

Social phobia and depression: Prevalence and comorbidity

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Abstract

Background: Social phobia may seriously impair the functioning of affected individuals. It is frequently associated with other mental disorders. **Aims:** To estimate the co-occurrence of social phobia with major depressive disorder (MDD) and to analyze their interaction. **Method:** Subjects were 18,980 individuals, aged 15 years or older, representative of the general population of the United Kingdom, Germany, Italy, Spain and Portugal, who were interviewed by telephone. *DSM-IV* diagnoses were made with the Sleep-EVAL system. **Results:** The point prevalence for social phobia was 4.4% (95% confidence interval: 4.1–4.7%) of the sample. It was higher in women (odds ratio: 1.6) and decreased with age. MDDs

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were found in 19.5% of participants with social phobia. Co-occurrence of another anxiety disorder was high and increased when a MDD was present (65.2%). The odds of developing a major depressive episode 2 years after the appearance of the social phobia was of 5.74. **Conclusions:** Social phobia is highly prevalent in the general population. It increases the risk of developing a MDD and has a high comorbidity with other mental disorders. Social phobia is often present in the course of depression, more obviously during remission period of MDD. Physicians must explore and treat more systematically this frequent pathology.

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Introduction

Social phobia is an anxiety disorder fairly common in the general population. In its more severe forms, the disorder has important repercussions in the daily life of the individuals. Since its introduction in the *DSM-III*, prevalence of social phobia was provided in more than 30 community-based surveys around the world [1]. Studies based on *DSM-III* classification reported 1-month prevalence ranging between 0.5% and 1.3% and lifetime prevalence between 1% and 8% [2–8]. Studies based on the *DSM-III-R* classification found 1-month prevalence between 2% and 7%, 12-month prevalence between 4.8% and 11.1%, and lifetime prevalence between 4.0% and 16% [9–14]. Prevalences based on *DSM-IV* classification show a one-month prevalence

between 1.6% and 15.6%, 12-month prevalence between 1.2% and 7.2% and lifetime prevalence between 2.3% and 7.3% [15–21].

Divergences between the reported prevalences are based primarily on three points:

1. The evolution of the *DSM* classification, especially between the *DSM-III* and its revision. Social phobia criteria remained roughly the same between *DSM-III-R* and *DSM-IV*.
2. The diagnostic threshold was rarely the same from one study to another. The level of interference in psychosocial functioning or distress varied between studies ranging from nearly non-existent to severe impairment. Studies that used different thresholds showed that small variations influenced the prevalence.
3. Cultural differences may also played a role as would suggest large discrepancies between Asian and Middle East countries and Western countries. However, studies that investigated these differences are seldom [22,23].

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Social phobia, although one of the most frequent disorders in individuals with mood disorders in clinical studies, has been surprisingly little investigated in co-occurrence with depressive disorders in the general population [14,24].

In clinical studies, high associations were found between social phobia and other phobias (59%), panic disorder (49%) and major depressive disorder (MDD) (17%) [25,26].

In the general population, individuals with social phobia had the highest likelihood of developing a MDD in the two years following the onset of social phobia [27]. Longitudinal studies showed that adolescents and young adults with social phobia were more likely to have experienced a depressive disorder in the 2–5-year follow-up period [24,28]. Social phobia has been also related to the severity and persistence of mood disorders [29].

Consequently, we decided to examine the current prevalence of social phobia in a European sample. More specifically, we wanted to assess how the co-occurrence of social phobia with depressive disorder modifies different key variables such as sociodemographic determinants, health care utilization, and psychotropic treatment. We also examined whether the co-occurrence of social phobia and depressive disorder increased the likelihood of other comorbid anxiety disorders.

Methods

Sampling

The participants in the five countries were interviewed by telephone between 1994 and 1999 as part of a study that had the broader aim to assess sleeping habits, sleep, and mental disorders in the general population. The studied countries were the United Kingdom, Germany, Italy, Portugal, and Spain. In each country, an ethical and research committee approved the study.

The target population was all non-institutionalized residents aged 15 years or over with the exception of Portugal, where the minimum age was set at 18 years at the recommendation of the Portuguese ethics committee. This represented about 206 million Europeans. The total sample consisted of 18,980 subjects aged 15–101 years.

A two-stage design was used for all countries. The population of each country was first divided according to its geographical distribution (State or Province) as per the official census data, and then telephone numbers were randomly drawn in each geographical area with respect of the size of the area. For example, the area of Sicily represented 9.9% of the Italian population. It means that about 390 telephone numbers (9.9% of the Italian sample) had to be picked up in this area. Second, within each household, a member was selected by age and gender using the Kish method [30] in order to maintain the representation of the sample and to avoid bias related to noncoverage error. This method is based on eight selection tables pre-emptively assigned to telephone numbers: four tables are assigned to

1/6 telephone numbers and the 4 other tables on 1/12 numbers. During the first phone call, it consisted in asking the age and gender of all eligible household members and sorting the household members from the oldest man to the youngest woman. Then, according to the assigned table and the number of household members, a subject was picked up in the sorted list as indicated in the table. The Kish method was implemented in the software; the interviewers only collected age and gender and the computer indicated the household member to interview.

Participants had to first grant their verbal consent prior to proceeding with the interview. For subjects younger than 18 years of age, the verbal consent of one of the parent was also requested. We excluded potential participants who had insufficient fluency in the national language, who had a hearing or speech impairment or with an illness that precluded the feasibility of an interview.

The participation rate was 79.6% (4972 of 6249 eligible individuals) in the UK; 68.1% (4115 of 6047 eligible individuals) in Germany; 89.4% (3970 of 4442 eligible individuals) in Italy; 83% (1858 of 2234 eligible subjects) in Portugal; and 87.5% (4065 of 4648 eligible individuals) in Spain. A total of 18,980 subjects participated in the study. The overall participation rate was 80.4%.

Instrument

The Sleep-EVAL Expert System [31,32] was used to perform the interviews. This software is designed to conduct epidemiological studies in the general population and to administer questionnaires. The Sleep-EVAL Expert System selected the questions and displayed them one at the time on the computer screen. Lay interviewers read the questions to the subjects and entered the answers in the Sleep-EVAL Expert System using the computer mouse or the keyboard.

The knowledge base of the system included a standard questionnaire and diagnostic pathways covering the International Classification of Sleep Disorders (ICSD) [33] and the *DSM-IV* [34]. The questionnaire consisted of socio-demographic information, sleep/wake schedule, physical health queries and questions related to sleep and mental disease symptoms. All the interviews began with general questions about demographic characteristics, followed by questions about sleeping habits. The interviews progressed to more private questions regarding mental health.

The system used the answers to select a series of plausible diagnostic hypotheses (causal reasoning process). Further questioning and deductions of the consequences of each answer allowed the system to confirm or reject these hypotheses (nonmonotonic, Level 2 feature). The differential diagnosis process was based on a series of key rules allowing or prohibiting the co-occurrence of two diagnoses in accordance with ICSD and *DSM-IV* guidelines. The interview ended once all diagnostic possibilities were exhausted.

The Fig. 1 presents a summarized decisional tree and results applied by the system during the exploration of social

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