقويم الصورة الاكلينكية لاضطراب الرهاب الاجتماعى لدى المرضى السعوديين

تم مؤخراً توصيف الرهاب (الخوف) الاجتماعى كاضطراب محدد ومتمايز ضمن اضطرابات القلق النفسى. وقد اجريت هذه الدراسة بهدف البحث فى خصائص الصورة الاكلينيكية لهذا الاضطراب كما يتبدى فى مرضى سعوديين. وشملت عينة البحث ٥٤ مريضا بالرهاب الاجتماعى، تم تشخيصهم وفقا لمواصفات دليل تشخيص الامراض النفسية الامريكى الثالث المعدل. وأجرى لهم تقويم اكلينيكى شامل بواسطة:

١ – مقابلة اكلينيكية شبه مقننة بهدف استكشاف الجوانب الاساسية المتعلقة بتاريخ المرض واعراضه والمظاهر المصاحبه له.

٢ – اختبارات نفسية ملائمة (اختبار الشخصية المتعدد الاوجه واستبيان مستشفى ميدل سكس) بهدف استكشاف سمات وملامح الشخصية المصاحبه للاضطراب.

وقد بينت النتائج أن الاضطراب كما تبدى فى عينة البحث يغلب عليه الصورة العامة من هذا الرهاب، كما أنه يأخذ مسارا مزمناً ومتصلاً دون تغيرات نوابية تذكر. وقد كان الاكتئاب هو أبرز المظاهر المصاحبه للاضطراب، بينما اشتملت المظاهر الأخرى على أعراض القلق العام، والملامح الوسواسية، والافكار البارانوية بالإضافة إلى سوء استخدام بعض العقاقير. من ناحية أخرى أظهر تقويم الشخصية ملامح عصابية وانطوائية بارزة. وقد نوقشت هذه النتائج فى ضوء نتائج الدراسات الحديثة المماثلة التى أجرى معظمها فى مجتمعات غربية.