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Shyness and social phobia in Israeli Jewish vs Arab students

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Abstract

Background: Social anxiety disorder (SAD) has been repeatedly shown to be very prevalent in the Western society with prevalence rates of 10% or above. However, very few studies have been performed in the Middle East and in Arab countries.
Methods: A total of 300 Israeli students participated in our study and were administered the Liebowitz Social Anxiety Scale (LSAS), the Cheek and Buss Shyness Questionnaire (CBSQ), and a sociodemographic questionnaire.
Results: A total of 153 Jewish and 147 Arab students participated in the survey. Social anxiety disorder was found in 12.33% of the sample, according to the LSAS cutoff score of more than 60. The 2 subsamples had similar LSAS and CBSQ scores and similar SAD-positive rates (LSAS >60). Females had higher scores on the LSAS, as were those without a spouse and those who had been in psychological treatment. Based on a regression analysis, the significant predictors of the LSAS score were the CBSQ score and female sex. A very high correlation was found between the LSAS and the CBSQ scores.
Conclusions: Although our sample is not representative of the whole Israeli population, we conclude that SAD and shyness were similarly prevalent in Jewish and Arab students in Israel. Social anxiety disorder scores were higher among females, those without a spouse, and those who received psychological treatment. Further studies on the clinical and cultural characteristics of SAD in Israeli subcultures would add to the growing body of knowledge on SAD in various cultures.

1. Introduction

Social anxiety disorder (SAD) is a highly prevalent disorder in Western countries, reaching lifetime prevalence rates of up to 13% in the general population [1,2]. Over time, increased disability and a reduced quality of life, as well as increasing rates of comorbidity with secondary mental disorders (ie, depression, substance abuse), can be expected in such individuals [3-8]. Social anxiety disorder was a relatively late addition to official psychiatric nomenclature and first emerged as a diagnostic category in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders III* [3]. Arguably, one reason for this late addition to the psychiatric nomenclature is the dispute on whether SAD is sufficiently disabling to be considered a psychiatric diagnosis or simply the confluence of extreme personality traits, namely, very high introversion and neuroticism [9]. This dispute may also account for the continued underdiagnosis and undertreatment of this condition [2].

Epidemiologic and clinical studies on SAD have become increasingly common in industrialized countries in the last 2 decades [2], in response to the recognition of SAD as a common disorder accompanied by significant comorbidity and burden. However, such studies are scant in the Middle East and in Arab communities. In a sporadic report from Saudi Arabia, SAD was reported to be a notably common disorder among Saudis and constituted approximately 13% of all neurotic disorders seen at a large clinic in Riyadh [10]. The plausible explanation for this high rate was the strict discipline in the Saudi culture with rigid moral codes and rituals. Even small deviations from the rules are unacceptable, and individuals who do not conform are quickly outcast. Adherence to all social demands could be stressful and requires discipline and self-control that is exercised at the expense of personal autonomy. Furthermore, one who has made a bad impression in public is likely to retain a poor

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reputation permanently, although the impression is subsequently shown to have been a false one. Taken together, these factors may affect those with unique personality traits or with a strong sense of individuality, thus increasing the incidence of SAD. Indeed, SAD has been reported to be more prevalent in young and well-educated Saudis who are more likely to have developed their own ideas and values and, therefore, are less willing to conform to a ritualistic social milieu. In addition, the low incidence of SAD in Saudi women might result from the situation that women are confined, not exposed to a variety of social situations, and their social gatherings are mostly recreational with minimal rituals [10].

Recent methodologically well-designed studies show, however, low SAD rates in Arab societies. Karam et al [11,12] interviewed a representative sample of the Lebanese population (n = 2857 adults) with the World Health Organization Composite International Diagnostic Interview (CIDI) 3.0 [13] and investigated the lifetime prevalence treatment, age of onset of mental disorders, and their relationship to the war in Lebanon. Karam et al [11,12] reported a 12-month prevalence of SAD of 1.1% and a lifetime prevalence of 1.9% (2.1% in females and 1.7% in males). The lifetime prevalence was 2.8% among subjects aged 18 to 34 years, 1.5% among those aged 35 to 49 years, 1% among those aged 50 to 64 years, and 0.4% among those aged 65 years and above. Karam et al [12] also found a very long delay for treatment of anxiety disorders in general, with a median duration of delay of 28 years. The authors claimed that this was not because of shortage of health care professionals in Lebanon but perhaps because of stigma, financial difficulties, and lack of awareness. In addition, a recent study from Iraq [14] with a large sample of household residents (n = 4332) reported a low lifetime prevalence of only 0.8%.

Very few studies examined the prevalence of SAD in Israel. Levav et al [15] examined the prevalence of mental disorders in a 10-year cohort of young adults in Israel. This study also examined the 1-year prevalence of phobic disorders (including SAD) and reported that the point prevalence of phobic disorders was 2.8%, less frequent than in American, European, and Australian samples [16-18]. Specific data on SAD prevalence were not provided [15]. However, in a previous study by the first author [19], we reported in a large group of Israeli soldiers that SAD was present in 4.5% of the sample, corroborating the high prevalence of SAD in Western countries. Overall, SAD symptoms were reported by a great percentage of subjects, as displayed by the rather high mean Liebowitz Social Anxiety Scale (LSAS) scores (mean ± SD, 29 ± 23.79) in this nonclinical sample. The following variables were accompanied by higher LSAS scores: inability to perform command activities, receiving psychotropic medication before army service, having less than 2 friends, shy family members, and treatment during military service. Sex did not influence the LSAS scores. Based on this primordial study in Israel, we were surprised that the recent Israeli National Health Survey [20] did not include SAD in the list of disorders assessed. Having said that, few studies have assessed the rates of shyness in Israel [21], and this issue warrants investigation.

Reports on the prevalence of SAD vary widely between different countries and cultures, and as such, research in Israel, a multicultural society, may provide important data. Arabs in Israel are a relatively collectivistic-communal, homogenous cultural group [22,23], meaning that the Arab social structure in Israel emphasizes the collective over the individual. The Arab society is a nonassimilating minority, differing from the Jewish majority in language, religion, and nationality. Nevertheless, this minority also perceives high school education as an opportunity for employment and a higher economic status [24]. An early study published in 1989 evaluated the degree of social anxiety with Sarason's tool of Reaction to Social Situations in Jewish and Arab students in Israel [25] and reported that Jewish and Arab students did not differ on social anxiety scores. Males had higher scores, and the author proposed that this derived from the traditional role of the male as initiator of heterosexual relationships.

The current study is the first to examine SAD among Jewish and Arab students in Israel with modern SAD tools. The present study's objectives were as follows: (1) to assess the prevalence of SAD in an Israeli sample of Jewish and Arab students; (2) to characterize the sociodemographic characteristics (sex, education, and relationships) of those having SAD; (3) to examine possible risk factors for the development of SAD; and finally, (4) to examine the correlation between shyness (a feature disregarded in Israeli studies) and social anxiety in the Jewish and Arab students.

We hypothesized that

1. SAD symptoms will be frequent in the sample, also less frequent in the Arab students who live in collectivistic communities.
2. Based on the article by Chaleby [10], we hypothesized that the Arab students will include more male subjects with SAD than the Jewish sample.
3. Shyness and SAD will be highly correlated.

2. Methods

2.1. Subjects

A convenience sample of 300 students from colleges in Northern Israel participated in the study. This sample of young adults was chosen because SAD often begins during childhood or adolescence and, if left untreated, may be masked and complicated by subsequent disorders [26]. The subjects were approached during an introductory psychology course open for all students, thus, our sample being a mixture of students. The subjects were requested to fill a survey on social behavior, shyness, and social anxiety. No exclusion criteria were used.