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The Influence of Parenting Styles on Social Phobia in a College Sample

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THE INFLUENCE OF PARENTING STYLES ON SOCIAL PHOBIA IN A COLLEGE SAMPLE

Kimberly Sue Fischer, B.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art

2002

ABSTRACT

Since researchers have only studied social phobia in the last several decades, the need to identify influencing variables is essential. While most researchers concur that familial factors have an impact on social phobia, the influence of family variables remain under investigation. Many studies have examined the impact of parenting characteristics on social phobia involving individuals in a clinical setting. However, few studies have focused on social phobia in a non-clinical setting with adults. This study explores the relationship between parenting styles of overprotection and rejection with social phobia in a college sample of adults. Subjects for this study were 35 college students at Lindenwood University. In addition to demographic data sheets, subjects were asked to complete a measure of social anxiety and a measure of perception of parenting styles experienced in childhood. A Pearson product-moment correlation was performed to examine possible relationships. No significant relationship was found between social phobia and parental characteristics. A significant result was found for care and over protection for both mother and father. A significant result was found for over protectiveness between mother and father. Also, a significant result was found for fear/anxiety and avoidance. A discussion of the limitations of this study and implications for future research are given.

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2002

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Chapter I

Introduction

Anxiety disorders have been increasingly recognized by the public and professionals over the last several decades. In recent years, panic disorder, agoraphobia, obsessive-compulsive disorder, and generalized anxiety disorder have obtained considerable attention (Liebowitz, Fyer & Klein; 1985 Ross, 1981). However, little research on the topic of social phobia has been investigated until the last several decades. Prior to 1980, mental health practitioners included social phobia into the broad category of phobic neurosis. It only became an official recognized diagnosis in 1980 by the Diagnostic Statistic Manual of Mental Disorders (DSM III). As a result, research on social phobia has lagged behind the other anxiety disorders, which has received most of the attention. In fact, Liebowitz, 1985, a pioneer in the research on social phobia, termed it as the "Neglected Anxiety Disorder". Recently, more studies have focused on this disorder, but social phobia still remains the least understood than phobia subtypes.

Social phobia is a persistent fear of being scrutinized or assessed by other people with the expectation that this judgment will be negative or humiliating. In accordance to the criteria in the DSM IV, exposure to the feared situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. Although the person recognizes that the fear is excessive or unreasonable, the feared social or performance situation(s) are avoided or endured with intense anxiety or distress. The qualities that distinguish social phobia from "typical anxiety"

are the duration and intensity of the fear. The physical symptoms commonly experienced by individuals with social phobia are similar to a fear response. However, these fear responses are typically unjustified and exaggerated. Some common physiological symptoms include palpitations, perspiring, trembling, blushing and a feeling of loss of control. An important factor in the determination of social phobia, according to the DSM IV, is the individual's avoidance, anxious anticipation, or distress in the feared social or performance situation, which interferes significantly with the individual's normal routine, occupation or academic functioning, social activities or relationships, or a marked distress exists about possessing the phobia. Since the individual suffering from social phobia generally recognizes their fear as unreasonable, it is not surprising that these individuals tend to avoid treatment longer than those diagnosed with other anxiety disorders (Cook, 1996). Often, social phobics will choose to suffer in silence rather than chance risk exposing fears.

Despite the increasing amount of research recently produced on risk factors, the etiology of social phobia remains unclear. Several risk factors have been suggested including biological, familial and genetics, behavioral inhibition, and psychological factors ranging from behavioral conditioning to cognitive variables (den Boer, 1985). Increasing evidence suggests that both familial and environmental factors have been implicated in the development of social phobia. However, a significant amount of literature primarily investigates the role of parenting characteristics with various forms of psychopathological disorders including agoraphobia, obsessive-compulsive disorder, depression, generalized anxiety disorder, schizophrenia and

addiction. The influence of parenting behaviors on social phobia has just recently been examined.

Etiological studies of social phobia have been hindered by issues such as lack of recognition and symptom overlap with other disorders. Recent progress in the differential diagnosis of anxiety disorders and the development of theoretical models of social anxiety has begun to allow the resources for such studies (Bruch, 1989). Therefore, it is understandable that it has only been in recent years that studies have explored the influence of parenting styles on the development of social phobia as a separate anxiety disorder (Bruch, 1989; Gerlsma, Emmelkamp & Arrindell, 1990; Lieb, Wittchen, Hofler, Fuetsch, Stein & Merikangas, 2000; Rapee, 1997). Researchers have indicated that rejection and parental control (overprotectiveness) are the parental characteristics, which seem most directly related to social phobia. (Lieb et al., 2000; Parker, Tupling & Brown, 1979). Research implies that social phobic individuals perceive both their parents' childrearing characteristics as rejective, lacking emotional warmth and over protective.

An abundance of the studies conducted on these parental characteristics investigate social phobia involving individuals in a clinical setting, both in-patient and outpatient. (Arrindell, Emmelkamp, Monsma & Brilman, 1989; Arrindell, Kwee, Methorst, van der Ende & Moritz, 1989; Parker, 1979). Some studies have focused on a community sample, but primarily have included children or adolescents as subjects, as well as symptom overlap with other disorders. (Caster, Inderbitzen & Hope, 1999; Lieb et al., 2000).

The purpose of this study is to examine the correlation between an individual's perception of parenting styles examined in childhood and social phobia in a college sample. It is proposed that the individuals who rate higher on social phobia will perceive their parents as more rejecting and over protecting. Therefore, the null hypothesis for the study is that there is no relationship between parenting styles and social phobia.

Chapter II

Literature Review

Demographics and Types of Social Phobia

Since social phobia has only been examined from 1980 as its own separate classification of anxiety disorder, the magnitude of this illness is more alarming than originally thought. Recent epidemiological studies indicate that social phobia is a widespread and disabling condition. The progression of this disease is lifelong and constant unless treated. With the compilation of the National Comorbidity Survey (NCS) in 1992, the breadth of psychiatric illnesses was more precisely established. (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994; Magee, Eaton, Wittchen, McGonagle & Kessler, 1996). The NCS is a congressionally mandated survey created to investigate the comorbidity of substance use disorders and nonsubstance psychiatric disorders in the United States (Kessler et al., 1994). According to the NCS, social phobia is the third most common psychiatric disorder, following depression and alcoholism, with a lifetime prevalence estimate at 13.3% in the adult population. (Cook, 1996; Magee et al., 1996). Typically, social phobia occurs at a young age with the first onset between 11 and 15 years old (Judd, 1994; Kessler et al., 1994). The NCS indicates that females are more likely to develop social phobia, with a lifetime prevalence of 15.5% to 11.1% for females and males, respectively (Kessler et al., 1994). It is not surprising that over half of all social phobics tend to be single, divorced or separated (Judd, 1994). Social phobics are more likely to be less educated with a mean years in school at 12.7 years and even more than 50% are unable

to complete high school (Judd, 1994; Weiller, Bisserbee, Boyer, Lepine & Lecrubier, 1996). As might be anticipated, social phobics tend to belong to a lower socioeconomic class and experience a higher rate of unemployment than the general population (Kessler et al., 1994). In fact, statistics indicate the unemployment rate for non-depressed social phobics is 6.2% while depressed social phobics rise to a high unemployment rate of 16% (Weiller et al., 1996). Consistent with previous epidemiological studies, results indicate no differences in occurrences of social phobia between Caucasians, Afro-Americans, Hispanics and other populations (Magee et al., 1996). Demographically, anxiety disorders, in general, are most prevalent in the Northeast region and lowest in the South region. However, the occurrence of social phobia, specifically, has not been shown to vary among regions in the United States (Kessler et al., 1994).

Social phobia is more than just shyness in daily encounters with social or performance situations. Many individuals normally experience some nervousness in meeting new people, staging presentations, or confronting authority figures. However, while most individuals cope or negotiate their uneasiness, social phobics experience excessive fear and anxiety throughout the entire situation.

Social phobia may be present in a variety of situations, but studies indicate two different types exist, discrete and generalized (Conger, 1999; Cook, 1996; Strahan & Heimberg, Hope, Dodge & Beckner, 1990). In discrete (or specific) social phobia, the feared situation is limited to a few social or performance-circumscribed situations. The most common fears include

public speaking, followed by speaking or interacting at informal gatherings, assertion, and/or being observed performing an activity such as eating, drinking, writing, or using public lavatories. (Cook, 1992; den Boer, 1997; Heimberg et al., 1990). The broadly defined form of social phobia is the generalized type. (Cook, 1996; Heimberg et al., 1990; Strahan & Conger, 1999). Individuals with generalized social phobia fear most social situations and generally lack in social skills. They cope with their fears by shunning social contacts in order to avoid opportunities for negative evaluation (Cook, 1992). Regrettably, social phobics intensely crave social involvement and acceptance of people.

Social phobics can perform these behaviors adequately in private without discomfort, but encounter extreme discomfort when performed in the presence of others. These individuals enter into the feared situation with anxiety and apprehension. It is not the task itself, which is feared, but the fear of performing poorly in the social situation. For instance, social phobics may fear a loss of words, visible voice trembling, blushing or visible perspiration while speaking in the presence of others (den Boer, 1997; Greist, Hope, Ganler & Heimberg, 1989; Strahan et al., 1999). Others may be apprehensive to write in public for fear their hands may tremble and be observed.

Paradoxically, social phobics (specifically discrete social phobics) are often viewed as possessing the necessary skills to perform adequately in the feared situation, but performance is hindered by negative cognitions. It is suggested that social phobics focus on negative incidents, which could occur in the feared situation that result in poor performance (Cook, 1996; Greist,

1995). Since the social phobic is preoccupied with these negative thoughts, they fail to concentrate on the present task or situation. As they become absorbed with these negative thoughts of embarrassment or humiliation, their anxiety becomes high enough that their functioning is actually impaired (Cook, 1996; Greist, 1995).

Previous studies indicate that some anxiety is beneficial for optimal performance, but too much anxiety impairs performance (Greist, 1995; Strahan et al., 1999; Yerkes & Dodson, 1908). Some anxiety prior to social situations assists individuals in preparation and practice for increased performance. Levels of anxiety and physiological arousal are related to performance in the Yerkes-Dodson curve (Greist, 1995; Strahan et. al, 1999; Yerkes & Dodson, 1908). As anxiety levels increase, performance increases to a level that is optimal for each individual in each situation. However, at high levels of anxiety, performance drops abruptly in which the individual is no longer able to function satisfactory. Therefore, it is proposed that social phobics may experience such high levels of anxiety that it prevents them from performing effectively in social situations (Greist, 1995; Strahan et al., 1999).

Since social phobics fear embarrassment or humiliation in social situations, they either seek to avoid these situations or suffer extreme anxiety as they endure them. Avoidance and social situation anxiety produces anticipatory anxiety for social phobics as they contemplate future contact with the phobic situation (Cook, 1992; Heimberg et al., 1990; Griest, 1995; Strahan et al., 1999).

Distinctions and Comorditiy of Anxiety Disorders

Distinctions between social phobia and other anxiety disorders have only been investigated in the last two decades since social phobia became a separate classification in the DSM III in 1980. Although social anxiety may exist among other anxiety disorders, many behavioral, cognitive and physiological factors differentiate these disorders. Other disorders evaluated with social phobia include simple phobias, panic disorder, agoraphobia, avoidant personality disorder (APD) and schizoid personality disorders (Greist, 1995; Jefferson, 1996; Liebowitz, 1987; Turner & Beider, 1989).

Some of the most common simple phobias include specific animal (bird, cats, insects, e.g.) and situational (height, darkness, thunderstorms, closed spaces, e.g.) phobias. The essential feature of simple phobia is a persistent recognized irrational fear of, and compelling desire to avoid an object or situation, which provokes an immediate anxiety response when exposed to the phobic stimulus (DSM-IV, 1994). In specific phobias, the fear is the actual stimuli itself, not of embarrassment in encountering the stimuli (Greist, 1995), which is contrary to social phobia. For instance, if an individual fears dogs, the fear in simple phobics pertains to the dog biting, not humiliation due to the bite. Therefore, simple phobics rarely experience emotional, occupational and social distress while it is a common occurrence in social phobics (Turner & Beidel, 1989).

Panic attacks occur in both social phobia and agoraphobia. According to the DSM-IV, 1994, panic attacks involve a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror associated with

feelings of impending doom. During these attacks, symptoms experienced include shortness of breath, palpititations, chest pain or discomfort, choking, or smothering sensations, and a fear of "going crazy" or losing control (DSM IV, 1994; Jefferson, 1996; Judd, 1994; Turner & Beidel, 1989). Panic disorder, specifically, involves recurrent unexpected attacks where there is concern. It is sometimes challenging to separate social phobia and panic disorder since some individuals experience panic attacks which occur only in particular situations. However, in contrast to panic disorder, social phobics encounter panic attacks always linked to exposure of social situations (Greist, 1995; Jefferson, 1996). The individual with unpredictable panic attacks acknowledges that panic attacks can occur at any time, any setting, and in non-social situations such as subways, supermarkets and bridges.

Distinguishing social phobia from agoraphobia can be somewhat complex since more variables exist. Agoraphobia is anxiety or avoidance due to fear of experiencing a panic attack or fear of loss of control in situations from which escape might be difficult or embarrassing (DSM IV, 1994; Judd, 1999; Liebowitz, 1987; Turner & Beidel, 1989). The agoraphobic is concerned about being alone in unfamiliar places that may present many kinds of stimulus and comprise varying degrees of distancing from his/her home base of security. Although both social phobia and agoraphobia depict feelings of panic or intense anxiety is specific situations, agoraphobics fear dying, going crazy, or losing control during a panic attack (Turner & Beidel, 1989). Social phobics seem less concerned about the physical consequences of their symptoms and more concerned that others will notice these symptoms and

think negatively of them as a result. Therefore, a discriminating factor between social phobics and agoraphobics involves the strategies that they used to avoid occurrence of anxiety (Greist, 1995; Liebowitz, 1987; Turner & Beidel, 1989). While agoraphobics will seek out individuals who may reduce their level of anxiety, social phobics will avoid interactions with individuals in order to diminish their anxiety.

Social phobia differs from schizoid personality disorder by the basis of desire for social contact (Greist, 1995; Liebowitz, 1987; Turner & Beidel, 1989). Social phobics long for social interactions and social comfort, but avoid social situations due to anxiety. Schizoids avoid social situations because of an absence of interest in individuals. According to the DSM IV, 1994, schizoid personality disorder encompasses a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings beginning by early adulthood. While social phobics possess a great need for acceptance and approval of individuals, schizoids appear indifferent to the praise or criticism of others. Social phobics, by definition, have established at least one and often several age-appropriate social relationships outside their families where schizoids lack close friends or confidants other than first-degree relations (DSM IV, 1994; Greist, 1995).

Avoidant personality disorder (APD) may lie at the extreme end of social phobia since it is so severe and pervasive. Avoidant personality disorder is the continuous pattern of social inhibition, feelings of inadequacy, and a hypersensitivity to negative evaluation, which begins by early adulthood

(DSM IV, 1994). These individuals encounter problems with occupational activities, involvement with people, intimate relationships and social situations. In addition, avoidant personalities possess feelings of ineptness and inferiority in assuming new activities or risks (Jefferson, 1996). Individuals with APD are apprehensive to engage in new social situations because of fear of ridicule, rejection, and criticism (Greist, 1995). Similar to social phobics, APD individuals crave social contact and intimate relationships, but lack the social skills to initiate or sustain a relationship. The boundary between social phobia and avoidant personality disorder is somewhat unclear. Professionals debate on whether these two conditions represent a continuum of severity within social phobia or represent two distinct disorders (Greist, 1995; Jefferson, 1996; Turner & Beidel, 1989).

Studies indicate that social phobia is distinct from other phobic subtypes both clinically and demographically (DSM IV, 1994; Greist, 1995; Jefferson, 1996; Liebowitz, 1987; Turner & Beidel, 1989). However, it is common for social phobia to co-exist with other anxiety disorders, substance abuse, and affective disorders (den Boer, 1997; Judd, 1994; Kessler et al., 1992; Schneier, Johnson, Hornig, Liebowitz & Weismann, 1992; Turner & Beidel, 1989; Weiller et al., 1996). On average, 80% of social phobics have met the diagnostic criteria for another lifetime condition (den Boer, 1997). Among individuals diagnosed with social phobia, studies have indicated lifetime comorbidity prevalence with simple phobia (59%), agoraphobia (44.9%), major depressive disorder (16.6%), dysthymic disorder (12.5%), obsessive-compulsive disorder (11.1%) and panic disorder (4.7%) (Judd, 1994; Schneier

et al., 1992). Also, since some social phobics seek comfort with alcohol or substances to decrease anxiety prior to a social situation, alcohol and/or substance abuse may develop. Alcohol abuse and drug abuse is often elevated with social phobics with lifetime comorbidity at 18.8% and 13%, respectively (Judd, 1994; Schneir et al., 1992; Weiller et al., 1996). Unfortunately, many social phobics attempt to conceal their disorder and fail to initially seek treatment. Typically, professional treatment is sought for comorbid disorders rather than the social phobia itself. At this point, treatment is more complicated since each disorder must be disentangled and addressed separately.

Etiology of Social Phobia

The etiology of social phobia still remains uncertain. Many researchers advocate that the causes are almost undoubtedly multiple (Beidel, 1998; Greist, 1995; Hudson & Rapee, 2000; Judd, 1994; Stemberger, Turner, Beidel & Calhoun, 1995). Studies have proposed that biological and genetic factors, familial factors, and environmental factors may be some underlying sources of this disorder.

Biological Studies

Some research has implied that biological differences exist between social phobic and non-social phobic individuals (Greist, 1995; Judd, 1994; Levin, Schneider & Liebowitz, 1989; Li, 2001). Biological proponents on social phobia have primarily focused on biochemical irregularities and genetic dispositions. Studies have indicated that panic disorder and agoraphobia with panic attacks differ in biology from social phobia (Judd, 1994; Levin et al.,

1989; Turner & Beidel, 1989). Researchers have noted that the primary complaints of somatic distress reported by social phobics differ than those individuals suffering other anxiety disorders such as agoraphobia and panic disorder (Judd, 1994; Levin et al., 1989). Social phobics most commonly report specific automatic symptoms such as rapid heart rate, trembling voice, shaking hand, sweating and blushing while agoraphobics report more dizziness, difficulty breathing, weakness in limbs, fainting and buzzing or ringing in the ears (Judd, 1994; Rapee & Heimburg, 1997; Turner & Beidel, 1989). In a well-known study by Liebowitz et al., 1985, researchers administered sodium lactate to fifteen patients with social phobia, twenty with panic disorder, and nine with agoraphobia. Forty four percent of the agoraphobics, fifty percent of the panic disorder patients and seven percent of the social phobics panicked during the infusion. Therefore, this result suggests that there may be a difference in the underlying pathophysiology of social phobia, panic disorder, and agoraphobia.

From a biological perspective, the somatic symptoms of social phobics are an irregular regulation of the chemicals that allow the nervous system to function. In all individuals, normal anxiety produces physiologic functions, which occurs when dangerous situations are perceived. This anxiety produces autonomic activity of increased blood flow, gastrointestinal, nervous, and muscular system activity, which increases heart rate, intensifies breathing, and changes blood pressure. These physiologic responses are essential for survival to cope with a dangerous situation. However, in social phobics, an imbalance of the systems sets off all sorts of false alarms. They experience

such somatic situations in social situations, which are inaccurately perceived as dangerous. Therefore, some studies have proposed that social phobics possess abnormalities in the functioning of the anxiety apparatus (Griest, 1995; Levin et al., 1989; Li, 2001).

Biological advocates suggest that social phobics may be more sensitive to certain chemicals released in the body during stressful situations (Greist, 1995; Judd, 1994; Li, 2001). As well, these chemicals may be active in higher quantities or for a longer duration for social phobics.

Studies have identified that most individuals experience a degree of social or performance anxiety, which can be advantageous for motivating preparation. In most individuals, this anxiety decreases with repeated exposure and during the course of the performance or social situation. However, social phobics report that the anxiety escalates and their somatic symptoms increase which becomes a further distraction (Liebowitz, 1987; Liebowitz et al., 1985). These physical indicators of anxiety become part of a vicious cycle that continuously heightens anxiety.

In support of this theory, some studies indicate that certain medications alter the functioning of neurotransmitters, which reduce the somatic symptoms for social phobics as they encounter the anxiety-producing situation (Levin et al., 1989; Li, 2001). However, it is not know if these abnormalities of neurotransmitters are the result rather than the cause of social phobia. Additional research will be necessary to investigate the extent that biological and biochemical aberrations contribute to social phobia.

Another area of research that purports biological explanations of social phobia is twin studies. Although the research is limited, it does imply a genetic association to social phobia (Griest, 1995; Hudson & Rapee, 2000; Judd, 1994; Rapee & Heimberg, 1997; Torgerson, 1983; Turner & Beidel, 1989). Torgersen (1983) studied 32 monozygotic (MZ) twin pairs and 53 dizgotic (DZ) twin pairs who had been diagnosed with anxiety disorders. In this study, the concordance rates for numerous phobic factors, such as concerns on being observed while working or eating, were evaluated between MZ twins and DZ twins. If genetic factors demonstrated a considerable influence, concordance rates would be higher in MZ twins than in DZ twins. Torgersen reported a higher concordance rate for MX twins than for DZ twins for any diagnostic classification of anxiety. On the whole, concordance was 34% for MZ twins and 17% for DZ twins.

In another study of female twins, results demonstrated substantial higher concordance rates for most phobics in MZ twins in comparison to DZ twins (Kendler, Neale, Kessler, Heath & Eaves, 1992). The researchers reported concordance rates for MZ and DZ twins on agoraphobia (23.3% vs. 15.3%), social phobia (25.5% vs. 11.0%), and situational phobia (23% vs. 23.0%). Therefore, these findings propose that genetic factors exist in social phobias, agoraphobias and animal phobias, but not situational phobias.

In view of twin studies, it appears that some genetic component resides in most anxiety disorders. However, presently no research exists to understand the exact effect of this genetic influence. Numerous studies suggest that genetic factors may lead to a general predisposition toward anxiousness rather

than the transmission of a specific anxiety disorder (Hudson & Rapee, 2000; Rapee & Heimburg, 1997; Turner & Beidel, 1989).

Temperament Studies

Another theory for social phobia proposes that individuals possess a social sensitivity to new situations. Researchers have investigated this inherited disposition for general neurosis through temperament students (Beidel, 1998; Griest, 1995; Hudson & Rapee, 2000; Stemberger, Turner, Beidel, Calhoun, 1995). The term temperament has generally been defined as characteristic response pattern identified early in life, which can be modified through interaction with the environment and persists into adult personalities (Hudson & Rapee, 2000). Behavioral inhibition is an area of temperament that has received notable attention in the last few decades. This refers to the excessive fear of unfamiliar people, objects, situations, or events, which results in withdrawal, guardedness, avoidance and shyness in new situations (Beidel, 1998; Hudson & Rapee, 2000). Several studies have discovered a relationship with behavioral inhibition and other anxiety disorders, specifically social phobia and panic disorder (Beidel, 1998; Biederman, Rosenbaum Hirshfeld, Faraone, Boldvc, Gersten, Meminger, Kagan, Snidman & Reznick, 1990; Bruch, 1989; Hudson & Rapee, 2000; Judd, 1994; Rosenbaum, Bierderman & Hirshfield, 1991; Stemberger et al., 1995). The early onset of behavioral inhibition may be a developmental antecedent of social phobia or behavioral inhibition may generate susceptibility for the development of social phobia and other anxiety disorders by increasing an individual's sensitivity to social evaluation.

Longitudinal studies advocate that behavioral inhibition can be identified in children as young as four months, which signifies the existence for a biological predisposition (Beidel, 1998; Bruch, 1989; Kagan, 1997; Kagan, 1989). In evaluating children from infancy through early years, Kagan (1989) discovered that 10% to 15% of children who are irritable infants become shy, fearful and behaviorally inhibited toddlers. In his research, the inhibited children had higher heart rates, larger increased papillary dilation, and higher tonal pitch when exposed to stress through completion of a cognitive task when exposed to stress. (Stress was examined through behavioral indexes of distress when exposed to strangers to determine inhibition.) Through these longitudinal studies, researchers determined that the physiological differences among the behavioral inhibition children and the non-behavioral inhibition children were stable over a one-year duration. As a result, it is concluded that an inheritance of a lower threshold for sympathetic arousal might exist for contact to unfamiliar stimuli (Bruch, 1989; Kagan, 1997; Kagan, 1989).

Several other studies conducted supported a correlation between social phobia and behavioral inhibition (Biederman et al., 1990; Rosenbaum et al., 1991). These researchers conveyed that children diagnosed as behaviorally inhibited at 21 to 31 months of age seem to possess a heightened risk for future developments of anxiety disorders, phobic disorders and panic disorders. Children with behavioral inhibition tend to display substantial behavioral restraint, become quiet, and tend to avoid or retreat when exposed to novel situations (Greist, 1995). The fears reported by behavioral inhibition children include a fear of standing up and speaking in front of the class

(55.5%), fear of animal or bugs (55.5%), fear of strangers (44.4%), fear pf the dark (44.4%), fear of being called on in class (33.3%), fear of crowds (33.3%), fear of elevators (22.2%) and fear of physicians (22.2%) (Biederman et al., 1990; Rosenbaum et al., 1991). Undoubtedly, these early fears are highly comparable to the fears of adult anxiety disorders, specifically including social phobia.

Familial Studies

In addition, familial factors may occupy an important role in the etiology of social phobia. Several studies have increasing evidence of a familial contribution to social phobia (Fyer, 1995; Fyer, Mannuzza, Chapman, Liebowitz & Klein, 1993; Hudson & Rapee, 2000; Turner, Beidel & Costello, 1987). These studies report that social anxieties tends to "run in families", thereby advocating a biological proponent. Family studies have conveyed an increased rate of social phobic symptoms among the family members of individuals with social phobia (Fyer et al., 1995; Fyer et al, 1993; Hudson & Rapee, 2000; Stemberger et al., 1995; Turner et al., 1987). In one family study, Fyer et al.(1993), researchers directly interviewed first-degree relatives of social phobic individuals and control probands. They reported an increased risk of social phobic disorder (16.6%) in relatives of subjects with social phobia in comparison to the relatives of non-phobic controls (5%). Other studies propose that familial social phobia might be particularly important in the development of the "generalized" subtype, a more severe form of social phobia, that is characterized by fears in a broad range of social situations (Mannuzza et al., 1996; Stein, Chartier, Hazen, Kozak, Tancer, Lander, Furer,

Chubaty & Walker, 1998). Fyer et al.(1995) contrasted the rates of three phobic disorders, including social phobia, with first-degree relatives of the four proband groups. The researchers indicated moderate, but statistically significant, familial aggregation for all three phobic disorders. They discovered that individuals with social phobia were more likely to have first-degree relatives with social phobia than with panic disorder or simple phobia. Relatives of each proband group had a considerably increased risk for the proband's particular phobia in relation to the relatives of the non-phobic control probands.

Since comorditiy of anxiety disorders exist, these studies must consider the possibility of familial overlap between phobias. Although strong evidence exists for a familial factor in anxiety disorders, this research cannot infer a specific genetic transmission within each phobia proband group (Fyer et al., 1995; Fyer et al., 1993; Hudson & Rapee, 2000; Rapee & Heimburg, 1997). Rather, it suggests that some genetic component exists in most anxiety disorders. Genetic factors may create a general tendency to interpret situations as threatening, but family and environmental factors may direct the outcome of these inherited dispositions. (Bruch, 1989; Fyer et al., 1995; Fyer et al., 1993; Rapee & Heimberg, 2000).

Environmental Studies

Several studies have indicated an environmental link, especially the family environment, in the etiology of social phobia (Beidel, 1998; Bruch, 1989; Hudson & Rapee, 2000; Rapee & Heimburg, 1997; Stemberger et al., 1995). Three crucial areas in which family factors may instigate social phobia

include restricted exposure to social situations, parental modeling and childrearing styles.

Researchers propose that children limited to social situations have insufficient opportunity to acquire appropriate social skills (Beidel, 1998; Hudson & Rapee, 2000; Rapee & Heimburg, 1997). A family who limits their socialization with other individuals and families decreases the likelihood for the child to develop relationships with age appropriate peers. Restricted exposure decreases contact to novel situations, which hinders the extinction of any social fears. In addition, through modeling, parents who are socially anxious may convey that social situations are unsafe and best avoided (Beidel, 1998; Hudson & Rapee, 2000; Rapee & Heimberg, 1997). Several studies have indicated that parents of offspring with social phobia rate higher on social phobia than parents of non-social phobic offspring (Bogels, Oosten, Muris & Smulders, 2001; Bruch et al., 1989; Fyer et al., 1993; Lieb et al.; 2000;). Therefore, a parent's own fearfulness could result in avoidance of social transactions that creates isolation for the child and discourages family socialization. In an adoption study by Daniels and Plomin (1985), researchers reported that socially phobic mothers avoid exposing their children to numerous types of social interactions due to their own anxiety. The mother's self –reports of their shyness and sociability were significantly connected with infant shyness. This association existed in non-adoptive homes as well as adoptive homes in which family environment, but not heredity is shared Consequently, through this parental modeling, children may develop social concerns and fears.

In addition, parents who emphasize the importance of other individual's opinions may unintentionally teach the child to fear other's opinions while creating a preoccupation with social concerns. Two studies reported that adult social phobics were more likely to describe their parents as maintaining greater importance on the opinion of others in comparison to nonclincial controls (Bruch, 1989; Bruch & Heimberg, 1999). Consequently, children may internalize these verbal and nonverbal messages, which advocates that individuals are scrutinizing the child's appearance and social behavior.

Parenting Styles and Social Phobia

Studies on the influence of parenting styles in the development of social phobia have only been explored in the last two decades (Arrindell et al., 1989; Arrindell et al, 1983; Bruch, 1989; Caster et al., 1999; Gerlsma et al., 1990; Lieb et al., 2000; Rapee, 1997). Some commonly studied concepts include authoritarianism, child-centeredness, intrusiveness, possessiveness, hostile detachment, strictness, expression of affection and neglect (Darling & Steinberg, 1993; Rapee, 1997). Such a vast amount of concepts produces difficulty in determining which child rearing factors are associated with a disorder such as social phobia. In order to systematically research childrearing effects, researchers decided that the most all-inclusive description of childrearing variables were the three factors originally described by Siegelman (1965b) which are Loving, Demand, and Punishment and Schaefer (1965) which are Acceptance/Rejection, Psychological Autonomy/Control, and Firm/Lax Control. Recent studies have produced similar structures including these childrearing variables (Rapee, 1997). Therefore, several

researchers, Gerlsma et al.(1990), Parker, Tupling & Brown (1979), Rapee (1997) have concluded that three factors depict the most comprehensive description of childrearing variables. The first factor describes behaviors and attitudes related to acceptance, warmth, or on the opposite side, rejection and criticism. Basically, this attribute is assessed by negative or hostile feelings of the parent toward the child. A second factor involves parental control, protection, or on the opposite side, autonomy. This attribute is assessed by behaviors designed to protect the child from possible harm. Such parental behaviors often reduce the child's individuality and autonomy. The third factor is the use of punishment, firmness or discipline. However, this factor has been determined the least consistent factor and has rarely been applied to anxiety studies. Therefore, the two main parenting characteristics, which have been researched as an influence on social anxiety, are rejection and control. (Gerlsma et al.1990; Lieb et al; 2000; Rapee, 1997). These parenting characteristics, sometimes referred to as "affectionless control", may result in difficulties in social interactions and social situations as the child develops.

Three of the most common measures to assess childrearing characteristics include the Children's Report of Parental Behavior Instrument (CRPBI), Schaefer, 1965; the Parental Bonding Instrument (PBI), Parker et al., 1979; and the Egna Minnen av Barndoms UppFostran (EMBU), Perris, Jacobson, Lindstrom, von Knorring & Perris, 1980. These questionnaires measure the perceived childrearing from the offspring's perspective. Each of the questionnaires specifies overall scores on factors related to rejection and control.

Many studies have proposed that phobias, in general, are associated with uncaring and overprotective parenting styles (Arrindell et al., 1989; Arrindell et al., 1983; Bogels et al., 1999; Caster et al., 1999; Gerlsma et al., 1990; Lieb et al., 2000; Parker et al., 1979; Rapee, 1997). In fact, many researchers have indicated a link between maternal overprotection and agoraphobia. Research on social phobic populations, specifically, indicate these individuals tend to perceive their parents as more protective, lacking in warmth, rejecting, and less caring (Arrindell et al., 1983; Arrindell et al., 1989; Bruch & Heimburg, 1994; Lieb et al., 2000; Parker, 1979). These studies have typically investigated social phobia and childrearing styles through three procedures. The most common method involves distributing questionnaires to the offspring to inquire on the childrearing patterns of their parents. This is sometimes referred to as retrospective studies since often the offspring completes the questionnaire by recalling their parent's childrearing styles from the past. A second, but less common, procedure involves presenting questionnaires to the parents to inquire on their childrearing behaviors and attitudes to childrearing. A third method involved directly observing interactions between the parents and children to assess childrearing techniques.

In one retrospective study, Parker et al. (1979) compared perceptions of parents with clinically social phobic adults and clinically agoraphobic adults against controls utilizing the PBI. The phobic patients, as a group, scored their parents as less caring and more overprotective than the controls. The results also indicated a difference between social phobics and agoraphobics on

several measures. While social phobics rated both parents as low on care and high on over-protections, agoraphobics only rated their mothers as less caring in comparison to the controls. In further analysis, differences between specific affects for each parent existed. Higher agoraphobic scores were linked with less maternal care and less maternal overprotection while higher social phobic scores were linked with greater maternal care and greater maternal overprotection.

Arrindell et al.(1983) produced similar results for negative parenting practices. The researchers investigated the perception of parents on clinical outpatients for three groups, agoraphobics, social phobics, and height phobics. Utilizing the EMBU, the patients' perceptions were measured on the scales of rejection, emotional warmth, and overprotection. The findings demonstrated that social phobics and height phobics reported greater parental lack of emotional warmth, rejection, and overprotection compared to the non-clinical controls. Agoraphobics depicted greater maternal rejection and both paternal/maternal lack of emotional warmth in comparison to non-clinical controls.

A further study by Arrindell et al. (1989) evaluated adult in-patient social phobics and agoraphobics with the EMBU. The social phobics scored both parents as rejecting, lacking in emotional warmth, and overprotective while the agoraphobics scored both parents as lacking in emotional warmth but only their mothers as rejecting.

These retrospective studies involving clinical patients indicate that, overall, social phobics perceive their parents as more rejecting and more

overprotective. It is proposed that rejection and overprotection of parents may produce a dysfunctional parent-child bond, which results in anxiety in social situations for offspring (Bowlby, 1977; Bruch, 1989). Over-protection may prevent the child from interacting in social situations, which limits opportunities to acquire social skills and autonomy. In addition, parental rejection may create a preoccupation in the child with others evaluative remarks leading to a generalized fear of negative evaluation in social situations.

One criticism of these studies previously described is the accuracy of an individual's perception in retrospective reports (Caster et al, 1999; Gerlsma et al., 1990; Rapee, 1997). Since most of the adults in this research are no longer under strong parental influence, the recollections may be distorted or biased. This bias is advocated especially for the clinical population since they often average 30 to 40 years in age. It has been suggested that adult's reports of their childhood experiences may be biased through selective attention, selective memory, or biased interpretation.

To overcome this retrospective disadvantage, other studies have investigated parental styles with observational, longitudinal and child/adolescent studies. In one longitudinal study, Lieb et al. (2000) examined social phobia and parental psychopathology, parenting styles, and characteristics of family functioning in a community sample of adolescents. Since this was the first study evaluating a community sample, the results minimized the biases associated with a clinical population. Subjects were previously tested on the study of Developmental Stages of Psychopathology.

Lieb and his researchers conducted interviews with parents for 14 to 17 years of age using the Munich-Composite International Diagnostic Interview instrument. Of the adolescent respondents who fulfilled the criteria for social phobia according to the DSM IV, they reported significantly higher parental overprotection and higher parental rejection. Therefore, these findings are in accordance with the results reported from the clinical samples. This study implies even stronger evidence for an association between social phobia and parenting styles since the information was acquired directly from adolescents still living at home (94%). Therefore, this finding advocates that parental psychopathology and social phobia is not just simply recall bias.

Attili (1989) conducted direct observations between the interactions of preschool children and their parents. Children who were over controlled by their parents without any explanation as well as children ignored by their parents were less socially successful at preschool. In addition, the results indicated that isolation and uneasiness of the child at school was linked with parental overprotection. This finding supports the proposal that overprotection may contribute to the development of social phobia since these two factors are characteristic of social phobia.

Caster et al. (1999) investigated the relationship between adolescents' perceptions of their parent's childrearing styles, family environment, and adolescent's reports of anxiety. After completing the Revised Children's Manifest Anxiety Scale, children ages seven to eleven from public and parochial schools completed questionnaires to assess student's perceptions of family environment and parental styles. Results concluded that the children in

the high social anxiety group scored both parents as more socially isolating, more concerned with other's opinions, and more ashamed of the students' shyness and poor performance in relation to the low social anxiety group. The conclusions of this study support the results of adult studies on social phobics. However, the parents' perceptions of child rearing styles did not fluctuate between the parents of socially anxious and non-socially anxious adolescents. This result could imply that parents of socially anxious children have limited interactions with others, which restricts their knowledge of other families parenting styles.

However, other researchers advocate that the pathological parental characteristics may not only be specific to social fears, but occur in other anxiety situations as well (Bogels et al., 2001.) Contrary to the previous studies, Bogels and his researchers indicated little support for childrearing practices in the development of social phobia. Based on the DSM IV, 1984, diagnosis by a clinician, the researchers examined a sample of clinical social anxious group, clinical control group of non-social anxious group, and control group of children by providing EMBU-C questionnaires on childrearing and social anxiety. In addition, parents of all groups completed questionnaires on their childrearing practices and their social anxiety. The results on the EMBU indicated that the parental rearing behaviors of emotional warmth and rejection were unrelated to social fears in children. The socially anxious group of children perceived their parents as less emotionally warm and more rejecting than the normal control children, but did not vary from the clinical control group. Therefore, this finding proposes that rejecting and non-

supportive parental behavior is not directly linked social fears, but that these parenting styles are associated with childhood psychopathology in general.

Purpose of Study

A review of the literature indicates that the parental styles of overprotection and rejection influence the development of social phobia. Since many studies focus on clinical patients, a recall bias is a controversial issue. Several studies employing observational, longitudinal or child/adolescent methods seem to produce similar results as the adult studies. The current study investigates the correlation of the parenting styles of overprotection and rejection with social phobia in a college sample. In order to minimize the potential memory bias, the sample includes young adults who typically, at this age, experience some parental influence. Therefore, the hypothesis expects that young adults with reported higher rates of social phobia will perceive their parents as more overprotective and rejecting in comparison to young adults without social phobia. The Parental Bonding Instrument and the Liebowitz Social Anxiety Scale are administered to investigate the link between parental styles and social phobia.

Chapter III

Method

Participants

Subjects for this study consisted of 35 freshman college students at Lindenwood University in St. Charles, MO. Participation was voluntary. All students signed a consent form prior to the study (refer to Appendix A). The gender mix of individuals participating was 42.9% men (n=15) and 57.1% (n=20) women. The age range consisted of 82.8% (n=29) of individuals up to 21 years of age, 14.3% (n=5) of individuals ranging from 21 to 30 years of age, 0% (n=0) of individuals ranging from 31 to 40 years of age, 2.9% (n=1) of individuals ranging from 41 to 50 years of age, and 0% (n=0) of individuals 51 years and older. Demographically, the participants reported the following as their ethnic origin: 2.9% (n=1) American Indian, 17.1% (n=6) Black, Non-Hispanic, 2.9% (n=1) Hispanic, 0% (n=0) Asian, 74.2% (n=26) White, Non-Hispanic and 2.9% (n=1) Other. Of the 35 participants, 80% (n=28) reported their family status as nuclear, 11.4% (n=4) reported a stepfamily status, and 8.6% (n=3) reported a blended family status. The current living analysis of the participants include 54.3% (n=19) living with mother/father, 11.4% (n=4) living with mother, 2.9% (n=1) living with father, 11.4% (n=4) living with a companion, 0% (n=0) living alone, and 20% (n=7) living with other.

Table 3.1 Demographic Data of Participants

Demographic Variable		N	%
Age	Up to 21 years old	29	82.8
	21 to 30 years old	5	14.3
	31 to 40 years old	0	0
	41 to 50 years old	1	2.9
	Over 50 years old	0	0
Gender	Male	15	42.9
	Female	20	57.1
Race	American Indian	1	2.9
	Black, Non-Hispanic	6	17.1
	Hispanic	1	2.9
	Asian	0	0
	White, Non-Hispanic	26	74.2
	Other	1	2.9
Family Status	Nuclear	28	80.0
	Stepfamily	4	11.4
	Blended	3	8.6
Current Living Analysis	Live with mother/father	19	54.3
	Live with mother	4	11.4
	Live with father	1	2.9
	Live with companion	4	11.4
	Live alone	0	0
	Live with other	7	20.0

Instruments

Parental Bonding Instrument

The Parental Bonding Instrument (PBI) by Gordon Parker, Hilary Tupling, and L.B. Brown's (1979) was used to measure the participant's perception of their parent's attitudes and behaviors toward childrearing. The PBI measures two parent dimensions, care (with the opposite being indifference and rejection) and overprotection (with the opposite being encouragement of

autonomy and independence). The scale consists of 25 items with 12 items assessing the care dimension and 13 items assessing the overprotection dimension. The care subscale includes items 1, 2, 4, 5, 6, 11, 12, 14, 16, 17, 18, and 24. The overprotection subscale includes items the remaining 13 items. The items are rated on a four point Likert scale ranging from 0= "very like" to 3= "very unlike". Items 1,5,6,8-13,19 and 20 are reverse-scored. The 12 items of the care subscales permit a maximum score of 36. The 13 items of the overprotection subscale permit a maximum score of 39. The participants completed two PBI forms, one for their perception toward mother and a second for their perception toward father.

The PBI has good to excellent internal consistency, with split half reliability coefficients of .88 for care and .74 for overprotection (Parker et al., 1979). The PBI has good stability with three-week test-retest correlations of .76 for care and .63 for overprotection. (Parker et al, 1979). The concurrent validity is good, correlating significantly with independent rater judgments of parental caring and overprotection.

Liebowitz Social Anxiety Scale

The Liebowitz Social Anxiety Scale (LSAS) by Michael Liebowitz (1987) was utilized to assess the participant's degree of social phobia. The LSAS assesses a wide selection of both social interaction and performance/observation situations, which are rated for the degree of fear/anxiety and frequency of avoidance. The scale consists of 24 items with 13 items assessing the subscale of performance anxiety and 11 items assessing the subscale of social anxiety. The items are rated on a four point Likert scale

ranging from 0= "none" to 3= "severe" for fear/anxiety and 0= "never" (0%) to 3= "usually" (67-100%) for avoidance. The LSAS further provides six subscale scores: total fear, fear of social interaction, fear of performance, total avoidance, avoidance of social interaction and avoidance of performance. An overall total score is usually calculated by summing the total fear and total avoidance scores. The present study examined the total fear scores and total avoidance scores.

The LSAS demonstrates a high degree of reliability and validity (Heimburg, Horner, Juster, Safren, Brown, Schneier and Liebowitz, 1999). For all subscales, Cronbach's alphas have been reported to be high, ranging from .81 to .96. The LSAS has been found to have a high degree of convergent validity with other measures of social phobia, such as the Social Avoidance and Distress Scale, (Watson & Friend, 1969), the Social Interaction Anxiety Scale (Mattick & Clarke, 1998), the Social Phobia Scale (Mattick & Clarke, 1998), the Fear of Negative Evaluation Scale (Watson & Friend, 1969), and the Social Phobia subscale of the Fear Questionnaire (Marks & Mathews, 1979), (as cited in Heimburg et al., 1999). The LSAS has shown to demonstrate discriminant validity in that the fear of social interaction subscale has a stronger correlation with the Social Interaction Anxiety Scale, a measure of anxiety in dyads and in groups then the performance subscales of the LSAS. In addition, the fear performance subscale has a stronger correlation with the Social Phobia Scale (SPS). The SPS measures an individual's anxiety due to being observed by other

individuals (Brown, Heimberg, Juster, Brown & Barlow, 1997; Heimberg, Mueller, Holt, Hope & Liebowitz, 1992), (as cited in Heimberg et al, 1999).

Procedures

The present study conducted was a correlational study. The design was chosen to investigate the relationship between social phobia and perceived parenting characteristics for both mother and father.

The participants were obtained by a voluntarily signing a sheet for the study posted on the school campus. The consent form given to the participant introduced the study and two questionnaires. Prior to filling out the questionnaires, the participants completed a demographic survey (refer to Appendix B). The participants first completed the LSAS, which assessed the level of social phobia for each participant (refer to Appendix C). Next, the participants completed the PBI for mother and PBI for father to determine the participants' perceptions of attitude and behaviors toward their parents (refer to Appendix D). After completing the two questionnaires, the individuals were given an information letter that explained the purpose and hypothesis of the study (refer to Appendix E). Any questions by the participants were addressed at this point.

Both questionnaires were scored and recorded by the researcher. The total score of social phobia for each participant was calculated for the LSAS. In addition, scores on the two subscales of social phobia, fear/anxiety subscale and avoidance subscale were readded for each participant. The total score for the PBI for mother as well as the total score for the PBI for father on each participant was calculated. The subscales of care and overprotection for the

PBI were examined for the mother and father. A Pearson r correlation was run to determine if individuals with higher levels of social phobia perceived their parents as more rejecting and more overprotecting.

Chapter IV

Results

The means and standard deviations were calculated for the Liebowitz Social Anxiety Scale. Results are reported in Table 4.1.

Table 4.1

Means and Standard Deviations for the Liebowitz Social Anxiety Scale.

Variable	M	SD
Total Fear/Anxiety	23.09*	12.33
Total Avoidance	20.71*	11.78

* Score range from 0-72.

The means and standard deviations were calculated for the Parental Bonding Instrument for mother. Results are reported in Table 4.2.

Table 4.2

Means and Standard Deviations for the Parental Bonding Instrument for Mother

Variable	M	SD
Total Score for Mother PBI	40.23*	6.62
Mother Care	24.31**	5.279
Mother Over protectiveness	15.06***	5.235

*Score range from 0-72.

** Score range from 0-36.

*** Score range from 0-39.

The means and standard deviations were calculated for the Parental Bonding Instrument for father. Results are reported in Table 4.3.

Table 4.3

Means and Standard Deviations for the Parental Bonding Instrument for Father

Variable	M	SD
Total Score for Father PBI	35.94*	6.46
Father Care	22.23**	6.56
Father Over protectiveness	13.71***	7.30

* Score range from 0-75.

** Score range from 0-36.

*** Score range from 0-39.

Correlations were obtained using the Pearson product-moment correlation. The total score for the social phobia scale was correlated with the scores for mother care, father care, mother overprotection, and father overprotection, respectively. There were no significant correlations. Therefore, the null hypothesis that there is no relationship between social phobia and parental characteristics could not be rejected.

A negative correlation was determined between care and over protectiveness on the PBI for mother. Those who scored higher on mother care (M=24.31), scored lower on over protectiveness (M=13.71), $r = -.570$, $p < .01$. A similar negative correlation was determined between care and over

protectiveness on the PBI for father. Those who scored higher on father care (M=22.23) tended to score lower on over protectiveness (M=13.71), r=-.570, p< .01.

Participants who scored lower for over protectiveness for mother (M=15.06) also tended to score lower for over protectiveness for father (M=13.71), r=.452, p< .01. There was no correlation between mother care and father care.

There was a positive correlation between the total scores for fear/anxiety (M=23.09) and avoidance on the LSAS (M=20.71), r=.858, p< .01. The score range for each of the subscales, fear/anxiety and avoidance, is 0-72.

Table 4.4

Correlations between LSAS and PBI subscales

Subscales	(1)	(2)	(3)	(4)	(5)	(6)
PBI subscales						
Mother care (1)	__	-.481	.187	-.191	.184	.216
Mother protection (2)	-.481	__	-.068	.452	.023	-.017
Father care (3)	.187	-.068	__	-.570	-.215	-.141
Father protection (4)	-.191	.452	-.570	__	.186	.093
LSAS subscales						
Total fear (5)	.184	.023	-.215	.186	__	.858
Total avoidance (6)	.216	-.017	-.141	.093	.858	__

+p<0.05; ++p<0.01

Chapter V

Discussion

The purpose of the present study was to investigate the relationship between social phobia and parental characteristics in a college sample. Although the study did not support the hypothesis, it does reveal some correlation between the characteristics of parental care and parental over protectiveness. For both parents, the participants who scored the parents higher on care tended to score the parent lower on over protectiveness. Therefore, parents perceived as more rejecting by the participants tend to perceive the parents as more overprotective. The relationship between these parenting characteristics supports previous studies, which examined parental characteristics in relation to psychopathology (Parker et al., 1979; Arrindell et al., 1989; Rapee, 1997; Lieb et al, 2000.)

Several explanations may exist for the lack of a significant correlation between parental characteristics and social phobia. One explanation, which needs to be examined, is the targeted population. The present study targeted the population of college students, which reported a relatively low degree of social phobia. (M=43.80, with a total score range of 0-144.) Since the lifetime prevalence estimate of social phobia, according to the NCS, is 13.3% in the adult population, several issues arise. Social phobia may be less prevalent in a college population. Although it has been reported that social phobics tend to be less educated, these studies do not distinguish between discrete phobia and social phobia. As previously noted, discrete social phobia is limited to a few social or performance-circumscribed situations such as public speaking,

interacting at informal gatherings, assertion, and/or observed performing an activity. The individual with generalized type of social phobia fears most social situations in addition to lacking social skills. Therefore, it is certainly not surprising that generalized social phobics would not be found in a college population since a college setting often requires daily social interactions and performance. However, it would be valuable information to examine the degree of discrete social phobia in this population. Since the instrument used in this study, the LSAS, does not permit such distinctions, the present study cannot examine this possibility.

In further examining the population of study, the targeted population of previous studies supporting a correlation between social phobia and parental characteristics must be considered. Most previous studies supporting the relationship between these two factors have focused on a clinical population, both in-patient and outpatient. Perhaps individuals in a clinical population are more aware of the disorder itself. Since the clinical population for social phobia is usually sought by the individual, the individual suffering from this disorder is more sensitive and aware of the feared and avoided situations. Therefore, individuals with heightened awareness of their social phobia may express their fears/anxieties and avoidances more accurately and readily.

Another notable observation is the positive correlation between the feared/anxiety subscale and the avoidance subscale on the LSAS. It may seem obvious that if an individual fears a particular situation, he/she may avoid it. However, an intricate part of the cycle of social phobia is the anticipatory cycle that occurs. As mentioned earlier, as an individual who

fears a situation tends to avoid that situation, the anticipatory anxiety of encountering that same situation heightens. Although this study did not address therapeutic approaches to social phobia, this correlation is certainly informative in implementing effective treatments.

Although the present study did not support the hypothesis, the correlations between the characteristics of parental care and over protectiveness are consistent with previous studies. Researchers are continuously evaluating the impact of pathological parenting characteristics on offspring. Although the etiology of social phobia is not yet clear, many researchers propose a link between these psychopathological parenting styles and social phobia (Arrindell et al., 1989, Bruch, 1989, Gerlsma et al., 1990; Lieb et al., 2000; Rapee, 1997).

Limitations of Study

A limitation of the present study was the relatively low degree of social phobia observed in the targeted population of college students. However, since most previous studies have focused on the clinical population, this particular study purposely examined the relationship between a non-clinical population and social phobia. Some studies have examined populations outside the clinical population, but the sample size was considerable larger. In one study, Lieb et al., conducted a prospective-longitudinal community sample study. The researchers obtained their subjects from a representative sample of 3021 individuals who participated in the Early Developmental States of Psychopathology Study. They obtained a baseline and follow-up date of 1047 adolescents aged 14 to 17 years at baseline and again 30 months

later. The researchers reported a significant correlation between social phobia and the parental characteristics of rejection and overprotection. Since the present study included a sample of only 35 participants, many more subjects may be needed to reflect an accurate sampling of the adult population with social phobia.

Appendix A

L.P.C. Program
Lindenwood University
Social Phobia Study

Kim Fischer: B.A in Psychology, Graduate Student
Marilyn Patterson, Ph.D.: Student Advisor

Consent To Participate in Research

I agree to participate in a research study being conducted on social phobia and parenting styles. Participation in this study involves completing demographic information and two questionnaires, which will take approximately fifteen to twenty minutes to complete. All participants remain anonymous since your identification is not requested on any forms. Information obtained will be treated confidentially. The participant may withdraw from the study at any time without penalty.

Kim Fischer who has the approval of Dr. Marilyn Patterson will coordinate this study. Kim is a candidate for a Master's Degree in the Professional Counseling program at Lindenwood College. The results of this study will be used to complete her thesis.

Your cooperation in this research is greatly appreciated. If you have any questions at a later time, you may contact Kim Fischer at 636-300-0244. If you have questions about your rights as a research participant or in the event you believe that you have suffered injury as a result of your participation in the research project, you many contact the student advisor, Dr. Marilyn Patterson at 636-949-4526.

____
Print Name Date

____
Participant Signature Date

____
Witness Date

Appendix B

Demographic Survey

1. Age — Up to 21 years (1) _______
   21 to 30 (2) ______
   31 to 40 (3) _______
   41 to 50 (4) ______
   Over 50 (5) ______

2. Gender — Female (1) _____ Male (2) _____

3. Ethnic Origin — American Indian (1) _______
   Black, Non-Hispanic (2) ______
   Hispanic (3) ______
   Asian (4) ______
   White, Non-Hispanic (5) ______
   Other (6) ______

4. Family Status — Nuclear (1) ______
   Stepfamily (2) _____
   Blended (3) ______

5. Current Living Analysis — Live with mother/father (1) _____
   Live with mother (2) _____
   Live with father (3) _____
   Live with companion (4) _____
   Live alone (5) _____
   Live with other (6) _____

Appendix C

LSAS

This questionnaire lists 24 various situations. In the first column, please indicate the level of fear or anxiety you would experience for each situation with a number from "0" representing "none" to "3" representing "severe". In the second column, please indicate the level of avoidance you would use for each situation with "0" representing "never" to "3" representing "usually". Please be as consistent as possible in your perception of the situation described.

	Fear or anxiety 0=none 1=mild 2=moderate 3=severe	Avoidance 0=never (0%) 1=occasionally (10%) 2=often (33-67%) 3=usually (67-100%)
1. Telephone in public	______	______
2. Participating in small groups	______	______
3. Eating in public places	______	______
4. Drinking with others in public places	______	______
5. Talking to people in authority	______	______
6. Acting, performing or giving a talk in front of an audience	______	______
7. Going to a party	______	______
8. Working while being observed	______	______
9. Writing while being observed	______	______
10. Calling someone you don't know very well	______	______
11. Talking with people you don't know very well	______	______
12. Meeting strangers	______	______
13. Urinating in a public bathroom	______	______
14. Entering a room when other are already seated	______	______
15. Being the center of attention	______	______
16. Speaking up at a meeting	______	______
17. Taking a test	______	______
18. Expressing a disagreement or disapproval to people you don't know very well	______	______
19. Looking at people you don't know very well in the eyes	______	______
20. Giving a report to a group	______	______
21. Trying to pick up someone	______	______
22. Returning goods to a store	______	______
23. Giving a party	______	______
24. Resisting a high pressure salesperson	______	______
Total score	______	______
Subscore for category 1	______	______
Subscore for category 2	______	______

Reference: Liebowitz MR. (1987). Social Phobia. Modern Problems in Pharmacopsychiatry, 22: 141-173

Appendix D

PBI

This questionnaire lists various attitudes and behaviors of parents. As you remember your mother in your first 16 years, please place a check in the most appropriate bracket next to each question.

	Very Like	Moderately Like	Moderately Unlike	Very Unlike
1. Spoke to me with a warm and friendly voice	( )	( )	( )	( )
2. Did not help me as much as I needed	( )	( )	( )	( )
3. Let me do those things I liked doing	( )	( )	( )	( )
4. Seemed emotionally cold to me	( )	( )	( )	( )
5. Appeared to understand my problems and worries	( )	( )	( )	( )
6. Was affectionate to me	( )	( )	( )	( )
7. Liked me to make my own decisions	( )	( )	( )	( )
8. Did not want me to grow up	( )	( )	( )	( )
9. Tried to control everything I did	( )	( )	( )	( )
10. Invaded my privacy	( )	( )	( )	( )
11. Enjoyed talking things over with me	( )	( )	( )	( )
12. Frequently smiled at me	( )	( )	( )	( )
13. Tended to baby me	( )	( )	( )	( )
14. Did not seem to understand what I needed or wanted	( )	( )	( )	( )
15. Let me decide things for myself	( )	( )	( )	( )
16. Made me feel I wasn't wanted	( )	( )	( )	( )
17.Could make me feel better when I was upset	( )	( )	( )	( )
18. Did not talk with me very much	( )	( )	( )	( )
19. Tried to make me dependent on her	( )	( )	( )	( )
20. Felt I could not look after myself unless she was around	( )	( )	( )	( )
21. Gave me as much freedom as I wanted	( )	( )	( )	( )
22. Let me go out as often as I wanted	( )	( )	( )	( )
23. Was overprotective of me	( )	( )	( )	( )
24. Did not praise me	( )	( )	( )	( )
25. Let me dress in any way I pleased	( )	( )	( )	( )

Reference: Parker, G., Tupling, H. & Brown, L.B. (1979). A parental bonding instrument. British Journal of Medical Psychology, 52, 1-10

Appendix E

PBI

This questionnaire lists various attitudes and behaviors of parents. As you remember your father in your first 16 years, please place a check in the most appropriate bracket next to each question.

	Very Like	Moderately Like	Moderately Unlike	Very Unlike
1. Spoke to me with a warm and friendly voice	( )	( )	( )	( )
2. Did not help me as much as I needed	( )	( )	( )	( )
3. Let me do those things I liked doing	( )	( )	( )	( )
4. Seemed emotionally cold to me	( )	( )	( )	( )
5. Appeared to understand my problems and worries	( )	( )	( )	( )
6. Was affectionate to me	( )	( )	( )	( )
7. Liked me to make my own decisions	( )	( )	( )	( )
8. Did not want me to grow up	( )	( )	( )	( )
9. Tried to control everything I did	( )	( )	( )	( )
10. Invaded my privacy	( )	( )	( )	( )
11. Enjoyed talking things over with me	( )	( )	( )	( )
12. Frequently smiled at me	( )	( )	( )	( )
13. Tended to baby me	( )	( )	( )	( )
14. Did not seem to understand what I needed or wanted	( )	( )	( )	( )
15. Let me decide things for myself	( )	( )	( )	( )
16. Made me feel I wasn't wanted	( )	( )	( )	( )
17.Could make me feel better when I was upset	( )	( )	( )	( )
18. Did not talk with me very much	( )	( )	( )	( )
19. Tried to make me dependent on him	( )	( )	( )	( )
20. Felt I could not look after myself unless he was around	( )	( )	( )	( )
21. Gave me as much freedom as I wanted	( )	( )	( )	( )
22. Let me go out as often as I wanted	( )	( )	( )	( )
23. Was overprotective of me	( )	( )	( )	( )
24. Did not praise me	( )	( )	( )	( )
25. Let me dress in any way I pleased	( )	( )	( )	( )

Reference: Parker, G., Tupling, H. & Brown, L.B. (1979). A parental bonding instrument. British Journal of Medical Psychology, 52, 1-10

Appendix F

L.P.C. Program
Lindenwood University
Social Phobia Study

Kim Fischer: B.A. in Psychology, Graduate Student
Marilyn Patterson, Ph.D.: Student Advisor

Information Letter

The purpose of the study in which you just participated is to examine the relationship between social phobia and parenting characteristics. As you may have heard from television advertisements, social phobia is a condition that has been increasingly recognized by the public and professional over the last several decades. Social phobia is a persistent fear of being scrutinized or assessed by other people with the expectation that this judgment will be negative or humiliating. The origin of this condition has not been identified, but several theories exist. One theory suggests that parenting styles may influence the development of social phobia. This particular study examines the correlation between the parenting characteristics of rejection and overprotection with social phobia. The hypothesis is that individuals who rate higher on social phobia will perceive their parents as more rejecting and overprotecting. It is essential for counselors to understand the variables involved with social phobia in order to provide the best possible treatment.

Your cooperation is this study is greatly appreciated. If you have any questions at a further date, you may contact Kim Fischer at 636-300-0244 or her advisor, Dr. Marilyn Patterson at 636-949-4526.

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