



Prevalence of Social Phobia, Gender and School Type among Young Adults in Nigerian Universities

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ABSTRACT:- Social phobia is a debilitating psychiatric condition that is treatable but often remains undetected and untreated and without treatment, clients are at risk for complications, such as reduced quality of life, social interactions, daily functioning, and treatment adherence. Not very much is known about social phobia in Africa and in Nigeria specifically. This study seeks to fill the gap by investigating the prevalence of social phobia and some demographic determinants of the same among young adults in Nigerian universities. 400 students were surveyed from 5 universities in southwest Nigeria, two of which are private universities and the other three are public ones. The Social Phobia Inventory (SPIN) was used to collect data for the study. Findings showed a high prevalence of social phobia among the participants, with 20% of them manifesting severe social phobia and 16.8% manifesting extremely severe social phobia. Neither gender nor school type revealed statistically significant differences in the manifestation of social phobia. Findings may be useful in further understanding the prevalence of social phobia among young adults and determining possible clinical intervention in schools.

Keywords:- Social Phobia, Gender, School Type

I. INTRODUCTION

According to Valente (2002) "social phobia is a debilitating psychiatric condition that is treatable but often remains undetected and untreated and without treatment, clients are at risk for complications, such as reduced quality of life, social interactions, daily functioning, and treatment adherence". Social phobia leads to more sick days, poor job performance, costly medical and emergency care visits, mental health visits, and greater reliance on disability or welfare and in the worst cases, the patient may decide that life is not worth living and consider suicide. Screening and careful assessment are the keys to detection and evaluation of social phobia (Valente, 2002). These outcomes are such that cannot be taken lightly anywhere in the world as global financial issues continue to face this generation and the ones to come. It is important that the human resources who are trained and skilled in our universities are also free of personal setbacks that will affect productivity and performance in the work sphere when social relations are challenged. It is normal for people generally to get anxious and self-conscious intermittently. For instance, when one is giving a speech or the individual is interviewing for a new job, people could get nervous or unsettled. Social anxiety, or social phobia, is more than just shyness or occasional nervousness. With social anxiety disorder, there is a fear of embarrassing one's self and that fear becomes so severe that one forms behaviour of circumventing circumstances that can trigger those intense moments. DSM-IV-TR defines social phobia as an anxiety disorder characterized by a strong and persistent fear of social or performance situations in which the patient might feel embarrassment or humiliation. Schneier (1991) postulates that social phobia remains among the least understood of anxiety disorders, although dramatic growth in the study of this condition over the past 5 years is yielding new information on its characteristics and treatment response. According to the Encyclopedia of Mental Disorders, generalized social phobia as a fear of most social interactions combined with fear of most performance situations, such as speaking in public or eating in a restaurant. Persons who are afraid of only one type of performance situation or afraid of only a few rather than most social situations may be described as having non-generalized, circumscribed, or specific social phobia (Mental Disorders, 2014). According to Schneier (1991), the (differentiation of phobic disorders into simple, social, and agoraphobia in DSM-III-R* following the findings of Marks and Gelder in the 1960s, has stimulated recognition of social phobia as a specific disorder that causes serious

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occupational and social impairment. In DSM-III-R, social phobia is defined by the central concept of excessive fear of scrutiny and/or embarrassment, while the feared situation may be discrete, such as public speaking, eating in public, or being observed while writing (Schneier, 1991). Social phobia, which is also known as social anxiety disorder, is a serious mental health problem in the United States and in any given year, social phobia affects 3.7% of the American population between the ages of 18 and 54, or about 5.3 million people leaving it as the third most common psychiatric condition after depression and alcoholism (Mental Disorders). In the generalized subtype, Schneier opined that most social situations are feared, often encompassing both discrete performance situations and social interactions, such as conversing on the telephone, initiating conversation with strangers, attending a party; or meeting with an authority figure. Sufferers may either avoid the feared situations or endure them with great anxiety, while the anxiety may include symptoms of autonomic arousal, such as palpitations, sweating, trembling, and blushing (Schneier, 1991). Patients diagnosed with social phobia have the highest risk of alcohol abuse of all patients with anxiety disorders; in addition, they suffer from worse impairment than patients with major medical illnesses, including congestive heart failure and diabetes (Mental Disorders).

Prevalence and Epidemiology of Social Phobia

Gren-Landell et al (2009) sampled data from a sample of 2,128 students and analyzed them. It showed a point-prevalence rate of 4.4% (95% CI 3.5-5.2) and a significant gender difference (6.6% girls vs. 1.8% boys, $P < 0.001$). No significant differences in prevalence of probable cases emerged across the ages. At sub-threshold level, marked social fear of at least one social situation was reported by 13.8% of the total group. "Speaking in front of class" and "calling someone unfamiliar on the phone" were the most feared social situations. In the social phobia group, 91.4% reported impairment in the school-domain due to their social fear. Gren-Landell et al (2000) concluded that social phobia is a common psychiatric condition in Swedish adolescents, especially in girls. As impairment in the school-domain is reported to a high degree, professionals and teachers need to recognize social phobia in adolescents so that help in overcoming the difficulties can be offered.

Schneier (1991) opines that the epidemiology of social phobia has only begun to be explored. Social phobia appears to be a common disorder, with a 6-month prevalence of 0.9% to 1.7% in men, and 1.5% to 2.6% in women according to the Epidemiological Catchment Area study. The preponderance of women with social phobia in the community contrasts with most clinical samples, where about half of social phobic patients are male (Schneier, 1991). It seems that cultural or other factors cause men to be more likely to seek out treatment for social phobia. Social phobics often fail to seek treatment, either due to the fear of self-revelation inherent in the disorder, or because of the assumption that social phobic symptoms are not treatable (Schneier, 1991). Another community survey" found that while more than 20% of the general population reported some fear of embarrassment while eating, writing, speaking in public, or using public restrooms, only 2% met the disability/distress criterion required for the DSM-III-R diagnosis of social phobia. A large proportion of the population that fears social situations does not experience intense distress or encounter circumstances that express the disability (e.g., a job that requires public speaking), so they would not receive a DSM-III-R diagnosis (Schneier, 1991).

Gender and Social Phobia

Turk et al (1993) conducted an exploratory investigation of gender differences in a large sample of persons with social phobia. Potential differences in demographic characteristics, comorbidity, severity of fear, and situations feared were examined. No differences were found on history of social phobia, social phobia subtype, or comorbidity of additional anxiety disorders, mood disorders, or avoidant personality disorder. However, women exhibited more severe social fears as indexed by several assessment instruments. Some differences between men and women also emerged in their report of severity of fear in specific situations. Women reported significantly greater fear than men while talking to authority, acting/performing/giving a talk in front of an audience, working while being observed, entering a room when others are already seated, being the center of attention, speaking up at a meeting, expressing disagreement or disapproval to people they do not know very well, giving a report to a group, and giving a party. Men reported significantly more fear than women regarding urinating in public bathrooms and returning goods to a store. Additionally, there were some differences in the proportion of men and women reporting fear in different situations. Specifically, more women than men reported fear of going to a party, and more men than women reported fear of urinating in a public restroom. Gender differences among patients with social phobia are discussed in the context of traditional sex-role expectations (Turk et al., 1993). According to McClean et al (2011), women have consistently higher prevalence rates of anxiety disorders, but less is known about how gender affects age of onset, chronicity, comorbidity, and burden of illness. Gender differences in DSM-IV anxiety disorders were examined in a large sample of adults ($N=20,013$) in the United States using data from the Collaborative Psychiatric Epidemiology Studies (CPES) (McClean et al., 2011). The lifetime and 12-month male:female prevalence ratios of any anxiety

disorder were 1:1.7 and 1:1.79, respectively. No gender differences were observed in the age of onset and chronicity of the illness. However, women with a lifetime diagnosis of an anxiety disorder were more likely than men to also be diagnosed with another anxiety disorder, bulimia nervosa, and major depressive disorder. Furthermore, anxiety disorders were associated with a greater illness burden in women than in men, particularly among European American women and to some extent also among Hispanic women. Ranta et al (2007) set out to examine age and gender differences in social anxiety symptoms during adolescence, and to investigate the psychometrics of the Social Phobia Inventory (SPIN) among adolescents. The SPIN was administered to a large general population sample ($n = 5252$) of Finnish adolescents aged 12–16 years. Age and gender trends in scores and internal consistency and factorial composition of the SPIN were examined in this sample. Results showed that girls scored higher than boys on the SPIN full scale and three subscales across the whole age range. Their results indicate that symptoms of social phobia may increase in mid-adolescence (Ranta et al., 2007). Bourdon et al (1988) carried out an analysis of gender differences in phobias which were presented based on Wave 1 of the five-site ECA community survey. A total of 18,572 respondents, aged 18 and over, were questioned about 15 phobic symptoms, yielding diagnoses based on DSM-III criteria for agoraphobia, social phobia, and simple phobia. Women had significantly higher prevalence rates of agoraphobia and simple phobia, but no gender differences were found for social phobia, the least prevalent of the phobic disorders. The most common phobias for both men and women involved “spiders, bugs, mice and snakes,” and “heights.” The largest differences between men and women were found on the agoraphobic symptoms of “going out of the house alone” and “being alone,” and on two simple phobia items, the fear of “any harmless or dangerous animal,” and “storms.” No sex differences were found in age of onset, reporting a fear on the phobic level, telling a doctor about symptoms, or recall of past symptomatology. Mean age of onset was significantly older for agoraphobia than for social or simple phobia, although all phobias evidenced onset at an early age.

Social Phobia and School Environment

According to the report of the National Institute of Mental Health (2009) the onset age when socio phobic symptoms begins to occur, is mainly in early adolescence. Negative experiences in childhood increase the risk of the development of SAD. The influence of education and family background is still considered to be unclear (Brook & Schmidt 2008). Shah and Kataria (2009) opine that there is paucity of information on the epidemiology of this disorder in the developing world, especially among university students. A cross-sectional survey of students at the University of Ibadan (Nigeria) is reported, using the Composite International Diagnostic Interview (CIDI) revealed a prevalence of social phobia at 8.5% (Shah and Kataria, 2009). Another study of 523 Swedish University students with the Social Phobia Screening Questionnaire (SPSQ) reported prevalence to be as high as 16.1% (Shah and Kataria, 2009). Izgic et al. from Turkey found the prevalence of social phobia at 7.9% among a stratified random sample of 1,003 university students. In India, there has been only one study on social phobia (among high school adolescents) which mentions a prevalence of 12.8% and also an association with impairment in academic functioning (Shah and Kataria, 2009). Social phobia even though being a common psychiatric disorder, is under recognized and under treated. It is more common in youth, is associated with lower educational achievements, unstable employment, higher frequency of being absent to work, individuals are less likely to marry, more likely to get divorced, and have reduced productivity that can lead to dependence from family, state, society, and country. Disability in diverse functional areas and impaired quality of life are the two important domains of consequences of social phobia.

In a study of social phobia and its impact in undergraduate students (young adults) of various faculties of a University in India, Shah and Kataria (2009) found that the prevalence of social phobia varies widely among different countries. In their study, social phobia was found in 19.5% of subjects, much more than other studies among university students. Previously, when prevalence estimates were based on the examination of psychiatric clinic samples, social anxiety disorder (ie., social phobia) was thought to be a relatively rare disorder. The opposite was instead true; social anxiety was common, but many were afraid to seek psychiatric help, leading to an understatement of the problem. Prevalence rates may vary widely because of overlapping symptoms with other disorders. Because of the difficulty in separating social phobia from poor social skills or shyness developmentally, some studies have a large range of prevalence. In community epidemiological surveys, the prevalence of social phobia depends heavily on where the diagnostic threshold is set, ranging from 1.9% to 18.7%²⁴. In this study, as SPIN has a specificity of 69-84% and the analysis using the disability scale suggests that between 15-20% of those scoring above cut-off on the SPIN experienced none or mild disability (implying that they would be unlikely to reach diagnostic criteria for the disorder), it can be inferred that the prevalence rates may be somewhat lower than identified. Even after this consideration, the prevalence rate appears quite high (Shah and Kataria, 2009).

Turner et al (1986) studied the clinical manifestations of social phobia in a diagnosed sample of 21 social phobics (aged 21–53 yrs). Social phobia was found to be a chronic and pervasive condition affecting a variety of life areas and producing significant emotional distress. In a second study, individuals with a diagnosis

of social phobia or avoidant personality disorder were compared using a subsample of 10 socially phobic Ss and a sample of 8 Ss with avoidant personality disorder (aged 30–60 yrs). Although physiological reactivity and cognitive content were essentially the same for both groups in a number of situational tasks, those Ss with a diagnosis of avoidant personality disorder were found to be more sensitive interpersonally, and exhibited significantly poorer social skill than did the social phobic Ss. Results are discussed in relation to Diagnostic and Statistical Manual of Mental Disorders (DSM-III) criteria for social phobia, the significance of social phobia as a clinical syndrome, and the research and treatment implications of the difference found between individuals with a diagnosis of social phobia and those with avoidant personality disorders.

Hudson and Rapee (2000) report that exposition literature indicate an average age of onset of social phobia between early and late adolescence and a suggestion of an onset period in early adulthood. Added to this on the other hand is the fact that in large epidemiological study, almost one half of the sample reported having suffered from the disorder all of their lives or since before the age of 10, suggesting that the age of onset may in fact occur earlier than adolescence (Hudson and Rapee, 2000). Hudson and Rapee (2000) therefore opine that it would appear, then, that data from retrospective reports indicating an average age of onset in adolescence and early adulthood may be misleading, and it would be more useful to allow for a much earlier age. They also agree that an alternative way to approach the question of the age of onset of social phobia may be to examine the age at which children first develop social-evaluative concerns or become self-conscious, as it is these themes that appear to be central to the disorder of social phobia considering the fact that several researchers have studied this area, even though some confusion still remains as to when social-evaluative concerns are first evident in children. Hudson and Rapee also report Buss (1980) who referred to a type of shyness called self-conscious shyness that is evident once a child has developed a sense of himself or herself as a social object, that is, the child's ability to become acutely aware of himself or herself and aware that others may also view him or her. Self-conscious shyness is characterized by public self-awareness as a result of being scrutinized, being uniquely different, a breaching of privacy, or being in a formal situation. This shyness is also transient and supposedly a relatively universal experience. In Hudson and Rapee (2000)'s report, Buss, Iscoe, & Buss (1979) carried out a retrospective study to examine the ages when children first experienced embarrassment. Buss hypothesized that when a child is capable of experiencing embarrassment, the child must possess a social self, that is, possess the ability to see himself or herself as a social object. The study found that around the age of 4 or 5, there appeared to be a definitive increase in a child's ability to experience embarrassment. This led Buss to conclude that children develop self-conscious shyness at around the age of 4 or 5. However, further studies have provided evidence that conflicts with the results of the Buss et al. (1979) study. Hudson and Rapee also report Lewis, Stanger, Sullivan, and Barone (1991), who in an observational study, were able to elicit embarrassment in roughly one half of the 2-year-old children and in the majority of 3-year-old children. The differences, however, may be a result of the method of obtaining data: maternal retrospective reports versus observational data. It is also unclear whether the evidence of embarrassment at this age is indicative of a child's ability to feel self-conscious, as there have been studies that have found evidence suggesting that self-consciousness or concerns about negative evaluation do not occur until about 8 years of age. For example, Bennett and Gillingham (1991) found that 8 year olds became embarrassed in front of a supportive audience whereas 5 year olds only became embarrassed in front of a derisive audience, suggesting that the emotions of 8 year olds are influenced by a self-awareness that is not evident in 5 year olds (Hudson and Rapee, 2000).

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32 generalized social phobic outpatients and 32 matched nonclinical control subjects participated in a dyadic 'getting acquainted' interaction by Alden and Wallace (1995) with an experimental assistant who engaged in either positive or negative social behaviour. The accuracy of social phobics' and control subjects' perceptions of themselves and their partners were compared in the two conditions. Relative to observers' ratings, the social phobics displayed a negative bias in their appraisals of some, but not all, aspects of their social performance. These results suggested that social phobics may have particular difficulty gauging the nonverbal aspects of their social behavior. The phobics discounted their social competence to the same extent in the

positive interaction, where their behavior was more skilful, as in the negative interaction. The social phobics were also less accurate than nonclinical controls in their appraisals of their partners, however, these phobic subjects displayed a positive bias when appraising their partner's performance.

1.1 STATEMENT OF PROBLEM

Social phobia is of major concern to society as a whole for two reasons according to the encyclopaedia on mental disorders. One reason is the disorder's very high rate of comorbidity with such other mental health problems as major depression and substance abuse. In comparison with patients diagnosed with other anxiety disorders, patients with social phobia have higher averages of concurrent anxiety disorders (1.21 versus 0.45); comorbid depression or other disorders (2.05 versus 1.19); and lifetime disorders (3.11 versus 2.05). The most common comorbid disorders diagnosed in patients with social phobia are major depression (43%); panic disorder (33%); generalized anxiety disorder (19%); PTSD (36%); alcohol or substance abuse disorder (18%); and attempted suicide (23%) (Mental Disorders, 2014). The implication to this is that we are looking at just more than a social menace here but also a catalyst to several other mental disorders that adolescents in Nigeria could be brewing up or even living with already.

The second reason is the loss to the larger society of the gifts and talents that these patients possess (Mental Disorders, 2014). Social phobia can have a devastating effect on young people's intellectual life and choice of career, causing them to abandon their educations, stay stuck in dead-end jobs, refuse promotions involving travel or relocation, and make similar self-defeating choices because of their fear of classroom participation, job interviews, and other social interactions in educational and workplace settings (Mental Disorders, 2014). One sample of patients diagnosed with social phobia found that almost half had failed to finish high school; 70% were in the bottom two quartiles of socioeconomic status (SES); and 22% were on welfare (Mental Disorders, 2014). In addition to their academic and employment-related difficulties, people with social phobia have limited or nonexistent social support networks, so they are less likely to marry and start families of their own because of their fear of interpersonal relationships, while a number of them continue to live at home with their parents even as adults, or remain in unfulfilling relationships (Mental Disorders, 2014). This is an eventuality that this study will help to report and resume the process of understanding. This study seeks to understand how much of social phobia we may already be dealing with in Nigeria and especially in the university system that is producing the next generation.

1.2 STATEMENT OF HYPOTHESIS

The following hypotheses are formulated to guide the data analysis and testing:

1. There will be a significant difference in the socio phobic health of female and male adolescents in Nigerian Universities
2. There will be a significant difference in the socio phobic health of adolescents in the selected private and public Nigerian universities

II. METHODOLOGY

This study seeks to understand the prevalence of social phobia among young adults in Nigerian universities while determining the influence of school type and gender on social phobia.

2.1 RESEARCH DESIGN

This study adopted a survey research design to examine the prevalence of social phobia among young adults in Nigerian universities while determining the influence of school type and gender on social phobia. The independent variable is Gender and School Type, while the dependent variable is Social Phobia.

2.2 RESEARCH POPULATION/ SAMPLE

The survey population of study is students from 5 Nigerian universities; University of Ibadan, University of Lagos, Obafemi Awolowo University Ife, Babcock University and Redeemers University. The adolescents were randomly selected and volunteered to participate in the study.

2.3 RESEARCH INSTRUMENT

SPIN - Social Phobia Inventory (Davidson, 2000)

This is a 17 item questionnaire developed by Davidson (2000) which assesses a range of avoidance behaviors (e.g., avoidance of talking to strangers), physical symptoms (e.g., distress as evidenced by sweating) and social fears (e.g., fear of people in authority positions). The scale has good ability to distinguish adults with and without social phobia. Items assessing fear, avoidance, and physiological distress make up the three subscales of the SPIN. It has good test-retest reliability; correlates highly with the Liebowitz and is more

sensitive to change. The 17 items are scored from 0-4, and are added together to give a total score with a range of 0-68. **Psychometric Properties**

Internal consistency

Evaluation of internal consistency according to Cronbach's α was performed for the total baseline SPIN score, the coefficient for social phobia subjects ranged from 0.87 to 0.94 compared with 0.82-0.90 for controls groups. Coefficients for baseline subscale scores for social phobia subjects v. controls were as follows: fear, 0.68-0.76 v. 0.76-0.79; avoidance, 0.71 v. 0.70-0.81; and physiological, 0.70-0.73 v. 0.57-0.68. In group II at end-point, Cronbach's α coefficients were 0.94 for the full scale, and 0.89, 0.91, and 0.8 for the fear, avoidance, and physiological subscales, respectively.

Convergent validity

The SPIN total and sub-scale scores were compared and a highly significant correlation coefficient was obtained ($r=0.57, P<0.0001$) ($n=67$ at baseline). Correlation coefficients for the sub-scale items of the SPIN relative to the BSPS were also highly significant, as follows: fear subscale, $r=0.61 (P<0.0001)$; avoidance subscale, $r=0.47 (P<0.001)$; and physiological subscale, $r=0.66 (P<0.0001)$. Correlation against the LSAS was 0.55 ($P<0.0001$).

Divergent validity

No significant correlation with the general health score of the SF-36 was found in group III ($r=0.01$). Relative to blood-injury phobia assessed on the FQ, the correlation was $r=0.34 (P<0.002)$ which, although significant, was lower than the correlations noted with other social phobia measures. Relative to disability as measured by the SDS, the correlation was $r=0.33 (P<0.03)$.

Construct validity

Total SPIN scores for subjects with social phobia ($n=148$) were compared with scores for non-psychiatric controls (group I; $n=68$). At baseline, subjects with social phobia had mean (s.d.) total SPIN scores of 41.1 (10.2) compared with 12.1 (9.3) in controls ($t=3.22; P<0.001$).

2.4 DATA COLLECTION PROCEDURE

The researcher obtained permission from the school authorities of Redeemer's University, University of Lagos, University of Ibadan, Obafemi Awolowo University and Babcock University to administer the psychological batteries on some of the randomly selected students of these schools. For the purpose of this study, adolescents from these five universities were surveyed and their scores in psychopathological symptoms were collected. A total of 400 students were surveyed for this study.

2.5 METHOD OF DATA ANALYSIS

Quantitative data was generated for this study through the administration of questionnaires. The scores obtained by the respondents will be compiled into contingency tables according to the main variables under examination. The data obtained was analyzed using both descriptive and inferential statistical methods (t-Test, standard deviation, mean, range and percentage count) with the data subjected to appropriate statistical analyses and tested at 0.05 level of significance.

Descriptive Statistical Analysis:

Mean and standard deviation were used to summarize the participant's scores for Socio Phobic health based on gender, and school environment.

Inferential Statistical Analysis:

The collected data was analyzed with the aid of SPSS 22 (The Statistical Package for Social Science); Independent Sample t-Test and One-Way ANOVA was used to test the hypothesis at 0.05 level of significance.

III. DATA ANALYSIS AND RESULTS

3.1 SOCIO DEMOGRAPHIC DATA

The demographic characteristics of the respondents in the studied population and variables like gender, and school type are analyzed and presented.

Table 1 Demographic Characteristics of Participants

VARIABLES		NUMBER	MEAN	SD
Gender	Male	157	37.35	11.88
	Female	243	37.95	12.19
School Type	Private	146	37.13	10.67
	Public	254	38.04	12.79

There were 400 respondents from five universities surveyed on this study. From the Table 1, the gender distribution shows that 157 of the respondents are male and 243 are female and they have on average of 37.35 and 37.95 respectively on their socio phobic health scores with a standard deviation of 11.88 and 12.9 respectively. The school type distribution shows that 146 of the respondents are from a private university and 254 are from a public university and they have on average of 37.13 and 38.04 respectively on their socio phobic health scores with a standard deviation of 10.67 and 12.79 respectively.

3.2 PREVALENCE OF SOCIAL PHOBIA

Based on the results from the analysis of the data collected, the following Table 2 shows the prevalence of social phobia among the participants surveyed.

Table 2 Prevalence of Social Phobia among Young Adults in Nigerian Universities

SEVERITY	PERCENTAGE
None	4.5%
Mild	24.3%
Moderate	34.5%
Severe	20%
Very Severe	16.8%

This study seeks to examine the prevalence of social phobia among young adults in private and public universities located in select southwest states in Nigeria. 400 young adults from these universities were surveyed to check for prevalence of social phobia. Results show that only 4.5% of these young adults do not report any social phobia at all. 24.3% of these adolescents report mild cases of social phobia while 34.5% of the young adults manifest a moderate level of social phobia. 20% of the participants surveyed manifested severe levels of social phobia and 16.8% of the surveyed participants manifested very severe levels of social phobia. Even though the severe and very severe levels of social phobia need clinical intervention for their situation, they are in no apparent danger.

3.3 TEST OF HYPOTHESES

The results for the two hypotheses tested for this study are presented in this section. The t-Test statistics was utilized for both hypotheses.

3.3.1 HYPOTHESIS ONE

There will be a significant difference in the socio phobic health of male and female adolescent in Nigerian Universities.

Table 3 t-Test Table for adolescents Gender and socio phobic Health

GENDER	N	MEAN	SD	T	P
MALE	157	37.35	11.88	-.486	<.05
FEMALE	243	37.95	12.19		

The t-Test scores showed that there were 157 male respondents and 243 female while the mean social phobia health was 37.35 and 37.95 respectively. The two-tailed p value associated with this test was .628. The t-Test failed to reveal a statistically reliable difference between the mean number of social phobia scores that the male adolescents from the Nigerian Universities has ($M = 37.35, s = 11.88$) and that the female adolescents from the Nigerian Universities has ($M = 37.95, s = 12.19$), $t(398) = -.486, p = .628, \alpha = .05$. It can be therefore concluded that the socio phobic health of male students in the five Nigerian Universities is not higher or lower than that of the female adolescents.

3.3.2 HYPOTHESIS TWO

There will be a significant difference in the socio phobic health of adolescents in the selected private and public Nigerian universities

Table 4.4 t-Test Table for adolescents Family Type and Psychological Health

SCHOOL TYPE	N	MEAN	SD	T	P
PRIVATE	146	37.13	10.67	0.726	<.05
PUBLIC	254	38.04	12.79		

The t-Test scores showed that there were 146 respondents from private university settings and 254 from public university settings while the mean social phobia scores was 37.13 and 38.04 respectively. The two-tailed p value associated with this test was .468. The t-Test failed to reveal a statistically reliable difference between the mean number of social phobia scores that the adolescents in the private Nigerian Universities have ($M = 37.13, s = 10.67$) and that the adolescents in the public Nigerian Universities have ($M = 38.04, s = 12.79$), $t(398) = 0.726, p = .468, \alpha = .05$. It can be therefore concluded that the socio phobic health of the adolescents in the private Nigerian Universities is not higher or lower than that of the adolescents in the public Nigerian Universities. The setting of the university has little or no influence on the socio phobic health of the adolescents.

IV. DISCUSSION

The objectives of the study were to examine the prevalence of social phobia among young adults in Nigerian universities while determining the influence of school type and gender on social phobia.

The result from hypothesis one which states that there will be a significant difference in the socio phobic health of male and female adolescent in Nigerian Universities, showed no apparent significant difference. This finding however appears to be both consistent and inconsistent with the previous empirical findings. McClean et al (2011) found that women had higher rates of lifetime diagnosis for each of the anxiety disorders examined, except for social anxiety disorder which showed no gender difference in prevalence. Turk et al (1998) however investigated gender differences in a large sample of persons with social phobia. Some differences between men and women emerged in their report of severity of fear in specific situations. Women reported significantly greater fear than men while talking to authority, acting/performing/giving a talk in front of an audience, working while being observed, entering a room when others are already seated, being the center of attention, speaking up at a meeting, expressing disagreement or disapproval to people they do not know very well, giving a report to a group, and giving a party. Men reported significantly more fear than women regarding urinating in public bathrooms and returning goods to a store. Additionally, there were some differences in the proportion of men and women reporting fear in different situations. Specifically, more women than men reported fear of going to a party, and more men than women reported fear of urinating in a public restroom (Turk et al., 1998). These empirical findings leave one question about the findings of this study. Perhaps if the study focused on individual aspects of psychopathology like mood disorders, anxiety etc then the difference in gender and psychopathological symptoms would have been more apparent. According to McClean et al (2011), women have consistently higher prevalence rates of anxiety disorders, but less is known about how gender affects age of onset, chronicity, comorbidity, and burden of illness. Gender differences in DSM-IV anxiety disorders were examined in a large sample of adults ($N=20,013$) in the United States using data from the Collaborative Psychiatric Epidemiology Studies (CPES) (McClean et al., 2011). The lifetime and 12-month male:female prevalence ratios of any anxiety disorder were 1:1.7 and 1:1.79, respectively. No gender differences were observed in the age of onset and chronicity of the illness. However, women with a lifetime diagnosis of an anxiety disorder were more likely than men to also be diagnosed with another anxiety disorder, bulimia nervosa, and major depressive disorder. Furthermore, anxiety disorders were associated with a greater illness burden in women than in men, particularly among European American women and to some extent also among Hispanic women.

The result from the second hypothesis which states that there will be a significant difference in the socio phobic health of adolescents in the selected private and public Nigerian universities shows that there was no significant difference in the socio phobic health of both groups. Interestingly, the students from the public university manifested a slightly but not statistically significant higher average in their level of social phobia than the students from private schools. Although no specific empirical data was found to support this result, there are possibilities that there are pressures inherent in the public school system that drives a higher level of social phobia among adolescents. The results however show that there is no significant difference and so the researcher opines that due to uncertainty of onset age of social phobia, even though literature places onset age as young as age 5 to 8 years, the social phobia of these adolescents may have reached its peak before entering the university system. Therefore the pressures of university system may not have any significant impact on their social phobia.

4.1 CONCLUSION

The prevalence of social phobia among adolescents in Nigerian universities, both private and public and from different family backgrounds is brought into focus in this study. Hypothesis focusing on comparison of social phobia scores among these adolescents and related variables like gender and school type are tested in this study. 400 adolescent respondents from five Nigerian universities, two private and the others public were randomly sampled and data collected were subjected to descriptive statistics and t-Test statistics. From the analysis and interpretation of results, it may be concluded that female adolescents did not manifest a higher level of social phobia than the male adolescents. School type was also not found to have a significant difference in social phobia health of these adolescents.

4.2 RECOMMENDATION

The following recommendations are made from the finding of this study to parents, school counselors and authorities, researchers and other professionals and/or experts who work with adolescents.

Parents must be aware of the fact that there is a prevalence of social phobia manifesting in a lot of adolescents and so must find a way to incorporate psychological health check-ups alongside regular health check-ups.

School counselors and authorities must also be aware of this prevalence in order to make genuine attempts to incorporate psychological health service provision on campuses. This is very important even though there is no significantly higher manifestation of socio phobic symptoms in private schools than in public schools.

Authorities must be aware of this prevalence which impact adolescent depression and drug use and find ways to target prevention.

Parents should become more educated about the warning signs of psychological ill-health like social phobia in their adolescents. The following situations are often stressful for people with social anxiety disorder:

Meeting new people

Being the center of attention

Being watched while doing something

Making small talk

Public speaking

Performing on stage

Being teased or criticized

Talking with “important” people or authority figures

Being called on in class

Going on a date

Making phone calls

Using public bathrooms

Taking exams

Eating or drinking in public

Speaking up in a meeting

Attending parties or other social gatherings

REFERENCES

- [1]. Alden, L. E. & Taylor, C. T. (2004). Interpersonal processes in social phobia. *Clinical Psychology Review*, 24(7), 857-882
- [2]. Alden, L. E. & Wallace S. T. (1995). Social phobia and social appraisal in successful and unsuccessful social interactions. *Behaviour Research and Therapy*, 33 (5): 497–505
- [3]. Beesdo, K., Knappe, S., & Daniel S. Pine, D. S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. *The Psychiatric clinics of North America* 32(3): 483-524
- [4]. Bracik, J., Krzysztof, K. And Zaczek, A. (2012). Impact of family and school environment on the development of social anxiety disorder: a questionnaire study. *Psychiatria Danubina*, 24,(1), pp 125-127
- [5]. Bögels, S. M. & Brechman-Toussaint, M. L. (2006). Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs. *Clinical Psychology Review*(26) 7: 834–856
- [6]. Bourdon, K. H., Boyd, J. H., Rae, D. S., Burns, B. J., Thompson, J. W., Locke, B. Z. (1988). Gender differences in phobias: Results of the ECA community survey. *Journal of Anxiety Disorders* 2 (3):227–241
- [7]. Brook, C. A. & Schmidt, L. A. (2008). Social anxiety disorder: A review of environmental risk factors. *Neuropsychiatr Dis Treat*, 4:123–43.
- [8]. Caster, J. B., Inderbitzen, H. M., & Debra Hope, D. (1999). Relationship between youth and parent perceptions of family environment and social anxiety. *Journal of Anxiety Disorders* (13) 3: 237–251
- [9]. Davila, J., & Beck, J.G.(2002). Is social anxiety associated with impairment in close relationships? A preliminary investigation. *Behavior Therapy*, 33 (2), pp. 447–464
- [10]. Gren-Landell M., Tillfors, M., Furmark, T., Bohlin, G., Andersson, G., & Svedin, C. G. (2009). Social phobia in Swedish adolescents: prevalence and gender differences. *Social Psychiatry and Psychiatric Epidemiology*, 44(1):1-7
- [11]. Heinrichs, N. (2003, September). Does a partner matter? Paper presented at the European Congress of Behavioural and Cognitive Therapy, Prague, Czechoslovakia.

- [12]. Hudson, J. L. & Rapee, R. M. (2000). The origins of social phobia. *Behavior Modification*, 24(1) 102-129
- [13]. James Reich, J. & William, Y. (1988). Family history of psychiatric disorders in social phobia. *Comprehensive Psychiatry* 29, (1), 72–75
- [14]. McLean, C. P., Asnaani, A., Litz, B. T., Hofmann, S. G. (2011). Gender differences in anxiety disorders: prevalence, course of illness, comorbidity and burden of illness. *Journal of Psychiatry Reviews*, 45(8):1027-35
- [15]. Mental Disorders (2014). Social phobia. *Encyclopedia of Mental Disorders*. Retrieved from <http://www.minddisorders.com/Py-Z/Social-phobia.html>
- [16]. Montesi, J. L., Conner, B. T., Gordon, E. A., Fauber, R. L., Kim, K. H., & Heimberg, R. G. (2013). On the relationship among social anxiety, intimacy, sexual communication, and sexual satisfaction in young couples. *Archives of Sexual Behavior*, 42(1), 81-91.
- [17]. National Institute of Mental Health (2009). The numbers count: Mental disorders in America. NIMH, 2009.
- [18]. Ranta, K., Kaltiala-Heino, R., Koivisto, A. M., Tuomisto, M. T., Pelkonen, M., & Marttunen, M. (2007). Age and gender differences in social anxiety symptoms during adolescence: The Social Phobia Inventory (SPIN) as a measure. *Psychiatry Research* 153(3): 261–270
- [19]. Schneier, F. R. (1991). Social Phobia. *Psychiatric Annals* 21(6), 349-353
- [20]. Shah, P., & Kataria, L. (2009). Social phobia and its impact in Indian university students. *The Internet Journal of Mental Health*, 6 (2).
- [21]. Stein, M. B., Chartier, M. J., Hazen, A. L., Kozak, M. V., Tancer, M. E., Lander, S., Furer, P., Chubaty, D. & Walker, J. R. (1998). A direct-interview family study of generalized social phobia. *American Journal of Psychiatry*, 155(1):90-7.
- [22]. Turner, S. M., Beidel, D. C., Dancu, C. V. & Keys, D. J. (1986). Psychopathology of social phobia and comparison to avoidant personality disorder. *Journal of Abnormal Psychology*, 95(4), 389-394.
- [23]. Turk, C. L., Heimberg, R. G., Orsillo, S. M., Holt, C. S., Gitow A., Street, L. L., Schneier, F. R., Liebowitz, M. R. (1998). An investigation of gender differences in social phobia. *Journal of Anxiety Disorder*. 12(3):209-23.
- [24]. Valente, S. M. (2002) Social phobia. *Journal of the American Psychiatric Nurses Association* 8, (3) 67–75
- [25]. Wenzel, A. (2002). Characteristics of close relationships in individuals with social phobia; a preliminary comparison with nonanxious individuals. In J.H. Harvey, A. Wenzel (Eds.), *Maintaining and enhancing close relationships: A clinician's guide*, Lawrence Erlbaum Associates, Mahwah, NY (2002), pp. 199–213