PREVALENCE AND PSYCHOLOGICAL CORRELATES OF SOCIAL ANXIETY DISORDER AMONG UNIVERSITY STUDENTS IN PESHAWAR

By

Saima Parvez

Supervisor

Prof Dr. Erum Irshad

Department of Psychology
University of Peshawar

A dissertation submitted to the department of psychology, university of Peshawar In partial fulfillment of the requirement for the DEGREE OF DOCTOR OF PHILOSOPHY IN PSYCHOLOGY

2013
PREVALENCE AND PSYCHOLOGICAL CORRELATES OF SOCIAL ANXIETY DISORDER AMONG UNIVERSITY STUDENTS IN PESHAWAR

By

SAIMA PARVEZ

Approved By

_________________________
Supervisor

_________________________
External Examiner

_________________________
Chairperson

Department of Psychology
University of Peshawar
APPROVAL CERTIFICATE

Certified that PhD dissertation entitled “Prevalence and Psychological correlates of Social anxiety disorder among University Students”, prepared by Mrs Saima Parvez has been approved for submission to the university of Peshawar Khyber Pakhtunkhawa, Pakistan as partial fulfillment of the degree of Doctor of Philosophy.

Supervisor
Professor Dr Erum Irshad
PREVALENCE AND PSYCHOLOGICAL CORRELATES OF SOCIAL ANXIETY DISORDER AMONG UNIVERSITY STUDENTS IN PESHAWAR

By

Saima Parvez

Supervisor

Prof Dr. Erum Irshad

Department of Psychology
University of Peshawar

2013
# TABLE OF CONTENTS

Table of Contents i  
List of Tables iii  
List of Figures iv  
List of Appendices v  
Acknowledgement vi  
Abstract vii

**Chapter-I**  
**INTRODUCTION**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>4</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>5</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>8</td>
</tr>
<tr>
<td>Obsessive-Compulsive disorder</td>
<td>12</td>
</tr>
<tr>
<td>Post-Traumatic disorder</td>
<td>15</td>
</tr>
<tr>
<td>Separation anxiety disorder</td>
<td>19</td>
</tr>
<tr>
<td>Phobic disorder</td>
<td>22</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>25</td>
</tr>
<tr>
<td>Theories of parenting styles</td>
<td>37</td>
</tr>
<tr>
<td>Parenting style and social anxiety disorder</td>
<td>41</td>
</tr>
<tr>
<td>Theories of self-esteem</td>
<td>49</td>
</tr>
<tr>
<td>Self-esteem and social anxiety disorder</td>
<td>51</td>
</tr>
<tr>
<td>Theories of Shyness</td>
<td>55</td>
</tr>
<tr>
<td>Shyness and social anxiety disorder</td>
<td>56</td>
</tr>
<tr>
<td>Theories of introversion extroversion</td>
<td>61</td>
</tr>
<tr>
<td>Extroversion and Introversion social anxiety disorder</td>
<td>62</td>
</tr>
<tr>
<td>Birth order and social anxiety disorder</td>
<td>67</td>
</tr>
<tr>
<td>Rural urban area and social anxiety disorder</td>
<td>69</td>
</tr>
</tbody>
</table>
Chapter-II  RATIONAL OF THE STUDY

Rational of the Study

Chapter-III  OBJECTIVES, HYPOTHESES

Objective of the research
Hypotheses

Chapter-IV  METHOD

Sample
Instruments
Procedure

Chapter-V  RESULTS

Chapter-VI  DISCUSSION

Chapter-VII  CONCLUSION

Conclusion
Limitations of the current study
Suggestions

REFERENCES

72
74
74
77
77
80
82-106
107-115
116
118
119
121
# LIST OF TABLES

<table>
<thead>
<tr>
<th>S.NO</th>
<th>TABLES</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table-1</td>
<td>Gender distribution of anxious and non-anxious Students (N=500)</td>
<td>84</td>
</tr>
<tr>
<td>Table-2</td>
<td>Mean difference and t-value of anxious and non-anxious Students on over control parenting style (N=500)</td>
<td>86</td>
</tr>
<tr>
<td>Table-3</td>
<td>Mean difference and t-value of anxious and non-anxious Students on rejecting parenting style, Introversion , Shyness &amp; Self esteem scale (N=500)</td>
<td>88</td>
</tr>
<tr>
<td>Table-4</td>
<td>One-way ANOVA results on the basis of area (N=500)</td>
<td>90</td>
</tr>
<tr>
<td>Table-5</td>
<td>Mean difference and t-value of anxious and non-anxious Students and birth order (first and last born) (N=280)</td>
<td>92</td>
</tr>
<tr>
<td>Table-6</td>
<td>Mean difference and t-value of introversion scale and birth order (N=280)</td>
<td>94</td>
</tr>
<tr>
<td>Table-7</td>
<td>Mean difference and t-value of shyness and birth order on shyness scale (N=280)</td>
<td>96</td>
</tr>
<tr>
<td>Table-8</td>
<td>Mean difference and t-value of self-esteem and birth order on self esteem scale (N=280)</td>
<td>98</td>
</tr>
<tr>
<td>Table-9</td>
<td>Mean difference and t-value of rural urban area and social anxiety on liebotwitz social anxiety scale (N=500)</td>
<td>100</td>
</tr>
<tr>
<td>Table-10</td>
<td>Mean difference and t-value of rural urban area and introversion on introversion scale (N=500)</td>
<td>102</td>
</tr>
<tr>
<td>Table-11</td>
<td>Mean difference and t-value of rural urban area and shyness on shyness scale (N=500)</td>
<td>104</td>
</tr>
<tr>
<td>Table-12</td>
<td>Mean difference and t-value of rural urban area and self-esteem on self esteem scale (N=500)</td>
<td>106</td>
</tr>
<tr>
<td>S.NO</td>
<td>FIGURES</td>
<td>Page No</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Figure -1</td>
<td>Gender distribution of anxious and non-anxious Students (N=500)</td>
<td>83</td>
</tr>
<tr>
<td>Figure -2</td>
<td>Mean difference and t-value of anxious and non-anxious Students on over control Parenting style (N=500)</td>
<td>85</td>
</tr>
<tr>
<td>Figure -3</td>
<td>Mean difference and t-value of anxious and non-anxious Students on rejecting Parenting style, Introversion &amp; Self esteem scale (N=500)</td>
<td>87</td>
</tr>
<tr>
<td>Figure -4</td>
<td>One-way ANOVA results on the basis of area (N=500)</td>
<td>89</td>
</tr>
<tr>
<td>Figure -5</td>
<td>Mean difference and t-value of anxious and non-anxious Students and birth order (first and last born) (N=280)</td>
<td>91</td>
</tr>
<tr>
<td>Figure -6</td>
<td>Mean difference and t-value of introversion scale and birth order (N=280)</td>
<td>93</td>
</tr>
<tr>
<td>Figure -7</td>
<td>Mean difference and t-value of shyness and birth order on shyness scale (N=280)</td>
<td>95</td>
</tr>
<tr>
<td>Figure -8</td>
<td>Mean difference and t-value of self-esteem and birth order on self esteem scale (N=280)</td>
<td>97</td>
</tr>
<tr>
<td>Figure -9</td>
<td>Mean difference and t-value of rural urban area and social anxiety on liebotwitz social anxiety scale (N=500)</td>
<td>99</td>
</tr>
<tr>
<td>Figure -10</td>
<td>Mean difference and t-value of rural urban area and introversion on introversion scale (N=500)</td>
<td>101</td>
</tr>
<tr>
<td>Figure -11</td>
<td>Mean difference and t-value of rural urban area and shyness on shyness scale (N=500)</td>
<td>103</td>
</tr>
<tr>
<td>Figure -12</td>
<td>Mean difference and t-value of rural urban area and self-esteem on self esteem scale (N=500)</td>
<td>105</td>
</tr>
</tbody>
</table>
LIST OF APPENDICES

Appendix –A _______________ Letter of Approval
Appendix –B _______________ Consent Form
Appendix –C _______________ In-Depth Clinical Interview
Appendix –D _______________ Liebowitz Social Anxiety Scale
Appendix –E _______________ Symptoms Check List
Appendix –F _______________ Rosenberg Self-Esteem Scale
Appendix –G _______________ Introversion Scale
Appendix –H _______________ Shyness Scale
Appendix –I _______________ Measure of Parental Style
ACKNOWLEDGEMENT

Thanks to Allah, the most gracious the most beneficent. Who enabled me to complete this work. In spite of all my shortcomings his blessings have always remained with me, as I firmly believe, without his gracious help, this accomplishment would have not been possible.

In the first place I feel honored to offer my gratefulness to all the teachers of my academic life who gradually raised me up to the present level of advanced studies.

My deep appreciation, gratitude, and indebtedness to the most important person to be acknowledged for the present research is my supervisor Professor Dr. Erum Irshad, for her continuous encouragement, moral support, and generosity in sharing her time and knowledge during the field work and the preparation of this thesis. Her clear vision and practical knowledge of research designing and conduction has been a great contribution towards the completion of my work. I am thankful to her for providing me the necessary motivation to overcome various academic problems in the way, encouraging feedback and guiding criticism.

I will never forget the help, encouragement and moral support of my parents. I would like to acknowledge the continuous backing and motivation they provided to me. They were always there to support me and clean my tears when I felt helpless and down. My husband cooperativeness, kindness, and valuable suggestions motivated me to finish my work.

I am also thankful to Mr. Usman, Lecturer National Institute of Psychology (NIP) Islamabad who helped me in the statistical analysis of my research and I must say thanks for his valuable assistance.

I would pay my thanks to all the participants who have cooperated in my study. Thanks offered to my friends for their support and cooperation in different aspect of completing this study.

Saima Pervez
ABSTRACT

The purpose of present study was to investigate the prevalence and psychological correlates of social anxiety disorder among university students. The research was carried out in three phases, in first phase social anxiety disorder was identified in university students, in second phase socially anxious students personality traits and perceived parenting styles was identified, and in third phase non anxious students personality traits and parenting styles were assessed for comparison purpose. A total sample of 500 students in which 250 were male and 250 were females ranging in age 17-25 years with educational background of 1st year to M.sc final year were selected randomly from different rural and urban universities. It was hypothesized that Social anxiety will be high among female students as compared to male students. Parenting style of parents of socially anxious students would be overprotective and rejecting as compared to non-anxious students. Students belonging to rural areas would have more social anxiety as compared to students belonging to urban areas. Liebowitz social anxiety scale, Rosenberg self-esteem scale, introversion scale, shyness scale, and measure of parental style were used to assess social anxiety disorder, self-esteem, introversion, shyness, and perceived parenting style. T-test, chi-square and one way Anova was applied on the result to investigate the significant differences between the two groups. Results confirmed hypotheses; it was found that social anxiety disorder is more among female students and students belonging to rural areas. It was also concluded that socially anxious students rate their parenting style as over control and rejecting. Social anxiety disorder affects personality traits such as shyness, self-esteem, and introversion.
INTRODUCTION

Every human being experiences anger and fear in his life many times as these are the very common emotions. Being anxious is a defensive reaction. In order for a human being to survive, fear and stress are also necessary. These emotions have their significance as they make the people to chase their goals and react properly in the situations of threat and hazards. The normal healthy human beings feel stressful when they feel the threat and face any challenging situation. Most of the people become nervous when they come across any problematic situation with their job or take any kind of exam or make a decision. This type of anxiety is positive in a way that it makes the person more attentive and cautious.

All the people regardless of their age and social background face anxiety. Anxiety becomes disturbing for the life if it arouses unreasonable fears in the individual. Many researchers are of the view that anxiety and fear are one and same feelings which are there in the conditions when people face any fear and danger. Some other researchers think that anxiety is unfriendly and hostile emotion which occurs in unidentifiable risks. The difference between anxiety and fear is that the reasons of fear may be known such as any danger but the reason of anxiety is not that much obvious.

There is no strict definition of anxiety given by psychologists, rather they explain three types of anxiety and present the differences between them. These types are Normal anxiety, neurotic anxiety and anxiety disorders. Normal anxiety is also termed as objective anxiety. In this type the individuals respond to a situation, which is the cause of anxiety, in an appropriate manner. An example is of a person who feels anxious on the very first day of his job, there are
many factors which may cause this anxious feeling. He might not be sure about the response of the co-workers. He may feel that he does not know what duties he will be assigned to. He may also feel uncertain about his decision of choosing the job. Considering all these feelings, the person controls his psychological emotions and tries his level best to adapt himself according to the situation. On the other hand, the anxiety disorder gives rise to very strong feelings of anxiety. The person fails to behave in a proper way. There are so many individuals who are unable to speak in front of a gathering as they have stage fear. These situations are dangerous and the person develops the feeling of severe anxiety. He fails to act according to his desires. According to Sigmund Freud, neurotic anxiety is very dangerous. Considering his Id-ego-superego scheme of human behavior, we see that anxiety is the result of a disagreement between sexual or aggressive tendencies and physical or moral limitations (Gale Encyclopedia of Psychology, 2001).

The component involved in anxiety includes behavioral, emotional, somatic and cognitive and this is stated that both is psychological and physiological. All the component mentioned are associated with each other in the creation of an unfriendly feeling. Anxiety does not need an activating stimulus and it can occur generally at any time. It is quite different from that of fear as fear is a cause of some known threat. The response of fear is generally avoidance and escape while anxiety is caused by the fears which one cannot control or avoid. Some other researchers are of the view that anxiety is the mood for the upcoming time in which the individual prepares himself to fight against the negative events. In reaction to stress, anxiety is considered to be a normal defense as it proves to be very helpful for the person to cope with problematic situations which may include working at a job or in school.
Anxiety may also cause physical stress in the form of faster heart beating, weakening of muscles and increase level of tension, tiredness, vomiting, shortness of breath, chest pain, pain in stomach or head. In situations, the individual’s heart rate and blood pressure gets increased, there is more sweating, more blood flows in major muscles and immune system and digestive system fail to function properly. In additions to these internal signs, there are some external symptoms also which include yellowing of skin, sweating and shivering. The person may also feel dread or panic. Panic is not necessary to be there with all the people suffering from anxiety. A panic attack is there without any caution but the person becomes fearful and feels something dangerous happening to him. Panic attack makes the individual feel that he or she is about to die.

In addition to the physical effects, there are emotional effects on the person feeling anxious. The person may feel uneasy or nervous, tense, irritable, feels the things in front of him to be dangerous for him and becomes restless.

Cognition of dying due to the threat of danger may be there and the person may feel that he is going to die now (Wikipedia, 2009).

A person can experience anxiety in different ways. There are three ways of feeling anxiety. Generalized anxiety and panic disorder are unfocussed forms of anxiety. In contrast, phobic anxiety arises due to the fear of a particular thing or condition. The third one is obsessive compulsive disorder in which the person feel anxious if he or she fails to engage in a specific behavior or thought (Bootzin,& Acocella, 1984).

When anxiety becomes exaggerated, it is called the abnormal form of anxiety. Excessive and intense anxiety is characterized as anxiety disorder. Anxiety disorder is very severe mental
sickness. The people who are the patient of anxiety disorder remain worried and fearful. They feel devastated and it may be crippling.

We can define anxiety disorder as a state of mind when the person excessively feels apprehend, insecure and stressful. The response given out of anxiety is not fear all the times. Still it can prove to be paralyzed for an individual and that individual fails to act appropriately. When the threat of the particular thing is removed, the person may feel relaxed but this does not mean that he is no more a patient of anxiety disorder rather he can again feel anxious when coming across any negative situation (URAC, 2011).

Simon (2011) provided a classification of anxiety on the basis of the harshness of the reaction and the duration of the signs and symptoms. This classification is as follows;

- “Generalized anxiety disorder (GAD)”
- “Panic disorder”
- “Phobias”
- “Obsessive-compulsive disorder (OCD)”
- “Post-traumatic disorder (PTSD)”
- “Separation anxiety disorder”

The most commonly known types of anxiety disorders include Generalized Anxiety Disorder and Panic Disorder. The main causes of these disorders include psychological factors, genetic factors and physical factors. They can be treated well by providing proper medication for the patient (Simon 2011).
**Generalized Anxiety Disorder**

In generalized anxiety disorder, there is a feeling of severe anxiety among patients and this is most commonly known (Simon, 2011).

**Diagnostic Criteria for Generalized Anxiety Disorder (DSM IV, 1994)**

- The state of anxiety lasts for more than six months the suffering is very intense and strong. The person becomes very uncomfortable and worried when he feels any unfavorable situation in school or workplace.

- The individual completely fails to control worry.

- The person faces at least six symptoms out of the mentioned symptoms and these symptoms may last for more than six months.

- The anxiety and uneasiness is not confined to features of an Axis I disorder for instance, the person may not experience a panic attack (Panic Disorder), become humiliated in public (Social anxiety), become contaminated (Obsessive Compulsive Disorder), become isolated from the family and friends (Separation Anxiety Disorder), gain a lot of weight (Anorexia Nervosa), physical illness (Somatization Disorder), suffering from sickness (Hypochondriasis), and anxiety is not there absolutely during posttraumatic stress disorder.

- Becoming anxious, worried and other types of physical illness may cause clinical distress and deficiency in the functioning of social and occupational areas.
The person does not feel anxious due to the effect of some substance such as drug or other medication e.g. “hyperthyroidism and does not happen solely in a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder”.

**Etiology of generalized anxiety disorder**

Different psychological perspective interpret generalized anxiety disorder in different ways which are as follows

**Biological perspectives**

Studies indicate that generalized anxiety disorder may have a genetic component. Although greater prevalence of this disorder has been reported among those who are relatives of the affected individuals (Noyes et al., 1992).

**Psychoanalytic perspective**

According to this perspective the source of generalized anxiety disorder is an insensible disagreement among id impulses and ego. The impulses are normally sexual and the person struggles to express the feelings. The ego hinders the feelings to be expressed. The reason is that there is the fear that the expression may result in to punishment. This types of anxiety is out of conscious control so the person may feel apprehend and distressed with out any sound reasons (Davison and Neale, 2001).

**Behavioral perspective**

Behavioral perspective of generalized anxiety disorder is identical to one of the learning view of phobias. The anxiety is characterized as being conditioned towards some external stimuli, although the range of external stimuli is considerably border. The attention of patients
with generalized anxiety disorder is easily drawn to stimuli that suggest possible physical harm or social misfortune, such as criticism, embarrassment, or rejection. (Macleod, C., Mathews, A.1986).

**Cognitive perspective**

Cognitive perspective emphasized the perception of not being in control as a central characteristic of all views of anxiety (Mandler, 1966). Thus the center of attention of a cognitive behavioral model of comprehensive anxiety is helplessness and having control on oneself. Another cognitive view has recently been offered by Brokovec and his colleagues (1995). Their main focus is on the main symptoms of generalized anxiety disorder, worry. They have organized evidence that worry is actually negatively reinforcing, it distracts patients from negative emotion. (Neale, 2001).

**Treatment for generalized anxiety disorder**

**Cognitive-behavioral therapy**

In order to treat the patient of Generalized Anxiety Disorder, the most commonly used therapy is Cognitive-Behavioral Therapy. All the negative thoughts which might be the reason for causing anxiety are examined by the therapist. The components of this type of treatment are desensitization, lengthy exposure, demonstrating, emergency management, and self-management or cognitive strategies. In many cognitive behavioral approaches, replacement of adaptive thoughts with those of relaxation, self-affirmative statements, visual imagery abd self-instruction is being used (Klykylo & Kay, 2005).
There are five major mechanisms associated with the treatment of GAD using cognitive behavioral therapy. These are “education, physical control strategies, monitoring, cognitive control strategies and behavioral strategies”.

In order to treat generalized anxiety disorder, medication can also be done as it can be effective in cases. Medication is only given at the very beginning to relieve the symptoms and it is temporary approach of treatment. Therapy is necessary for long term success (Segal, J. 2010)

**Panic Disorder**

In panic disorder, the affected individual faces periodic spasms of anxiety. The duration of such attack is usually 15 to 30 minutes but the effects remain there for longer periods of time. The treatment for the disorder depends upon the severity and state of anxiety in the patient. All the patients suffering from anxiety experience panic attacks. In the other types of anxiety disorder, the attacks occur in a cue (Simon, 2011).

There are 200 percent chances for women to develop panic disorder as compared to men. (Katerndahl & Realini, 1993). The median age of onset is 24 years. Frequency of attacks can vary widely. Some people have frequent attacks which may remain there for months. Some patient may experience attacks on daily basis, after some weeks or even after months. These attacks may be there due to some situations or some spontaneous response. Recalling a situation may also prove to fatal and trigger a panic attack (Stricker, widiger, & weiner 2003).
Diagnostic Criteria for Panic Disorder with Agoraphobia (DSM IV, 1994)

- Repeated unpredicted panic attacks

- In one month, the person experiences at least one attack or more. There may be thoughts of having attacks; the person may become fearful of the attack and the consequences of the attack i.e. loss of control, heart attack or being crazy. The behavior of the person completely changes when he experiences an attack.

- The presence of Agoraphobia

- The person does not feel anxious due to the effect of some substance such as drug or other medication e.g. hyperthyroidism

- “The anxiety and uneasiness is not confined to features of an Axis I disorder for instance, the person may not experience a panic attack (Panic Disorder), become humiliated in public (Social anxiety), become contaminated (Obsessive Compulsive Disorder), become isolated from the family and friends (Separation Anxiety Disorder), gain a lot of weight (Anorexia Nervosa), physical illness (Somatization Disorder), suffering from sickness (Hypochondriasis), and anxiety is not there absolutely during posttraumatic stress disorder”.

Etiology of panic attacks

Different psychological perspective interpret panic attack in different ways which are as follows.
Biological perspective

Panic attacks do not occur due to a specific reason such as panic is not caused by some emotional pressure rather it occurs as a result of thinking patterns, biological vulnerabilities, the human body’s alarm system which is a combination of mental and physical mechanisms to respond against threat, is triggered without a situation of stress and danger. Scientists are of the view that they do not understand the fact that what the reason is for some people being more susceptible to threat than others. It has also been seen that panic is inherited in many people so inheritance is an important factor in having panic disorder. There are certain people with panic disorder who have not inherited it. There are different views regarding the fact that deficiency of magnesium and zinc may also be a cause of panic disorder but all the researchers do not agree with this fact. Statistics also show that there are more chances of majority population of US to suffer from panic disorder than those of ethnic minorities. Some other researchers are of the view that there might be a difference in how people give meaning to the symptoms of fear such as panic attacks.

Psychoanalytical perspective

According to this perspective, the people who suffer from anxiety disorder had a history of some kind of anxiety sensitivity. The meaning of anxiety sensitivity is that the person is fearful of the fact that the short live chest pain in the situation of anxiety may lead to severe heart attack and the heart may stop working. Sociologists are of the view that the people who had suffered from some kind of sexual abuse have more chances of developing panic disorder in their adolescence and adulthood. Such situation increases the chances of panic disorders than anxiety disorders. The first attack is activated by physical illness which is also a stress or the brain might
be functioning more actively due to medications. The frequency of attacks in females increases when they are pregnant and during this time they become more anxious (Edwards, 2011).

**Treatment for panic disorder**

**Cognitive-behavioral therapy**

“Cognitive behavior therapy is the combination of cognitive therapy and behavioral therapy in which cognitive therapy aims to modify the thinking patterns which lead to the anxiety symptoms while behavioral therapy aims to change the behavior of the affected person”.

According to the cognitive model, there are some distortions in the thinking patterns of the individual suffering from panic disorder and theses distortions are not known by the individual himself and they are the cause of fear. Those who are the supporters of this theory are of the view that such people can know the thoughts and feelings in advance and try to change their responses with the help of an expert therapist. This helps the patient to gain more self control in the situations of panic.

In the behavioral part of the cognitive behavioral therapy, the therapists use some systematic training and relaxation methods. When the patient knows how to relax himself, he can easily decrease the level of generalized anxiety and can keep himself prevented from a panic attack.

Breathing exercise is an important part of behavioral therapy. The patients learn to have control on breaths which makes them avoid the hyperventilation which may also lead to panic attack (NIMH, 2002).
**Obsessive-Compulsive Disorder**

Obsessive compulsive disorder affects the proper functioning in the patients and is a long lasting, upsetting mental illness. The significant features of this disorder include an exaggerated sense of accountability and the person thinks of all the dangerous situation he may encounter the actions he would need to take against them (URAC, 2011).

**Diagnostic Criteria for Obsessive-Compulsive Disorder (DSM IV, 1994)**

Obsession are defined as:

- The thoughts, emotions, impulses and images which come repeatedly and the person experience them when he is not feeling comfortable. These feelings are interfering and unpleasant and lead to distress and anxiety.

- The images, impulses and thoughts of the person are not meaningless rather they are everyday problems.

- The person experiencing theses images, thoughts and impulses tries to minimize them by engaging himself in some other kind of action.
Compulsions are defined as

- The person sets some rules which he strictly follows and repeats some physical or mental actions in response to an obsession. They may include washing hands, ordering, checking things again and again, praying, counting or saying same words silently.

- The person keeps on repeating the behaviors and mental acts in order to prevent from certain situation or reducing the stress level. This is not necessary that these behaviors are linked with what they aim to neutralize.

- The person himself recognizes at some point of time that the actions he is repeatedly doing have no reasonable significance.

- These obsessions and compulsions are marked distress and they take at least one hour in the whole day and also interrupt the individual daily routine, professional functioning and social relationships and actions also.

**Etiology of obsessive compulsive disorder**

Different psychological perspective interprets obsessive compulsive disorders in different ways. Psychologists have the common viewpoint that both psychological and biological factors are responsible for obsessive compulsive disorder. They are different in terms of their degree.

**A biological perspective**

The biological view of obsessive compulsive disorder is focussed upon the initiation of the “frontal lobes and basal ganglia” may be because of genetic disposition (Chambless, 1998).
**Psychoanalytical perspective**

According to the psychoanalyst viewpoint, in obsessive compulsive disorder the personality development gets affected at the anal stage because of very strict toilet training.

**Behavioral perspective**

The behavioral accounts of obsessive compulsive disorder point to learned behaviors reinforced by free reduction.

**Cognitive perspective**

According to the cognitive viewpoint, the people suffering from obsessive compulsive disorder have a normally negative and interfering schema for example; obsession reduce anxiety with compulsions (Chambless, 1998).

**Treatment for obsessive compulsive disorder**

**Cognitive-behavioral therapy**

There are two main components of obsessive compulsive disorder associated with cognitive behavioral therapy.

- “Exposure and response prevention”

- “Cognitive therapy”

**Exposure and response prevention for obsessive compulsive disorder**

This is the periodic interaction with the cause of obsession. The patients after this are supposed to refrain from the compulsive behavior which they repeatedly performs to control anxiety.
Cognitive therapy for obsessive compulsive disorder

In the cognitive therapy part of obsessive compulsive disorder, the therapist has his focus mainly on the awful thoughts and overstated sense of accountability. The patients are taught about the healthy reaction towards the obsessive thoughts without resorting to compulsive behavior and this is the major part of the therapy (Melinda Smith, 2010).

Post-Traumatic Stress Disorder

PTSD is the severe reaction to the severe stressors. Stressors are the thoughts related to death or being seriously injured for the himself or for others. The response given for such thoughts may include fear, defenselessness and dreadfulness. Post traumatic stress disorder is a very strong, long lasting emotional response to a disturbing event which interferes in the individual’s life. This is called anxiety disorder due to the fact that the symptoms of both are same. The statistics show that around 1 percent to 3 percent of general population suffers from this disorder and 9 percent are prone to develop this illness.

1 to 3 percent people in the general population experience this disorder and 9 percent people in at-risk (e.g., “combat veterans, victims of volcanic eruptions or criminal violence”) to face this disorder (Chambless, 1998).

Diagnostic Criteria for Posttraumatic Stress Disorder (DSM IV, 1994)

- The person who was diagnosed with both physical threat and emotional threat were exposed to traumatic events. They had experienced some event in their life which had led to the threat of death or a serious injury or he had experienced a fear of physical integrity of himself or others. The reaction to these events are terror, weakness and repulsion. In the children, a disorganized behavior may be seen.
• The person may face the traumatic event repeated in the following ways. Repeated and interfering reminiscences of the event, including thoughts, images and perceptions.

• Physiological reactivity on acquaintance to the interior or exterior signals that signify or look like a feature of the traumatic event.

• There are three factors associated with the continued avoidance of stimuli related to trauma and some general responsiveness which is not there before the trauma. These factors include avoiding the thoughts, emotions and discussion related to trauma, avoiding actions, places and persons which have any link with trauma, not being able to recall the aspects of trauma, no participation in the activities like having even feelings for the beloved ones, thoughts of having an uncertain life with no career, marriage and children. In short the person feels like having no normal life.

• Continuous signs of having increased stimulation which were not there before trauma. The person may feel difficulty in sleeping, easily irritated, low level of concentration, hypervigilance and sudden shock responses.

• The person may feel disturbed an distressed and lose a link with social, professional and all the other important aspects of life.

**Etiology of Post Traumatic Stress Disorder (PTSD)**

Different psychological perspective interprets posttraumatic stress disorder in different ways which are as follows.
Biological perspectives

“The amygdala is a structure in the brain linked to the limbic system of the body is the one which controls the emotions and their expression”. Specifically the emotions like fear, emotional memory and autonomic are controlled by this part of the brain. PTSD is caused by the dysfunction of the Amygdala.

Unbearable sudden trauma can be the reason for the changes in the functioning of the brain which produces the signs of PTSD like agitated arousal, shocking, sleep trouble, touchiness, disturbing emotions and recollections, hallucinations, eruptions, and memory damage.

Human body releases different stress hormones to respond against stress and trauma. These hormones are norepinephrine and epinephrine. When an individual face a serious trauma, he responds back with the symptoms of PTSD due to high physiological stress leading to hyperactive and hyperarousal.

Biological component to numbing and other dissociative symptoms of PTSD. There are reserachers who are of the view that the people suffering from long term or recurred trauma in the past, can again suffer from trauma if they are subject to any such stimulus. In this situation the brain releases opiates e.g., endorphins, enkephalins which are the cause of emotional responsiveness and amnesia.

Reduction in the level of serotonin can cause repeated stress and trauma which may make the person suffering from PTSD easily irritated and angry.
Psychoanalytical perspectives

The factors which can be risky for PTSD patients involve the deterioration in mental health, severity of the trauma faced and the lack or required level of support after the trauma. There are also chances of PTSD in the individuals who have none of these risks associated with them. Pre-trauma risk factors: a person may develop the PTSD after facing a trauma on the basis of his psychological history.

- “Borderline personality disorder and dependent personality disorder”
- “Low self-esteem”
- “Previous trauma”

Those people who have a severe personality disorder might have faced physical or sexual abuse, ignorance, strong disagreements, losing parents and separation. The consequences for the dependent personality disorder are “low self-esteem, fear of separation, and the excessive need to be cared for by others”.

There are more chances of developing the PTSD in the people who have already faced some trauma in the past. In these people the release of stress hormones is quite high which may lead to PTSD.

Trauma Related Risk Factors: “The strictness, duration, closeness to uninterrupted or viewed kind of traumatic event are the most noteworthy risk factors for developing PTSD”.

The traumatic events which a person may experience directly include Fighting, Abducting, Natural tragedies, Disastrous accident, Fierce sexual assault, and Vicious physical assault.
The traumatic events which may be witnessed include:

- Seeing another person brutally murdered or wounded
- Suddenly seeing a dead body or body parts

Post trauma risk factors: in case the person is not supported by his family, fellows and society in case of trauma, then there are more chances for him to develop long lasting PTSD. An example may be of a person who is raped but he is not believed and blamed. A person who is raped by a family member has more chances of developing PTSD (Croft, 2009).

**Treatment for post-traumatic stress disorder**

**Cognitive-behavioral therapy**

“Cognitive-behavioral therapy for PTSD and trauma” involves the person to recall the thoughts and situations very slowly and carefully that are the cause of trauma. The person is also made think of the thoughts which are unpleasant about his trauma. This is done carefully replacing the disturbing thoughts with those of balanced ones. The patients are advised medication to relive the secondary symptoms of stress but this does not eliminate PTSD (Melinda Smith, 2010).

**Separation Anxiety Disorder**

Children are the victims of separation anxiety disorder. Those children who are anxious about the situation of getting separated from their family and home are most likely to develop separation anxiety disorder. The anxiety may vanish with the child growing up but this can
become “a panic disorder, agoraphobia, or combinations of anxiety disorders” if it remains unaddressed (NIMH, 2010)

**Diagnostic criteria for separation anxiety disorder (DSM IV, 1994)**

- The child may develop the fear of getting separated from his home or from his loved ones which may lead to anxiety. There may be three reasons for this which are as follows. Frequent unnecessary suffering at time of separating from home or from those with whom the patients is attached to, obstinate and unjustified consideration and thoughts about being misplaced or about a possible harm occurring, determined and unwarranted anxiety that an unfortunate event may be there which may be a cause of separation from something very appealing, obstinate unwillingness or denial to go to school or somewhere else for the reason of a terror of separation, tenaciously and arbitrarily awful or reluctant to get separated from those who are attachment figures or being in a situation here no adults are present, refusing sleep with the people who are attached to him, refusing to sleep away from home, having dreams of getting separated from family, frequent body movement showing grievance such as “headaches, stomachaches, nausea, or vomiting” in the situations of getting separated from the loved ones.

- The duration of the disturbance may remain for a month

- The people younger than 28 years normally face the disorder

- The disorder may make the person unable to function in social, professional and academics and also cause the clinical substantial illness.

- “The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents
and adults, is not better accounted for by Panic Disorder with Agoraphobia”. (DSM IV 1994).

**Etiology of separation anxiety disorder**

Different psychological perspective interprets separation anxiety disorder in different ways which are as follows.

**Psychoanalytic perspective**

Development of separation anxiety disorder indicates that its onset is most likely due to the interaction of environmental events and stresses, temperamental characteristics, developmental experiences of care and attachment, and various biological vulnerabilities. Developmental theorists have identified the period of early childhood as a duration when attachment develops and the organization of the child caregiver system during this period will set the stage for later development (Thompson, 1991, Hofer, 1994).

According to attachment theory, an early attachment pattern characterized by consistency, responsiveness, and warmth is considered an antecedent to healthy development (Campbell, 1989, Greenberg, Speltz, & Deklyen, 1993).

According to Hudson & Rapee (2000) problems also exist in the family relationships of children with anxiety disorders. Previous research shows that those parents who have high control and low warmth towards their children may have more chances that their children will have an anxiety disorder as compared with the parents whose children do not have a psychiatric diagnosis. (Stricker, Widiger, & Weiner 2003).
Treatment for separation anxiety disorder

Psycho educational, behavioral and cognitive techniques

In order for the treatment of separation anxiety disorder, Psycho educational, behavioral and cognitive procedures are suggested.

Psycho educational intervention is the technique in which the parents and family members are supposed to pay attention towards the diagnosis given to the child, the relationship and effects of the diagnosis on the negative behaviors of child and what changes are required in the behaviors and attitudes of family members to help the child feel better. The parents are educated so that they could engage the child in the suitable development tasks, and encourage and support the child so that he could deal with the negative family dynamics.

In separation anxiety disorder, it has been reported that the behavioral techniques are very useful. The children are motivated to do the desired things through positive reinforcement and negative reinforcement is done in case of anxious behavior which proves to be very helpful in shaping the behavior of the child. In addition to this, “Modeling and exposure based treatments are also useful”. “Cognitive interventions concentrating on the maladaptiveness of disastrous views and exchange of these thoughts with the more suitable conditions in grouping with self instruction and coaching truthful evaluation of terror producing situations, can be productive”. (Klykylo, Kay, 2005).

Phobic Disorders

“A phobia is an irrational, intense and persistent fear of certain situations, activities, things, animals or people”. The prominent symptoms associated with phobic disorders include
extreme and unnecessary wish to avoid the feared stimulus. The person realizes that the fear is irrational but cannot control it. (Sdorow, 1993).

**Diagnostic criteria for phobic disorder (DSM IV, 1994)**

- The long lasting fear which is very strong, extreme and irritating. This fear is caused by the existence and anticipation of a situation or event which causes anxiety.
- When the individual comes across a stimulus which causes phobia leads to sudden anxiety. This anxiety is bound to situation and creates a panic attack.
- The individual himself knows that his fear is extreme and has no significance.
- The person tries to avoid the phobic situation or it results in extreme anxiety and stress.
- The person's routine is greatly affected by the ignorance, anxious anticipation and fearful conditions. His work life gets disturbed, he fails to socially interact with family and friends and he becomes fearful of having a phobia.
- For the individuals below 18 years, the duration is about six months.

**Etiology of phobic disorder**

Different psychological perspective interpret phobic disorder in different ways which are as follow.

**Psychoanalytic perspective**

According to the psychoanalytical theory, “phobia is defined as an effort to master anxiety and fear which comes from the inhibited libidinal and aggressive urges”. So the fear and anxiety which are not connected with an inhibited material is being displaced onto a phobic object. The child gains control on his thoughts and phobic ignorance.
**Behavioral perspective**

The focus of behavioral theories is on the learned experiences for the management and the generation of phobias. In the three pathways theory given by Rachman’s (1997), three mechanisms which are supported due to their strong empirical evidences; “Aversive classical conditioning, modeling, and negative information transmission”. This theory suggests that the children may develop a phobia due to a fearful experience in the past such as a child has the phobia of dog if he has ever bitten by it. Witnessing another individual who has shown a fearful response to an object such as a sibling responding fearfully to the dog or the parents or some elder has given any instruction if fearing from something like a dog can bite you (Klykylo, Kay, 2005).

**Treatment for phobic disorder**

Cognitive- behavioral therapy

In cognitive behavioral therapy, the patient is made aware of the cycle of negative thoughts and how these thoughts can be changed. This therapy is conducted for a number of individuals in a group. Gradual desensitization treatment and CBT are usually productive with the situation that the patient himself is interested in releasing his stress. The report for a clinical trial shows that after having a session of cognitive behavioral therapy, 90 percent of the patients did not show a phobic reaction (Wikipedia, 2008).

**Social anxiety disorder**

The term social anxiety is defined as emotional distress, terror, nervousness, hesitation and uneasiness in some social event, communicating with others, getting responses and feedback
from others. This happens at different timings and due to different reasons. In childhood
development social anxiety is a part of normal life and social interaction. The situations and the
circumstances are all different in different individuals to cause anxiety. Also different people
cover the anxiety in different ways. For some people, it is very easy to control anxiety and they
feel like time passing will be enough for covering it, while other individuals feel very
uncomfortable and they just fail to overcome their stress. The reasons for anxiety are not that
much known. This might be due to shyness or anxiety disorders but the causes are different from
individual to individual (Wikipedia, n.d)

Social anxiety and social anxiety disorder are long lasting and disturbing for normal life.
This is termed as a psychopathological form of social anxiety and this greatly affects the quality
of life. It is very hard for the people suffering from social anxiety to overcome it. The patients
with obsessive compulsive disorder can suffer from social anxiety which is tenacious. In this
situation it is even harder to overcome social anxiety (Wikipedia, n.d)

Social anxiety is a normal and important emotion for the proper social functioning of an
individual along with growth and development. This normally occurs in infancy. In adolescence,
the individuals feel anxiety when they have to speak in public, they get rejected by peers. Most
of the times, the adolescents, recover through these fears. The adults feel anxiety in the form of
nervousness, presentation anxiety, communal speaking anxiety, stage fear, etc. These forms of
anxiety may become advanced and result in clinical anxiety disorder. Social anxiety is also an
experience of embarrassment and shame. There are so many psychologists who present some
differences between the types of social anxiety and this distinction is based on the anticipation of
anxiety. An example is that embarrassment is not social anxiety while anticipation of it comes
under social anxiety.
The intensity of anxiety and the level of discomfort caused, are the standards against which the distinction is made between the clinical and non clinical kinds of social anxiety. Due to the anticipatory nature of fear, we can classify the social anxiety on the basis of activation of social situations. An example is that the scope of fear of eating in front of people is narrow and the scope of being shy has a wider scope. The clinical forms of social anxiety include general or generalized anxiety which come under social anxiety disorder.

The people suffering from specific social anxiety are fearful of social situations which make them disable to act properly. They feel scared of people evaluating them and behave in an awkward and shameful manner. They feel difficulty in speaking in front of gathering, using a public bathroom and eating or writing in front of someone as they do not have confidence in themselves. Due to these feelings, they either ignore such gatherings or become very stressful. The most common form of social anxiety is that of speaking in front of a gathering.

The people having generalized social anxiety are fearful of the social interactions for both performing in front of people as well as in the situations where they have to interact with one another. In order to prevent themselves from the personality disorder, they share the diagnosis (Carson, Butcher, & Mineka, 2004).

The other name for social anxiety disorder is also social anxiety in which the person feels unreasonable and extreme fear from having any interaction with other people. The person feels anxiety and fear when he notices that somebody is watching him, judging him or criticizing him.

The person feels that he will make a mistake in front of people which will make him embarrassed and humiliated. This fear may take the worst form, if the person is low in social interactions in situations when there are lots of people present. The result of this anxiety may be a panic attack.
Because of this fear, the person may come across certain conditions which increase stress level and try to ignore them all. The people suffering from anxiety have misleading thoughts like untruthful beliefs regarding the social situations and wrong opinions about others. If attention is not paid towards social anxiety disorder, this can interrupt the person's daily routine like academics, social and professional activities.

People suffering from anxiety disorder are afraid of speaking out in the presence of people around them. Most of people are afraid of more than one thing. Any other situation which may cause stress and anxiety include eating in the presence of people, writing or doing some action in front of people, being noticed by others, and they avoid going into the parties where there are a lot of people. They do not tend to use the public toilets and even feel shy taking on the phone (web MD,n.d).

**Diagnostic criteria for Social anxiety disorder (DSM IV, 1994)**

- The person feels fear in the situations where there is more than one person present or when the person need to perform in front of other people or there are evaluation from others. The fear is due to the feeling that the person may commit something which may be embarrassing or humiliating for him.

- There are certain specific situations which may cause anxiety when the person comes across with that particular situation. This is termed as situationally bound anxiety and results in panic attacks.

- The person may develop a feeling that he is being anxious without a reason.

- There are certain situation which the person has to bear with strong nervousness and pain. They also make the person anxious.
• The inhibition, uneasy expectation, or grief in the feared social or presentation situation(s) hinders with the individual’s normal routine, professional and academic activities. The social interaction may also suffer to a noticeable extent due to fear and anxiety.

• The duration is about 6 months among the people under the age of 18 years.

• The person does not avoid situations due to direct physical effects of something for instance drug of abuse or treatment or common medical illness and is not well accounted for by another mental disorder for instance Panic Disorder With or Without “Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder”.

**Etiology of social anxiety disorder**

Different psychological perspective interprets social anxiety disorder in different ways which are as follows.

**Biological factors**

Peoples who are badly affected by stress experience, a biological breakdown which results in the development of phobia resulting in a specific stressful event. The autonomic nervous system and genetics are two main biological factors which cause social anxiety.

**Autonomic Nervous System**

One difference is how different individuals respond to different environmental conditions. This is the comfort level of autonomic nervous system to get aroused. Lacey (1967) suggested “a dimension of autonomic activity that he called stability, liability. Labile, or jumpy,
individuals are those whose autonomic systems are readily aroused by a wide range of stimulus”. There is an extent to which the autonomic nervous system is associated with fear and then the phobic disorder. “A dimension such as autonomic liability assumes considerable importance. Since there is reason to believe that autonomic ability is to some degree genetically determined, heredity may very well have a noteworthy part in the expansion of phobias”.

**Genetic Factors**

Several studies have examined whether a genetic factor is involved in phobias. For both social (especially the generalized type) and specific phobias, prevalence is greater than normal in first-degree relations of patients. Identical studies have also provided evidence that phobias have a heritable component (Kendler, Kerkowski, and Prescott, 1999).

**Psychoanalytic Perspective**

Freud was the first who attempt to account systematically for the development of phobic behavior. According to Freud, phobias are a defense contrary to the nervousness created by suppressing id impulses. This nervousness is exiled from the dreaded id impulse and move to an object or situation that has some symbolic connection to it. These objects or situation for example, elevators or closed spaces then become the phobic stimulus. By avoiding them the person is able to avoid allocating with suppressed disagreements. “The phobia is the ego’s way of warding off a conflict with the actual difficulty, a repressed childhood conflict”.

According to another psychoanalytic theory of phobias, proposed by Arieti (1979), the repression is of a particular interpersonal problem of childhood rather than of an id impulse. Arieti theorized that as children, people with phobias first lived through a period of innocence
during which they trusted the people around them to protect them from danger. Later they come to fear that adults, usually parents, were not reliable. They could not live with this mistrust, or generalized fear of others. To be able to trust people again, they unconsciously transformed this fear of others into a fear of impersonal objects or situations. The phobia surfaces when, in adulthood, the person undergoes some sort of stress. As with most psychoanalytic theorizing, evidence in support of these views is restricted for the most part to conclusions drawn from clinical reports.

**Behavioral Perspective**

Behavioral theories aim to learn the ways which create phobic situations. There are different kinds of learnings involved in it.

**Avoidance conditioning:** The main behavioral account of phobias is that such reactions are learned avoidance response (Davison and Neale, 2000).

**Social Skills Deficits in Social anxiety disorder:** A behavioral model of Social anxiety considers inappropriate behavior or a deficiency of social skills as a reason for social anxiety. According to this view, the individual has not learned how to behave so that he or she feels uncomfortable with others, or the person repeatedly commits mistakes, which is awkward and socially inept, and is often criticized by social companions.

Social skills deficits may have arisen over time because the person was fearful for other reasons such as classical conditioning of interacting with others and therefore had little experience doing so. The lack of interpersonal skills in an adult who has a Social anxiety may
therefore reveal little of ethological significance, though the information may be very important in planning effective therapeutic intervention. (Davison and Neal, 2000).

Cognitive Theories

Cognitive views of anxiety in general and of phobia in particular aims to study the way the people thoughts are related to phobia and how people tend to manage the phobic situations. Anxiety is the condition when a person feels like having a negative stimulus and the unclear thoughts lead to phobia. The same conditions when faced in future can again lead to anxiety (Mathews & Macleod, 1994).

Studies of socially anxious people are also relevant to ideas about the cognitive factors related to Social anxiety. The people suffering from social anxiety are more sensitive towards the evaluation as compare to non socially anxious people (Goidfried, Padawer, & Robins, 1984), and have more knowledge of what people will feel about them (Bates 1990) and tend to view them negatively even when they have actually performed well in a social interaction (Wallace & Aldan, 1997).

Cognitive theories of phobias are also relevant to other features of these disorders, the persistence of the fears and the fact the person experiencing the fear also knows that the fear is unreasonable. The reason behind this phenomena is that the fear is caused by some early cognitive processes which are not in conscious control. After this initial processing the stimulus is avoided, so it is not processed fully enough to allow the fear to extinguish. (Davison and Neale, 2000).

Treatment for social anxiety disorder
In order to treat the social anxiety disorders, several kinds of therapies are commonly used. These are as follows:

- Cognitive behavior therapy: It is useful in identifying the situation which can be the result of anxiety. The person may feel pain and uneasiness in addressing the situation which is the cause of fear but it greatly helps in the recovery. There are different types of cognitive behavior therapies.
- Exposure therapy: Under this therapy, guidance is given by the professional counselor till subject has no longer fear of a specific situation, such as eating in public.
- Social skills training: in this therapy the individual is allowed to rehearse and role play the social interactions. The person becomes comfortable and confident by practicing what he needs to do in social gatherings and the level of fear and confusion is reduced.
- Cognitive restructuring: in this therapy, the fearful thoughts is identified and controlled.

The treatment given to the patients with social anxiety disorder includes the ongoing psychological counseling and checkups at regular intervals in order to see the effects of medicines. In case a person does not feel better after receiving the counseling sessions, then medicines are normally added to their medication for better results (Web MD, 2009).

According to Fredrikson (1999) the occurrence of social anxiety among the respondents was 15.6 percent. The most commonly occurring social fear was speaking in the presence of people. Females were found to be more socially anxious. The people with less educational achievements, using psychiatric medication and less social support were more susceptible to social anxiety.
In general population, it has been observed that females mostly suffer from social anxiety disorders (Chapman, Mannuzza & Fyer 1995, Moutier & Stein, 1999). Although, males tend to get the treatments for social anxiety disorders, more common as men can have more socially phobic symptoms and they have to face more challenging situations as compared to women (Weinstock, 1999).

Liliana (2002) investigated social anxiety symptoms in both genders across “social anxiety spectrum and the relationship with other psychopathological features”. The sample chosen was consisted of 250 students and two questionnaires were used to gather data: “The social anxiety spectrum Self report (SHY-SR), which discovers the social anxiety spectrum, and the general spectrum measure (GSM), which discovers panic-agoraphobia, temper, obsessive-compulsive, and eating behavior features”. “The mean total score for SHY-SR was higher in female students as compared to that of male students and gender differences were mainly marked in the interpersonal sensitivity field”. Similarly, “the scores in the general spectrum measure were high for female students as compared to male students excluding the manic section”. The conclusion is that more symptoms were seen in female students than those of male students and the social anxiety spectrum profile of both genders was different quantitatively but it was same qualitatively.

The lifetime occurrence of social anxiety was observed to be 11 percent among the age group of 21 years to 24 years. And the occurrence was quite lower among the individuals of 25 years and the value was 5.5 percent. (Izgic et al. 2004).

Among college students, social anxiety is noticed to be a very common issue. Most of the students report social anxiety issues in many situations when they need to interact with one
another (Purdon, Antony, Monteiro, & Swinson, 1999).

“Anxiety sensitivity” is defined as the fears and uncertainties regarding the signs, feelings and symptoms related to anxiety. Anxiety sensitivity becomes very high in the people suffering from social anxiety disorders (Taylor, Koch, & Crockett, 1991). Though, it is not known that what factors of fear lead to social anxiety. In addition, the previous researches have not focused on the social anxiety in the college students. Prima Vitasari conducted another study in which the data were collected randomly. The data collection was done through Social phobia Diagnostic Questionnaire and the Anxiety Sensitivity Index. In response to this first study another study was conducted to expand this one. The researcher administered the SPDQ and Revised Anxiety Sensitivity Index in addition to a certain measure for social anxiety. The sample of students in this study was also random. There was a prediction that there are equal chances of anxiety disorders among college students and in the general population. One hypothesis of the study was that “college students meeting diagnostic criteria for social anxiety disorder would display greatest stages of anxiety sensitivity equated to those who did not meet criteria for the disorder”. The last estimate was that elevated results will be there for social and physical concerns out of the students with social anxiety being studied. The results of the study were partially in accordance with the hypothesis made in the beginning. The occurrence of social anxiety in the general population and college students was almost same. The score of the students meeting criteria was quite higher as than those who did not meet the standards. The criteria were anxiety sensitivity, speaking out in front of people, and trait anxiety, fear of negative feedback, social anxiety and depression.

Another research work was conducted in which the study anxiety of the university students was studied. The study anxiety includes the new experience in a new environment and
conditions. Study anxiety does exist in reality. The environment if the university is an important factor in increasing the study anxiety. This study was conducted to identify the factors which may lead to study anxiety among university students. A sample of 770 students was selected and the students were questioned about their feelings, emotions and experiences which cause study anxiety in them. The data showed that there were seven factors but five of them were potential factors. They include mathematic anxiety, class presentation anxiety, exam anxiety, social anxiety and language anxiety (Prima Vitasari 2010).

According to Shah & Kataria (2010) 19.5 percent of the respondents had social anxiety disorder. The level of this anxiety was different in different participants from different faculties. The social anxiety made the people fail to work properly in their family life as well as social life. This badly affected the quality of life. The most commonly occurring fear was performing in front of people. Students also told that many clinical manifestations also affected their educational, social and interpersonal life.

Many factors are there to play their role in child behavioral and psychological problems, “parenting style” is one of the most significant which play crucial role in the personality of the child.

The relationship of parents with one another, with the child and style with which they raise their children are very effective in their development into adulthood.

Parents are no doubt one of the main leading figures in the development of our personalities. Parenting style is a prominent cause of social anxiety disorder. The extraordinary restriction as well as care may cause the psychological problems in children's personalities.
There are many parenting styles which have been seen to be related to the development of various anxiety disorders. The following section of the research work is going to focus on parenting styles.

PARENTING: most of the time of the individual is spent with parents including different stages of life cycle. These are infancy, childhood and adolescence. Parents provide food, shelter, protection and we learn our early experiences from our parents. Parents are the most important ones to provide a healthy start for our life.

Theories of parenting style
Diana Baumrind (1964) developed the best theory for parenting styles. She defined three categories and divided the parents into these categories. The first category was authoritarian in which parents direct their children to the desired actions. The second category was indulgent in which parents allow the children to do whatever they want and the third category was authoritative in which parents restrict the children to follow the rules made by them and do not even consider that following the rules cannot be always possible. Later, another category was added to the theory which was negligent parents who do not pay attention towards their children and focus only on their own interests.

Christianity proposes various ethical parenting styles. Some of them are strict as authoritarian style where children are strictly asked to follow the scriptural law i.e. Bible. Some other are empathy based which are concerned with the emotional state of child. Yousafali (2011) presented some facts from the Islamic teachings according to which the children must be assigned the duties and tasks on the basis of their character and abilities. The undue influence on the children can lead to negative outcomes as the self-esteem and the character of the child may suffer. This could also affect the relationship between the child and the parents. Hazrat Mohammad PBUH says, “May Allah bless him who helps his child in doing good” He was asked,” How can help him in doing good”? to which the prophet (PBUH) answered: “That he accepts the little that he can do, he forgives whatever he cannot do, he does not overburden him, and he does not demand too much from him, for there is nothing between him and entering a dimension of disbelief other than (due to the behavior of his parents) he disobey his parents or cut ties with his kin.” (Al-Kafi, vol.6, p. 50).

The subject of parent’s involvement is a matter of debate. There are two extremes of parental involvement. One is slow parenting in which parents do not interfere with whatever
their children are doing and only guide them when children feel any difficulty in making their decisions. On the other hand is concerted cultivation, where parents give a large number of lessons to their children and try to make them organized. The aim is to teach valuable skills and abilities and parents themselves take decisions for their children.

In the 17th century, two distinct materials have been written by two philosophers who are helpful in the child rearing. John Locke in 1963 proposed that the experiences in child’s development are very important and the parents are required to develop their habits first. In 1762 French philosophers Jean Jacques Rousseau proposed that early education of the child is not about what he learns from books but it is what he interacts with the world. The viewpoint of Locke supports concerted cultivation while Rousseau supports slow parenting.

The researchers from 20th century focused on children development and its impact on children’s education and the ways parents rear them.

Jean Piaget’s (1926) theory of cognitive development clarifies the children perceptions and the meanings they give to the outer world. This theory is called developmental stage theory which is consisted of “sensorimotor stage, Preoperational stage, Concrete operational stage, and Formal operational stage”. Piaget was amongst the pioneers who studied child development and the relationship with parents, educators and theorists.

“Erik Erikson (1963) was a developmental psychologist” who suggested that there are eight different stages which a person passes through during his development. There are two conflicting forces which are needed to be balanced at every stage. The parents can choose different parenting styles which are appropriate at different stages of development.
Rudolf Dreikurs (1971) was of the view that pre-adolescent children’s misbehavior is normally the result of the wishes of children to be a part of a social group. He said that the children respond in four mistaken goals. They try to get attention. In the absence of attention from the parents, the children develop a desire for power which leads to revenge and ultimately they tend to feel uncomfortable. This theory is equally beneficial in parenting and education. There are certain other parenting techniques which can help in learning and happiness of children.

Frank Furedi (2001), a sociologist, particularly studied parenting and families. He says that the claims made by others regarding actions of parents are less conclusive. He introduces the word infant determinism, which is the willpower of an individual’s life forecasts by what they go through in their infancy. He argued that there is no confirmation for its certainty. All the commercial, government and other interest are of the view that parents need to pay more attention to their children and children can develop in all kinds of situations. “No Fear” was the book written by the journalist Tim Gill in which he expressed the extreme danger distaste by parents and those accountable for children. The aversion limitation make the children to be lacking in sufficient skills and they fail to deal with risk in future, they are less adventurous and have less creative activities (Wikipedia ,2008).

**Parenting and discipline style**

The discipline styles are considered to be very important in parenting techniques. In all the aspects of infant’s movements, the adults must be there for the guidance and protection to provide their child a better direction. It can also be said that the parents must guide the children
and educate them about the disciplines. Diana Baumrind (1983) was the one to study the discipline styles in detail which are commonly used by the parents. The discipline styles were divided into three categories. These are authoritarian, permissive, and authoritative.

**Authoritarian**

In this style, there are strict rules and regulations defined by the parents and normally parents do not give any reasons for those rules. Authoritarian parents are openly critical of their children and frequently give them instructions on how to behave. Rules are enforced by punishing a child who does not obey, sometimes quite harshly. The children are just asked to obey without providing them any chance to discuss on any issue. The parents are demanding and directing. There is no give and take between the parents and children rather children just have to obey the orders. Parents are not sensitive towards the children and demand children to always agree to what parents say.

**Permissive**

On the other hand, there are few rules and regulations given by the parents and parents normally do not punish for the misbehaviors. The child is given great respect and autonomy but often too much independence at too early age. Permissive parents accept the decisions made by the children and have less control on children. The limits are not defined by the parents rather children define their own rules and regulations regarding their activities. Parents are not demanding for high level behavior like authoritative parents.

**Authoritative**

These parents have authority on their children and set strict rules and regulations but at the same time they provide the reasons for every single rule. The children are allowed to discuss
the issue with their parents and parents share their opinions with their children. In some cases, after discussions there are chances that the parents alter their rules through logical argument from them, authoritative parents give a great deal of sense involvement in their own rules. This style provides the positive reinforcement for the children and there is appropriate behavior from the children. The parents prefer warmth and affection rather than punishment for the children. The children are encouraged for independence but clear limits are defined for the development of children. Authoritative parents provide certain level of authority to their children but at the same time they make the children realize that parents love and respect their ideas (Lahey, 2004).

**Parenting styles and social anxiety disorder**

Research clearly indicates that children whose parents adopt an authoritative style are better behaved, more successful, and happier than the children of parents who use other styles of discipline (Lahey, 2004).

Lieb et al.(2000) indicated that family has a substantial role in the development of social anxiety but there are less empirical proofs in regards to the nature of effects on the children due to genetic influence. Heritable biological factors and particular family environmental factors might be related with the development of social anxiety in the children. The family environmental factors include parenting styles. Different studies in the past indicated that the children suffering from social anxiety disorder are of the view that their parents are either rejected or over protecting them. Both these styles have their individual or combined effect on children and they fail to interact with people in social situations. So we can conclude that parental social anxiety and the parenting styles have a great influence on the development of social anxiety in the children.
“5.6 percent adolescents, 6.9 percent females and 4.2 percent males” reported social anxiety. Among these individuals, 4.4 percent were suffering from non-generalized social anxiety and 1.1 percent had generalized social anxiety disorder. 137 respondents were those who had their parents with social anxiety, showed an earlier onset of generalized type social anxiety as compared to those suffering from non-generalized social anxiety. The children of people with social anxiety had a 9.6 percent rate of social anxiety and the children of normal parents had a 2.1 percent rate of social anxiety. The rate of social anxiety was high in the offspring who had overprotective and rejecting parents (Lieb, 2000).

Anhalt et al. (2008) studied social anxiety and found that the children suffering from social anxiety are of the view that their parents are rejecting, overprotecting and have no social warmth (Arrindell, Emmelkamp, Monsma, & Brilman, 1983; Arrindell, et al., 1989). There is literature available on the relationship between “trait anxiety, depression and parenting style”. The people with trait anxiety and depression report that their mothers are overprotective and not care for them (Parker, 1979). In respect of parental variables, Parker was of the view that depression and anxiety cannot be predicted by parental characteristics. Though, the later studies found that people suffering from anxiety neurosis reported that their fathers were not caring and overprotective for them as compared to the respondents in the control group (Parker, 1981).

Prashant (2005) studied perfectionism as a mediator between the relationship of social anxiety and over protection. He used a Frost Multidimensional Perfectionism scale to study the three dimensions of perfectionism: “Concern over mistakes, Doubts about actions, and parental criticism”. A sample of 280 respondents was selected and data were collected through questionnaires. “These questionnaires measured dimensions of perfectionism, social anxiety and retrospective reports of parental overprotection”. The results were supportive for all the three
dimensions of perfectionism as a mediating variable between social anxiety and over protection. “Fear of negative evaluation scale” and “social anxiety and distress scale” were used as two distinct measures of social anxiety.

“Darcy, Davila, and Beck (2005) studied the addition and interpersonal styles of socially anxious university students” and they found a relationship between social anxiety and preoccupied and fearful attachment styles. They also reported that the students with social anxiety were less assertive, had high level interpersonal tension, used to avoid the conflicting situations, and were not willing to express their emotions and dependent as compared to the students with less social anxiety (Nialsen, 2009).

According to Ozturk and Mutlu (2011) in order to be happy, the people need to have active communication with others in the society. This cannot be happening all the time as there are so many students who fail to actively communicate with other due to certain reasons. There are many factors associated with why they fail to interact with others. These factors include a person’s “happiness level, personal well-being level, affection styles and social anxiety level”. “This study was conducted to study the relationship between personal well-being, affection style, happiness in relationship and social anxiety”. A sample of 305 university students was selected and data analysis was done in SPSS. The results showed that there was a positive correlation between “personal well-being and happiness in relationship”. Moreover, the level of social anxiety was higher in fearful, preoccupied and dismissing students as compared to attached students. The level of personal well being in socially anxious students was lower.

According to Spokas and Heimberg (2008) several researches have been conducted to study the relationship between social anxiety and parenting styles like over protection and low
warmth (Bruch et al. 1989; Lieb et al. 2000). The study supported the literature already present and once again the data was collected from college students to study the social anxiety in relation to overprotective and cold parents. A mediating variable external locus of control was seen to have an effect on the relationship between social anxiety and parenting. Though, these studies used “cross-sectional data, and an alternative meditational model was also significant, highlighting the various ways in which these factors interact”. Finally, recollection of maternal overprotection projected an increase in social anxiety during the first semester of college, suggesting their influence on current functioning.

A sample of 351 Egyptian adolescents was used to collect data with the help of three questionnaires to measure parenting styles, adolescent-family connectedness, and mental health. The findings showed that authoritarian style of parenting for male adolescents was more existent in the rural areas and for female adolescents, authoritative style was more dominant. On the other hand, in urban areas, the authoritarian style was more common in female adolescents. Female adolescents were more connected with their parents as compared to male adolescents. The nature of this connectedness was emotional and financial in rural communities and functional in urban communities. It was observed that females had more problems of psychological disorders. There was a connection between mental health and authoritative parenting and no relationship between mental health and authoritarian parenting. It was reported that “authoritarian parenting within an authoritarian culture is not as harmful as within a liberal culture” (Dwairy & Mensher, 2005).

The individual with social anxiety disorder feel difficulty and nervousness in the situations where they have to interact with others. They think that the other people will have negative thinking about them or they will do something stupid in the gathering. These people become self-conscious. Moreover, social anxiety disorder brings worst impression on the
personality traits, such as self-esteem, shyness and introversion. The people who have the problem of social anxiety disorder are self-centered, underestimate themselves and consider their entity as worthless and avoid gathering, public interaction as well as cannot take active part in the routine life activities. So the next section will focus on traits (self-esteem).

Gorden Allport (1966) was the most influential of the trait theorists. In his view, personality is made of “traits, the guideposts for action, and the source of the uniqueness of the individual”. Traits are defined as secondary predilections that shape the person’s behavior in reliable and individualities ways. The consistency in behavior is due to traits as traits are the long lasting attributes and are normally generally or broad in their scope. Allport identified three types of traits. Cardinal traits are extremely widespread characters around which a person arranges his or her whole life. For some it may be power or achievement, while others of us are disposed toward self-sacrifice for the good for others. Less dominant or in less total control of behavior are central traits. They are, however, still broad and general in their influence. The specific traits that guide our actions in more limited channels are called secondary traits.
Traits form the structure of personality which, in turn, determines an individual’s behavior. Allport was the one who discovered the distinctive traits which make all the people a separate entity.

Raymond Cattell (1965) share in common the following beliefs.

- Traits are the basic unit of personality organization.
- Traits are inferred from behavioral indicators (usually paper-and-pencil personality tests).
- By integrating behavior and stimulus events, traits give personality continuity and consistency.
- Traits may be either surface traits (clusters of overt responses that are interrelated) or source traits (underlying processes that determine the surface manifestations).
- The task of personality assessment is to distinguish superficial from basic traits and to identify the smallest number of these basic units of personality that will explain the greatest amount of the variability in human behavior. (Zimbardo, 1979).

**Carl Rogers’ Self-Theory**

Like other humanistic psychologist, Carl Rogers believed that people tend to shape themselves through freedom of choice and action.

Roger’s views are termed self-theory because of his interest in the self as the administrative of personality. To Rogers the sense of self is innate or inborn. It is an “ordered, reliable, concrete gestalt based on the opinions of the features of the ‘I’ or ‘me’ and the opinion of the associations of the ‘I’ or ‘me’ to others and to numerous phases of life collected with the
values attached to these opinions”. The self is the center of experience. The self provides the experience of being human in the world. It is the counting sense of “who we are our sense of how and why we react to the environment, and how we elect to act upon the environment”. According to Roger, the choices are conscious and founded on personal values. “Values are also parts of the self”. The self is at the heart of the Rogers’ theory.

Rogers believed that people have unique ways of seeing themselves and the world-unique frame of reference. We define ourselves in different ways and judge ourselves according to diverse sets of values. Rogers assumes that we all develop a need for self-regard or self-esteem, and our self-esteem is wrapped up in how we live up to our ideals.

When our principles are genuine and authentic, when they come from within, we have the opportunity to actualize ourselves. When our ideals are based purely on the demand of others, we will have it hard trying to live up to them, and our self-esteem may drop. Parents help children develop self-esteem and actualize themselves when they show children unconditional positive regard accept them as having intrinsic worth regardless of how they behave at the particularly moment in time.

When parents respond to children by showing conditional positive regard accept them only when they approve of their behavior children may learn to become detached from the thoughts, feeling, and behaviors that their parents have rejected. With conditional positive regard, children may learn to develop conditions of worth, to think of them as worthwhile only if they behave in certain approved ways.

The children facing the disapproval from their parents are of the view that they are rejected and what they think is absolutely wrong with their parents. They are evil and selfish. In
case, they may try to retain their self-esteem, they might need to deny many of their reliable feelings, or reject parts of themselves. In this way their self-concept, or views of themselves, also grow distorted. According to Rogers anxiety often arises from the partial perception of ideas and feelings that are inconsistent with one’s distorted self-concept. To avoid anxiety, we may deny to ourselves that these feelings and ideas even exist. And so the actualization of our authentic self is bridled by the denial of important ideas and emotions (Rathus & Nevid, 1991).

Maslow (1970) presented that there are two levels of esteem needs which are reputation and self-esteem. Reputation is defined as the image of the person in the other’s eyes, his fame and recognition. On the other hand, self-esteem is individual’s feelings about himself including the level of confidence and value. Self-esteem is more than prestige and reputation. It is about the desire of strength, for attainment, for competence, for mastery and capability for self-assurance in the face of the world, and for the freedom and independence. So we can say that self-esteem is about the real competence and not just the views of others. When the self-esteem need of a person is fulfilled, he starts realizing the self-actualization which is the highest level of need presented by Maslow (Feist & Feist, 2002).

**Theories of self esteem**

Maslow presented the hierarchy of needs. In addition to the basic needs of food, water, air and sex, he divided the needs into five categories. These are “the physiological needs, the need for safety and security, the needs for love and belonging, the needs for esteem, and the need to actualize the self, in that order”.

1. **The physiological needs:** These are the basic needs for “oxygen, water, protein, salt, sugar, calcium, and other minerals and vitamins”.


2. **The safety and security needs:** They also stand in the lower level needs and are the physiological needs being cared. This is the second level need.

3. **The love and belonging needs:** when the person feels that physiological and safety needs are fulfilled, then comes this third level need. In this need the person wants to have social interactions with fellows, friends, beloved ones, children and others in the society. The dark side of this need is that the person may become lonely, which may lead to social anxiety.

4. **The esteem needs:** The next level need is self-esteem need. According to Maslow, self-esteem need has two versions. The lower and higher version. In the lower version is the respect of others, the need for rank, reputation, brilliance, gratitude, courtesy, status, appreciation, self-respect, even supremacy. In the higher version are needs of self-respect, including such feelings as self-assurance, capability, accomplishment, mastery, individuality, and liberty. On the negative end of this need is the low self-esteem which leads to an inferiority complex. According to Maslow’s point of view, “Adler was completely against something when he proposed that these were at the roots of many, if not most, of our psychological problems”. (George Boeree 2006).

5. **The self-actualization needs:** This is the highest level in the need hierarchy. There were different terms used for this level of need. These terms are growth motivation, being needs, and self-actualization. This need includes self-fulfillment, the understanding of all one’s capacities, and a wish to develop inspired in the occupied sense of the word. “People who have reached the level of self-actualization becomes fully human” (Feist, and Feist, 2002).

**Sociometer theory**
It is a widely known concept that self-esteem motive tends to increase the self-esteem (Leary 2000). According to the socio-metric theory, self-esteem reduces the chances of getting rejected in the society (Anthony 2007, Leary 2000). The people try to increase their self-esteem and in reality they do so to increase the value of their relationship with the people in the society. The socio-metric theory also explains that the events which are known by many people tend to be more reflective as compared to the events which are only known by the individuals. There are many researchers in the past who have suggested that low self-esteem badly affects the physiology and personality of a person and can lead to depression, teenage pregnancy, substance abuse, failure in studies and criminal attitude. High self-esteem also is not that good for a person and has a dark side. According to the socio-metric theory the personality and physiological problem mostly arise due to low relational evaluation and rejection. The behavioral problems as the result of self-esteem are the co-effects and they do not cause each other. Low self-esteem causes the problems as the person is rejected by others and has a maladaptive behavior which is not accepted by the people in the community. A high level of self-esteem can have positive physiological changes but it also depends on how people view their values. People feel that they are highly accepted in the society if they see a positive attitude of the people and this increases their self-esteem (Psychwiki, 2010).

**Self-esteem and social anxiety disorder**

Lzgic et al. (2004) found that the people suffering from social anxiety had low self-esteem as compared to those who were normal. Students with Social anxiety have more distorted body image than do those without Social anxiety.

According to Kocovski (2000), in order to study social anxiety, a self-regulated
framework was used with the help of a sample size of 174 individuals including 124 female and 50 male undergraduate students. The results have been just according to the expectations. The people with higher levels of social anxiety had less expectation regarding accomplishing their goals, had low self-esteem and low self-reinforcement. Multiple regression analysis showed that there was 33 percent variance for the achievement of goals, having negative feedback and public self-consciousness in social anxiety. The mediator between social anxiety and self-esteem was fear of negative feedback. The same mediator was there between social anxiety and self-reinforcement.

In another study, the sample of 73 college students was used to study the role of self-importance and imperatives in social anxiety. The task given to the students was that they had to speak in front of their fellows and the length of time they spoke and the level of anxiety they felt was noted. There was no correlation seen between lower self-importance and social importance. In addition there was no correlation between imperative thinking and level of anxiety. The findings showed that the people spoke for less time that had higher levels of imperative thinking. This shows that the level of anxiety for each participant was moderated by the performance of an instrumental response. The results show that significance of imperative thinking in determining behavior in the field of social anxiety (Nieastro et al., 1999).

Peter (2002) conducted a research work to study the importance of self-image on social anxiety. The sample of the study included “19 high and 19 low socially anxious females”. As self-esteem is subtle to self-presentation and impression management strategies, an Implicit Association Test (IAT) was used to assess participant’s self-esteem as well as their general evaluation of others (other esteem). The women with social anxiety had low self-esteem on self-report measure. Though, the positive self-image of both low and high anxious women was same.
Shepherd & Edelman (2009) studied the effects of anxiety, depression, locus of control, self-esteem, ego strength and the ways of coping with the situations. The sample of university students was used for this purpose. Those who had high levels of social anxiety were more anxious, depressed, had low ego strength, low self-esteem, external locus of control and used to cope with problems in the emotional way rather than focusing on the problem. The results were shown predictive of causality and they created certain issues in relation to the theory, anticipation, involvement and endorsing mental health within a university setting.

People with low level of self-esteem are reported to be shy and shyness normally creates fear and lack of self-confidence. When someone is shy, this means that he or she is being conscious about himself. He or she may be worried about what people are thinking about them.

Being shy sometimes is not bad but if it becomes a habit, it can badly affect the education, profession and even social life (Hines, 2010).

Shyness is described as the clumsiness or uneasiness which people feel when they have to interact with other people in the community. In contrast to introverts, shy people have a strong desire for being connected with people but their anxiety makes them unable to mix with people. The symptoms of social anxiety disorder and shyness are almost similar in nature such as avoiding social gathering, self-centered and lack of confidence level etc. So the next section focuses on shyness.
Shyness has an effect on the way people interact with others. The shy people feel difficulty, discomfort, self-conscious, worried, cautious, fearful, or apprehensive. Shy people sometimes have certain physical sensations such as blushing, unable to speak, shivering and even breathless.

Shyness can be defined as the distress and embarrassment in social conditions that inhibits with following one's relational or certified goals. The person has an excessive focus on himself and becomes preoccupied with what people will think. Shyness can be little social clumsiness or fully constraining Social anxiety. Shyness may be long-lasting and dispositional, which becomes personality feature. Situational shyness is when a person feels shy in some particular situation and not incorporating it into one's self-concept. Shyness can be there in certain or all of the stated situations: “cognitive, affective, physiological and behavioral factors might be activated by a number of arousal signals”. The most typical types of shyness include authorities, one-on-one opposite sex interactions, familiarity, outsiders, and starting social
actions in shapeless, impulsive behavioral settings.

There are symptoms of shyness which shows one behavior. These are inactiveness, gaze hatred, escaping of dreaded situations, low talking voice, less body movement, language disfluencies, anxious behavior, such as touching one’s hair and face.

Certain physiological symptoms are also there which include faster heart beating, drying of mouth, shivering, and sweating, feeling feeble or losing self-control.

Cognitive symptoms of shyness are thinking about oneself, others, situations, thoughts of having negative feedback, looking foolish to others, being worried and contemplation, self-blaming characteristics, mainly after social communications, adverse acceptance about self and others, destructive prejudices in the self-concept, e.g., I am socially insufficient, unlovable, and unappealing.

Affective symptoms are awkwardness, disgrace, low self-esteem, unhappiness and grief, solitude, despair and nervousness. (Henderson, 2008).

**Theories of shyness**

Zimbardo (1977) was among the initiators to study shyness. His viewpoint was that shyness exists universally. All the people experience shyness at certain point of time in life but the severity in different people is different. A person can be privately shy or publicly shy. A privately shy person has certain feelings about himself which he keeps on focusing. A publicly shy person is always concerned about what people feel about him. Zimbardo also noted that shyness has a positive impact also so we cannot say that shyness must be eliminated completely. The positive side of shyness is that it can prevent intimidation or conflicts among people,
provides an opportunity to reflect on the situation while standing at the back, allows the person to see the behaviors of others etc. moreover, a shy person may catch an impression of being decent, intelligent and discrete.

There are many psychologists who study the impact of shyness on social anxiety. The reason is that a shy person has an extreme obsession with what people think about him and he always remains fearful from bad assessment. So, Harris (1990) refers to “Acute Negative Public Self attention”, which is a condition when shyness, shame and embarrassment create discomfort due to the presence of people around. Certainly, theories of shyness are related to Schlenker & Leary’s (1982) the theories of social anxiety. In the same way, in the “diagnostic criteria of the DSM IV”, social anxiety means the clear and determined fear of performing in social situations when there are strange people around and the person is concerned about what people will think about him. There is a common feeling that the person will do something wrong which will humiliate him in front of others (American Psychiatric Association 1994).

Shyness and social anxiety disorder

Buss (1890) suggests that the common link between shyness and social anxiety or discomfort is characteristic of self-consciousness. He also presents the distinction between the public and private self-awareness, a transitory situation in which one assesses his own outer appearance and behaviors, consistently and community and isolated self-consciousness, the gesture or appeal to feeling self-aware in either of these ways.

In contrast, Miller (2001) delivers a quantity of alterations between “shyness and embarrassment”. He claims that shyness is pre-emptive, which is caused in the situations when people are fearful of undesired feedback from others before anything to happen creating any cause such as opposing decisions, while embarrassment is responsive which is based on the real
happening when one actually acts in a way which is not socially accepted. So we can define embarrassment as a severe state of astonished, uncooperative attachment which is the result of situations which are against our expectations. This increases the fear of getting negative evaluation from the people around. Having this thing in mind, he argues that there are social benefits of embarrassment as it can prevent the person from making mistakes. Shyness is considered to be detrimental as it makes the person to avoid the social situations and the person fails to interact with people and having any social relationships.

To experience shyness is to feel unsure in social situation. In shyness one’s feel that he is not measuring up, and feel very uncomfortable in the presences of others. Feel unable to communicate effectively. Feel that any moment may do or say something that will embarrass him. If the situation is prolonged, may develop a tension headache from the stress. Shyness is a chronic feeling of inability to interact with people confidently and comfortably. It frequently reflects a true deficit in social interaction skills, and intensely shy people, who may be brilliant or highly talented, protect themselves from occupations and recreation that make high demands on social skills.(Lzard, 1991).

Heiser, Turner, and Beidel (2002) studied the correlation between social anxiety disorders, shyness and other kinds of psychiatric disorders. It was noted that comparing with non-shy people, the shy people had more social anxiety disorders and it was noted that 18 percent of the people with social anxiety were shy and only 3 percent were non-shy. Though, most of the shy people like 82 percent had no social phobia. The relationship between “shyness and social anxiety disorders” was found to be positively significant. The data also shows that it is not necessary that all the shy people suffer from social anxiety. Another relationship was seen among social anxiety and introversion and neuroticism. They have a moderate relationship with
each other.

The nature of relationship was moderate. This means that the shy people suffering from social anxiety were more shy, more introverted and more neurotic. But these factors were not enough to differentiate between the shy people suffering from social anxiety and those who were not socially anxious.

In addition to social anxiety, more shy people were diagnosed with other psychiatric disorders as compared to those who were not shy. This shows that the shy people have more chances of getting psychiatric disorders. The people suffering from generalized social anxiety disorders are noted to be very shy. They want to be socially active but they fail to do so because of their anxiety. They feel that they have many difficulties in their life. They are of the view that most of their life has been spent with their shyness and they just fail to bear the minor rejections by the people around them. They remain in isolation and this affects their academic, professional and social life. There are chances that they suffer from avoidant personality disorder. (Watkins, 2004).

Shyness and introversion are related to one another. This is because shyness makes the person less social and shy people avoid being part of social gatherings. Shyness is also related with neuroticism as the person feels awkward and inhibited in addition to having low self-esteem. Shyness and low sociability have moderate relationship in cases when phenomenological perspectives are employed to define shyness. Introspection and introversion are also related to one another in theory (Vamer, 2011).

Introverts are generally more introspective, they spend a lot of time looking inward. As a result, they are often more self aware than extroverts, who are often able to relate to others well. While often overlooking their own insecurities. Introverts can cope just as well as extroverts in
social situations, in some cases, their self heightened awareness often makes more socially
certain and adaptable than extroverts. An introvert could be the most socially confident and
talkative person in the world if they have the energy to sustain the front, but this is only done by
curbing their inferior function. The next section focuses on introversion extroversion.

The trait extroversion introversion is the central dimension of human personalities. Eysenck has developed a personality inventory that can identify people who vary along the trait
dimension of extroversion-introversion. Extroverts are sociable, outgoing, active, implusive,"though-minded” people. Introverts are their psychological opposite; they are “tender
minded” individuals, noted for being withdrawn, inner directed, passive, cautious, and reflective
(Eysenck & Eysenck 1967).

The term introversion extroversion was first popularized by Carl Jung. Introverted are
assumed to be born with a more sensitive, easily arousable autonomic nervous system than
extroverts. Introverts have been shown to have lower thresholds than extroverts for pain, and to
condition faster with weak unconditioned stimuli for partial reinforcement training.

The dimension of introversion extroversion found in the Eysenck personality inventory
uncovers individuals differences in the degree to which people need others as sources of reward
and cues to appropriate behavior. The outgoing, impulsive extrovert needs people to interact
with, while the reserved, cautious introvert relies less on other people for stimulation and more
on books or nonsocial sources. Introverts are more unchangeable, passive, careful, pessimistic,
peaceful, controlled, reliable, and anxious. Extroverts tend toward being changeable, active, impulsive, aggressive, excitable, and carefree.

The internal external personality types are extremely on the field of beliefs about locus of control; that is about whether sources of reinforcement are primarily internal or external. Internal people perceive that reward is contingent on their own behavior and their personal attributes. Externals perceive that rewards occur independently of their actions and are controlled by external forces (Zimbardo, 1979).
Extraversion is defined as the deed, state or practice of being primarily apprehensive with and gaining satisfaction out of what is out the self. The people who are extroverts tend to feel happy when they interact with others in the society. They are enthusiastic, chatty, self-confident, and outgoing. They feel excited when they get involved in the activities where a lot of people are participating like community gatherings, parties, public demonstrations, business and political gatherings. The professional fields they favor include politics, sales and marketing, teaching, brokering etc. the extrovert people enjoy the time which they spend with others and they are of the view that the time spent alone has no value. They feel full of energy when they are in the social gatherings and get easily bored when they are alone.

Introversion is defined as the capacity of primarily concerned with one’s own interests and mental life. Introverts are opposite to extroverts as they are not talkative and tend to remain quiet in the gatherings. The activities they like include reading, watching movies, drawing, writing, playing computer games and using computer. These activities include less social interaction. They are also engaged in some outdoor activities but those activities are also reserved ones for example fishing. The typical artist, author, engineer, musician, and originator are very introverted. Introverts only like social interactions with the people who they are very closed to. They tend to be involved in one activity at one time and are very keen to analyze the situation before participating. Introversion and shyness are two different terms and introverts try to engage themselves in the solitary activities rather than social gatherings. The difference with shy people is that shy people do not engage in social activity due to their fear.

People are not either completely introverted or completely extroverted. Most have some elements of both attitudes; that is, they are influenced by both the subjective and objective world. Also, introversion and extroversion should be equally valued. Each tendency has strengths as well as weakness, and the healthy people are recognized by physiological balance in two ways
i.e. they feel comfortable in their external as well as internal environment.

Freud himself was an introverted person while Adler was an extroverted person. Adler felt comfortable in the social gatherings, he used to play piano and sing songs in the coffeehouse. Jung’s theory was based on extroversion as it was aimed to minimize the experience regarding the world of sex and aggression. He was of the view that the theory presented by Adler was introverted as it focused on fiction and subjective perception. Jung’s point of view was that his theory was balanced and it accepted both objective and subjective views (Feist & Feist 2002).

Theories of introversion extroversion

Jungian theory

According to Carl Jung, (1921) introversion and extroversion are the ways of psychic energy. In case the energy of the person flows outwards, he is considered to be extrovert. If the energy of a person flows inwards, then he is considered to be an introvert. Extroverts are energetic and enthusiastic when they interact in the society and feel low energy levels if they are alone. On the other hand, introverts feel lack on energy in the presence of people or in the social gathering while their energy levels are high when they are alone.

Eysenck’s theory

Hans Eysenck (1971) explained the concept of introversion and extroversion as the capacity of the person to be outgoing and communicating with people. The difference in the behaviors of people is normally due to the differences in brain psychology. In order to keep the energy arousal high, extroverts try to actively interact with people and engage in social situations. On the other hand, introverts tend to avoid interactions in the society in order to minimize the arousal level. Eysenck presented extroversion as one among the three main and significant personality traits including psychoticism and neuroticism. Eysenck suggested that
extroversion was made of two kinds of tendencies which are impulsiveness and sociability. He added other personality traits in this which were dynamism, action level, and impulsiveness. He linked these traits later with the personality hierarchy he presented to more precise usual responses, such as celebrating on the weekend. (Wikipedia n, d).

**Extroversion Introversion and social anxiety disorder**

The person’s perception is made up of the three factors which have a relationship among them. These factors include affect, behavior, and cognition. Wells (2000) found the perception of people about themselves largely affects the way he or she interact with the people around. The people with social anxiety have negative feelings about themselves than the positive feeling. This negative feeling prevents him to be a part of a social gathering as he feels himself inferior. The person becomes introverted. The person with positive thoughts tends to be more extroverts (Leary & Kowalski, 1995).

Keighin, Butcher, and Darnell (2007) studied the relationship between negative evaluation and the personality types of introversion and extroversion. A sample of students from a “small Christian affiliated liberal arts university” was selected. Convenience sampling was used and “Myers-Briggs type indicator” was employed in addition to the “fear of negative evaluation scale”. The hypothesis was that the introvert people will be more fearful of negative evaluation as compared to the extroverts. Two tailed independent t-test was measured the results. 0.05 was the level of significance. The results did not accept the null hypothesis as a very unexpected and different relationship was found between “introverted individuals and fear of negative evaluation”. The hypothesis was supported that the extrovert had less fear of negative evaluation as compared to the introverts.
Janowsky and Morter (2000) studied the personalities of people suffering from social anxiety. It was noted that among the patient of social anxiety 93.7 percent were introvert. The people suffering from social anxiety in the normative population counted to be 46.2 percent. Moreover, the continuous scored showed that introversion was more common among socially anxious people.

In another study, a sample of 109 college students was used to examine the relationship between “social anxiety, self-esteem and introversion”. The significant, strongly negative relationship was seen between “social anxiety and self-esteem”. “The relationship between social anxiety and introversion was moderately positive”. Moreover, the results showed that self-esteem was a stronger indicator of social anxiety as compared to that of introversion. Results also indicated that by considering self-esteem and introversion, the prevention, assessment, diagnosis, and treatment planning for social anxiety can largely be improved (Mull, 2006).

Sulloway (1996) proposed that “personality traits settled in childhood mediate the relationship of birth order with methodical extremism”. The effects of birth order were studied in the “five factor model of personality in three different studies; self-reports on brief measures of Neuroticism, Extraversion, and Openness”. Nineteen thousand six hundred and sixty four people among the sample showed that “there was no relationship between birth order and social anxiety”. Self reports on the 30 facet scales of the revised NEO personality inventory in an adult sample supported the hypotheses that the later born children are more agreeable and open minded. These findings were not replicated by the spouse ratings. Perceived personality may get affected by birth order but the it does not necessarily mediates the relationship with scientific radicalism. (Jefferson, 1998).
The birth order is one of the major factors which develop social anxiety disorder. It has been observed that 1st born in a family is found more socially anxious as compared to middle and last one. In our culture where there is usually a large family. The parents are paying more attention to the first born but till the 2nd born and so on, that’s why they develop social anxiety disorder. So the next section will focus on birth order.

Birth order is the rank of children among siblings. It can be first born, last born, middle born, only child or twin. Alfred Adler was among the beginners who studied the impact of birth
order on social anxiety. He also studies the relationship between parents and children and between siblings on the basis of birth order. He suggested that the personality of children and their development is also affected by the birth order. There are five positions of birth order which are being studied now days. First born, second born, middle born, last and only children. There are so many researches being conducted on the relationship between “birth order, personality and intelligence”. Studies showed that the first born children are more intelligent in the academic field as compared to those of last born children. The first born children are more responsible, self-confident, and task focused. They often reach to leadership position in their profession. The elder children have more abilities and the middle born feel inferior.

It is found that the middle born children are more successful in team sports. The middle born and last born has more social adjustments if they are part of large families. The last born are the family babies and they get the attention and love from all the elders of the family so they are more successful in social and problem solving skills. They are most successful in social interactions and have higher level self-esteem.

Only children are also family babies like last born but they have differences in the way they are grown up and interact with others. They are mostly successful in their educational life. They are accomplishment oriented and attend college with great success. The only children are seen to be less socially interactive and can suffer from psychiatric disorders most commonly.

Frank J. Sulloway (1996) studied the effect of birth order on the later life. He focused on the factors like “Birth order, Dynamics, and Creative lives”. He said that it is easy to mold the children to a greater degree with respect to the relationships with siblings as compared to their relationship with their parents. Children spend more of their time with siblings as they play fight and compete together. They also compete for gaining more attention from the parents. He also
argued that the rivalry among the siblings pursue their lives which create many differences in their life. He also claimed that younger children are reported to be more innovative intellectuals, they have the ability to change the environmental situations politically, artistically or intellectually.

Sibling rivalry is a very common thing happening in the family. It is very natural for the siblings are jealous of the love and affection the other ones are getting from the parents. When the parents get a new baby, the elder one gets jealous as they think that now parents attention will get diverted now. They think that the new baby is the intruder who has taken a position in their home. This type of jealousy and competition is mostly seen when the age gap is less than three years. A little rivalry is acceptable but when grows high to an extent that it becomes unavoidable then this creates problems. The parents are supposed to take action in order to control the level of competition and resentment as it has bad effects on the personality of the child.

It is important for the parents to mentally prepare the child for the coming one in the family. The child is to be told about the new member in a way to create love in his heart. He must also be told that the other people in the home will take care of him when the mother will be in hospital. Steps must be taken to continue the child’s daily routine with the least possible disturbance. It is better that the child must stay at home with any other family member who is very close to him. If the parents are planning to have a new caretaker of the new child, then the parent to supposed to arrange an advance meeting of their elder child with the caretaker so that the child would not consider him strange. In case child visit is allowed, the family must take the child to the hospital to meet the mother and the new sibling.
When the new baby comes home, it is natural that the elder baby will feel hurt to see that new baby is the center of attention for the family and relatives. This can create some emotional disturbance and the child may stop eating or find difficulty in sleeping. Some children also get affected as they lose their realization for wearing, bowel and bladder control, or clear speech. The aim is to regain the attention of the parents by acting like small babies.

There are many steps which can be taken by the parents to minimize the jealousy due to which the life of the child gets disturbed. When any relatives visit to see the new baby, the parents must give special attention to the elder child and the gift received from the guests can be given to the elder child to minimize the jealousy. In addition, the elder child’s self esteem can be raised by engaging him in taking care of the newborn such as the child can be engaged in changing the diaper, dressing the newborn and pushing the carriage. The older child must also be realized that his responsibilities and the position in the house has been raised because of his being an elder. He has the hold on things the newborn is too young and is unable to anything. One more way to make the child feel appreciated and loved is to provide some quality time alone to the children on a regular basis. The parents must not compare the child with other siblings and no favoritism for any child should be there. (Gale, 2005).

**Birth order and social anxiety disorder**

Eisenmen (1992) claimed that first born children are most anxious and some of them are found to be most fearful among all the other siblings. The reason might be that the first born children are mostly protected and restricted by the parents and they spent most tame alone with their parents when they have no siblings. (Guastello, 2002).

Ernst & Angst (1983) studied the relationship between the position of birth order and the psychopathologies. It was believed that the first born children have more chances to face the
mental disorders (Skinner, 1997). A study showed that the eldest male children reported more psychological problems as compared to the later born children. There were no differences seen among the female children in accordance with their birth order (Fullerton et al., 1989). It was also noted that the first born children scored low on depression and anxiety and high on self-esteem as compared to those of second, third, fourth born and youngest children (Gates, Lineberger, Crockett & Hubbard 1988).

It is important to study these effects at various stages of life as it considers that the result in this context have always been so conflicting and the effects may change with changes in time (Sulloway, 1999).

Wilkinson (2002) studied the effects of the birth order on the level of anxiety a person experiences in his daily life. The hypothesis of this study was that the oldest born children score higher on social anxiety and the last born children have lower levels of social anxiety. The only children show less social anxiety when compared to any other ordinal birth order. The convenience sampling was done to gather the data and a sample of 94 students from Loyola University New Orleans was selected. They included 21 males and 73 females. The level of anxiety was examined through brief symptom survey. The results of this study showed that the lowest level of anxiety was there in the middle born students. The results did not support any of the hypotheses so they were not significant.

Tramontana (2009) reported that the general anxiety was higher in the first born children as compared to the last born. The middle children were found to have less anxious than the first and last born. The hypothesis of the study was that the only children have the least anxiety compared with all the other participants. 21 male and 73 female undergraduate students
participated in this study from Loyola University New Orleans. Out of all the participants, the first born counted to be 35, last born were 33, middle born were 19 and only children were 17. The method used for measuring the anxiety level was the Brief symptom inventory survey. The hypothesis was rejected and the results showed that anxiety levels were not associated with birth order.

**Rural urban area and social anxiety disorder**

In order to study the difference between the strength of anxiety symptoms on the “Taiwanese small Christian affiliated liberal arts university Version of the Multidimensional Anxiety scale for children (MAS-T) between Taiwanese children and adolescents and the original American standardization sample across gender and age, and to examine differences in sex, age, and residential background in the level of anxiety symptoms”. MASC-T was completed by a sample of 10,566 participants of Taiwanese children and adolescents in the community. “Their level of anxiety symptoms on the MASC-T were compared with the original American standardization sample in March’s study”. The level of anxiety symptoms in relation to age, gender and residential areas was studied with the help of three way analysis of variance. The results showed that the level of anxiety was quite different on nearly all “MASC-T scales between Taiwanese and American children and adolescents across sex and age”. Girls reported more anxiety than boys on all scales of the MASC-T. “It was also seen that the age group of 16 to 19 years showed higher levels of social anxiety and lower level of harm avoidance and separation than those in the 8-11 years-and 12-15 years-old groups”. The physical symptoms were higher for the people living in rural areas as compared to those living in urban areas. The people belonging to urban areas showed higher harm avoidance as compared to those living in the rural areas (Yen, 2010).
Susan and Chong (2005) compared urban to their counterparts. “The results indicated that the rural adolescents reported high on the conduct disorder, oppositional defiant disorder, and substance use disorder, specific phobia”. On the other hand, it was seen that urban adolescents were more socially anxious. There were no noticeable differences in the level of depression and anxiety disorders among rural and urban children.

According to Susan and Chong (2005), “disruptive behavioral disorders (mainly a conduct disorder and ADHD) and substance use disorders were more prevalent in rural boys than girls, whereas the reverse was observed in depressive disorders across the 3 years”. Girls reported more anxiety and adjustment disorders as compared to boys. Specially, the phobia was high among grade 8 and social anxiety was high among grade 9 students.

According to Ingman (1999), the previous research showed that American students reported significantly high level of social adjustment as compared to the international students studying at American universities. This issue might be due to the factor of cultural difference. This has also been noticed that the adjustment becomes higher with the relationships of American students with those from other countries. This is also a fact that many foreign students fail to have good relationships with American students. “In this study, self construal, social anxiety, and social skills were investigated as possible mediating variables for international student’s social adjustments”. In the first level of study, the sample was consisted of 105 American and 59 Chinese students at a “large state university in the southeastern United States”. “Results indicated that Chinese students experience lower social adjustment, higher level of social anxiety, and higher interdependent self construal than American students”. “Independent self construal was inversely related to social anxiety for both groups. In addition, an inverse relationship between social anxiety and social adjustment was found for the American students only”. In the second level of this study, “a subset of Chinese (N=28) and American (N=32)
students from the first phase participated in four separate dyadic interaction with both Chinese and American confederates. The students were asked to rate their level of anxiety both before and after the interaction, and their behavior during the interaction was videotaped and later rated by independent observers. Analyses of these data revealed that American students experienced higher anxiety than Chinese students both before and after the interaction.”
CHAPTER II

RATIONALE OF THE STUDY

Social anxiety disorder is the 3rd psychiatric disorder. This disorder has been observed comparatively high in female students as compared to male students in our culture. Parents are no doubt one of the main leading figures in the development of our personalities. Parenting style is a prominent cause of social anxiety disorder. The extraordinary restriction as well as care may causes the psychological problems in children personalities. Personality traits are influenced by the social anxiety disorder such as shyness, introversion, and self esteem, social anxiety disorder brings worst impression on the personality traits such as shyness, introversion, and self esteem. The student who have the problem of social anxiety disorder are self centered, under estimate themselves and consider their entity as worthless and avoid gathering, public interaction as well as cannot take active part in the activities of routine life as compared to non anxious students. The residential area is also one of the main factor which affect the social anxiety disorder. The social anxiety disorder has been found more in the students of rural area as compared to the students of urban areas. The reason may be the state of deprivation, non availability of basic fundamental facilities as well as rights of the rural area, whereas the students of urban area do not have such type of problems. Similarly the female students who belong to rural area are more socially anxious as compared to male students. The birth order is also one of the major factor which develop social anxiety disorder. It has been observed that 1st born in a family is found more socially anxious as compared to middle and last one. In our culture or society where there is usually large families. The parents are paying more attention to the first born but till the 2nd born and so on, that’s why they develop social anxiety disorder.
“Adolescence and adulthood is a time when many young people leave familiar settings to live at college and university”. They get a chance to develop social relationships and also need to perform in front of others like meeting new people, writing and giving presentations in front of others, having group discussions, dating and exam anxiety. For many students, these situations are a source of excitement and for many, these situations are frightening. The concept of social anxiety disorder varies from culture to culture depending on social demands. Whereas girls are more competent and intelligent than boys but they are not given proper attention and importance and criticized by their parents and family members without having any valid reason and grounds. Therefore the ability to work, talk, perform, and decision making is adversely affecting.

Furthermore in Pakistan it was found that there is dearth of research on this particular topic. Keeping in view these factors, this research work is aimed to find out the “Prevalence rate of social anxiety disorder among college and university students and to investigate its psychological impact on various aspects of personality.”
CHAPTER III

OBJECTIVES:

1. To identify the prevalence rate of social anxiety disorder in the students belonging to both urban and rural areas.

2. To find out the level of self-esteem, introversion, and shyness among socially anxious and non-anxious students.

3. To find out “parenting style of parents of socially anxious and non-anxious students”.

4. To Investigate the relationship of birth order with social anxiety disorder.

HYPOTHESES

Hypothesis I: “Social anxiety will be high in female students as compared to those of male students”.

Hypothesis II: “Parenting style of socially anxious students will be overprotective and rejecting as compared to non-anxious students”.

Hypothesis III: “Socially anxious students will score high on introversion scale, shyness scale, and low on self-esteem scale as compared to non-anxious students”.

Hypothesis IV: “Students belonging to rural areas will have high social anxiety as compared to students belonging to urban areas”.

Hypothesis V: “Social anxiety will be high among female students belonging to rural areas as compared to male students belonging to rural areas”.

Hypothesis VI: “First-born students will score high on Liebowitz social anxiety
scale as compared to last-born students".
CHAPTER IV

METHOD

The study was carried out in three phases.

1 In the first phase of study, consent forms were distributed among the student in order to know their readiness and inclination to take part in the study. After this, clinical interviews were conducted in order to gather personal information, educational background, nature of problem they face, interval and strength of the problem and the information regarding any psychopathology. In the next step, Liebowitz social anxiety scale was administered, to identify social anxiety disorder in the college as well as university students. The students who scored between 55 to 80, were further assessed with the symptom checklist of social anxiety disorder derived from DSM IV in order to screen them for social anxiety disorder. Those who scored less than 55 were excluded from the study.

2 In the second phase of the study, socially anxious students personality traits such as self-esteem, shyness, introversion, and perceived parenting style were assessed through the Rosenberg self-esteem scale, shyness scale, introversion scale, and measure of parenting style.

3 The third phase was aimed at assessing those students who scored below 55 on Liebowitz social anxiety scale and showed no symptoms of social anxiety disorder on symptoms checklist of social anxiety disorder derived from DSM IV. Four psychological tests i.e. Rosenberg self-esteem scale, shyness scale, introversion scale, and Measure of parental style were administered on each student independently to gather related information regarding different aspects of personality i.e. self-esteem, shyness, introversion, and
perceived parenting style.

Sample

For this study a sample of 500 students was selected (N=500). There were 250 female students and 250 male students (n=250). They were selected from MSc (from 1st year to final year) including an equal number of socially anxious and non anxious students, were randomly selected from different colleges and universities of Peshawar, Swabi, and Nowshera. The students had the age between 17 years and 25 years. All the students had related educational and socioeconomic background.

Exclusion criteria

Those students who have social anxiety disorder due to the following reasons were excluded from sample.

“Panic disorder with agoraphobia, Agoraphobia without history of panic disorder, Separation anxiety disorder, generalized anxiety disorder, Pervasive developmental disorder, Personality disorders, Major depressive disorders, psychotic disorders and other medical conditions”.

Inclusion criteria

Those students who have social anxiety disorder both generalized and non-generalized were included in the sample.

Instruments

1. In-Depth clinical Interview

“In depth clinical interview was conducted for each student in order to gather relevant
information regarding personal information, educational background, nature of problem they face, interval and strength of the problem and the information regarding any psychopathology”.

2. Liebowitz Social Anxiety Scale (1987)

The Liebowitz social anxiety scale was developed by Michael Liebowitz in order to evaluate the patients suffering from social anxiety disorder in terms of their performance in society as well as social interaction with other people. This scale consists of 24 items which shows the whole possible range of the social anxiety severity rating. There are four subscales which provide the score. “1) Performance fears 2) performance avoidance, 3) social fear and 4) social avoidance”. The score between 55-60 shows moderate social anxiety, 65-80 marked social anxiety, 80-95 severe social anxiety and greater than 95 shows very severe social anxiety. “The Liebowitz social anxiety scale is valid, reliable and treatment sensitive measure for social anxiety disorder” (Michael Liebowitz1987).

3. Rosenberg Self Esteem Scale (1965)

The Rosenberg self-esteem scale consists of 10 items. It is a self reporting measure of global self-esteem, self-worth or self-acceptance. This scale is considered to be a reliable and valid scale as it showed its worth when applied to different sample groups. This scale is equally beneficial for males, females, adolescents, adults and elder population samples. Sum the scores for the 10 items, higher the score, higher the self-esteem. The alpha reliability value of this scale is 0.85 (Rosenberg 1965).for 1


McCroskey was the one to develop this scale. This scale successfully measures the
introversion without mixing it out with communication anxiety items and measures communication and introversion as two separate indicators of communication behaviors. The score range should be between 12-60, score above 48 indicate high level of introversion, below 24 indicate low level of introversion, and between 24-48 indicate moderate range of introversion. The alpha reliability estimates have been above .80. (McCrosky 1995).


“This scale was developed to obtain individuals self-report of their shy behavior. This measure has generated high alpha reliability estimates (>0.90) and has excellent face validity”. The score range should be between 14-20, scores above 52 indicate high level of shyness, scores below 32 indicate low level of shyness, and scores between 32 and 52 indicate moderate level of shyness. (McCrosky 1982).


This scale is very efficient in covering up the shortcomings in the parental bond instruments. This scale is a self-assessment scale in which the respondents give information about the perceived parenting style into consideration to three measures which are indifference, abuse and over control and the face validity of this scale is exceptional and the alpha reliability is 0.82. The scoring instruction of the scale is item 5, 8, 10, 11, 12, 13 relate to the indifference measure, items 2, 7, 9, 14, 15 relate to the abuse measure, and items 1, 3, 4, 6 relate to the over control measure. Sum the scores of the responses to items in each of the three categories to produce a total score for each category. The total score of each caterogy provides a dimensional measure showing the degree to which that parenting style was experienced by an individual. (Parker and
Roussos 1997).

Procedure

The procedure of this research work is that permission was taken from different universities of Swabi, Nowshera and Peshawar. 500 students including 250 males and 250 females were selected as a sample. The age range of the respondents was from 17 years to 25 years and their selection was random (lottery method of selection). They were from 1st year to final year of MSc. Rapport was developed with the students and they were provided with a consent form. This was got signed in order to ensure the willingness to participate in the process.

After this, clinical interviews were conducted to collect personal information, educational background, nature of problem they face, interval and strength of the problem and the information regarding any psychopathology. In the next step, Liebowitz social anxiety scale was administered. The students who scored between 55 to 80, they were further assessed with the symptom checklist of social anxiety disorder derived from DSM IV in order to screen them for social anxiety disorder. The people with the score less than 55 were excluded and those who had most of the symptoms of this disorder were included for further screening.

In the second phase, the influence of social anxiety disorder on the numerous features of personality were investigated through Rosenberg self-esteem scale, shyness scale, and introversion scale. Socially anxious students parenting style were measured through Measure of Parenting style (MOPS). All the students were ensured that their score will be kept confidential.

In the third phase of the study, non-anxious students were given four psychological tests, i.e. Rosenberg self-esteem scale, shyness scale, introversion scale, and Measure of parental style
were administered on each of them individually to get some relevant information about their various aspects of personality, and parenting style of parents.
CHAPTER V

RESULTS

The goal of this research is to study social anxiety disorder and its psychological correlates among university students. “The research attempted to empirically examine the relationship between social anxiety disorder, shyness, self-esteem, introversion, and Social anxiety disorder relationship with over control and rejecting parenting style”. The researcher further investigated the rural-urban area and birth order relationship with social anxiety disorder.

“The data analysis is mainly consisted of the chi-square, t-test, and one way analysis of variance”. All statistical analysis was carried out with the help of statistical software SPSS (statistical package for social science).
Figure No 1

“Gender distribution of anxious and non anxious students (N = 500)”
Table No. 1 shows the frequency distribution of male and female, anxious and non-anxious students. This is showing that female students have been found to be more anxious as compared to male students. Among male respondents, 50% were anxious while among female respondents, 65.2% were anxious. The frequency difference is statistically significant at p<.01.
Figure No 2

“Mean difference and t-value of Anxious and Non anxious students on over control parenting style (N=500)”
Table No 2

“Mean difference and t- value of Anxious and Non anxious students on over control parenting style (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – Anxious</td>
<td>212</td>
<td>3.75</td>
<td>2.594</td>
<td>8.824***</td>
</tr>
<tr>
<td>Anxious</td>
<td>288</td>
<td>6.05</td>
<td>3.042</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001;df=498

Table No. 2, shows the mean difference between male and female anxious and non anxious students on over control parenting style sub scale of MOPS. This figure shows that the students with more parental control are more anxious as compared to those who do not have strict parental control.
Figure No 3

“Mean difference and t-value of Anxious and Non anxious students on rejecting parenting style, introversion, shyness, and self-esteem scale (N=500)”
Table No 3

“Mean difference and t-value of Anxious and Non anxious students on rejecting parenting style, introversion, shyness, and self-esteem scale (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – Anxious</td>
<td>212</td>
<td>1.16</td>
<td>1.891</td>
<td>9.905***</td>
</tr>
<tr>
<td>Anxious</td>
<td>288</td>
<td>3.44</td>
<td>2.928</td>
<td></td>
</tr>
<tr>
<td>Non – Anxious</td>
<td>212</td>
<td>27.82</td>
<td>9.550</td>
<td>17.759***</td>
</tr>
<tr>
<td>Anxious</td>
<td>288</td>
<td>41.07</td>
<td>7.117</td>
<td></td>
</tr>
<tr>
<td>Non – Anxious</td>
<td>212</td>
<td>30.11</td>
<td>9.398</td>
<td>18.718***</td>
</tr>
<tr>
<td>Anxious</td>
<td>288</td>
<td>45.40</td>
<td>8.724</td>
<td></td>
</tr>
<tr>
<td>Non – Anxious</td>
<td>212</td>
<td>14.91</td>
<td>4.125</td>
<td>15.640***</td>
</tr>
<tr>
<td>Anxious</td>
<td>288</td>
<td>10.03</td>
<td>2.838</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=498

In Table No. 03, we see the mean difference between anxious and non anxious students on rejecting parenting style sub scale of MOPS, introversion scale, shyness scale, and self-esteem scale. The figure shows that more the rejecting parenting style, more is the anxiety among children, scores on introversion scale and shyness scale is higher for socially anxious students. Figure also shows that anxious students self-esteem is low as compared to non-anxious students.
Figure No 4

“One- way ANOVA results of male and female of urban and rural area (N=500)."
Table No 4

“One-way ANOVA results of male and female of urban and rural area (N=500)”.

<table>
<thead>
<tr>
<th>Area</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Urban</td>
<td>51.68</td>
<td>12.86</td>
<td>56.47</td>
<td>12.270</td>
<td>54.45</td>
<td>12.72</td>
</tr>
<tr>
<td>Rural</td>
<td>52.12</td>
<td>12.087</td>
<td>67.07</td>
<td>14.50</td>
<td>60.24</td>
<td>14.42</td>
</tr>
<tr>
<td>Total</td>
<td>53.77</td>
<td>12.487</td>
<td>61.32</td>
<td>12.70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

“There is a significant main effect on anxiety score between male and female”.

F(1,495) = 51.249; P<.001

“There is a significant main effect on anxiety score between rural and urban areas”.

F(1,495) = 36.064; P<.001

“There is highly significant interaction effect between gender and area on the anxiety score”.

F(1,495) = 9.404; P<.001
Figure No 5

“Mean difference and t-value of Anxious and Non anxious students and birth order (first and last born) (N=280)”
Table No 5

“Mean difference and t-value of Anxious and Non anxious students and birth order (first and last born) (N=280)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st born</td>
<td>163</td>
<td>62.72</td>
<td>15.39</td>
<td>5.074***</td>
</tr>
<tr>
<td>Last born</td>
<td>117</td>
<td>53.69</td>
<td>13.625</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=278

Table no 5 shows the mean difference between first born and last born students and social anxiety disorder. The figure shows that first born students have higher anxiety as compared to last born students.
Figure No 6

“Mean difference and t-value of introversion on introversion scale and birth order (N=280)”
Table No 6

“Mean difference and t-value of introversion on introversion scale and birth order (N=280)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st born</td>
<td>163</td>
<td>38.58</td>
<td>10.47</td>
<td>5.141***</td>
</tr>
<tr>
<td>Last born</td>
<td>117</td>
<td>32.09</td>
<td>10.34</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=278

Table no 6 shows the mean difference between first born and last born students and introversion on introversion scale. The figure shows that first born students scored high on introversion scale as compared to last born students.
Figure No 7

“Mean difference and t-value of shyness and birth orders on shyness scale (N=280)”
Table No 7

“Mean difference and t-value of shyness and birth order on shyness scale (N=280)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st born</td>
<td>163</td>
<td>42.37</td>
<td>11.661</td>
<td>4.111***</td>
</tr>
<tr>
<td>Last born</td>
<td>117</td>
<td>36.60</td>
<td>11.506</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001;df=278

Table no 7 shows the mean difference between first born and last born students and shyness on shyness scale. The figure shows that first born students scored high on shyness scale as compared to last born students.
Figure No 8

“Mean difference and t-value of self-esteem and birth order on self esteem scale (N=280)”
Table No 8

“Mean difference and t-value of self-esteem and birth order on self esteem scale (N=280)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st born</td>
<td>163</td>
<td>11.19</td>
<td>4.076</td>
<td>3.344***</td>
</tr>
<tr>
<td>Last born</td>
<td>117</td>
<td>12.88</td>
<td>4.272</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=278

Table no 8 shows the mean difference between birth order and self esteem on self esteem scale. The figure shows that first born students scored low on self esteem scale as compared to last born students.
Figure No 9

“Mean difference and t-value of rural urban area and social anxiety on liebotwitz social anxiety scale (N=500)”
Table No 9

“Mean difference and t-value of rural urban area and social anxiety on liebowitz social anxiety scale (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>234</td>
<td>54.45</td>
<td>12.720</td>
<td>4.722***</td>
</tr>
<tr>
<td>Rural</td>
<td>266</td>
<td>62.24</td>
<td>14.424</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=498

Table no 9 shows the mean difference between rural and urban area and social anxiety on liebowitz social anxiety scale. The figure shows that rural area students have higher level of anxiety low self esteem as compared to urban area students.
Figure No 10

“Mean difference and t-value of rural urban area and introversion on introversion scale (N=500)”
Table No 10

“Mean difference and t-value of rural urban area and introversion on introversion scale (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>234</td>
<td>32.53</td>
<td>10.078</td>
<td>5.987***</td>
</tr>
<tr>
<td>Rural</td>
<td>266</td>
<td>37.99</td>
<td>10.253</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=498

Table no 10 shows the mean difference between rural and urban area students and introversion on introversion scale. The figure shows that rural area students scored high on introversion scale as compared to urban area students.
Figure No 11

“Mean difference and t-value of rural urban area and shyness on shyness scale (N=500)”
Table No 11

“Mean difference and t-value of rural urban area and shyness on shyness scale (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>234</td>
<td>36.16</td>
<td>11.903</td>
<td>4.987***</td>
</tr>
<tr>
<td>Rural</td>
<td>266</td>
<td>41.30</td>
<td>11.115</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=498

Table no 11 shows the mean difference between rural and urban area students and shyness on shyness scale. The figure shows that rural area students scored high on shyness scale as compared to urban area students.
Figure No 12

“Mean difference and t-value of rural urban area and self-esteem on self esteem scale (N=500)”
Table No 12

“Mean difference and t-value of rural urban area and self-esteem on self esteem scale (N=500)”

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>234</td>
<td>12.94</td>
<td>4.184</td>
<td>4.254 ***</td>
</tr>
<tr>
<td>Rural</td>
<td>266</td>
<td>11.36</td>
<td>4.086</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001; df=498

Table no 12 shows the mean difference between rural and urban area students and self-esteem on self esteem scale. The figure shows rural area student’s scored low on self-esteem scale as compared to urban area students.
CHAPTER VI

DISCUSSION

This research work was aimed to study the prevalence of social anxiety disorder in university students and the comparison between psychological correlates and parenting styles of socially anxious and non-anxious students. The participants of the research study were 500 rural or urban area university students. Out of them 250 were male students and 250 were female students.

The present study shows a major distinction between the students who were anxious and those who were non-anxious and their psychological correlates (self-esteem, shyness, introversion) and parenting style (over control, rejecting).

Social anxiety disorder has been observed comparatively high in female students as compared to male students in our culture. There are number of reasons which cause the higher ratio of social anxiety disorder among the students. In this research the detail study has been carried out to sort out the main factors which can lead to the development of this disorder in female students.

The results of the research work shows that female scored high on the “Liebotwitz Social anxiety scale” as compared to those of male students (Table no 1) which is in accordance with the first hypothesis of the present study. It has been found that out of 250 male students 50 percent were anxious while out of 250 female students 65.2 percent were found to be anxious which shows that the ratio of female students is higher. Conrad (1999) also presented the same type of findings. He showed that there were more females who were identified with social anxiety disorder and the severity of their disorder kept on increasing with age. The strength of
social fear was higher as compared to social anxiety. The people used to be fearful in specific situations like doing anything in the presence of people around, and speaking in front of people. Social anxiety is also there among the patients with depressive disorders, somatoform disorders, and substance abuse disorders. According to the present findings it has been found that generalized social anxiety disorder which is a sub type of social anxiety disorder is more among female students. The result was similar to the earlier findings of the previous researches, most of the literature describes prevalence, impairments, patterns of co-morbidity and other correlates of DSM IV social anxiety among adults and adolescents with distinctions between generalized and non-generalized social anxiety disorder. It was also seen that the occurrence of life time social anxiety in females is higher than males. In females the percentage is 9.5 and in males it is 4.9 percent. The patients of social anxiety report an early onset, more persistent signs and symptoms, more severe damages, more co-morbidity, higher cure rates and indicated that the parents were suffering from the same disorder as compared to those of non-generalized social anxiety (Wittchen and Kessler, 1999).

Stein and colleagues (2000) studied how the social anxiety affects the lifestyle, the functioning of life, and the person’s level of satisfaction. They also suggested that depression is a very common condition seen in the people suffering from social anxiety. They studied all the factors mentioned in accordance with the age, sex and social status and class. They presented that females were more likely to suffer from social anxiety and it was also noticed that level of social anxiety was significantly higher among the age group of 15 to 24 years.

Liliana (2002) investigated “certain psychopathological feature in addition to the gender differences across the social anxiety spectrum”. The finding indicates that “women student reported more symptoms than men student and display a profile of social anxiety spectrum that
differs quantitatively but not qualitatively from men’s profile”. Fredrikson (1999) proposed that 15.6 percent of the people in the society had the social anxiety disorder and among them the most commonly occurring problem was speaking in front of people. It was also found that females had higher level of anxiety, people with low educational achievements had higher level of anxiety, the medication affected the anxiety and those with less social support were more susceptible of social anxiety disorder.

Keeping in view the above mentioned facts, and findings of the present study there seems to be certain factors and reasons which cause social anxiety disorder in females as compared to those of males.

In our culture, males are dominated and they receive special care and attention from the parents. They are preferred in families and on the other hand, females do not receive such attention. This is the major factor which affects the personality and psychology of females. This leads to social anxiety disorder and as a result, females remain unable to show their abilities and even feel uncomfortable in social gatherings. Similarly there is another major issue in our society that is, when the female students leave for the universities they have to face obstacles in the form of non-supportive attitude, male dominancy, lack of due respect, and financial support, because in our culture parents prefer to spend money on education of males as compared to females. As a result female are very much conscious regarding their image, performance and any mishap in the university or college which may bring bad name or discontinuation of their studies, which further induce insecurity and anxiety in them, as a result they become overcautious in expressing themselves in different situation, which if continue may lead to social anxiety disorder.

The result of the study yield consistent relationship between social anxiety disorder and
parenting style which is in accordance with the second hypothesis. The second hypothesis states that the parents of the children suffering from social anxiety are more protective and rejecting than those of non-anxious children (Table 2 and 3). The results also showed the fact that the scores of socially anxious students are very high on parenting style scale than those of non-anxious students. These findings are in accordance with the researches done in the past. Bogels, Oosten, and Smulders (2000) explored whether the students who are more anxious are of the view that their parents are very protective, rejecting and do not show warmth to their children. They also tend to emphasize that parent’s opinions are always right and there is a lack of social activities from the parents. The parents do not encourage social interactions. They also investigated whether the parents of socially anxious students believe that these practices are right and they themselves are socially anxious and have fears of interacting with others. It was seen that this affects the children and develops social anxiety among them. The children who were overprotected by their mothers were found to be more socially anxious. In additions, the mothers who themselves were socially anxious had socially anxious children. Caster (1999) investigated what children think about the parenting styles of their parents, family environment and the effects on children’s social anxiety. The children who were socially anxious reported that their parents have very few social interactions, gave importance to their own opinions, thought that they are shy and not good performers and were socially inactive as compared to those with lower levels of social anxiety. As far as the parents’ opinions are concerned regarding the parenting styles, the views were almost same of both parents of socially anxious and non-socially anxious children.
The above findings of the present study as well as literature review, revealed that unnecessary restriction in the form instructions, dictations of parents in every field and sphere of life, cause social anxiety disorder among children. However children of those parents, who have the normal and moderate attitude, do not face such type of psychological disorder. Similarly the social anxiety disorder is found more in the children who are usually criticized by their parents. This has also been found comparatively higher in the children of those parents who are preoccupied others opinion regarding their children. Furthermore the parents who do not pay proper attention and are careless and even ignore their children, they will have to suffer a lot from social anxiety disorder.

The results of this research work are in accordance with the third hypothesis that “socially anxious students scored high on introversion scale, shyness scale, and low on self-esteem scale as compared to non-anxious students” (Table no 3). The results showed that the relationship between social anxiety disorder and personality correlates is consistent. “Finding indicates that level of shyness and introversion is high and level of self-esteem is low among socially anxious students”. Previous studies showed the same finding as Heiser, and Turner (2003) cross-examined “the correlation of shyness, social anxiety and certain other psychiatric disorders”. He found that there were more chances of shy people to be socially anxious. But this does not mean that all the shy people are socially anxious. The data showed that 82 percent of shy people were not found to be anxious. “The positive correlation was seen between the level of social anxiety and severity of shyness. The correlation was moderate between social anxiety and introversion and neuroticism”. Results also showed that shy people suffering from social anxiety disorder were shyer. They were found to be more reserved, quiet and neurotic as compared to the shy people with no social anxiety. “It was also seen that the psychiatric diagnosis was higher in the shy people with social anxiety as compared to those who were not shy”. This shows that shy
people have more chances to be socially anxious. Wilson, and, Rapee (2005) reported “two studies which were aimed to study the beliefs about self-attributes in social anxiety and the level of uncertainty with which these beliefs are held. The findings of both studies suggested that socially anxious person had more negative feelings about their personality as compared to non-anxious people. Moreover, the people with social anxiety had less confidence in themselves”. Shepherd & Robert (2009) investigated the “relationship between social anxiety and the other variables including locus of control, depression, ego strength, self-esteem, anxiety and the ways to cope in a sample chosen from university students”. There were high scores of social anxiety which were related to high scores on measures of anxiety and depression, low ego strength, low self esteem, external locus of control and emotion coping rather than problem focused coping. These results are coherent and not projective of causation. They can raise a lot of problems with regards to theory, anticipation, interference and stimulating mental health among the university students.

In the light of aforesaid study, analysis and review of earlier studies, it can be concluded that social anxiety disorder brings worst impression on the personality traits such as shyness, introversion, and self-esteem. The student who has the problem of social anxiety disorder are self-centered, underestimate themselves and consider their entity as worthless and avoid gathering, public interaction as well as cannot take active part in the activities of routine life as compared to non-anxious students.

The finding of the present study supported the hypothesis that socially anxious student scored high on introversion scale, shyness scale and low on self-esteemed scale as compared to non-anxious students. (Table no 3).

Present study supported the fourth and fifth hypotheses, that rural area students would
have high social anxiety as compared to urban area students and social anxiety would be more prevalent among rural area female students as compared to rural areas male students (Table no 4, 9, 10, 11, and 12). The results of this study are in accordance with the hypothesis as it has been noticed that the level of social anxiety is higher in rural area students than in urban area students. Also, female students belonging to rural area are more socially anxious as compared to male students of rural areas.

The findings of the present study is also supported by the study conducted by Mohammadi et al, (2006) are similar. Mohammadi et al, (2006), studied the occurrence of social anxiety in the general population of Iran in consideration with the social demographic features of individuals with Social anxiety, and its “Co morbidity with other lifetime psychiatric disorders”. The life time prevalence of Social anxiety was 0.82 percent. The rate in females was 1.3 and in males was 0.4. Younger people had higher rates. There was no association of social anxiety with residential area and educational background. “Specific phobia 66.7 percent, obsessive compulsive disorder 17.4 percent, major depressive disorder 15 percent, and panic disorder 12.1 percent where the most common life time psychiatric disorder among subjects with Social anxiety”. “The rate of Social anxiety in Iran is more similar to that in other Asian countries, and it is lower than that in western countries”. “The rate of other psychiatric disorder among subjects with Social anxiety is more than that in the general population, and the most common psychiatric disorders were the other anxiety disorder and major depressive disorder”. Pillai, et al (2008) investigated the occurrence and relationship of mental disorders in adolescents. A sample of adolescents was selected randomly from six urban areas and four rural areas. The commonly seen disorders are as follows. 1 percent people had anxiety disorders, 0.5 percent people had depressive disorders, 0.4 percent people had behavioral disorders and 0.2 percent people had attention deficit hyperactivity disorder. The girls from urban areas who had
ever experienced gender discrimination were more affected. “The final multivariate model found an independent association of mental disorders with an outgoing nontraditional life style (frequent partying, going to the cinema, shopping for fun and having a boyfriend), difficulties with studied, lack of safety in the neighborhood, a history of physical or verbal abuse and tobacco use”. Those who had their family supports were less susceptible to mental disorders.

According to Susan and Chong (2005) disruptive behavioral disorders which are the disorders in which the person’s conduct is affected are actually the substance use disorders. These disorders are seen to be more common in the boys living in rural areas as compared to the girls living in those areas. The opposite was seen in the depressive disorders. Girls were reported to have more anxiety disorders as compared to boys. The most commonly occurring anxiety disorders among girls were phobia and social anxiety.

The findings of the present study suggest high prevalence of social anxiety disorder among rural area students as compared to urban area students which may be due to the fact of less qualified teachers and their inappropriate/less attention towards personality development of the students. On the other hand in urban areas teachers are well-qualified and focusing on grooming the personalities of the students which built confidence and good communication skills.

Present study result also supported the sixth hypothesis that, level of social anxiety would be high among first born students as compared to last born (Table no 5,6,7 and 8). Finding of the result also showed that first born scored high on shyness scale and introversion scale and low on self-esteem scale as compared to last born students. Studies as by Tramontana (2009) investigated the relationship between anxiety and birth order. The researcher presented a hypothesis that the last born child had least anxiety and the first born had the most general
anxiety. The middle children had the least anxiety among all the children. Another hypothesis was that only child was least likely to have any anxiety disorder. In this study, the sample included 21 males and 73 females who were all undergraduate students. Out of all the respondents in the sample, 35 were first born, 33 were last born and 19 were middle children. 7 were the only children. The researcher used Brief symptoms inventory survey in order to determine the anxiety levels. The hypothesis was not accepted and the results showed that birth order and anxiety level had no correlations. Eisenmen (1992) showed that some first born are anxious while others are creative. The reason for this can be that the parents are more preventive and worried for their first child or the first child spends more time alone with his parents (Guastello, 2002). In case the birth order would affect the anxiety level, this means that the eldest child would have maximum anxiety, youngest one and the only one would have least anxiety. The research results were not significant which does not support any of what was hypothesizing (Wilkinson, 2002).

It has been observed that the social anxiety disorder is high among the first born child as compared to the last born. The main reason behind this which may be, that the first born child is given proper attention, affection as well as care but gradually when the family expands and the attention diverts or divides which cause insecurity, jealousy, anxiety, and social isolation among first born. In addition to this, in our society the parents expects more from first child which may lead to high level of social anxiety disorder among them as compared to the last child.
CHAPTER VII

CONCLUSION

Social anxiety disorder is the 3rd main psychiatric disorder, which is increasing day by day in our society and culture. Reliable and authenticated information about this disorder is essential for the diagnosis, and its worst affect as well as impact on the personalities of the university students. The present research work was aimed to explore the occurrence and psychological correlations of social anxiety disorder among the university students. The outcomes and results of this research work recommend that social anxiety disorder disturbs the personality traits of the students.

Social anxiety disorder is more among the female students living in rural area but the result of the present study showed that social anxiety disorder is more among the female students irrespective of their living or residential areas. It can be simply said that it is more and common in female students either living in rural areas or urban areas as compare to the male students.

Furthermore parents being the first and initial school for their children, play a very major and vital role in the child physical, mental, moral and emotional development. Parenting rearing practices provide base for the development of various aspect of personality. The present research suggests that over control and rejecting parenting style developed social anxiety disorder in the children. Socially anxious students rate their parenting style as over control and rejecting.

The result of the present study also revealed that social anxiety disorder affect personality trait such as shyness, introversion and self esteem.
Birth order has positive as well as negative aspects which affect the personalities of the students. In negative aspects one of them is the development of psychological disorders. The findings of the research suggest that first born students have more social anxiety disorder.
LIMITATIONS OF THE CURRENT STUDY

The first limitation is that only students were focused however any person can be affected by social anxiety disorder. Then the socially anxious students with no parents and divorced parents were not focused. While choosing the sample, Socio economic status of respondents was not considered. Parents’ education was also not taken into consideration. Another major limitation of this study is that data was collected from only one province i-e Khyber Pakhtunkhawa and the other three provinces were ignored, because of cultural differences, there may be different findings from other provinces.

The total sample was about 500 students that is too short to gernalize the results through out the population.
SUGGESTIONS

This research work has a scope for future research and this can be expanded to explore certain other issues which are in relation but have not been covered in this research work. The sample used in this research was only university students while the same research can be done on any other population sample. This can benefit in a way that the sample of the people from different age groups can be studied and then a comparison can be made. Moreover, the people from different geographic areas can be selected and then their results can be compared. This will help to examine the anxiety level of people in different parts of the country in relation to the possible reasons behind them. This will enhance the knowledge in this particular area of research.

The research is conducted only on university students and students having parents irrespective of their educational level whereas it is recommended that in future, school level students, students having no parents and in case the parents are alive their educational level could also be taken in to consideration for research.

Socio economic factor can be taken into account to study the factors affecting the social anxiety disorder.

Research shows that the parenting style is one of the significant reason in the development of social anxiety disorder, therefore it is suggested that parents training should be conducted in order to help them in adopting better parenting style. Academic institution should provide psychological consultation and proper psychotherapeutic measures for those students who are suffering from social anxiety disorder so that they can cope with it effectively.
Teachers training programme should also need to be conducted so that they can identify such cases at initial stage which will further help the students to seek treatment at proper time.
REFERENCES


