

An Evaluation Study on Social Anxiety Disorder, its Risk Factors and Medical Management in tertiary Care centre of Haldia – A Cross-Sectional Study

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ABSTRACT

Background: Social Anxiety Disorder (SAD) is a prevalent yet under diagnosed condition that impairs psychosocial functioning. **Objective:** To describe the demographic characteristics, risk factors, and patterns of medical management in a clinical sample of adults with SAD. **Methods:** Twenty six outpatients (18–45 y) meeting DSM 5 criteria for SAD were assessed with a structured questionnaire covering sociodemographics, putative risk factors, and current/previous treatments. Descriptive statistics were generated. **Results:** Mean age was 27.6 ± 6.3 y; 57.7 % were female. Family history of anxiety (38 %), childhood bullying (35 %), and behavioral inhibition in childhood (31 %) were the most frequent risk factors. Selective serotonin reuptake inhibitors (SSRIs) were prescribed in 69 % of cases, cognitive behavioral therapy (CBT) in 54 %, and combination therapy in 38 %. **Conclusion:** SAD in this small cohort clustered in young adults with notable psychosocial risk factors. SSRIs and CBT remain core treatments; combined modalities were common. Early identification of high risk individuals could improve outcomes.

KEYWORDS: Social Anxiety, Behavioural.

INTRODUCTION

Social Anxiety Disorder, formerly “social phobia,” affects 7–13 % of the general population and typically onsets in adolescence. Untreated SAD predisposes to depression, substance misuse, and occupational underachievement[1]. Identifying modifiable risk factors and evaluating real-world use of evidence-based treatments can guide targeted interventions.

The prevalence of Social Anxiety Disorder (SAD) in India is estimated to be around 0.47% in the general adult population. However, studies focusing on specific populations like undergraduates have found higher prevalence rates, such as 7.8% in Indian undergraduates[2-4].

Nationally Representative Study: A study using a nationally representative sample in India found a 0.47% prevalence of SAD, with an average age of 35.68 years. **Higher Odds in Specific Groups:** The study also found

that male gender, unemployment, and living in urban areas were associated with higher odds of SAD, while the elderly had lower odds. Prevalence Among Undergraduates: A study focusing on Indian undergraduates found a significantly higher prevalence of SAD at 7.8%, suggesting a higher burden in this age group. Social Anxiety and Internet Use The study on undergraduates also indicated a link between SAD and attitudes and patterns of Facebook (FB) usage. Other Factors: Factors like dissatisfaction with facial appearance and language barriers during communication have also been identified as predictors of SAD among medical undergraduates[5-8].

Comorbidity: SAD often co-occurs with other mental health conditions, with depression being the most common comorbidity, followed by alcohol use disorder (AUD). Gender Differences:

While some studies show a higher prevalence of SAD among females, other studies indicate that the differences are not significant. Age: Younger age groups, particularly those in the 18-29 age group, show a higher distribution of anxiety disorders. Education: Illiterates and those with primary education tend to have a higher prevalence of anxiety disorders[9-12].

Rural vs. Urban: Some studies indicate that individuals living in rural areas may experience higher rates of SAD compared to those in urban areas. Important Considerations: Varied Prevalence Rates: Prevalence rates can vary depending on the study population, methodology, and specific diagnostic criteria use

METHODS

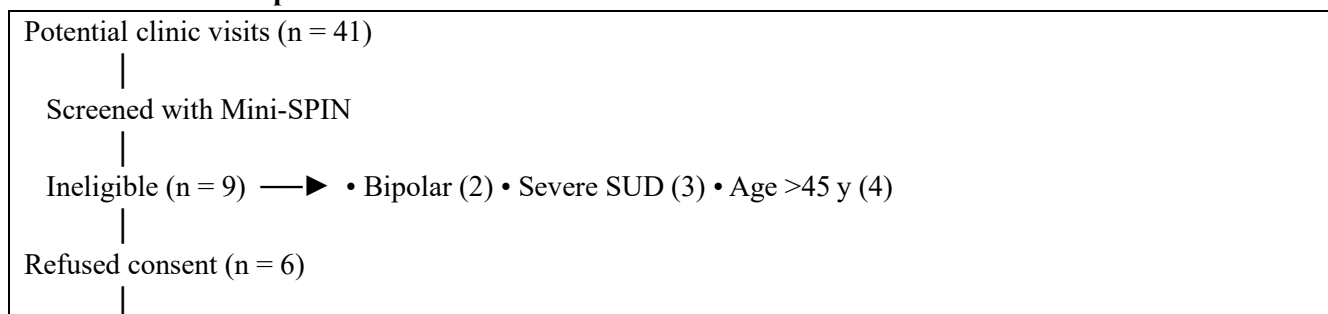
This study was conducted in a tertiary hospital. After obtaining institutional ethical committee approval. It was Cross-sectional observational study conducted on 41 patients in the department of Psychiatry, at a tertiary care centre, from February/ 2020 to August/2020. All patient were selected from OPD of General Medicine.

Total 41 participant were approached to project among them 15 were excluded due to non-fulfilling of eligibility criteria and Total 26 Confirmed cases were included on the basis of fulling of the eligibility criteria .

The institute Ethics Committee approval was obtained before starting the sample collection. A written and informed consent was taken from the patient regarding the study in his/her vernacular language and English. In this study Patients were subjected to: A detailed history of sign & symptoms and its duration. Detailed history of systemic diseases and its duration, medication were noted. Patients were subjected to General physical examination

Item	Description
Design	Cross-sectional descriptive study (February/ 2021 to August/2021)
Setting	Anxiety Disorders Clinic, tertiary-care teaching hospital
Participants	Consecutive adults (18–45 y) meeting DSM-5 SAD criteria; n = 26
Exclusions	Active psychosis, bipolar disorder, severe substance use, cognitive impairment
Data collection tools	Structured interview (demographics, clinical features, risk factors), Mini-SPIN screening, Liebowitz Social Anxiety Scale (LSAS)
Treatment data	Current/past pharmacotherapy, psychotherapy duration, adherence
Analysis	Descriptive statistics (mean $\pm$ SD, n, %) with SPSS v29

Flow chart – Participant Inclusion



Enrolled participants



Final sample (n = 26)

RESULTS

In this study we found that Social Anxiety Disorder is associated with demographic profile of patient. Mean age suffered of for this disorder is 27.6 ± 6.3 age group.

It means age is important factors for Social Anxiety Disorder. Younger age group were more prone to develop Social Anxiety Disorder.

Female (57.7%) were more prone to suffered of Social Anxiety Disorder as compared to male gender. (Table 1).

Among college student its prevalence is 65.4%. Among Single / never-married its prevalence is 73.1%.

Prevalence in Urban residence is more as compare to Rural area, its prevalence are 69.2 % of Social Anxiety Disorder (Table 1)

Demographic profile

Variable	n (%) or Mean $\pm$ SD
Age (y)	27.6 $\pm$ 6.3
Female sex	15 (57.7 %)
Urban residence	18 (69.2 %)
College education	17 (65.4 %)
Single / never-married	19 (73.1 %)
Employed	14 (53.8 %)

In this study we found that Family history of anxiety disorders is important risk factors for Social Anxiety Disorder. its prevalence is 38% Followed by Childhood bullying/teasing, its prevalence 35 % (Table 2). Behavioural inhibition (retrospective) is also important risk factors for Social Anxiety Disorder

Risk factors table

Risk factor*	n	%
Family history of anxiety disorders	10	38
Childhood bullying/teasing	9	35
Behavioral inhibition (retrospective)	8	31
Parental over-control	7	27
Traumatic public embarrassment	6	23
Comorbid major depression	5	19
High social-media use (>4 h/d)	4	15

*More than one risk factor possible per participant.

Treatment patterns

Modality	n	%
SSRI monotherapy (sertraline, paroxetine, escitalopram)	9	35
CBT alone (12-session group protocol)	5	19
SSRI + CBT combination	10	38
Benzodiazepine as needed (<2/wk)	4	15
Beta-blocker situational use	3	12

Mean LSAS baseline score: 76 ± 15 (moderate–severe). Among those on treatment ≥ 12 weeks ($n = 18$), mean LSAS reduction was 31 %.

DISCUSSION

The study replicates prior epidemiological patterns: female predominance and onset in the twenties. Psychosocial stressors—bullying, parental over-control—and temperamental traits (behavioural inhibition) emerged as prominent risk factors, echoing longitudinal cohort findings[13-16]. The high uptake of combination therapy may reflect clinician perception that dual-modality yields faster improvement. LSAS reductions approached the 30-point threshold considered clinically meaningful

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Social Anxiety Disorder (SAD) is often treated with a combination of psychotherapy and/or medication[17-19]. Cognitive Behavioral Therapy (CBT), particularly exposure therapy, is a highly effective psychotherapy approach. Medications like SSRIs, SNRIs, or beta-blockers may also be prescribed. In some cases, anti-anxiety medications (benzodiazepines) may be used short-term, but they are generally not recommended for long-term use due to potential dependence[20].

Psychotherapy: Cognitive Behavioral Therapy (CBT): This therapy helps individuals identify and challenge negative thought patterns and behaviors associated with social situations. Exposure Therapy: A key component of CBT, exposure therapy involves gradually and systematically exposing individuals to social situations they fear, helping them become desensitized to anxiety[21].

Other Psychotherapy Approaches: Short-term psychodynamic psychotherapy can also be helpful in addressing the underlying relationship conflicts that may contribute to social anxiety. Medications : Selective Serotonin Reuptake Inhibitors (SSRIs): These antidepressants, such as paroxetine (Paxil) and sertraline (Zoloft), are often the first-line medication choice for persistent SAD symptoms. Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs): These antidepressants may also be effective in treating SAD[22-26]. Beta-Blockers: Medications like propranolol can help manage the physical symptoms of anxiety, such as sweating and trembling, particularly in performance-related situations[27-29]. Benzodiazepines: These anti-anxiety medications can provide quick relief from anxiety symptoms but are generally not recommended for long-term use due to the risk of dependence. Other Approaches: Support Groups: Connecting with others who experience SAD can provide validation, reduce isolation, and offer coping strategies. Mindfulness and Relaxation Techniques: Practices like mindfulness can help manage anxiety symptoms and improve overall well-being. Lifestyle Adjustments: Addressing sleep problems, engaging in regular exercise, and limiting caffeine and alcohol intake can also play a role in managing SAD.

Strengths: structured assessment, real-world treatment snapshot.

Limitations: small convenience sample, single-center, no control group, self-reported risk factors subject to recall bias.

CONCLUSION

In this cohort adults with Social Anxiety Disorder, salient risk factors were familial anxiety load and adverse social experiences, while SSRIs and CBT—often combined—formed the backbone of medical management. Systematic screening in primary care and early psychosocial interventions targeting bullied or inhibited youth might mitigate progression to full-blown SAD. Evaluate digital CBT to overcome access barriers. Mindfulness and Relaxation Techniques: Practices like mindfulness can help manage anxiety symptoms and improve overall well-being. Lifestyle Adjustments: Addressing sleep problems, engaging in regular exercise, and limiting caffeine and alcohol intake can also play a role in managing SAD

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CONFLICT OF INTEREST

The authors report no conflicts of interest

SUBMISSION DECLARATION

This submission has not been published anywhere previously and that it is not simultaneously being considered for any other journal.

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