SOCIAL ANXIETY IN ADOLESCENTS

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Abstract

It has been argued that the history of anxiety and depression should be interpreted as an interaction of cultural changes as well as changes not only in psychopathological symptoms per se, but also in their scientific interpretation, hence the increased interest in addressing such a topic and in carrying out an approach of knowing the peculiarities and emphases characteristic to such an analysis. The current fascination of clinicians and researchers with the biological approach, therefore, comes as no surprise. This approach seems to hold the promise of control and tangible results, in contrast to the unpredictable and much less concrete results achieved by the psychological and social intervention. However, it is necessary to issue a warning at this time, since history has shown us how difficult psychopathological reality can be resolved. The history of the classification of anxiety and depression serves to emphasize that a dose of scepticism was often appropriate. Whenever attempts have been made to refine a particular theory, or combination of theories, the clinical reality has always been shown to have an overabundance of ambiguity and unpredictability. In general, the longitudinal clinical observation has advanced the idea of classifying anxiety disorders, and especially mood disorders, more than any other classification based on preconceived theoretical assumptions. Given the controversy between unitarians and separatists, a combination of longitudinal and interdisciplinary (bio-psychosocial) research would seem to hold a particular promise for the future (Kasper et al., 2003).

Keywords: *social anxiety, adolescents, depression, mood disorder*.

I. THEORETICAL PART

1. INTRODUCTION

Social anxiety. General framework

1. Definitions

Anxiety is an uncomfortable, vague, diffuse affective state. The anxious person exhibits an intense feeling of insecurity without objective reasons. Anxiety is a mental disorder. It can be accidental, caused by certain external excitements or it can be permanent, being one of the psychic traits of an individual.

Spilberger defines anxiety as "an emotional state or unpleasant condition, characterized by a tense, subjective situation, fear and anger, being stimulated by the activity of the autonomic nervous system" (Vîtu, 2007). Anxiety is "an affective state characterized by a feeling of insecurity, of diffuse disorder" (Silamy, 1972), a "predisposition of a person to anxious states" (Larousse, 2006).

"Anxiety is an affective disorder manifested by states of restlessness, fear and unmotivated worry, in the absence of causes which may trigger them. Anxiety is defined as a fear without an object, unlike phobia which represents a fear with an object, the subject has the impression of impending misfortune. The states of anxiety are accompanied by organo-functional phenomena such as: palpitations, shortness of breath, etc." (Popescu-Neveanu, 1978; Marsee et al., 2008).

"Anxiety is an emotion. It is a subjective sensation that accompanies the body's response, either real or perceived" (Stan, 2008).

Anxiety is an objectless fear. Fear involves the presence of objects or events. Anxiety is a more general emotional state. "Anxiety is irrational ... it is comprised of... fear, anger and nervousness" (Robu, 2011).

Anxiety differs from fear in terms of the duration and intensity of symptoms. Fear disappears, anxiety can be chronic.

"Fear, the normal reaction to a real or imagined danger, is different from phobia or clinical fear. Thus, fear reactions such as panic attacks or phobias stem from three 'fundamental fears': fear of negative evaluation, sensitivity to anxiety, and sensitivity to disease" (Byrne, 2000).

Phobia – an unjustified, very intense and persistent fear regarding a certain thing, situation. Panic has a higher level of intensity than anxiety.

Panic appears and disappears suddenly. Anxiety evolves slowly and becomes permanent.

"Anxiety disorders can be defined as states characterized by pathological anxiety" (Starcevic, 2005). Given the fact that the pathological anxiety has been postulated as a sine qua non condition of anxiety disorders, it is important to first distinguish between pathological and normal anxiety. Anxiety and fear are used here as alternative terms (both denote a response to a perceived threat and danger), although some argue that there are no conceptual differences between them.

There is a broad consensus that pathological anxiety and normal anxiety can be differentiated based on criteria. They are common to all components of anxiety: subjective, physiological (somatic), cognitive, and behavioural. Although the criteria may seem clear, in practice it can be difficult to draw a precise line between pathological and normal anxiety.

"The most common response to a stressor is anxiety." (Smith, et al., 2005).

"It is often assumed that normal anxiety has an adaptive role because it serves as a signal: that there is danger and that measures need to be taken (e.g. a fight or flight response) to protect against that danger; both perceived danger and the measures taken are considered appropriate (i.e., not exaggerated) in normal anxiety" (Starcevic, 2005).

"Anxiety disorders include a group of disorders in which anxiety is... the main symptom." (Smith et al., 2005).

Although the existence of social anxiety disorder as a psychopathological entity has been known for at least 100 years, it was only relatively recently, with the publication of DSM-III in 1980, when the social anxiety disorder or social phobia as it was then called, acquired the status of official psychiatric diagnosis.

"Social anxiety includes an excessive fear of interpersonal relationships and potential humiliation as a result" (Erath, et al., 2007; Holdevici, 2011). This problem begins to appear mainly in pre-adolescence and adolescence, facilitating the phenomenon of "social phobia," which is seen around the age of 15. Early identification of social phobia, as well as treatment can significantly reduce negative the consequences, which is why discovering the factors that can generate this problem in pre-adolescence is crucial.

2. CLASSIFICATIONS

Anxiety disorders were introduced in 1980 as a distinct nosological group in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (Starcevic, 2005). Before DSM-III, anxiety disorders were conceptualized as *neuroses*, and comprised four conditions: (1) anxious neurosis; (2) phobic neurosis; (3) obsessive-compulsive neurosis, and (4) traumatic neurosis. In DSM-III, anxious neurosis was divided into panic disorder and generalized anxiety disorder, while phobic disorders were divided into agoraphobia, social phobia (social anxiety disorder), and simple (specific) phobias. Anxiety disorders have been retained as a distinct nosological group in subsequent DSM revisions since the fourth edition, DSM-IV (American Psychiatric Association, 1994, apud. Starcevic, 2005) until text revision in DSM-IV, DSM-IV-TR (Portman, 2009; Fresco et al., 2001).

However, the conceptualization and diagnostic criteria for all psychopathological entities within anxiety disorders have undergone changes from DSM-III, to DSM-IV-TR. In DSM-IV-TR, the group of anxiety disorders includes the following diagnostic entities: panic disorder (with or without agoraphobia), agoraphobia without history of panic disorder, generalized anxiety disorder, social anxiety disorder (social phobia), specific phobia, obsessive-compulsive disorder, acute stress disorder, posttraumatic stress disorder, anxiety disorder due to a general medical condition, substance-induced anxiety disorder, unspecified anxiety disorder.

"Within anguish, somatic disorders predominate, while anxiety can rather be talked about when anxiety is experienced psychologically" (Robu, 2011).

An unspecified anxiety disorder is a residual diagnostic category, to be used in those situations where a diagnosis of a specific anxiety disorder cannot be ascertained (Starcevic, 2005).

In the latest version of the International Classification of Diseases, ICD-10 (Starcevic,

2005), anxiety disorders have not been granted a separate, independent status. Instead, they are part of a larger group of disorders called neuroses, stress-related and somatoform disorders. Within such a group, anxiety disorders encountered in the DSM system are placed into four subgroups that resemble the pre-DSM-III classification. For most anxiety disorders there are important differences between how they are conceptualized and diagnosed in the DSM and ICD systems. "In addition, ICD-10 has included in anxiety disorders conditions not present in the DSM (e.g., mixed anxiety and depressive disorder) and conditions that are in the DSM system but classified elsewhere (e.g., adjustment disorders)" (Starcevic, 2005).

3. SUBTYPES: GENERALIZED AND NON-GENERALIZED SOCIAL ANXIETY DISORDER

Social anxiety disorder comprises two subtypes: generalized and non-generalized (called focal, isolated, limited, discrete, circumscribed, and specific). Generalized social anxiety disorder is the term used to characterize the fear of numerous social situations, which include both performance and interactional situations; non-generalized social anxiety disorder refers to the fear of one or only a few such situations, and these are usually (though not invariably) performance-type situations.

"Subtypes of nongeneralized and generalized social anxiety disorder can be conceptualized on a continuum of severity and characteristics associated with severity. This predicts differences between these subtypes of social anxiety disorder, which are mainly quantitative in nature" (Starcevic, 2005). Given the relatively few qualitative differences and unclear boundaries between the two subtypes, in many cases the reason for dividing social anxiety disorder into subtypes is not unequivocally supported by existing clinical data and research.

"In a form of anxiety disorder, generalized anxiety, the person experiences a constant feeling of tension and fear." (Smith et al., 2005).

In clinical evidence, generalized social anxiety disorder is more common than non-generalized social anxiety disorder, but their prevalence appears to be different in the community, with the ratio of generalized to non-generality being one to two (Starcevic, 2005). The main reason for this difference between clinical and epidemiological evidence is the higher degree of severity in the generalized form of social anxiety disorder; Sufferers of this type are more likely to seek professional help. While the prevalence of non-generalized social anxiety disorder in clinical experiments is similar between women and men, there appear to be more men than women with generalized social anxiety disorder under the same conditions.

One form of anxiety disorder is generalized anxiety disorder. People suffering from this anxiety disorder are usually very tense and worry excessively. They have profuse sweating, redness of the face, palpitations and excessive disorders. These somatic manifestations can occur without an obvious cause (Tallis, 1996).

The onset of generalized social anxiety disorder is usually gradual and dates back to the patient's adolescence or childhood. Patients usually say that they have always been shy and anxious in social situations. "In the non-generalized subtype of the social anxiety disorder, onset after adolescence is not uncommon and may be relatively abrupt, for example, after an unpleasant or traumatic event, manifesting sudden redness, shaking, loss of voice, or even a panic attack while having a discussion" (Starcevic, 2005; Flanagan et al., 2008).

A genetic link appears to be stronger for generalized social anxiety disorder. Patients with generalized social anxiety disorder are significantly more likely to have a first-degree relative with generalized social anxiety disorder than the control group. The frequency of first-degree relatives with social anxiety disorder, by contrast, was similar among patients with non-generalized social anxiety disorder compared to control subjects.

Social anxiety in adolescents

1. DEFINITIONS

"Adolescence, with its biological, psychological and social development, is a stage in human life, considered by specialists as an "anxiety phase"

(Ulete, 2008). When it crosses a certain limit or exceeds a certain degree of intensity and duration, the individual slides into pathology. A distinction is made between symptomatic anxiety and veiled, conscious anxiety.

For some authors, anxiety and anguish are identical. This identity is argued by the fact that "anxiety is accompanied by physical manifestations, and anguish is felt psychologically" (Vîtu, 2007). Most psychologists believe that organic disorders predominate in anguish, and anxious individuals experience psychological anxiety. "Restlessness and anxiety are distinguished only by intensity, fear has a known object, while anxiety has a semi-known object" (Vîtu, 2007).

In the case of fear, danger is transparent, objective, whereas in anxiety it is hidden and subjective. When anxiety reaches a higher degree, it becomes psychic anguish that manifests itself through painful affective experiences. The characteristic feature of anxiety is the lack of an object of fear [...] incredibly anxious are the diffuse feeling of insecurity and the feeling of being helpless in the face of threats" (Pearson, 2011).

Anxiety disorders occupy the second most frequent place in child and adolescent psychiatric pathology. In some ways, girls are more affected than boys. This mental disorder persists into adulthood.

It has been found that, worldwide, there are more than 120 million individuals suffering from anxiety. An analysis of the affective states of today's young people, of the existing society, can be found in "The Psychology of Ages" (Şchiopu & Verza, 1981).

"Anxiety disorders are a common type of mental disorder encountered in childhood and adolescence. In adulthood, anxiety interferes with work, relationships and overall satisfaction and increases the risk of depression, suicide or medical problems." (Rapee, et al., 2011). Anxiety increases steadily by the age of 15-16. It evolves with age, from fear of darkness, loneliness or school to fear of the future and the world.

2. CAUSES OF ANXIETY IN ADOLESCENTS

The roots of mental illness can be "intrapsychic, familial, social" (Stan, 2008). "Older adolescents will be concerned about the cause of their anxieties and how treatment will help them" (Rapee et al., 2011).

"Post-traumatic stress disorder ... can occur in children and adolescents who are particularly vulnerable to violence, [...], experiencing disasters ..." (Stan, 2008). Following such traumatic experiences, the individual experiences a sensation of intense fear. There are changes in behaviour manifested by shyness and agitation.

It is sometimes considered that anxiety is acquired. Psychoanalysts believe that anxiety is explained by the frustration of libido (psychic energy related to vital impulses, especially sexual impulses) and prohibitions on the ego, regarding what would be dangerous for me, conscious personalities, "anxiety also constituting a mechanism for mobilizing prevention mechanisms" (Şchiopu et al., 1979).

"Anxious reactions caused by certain stressors such as the presence of imminent danger, an exam or illness, are normal. These reactions dissipate when the stressor has disappeared" (Sillamy, 1972).

Anxiety can be caused by everyday stresses in the family. "All these family aspects have the immediate effect of increasing anxiety rates, especially during adolescence" (Ulete, 2008). Family factors are most important in the emergence and development of anxiety during adolescence. In adolescents, "we are dealing with borderline anxiety that marks the boundary between normal and pathological... It is important that fear and anxiety are detected from the early stages of manifestation in order to prevent undesirable consequences" (Ulete, 2008). During schooling, there is fear of evaluation, of diseases, of injuries.

"In adolescence, there is opposition to routine, skills, learning [...] the adolescent "unknowingly digests everything" (Schiopu & Verza, 1981). Naturally, there are mismatches of opinions, ideas about existence, between different age groups, the most frequent being those between parents and children. "Relationships between parents also appear flat and plain and full of compromises" (Schiopu & Verza, 1981). These intergenerational conflicts are caused by educational differences between parents and children, even during puberty and adolescence. Another area faced by adolescents is that of

death. This outlines an increase in the background of anxiety. However, there are also school, family and social adaptation difficulties, as well as situations of maladaptation and even maladaptation, i.e. deterioration of already formed structures.

3. ETIOLOGY OF SOCIAL ANXIETY IN YOUNG PEOPLE

- **Demographics: gender, age**

The vast majority of psychometric studies with self-report measures of children indicate that girls express social anxiety more often than boys, especially in relation to fear of negative evaluation.

Certain types of social phobias and related constructs also have a higher prevalence among girls. They report fear of performing in public and fear of testing towards boys, although no gender differences were found in eating or drinking in public, or conversing with others (Essau et al. apud. Kearney, 2005, p. 28). At the same time, girls are afraid of making a fool of themselves, of being judged as stupid, weak by nature or crazy, of having panic attacks, of experiencing shame or confusion, or of blushing. Female subjects internalize problems more, are more neurotic, and experience stress at a higher level (Kearney, 2005).

The age at which social phobia is diagnosed in young people occurs in late childhood and adolescence rather than early childhood. Social phobia in children has a bimodal distribution with reference to early age: very early in life, in early adolescence. Many children suffering from such phobias are only considered treatment after the disease has worsened considerably.

"The ways by which adolescents adapt to stressful situations in life vary according to their gender. Thus, women rely on social support, while men focus on problem solving" (Byrne, 2000).

- **Biological vulnerabilities: genetics, concepts related to social phobia**

"There is sufficient empirical evidence that anxiety disorders have a family history" (Beidel & Turner, 2005). If one of the members manifests such a disorder, the percentage of relatives who will inherit this disease is significantly higher than that of people who do not have a relative suffering from anxiety.

Genetic influences account for 34% of the variance in scores of children with social anxiety related to shyness or inhibition behaviours (Kearney, 2005). Studies were conducted on genes, on heredity indices for behavioural inhibition at levels of .64, .56, .51 at the ages of 14, 20 and 24 months, respectively. Changes in shy, inhibited behaviour in the early stages of development appear to be more specific to identical twins than fraternal twins. At the same time, shyness or anxiety-based behaviour of refusing to go to school is also linked to family or hereditary inheritance. Other constructs related to social anxiety have genetic bases including introversion, neuroticism, and high levels of sensitivity. Social anxiety has evolutionary-genetic basis. In essence, it can help maintain social order by predestining certain individuals to submit to more dominant ones, and thus avoiding conflict and forming well-defined hierarchies.

- **Temperament: Behavioural inhibition, negative affects, positive affects, physiological overexcitement and control.**

This specific type of temperament – behavioural inhibition – is associated with characteristics of withdrawal behaviour, closeness only to people who offer help, inactivity and frequent expression of stress, and it is also associated with physiological characteristics such as increased heart rate, blood pressure and muscle tension.

Negative affects are related to anxiety, low positive affects with depression, and physiological overexcitation with fear. One line of research that received particular attention focused on the idea of perceived control over one's own environment. "In essence, there are authors who propose that previous experience of uncontrollability (i.e., inability to control outcomes) and unpredictability about everyday life events is a generalized psychological vulnerability that helps produce negative emotions and then anxiety disorders" (Kearney, 2005). Thus, control can become a mediator between stressful events and negative affects, so that negative experiences of lack of control

accumulate over time and facilitate anxiety and depression.

- **Generalized psychological vulnerabilities**
  Cognitive and affective characteristics

Children with high levels of social anxiety exhibit cognitive and attributional biases, selectively choose threatening stimuli in ambiguous situations, engage in self-denigration, emphasize negative outcomes, and have poor coping skills even in situations that pose no danger. Young people with social phobia are often described as overly self-aware, highly focused on their level of stimulation, highly sensitive to indicators of negative evaluations of others, overestimating threats from others, and underestimating their own social skills with thoughts about negative endings, self-depreciation, shame, ridicule, rejection, and negative estimates.

Epkins (Kearney, 2005, p. 57) states that "young people suffering from social anxiety show more *cognitive distortions*, and by using social-evaluative role play and reading tasks, they experience a higher level of anxiety before completing these tasks and have lower expectations of solving them successfully." Adolescents with social phobia do not anticipate the presence of positive social events, but no significant differences were found in encountering social situations with negative aspects. Research findings show that when presented with stories with ambiguous themes, anxious children were significantly more negative in interpreting the negative aspects of the text, but did not notice significant differences in the positive ones. These young people exhibit dysfunctional cognitions and underestimations of competence.

Daleiden and Vasey (Kearney, 2005), highlight the cognitive process underlying findings of social anxiety behaviour in young people. In terms of information processing, the latter selectively choose, focus and are distracted by threatening environmental stimuli. Thus, these children can also understand ambiguous stimuli as situations that provoke fear, make negative attributions and assume negative results, and feel unable to cope with the dangers and anxiety that accompany them. This way of processing information can lead over time to an exaggerated practice of such escape and avoidance strategies to ensure their personal safety and thus fail to coherently evaluate their own anxiety-provoking thoughts in those situations.

- **Parental and family features**
  Parenting style and family environment

Parents of anxious children are described as controlling, biased, intrusive, unaffectionate, overprotective, highly demanding, encouraging avoidance behaviours, discouraging proactive or prosocial behaviours, and promoting withdrawal, avoidance, and social isolation. Expressed maternal emotion is closely related to inhibition behaviour in young people, shyness is evident in parents and foster children, and lack of authoritarian parenting is linked to peer rejection and low levels of social competence (Kearney, 2005; Collins et al., 2005).

Some of the practices that facilitate the development of social anxiety are: isolating children from social activities, overemphasizing negative opinions and evaluations of others, low family sociability, behaviours lacking warmth and support, rejection of the child, general instability characterized by separation, lack of close relationships, parental conflicts, dropping out of school or running away from home.

Children in this situation see their parents as overly preoccupied with the ideas of others, ashamed of the shyness and poor performance of young people, and focused on isolating them. The social anxiety of adolescents positively correlates with an overprotective parenting style, rejection, family cohesion, low communication and low levels of personal development encouragement.

The perspective of both parents is important in this respect. A probable cause for this situation is the difference in attitude. For example, in terms of school performance, mothers are probably more sensitive than fathers to problems with social adjustment and self-esteem derived from anxiety, details more visible to a caring person who, stereotypically, spends more time with the young person. On the other hand, fathers become more concerned and report problems in more concrete areas such as academic performance. (Mychailyszyn et al., 2010).

- **Attachment**

Parent-child attachment and related problems, such as insecure, disorganized, or anxiously ambivalent attachment styles, are causes of social anxiety. Attachment type is also a better predictor of anxiety disorder than maternal temperament or anxiety. Children with secure attachments tend to be more popular with peers and are seen in a more positive light compared to children with insecure attachment.

The parent-child relationship is important for their mental development. The lack of security, of protection, since the infantile period leads to the subsequent appearance of mental health problems. Thus, anxiety in childhood and adolescence is associated with that during childhood (1 year). "Therefore, childhood anxiety depends on the degree of care, warmth, and affection expressed by parents, while exaggerated control and the desire of grown-ups to monopolize their children's existence is severely harmful" (Elisabeth et al., 2006).

"Early maturation leads to higher levels of anxiety and depression" (Smith et al., 2005).

- Learning experiences

"Common ways of encountering fear during childhood include modelling, information transfer, and direct conditioning" (Kearney, 2005). When fears develop in late childhood and adolescence, as is the case with many social and evaluation fears, the learning mechanism is often the modelling and transfer of information. Parents can be excellent models of social phobic behaviour, and the information received from them is fully accessed and learned in order to shape children's behaviours. Likewise, direct conditioning helps acquire and maintain fears of social evaluation. In terms of the latter, stressful or traumatic events facilitate the upheaval of classical conditioning, with many adults linking their shyness or social phobias to negative social events.

Learning experiences can also lead the young person's view of internal sensations or social/ evolving situations as dangerous, thus creating a specific psychological vulnerability.

4. TYPES OF ANXIETY

There are several types of anxiety: "separation, generalized, specific phobias, social phobia, posttraumatic stress disorder, panic attack" (Stan, 2008). Clinically, anxiety has two components:

a) a psychic one, called anxiety, or *subjective anxiety*;

b) another physical, classically referred to as anguish, or *somatic anxiety*.

"Psychic anxiety consists in the feeling of fear, in the feeling of imminent danger" (Vîtu, 2007).

Psychologists talk about general anxiety and special forms of school, family anxiety. Some psychoanalysts speak of a primary anxiety, that is, anxiety experienced for the first time at birth. "Each type of anxiety is characteristic to a certain period of development. We can talk about generalized anxiety, panic attack disorder and social phobia – in adolescents." (Vîtu, 2007).

According to the causes that produce it / by origin, there can be an "anxiety – state" and an "anxiety – trait." Anxiety state – is an emotional, fleeting state and can occur in any individual. Anxiety – trait is an individual, apparently innate/congenital characteristic. It manifests itself in two ways:

- predisposition to feel states of fear in the presence of stimuli;
- predisposition to develop conditioned fears about stimuli that do not exist.

Anxiety – trait may have a pathological character. "The state of anxiety in which fear prevails about a situation which, although generally undetermined, may prove disagreeable and even dangerous." (Vîtu, 2007).

"Other types of affective-active states in puberty and adolescence are fear and anxiety. It is difficult to differentiate between two types of affective states. This is all the more so because in some situations that are known to have undesirable effects, curiosity (a real attraction) is manifested, and other unknown situations provoke fear – not anxiety" (Schiopu & Verza, 1981).

5. SYMPTOMATOLOGY

"At puberty-adolescence, anxiety is manifested by sleep disorders, appetite, extreme sensitivity, destructive behaviour, sometimes aggressive,

irritability, absenteeism, school failure, tendency to run away or even run away from home, bursts of screaming, unexplained irritability, easy crying, isolation, boredom. The overall functioning is affected. There are more behavioural problems and fewer neurovegetative symptoms (diminished energy, psychomotor slowness) compared to adults with depression" (Stan, 2008). The teenager has a "black and white" thinking.

Anxiety problems can lead to refusal to go to school and increased absenteeism. However, anxious children face significant emotional problems and studies are needed to investigate the impediments they face in school (Mychailyszyn et al., 2010).

The generalized anxiety disorder is manifested by a state of extreme worry, without real foundation, about mundane, everyday activities in the past, present and future. The one who suffers from this disorder is very conscientious, conformist, perfectionist and insecure, feels tense, complains of stomach and headache. Fear is accompanied by somatic reactions (palpitations, sweating, redness). "The child/adolescent is afraid of being ridiculed, of being embarrassed, humiliated by his or her own actions, of making a fool of himself/herself. Grown-ups can completely avoid school, contacts, playing with equals." (Stan, 2008, p. 88)

Young people who struggle with anxiety face far more impediments to attending school than those who do not. Tasks such as adaptation are really more difficult for them (Mychailyszyn et al., 2010).

During panic attacks, "anxious thoughts are accompanied by physical symptoms: tachycardia, the feeling of suffocation, sweating, dizziness; cognitive symptoms, the feeling of imminent death. Panic attacks are multiple and rapid. They occur unexpectedly, out of nothing and in different situations: at home, at school, on the street, at the market, in a store, etc. Therefore, children and adolescents avoid going to certain places, not doing certain activities for fear of having a panic attack. The anxious person is afraid of an impending misfortune, an accident. His imagination unfolds adventures, sometimes frightening, without being able to ignore them. For these reasons, anxiety sufferers are always alert and have an awkward feeling of helplessness in the face of approaching dangers. Anxiety may be accompanied by muscle tension, motor inhibitions, especially neurovegetative manifestations such as palpitations or tachycardia, dizziness, hot flashes of heat and cold, dry mouth, nausea, feeling of a lump in the throat.

School anxiety encompasses the same fears that concern the student's activity: the fear of failure, of exams, of not passing the grade, of sanctions, of teachers. These fears affect the intellectual activity of students. Fear of heights, noises, explosions are also forms of anxiety.

Regarding school and professional orientation, "anxious adolescents are indecisive, oscillate between two or more options and are distrustful of their decision" (Ulete, 2008).

Children and adolescents with generalized anxiety disorder are always worried. They display care for family, school, friends, health and unusual situations. They tend to make negative predictions. They believe their predictions will come true, especially the bad ones. Generalized anxiety is also manifested by difficulty concentrating, irritability, restlessness, fatigue, sleep disturbance, somatic symptoms, muscle tension, headache, stomach pain. Those who suffer from social phobia are afraid that they will do something or behave in such a way that they will be in a humiliating or embarrassing situation.

Adolescents with social phobia recognize that their fear is excessive and unrealistic. This type of anxiety is associated, in social situations, with a series of physiological changes such as nausea, flushing, stomach pain, sweating, palpitations, dizziness. Children and adolescents with social phobia tend to have fewer friends, engage less in recreational or extracurricular activities, and have less developed social skills.

Panic is accompanied by somatic symptoms such as sweating, dizziness, palpitations. Panicked teenagers avoid crowded places, public transport, auditoriums, classrooms.

Generally, a shy teenager doesn't have many friends. These friendships are restricted, only at school and not outside school. He doesn't like going to parties or going out with his colleagues. He's a reclusive, lonely, solitary guy. He is agitated when he has to speak in front of the class. He has an aversion to school. To avoid

such awkward situations, he misses school. He doesn't trust himself. Sometimes he is downcast, depressed. Sometimes he suffers from insomnia, so he feels tired and becomes irritable. This adolescent "meets the criteria for a primary diagnosis of social phobia and a secondary diagnosis of major depressive disorder" (Rapee et al., 2011).

The anxious person is emotionally unstable, unconscious, excitable, difficult to adapt, impatient, shy, unsafe. Caring, restless, depressed, solitary, has, perhaps exaggerated, a sense of duty, austere, demanding of himself, not allowing himself the slightest mistake or, if he has committed it, he takes drastic measures against himself (Ulete, 2008).

Anxiety can cause affective changes, reaching states of total indifference, on several levels:

- intellectual (restriction of interest, indecision, abulia (lack of will);
- instinctive (renunciation of pleasures);
- psychomotor (slowness in gestures, mimicry). At the same time, anxiety influences the cognitive component of the personality.

Somatic complaints include heart palpitations, shortness of breath, shaking, redness, sweating, "nervous" or "butterfly" stomach. Other manifestations include belly pain, inconstant voice, the need to cling to someone, as well as crying, breathing problems, pain, motor difficulties, nausea, headaches (Kearney, 2005).

In relation to non-social fears, there were found among children suffering from social phobia disorders, anxiety states that include injections (51%), blood tests (35%), fear of heights (30%), seeing blood (28%), fear of the dark (23%), fear of insects (21%), fear of thunder / lightning (21%), fear of doctors / dentists (21%).

Young people who suffer from social anxiety report themselves as being more depressed than those who do not, and many express negative affects. (Kearney, 2005). Parents and teachers describe them as having more internalized problems, children in this category manifesting negative thoughts about themselves. General anxiety disorder and its symptoms precede depression in many cases.

"Another symptom observed is selective mutism, which refers to the persistent failure of speaking in social situations, for example at school or with peers, the reasons for this behaviour have been debated over time, and many researchers have concluded that it is based on temperament and anxiety in general and is related to social phobia in particular" (apud Kearney, 2005).

It also talks about refusing to attend school and/or having difficulty staying in class throughout the day. This behaviour is referred to in the literature as *school phobia*, school refusal or separation anxiety. The relationship between the two aspects is obvious, given that many young people worry about social interactions, tests, peer evaluation and performance expectations by which the educational institution is characterized.

In terms of coping mechanisms, the responses of young people suffering from social anxiety to events that provoke fear, avoidance is most common: pretending for illness, crying, noncompliance, refusing to go somewhere, avoiding looking or pretending deafness. This attitude prevents young people from facing important developmental challenges in adolescence. These include dating, working outside school, completing studies, gaining social independence, assertiveness, developing social media and learning about the world at large.

In addition, this avoidance is complemented by discontinuous relationships with people of the same age.

6. COURSE OF DISEASE

In cases of social anxiety and social phobia, there has been a relatively stable development over time. Firstly, adults with anxiety disorder report that symptoms and related characteristics (e.g., behavioural inhibition) began in childhood or adolescence and persisted into adulthood. Secondly, the presence of anxiety disorder in childhood generally appears to be a good predictor of developing anxiety and other disorders with age. Thirdly, behavioural inhibition, a very stable temperament trait, was discovered at an early age and has been linked in some cases to social phobia in young adolescents.

Other factors related to social phobia are very stable throughout life, including shyness, high levels of self-awareness, and worry about the

negative estimates of others. Fourthly, the presence of avoidance disorder during childhood has been shown to be stable over time and associated with various psychotic disorders. Research has found that the frequency of social fears and different types of social situations associated with fear did not change much from the age of 12-13 up to age of 16-17, although the prevalence of social phobia increased with age (Starcevic, 2005).

The course of the disease varies greatly from person to person. The prognosis is very good for cases where the disorder was identified early and appropriate treatment was followed. Conversely, for people whose disorder has become chronic and remained untreated, the prognosis is neither good nor optimistic. In the long run, these people fail to live up to their real expectations and possibilities, they record many failures professionally and personally; have an increased risk of major depression and suicide. (Kashdan & Herbert, 2001). The more time passes, the harder it is to fight this disorder and the harder it is to maintain a normal life. However, if the appropriate treatment is followed, there are very good chances for partial or almost full recovery and leading a normal and rewarding life.

7. CONSEQUENCES OF SOCIAL ANXIETY IN ADOLESCENTS

One consequence of anxiety is shyness, which negatively influences the adolescent's intellectual activity. "It has been observed that shy students tend to have narrower career options compared to those who are not shy" (Rapee, 2011). However, it was found that educational outcomes were relatively similar in anxious and non-anxious subjects. School results in anxious people are not affected as long as anxiety is not pathological.

Shyness has no remedy. It does not heal with age. It has been observed that those who had been among the shyest children continue to be the shyest adults. Or only some of them reduce their anxiety levels throughout their lives, and therefore their shyness.

Negative life events can maintain anxiety. Other data, from adults with different anxiety disorders, indicated particular aspects in terms of the number of negative events in each person's life. "The traumatic event is relived through memories, images, nightmares." (Stan, 2008) Young people avoid talking about these events. They lose interest in things they are passionate about, they become irritable, aggressive or violent, they no longer feel able to be affectionate. The severity of symptoms is greater when the trauma was inflicted intentionally (e.g., abuse). Usually, symptoms appear within the first three months following the event, but sometimes they can appear years later. Sometimes recovery is possible, sometimes chronic suffering remains.

8. ANXIETY THERAPY/TREATMENT IN ADOLESCENTS

"This mental disorder can be combated by:
- rationalization – turning anxiety into a rational fear;
- denying the existence of anxiety through physiological phenomena;
- avoiding situations, thoughts and feelings that generate anxiety - this process can be conscious or vaguely conscious" (Vîtu, 2007).

"One of the therapies is to teach individuals suffering from this disease to be realistic, to think healthily" (Stan, 2008).

Non-drug treatment is done by:
- identification of erroneous beliefs;
- development of social skills, relaxation techniques;
- adolescent involvement in creative activities;
- granting a greater degree of freedom;
- contact with patient and family.

As psychotherapy, for anxiety disorder, it is recommended to "keep calm and distract."

In the drug treatment of anxiety, tranquilizers are used. They are used according to the types of anxiety and exert only a symptomatic action. They should not constitute the background treatment of the condition. Medicines should be used with caution and only on medical advice.

In older adolescents (those over sixteen years of age), conceptualization and treatment are similar to those in adults. The treatment is applied in group or individual format. A group treatment is good, but an individual treatment program is excellent. In a group treatment – family, for example – the methods used are different depending on different situations. Therefore, applying these strategies to a group format will be different. Clinically, there seem to

be benefits anyway from including parents in treatment, even for adolescents, not just children.

Those who suffer from an anxiety disorder are likely to have another mental disorder such as depression. For example, if a teenager is depressed, the anxiety reduction strategy will not be applied until the first one is stopped, even though anxiety is a dominant problem. As such, in the treatment of comorbid disorders, the main strategy is to address problems systematically.

There are many similarities in the treatment of different disorders that can be primary and secondary. Treatment of primary and secondary disorders should be done in parallel. It is necessary to build relationship and credibility between therapist and adolescent. It is good / important to work with adolescents individually without the need for the presence of parents. The adolescent should also feel that the therapist respects his independence and individuality.

"At the beginning of any treatment, it is important to instil in the young person the feelings of confidence, hope and encouragement; Treatment has minimal sources of success in the absence of strong motivation. Adolescents will be more strongly motivated when they have a close relationship with the therapist." (Rapee, 2011) "For older and more mature adolescents, therapy sessions involving the whole family are likely to be limited, especially at first" (Rapee, 2011). It is important to tell adolescents that their personality/individuality is respected and that they are equal partners in dialogue.

It is observed that children and adolescents are best able to identify unrealistic thoughts if they ask themselves questions, such as, "What makes me scared?" (Rapee, 2011).

"When asked about past experiences, some people, especially adolescents with more severe symptoms, test negative for all of the past experiences described. To avoid these difficulties, it is good for young people to focus their attention on the details of the experience rather than on their feelings or how they perceive the event." (Rapee, 2011, p. 77).

They are taught to look at situations from another person's perspective. Older adolescents and adults, especially those with social fears, are better at adopting a different perspective. The purpose of evaluating thought based on the evidence gathered is to reduce the estimation of the probabilities of the negative event occurring and thus reduce anxiety. Some teenagers and their parents will be able to work well with probabilities.

II. PRACTICAL PART

1. RESEARCH OBJECTIVES

The present research aimed at investigating the relationship between the tendency towards social comparison, fear of negative evaluations and social anxiety in adolescents. To the extent that most research has focused on the interaction of factors such as depression (Laurent & Ettelson, 2001; Kinnier et al., 2009; Marker, 2013) or relationship with peers (Vernberg et al., 1992; Erath et al., 2007) and social anxiety, the present study focuses on addressing these new variables in the context of experiencing these states in today's adolescents.

"Few statements have generated such interest in social psychology as did Festinger's (1954) statement of social comparison theory that in each individual there is a drive to evaluate his own opinions and abilities." (Gibbons & Buunk, 1999).

At the same time, fear of negative evaluation (NEF), first defined by Watson and Friend in 1969 as "the perception of evaluations from others, the distress caused by their negative evaluations, and the expectation that others will make negative value judgments" is a well-researched variable in relation to anxiety disorder (Turner, 1999).

Social anxiety disorder (SAD) is a chronic mental health problem that involves an irrational anxiety and fear of situations and activities in which individuals believe they are being observed, evaluated and/or judged by others and will embarrass themselves or be humiliated. Although SAD is quite common among children and especially adolescents, most studies on this problem have focused on adults (Kashdan & Herbert, 2001).

The research problem I formulated was intended to answer the following question:

- Is *the trend toward social comparison* a good moderator as well as a good predictor, along with *fear of negative evaluation,* of the level of *social anxiety* among adolescents?

2. ASSUMPTIONS

1. There is a primary effect of the independent variable *tendency toward social comparison* on the dependent variable, *social anxiety,* in that adolescents who have a high level of *tendency toward social comparison* experience more *social anxiety* when faced with evaluation situations than those with a low level of *tendency toward social comparison*.

2. There is a primary effect of the independent variable, *fear of negative evaluation*, on the dependent variable, *social anxiety,* in that people with a high level of *fear of negative evaluations* will experience *social anxiety* more often than people with low levels of *fear of negative evaluations*.

3. There is an interaction effect between the independent variable *fear of negative evaluation* and the independent variable *tendency towards social comparison* on the dependent variable *social anxiety*, in the sense that people with a high level of *fear of negative evaluation* and who have a high level of *tendency towards social comparison* will experience an increased level of *social anxiety*, towards people with a low level of *fear of negative evaluation*, and a low level of *tendency towards social comparison*.

3. DESIGN

- ***dependent variables***:

V1= tendency towards comparison - low;
-High.

V2= fear of negative evaluation - low;
-sea.

- ***Dependent variable***: **VD** = social anxiety.
- 2x2 design.

4. METHOD

The research method is quasi-experiment, since both independent variables V1- *the tendency towards social comparison*, and V2- *the fear of evaluations* are invoked.

Statistical analysis used: differential inferential statistics (ANOVA).

- **Participant squad**

For this research, the targeted subjects are 150 adolescents, both female (107 subjects) and male (43 subjects), aged between 14-19 years, from the urban area, students in grades VII-XII, from the "Emil Racoviță" National College of Iasi.

- **Tools**

o 1. Liebowitz Social Anxiety Scale, Liebowitz, 1987, 24 items.

It measures social anxiety, on two dimensions, fear and avoidance, that an individual reports in the past week.

Likert scale: 1 (not at all) and 4 (very much/ often).

o ***2. The Social Comparison Scale, Schneider &; Schupp, 2011, 11 items***.

It measures the tendency of subjects to make social comparisons with others based on statements within items.

Likert scale: 1 (strongly disagree) and 5 (strongly agree).

o 3. FNE Scale (Fear of Negative Evaluation Scale, Watson & Friend, 1969, 30 items.

Dichotomous statements true / false

Measure negative evaluations, i.e. understanding others' assessments, stressing them, avoiding them, and expecting others to make negative assessments.

Procedure

The subjects who participated in this research, students from the "Emil Racoviță" National College of Iasi, expressed their agreement to participate in the research conducted between April and May 2014, carried out during the directing classes. The consent of parents, class teachers, as well as written consent from the school management were required in order to conduct the study. Participants were asked to complete a set of questionnaires (Social Comparison Tendency Scale, Negative Rating Fear Scale, and Social Anxiety Scale). The teenagers were later asked to keep the test results secret in order to ensure anonymity. Interested

persons were indicated and they could request, after processing the data, the scores obtained on the three investigation tools.

5. RESULTS

Univariate ANOVA

1. Main effect of V1 ***tendency towards social comparison.***

F (1.149)= 1.387

p= 0.241> 0.050→ We accept the null H0 hypothesis and reject the research hypothesis: There is no primary effect of the tendency toward social comparison on social anxiety, in the sense that subjects with a high level of social comparison tendency do not show significant differences in social anxiety compared to subjects with a low level of tendency toward social comparison.

2. Main effect of V2 ***fear of negative evaluation.***

F (1,149)= 21,845

p= 0.001< 0.050→ we accept the research hypothesis H1 and reject the null hypothesis:

There is a primary effect of fear of negative evaluation on social anxiety, in the sense that subjects with a high level of fear of negative evaluation experience greater social anxiety than subjects with a low level of fear of negative evaluation.

3. Interaction effect V1 ***tendency towards social comparison*** *** V2** ***fear of negative evaluation.***

F (1,149)= 0,575

p= 0.449> 0.050→ we accept the null hypothesis H0 and reject the research hypothesis:

There is no interaction effect between the two independent variables on the dependent variable.

T-Tests

1. VI Fear of negative evaluation

Tendency towards social comparison

A. Low

Me anxsoc small= 80.34

Me anxsoc high = 92.87

F= 1,744

p = 0.191> 0.050→ we accept the null hypothesis H0 and reject the research hypothesis H1: the variances of the samples are equal.

t(76)= -2,903

p = 0.005< 0.050→ There are significant differences, subjects with a low level of social comparison who have a high level of fear of negative evaluation are more anxious than subjects with a low level of tendency towards social comparison who have a low level of fear of negative evaluation.

b. high

Me anxsoc small= 81.68

Me high anxsock= 99.06

F= 0,466

p = 0.497> 0.050→ we accept the null hypothesis H0 and reject the research hypothesis H1: the variances of the samples are equal.

t(70)= -3,664

p = 0.001< 0.050→ There are significant differences, subjects with a high level of social comparison who have a high level of fear of negative evaluation are more anxious than subjects with a high level of tendency towards social comparison who have a low level of fear of negative evaluation.

2. VI Tendency towards social comparison

Fear of negative evaluation

A. Small

Me anxsoc small= 80.34

Me anxsoc high = 81.68

F= 0,598

p= 0.442> 0.050→ we accept the null hypothesis H0 and reject the research hypothesis H1: the variances of the samples are equal.

t(73)= -0,325

p = 0.746> 0.050→ there are no significant differences, subjects who show fear of low evaluation and tendency to high social comparison do not show significant differences from subjects who show fear of low evaluation and tendency to low social comparison.

V3 Gender of subjects

Me masc = 78.58

Me fem= 92.69

F = 4,276

p= 0.040< 0.050→ we accept the research hypothesis H1 and reject the null hypothesis H0: the sample variances are different.

t(148)= -4,135

p = 0.001< 0.050→ There are significant differences between male and female subjects in that male subjects have significantly lower levels of social anxiety than female subjects.

b. sea

Me anxsoc small = 92.87

Me high anxsoc = 99.06

F= 0,005

p= 0.944> 0.050→ we accept the null hypothesis H0 and reject the research hypothesis H1: the sample variances are equal.

t(73)= -1,270

p = 0.208> 0.050→ There are no significant differences Subjects who show fear of high evaluation and tendency towards high social comparison do not show significant differences from subjects who show fear of high evaluation and tendency towards low social comparison.

6. DISCUSSIONS. LIMITS

The study started from three hypotheses that supported in turn the main effects of variables: *tendency towards social comparison* and *fear of negative evaluation* on the dependent variable: *social anxiety*, as well as an interaction effect between the first two variables. Of the three hypotheses, only hypothesis two has been confirmed, there is only one main effect of the variable *fear of negative evaluation* on the dependent variable, *social anxiety*. Thus, the study joins research with similar results (Weems et al., 2001; Byrne, 2000). There were no main effects of the independent variable *tendency toward social comparison* on the dependent variable *social anxiety*, as well as no interaction effect between the two independent variables on the dependent variable.

Although previous studies have shown that *the tendency toward social comparison* can lead to increased *social anxiety* (Gibbons & Buunk, 1999), the present research has found no similar effects.

Studies have shown that there are at least two types of SAD. The first (non-generalized) is a less pronounced form, which manifests itself through fear/avoidance of situations such as giving a speech in front of an audience (Kashdan & Herbert, 2001). The second (generalized), more severe, is manifested by fear/avoidance of most social situations such as having regular conversations especially with new people, meetings, group meetings, etc. These people describe themselves as shyer and more anxious in childhood, describing their parents as emotionally distant and who like to keep everything under control. The generalized form appears earlier, in preadolescence, while the second appears around the age of 17.

Although it is a very common problem in childhood, it often goes unnoticed by parents or even qualified people. By definition, people with this disorder are very concerned about how others perceive them and so they do not manifest themselves so as not to draw attention to themselves. Because they tend to be invisible at school and neglected during class, they are not identified by qualified school staff unless it reaches a point where they refuse to come to school. Because the opinion that those around them have about them affects everyone to some extent, as well as a certain amount of anxiety, most parents see their children as shy and do not realize that they are actually suffering from a treatable disorder.

Although the literature on this issue is constantly developing, the cause that triggers SAD is not fully known and so several factors can be identified. Social causes, however, represent the most possible triggers. Some researchers and psychologists believe that social anxiety is actually a learned behaviour, in other words it can develop from observing and interacting with people who have this problem (Kearney, 2005; Barlow, 2002).

There could be an association between parents who are overprotective, trying to control everything, and even social anxiety. Often such parents do not realize their child's problem because they themselves have this problem and it seems normal to them (Kearney, 2005).

Some people may develop social anxiety as a result of having a very negative social experience. For children, such experiences may include teasing, beatings and harassment by peers, or

some extremely embarrassing incident in public. Language problems or speech disorders, family conflicts, and neglect can contribute to the development of social anxiety. Psychological factors include having an emotional or psychological trauma in childhood or not having a proper attachment relationship in the early years of life.

Genetic factors have also been discussed. Studies so far have shown that social anxiety is transmitted within the family. "However, it is not clear the process by which this phenomenon occurs: whether it is a genetic component that is transmitted or the anxious behaviour that is learned through modelling from other family members." (Kashdan & Herbert, 2001)

Researchers are exploring the idea that certain chemicals in the human body could play a role in social anxiety disorder. For example, an imbalance in the brain of the neurotransmitter chemical serotonin could be a factor. Among other aspects, serotonin is involved in regulating mood and emotions. Individuals with social anxiety might be more sensitive to the effects of serotonin.

Social anxiety disorder can be treated in different ways, depending on the degree of its intensity. The most widely used form of psychotherapy for social anxiety is CBT (CBT) – cognitive-behavioural therapy. The basic premise for this form of psychotherapy is that our own thoughts — not other people or situations — determine how we react and behave. "Even if the unwanted situation cannot be changed, we can change for the better the way we think and behave. CBT teaches us how to reduce the anxiety we feel in social situations so that we can cope with them and stop avoiding them." (Kashdan & Herbert, 2001)

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