A Review on Social Anxiety Disorder

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ABSTRACT

Social Anxiety Disorder is characterised by an intense fear of social situations in which the person anticipates being evaluated negatively. According to Global surveys, about 33.7% of the population is affected by anxiety disorder. (Bandelow 2015). The objective of this paper is to investigate the underlying causes of Social Anxiety Disorder (SAD) and its prevalence among the global population. This study aims to identify common medical and psychological interventions employed to treat or assist individuals in adapting to SAD and to evaluate the effectiveness of these interventions. Furthermore, this study seeks to consolidate and analyse findings from current, highly-regarded research papers on SAD, with the goal of synthesising their outcomes into a comprehensive study.

Additionally, this paper endeavours to explore the potential influence of genomes and Single Nucleotide Polymorphisms (SNPs) on Social Anxiety Disorder and other general anxiety disorders. By doing so, it hopes to contribute to the broader understanding and treatment of these conditions.

Keywords: - *Social Anxiety Disorder (SAD), Genetic basis , Treatment of SAD*

1. INTRODUCTION

Social anxiety disorder (SAD) is a common psychiatric disorder that is often associated with avoidant temperament. SAD includes certain essential features of complex fear and anxiety of either one or multiple social situations during which either but often not under the scrutiny of others.

Exposure to such a social environment often triggers fear or anxiety in the affected individual. In the long run, this adversely affects the individual's social life, causing impairment in social, occupational, cultural, and other unavoidable realms to function in society. Studies have shown that social anxiety has high socio-economic costs. (Bandelow 2015).

1.2. METHODOLOGY

This study is prepared solely based on publicly available secondary sources of data, including other journals, articles, surveys and research papers, as well as published books from 2015 to 2021.

2. AETIOLOGY OF SOCIAL ANXIETY DISORDER

Similar to multiple other disorders of the same kind, SAD could be best understood as an interaction between several other biopsychological factors.

According to DSM-5(American Psychiatric Association, 2013), the main characteristics of SAD are fear or anxiety in social situations where the person may be subject to scrutiny from others and a fear of acting in a way that will be perceived negatively by others(either as a result of the person's own behaviour or a result of exhibiting anxiety symptoms like blushing, trembling or sweating).

The social encounters are either avoided or endured with great anxiety whenever feasible. The DSM-5 adds additional requirements, including that fear must be clinically significant, out of proportion to the threat, persisting for more than 6 months, unrelated to substance use or another medical condition, and it impairs key social functioning domains. Our understanding of the epidemiology of SAD, which is relatively common among children and adolescents, has been updated by recent studies(BURSTEIN ET AL., 2011; LAWRENCE ET AL., 2015). Although no such rise was discovered in a sizable UK epidemiological study (Ford, goodman & Meltzer 2003), prevalence rates in community samples are typically observed to increase from childhood to adolescence (Beesdo et al, 2007 Burstein et al., 2001, Camino et al, 2004, LAWRENCE ET AL, 2015).

Studies have shown that untreated SAD during childhood and adolescence persists into adulthood(Beesdo-Baucen et al., 2012, Burstein et al, 2001, Kessler et al, 2012); earlier onset of SAD increases this risk (Abidin, 1999, bees do et al 2007, wittchen and felinn, 2003). Although it is more likely to have a waning and waning rather than a stable course, SAD is really one of the more chronic and persistent mental disorders over the lifespan (beesdo- Baun et al, 2005).SAD in youth is combined with other multiple significant mental health distresses, in particular, other anxiety disorders & depression and with substance use in the later part of adolescence (beesdo- baunn et al., 2012, bursteen et al, 2011, wittchan et al 1999). Yet there is this insufficiency of evidence to state that SAD is a result or effect of such comorbid problems or that such patterns of comorbidity reflect any commonly underlying causal factors.

Yet studies that time are stating to look into these intricate relationships. For instance, beesdo et al (2007) showed that SAD during adolescence considerably raised the risk for depression throughout the early stages of adulthood, despite the fact that Bucker et al did not see this effect (2008). Similar other longitudinal studies have demonstrated that SAD during adolescence increases the risk of future alcohol use as well as cannabis and alcohol dependency in early adulthood (black et al, 2015; Buckner et al., 2008). However, this association may only apply to females (Buckner & turner, 2009).

However, the study by Bucker et al(2008) found that whereas depression predicted future substance use, this effect was explained by the link between depression and SAD, showing that SAD, in particular, may raise young people's risk for substance usage in the future.

Contrary to these trends, a previous study found no evidence that adolescent social anxiety predicted any other adult diseases (pine, cohen, Gurley, Brook, & Ma 1998). Further longitudinal study is required to provide light on exact patterns and the system by which early SAD may continue or may aid in the emergence of other mental health issues. It is clear that the heterotypic continuity of SAD from adolescence is complex.

3. HOW COMMON IS SAD?

The prevalence of SAD varies across different regions and populations. In general, an estimation states that about 7.1% of adults in the United States experience SAD in any given year. This is slightly high in of 17 to 29 age category, with around 91%. SAD is most commonly observed among the younger population. Also, the lifelong prevalence of SAD ranges from 3.6 to 9.2% amongst the age group of 10-24 in Western countries, including the U.S., Germany and Australia.

In 2022, the prevalence of SAD among adults aged from 18 or older is estimated to be 7.1%, and this data solely represents the United States. And when it comes to the age group of 18-29, this goes higher to around 9.1%.

In a controlled study conducted in Germany in 2015/16 on a randomised population-based sample of 14-21 years of age, the lifetime prevalence of SAD was found to be around 6.6%. Also, certain studies indicate that younger individuals are disproportionately affected by SAD, with a prevalence rate of around 10% by the end of the period of adolescence. Also 90% of occurring by age 23. Even greater rates of SAD have also been observed amongst females who are often unemployed also have lower educational qualifications, typically from rural areas amongst the younger population. Also, a higher incidence of SAD amongst the younger population also signifies moving away from family and higher interaction and dependency on peer groups. Also, this earlier stage of development of neurocognitive abilities that includes publicly represented self-consciousness may also be seen as a brief time period of vulnerability towards SAD. And those who may be more behaviorally inhibited by temperament are at a greater risk of developing and maintaining SAD(Leigh & Clark).

4. WHAT OTHER MENTAL DISORDERS ARE ASSOCIATED WITH SAD?

According to a cross-sectional study conducted amongst medical students in 2022, social anxiety disorder has been found to be associated with multiple other factors. Primarily, it was found to be associated with age. Also, a statistical association with sex, in which females were found to have more SAD compared to their male counterparts, where also found.

Meanwhile, some other studies conducted on similar samples or students from other institutions of different political and social environments show that, for interactions and speech tasks, regression analysis showed a substantial, moderate connection between social anxiety and behaviours. Tho there is no association with other performance aspects (such as verbal fluency or quality of verbal expression. Also, there were no sex differences noted.

Even Though a hefty number of studies have identified a link between social anxiety and impaired social behaviour. According to Levitan et al's research, individuals with SAD scored considerably worse than controls on observer assessment of voice interactions and fluency during a three-minute speech.

In other research, it was shown that individuals with SAD had more negative social behaviours (such as awkwardness) during talks and received worse ratings from observers for their eye contact and speech clarity. In a non-clinical research involving 48 women, Thompson and Rapee discovered that people with high social anxiety were judged worse overall and on summed measures of various behaviours (such as voice quality and conversational proficiency) during an opposite-sex " getting to know you " assignment.

However, according to a study by Schneider and Turk, variations among studies in elements like Statistical lower Sample characteristics and the kind of behavioural evaluations utilised are likely seemingly erratic relationships between social anxiety and behaviour.
Assessment methods, for instance, have included global impressions ratings and molecular behaviours composite scores. It's possible that anxiety affects some social behaviours but not others. Although there is some evidence to suggest otherwise, social anxiety appears to have minimal effect on the quality of performance. However, Schneider and Turk point out a consistent pattern that determines which performance component may be hampered by SAD and which may not.

5. TREATMENT AND MANAGEMENT

Some of the most provided treatment methods for social anxiety disorder include psychotherapy, medication and, in some cases, both.

5.1 Psychotherapy typically includes,

1. COGNITIVE BEHAVIORAL THERAPY: This is the most successful kind of psychotherapy for anxiety, and it works just as well in groups as it does one-on-one. With exposure-based CBT, the individual progressively gets more comfortable confronting their worst fears. This can help them become more adept at dealing with and give them the self-assurance they need to handle anxious circumstances.

5.2. SKILL TRAINING OR ROLE-PLAYING

This helps in improving social skills, feeding more at ease and being self-assured with others :

MEDICATIONS OFTEN INCLUDES

- Selective serotonin reuptake inhibitors When SAD symptoms are chronic, SSRIs are frequently the first class of medications used.Setraline (zoloft) or Paoxetine (Panil) are commonly recommended by physicians

- Serotonin – Norepinephrine reuptake inhibitors(SNRI). : If an SSRI fail to alleviate social anxiety, SNRI will be recommended as an alternative.

- Monoamine Oxidase Inhibitors (MAOIs): Physicians often prescribe or think about prescribing an MAOI if SSRIs or SNRIs are ineffective for treating your social anxiety.

Furthermore (foa and Kozak 1986) specify that the behaviour that withstands social anxiety is avoidance. It can be described as complete avoidance of the given situation or other subtle changes that are made to reduce the individual's worry in that given situation (avoiding eye contact, alcoholism, or other neutral methods to blend in). Since the subjects use avoidance, they are protecting themselves from the threatened situation, thus preventing any form of corrective learning from occurring. Thus, in short, avoidance drastically lowers anxiety, thus resulting in negative reinforcement of avoidance behaviour. This can be counted as a self-inflictive situation by the subject.

Thus, in order to force the subject to withstand and overcome such situations without causing any sort of impairment with the subject's social attributes, which occurs during avoidance behaviour, a sort of cognitive behaviour therapy can be utilised -:

1. Exposure therapy

Exposure treatment involves frequent and extended amounts of lines, placing the socially anxious client in a dreaded social scenario. Exposures are used to assist nervous people in confronting fearful circumstances while keeping them psychologically engaged, enabling the natural conditioning process involved (Heinberg,2002).

The majority of variants of SAD cognitive behavioural therapy use exposure as a key component of therapy.

Thus, in effect, this provides the subject with an opportunity for an activated fear response that could result in corrective learning through the integration of incompatible information with the structure of the previously learned response to fear (raskeetal 2008).

According to the already existing Pavlovian conditioning approach, the original conditioning stimulus (CS) - unconditional Stimulus association response to fear is not really erased during the execution; in fact, secondary inhibitory learning about the CS-US develops.

The "desirable difficulties" are activated using changing conditions, meanwhile learning a means of exchanging long-term learning. Thus, by placing more emphasis on fear tolerance than on fear reduction, exposure therapy can make use of the underlying idea of "desirable difficulties".

6. HOW MANY SEEK TREATMENT?

Although specific studies showed a 12% of life long prevalence of SAD, which is a lot higher when compared to other anxiety disorders, only over half of people with the condition ever seek therapy, and those that do often do so only after exhibiting symptoms for 15-20 years despite the severity of their suffering and disability (Grant et al.,2005a).

The belief is that social anxiety is a personality trait that cannot be destroyed or, in the case of children, that they will outgrow it. The stigma attached to mental health services, the fear of receiving a poor evaluation from a mental health professional, a general lack of knowledge about the availability of effective treatment and the limited availability of services in many areas are likely explanations for the low rates and delays.

A study conducted in the latter half of 2016 shows that 40% of those who develop the condition in childhood or adolescence recover before adulthood, but the other 60% of whom having the disorder progressing towards adulthood have a limited chance of spontaneous recovery, especially, if they are suffering from any other mental health disorders.

Also, according to a study conducted by National Survey Replication on an enormous number of those with social anxiety disorder or any other generalised anxiety disorder, about 75% of 1000 subjects surveyed had not received treatment in the same year in which the study was conducted(wang et al., 2005). Moreover, research conducted by scientists at the Massachusetts General Hospital and Temple University (goetternet al., 2008) identified one of the significant reasons why people with SAD or GAD

haven't approached for professional help is solely out of fear about what others will say or think, showing how significantly the stigma influences. multiple reasons, including a lack of financial resources and not knowing whom or where to approach for help also comes under this.

7. GENETIC PREDETERMINATION OF SOCIAL ANXIETY DISORDER

Complex in nature, SAD is impacted by both environmental and genetic factors. Researchers have discovered a number of genes, including the serotonin transporter gene (SLC6A4), that may play a role in the onset of SAD. Dopamine receptor genes (DRD2, DRD3, DRD4), BDNF gene (Brain-derived neurotrophic factor gene), Oxytocin receptor gene(OXTR), Glutamate receptor genes and Corticotropin-releasing hormone receptor 1 (CRHR1) are the other genes found to have associated with Social Anxiety Disorder. Research has demonstrated that the hypothalamic-pituitary-adrenal (HPA) axis, which controls the body's reaction to stress, is altered in those with SAD. Additionally, the HPA axis regulates the immune system, and changes to this system have been connected to the emergence of anxiety disorders.

Similar to neuroticism and extraversion, twin studies have demonstrated the hereditable foundation of social anxiety. However, genetic investigations have not yet revealed strong risk variants.

8. CONCLUSIONS

The primary sources of this research were other studies conducted under controlled environments supervised by expert empiricists. The reliance on these sources was necessitated by the unavailability of efficient scientific tools and the limited time frame for conducting this research.

The findings suggest that Social Anxiety Disorder (SAD) predominantly affects individuals in the age group spanning early puberty to the onset of adulthood. The persistence of SAD into later life stages is infrequently observed. However, in some instances where it does persist, it may lead to a state where the patient becomes unresponsive to therapies, primarily Cognitive Behavioral Therapy (CBT), which has demonstrated significant efficacy in treating SAD, apart from medications.

It is also noteworthy that the number of individuals seeking help for SAD is relatively low. This can be attributed mainly, if not solely, to the social and other stigmas surrounding SAD. This is similar to other anxiety disorders, where societal norms often dismiss such anxious reactions as non-disorders, thereby discouraging the need for professional intervention.

Furthermore, the genetic predisposition of SAD is unique and warrants further study for more precise results.
Some studies have observed that SAD is heritable and may manifest in an individual's life during periods or situations that trigger such reactions. It might also appear as a part of other mental disorders and often
disappears when the individual seeks treatment for such mental disorders, either through therapy or, more promisingly, through medications.

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