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Research Paper

Social Anxiety: Mirroring Psycho-Social Aspects

Aruna Kad[1]*

ABSTRACT

Social Anxiety Disorder (SAD) is a disorder that is perceived but usually not accepted by the sufferer so its prevalence and comorbidity increase. Most of the times it is not considered as a serious disorder by the society that is why importance is not given to either its causes or treatment. It is a subjective expression of symptoms as well as a subjective preference for treatment. A review of studies has focused on the onset, prevalence, gender difference, and psycho-social aspects of social anxiety disorder. The need of the hour is that Governments, Private institutions, and NGOs should come forward for their meticulous research and apply findings for the prevention and treatment.

Keywords: *Social Anxiety Disorder, Onset, Prevalence, Causes, Prevention, Gender Difference*

According to Vahia (2013) in the Diagnostic and Statistical Manual of Mental Disorders [5th ed.; DSM-5]; and the American Psychiatric Association (2013), social anxiety disorder (SAD) is portrayed by an excessive and ongoing dread of being judged or criticized in social circumstances. An individual avoids or experiences such events with great anxiety because they fear acting in a way that they will be humiliated or embarrassed. Various spectrums are being put forward for SAD, including social anxiety and avoidance, body-focused concerns, emotional difficulties, and social deficits (Stein, 2004). SAD is linked to issues across a variety of life domains like significant pain and functional impairment (such as in relationships and the workplace), although the majority of those who have it do not go for treatment (Crome et al.,2015). The person may exhibit acquisition deficit, which is defined as the absence of social skills prior to the environment's demands, performance deficit, which is defined as the occurrence of a particular ability less frequently than anticipated given the environment's demands, and fluency deficit, which is defined as the occurrence of abilities with lower proficiency. then the one expected for the social demands (Angélico et al., 2013)

Onset

According to McEvoy et al. (2011), SAD often has onset at an early age (13 years old is the median age in Australia) and usually accompanied by a chronic course. Nearly 70% of people with SAD have had a comorbid condition at some point in their lives, according to the prevalence rates for SAD in Australia, which are correspondingly 4.2% and 8.4% (Crome et al., 2015). According to Wong & Rapee (2015), SAD often manifests in late childhood and early adolescence.

[1]Associate Professor, Dayanand College, Hisar, Haryana, India
*Corresponding Author

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Prevalance

According to epidemiologic research conducted in Europe, roughly 7% of the general population has social anxiety disorder at some point in their lifespan (Jefferies & Ungar, 2020; Lecrubier et al., 2000). In India, the prevalence of SAD was calculated to be 15.3% (Jaiswal et al., 2020). Following the lifting of the COVID-19 lockdown, there were 19.57% and 12.36%, respectively, of left-behind youngsters, had depression and social anxiety, with an 8.98% co-morbidity rate (Li, K., et al., 2022).

Gender disparity

According to Kessler et al. (1994) and American Psychiatric Association (2013), women are more likely than males to have SAD. Women report higher incidence and clinical severity of social phobia, as shown by more severe symptoms, higher levels of social phobia, and overall, more social phobias. Adolescence is the time when this gender discrepancy in frequency is most noticeable, and it appears that it gets less with time (Maya Asher et al., 2017). Men with SAD are more likely to seek treatment, despite the fact women are more prone to develop the ailment. (American Psychiatric Association, 2013). In contrast to males with SAD who are more likely to have concurrent externalizing disorders, women with SAD are more likely to have comorbid internalizing disorders, according to says nationwide epidemiologic sample on alcohol and associated diseases (Xu et al., 2012).

Why is SAD?

A number of variables have been postulated to raise the chance of getting SAD, but no definite pathway in its development has been found. A number of variables, including genetic, neurological, and temperamental ones, have been linked to the emergence of SAD. According to models of the etiology of SAD, traumatic life events, unpleasant social experiences, and parental variables are the main environmental impacts on the development of SAD (Beidel & Turner 2007).

Interactions between children and parents impact the chances of developing SAD (Higa-McMillan & Ebesutani (2011). Although, (McLeod, Wood, and Weisz 2007) claimed that only 4% of the difference in child anxiety is due to parent-child interactions. Compared to other anxiety disorders, SAD is more likely to develop due to parental influences (Bogels et al.,2001). The impact of parents may interact with children's anxious or hesitant actions in a way that strengthens social anxiety in the child's cognitive, conative, and emotional modes of behavior. parenting style, behavioural modeling, and quality of attachment are the foundation and significant parental influencers for the development of SAD (Ollendick & Hirshfeld-Becker, 2002).

Social anxiety disorder (SAD) has also been linked to the way parents impart information about social anxieties and social avoidance as well as how children go for observational learning of these situations. (Hudson & Rapee, 2000). (Bruch, 1989; Bruch & Heimberg, 1994) SAD people claim that their parents tended to accentuate the value of others' views and the significance of looks. Parents of SAD sufferers are less involved with their kids, more inhibited, less socially active, and more worried (Festa & Ginsburg, 2011; Knappe et al., 2009; Woodruff-Borden et al., 2014). Nervous parents may obstruct chances for social interaction or encourage limit or social withdrawal, wither growth of Social capacities, and therefore conserve recurring social anxiety (Bruch & Heimberg, 1994; Caster et al., 1999).

SAD parents are more likely to imitate avoidant actions according to multiple studies. For a large number of SAD patients, their parents were less socially active and demoralized family

members and friends from getting together. (Anhalt & Morris, 1989; Festa & Ginsburg, 2011; Rapee & Melville, 1997). Additionally, women with Social Anxiety Disorder individuals assert having more control over their children's socialization experiences. (Rapee & Melville, 1997). After talking to their parents, stressed kids were more likely than non-stressed little ones to perceive unclear circumstances to see it as hazardous and to use more defensive strategies to cope (Barrett et al., 1996). Families may create an environment in which kids learn to perceive and react to potentially dangerous circumstances, and worried parents may serve as role models for their worried teens, providing encouragement and support. (Norton and Abbott 2017).

Parental control and overprotection have been linked to the emergence of anxiety disorders (Rapee & Spence 2004). (Arrindell et al., 1989; Bandelow et al., 2004 Festa & Ginsburg,2011; Gulley et al.,2014) found that adults with SAD typically believe they're parents limit their liberty and are excessively controlling. Additionally, Hudson et al. (2008) showed that moms of nervous children were more curious and involved while working together or discussing experiences including unpleasant emotional states. It was shown that the parents of these anxious children exhibited more controlling conduct while introducing their children to a challenging task, particularly in the context of social anxiety (Rork & Morris, 2009. Hudson & colleagues (2008), found mothers of anxious children were more nosy and more engaged while working together or talking about experiences involving unpleasant emotional states. Particularly with regard to social anxiety, it was discovered that parents of socially anxious kids showed more controlling behaviour while putting their kids through a difficult assignment (Rork & Morris, 2009). Importantly, a longitudinal study that looked at this issue discovered that there was a positive correlation between social anxiety symptoms and a greater prevalence of SAD diagnoses in adolescence. discovered that these connections were predicted by greater detected maternal control when the child was 7 years old. (Lewis et al., 2012). People with SAD typically claim that their parents were overprotective, which is closely connected to being in control (Arrindell et al., 1983; Knappe et al., 2009; 2012). The likelihood of developing SAD in teenagers has also been linked to an overly protective parenting style (Lieb et al., 2000)

The development of SAD looks like to be encouraged by demanding parental behaviour, in contrast, when a child is prompted to push their boundaries (Majdandzic and colleagues 2014). Although not all research has shown a connection comparing SAD and overbearing or overly cautious parenting, this suggests that it may or may not have a role when SAD first started (Arkinsola & Udoka, 2013; Bogels et al., 2001). Furthermore, some SAD people report that their parents were less accepting, critical, and shameful than healthy controls were (Bandelow et al., 2004); these parenting characteristics have been linked to increased levels of social anxiety (Mothander & Wang, 2014).

According to research by Brumariu & Kerns (2010), People with low self-esteem are more reluctant to take part in healthy peer social interactions and interpersonal interactions because they are less socially and emotionally competent. They also seem to be not as popular, upbeat, and socially active at school. A delayed onset of anxiety-related illnesses, including SAD, has most frequently been associated with an anxious-ambivalent attachment style (Kerns & Brumariu, 2014).

According to Warren et al. (1997), neonates who had an attachment that is tense and conflicted (but not anxious-avoidant attachment) were more likely to develop anxiety disorders as teens sixteen years afterward, 38% of this population still have SAD.According

to Eikenaes et al., (2015), SAD adults most frequently display that contrasted to controls, close relationships are uncomfortable, it's tough to rely on others, and you worry more about being rejected or abandoned.

Negative events increase the possibility of several types of psychological disorders, such as (but not exclusively) SAD, even though there could be triggering factors that occur just before SAD onset (Higa & Ebesutani, 2011). (Kessler et al., 1997; Wong & Rapee, 2015) also revealed that 70% of the SAD sample had experienced some form of child abuse. Negative events, such as parental divorce, and emotional, sexual, or physical abuse, may have a significant influence on the development of SAD, which is relational or social in character, according to Wong & Rapee (2015). Compared to physical or sexual abuse, emotional abuse and neglect are more significantly associated with SAD (Gibb et al., 2007; Iffland et al., 2012; Kuo et al., 2011). In addition, it has been discovered that parental emotional abuse mediates the effects of sexual and physical abuse on the signs of anxiety about social situations (Iffland et al., 2012).

The probability of acquiring the illness and the intensity of social anxiety symptoms have both been linked to sexual abuse, particularly in females (Bruce et al., 2013; Cougle et al., 2010). U.S. National Comorbidity Survey data show that those who had been the victims of rape or molestation were noticeably more likely to report SAD (Kessler et al., 1997). Additionally, greater psychological distress and earlier initiation of sexual abuse, stronger social avoidance, and anxiety have been linked to actual or attempted intercourse, as well as the age of sexual assault initiation and stronger psychological coercion to participate (Feerick & Snow, 2005).

The probability of development of SAD and the intensity of its symptoms have both been linked to physical abuse/violence and neglect (Bandelow et al., 2004; Bruce et al., 2012; Spinhoven et al., 2010). Family violence did, in fact, predict increased social anxiety. According to research by Binelli et al. (2012), being a hostile parent, either your mom or your dad increases the likelihood that a child may get SAD (Kessler et al., 1997).

Other socially harmful occurrences are also correlated to the onset of SAD like parental marital strife (Bandelow et al., 2004), separate or divorce of parents (Kessler et al., 1997), or the death of a parent or parents have all been linked to SAD. In addition, SAD sufferers were more likely to admit to having parents or other close relatives who had serious psychopathology, such as mood, drug use sickness, or anxiety (Chartier et al., 2001).

Bullying and other negative and traumatic experiences related to peers are also thought to play a direct conditioning role in the onset and development of SAD, including increased perturbation and social situation avoidance (Higa & Ebesultani, 2011; Wong & Rapee, 2015). Relative to other anxiety disorders, peer victimisation more significantly contributes to SAD (Cohen & Kendall, 2015). Additionally, vicariously experiencing someone else's humiliating social experience might result in traumatic conditioning (Beidel & Turner, 2007). Peer victimisation, which can include overt or relational victimisation or reputation damage is increasing social anxiety and was discovered to predict with time (Siegel et al., 2009).

Conversely, higher degrees of social avoidance and retreat are associated with lower levels of social anxiety, as are higher levels of support from society, consent, and peer approval (Boulton, 2013; Craig, 1998). In addition, loneliness, fewer companions and issues forming

new friendships, lower peer approval, more adverse relationships between close friends, and more are all positively correlated with social anxiety and SAD, particularly among girls. However, relational victimisation was shown to be the largest risk factor for SAD (Landoll et al.,2015)

Although less strong than relational victimisation, overt victimisation, such as physical or verbal abuse, is also positively related to worries of poor judgment, social avoidance, and the emergence of SAD (Storch & Masia-Werner 2004). Adolescents with SAD report overt victimisation occurring more frequently than adolescents without SAD do (Gren-Landell et al., 2011), and adults who have been overtly bullied have a greater frequency of SAD than adults who have not been overtly tormented (Gladstone, 2006). According to McCabe et al. (2010), taunting or name-calling throughout childhood has been linked to increased social anxiety symptomatology. Verbal bullying has also been linked to social anxiety. Additionally, there is evidence that social anxiety and cyber victimisation are related (Landoll et al., 2015).

Social victimisation and rejection are inversely correlated with social anxiety (Blöteet al., 2012; Ranta et al., 2013). Socially nervous people are more likely to be rejected or treated unfairly in this vicious cycle (Blöte et al., 2015), which in turn causes social avoidance and threat to rise, furthering victimisation and rejection, (Pabian & Vandebosch 2015). It's interesting to note that socially unpleasant situations are also reported by people who do not have SAD, and not all people with SAD can recall specific instances of social trauma (Ost, 1987), indicating that this is insufficient or required a reason for the illness. According to Beidel and Turner (2007), it is likely that SAD is the consequence of a complex interaction between these conditioning events, biological variables, aspects related to cognition, parenting, and other traumatic situations. Self-esteem and self-concept are also observed to modulate the correlation of peer interactions consisting of anxiety about social situations among teenagers (Bosacki et al., 2007), and the relationship between peer victimisation and social anxiety is moderated by coping style (Boulton, 2013; Wilson & Rapee 2006)

Additionally, negative self-imagery contributes to the development and maintenance of SAD (Clark & Wells, 1995; Sansen et al., 2015), as it seems to support the maintenance of Social fear by supporting adverse assessments of unclear social knowledge (Hirsch et al., 2006) and inhibiting the search for of optimistic, truthful imagery, experiences, and self-reflection working models (e. Focusing on negative self-referent images makes people more anxious and more likely to engage in safety measures, which reduces social performance and raises the risk of receiving unfavourable feedback. (Hirsch et al., 2004.)

Shame is an insecure emotion in which a person perceives the entire self as flawed and desires to run away, vanish, or die (Lewis, et al., 2008). Even though they are conceptually different, social anxiety and shame clearly overlap (Gilbert and Weeks,2014) and several research have shown a connection between the two. (Gilbert, 2000; Hedman, et al., 2013; Fergus et al., 2010). Despite the fact that SAD is a condition associated with anxiety, it is debatable whether shame plays a more significant role in the experience of those who suffer from severe social anxiety than anxiety does (Herman, 2011). As a result, it is possible to conceptualise this illness as a regret disorder. Internalised judgments of one's unsuitability and internalised shame appear to be substantially correlated with social anxiety. According to Matos et al. (2013), internal shame—which entails internalized unfavourable evaluations of themselves as unwanted, defective, insufficient or nasty—is substantially connected with

social anxiety. However, social anxiety has also been connected to external shame or the dread of having one's looks poorly evaluated.

Limitations of Preceding Research

Most research has been retroactive to date, self-reported information, and cross-sectional, and the subjective reports of anxious persons may be biased. which are sometimes made several years after the fact. The very feature of the memory may have an effect on it. The number of research on environmental variables such as SAD causes has certain limitations. The majority of research has examined the connection between SAD and the key environmental factor separately; as a result, the intricate interaction, relative significance, and timing of such factors have received very little attention. In addition, rather than focusing on SAD specifically, many research discusses childhood distress.

Additionally, many theorists contend that, rather than specifically increasing an individual's risk for getting SAD, a variety of adverse childhood experiences may actually enhance a person's propensity to develop psychopathology in general. Therefore, it is yet unknown if non-peer childhood trauma has a particular or general influence on SAD development. Furthermore, no research has yet looked into how carer reactions to child abuse affect children. The relationship between unpleasant social experiences and the establishment of a detrimental, distorted self-image requires clarification.

Future Consequences

The evidence mentioned above points to a variety of key contributing variables to SAD including environmental factors. Anxiety-ridden bonding, psychological assault, and to a lesser degree, sexual and physical abuse are all examples of insecurity., as well as bad relationship experiences in childhood, as well as too controlling, critical, and frigid parenthood, all increase the chance of developing SAD, according to theory and research. Additionally, these elements could result in PTSD reactions, skewed entrenched shame-based beliefs, and unfavourable perceptions of oneself. We still don't completely understand the nature, linkages, and proportional contributions of these components.

A complex interaction of biological and environmental variables is also thought to have a role in the development of SAD, and the illness may manifest itself in a number of different ways. In spite of the fact that environmental variables may operate as risk factors that raise the possibility of getting SAD, neither the condition nor a risk factor alone may cause SAD to occur. The utilization of long-term prospective investigations and a greater emphasis on impartial observational measurements in future research would both be highly advantageous as opposed to subjective self-report, and an investigation of the interconnections between the many environmental risk factors for SAD.

It's also necessary to conduct further research on the parental influences and adverse life experiences that cause SAD. Further research is needed to understand how adverse peer encounters affect posttraumatic symptomatology (such as poor self-imagery) and how they contribute to the maintenance of SAD. Last but not least, there has to be thought given to conceptualising SAD as a shame-based condition and the understudied shame's role in the growth and ongoing upkeep of SAD. Despite the paucity of gender literature on SAD, it can provide useful data for both researchers and therapists (Schneier & Goldmark, 2015).

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Conflict of Interest
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