

## Size and burden of social phobia in Europe<sup>☆</sup>

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### Abstract

This paper provides a critical review of the prevalence of social phobia in European countries, a description of associated disability and burden and of clinical correlates and risk factors associated with social phobia. On the basis of a comprehensive literature search we identified 21 community studies and two primary care studies. The median lifetime and 12-month prevalence rates of social phobia in community samples referring to DSM-III-R and DSM-IV criteria were 6.65% and 2.0%, respectively. Younger individuals showed the highest rates, and women were more frequently affected than men. Social phobia was shown to be a persistent condition with a remarkably high degree of comorbid conditions, associated impairment and disability. Research deficits lie in a lack of data for most EU countries and in a lack of studies in children and the elderly. No data are available addressing met and unmet needs for intervention and costs, and data for vulnerability and risk factors of malignant course are scarce.

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### 1. Introduction

In the past, social phobia and various other conditions were grouped together under the term of *neurotic disorders* in DSM-II or ICD-9. Only two and a half decades ago, in DSM-III (APA, 1980), it was recognized as a single diagnostic category (ICD-10: F 40.1; WHO, 1990). Since then, its significance as a highly impairing and persistent condition has been well documented. Also known as social anxiety disorder, social phobia is characterized by intensive fear reactions triggered by a wide variety of social situations, in which the person might be negatively evaluated by others. The anxiety is distinct and persistent, and it is often

accompanied by disorder-specific bodily symptoms such as blushing, trembling, or sweating (Criterion A; DSM-IV; APA, 1994). When confronted with the feared situation, the individual immediately reacts with anxiety symptoms (Criterion B), whereas the person acknowledges that the fear is unreasonable and/or exaggerated (Criterion C). The anxiety leads to avoidance of the feared situations or to intensive discomfort when avoidance is not possible (Criterion D). The experience of anxiety and its symptoms, the anticipatory anxiety, and avoidance behaviour typically lead to distinct impairment in role functioning and to associated disabilities (Criterion E). To delineate temporary developmental social phobic syndromes from clinically significant social phobia, for individuals under 18 years of age, the symptoms have to persist for at least 6 months (Criterion F). Social phobia symptomatology can also occur as a more or less transient syndrome due to substance use and withdrawal syndrome, and potentially embarrassing medical conditions (e.g. trembling in Parkinson's Disease, stuttering, or binge eating such as in eating disorders). Thus, to delineate social phobia from such substance and/or somatic

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condition-related syndromes, Criteria G and H from DSM-IV require a series of differential diagnostic considerations. From the standpoint of epidemiological case finding methods, the latter differential diagnostic criteria as well as the impairment/distress criterion and the way they are translated in diagnostic interviews have been shown to be important sources of variation in prevalence estimates (Wittchen and Fehm, 2003). Also note that, since the introduction of social phobia in the DSM-III (APA, 1980), the diagnostic criteria have been subject to changes, in an attempt to provide a sharper description of the disorder (e.g. with regard to the range of trigger situations). Consequently, corresponding changes in diagnostic assessment instruments and tools have had some influence on resulting prevalence estimates. In particular, the definition or operationalisation of impairment (see Criterion E) has been shown to be among the most important sources for variations in prevalence findings (Pélissolo et al., 2000), as cases of social phobia may differ in the degree of severity. Design factors such as sampling process, sample size, and age group composition are other important sources of variability.

## 2. Aims

Our main objective in this paper was to review critically epidemiological studies on the prevalence and/or incidence of social phobia in European union (EU) countries, with the focus on studies using DSM-III-R or DSM-IV definitions. An additional objective was to highlight important clinical correlates of social phobia (including risk factors, socio-demographic characteristics and cost and burden indicators), as revealed by epidemiological research.

## 3. Methods

Focusing on epidemiological studies in the community or services conducted in European countries (plus Iceland, Norway and Switzerland), we performed a comprehensive search of literature databases (Web of Science, Medline). Studies published since 1980 and using DSM-III upwards diagnostic criteria were included. Search results were circulated among experts to supplement studies that were not identified and to include reports accepted for publication as well as unpublished data, if accessible. Results were also compared with search results of the European Brain Council (EBC) project group in Dresden (see Wittchen and Jacobi, 2005).

## 4. Results

### 4.1. Prevalence studies

As shown in Table 1, a considerable number of community studies is available ( $n=21$ ), the majority

targeting the adult general population. Two studies have examined social phobia in primary care samples. Nearly all were cross-sectional prevalence studies; only two were longitudinal studies providing some information about incidence patterns (Wittchen et al., 1999a, Merikangas et al., 2002). At first sight, these studies reveal a considerable degree of variation in terms of prevalence estimates. As noted above, a large part of this variation can be attributed to changes in the diagnostic criteria and to the instrument used in the respective study. Therefore, we discuss these findings according to the time when the study was conducted.

Early (pre-1990) studies based on DSM-III revealed—consistent with US American studies—fairly low lifetime prevalence estimates ranging between 1% and 4% (Degonda and Angst, 1993; Faravelli et al., 1989; Lindal and Stefansson, 1993, Wittchen et al., 1992). These initially low estimates were largely attributed to the fact that the diagnostic instruments used did not examine the condition in a separate diagnostic module, which possibly resulted in an underestimation of the true prevalence (Wittchen et al., 1999b).

Subsequent studies relying on the revised DSM-III-R criteria and expanded diagnosis-specific modules revealed considerably higher lifetime prevalence rates for social phobia ranging between 4.1% (Lépine and Lellouch, 1995) and 16% (Wacker et al., 1992). It is noteworthy that the authors of the Swiss study also reported a considerably lower ICD-10-based estimate of 9.5%—despite using the same sample and instrument—without revealing where this divergence comes from. The probably most frequently cited international DSM-III-R prevalence estimate has been 13.3%, as determined by the National Comorbidity Survey for the US adult population (Kessler et al., 1994; Magee et al., 1996).

Whereas the DSM-III criteria for social phobia were revised profoundly, only minor differences exist between the DSM-III-R and DSM-IV definitions. The DSM-IV assessment tools, however, were revised addressing more comprehensively social trigger situations as well as impairment issues. The lifetime prevalence in adult samples, when modern diagnostic criteria were used, ranged from 3.9% in Belgium (Ansseau et al., 1999) to 13.7% in Norway (Kringlen et al., 2001); the median was 6.65%. Twelve-month prevalence ranged from 0.6% (Spain) to 7.9% (Norway), and the median was 2.0%. Prevalence estimates were generally higher in women than in men. In few studies, shorter ( $\leq 1$  month) prevalence periods have been reported, but these estimates varied between 1% and 15.6%.

Table 1 also signals that only few EU countries, namely Belgium, France, Germany, Italy, the Netherlands, Spain and Sweden, have ever published any prevalence rates for community samples and a sizable age range. Further noteworthy issues are: (i) A small number of studies have been conducted using ICD-10 criteria for social phobia. (ii) In addition to community surveys, some surveys have also been conducted in general health care settings. In this

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