MINISTRY OF SCIENCE AND EDUCATION OF THE REPUBLIC OF AZERBAIJAN

KHAZAR UNIVERSITY

GRADUATE SCHOOL OF SCIENCE, ART AND TECHONOLOGY

The code of major	**060209 - Psychology**
The name of specialty	**Clinical Psychology**

Master student of the Department of Psychology

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For the master degree

Topic: "THE RELATIONSHIP BETWEEN SOCIAL PHOBIA AND ATTACHMENT STYLES IN ADOLESCENTS"

MASTER THESIS

Supervisor: PhD in psychology, docent

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June-2023

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Yeniyetmələrdə sosial fobiya və bağlanma tərzləri arasındakı əlaqə

Xülasə

Təqdim olunan dissertasiya işində yeniyetmələrdə yaranan sosial fobiya ilə bağlılıq arasında olan əlaqəni eksperimental şəkildə öyrənilmişdir.

Tədqiqat işi ümumi bir şəkildə giriş, üç fəsil, on yarımfəsil , nəticə, ədəbiyyat siyahısı və əlavələrdən ibarətdir. Dissertasiyanın tədqiqat qrupunu 60 nəfər orta məktəb şagirdi təşkil edir.

Birinci fəsildə sosial fobiya ümumi bir şəkildə təhlil edilmişdir, sosial fobiyaya nələrin səbəb olduğu və necə yarandığı haqqında məlumatlar verilmişdir. Həmçinin sosial fobiya yeniyetmələrdə necə təzahür edir və xüsusiyyətləri haqqında təhlil aparılmışdır.

İkinci fəsildə Bağlanma probleminin elmi-nəzəri aspektləri müzakirə edilmişdir. Bu fəsildə sosial fobiya və bağlılıq arasındakı əlaqə, xüsusiyyətləri qeyd olunmuşdur. Son olaraq isə, bağlanma tərzlərinin şəxsiyyətin formalaşmasında rolu haqqında məlumatlar qeyd edilmişdir.

Tədqiqat işinin 3 – cü fəslində müəyyən tədqiqatlar aparılmışdır. Tədqiqatda məlumat toplama vasitələri kimi Sosial Fobiya Şkalası (Liebovitz), tədqiqatçı tərəfindən hazırlanmış Sosial-Demoqrafik Sorğudan, Yeniyetmələr üçün Sosial Fobiya Şkalası (Greca və Lopez) və Yeniyetmələr üçün Münasibətlər Ölçüsü Anketi (Bartholomev, Horovitz , Qriffin və Horovitz) istifadə edilmişdir.

Təhlillər nəticəsində Sosial Fobiya və Bağlanma tərzləri arasında əlaqə ilə yanaşı sosial fobiyanın bəzi xüsusiyyətlərə əsaslanaraq dəyişib-dəyişmədiyidə qeydə alınmışdır.

Ümumi tədqiqat nəticəsində sosial fobiya və bağlanma tərzləri arasında əhəmiyyətli əlaqə olduğu nəzərə alınmışdır. Yeniyetmələrdə yaranan sosial fobiya və yaxud bağlanma tərzlərinin valideynlərinin təhsil səviyyələrinə əsasən fərqlənmədiyi nəzərə alınmışdır.Tədqiqat nəticələrinin riyazi-statistik təhlilini aparmaq üçün SPSS proqraməndan istifadə olunmuşdur. Tədqiqatda

alınan nəticələrə görə müəyyən olunmuşdur ki, yeniyetmələrdə sosial fobiya və bağlanma tərzləri arasında əlaqə mövcuddur.

Fidan Mammadova

The relationship between social phobia and attachment styles in adolescents

Abstract

In the presented dissertation, the relationship between social phobia and attachment in adolescents was experimentally studied.

The research work consists of introduction, three chapters, ten sub-chapters, conclusion, references and appendices. The research group of the dissertation consists of 60 high school students.

In the first chapter, social phobia was analyzed in a general way, information was given about what causes social phobia and how it arises. Also, an analysis was made about how social phobia manifests itself in teenagers and its characteristics.

In the second chapter, scientific-theoretical aspects of the attachment problem were discussed. In this chapter, the relationship and characteristics between social phobia and attachment are mentioned. Finally, information about the role of attachment styles in the formation of personality was mentioned.

The 3rd chapter of the research work, certain studies were conducted. The Social Phobia Scale (Liebowitz), researcher-made Socio-Demographic Questionnaire, Adolescent Social Phobia Scale (Greca and Lopez) and Adolescent Relationship Scale Questionnaire (Bartholomew, Horowitz, Griffin and Horowitz) were used as data collection tools in the study.

As a result of the analysis, it was recorded whether social phobia changes based on some characteristics, along with the relationship between Social Phobia and Attachment styles.

As a result of the study, it was considered that there is a significant relationship between social phobia and attachment styles. It was taken into account that the social phobia or attachment styles that arise in teenagers do not differ based on the educational level of their parents. SPSS software was used to conduct a mathematical-statistical analysis of the research results.

According to the results obtained in the study, it was determined that there is a relationship between social phobia and attachment styles in adolescents.

CONTENTS

INTRODUCTION

The actuality of the research. Social phobia is a marked or intense fear or anxiety in social situations in which a person may be judged by others. This fear or anxiety of children should show itself not only in their interactions with adults , but also in social environments where they are with their peers. When the person stays in these social situations, he/she fears being evaluated negatively. The person is afraid to act or appear a certain way or show signs of anxiety such as blushing, trembling, sweating, stuttering or staring, so they are negatively evaluated by others.

Children with symptoms of social anxiety experience difficulties in attending school, in academic matters, and in establishing and maintaining friendships, in addition to the restlessness

they experience. It has also been reported that negative outcomes such as social phobia, other anxiety disorders, depression, somatoform disorders, suicide, alcohol and substance use to suppress anxiety are common. Social phobia typically begins early in life and is chronic and often co-occurs with other comorbid disorders. In some cases, comorbidity has been shown to cause greater dysfunction and lower quality of life.

Social phobia is a disease that has high economic costs and impairs quality of life because it causes academic failure, social inadequacy, economic dependence in adulthood, deterioration in family and peer relations, and decreased work efficiency. Fear of negative evaluation is associated with a cognitive structure programmed to look for traces of it in the environment. Social anxiety has cognitive, behavioral, somatic and emotional aspects.

Although social phobia is a disorder with a very high lifetime prevalence and the number of accompanying behavioral disorders is high, the number of etiological studies to determine the source of this disorder is very few. Social phobia disorder has started to attract more attention in recent years and is considered as a serious health problem because it is common, starts at an early age and lasts for many years, is unlikely to recover without treatment, and negatively affects quality of life.

Attachment theory, according to Bowlby, refers to people's tendency and need to form strong emotional bonds with others who are important to them and the attachment system that is developmentally functional and necessary for newborn survival. The attachment system helps the baby be close to the caregiver and protect the child from external dangers. For this reason, the primary goal is to maintain closeness with the caregiver within the attachment system by providing newborns with a space where they can develop safely. According to Bowlby, proximity functions as a safe base from which the child can explore his environment and a solid shelter from which he can be protected in case of danger.(Burstein et al,2011)

Studies show that there is a high correlation between parents' attitudes towards their children and the attachment styles that children will develop. It has been observed that parents of securely attached children are more sensitive to their children's needs and establish satisfactory relationships than parents of insecure children. Parents of children with avoidant attachment style generally do not like bodily contact, they tend to withdraw, scold and reject, especially when their children need it most. Parents of children with anxious/ambivalent attachment style, on the other

hand, are more concerned with their own needs than their children's needs, focus on their own concerns, and are often inconsistent in caregiving. In this respect, researchers suggest that anxiety disorders emerge in early childhood, that is, social phobia may result from the person's experiences with caregivers or important people around them, and from the way of attachment.

Background of the subject: Researchers in our country, doctor of psychology;professor Shafiyeva E . I. , A.S. Bayramov , A.A. Alizadeh , S.I. Seyidov, R.Jabbarov, M. A. Hamzayev et al. conducted a series of studies on adolescence and processes occurring in this period. There are also studies on social phobia, one of them is the S. Seyidova(2019) research thesis.

It has been suggested that there is enough in foreign studies on this subject. It may be possible to give examples of these studies; Bowlby (1973), Stayton and Ainsworth (1973) suggested that there is a relationship between insecure attachment and childhood anxiety. A few decades later, Sroufe (1996) identified separation stress as a very early form of anxiety. If the child repeatedly experiences a stressful parent-child relationship, it may be a sign of a future anxiety disorder. The number of studies that find a relationship between anxiety disorder and attachment in childhood and adolescence is increasing.

Papini et al. (1991) stated that the perception of strong attachment to parents had a predictive value for less depression and social anxiety in early adolescence.

Warren, Huston, Egeland, and Sroufe (1997) classified infants as secure and insecure attachment. When the children reached 17.5 years of age, current and past anxiety disorders were reassessed using a standard interview method. Insecurely attached children had more anxiety disorders (extreme anxiety disorder, separation anxiety disorder, and social phobia) than securely attached children.

Muris, Mayer, and Meesters (1999) also found that insecurely attached children (avoidant and ambivalent) had higher levels of anxiety disorder than securely attached children. Muris et al. In 2000, they found that 91 12-year-olds and insecurely attached children showed higher levels of anxiety symptoms and depression than securely attached children. They stated that attachment style is associated with other anxiety disorders (such as panic disorder) and depression rather than only socially related anxieties such as social phobia and separation anxiety. Again, supporting these findings, Muris et al. In another study conducted with insecurely attached adolescents,

higher levels of anxiety and depression were found compared to securely attached adolescents (Muris et al. 2001).

Bohlin, Hagekull, and Rydell, in a study on social functioning and attachment in Sweden in 2000, found that 8-9 year old children with anxious attachment were much more severe than those with secure attachment.

Tüzün and Sayar (2006) mentioned some situations that can be caused by short and long-term maternal deprivation in their study called Attachment Theory and Psychopathology. One of these situations is separation anxiety. According to research, this condition may manifest as separation anxiety disorder or school phobia during childhood. When looking at adult life, especially depression, agoraphobia and borderline personality disorder are closely related to separation anxiety. The early loss of a mother, especially if it is accompanied by apathy or disruptions in care, makes the person much more susceptible to depression when faced with difficulties in adult life. In the study, it is said that agoraphobia is a type of separation anxiety and is seen similar to school phobia. Borderline personality disorder is another issue closely linked to separation anxiety, according to the study. The research says that, according to empirical studies, these people were exposed to high levels of emotional neglect and abuse in their childhood.

The object of the research: The research was done with possible class groups at school. The object of the research is 11-18-year-old teenagers. Between 60 students participated in this research.

The subject of the research: Investigation of attachment styles in adolescents, detection of social phobia and analysis of the relationship between them.

The purpose of the research: Our aim in this study is to investigate the role of social phobia symptoms and attachment styles, that is, attachment characteristics, in the etiology of social phobia in adolescents.

Missions of research:

1. Elucidating the relationship between attachment and social phobia.
2. Researching differences in attachment styles between girls and boys .
3. Clinical-psychological, comparative and mathematical-statistical analysis of the results obtained.
4. Learning the effects of attachment styles on personality formation.

Hipothesis of research:

1. There is a correlation between attachment and social phobia in adolescents.
2. There are gender differences in the relationship between social phobia and attachment styles.

Methodological basis and research methods of the study: The theoretical and methodological basis of the research is scientific studies, researches of researchers, internet resources. To solve the set tasks, analysis, synthesis, empirical, inductive, deductive, statistical research methods were used. To talk about these methods in a little more detail: Various scientific sources and scientific literature in Azerbaijani, Russian and English languages were used for data collection during the research. In the implementation of the research process , a questionnaire consisting of Liebowitz "Social Anxiety Scale" , La Greca and Lopez "Social Anxiety Scale for Adolescents" , Bartholomew & Horowitz "Adolescent Relationship Scale" and socio-demographic questionnaire was used.

The scientific novelty of the study: During the study, the relationship between social phobia and attachment styles in adolescents was determined through tests.

Theoretical and practical significance of research: The results obtained during the research can be used as a source of scientific-theoretical information and during practical work.

The structure of the case: Dissertation consists of introduction, 3 chapters, 10 subchapters, conclusion, list of used literature and appendices.

CHAPTER 1. THE PHENOMENON OF SOCIAL PHOBIA AND ITS MANIFESTATIONS IN ADOLESCENTS

1.1. The definition of social phobia as a term

In a literal translation, the word "sociophobia" (hereinafter - SP) means "fear of society." As T. E. Dowd notes: “In past centuries, anxiety usually arose with the perception of physical danger, today the danger is predominantly social and interpersonal in nature” (Durukan et al, 2001). Social phobia manifests itself in an unmotivated fear of committing any public actions (for example, public speaking).

Based on my readings and observations, it seems that people with social anxiety disorder feel helpless in the face of their crippling social anxiety. This anxiety might prevent some individuals from doing routine tasks like going to work or school. Some individuals may be able to achieve these things, but they do it out of extreme worry or dread. People who suffer from social anxiety disorder often experience excessive concern in the lead up to potentially stressful social events. This anxiety may last for many weeks. They may try to avoid situations that make them feel uncomfortable or embarrassed. Those who suffer from this condition often experience performance anxiety instead of social anxiety. They experience the physical manifestations of anxiety when they are put in circumstances like as making a speech, participating in a sporting event, or playing a musical instrument on stage. In its early stages, social anxiety disorder might seem like severe shyness or an unwillingness to engage with others. The gender disparity is more prominent among young individuals, with girls affected more often than men. The effects of social anxiety disorder, if left untreated, may linger for decades.

In the general case, social phobia is expressed in the fear of being in the center of attention, which manifests itself in painful fears of a negative assessment of others and in avoiding such situations. The prevalence of social phobia in the population ranges from 3 to 13% (Morarty,et al 2015). It is typical for people from families with low socioeconomic status, incomplete or dysfunctional families (Erözkan,2004). Often combined with depression, as well as with other disorders of the anxiety spectrum. Unlike most other phobias, social phobias are equally common in both men and women (Knappe,Beesdo-Baum et al ., 2012).

There are two subtypes of social phobia:

1. Specific;
2. Generalized.

Specific Social Phobia symptoms are a destructive fear of one or more very specific social situations. People with this fear either avoid these situations or "tolerate them, experience extreme distress, the most common is a strong fear of talking about SP in public" (Köroğlu,2014). People with generalized social phobia experience intense fear in most social situations (including both public speaking and situations requiring social interaction).

External sources emphasize the need to distinguish between generalized social phobia and avoidant personality disorder. "People with avoidant personality disorder are characterized by a pattern of extreme social inhibition and introversion, which leads to lifelong patterns of restricted social relationships and reluctance to engage in social interaction" (Eng,Heimberg,Hart, Schneier,Liebowitz,2001).

In addition, such people are sensitive to criticism, feel guilty, fear, but at the same time want love, suffer from loneliness and longing. Numerous studies have found significant similarities between these types of social maladjustment (Bifulco et al,2006). In conclusion, it was concluded that avoidant personality disorder is a more severe form of generalized social phobia (Morsünbül et al.,2011). Thus, research on the causes of social phobia also applies to avoidant personality disorder.

Based on my investigation, I've come to the following conclusion ; There are a number of risk factors that contribute to social anxiety disorder, some of which consist of Background of the family. If one of your parents or one of your siblings suffers from social anxiety, your risk of developing the illness is increased.

Disappointing events. Social anxiety disorder is more common in children who have been teased, bullied, rejected, ridiculed, or humiliated. This illness may also be linked to a history of adverse experiences, such as family strife, trauma, or abuse. Temperament. Adolescents who are easily overwhelmed by unfamiliar environments or individuals may be at a higher risk of harm. Altering obligations in one's personal or professional life. Meeting new people, delivering a public speech, or making a significant presentation at work may all be triggers for someone with social anxiety disorder.

Being in a state or with a look that demands notice. Disfigurement of the face, stuttering, or the tremors associated with Parkinson's disease are all conditions that may lead to increased self-consciousness and, in some cases, social anxiety disorder.

A significant amount of research in the field of social fears is devoted to the study of the relationship between the concepts of shyness, social anxiety and social phobia. Many researchers note that the differences between them are more quantitative than qualitative. So, S. M. Turner et al, comparing these concepts, identify the following common characteristics for them [52, p.501]:

- negative ideas about social interaction;
- increased physiological excitability;
- the desire to avoid social situations, lack of social skills.

Social phobia and social anxiety are not easily distinguished from each other due to the similar intensity of experiences, however, an important indicator of social phobia is the regular avoidance of the corresponding situations in social phobia, which increases maladjustment. This phenomenon is used in the social phobia questionnaire by M. R. Leibovich and is the key one Eve (Khlyavich Freidl,2017; Gren-Landell, 2009; 2017 Hoffman,2010).

Let's look at the key differences between shyness and social phobia. Shyness is often a situational condition, while social phobia is included in behavioral patterns in the form of avoidance. Despite the fact that both of these conditions are associated with emotional and social difficulties, it is clear that people suffering from social phobia are more maladjusted and experience significantly more distress. According to a hypothesis shared by many researchers, social phobia is an extreme degree of shyness (Detweiler,Comer,Crum,Albano,2014). For example, L. Henderson and P. Zimbardo describe shyness as a range from mild social alertness to completely paralyzing social phobia (Göker,Güney,Dinç,Hekim, Üneri, 2015.)

D. W. McNeil's model, shared by many researchers, proposes that shyness and social phobia are located at different points on a continuum of social anxiety intensity, where shyness is located on a segment from normal to pathological anxiety, and then follows it in turn (Knappe et al., 2011):

- non-generalized social anxiety;
- generalized social anxiety;
- in its extreme form;

- avoidant personality disorder.

A. Leng and M. Stein propose to consider the spectrum of anxiety disorders on a continuum of increased anxiety (Gentili et al., 2009). There are not only individual situational manifestations of SP, but also non-generalized and generalized forms. On the left side of the continuum (see Fig. 1.1.1), with a low level of anxiety, there are situational phobias - cases of maladaptive behavior caused exclusively by a specific situation.

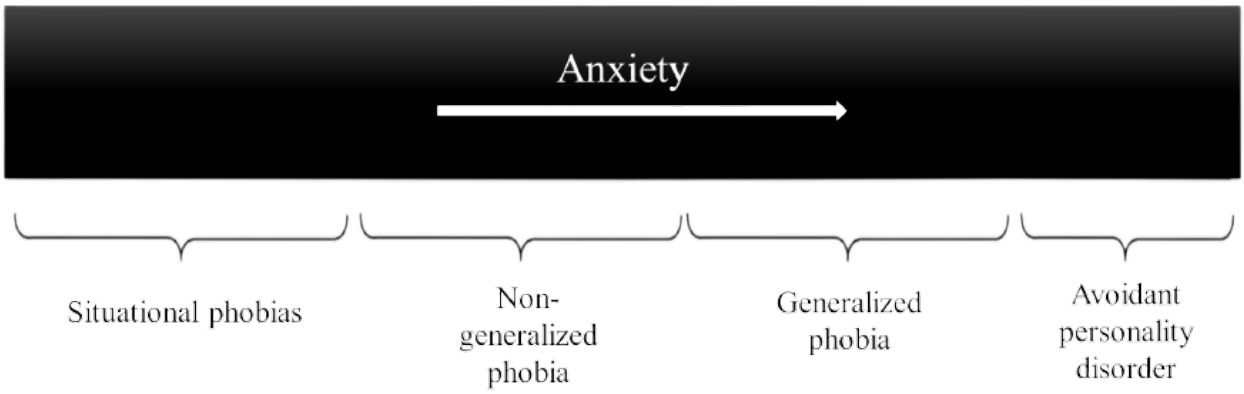


Figure 1.1.1. Levels of anxiety and anxiety disorder

In the middle part of the continuum, there are non-generalized and generalized forms of social phobia, respectively. In the non-generalized form, the number of situations of social contact that cause maladaptive behavior increases and is grouped into separate areas of life, when this number becomes predominant, then we can state generalized social phobia, however, fear focuses on social situations. The ability to establish informal contacts, although retained, but decreases with increasing levels of anxiety.

Avoidant disorder, which is on the right side of the personality continuum, resembles social phobias. Typical symptoms include fear of humiliation and self-doubt, and many people with one of these personality disorders also have another. However, people with social phobia are mostly afraid of certain social situations, while people with personality disorder tend to be afraid of close social relationships (Fehm, Pelissolo, Furmark, Wittchen, 2005).

Thus, the following phenomena are characteristic of social phobia when interacting with the social environment:

1. Marked or persistent fear of one or more social situations in which the person is confronted with strangers or is judged by others. In this case, the individual is afraid

to show symptoms of fear, because he will feel embarrassed (Aydın, Tekinsav Sütçü, 2007).

2. Encounter with a frightening social situation almost always causes an immediate anxiety reaction, which can take the form of a panic attack associated with the situation or caused by it (Ainsworth, 1969).
3. The person realizes that his fear is exaggerated or unfounded.
4. Frightening social situations or situations in which success is assessed are avoided or experienced with increased anxiety (Özdemili,2009).
5. Avoidance behavior, a state of anxious anticipation or severe discomfort in frightening social or work situations significantly disrupts the person's normal lifestyle, professional success (or studies), and social interactions with other people (or the phobia causes severe suffering).
6. Anxiety or avoidance is not related to the direct physical effects of psychoactive substances (e.g. drugs, narcotics) or physical illness and cannot be better explained by a mental disorder.

Considering SP within the framework of social psychology, it is currently possible to state the presence of social phobia in a person not only in the case of avoiding social situations, but also when experiencing them with significant stress (Nedimbal and Öner,2014). Which leads to a subjective decrease in the quality of life. With this approach to considering the problem of social phobia, it becomes the object of socio-psychological assistance, which expands the ways of working with this type of maladaptation.

1.2. Manifestations of social phobia and its specificity in adolescents

What is a person afraid of, what phobias arise. We know that we are always taught to protect our child from something, that very protective reflex gently penetrates the mind, forming fears and phobias. In general, adolescents with adolescence addiction have higher sleep characteristics. Thus, fear and phobia are products of fantasy and defense.

Phobia hurts. Social phobias, such fears can arise from external imaginary or real observation. A person with a social phobia may realize that their fears of social interaction are

excessive or unfounded, but it will not be easy to deal with them. Some people with social phobia are afraid of a wide range of social situations, others are peculiar, for example, they need to show their abilities to the best of their ability. In most cases, social phobia begins to manifest itself at an early age. In 50% of those suffering from this disease, its symptoms are detected before the age of 11 years, and in 80% - before the age of 20 years (Рузиев , 2021).

Since the disease begins to manifest itself very early, comorbidities such as depression or drug addiction may occur. Psychological signs of social phobia usually manifest physiologically, such as reddening of the skin, hyperhidrosis (sweating), heart palpitations, and nausea. It can be a stupor and fast, sensational speech. Panic attacks can occur in situations of extreme stress. Early diagnosis usually helps prevent additional illnesses such as symptom reduction and depression. Social phobia is sometimes referred to as the "opportunity disease".

In developed countries, including Azerbaijan, the frequency of clinically manifested anxiety disorders (including phobic disorders) in children and adolescents is about half of all mental pathologies in this age group (Слободская , Ахметова, Кузнецова, 2008).

Although social phobia is one of the most common and significant disorders in childhood and adolescence (Iverach,Rapee,2014), it is often not recognized or underestimated for many years. So, S. Blomhoff et al. (Bowlby, 1980), the interval between the appearance of complaints and the visit to a doctor can be 13 years or more. WJ Magee et al. determined that social phobias occur in approximately 15% of the population aged 15-23 years (Iverach and Rapee, 2014).

At the same time, according to various researchers (Lopes and Albano, 2013), the fears associated with social situations are more diverse, affectively vivid and painful for those who experience them.

One of the variants of social phobia is a school phobia that occurs with the beginning of school attendance - at the same time, it is the main place for obtaining academic knowledge, acquiring and training social and communication skills, and forming a landmark.

B. Chorpita, D. Barlow (Brumariu and Kerns, 2008) found a pathological fear of school in 5% of all students who sought help from a psychiatrist, S. Gillberg (Dilbaz ve Güz 2002) - in 1% of the total contingent of schoolchildren. There are practically no clinical studies devoted to this problem in the domestic literature.

The data of recent years obtained by Russian authors (Göker, Güney, Dinç, Hekim. Üneri,2015), including ours, are fully consistent with the research results of scientists from other countries (including not only England, Germany, the USA, but also China, Japan).

Among the reasons for the increase in the prevalence of school phobia, a number of factors can be distinguished (Захаров, 2007):

1. somatoneurological factors: a decrease in the general health level of the child and adolescent population (many intercurrent diseases in the anamnesis of patients, organically polluted soil) contributes to the development of an alarming pathology;
2. İn connection with the biological and psychological stage at which school begins. A combination of retardation of socio-psychological development and reduction of the age of starting systematic education. The latter is associated not only with the slow pace of growth, but also with the lack of formation of communication skills: lack of "live" communication with the predominance of virtual forms that do not require emotional development, behavioral flexibility in childhood, developing social norms and rules that are not always unambiguous;
3. İs directly related to school education: changing the conditions in which it occurs (increasing the amount of knowledge in teaching, accelerating the speed of assimilation, and building interpersonal relationships in the school staff, students who require special psychological stability in terms of knowledge level) and modern students demands, disciplinary and existential demands and expectations.

In the development of social (including school) phobia in adolescents, the social situation in which fear is concentrated for immaturity of the personality and its potential or actual problems plays an important role.

Confidence characteristic of maturity, a more attentive and critical attitude towards others, especially peers, exaggerating even the smallest signs of their disapproval, dissatisfaction with one's own "imperfectness", reality and some ideal physical, psychological and social standards, and constant anxiety are observed

Teenagers are constantly worried about how they look on the outside. The fear of attention and ridicule, the desire to make a good impression, exaggerating one's own shortcomings, mistakes, shortcomings leads to a violation of already imperfect functioning. The

feeling of fear arises from a painful situation, and as a result, avoidance behavior is formed in the absence of adequately developed strategies to cope with such situations.(Durukan et al.,2011)

Of many other phobias, social phobia is characterized by a violation of social stability. Social phobia is experienced not only in traumatic situations (in the society of people), but also before it (anxious expectation) and after it (constant comprehension of the situation, negative interpretation of relationships, assessment of others). Thus, anxiety almost always poisons the life of a social phobe. The peak of negative emotions coincides with the time when a person with social phobia is forced to communicate with people. At such moments, his fear increases dramatically, up to a panic attack.(Özdemili, 2009)

There are several main features inherent in the behavior of people suffering from social phobia:

Social phobia does not face the fear of logical explanations, hatred, rejection, disgust for situations that need to be spoken about publicly, to do something under the supervision of other people, to talk to him with a significant person. (Comer and Olfson, 2010)

Accordingly, a person suffering from social phobia completely avoids such situations: meetings, shopping trips, speeches at work meetings, visits to government agencies, etc.

Social phobia is constant obsessive thoughts: about me, about what I think, how they evaluate me, and social phobia always comes to negative conclusions. He may become embittered when it is difficult for him to start or even maintain a conversation.

There are many types of social phobia in which fears are more pronounced: for example, a person is not afraid to communicate, but is afraid to blush in front of people or telephone conversations, and in personal communication it becomes easier.

We repeat once again that the main problem of a person with social phobia is to wait for a negative assessment of other people. This happens not because of the fear of people, but because of the fear of escaping from society.

Important causes of concern in social phobia are (Bayramkaya 2009):

- Wrong, overly strict upbringing in childhood;
- Wrong behavior of parents, lack of an adequate assessment of what is happening on their part;
- Presenting a child with demands that may be excessive, difficult to fulfill;

- Fear of osspirins in youth, when they enter into a big life;
- In the period of maturity - criticism in the formation of personality;
- Lack of adequate social confirmation, frequent conflicts;
- Suppression of manifestations of sexuality and sexual intercourse;
- Wrong way of life and moral needs of the social environment;
- Think of financial problems as life's problems;
- Addiction in the past - an unsuccessful experience of communicating with the opposite sex;
- Compliance with the rules of each action or fear of separation;
- Relatives would be ashamed in front of everyone to tell him about the bad sides;
- Masquerade, adding fun events to it;
- Weakness of jismonan;
- Decreased self-confidence, assessment of one's economic situation;
- Being told to confess their shortcomings to the team;
- Feels uncomfortable among the majority, residents avoid crowded places;
- High sense of guilt;
- Fear of big cities;
- The desire to avoid negative assessments of others, in fact, leads to the fact that social phobias can be completely different than the stereotype of withdrawn, depressed people;
- Patients with social phobia are pleasant, they can please all people, as they strive to make a positive impression on others;
- Categorically avoid situations in which fears of social phobias may appear;
- Or they carefully plan such events down to the smallest detail and practice their behavior so as not to fall into a trap. Therefore, their colleagues and acquaintances may not even be aware of such problems;
- Some social phobes create a cheerful image for themselves, hiding in order to buy their own complexes;

- It should also be noted that a person who often suffers from social phobia does not even realize that he has a problem, attributing everything to his natural anxiety and his imperfection.

Social phobia - symptoms are characterized by the extreme intensity of negative emotions experienced by social phobia, starting with the usual confusion for all ordinary people before important social events (exams, speeches, etc.).

Emotional and behavioral features of social phobia include (Bayramkaya,2009):

- Negative evaluation, condemnation, irrational ridicule by others, fear of consumption;
- The influence of past episodes of negative communication experience;
- Anxiety, worry;
- Sense of risk without logical explanations;
- Fear that others will see your anxiety;
- Feeling of "emptiness in the head", accumulation of thoughts, inability to concentrate;
- Weakness, sensitivity;
- Constant tension, fatigue.

Physiologically, social phobia can manifest itself (Beidel et al,. 2007):

- sweating;
- indigestion, nausea;
- fast heartbeat or high blood pressure;
- handshake;
- sound timbre;
- shortness of breath, rapid breathing;
- redness or, conversely, a change in skin color;

Most psychotherapists agree that social phobia is based on self-doubt, and it develops most often in adolescence (10-15 years) and in adulthood (16-18 years) - when active communication with society begins. Causes of self-doubt and, as a result, social phobia can occur in childhood (Bifulco et al,. 2006):

- Wrong, valuable education of the child, that comparing him with other children is not in his favor;
- Very strict requirements for the child;
- Criticism from adults;
- Criticism during the formation of personality;
- Lack of social validation, etc.

Social phobia occurs in the following cases:

- Wrong social environment without moral support;
- Prolonged stay in a stressful situation;
- One-time stressful situation of high intensity (terrorist attack, catastrophe);
- Various films, series, action films related to emotions;
- Decreased self-esteem of the individual;
- From limiting one's own freedom;
- At the peak of extreme caution;
- From excessive emotional stress;
- In obsessive cases.

Social phobia affects women more often (2 times faster than men). In addition, the phobia is common among well-educated married people.

There is a concept of normality in everything, therefore, in order to avoid social phobias, the autonomy of family education comes first. It is right to educate in each child their own self-esteem. The ability to express a sense of confidence, to orient the child to find his place in society, the correct organization of the role of the parent in the family serves to prevent social phobias.(Beidel et al.,2007)

1.3. Factors that causes of social phobia

About 100 years ago, Freud coined the term anxiety neurosis and defined two types of anxiety. The first type of anxiety stems from uncontrolled libido. In other words, it is the physiological increase in sexual tension that occurs with the increase in libido, which is the mental reflection of physiological events. Freud states that this will happen through sexual intercourse. In the other type of anxiety, it is characterized by an extreme sense of distress and

anxiety arising from the original structures of repressed desires and thought patterns. This type is responsible for anxiety, phobia, hysteria, obsessive neurosis and psychoneurosis. Freud attributes these conditions and the anxiety associated with these conditions to psychological rather than physiological effects.(Knappe,Sasagawa,Creswell, 2015)

Numerous studies have shown that both children and adults might inherit a susceptibility to developing social phobia or social anxiety. Fyer (1993) and colleagues (1995) found that close relatives of social phobia patients also had higher incidences of the disorder. Children of parents with social phobia were at an increased risk for the disease themselves (Lieb et al., 2000; Mancini et al., 1996). This was true both for children who themselves suffered from social phobia and for their non-affected classmates.

Multiple large-scale twin studies (Kendler et al., 1992; Nelson et al., 2000; Stein, Jang, & Livesley, 2002; Warren, Schmitz, & Emde, 1999) now point to a moderately strong genetic component in the emergence of social phobia and social anxiety. Heritability estimates for social anxiety range from around 0.40 to 0.65, according to a recent meta-analysis of twin studies (Beatty, Heisel, Hall, Levine, & La France, 2002), however many writers assume a considerably more moderate value of approximately 0.4-0.5 (Albano & Detweiler, 2001; Ollendick & Hirshfeld Becker,2002). In a study of 2163 female twins, Kendler et al. (1992) found a strong genetic contribution to social phobia of 0.31. After 8 years, this team revisited the genetic contribution to social anxiety, this time accounting for measurement consistency. Estimates of heritability rose to the 0.50 range (Kendler, Karkowski, & Prescott, 1999).

These findings provide credence to the notion that social phobia is substantially influenced by genetics and provide more evidence of the disorder's high heritability.

There's a lot of curiosity about whether or not a child's temperament at a young age might predict whether or not they'll develop social anxiety later in life. This does not imply that a child's temperament predicts their risk for developing psychopathology, but it does show that there may be genetic and/or environmental factors at play in the development of social anxiety and certain kinds of childhood temperament. It is also likely that some temperament types are the first manifestations of the same construct that is subsequently termed a disease when it is present at a more severe level and is linked with impairment or disruption of everyday functioning.

Behavioral inhibition is the best studied concept of this sort (Kagan, Reznick, Clarke, Snidman, & Garcia Coll, 1984). The term "behavioral inhibition" was created by Kagan et al. (1984) to characterize a generally regular pattern of behavioral and emotional reactions to new persons, places, or things. In the presence of strangers, children that are prone to inhibition tend to be reserved, cautious, approach rates are low, and they retreat quietly (Belsky & Park, 2000). Avoidant behaviors, passive retreat, reluctance to approach strangers, and a shorter latency to speak were all identified as shared behavioral expressions of BI and social anxiety by Neal, Edelmann, and Glachan (2002). In addition to the term "shyness," other terms like as "approach," "withdrawal," and "inhibition" have also been used to refer to what seems to be fundamentally the same temperamental construct.

As has been suggested by several researchers (Clark & Wells, 1995; Fenigstein, Scheier, & Buss, 1975; Rapee & Heimberg, 1997; Schlenker & Leary, 1982; Trower & Gilbert, 1989), social phobia is characterized by prejudices and distortions in social-information processing as well as thoughts, attitudes, and beliefs. The research review by Clark and McManus (2002) on the cognitive processes of people with social phobia is good (see also Hirsch & Clark, same issue). Children with social anxiety also show many of these symptoms. These authors detailed data that suggests people with social phobia engage in biased pre- and post-interaction cognitive processes that serve to create apprehensive feeling and may degrade social performance, perpetuating a vicious cycle that keeps them unable to connect with others. Further, it is suggested that the idea that social interactions will lead to poor consequences is reinforced by subsequent social avoidance and unfavorable social outcomes (Banerjee & Henderson, 2001). Epkins (1996), Muris (2000a), Spence (1999b), Donovan (1999), and Brechman Toussaint (1999) report that similar cognitive processes are present in socially anxious and phobic youngsters as early as eight years old. Cognitive distortion and prejudice were studied by Spence et al. (1999) in a clinical sample of children with social phobia who were given reading aloud and social role-playing tasks. The children participated in a video-mediated method in which they were asked to assess the quality of their anticipated performance, evaluate their performance after completion, and recollect their cognitions relevant to task performance. In addition, participants filled out a scale that measured the perceived likelihood of both good and bad outcomes in social and nonsocial contexts. Children with social phobia had the same pattern of negative thinking about

how other people see them as adults with social phobia do. Socially anxious youngsters scored higher on social evaluative tests, had more negative cognitions, and were more likely to expect bad outcomes compared to a matched sample of non-anxious peers. Moreover, the impact was confined to gatherings of friends and family. Children with social anxiety scored lower than controls on the social task, but neither group performed differently on the reading test. Children with social anxiety reported low levels of success in both reading and social activities, indicating that their low assessments of their abilities may not be entirely accurate.

The origins of social anxiety and its accompanying thought processes and actions are a mystery, and all we can do is guess. Theoretically, a predisposition to see the social environment as more dangerous, pay more attention to threat indicators, and/or interpret social cues as suggestive of threat might come from hereditary factors' effect on neural structures and processes. extremely little is known about how newborns of extremely early ages understand and react to social threats. Later childhood is not when children suddenly begin to think, pay attention, understand, and evaluate their social surroundings. They've been doing it from birth, and we need to investigate the role of social anxiety in how people's understanding of the world changes through time. In addition to being receptive to their social contexts, young children are also active participants, shaping and being shaped by their peer groups. Responses from others are shaped by one's early social conduct, which may be controlled by genetics, upbringing, or both. A youngster who is easily upset by social interactions, who does not smile and react favorably to others, is more likely to get hostile responses from others. Anticipatory social anxiety may emerge in certain people due to a history of unfavorable social outcomes or painful social encounters.

Early theories of social anxiety emphasized the importance of lacking social skills. Although many researchers have shown that those with social phobia also have trouble communicating with others, there is not a consensus among researchers. Some writers have argued that a lack of social competence does not always indicate a basic incapacity to engage in the relevant conduct. Instead, it's possible that the poor performance is due to an inability to react appropriately due to stress (Kashdan & Herbert, 2001; Rapee & Heimberg, 1997). It's also likely that youngsters are more at risk for developing and maintaining social phobia than adults because of deficiencies in social skills. By maturity, people may have picked up a wide variety of compensatory social abilities and coping mechanisms, such practicing social activities over and

over again, that allow them to make it through difficult social settings from which there is no escape. Although statistics on this subject are varied (e.g., Rapee & Lim, 1992), it is supported by empirical studies demonstrating that adults with social phobia are not necessarily rated as less socially adept than nonclinical controls. There is some evidence to indicate that people with social anxiety may have their social skills blocked rather than missing, and that this inhibition is overcome when they are under pressure to perform (Thompson & Rapee, 2002).

In contrast to the studies aimed at adults, there is solid evidence that children who suffer from social anxiety also tend to do worse on activities that require interacting with others. A number of studies (Gazelle & Ladd, 2003; Inderbitzen, Walters, & Bukowski, 1997; La Greca & Silverman, 1993; La Greca, Silverman, & Wasserstein, 1998; Walters & Inderbitzen, 1998) support the idea that children with social anxiety are less popular among their peers and more likely to be ignored, neglected, rejected, and excluded by the peer group. Such reactions from peers are likely to be indicative of ingrained habits of relating to one another. We need to learn how children's actions or characteristics affect their social standing. Child social phobics were evaluated worse on measures of social competence, social ability, and assertiveness than their nonanxious classmates, according to research by Spence et al. (1999). Both Beidel, Turner, and Morris (1999) and the current study's authors found that socially anxious children performed considerably worse on a behavioral assessment test measuring social skills. Spence et al. found that children with social phobia initiated fewer interactions with other children, talked less, and engaged with others for shorter durations than their non-anxious counterparts during classroom observations of behavior.There is also some evidence that kids who struggle with social anxiety also struggle with nonverbal communication and social perception. Melfsen, Osterlow, and Florin (2000) found that, compared to non-anxious controls, children with social anxiety had lower levels of overall facial activity and less accurate facial expression when communicating emotions. A recent research by Banerjee and Henderson (2001) is of special relevance since it shows that instructors assessed socially anxious youngsters as inferior than their non-anxious counterparts solely on social abilities that needed insight into others' mental states.

This finding is consistent with the theory that children who suffer from social anxiety, and especially those who experience high levels of relevant negative emotion, have a diminished capacity to comprehend the thoughts and feelings of others during social interactions and a

diminished capacity to appreciate the methods others use to present themselves. This is supported by research by Banerjee and Henderson, who showed that children with social anxiety and high levels of shy negative affect have difficulty with social-cognition but not a fundamental weakness in grasping recursive mental processes related to the physical environment.

There are likely to be intricate interactions between numerous elements when trying to understand the impact of parental influence on the development of anxiety. Previous empirical studies of this topic have been rife with insufficiencies (Rapee, 1997; Wood, McLeod, Sigman, Hwang, & Chu, 2003), and so, have provided only a limited understanding of the problem. Despite the research's many flaws, as pointed out by Rapee (1997), a somewhat consistent picture has developed showing that parental warmth and control are negatively correlated with their children's anxiety. Although evidence suggests that genetic factors play a relatively small role in individuals' reports of parental overprotection (Kendler, 1996; Rowe, 1981), it remains unclear whether these features play a causal role in the development of anxiety or whether they are more peripheral (e.g., reflecting shared genetics or a consequence of child anxiety).

Less substantial research has been conducted on the topic of parent/child relations and social anxiety, although some clues have emerged. Similar to other anxiety illnesses, adult social phobics' recollections tend to reinforce a picture of increased control and less friendliness. Some studies (Arrindell, Emmelkamp, Monsma, & Brilman, 1983; Arrindell et al., 1989; Parker, 1979; Rapee & Melville, 1997) suggest that people with social phobia experience even more pronounced effects than those with panic disorder.

When the history of anxiety is examined, it is seen that Latin writers and ancient Greeks reported cases of pathological anxiety as medical disorders. In the mid-19th century, typical cases of anxiety continued to be reported in medical writings.

Phobias were first described as a "phobic response" in the DSM-I. It was changed to "phobic neuroses" in DSM-II and no categorization was made. It is seen that DSM-III is divided into three categories as social phobia, specific phobia and agoraphobia. Thus, the concept of social phobia was first defined in the DSM (Lopes and Albano,2013).

Many of the terms for anxiety disorder in the DSM-I and DSM-II were derived by Freud. New terms such as generalized anxiety disorder (GAD) and post-traumatic stress disorder (PTSD) have been added to these terms in DSM-III. The term separation anxiety was added to

the DSM-III-R. Additionally, many overdose anxiety disorders are included in the GAD subclass and conceptualized as social phobia and avoidance disorders. Anxiety disorders have been defined differently in adolescents and children with DSM-IV (Muris et al,. 2011).

Then there were some new developments with the release of DSM-IV in 2013. The first of these; Spectrum-directed anxiety disorder is grouped according to the sharing of common features. Disorders whose development is interrelated are grouped in the same section.

There are many studies showing that genetic symptoms are an important factor in the etiology of social phobia. In this context, many genes sensitive to anxiety traits such as obsessive disorders, panic disorders, and harm avoidance have been investigated. As a result of the researches, it is thought that mental disorders such as eating disorders, autism and alcohol have a genetic predisposition due to environmental factors.

Until the 1980s, cognitive and psychodynamic theories were dominant in explaining the etiology of anxiety disorders. In this context, the factors causing social phobia; It can be examined in two groups as biological and environmental factors (Caouette,Guyer, 2014):

Biological factors: It is stated that genetic structure plays a role in the formation of social phobia, as in other phobic disorders. Experts agree that environmental factors and biological factors interact. At this point, studies have shown that people with social phobia in their families show higher levels of social phobia symptoms than those who do not have social phobia in their family. In this case, it may be an indication that biological factors are effective on social phobia.

Environmental factors: There are many studies showing that environmental factors are as effective as biological factors in the emergence of social phobia. In studies conducted in this context, it has been determined that environmental factors such as protective and authoritarian parental attitudes, low education level of parents, low economic level, living and being born in the countryside, and stressful lifestyle are effective.

As with other psychiatric disorders, many reasons for the formation of social phobia have been listed, but these reasons have not been fully elucidated. Although many studies have been conducted to explain social phobia, it is stated that the factors that cause social phobia also differ due to the diversity of the sample groups studied. Therefore, many factors such as biological causes, psychological causes and neurobiological factors can be mentioned about the causes of social phobia (Wagner et al ,2006)

There are studies showing that social phobia is transmitted within the family and its incidence in first-degree relatives is approximately ten times higher than in the normal population. If this assumption is accepted, the question of which aspect of social phobia is genetically inherited also comes to mind. At this point, the possibility of transferring some traits that will cause general anxiety disorders is more realistic than the possibility of transferring social phobia as a whole through genetics. The most important feature discussed in this context is "behavioral inhibition". This concept can be defined as the act of approaching timidly and fearfully towards the stimulus that the individual does not know or has just known. Children with this action establish close contact with their mothers when they encounter a new stimulus. Behavioral inhibition is relatively permanent and possibly inherited. Behavioral inhibition predisposes to anxiety disorders in the future and is thought to increase the likelihood of these disorders occurring in the early stages. Studies conducted in this context have shown that children with behavioral inhibition in childhood are prone to behavioral disorders such as social phobia, agoraphobia and panic disorder in adulthood (Pickren and Duschinsky,1979-1982).

There are also many studies showing a relationship between social phobia and growth hormone. In studies conducted with a limited number of patients in this area, it is seen that anxiety is high in cases with developmental delay and the level of anxiety improves with growth hormone.

Bell et al. (1998) thought that anxiety disorder may cause growth hormone deficiency or that growth hormone deficiency may be a risk factor for the development of anxiety disorder.

There are assumptions that social phobia can develop as a result of traumatic conditioning of life. Individuals who exhibit social phobia behavior under traumatic conditioning can remember the source of the phobia from their memories. In observational conditioning, observing someone else's fear of a situation or object is sufficient for a phobia to occur.

Although social phobia is based on the individual's effort to make a positive impression on others, there is an insecurity and uncertainty that it can create. When the individual encounters the feared social situation, an acceptance occurs by creating a perception of danger towards the current situation with the interaction of innate predispositions and negative thoughts about his previous life and experiences. Individuals with social phobia behavior accept the following two situations when they enter such an environment (Burstein, 2011):

- They run the risk of being unacceptable or incompetent by others.
- This risky behavior will have a negative result that will lead to loss of value, loss of social status or rejection in the individual.

When an individual with social phobia encounters such a threat, his anxiety turns into a reflex and becomes the source of danger anxiety. The fact that these individuals focus their attention on negative situations in order to find evidence for their thoughts and judgments that can be evaluated negatively also increases anxiety. Nonsocial phobias often blame the external environment for their negative performance and social experiences. In this way, they manage to increase the probability of negative experiences and downplay positive possibilities.

Another area that has been investigated among the causes of social phobia is neurobiological factors. Studies investigating the neurobiological aspect of social phobia mostly emphasize the importance of basic neurotransmitter systems and the functioning problems of these systems. In this context, the relationship between social phobia and serotonin and dopamine was investigated. In studies on this subject, it is stated that the individual has an alarm system in the amygdaloid-hippocampal region that affects the prefrontal region. It is suggested that when this region is active in the individual, the individual's perception level of social situations changes. The findings obtained as a result of the research show that although genetics has a role in the formation of social phobia, the brain structures of social phobic individuals in social environments differ from the brain structures of other individuals in social environments (Knappe et al, 2012)

Panic Disorder: It has been determined that the lifetime prevalence of panic disorder in social phobias varies between 17-50%. The presence of panic attack and social phobia symptoms in the individual is a factor that complicates the differential diagnosis. Symptoms of social phobia in the individual: sweating, blushing, in case of panic disorder; headache, dizziness, palpitations, shortness of breath, blurred vision, chest pain.

Obsessive-Compulsive Disorder: It is stated that the lifetime prevalence of obsessive-compulsive disorder in social phobias varies between 4-11%. While individuals with obsessive-compulsive behaviors show anxiety when they are with other people due to the content of their obsessions, social phobic people experience intense anxiety for fear of being negatively evaluated by these people.

Body Dysmorphic Disorder: Individuals with body dysmorphic disorder avoid entering social environments because they are ashamed of their appearance. The differential diagnosis is that those with body dysmorphic disorder will not have problems even if they are away from the social environment. However, as social phobics move away from the social environment, their problems disappear.

Major Depression: The lifetime prevalence of major depression in social phobias varies between 35-80%. It is stated by some researchers that social anxiety poses a risk for depression in patients exhibiting panic disorder behavior (Muris et al, 2011).

Eating Disorders: The finding of social anxiety as an additional diagnosis in women with eating disorders is a remarkable result.

Substance Addiction: The rate of social phobia in alcoholics is between 8-56%. Social phobia patients use alcohol instead of drugs to cope with this disease.

Avoidant Personality Disorder: When examining the diagnostic criteria for social phobia and avoidant personality disorder, the two disorders share many common criteria. Therefore, it can be said that these two diagnoses often overlap. Patients with avoidant personality disorder have higher levels of anxiety and more functional deficits than patients with generalized social phobia. Avoiding interpersonal relationships due to fear of criticism, avoiding close relationships due to fear of being ridiculed, struggling excessively with fear of rejection in the social environment, believing oneself to be inadequate, not doing new activities due to fear of embarrassment are similar diagnostic criteria of social phobia.(Muris et al ,2011)

1.4. The research directions of social phobia

Researchers of social phobia, anxiety and similar conditions, belonging to different areas of psychological science, usually consider the phenomenology of social phobia from the standpoint of the direction of psychology to which they themselves belong.

While only the phobic syndrome is included in the ICD-9 prepared by the World Health Organization, the diagnosis of social phobia is also included in the ICD-10, similar to the DSM-II (WHO 1992). ICD-10 and DSM-IV diagnostic criteria are similar when it comes to social phobia (Rutter et al, 2008).

Diagnostic Criteria for Childhood Social Phobia According to ICD-10 (Ainsworth,1969):

- Persistent anxiety as manifested by social avoidance behavior that the child will be exposed to strangers in social situations, including peers.
- The child displays an inconsistent self-awareness, embarrassment, or excessive anxiety when communicating with unfamiliar people;
- Causes marked distress and discomfort when experiencing new or challenging social situations resulting in significant inhibition in social relationships (including with peers), crying, decreased spontaneity, or withdrawal from the social environment;
- The child has satisfactory social relationships with familiar people (family members, well-known peers);
- The onset of the disorder usually coincides with a developmental stage in which anxiety symptoms are considered normal. The degree of abnormality, persistence over time, and associated deterioration should occur before the age of 6 years;
- Does not meet criteria for generalized anxiety disorder in childhood;
- The disorder does not occur as part of emotions, behaviors, or personalities, or as a broader disorder such as pervasive developmental disorder, psychotic disorder, or psychoactive substance use disorder;
- The duration of this disorder is at least 4 weeks.

Social Phobia DSM-5, F40.10:

- Marked fear or anxiety in one or more social situations in which the person may be judged by others (such as talking to each other, meeting strangers, being watched while eating, speaking in public). Note: Anxiety in children should arise in peer settings, not just interactions with adults;
- The person fears engaging in behaviors that will be negatively evaluated or showing signs of anxiety (in a way that will embarrass or embarrass others, ostracize or hurt);
- Such social situations almost always provoke fear or anxiety. Note: Fear or anxiety in children may be manifested by crying, shouting, stabbing, freezing, hugging, fawning, or not being able to speak in social situations;
- The social situation in question is avoided or endured with intense fear or anxiety;

- The fear or anxiety felt is disproportionate to the situation to be feared in the social environment and socio-cultural context;
- Fear, anxiety, or avoidance is persistent, lasting six months or longer;
- Fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;
- The fear, anxiety, or avoidance cannot be attributed to the physiological effects of a substance (a substance of abuse, a drug) or another health condition;
- The fear, anxiety, or avoidance is not better explained by another mental disorder such as panic disorder, body image disorder, or autism spectrum disorder;
- If there is another health condition (for example, Parkinson's disease, obesity, malformation from a burn or injury), the fear, anxiety, or avoidance is clearly unrelated or excessive (Köroğlu, 2014).

The high prevalence of social phobia in epidemiological studies and low rates in treatment studies suggest that patients seek less help for treatment and social phobia is diagnosed less frequently in clinical practice (Lewis-Morrarty, 2015). The average age of onset of social phobia in the United States is 13, and 75% of these people have an age of onset between 8 and 15 (Blakemore,2008.). There are publications reporting that the lifetime prevalence of social phobia is between 5% and 15% (Dutra,Bureau,Holmes,Lyubchik,Lyonsruth.,2009) and approximately 6.8% in adults (Frenkel,Fox,Pine,Walker,Degnan and Chronis,2015)

In a study of 39 cases of social phobia and their first-degree relatives, Fyer et al (1993) found that first-degree relatives of patients were more likely to be diagnosed with social phobia than controls (Dutra et al., 2009) Mancini et al. (1996) examined children of parents with social phobia and found that 23% of the children were diagnosed with social phobia (Keklik,2011). Another study looked at some genetic analyzes of people with social phobia in close relatives, but these analyzes did not find sufficient evidence for a Social Phobia link of the studied serotonin transporter protein gene.

There is substantial evidence that SF has a strong family connection. Children of parents with SP have a significantly higher risk of developing this disorder [30, p.158]. Studies suggest that these familial entities reflect increased risk for general internalizing symptoms rather than

specific risk for SP. Of course, familial compatibility may reflect the influence and interaction of heredity and/or shared environment.

A highly significant relationship between SP in parents and SP in children has been reported, but parents' overprotective or rejecting parenting styles are strongly associated with SP in children (Ginsburg,Kendall,Sakolsky, et al. 2011). Twin studies have reported rates of genetic transmission of SF between 20–50% and genetic transmission in SP is not dominant (Clark,Symons,2009). In another study, Eley et al. (2008) conducted a multivariate analysis of the anxiety phenotypes (assessed by a semi-structured clinical interview) of a group meeting diagnostic criteria for social phobia up to the age of six (Comer,Olfson, 2010). They reported that social phobia was the only significant factor (79%), followed by genetics (14%) and a shared environmental factor (10%). Individual experiences that contribute to nonshared environmental influences, such as school, extracurricular activities, and peer relationships, are also important in SF. Also, measurement error in non-shared environmental effects was thought to contribute to this study.

Considering all these data, it seems that the interaction of environmental, genetic and family risk factors is important in the formation of SP. Parents are thought to be influential in the development of SP by inhibiting the development of children's genetic and social skills and by influencing children by observing and modeling their own anxiety (Bohlin, Hagehull,Rydell, 2000).

After discovering that genetics played a role, researchers sought to identify the exact genes and biological pathways, although the effects were modest. Many researchers have focused on genes involved in the serotonergic (5-HT) and dopaminergic pathways. To date, no specific genes associated with SP have been identified in anxiety-prone or behavioral inhibition-prone temperament states (GarciaLopez,Saez-Catillo,Beidel,Lagreca, 2015). Although research suggests a modest genetic influence in childhood, the changes that emerge are environmental influences that are not shared by the relative contribution of genes; suggesting that genetic factors have less influence and non-shared environmental influence increases. Interestingly, although shared environmental factors do not exclude the possibility of interaction with genetic factors in the expression of social phobia, they contribute little to the development of SP. Researchers have yet to find a definitive gene for SP. An important area for future research is the identification of

genetic risk factors and environmental variables that influence the development and maintenance of SP.

Cognitive models have focused on factors that contribute to the persistence of SP rather than initial development (Burstein,Kattan,Albano,Avenevoli,Merikangas, 2001). Emphasizing that social phobia can range from mild shyness to social phobia and avoidant personality disorder, Rapee and Heimberg (1997) contributed to a model of the formation and maintenance of anxiety in social or evaluative situations and emphasized that it is effective in sustaining cognitive processes (Knappe et al,2012). When these individuals enter a social environment, they form a mental representation of themselves that they believe others (the audience) perceive. These images are influenced by past life events, internal cues, and external cues (audience feedback). The socially phobic person often assumes that the audience has unrealistically high standards and thus underestimates the quality of their performance and expects negative consequences, thus leading to cognitive, behavioral, and somatic manifestations of anxiety. This model explains that previous experiences and learning history contribute to the development of social phobia by influencing the self-representation in the individual's mind. While discussing etiological factors, Rapi and Heimberg noted that genetic influences play a role in the tendency to divide attentional resources according to threat. However, they said that the "tendency" to focus on social situations perceived as a source of danger and threat also affects family environment factors. Rapee and Heimberg emphasized the role of the parent in the child's anticipation of negative evaluation by other people and communication information that helps avoid social situations. Both models suggest that socially anxious people adopt safety behaviors aimed at avoiding negative consequences and therefore attribute any social success to safety behaviors rather than their own abilities. These behaviors help maintain expectations of danger even in the absence of an actual negative experience (Rapee, Coplan, 2010).

They found that adolescents with social phobia experienced more negative social events and evaluated their outcomes more negatively than the control group. Although much research has been conducted on the cognitive examination of social phobia in adults, more research is needed in children and adolescents.

It is difficult to determine the age of onset of social phobia. However, clinical and epidemiological studies on the age of onset of social phobia reveal that the disorder usually

begins in adolescence. In many studies on this subject, it is seen that the average age of onset varies between 13-14. It is rare for it to start over the age of 25. There are publications reporting that social phobia begins before the age of 10 in approximately 40% of cases and before the age of 20 in 95%.

Although the onset of the disease is in adolescence, patients with social phobia apply for treatment years later. This delay leads to the development of additional psychiatric disorders such as major depression and substance abuse, and significant deterioration in social and occupational functionality and school success. In this case, early diagnosis and treatment of social phobia is of great importance.

False beliefs fuel anxiety and encourage the development of more negative cognitions in these patients. Minor mistakes in social situations or beliefs about the meaning of anxiety increase the emotional response to these events in the patient with social anxiety disorder.

In studies on the causes of social phobia, it is emphasized that biological and environmental factors may be more determinant in the development of social phobia than other causes. It has been reported that sustained behavioral inhibition and attitudes during infancy may be an early determinant of biological predisposition. These attitudes are most common in children of parents with panic disorder. And these kids can get very shy as they get older. Restricted children are at high risk for childhood-onset anxiety disorders, and it has been emphasized that this may be a predictor of future anxiety. At least some people with social phobia show behavioral inhibition in childhood.

First-degree relatives of people with social phobia are about three times more likely to develop social phobia than the same relatives of people without social phobia. The fact that the disorder is more common in some families suggests that in addition to the genetic link, some behaviors of the parents may directly affect the development of social phobia in the child. In studies investigating psychological predisposition, it has been shown that the parents of people with social phobia are more rejecting and protective than other parents. In the example of an over-anxious parent, the mother or father may be so overprotective and protective of the child that it interferes with the child's need for self-examination and research. This type of inhibition makes it difficult for the child to be autonomous and gain self-confidence. The child, who is in constant fear, uses avoidance as a defense mechanism and cannot experience confrontation with

people. This prevents the development of important team coping symptoms.(Beidel, Turner , Sallee, Ammerman, Crosby, Pathak, 2007).

Since the fear of social phobia is related to being with other people, it cannot be prevented as easily as other phobias (Butler, 1989). Since we can co-exist with society, communication with other people will be inevitable. Therefore, social phobia needs to be treated.

CHAPTER 2. THE RELATİONSHİP BETWEEN SOCİAL PHOBİA AND ATTACHMENT STYLES

2.1. The origins of attachment theory

Attachment theory is the joint work of John Bowlby and Mary Ainsworth. Drawing on the concepts of ethology, neuroscience, information processing, developmental psychology, and psychoanalysis, John Bowlby formulated the basic principles of the theory. Thus, it revolutionized the way we think about a child's bond with his mother, and that bond broken by separation, loss, and death. Mary Ainsworth's innovative methodology not only made it possible to empirically test Bowlby's ideas, but also helped expand the theory and is responsible for some of the new directions the theory is currently taking. Ainsworth introduced the concept of the attached figure as a safe hub from which the child could explore the world. He also formulated the concept of maternal sensitivity to the signals of the child and its role in the development of child-mother attachment patterns.(Рузиев, 2021)

The ideas that currently guide attachment theory have a long developmental history. Although Bowlby and Ainsworth worked independently in the early years of their careers, they were both influenced by Freud and other psychoanalytic thinkers.

John Bowlby. After graduating from Cambridge University in 1928, he took rigorous scientific training and courses in what is now developmental psychology. While reconsidering her career goals, she volunteered at a school for misfit children. His experiences with two children at school put his professional life back on track. One of the children had been expelled from her previous school for stealing and was a very isolated, distant, disinterested adolescent without a fixed mother figure. (Bowbly,1980)

The second child was an excited 7-8 year old boy known as his shadow, who was running around and following Bowlby. Based on this experience of the effects of early family relationships on personality development, Bowlby decided to pursue a career as a child psychiatrist.

Bowlby studied medicine and psychiatry concurrently with the British Institute of Psychoanalysis. During this period, Melanie Klein had a significant influence there (the institute had three factions: Group A, which sided with Freud, Group B, which sided with Klein, and the Middle Group, which neither supported). Bowlby was influenced by Kleinist ideas through Joan

Riviere, Klein's close friend and eventually education analyst under Melanie Klein's own supervision. While he acknowledged that Riviere and Klein grounded himself on the object relations approach to psychoanalysis, he had deep reservations about the quirks of the Kleinian child psychoanalytic approach, which emphasized early relationships and the potential for pathogenic loss. Klein believes that children's emotional problems are rooted almost entirely in fantasies that stem from the internal conflict between aggressive and libidinal impulses rather than events in the outside world. That's why she forbade a 3-year-old boy, whom she was examining under Bowlby's supervision, from talking to her mother. This was repulsive for Bowlby, who, during his postgraduate training with two psychoanalytically trained social workers at the London Child Guidance Clinic, came to believe that real family experiences were much more important if not the root cause of emotional distress. (Bowbly,1980).

Bowlby's plan to challenge Klein's ideas through research is evident in an early theoretical work (1940) in which psychoanalysts, like gardeners, must examine the nature of the organism, the properties of the soil, and their interaction. She goes on to argue that for mothers who have difficulties in parenting, a weekly meeting where their problems are approached in an analytical way and their problems are taken back to their childhood is sometimes quite effective. When a mother is helped to recognize and remember the feelings she had as a child, and to see that she is accepted in a tolerant and understanding way, her own child will become increasingly empathetic and tolerant of the same things.

These excerpts illustrate Bowlby's early theoretical and clinical interest in the intergenerational transmission of attachment relationships and the possibility of helping children by helping parents. The psychoanalytic object relations theories developed later by Fairbairn (1952) and Winnicott (1965) supported Bowlby, but Bowlby's ideas developed independently of them.

Bowlby's first empirical study based on case notes from the London Child Guidance Clinic dates back to this time period. Many clinical patients, such as the boy at school for maladjusted children, were disinterested and prone to stealing. By examining 44 cases in detail, Bowlby was able to relate his symptoms to a history of maternal absence and separation. Although World War II interrupted Bowlby's burgeoning career as a practicing child psychiatrist, it laid the foundation for his later career as a researcher. His role was to work with a select group

of colleagues from the Tavistock Clinic in London on officer selection procedures. It was an experience that gave Bowlby a level of methodological and statistical expertise unusual for a psychiatrist and psychoanalyst at the time. This education is most evident in the "Forty-Four Kid Thieves: Their Characters and Home Lives" revision, which includes detailed case histories alongside statistical tests.(Bowlby,1980)

At the end of World War II, Bowlby was offered the position of head of the Children's Department at the Tavistock Clinic. Consistent with his previous ideas about the importance of family relationships in child therapy, he promptly changed the division's name to the Department for Children and Families. In what is thought to be the first published work in the field of family therapy, Bowlby (1949) describes how he often achieved great clinical success by interviewing parents about their childhood experiences with their troubled children. What upset Bowlby, however, was that most of the clinical research in the department was conducted by people of a Kleinian orientation, who, according to Bowlby's testimony, felt that his emphasis on real models of family interaction was irrelevant. Therefore, she decided to create her own unit of study that focused her efforts on the mother-child distinction. Because separation is an obvious and irrefutable event, its effects on the child and the parent-child relationship are easier to prove than the more subtle effects of parent-family interactions.

Mary Ainsworth. Mary Ainsworth (née Salter), 6 years younger than Bowlby, completed her undergraduate studies at the University of Toronro just before World War II. Blatz chose not to recognize his debt to Freud because of the anti-Freudian climate that dominated the University of Toronto at the time. But Mary Ainsworth's lessons from William Blatz introduced her to security theory, which both reformulated and challenged Freudian ideas. One of the basic tenets of safety theory is that infants and young children must develop a secure bond with their parents before embarking on emergencies. (Ainsworth. 1969).

Interestingly, Mary Salter's dissertation research included an analysis of students' autobiographical narratives confirming the validity of pen-and-paper self-report scales on domestic and extra-family safety. This heralded the later trend towards descriptive data collection methods. In fact, few researchers realize the tremendous experience he brings to connectivity studies in device development and diagnostics.

Like Bowlby's, Mary Salter's professional career was in the aftermath of World War II. She was shaped by her duties as military personnel (in the Canadian Women's Corps) during WWII. After the war, she began to deepen her clinical skills when she was asked to lecture on personality assessment as a faculty member at the University of Toronto. To prepare herself for this task, she attended the seminars of Bruno Klopfer, a known expert in the interpretation of the Rorschach test. This experience led to a co-authored book on the Rorschach technique and is still in print. He married Mary Salter Leonard Ainsworth in 1950 and stayed with him in London, where he did not complete his doctoral studies. Someone there drew his attention to a job posting in the London Times about the impact of early separation from mother in childhood on personality development, including research led by John Bowlby. As Mary Ainsworth reports, joining Bowlby's work unit completely reset the direction of his professional career, although both Bowlby and Ainsworth didn't realize it at the time.

Attachment theory is a theory of psychopathology as well as a theory of development. According to the attachment theory, which suggests that early attachment relationships are the determinant of future relationships, attachment styles developed in early childhood affect psychological adjustment in adulthood.

In order for people to develop in a healthy way, they need an attachment that they can satisfy. Attachment behavior requires the caregiver to be close to the newborn baby. This relationship enables the baby to acquire the skills necessary for survival. According to attachment theory, the infant internalizes early experiences with the caregiver in the form of object relations. The quality and continuity of early relationships form the basis of object relationships. Internalized object designs determine expected behaviors and attitudes in relations with other people in the future. While continuous and satisfactory object designs create a sense of trust and security in relationships, defects in object design cause the feeling of trust to be shaken and the susceptibility to anxiety increases (Dilbaz, 1997).

According to Bowlby (1973), the insecure attachment relationship that an individual establishes with his or her first caregiver during infancy is a risk factor for future psychological problems. It is stated that the insecure attachment pattern that develops in the early period also plays an important role in anxiety disorders, especially in social phobia.

Attachment theory is a personality development theory based on ethology, object relations and psychoanalytic theory by Bowlby. Defining attachment as the strong emotional bonds that people develop with people who are important to them, Bowlby is based on infancy and childhood. (Morsümbül et al., 2011).

Working with children with adjustment problems, Bowlby believed that the mother-child relationship was very important and that the problems to be experienced in this relationship were the determinants of future psychopathologies. They did not find the explanations of traditional secondary drive theories sufficient, as they explained the child's bond with his mother with the satisfaction arising from the elimination of the hunger instinct and tried to understand why and how the child's emotional bond with the caregiver was formed.

Bowlby discovered that children who have been separated from their mothers for a period of time usually show a common reaction consisting of three stages. First stage; The second stage is protest, which consists of reactions such as crying, searching, and resisting efforts to be appeased by others; hopelessness, manifested by impaired eating and sleeping behavior, passive inactivity, and overtly perceived sadness. The third stage, the emotional separation stage, is a process that facilitates the baby's return to normal pre-separation functions by breaking away from the lost attachment figure.

Examining the results of studies conducted by researchers such as Lorenz, Tinbergen and Harlow on birds and many other mammals, Bowbly found that there are great similarities between animals and infants and young children in terms of attachment and separation behavior from the mother. This led Bowlby to the conclusion that attachment is a part of an evolutionary process.

Bowlby suggested the existence of an attachment system that emerged with the evolutionary process. This system ensures that the baby, whose self-protection and feeding capacity has not yet developed, is safer against the dangers that may come from outside and close to the caregiver. Intimacy with the caregiver is the primary goal for the baby to be sustained, thus providing a space where the baby can develop in confidence. The caregiver functions as a safe base where the baby can take shelter at any time while exploring his/her environment. (Bowlby,1973)

“Internal working models” form the basis of Bowlby's theory. Accordingly, the child's relationship with the caregiver in development, whether he can reach the caregiver who needs shelter, and the behaviors exhibited by the caregiver in response to the need for closeness are coded as cognitive representations in the child. Bowlby calls these representations "internal working models". The child develops positive cognitive representations if they can get the necessary attention, trust, and support from the caregiver when they need it. The child, who does not receive the necessary attention from the caregiver, internalizes the attachment figure as someone who rejects and is not worthy of being loved and valued. Internal working patterns develop and are reinforced during adolescence and become more resistant and persistent to change in adulthood. In adulthood, individuals use internal working models in their close relationships (Morsünbül et al., 2011).

Ainsworth's systematic research on individual differences in attachment has examined that each caregiver-child relationship is different from each other and therefore different internal working patterns develop in each individual. Ainsworth not only did empirical work on the existing theory but also contributed to the expansion of the theory. The concept of "secure foundation" and the explanations it brings to individual differences in attachment are important contributions to the theory. Using the "Stranger environment" experimental method to study infants' attachment patterns, Ainsworth examined three phases of how infants use their caregivers as a safe base in an unfamiliar environment, how they respond to strangers' intimacy efforts, and how they cope with anxiety. He defined three types of attachment patterns: Secure, avoidant, and anxious/ambivalent (Anxious/Undecided). (Ainsworth,1969)

Based on the self and others model presented by Bowlby, Bartholomew and Horowitz defined the "four-category model" to explain attachment styles in young adults. The positive self-model can be defined as an undoubted sense of self-esteem and lovability that is developed internally without needing the approval of others. The negative self-model includes low self-esteem and the need for approval by others. The positive model of others includes positive expectations and beliefs that others, especially those that are important to the individual, are reliable and available when needed, while the negative model of others includes feelings that others are untrustworthy. The quadruple attachment model is defined by considering the intersections of these basic dimensions. Accordingly, as seen in Figure 2.1.1, individuals with

positive self and positive others model are secure, individuals with positive self and negative others model are indifferent, individuals with negative self and positive others model are preoccupied and negative. It has been suggested that those who have negative models about themselves and others have a fearful attachment style.

Contrary to Hazan and Shaver (1987), Bartholomew and Horowitz (1991) suggested fearful and dismissive attachment styles. Details of Bartholomew and Horowitz's four-category model are given below as seen in Figure 2.1.1.

Secure attachment style: The secure attachment style, which is a combination of the positive self model and the positive others model, defines the sense of worthiness (the capacity to love) and includes the belief that others are also accepting and sensitive; Hazan and Shaver (1987) and Main et al. (1985) corresponds to the concept he defines as secure attachment.

The preoccupied attachment style, which is a combination of a negative self model and a positive others model, includes feelings of worthlessness (lack of the capacity to love) and positive thoughts about others. The combination of these traits causes the individual to need the approval of those he deems valuable in order to be accepted. This pattern is conceptually derived from Hazan and Shaver's (1987) ambivalent group Main et al. (1985) defined it as being obsessed or obsessed with the attachment pattern.

Fearful-avoidant attachment style: The fearful attachment style, which is a combination of negative self model and negative others model, is a combination of feelings of worthlessness and the feeling that others will be negative (untrustworthy and rejecting). This attachment style avoids forming close relationships with others and allows the person to protect themselves from rejection. Hazan and Shaver (1987) can conceptually be considered as a part of the Avoidant attachment style, although it is not explicitly stated in their previous studies.

Indifferent-avoidant attachment style: The dismissive attachment style, which consists of the combination of the positive self model and the negative others model, exhibits a negative tendency towards the self-model that it finds worthy of love. These individuals develop independence and a belief that they will not be harmed by avoiding close relationships to avoid disappointment. This category conceptually corresponds to Main's (1985) disconnected or denied binding.

	Model of self (Positive)	Dependence (Negative)
Model of others (Positive)	Secure Comfortable with intimacy and autonomy	Preoccupied Preoccupied with Relationships
Avoidance of intimacy (Negative)	Dismissing Dismissing of intimacy Counter – dependent	Fearfull Fearfull of intimacy Socially avoidant

Figure 2.1.1. Four category models. Taken from Bartholomew and Horowitz (1991).

2.2. Attachment process and psychosocial adjustment in adolescence

Adolescence is a period in which important changes are experienced in the life of the child and his family. Adolescents live a stressful life in which severe storms are often characterized by breaking the rules.(Clark and Symons, 2009)

Adolescence is a period when non-family relations intensify, progress towards independence from parents, and honest and close relations with the family are tried to be maintained. Adolescents' secure attachment to their parents is important for their identity and self-development. Although the adolescent begins to gain autonomy by separating from his parents, this autonomy does not prevent him from establishing a strong relationship with his parents. This secure attachment helps adolescents to form and develop their identities, increase their self-esteem and build their identities.

The independent role of attachments to father, mother, and peers is noteworthy, with the utmost significance placed on attachment to parents. The correlation between parental attachment and academic proficiency and self-worth is affirmative, while it also diminishes involvement in problematic conduct and sentiments of despondency. The correlation between peer attachment and social competence is robust, and it also amplifies involvement in problematic conduct. Verily, in a population of adolescents who are not under clinical care, it is the caliber of the bond with their parents that holds greater significance than that with their peers in terms of their psychosocial well-being. (Helsen et al, 2000)

In many studies dealing with adolescent attachment; showed that attachment during adolescence is shaped around the adolescent's beliefs, emotions, and close friendships. It is seen

that the effect of the mother, which is the main attachment element in childhood, on the individual decreases when it comes to adolescence. Paterson et al. (1995), it is interesting to note that while female adolescents state that maternal support increases in late adolescence, male adolescents say that support decreases.(Bohlin,Hagehull, Rydell , 2000)

Adolescence is a period in which significant changes are experienced in the attachment relationship. This is a change that must be experienced in order to live safely in a world that is both safe and dangerous, and to be connected to one's own children and spouse in the future. Adolescence is a period in which childhood behaviors and thoughts are shaped and the individual prepares for life outside the family.

The attachment process affects the adolescent's family functions. The secure attachment pattern developed by the adolescent positively affects family functions. It has been revealed that the secure attachment developed for parents only develops in the family environment where cooperation and interaction within the family is intense. The adolescent who develops insecure attachment begins to experience problems in the family. Because, in the parental structures of adolescents who develop insecure attachment, a thought has developed that their individuality is mostly taken away by the adolescent. In addition, insecurely attached adolescents come into conflict with their parents because they perceive their parents as a threat to their individuality, and the parent often expresses disappointment towards the adolescent because of this conflict. Insecurely attached adolescents are often easily inhibited and rejected by their parents because they do not need to understand and feel their parents.

As Joseph P. Allen and Deborah Land (1999) reported, during a transitional period such as adolescence, adolescents become less dependent on their parents. But that doesn't mean parents aren't important in their lives. Although adolescents are less attached to their parents, they relate and interact more with them. Although adolescent autonomy seems to negatively affect attachment to parents, on the contrary, it manifests itself as a tendency to bond and establish secure relationships throughout adolescence.

From this point of view, although adolescence seems like a period when the need for attachment and behaviors are abandoned, it is transferred to peers by increasing its effect over time. This transition transforms from attachment relationships developed against peers to hierarchical attachment relationships developed primarily against parents.

It has been determined that adolescents with nervous-avoidant attachment generally tend to control people, cannot express their anger directly, do not have a sense of integrity, and cannot protect their sense of self-worth because they cannot trust their environment. These people have problems with their identity organization.

Although attachment develops in the first months of life, it affects the later years of life positively or negatively and is the basis of the development of lifelong social relations. Pre-adolescent attachment refers to the self-protection strategies a child uses when he or she feels threatened or uncomfortable. Connect later; relationships are shaped on self-protection strategies.

Attachment relationship affects cognitive development in adolescents. For example, the formation of formal functional thinking capacity (especially the capacity for quick summary in the mind) depends, in a way, on the development of a good attachment relationship. The attachment relationship that differentiates by being transferred to the self is affected by internal processes. While it is important for the child to perceive the child's age and the relationship of caregivers in the internal working model, individual differences according to the child's cognitive development process in the internal working model is also a situation that should be taken into account. According to the internal working model, behavioral processes (intimacy seeking, coping) and emotional processes (perception, interpretation, expectation) are affected by attachment styles. The internal working model in adolescents reflects the mental process of the adolescent regarding attachment and interpersonal relationships and continues to be effective on the individual throughout his/her life.(Bohlin,Hagehull, Rydell, 2000)

A warm, satisfying relationship with their parents provides a higher quality of relationship and emotional satisfaction for the adolescent in the future. Insecure attachment that develops due to negative experiences (trauma, migration, maternal depression) causes depression in the child in later years, which may lead to more behavioral problems in adolescence. Again, individuals who develop a secure attachment with their mother during childhood do not experience loneliness during adolescence.

Not everyone may experience positive things during the transfer of attachment behavior from parents to peers. Adolescents who develop insecure attachment to their families may not be able to balance their attachment and autonomy needs. These adolescents have a decreased sense of confidence; they always have an end, indecision or problem in their attachment relationships,

so they avoid having a relationship in order not to have a new problem. However, securely attached adolescents can quickly find a solution when they encounter a problem. Adolescents who develop insecure attachment due to avoidance behavior quickly become depressed when they experience a problem with their attachment figures. Adolescent depression here is actually an extension of insecure attachment to parents. From this point of view, the adolescent's need for parental support never ends, he always perceives himself as an individual independent of his parents.(Morsünbül,2011)

Adolescents who develop insecure and disorganized attachment cannot show a regular behavior in coping with stress, and the presence of stereotypical, asymmetric and untimely movements, freezing or slowing of movements are observed in the alien situation test. It is stated that the underlying reason for the disorganized attachment pattern is an insecure, inconsistent, rude, egocentric or bullying attitude in the caregiver's reactions and the individual's fear of the caregiver. It has been observed that these adolescents frequently use physical violence and exhibit destructive behaviors, break the rules without thinking and become suddenly angry.(İmamoğlu, 2006)

2.3. The attachment features of social phobia

Attachment theories state that insecure attachment plays an important role in the development of anxiety. Bowlby (1973), Stayton and Ainsworth (1973) suggested that there is a relationship between insecure attachment and childhood anxiety. A few decades later, Sroufe (1996) identified separation stress as a very early form of anxiety. If the child repeatedly experiences a stressful parent-child relationship, it may be a sign of an anxiety disorder that will develop in the future. The number of studies finding a relationship between anxiety disorder and attachment in childhood and adolescence is increasing. Although the important role of attachment experiences in the interpersonal relations of the individual in the later stages of his life is known, the etiological contribution to the formation of social phobia is not fully known. There are limited number of studies done in this area.

The preceding discourses on attachment theory and social anxiety reveals that social relationships hold significant importance in both of these constructs. Insecure attachment styles are believed to arise from early interactions with caregivers who exhibit inconsistency,

unavailability, and unresponsiveness. The anticipation surrounding these relationships gives rise to constructs of both the self and others that are, to some extent, unfavorable. Sroufe et al. (2000) suggest that relationship difficulties are a probable central component of social anxiety. It is possible that the development of dysfunctional assumptions and models of social self occurred through a similar mechanism as that of working models of attachment. According to Bowlby's (1973) proposal, anxiety disorders may be accounted for by the anxiety elicited in reaction to the accessibility of attachment figures. The researcher postulated that anxiety disorders may arise in environments where a child experiences concerns related to abandonment or rejection, anxiety about the survival of caregivers in their absence (e.g. due to domestic violence, suicide attempts, etc.) , the child taking on the role of a companion or caregiver to the parent, and/or where the caregiver is apprehensive about promoting independence due to the fear of harm befalling the child. The internal working models of attachment have the potential to shed light on the underlying causal mechanism that leads to the development of social anxiety (Vertue, 2003). Additionally, these models can provide a comprehensive understanding of how individuals are influenced by their environment and how they, in turn, impact their surroundings.

It certainly seem as if attachment and anxiety are related. Even when temperament was taken into consideration, Warren, Huston, Egeland, and Sroufe (1997) discovered a substantial correlation between resistive (preoccupied) attachment in infancy and an anxiety disorder diagnosis in adolescence. According to Chambless, Gills, Tran, and Steketee's 1996 study, the majority of individuals with anxiety disorders regarded their parents as being unloving and intrusive. Few research particularly address the connection between attachment and social anxiety, despite studies looking at the association between attachment and anxiety disorders. This is unexpected considering that one could assume that social anxiety would be closely tied to the internal working model of attachment (self and others models). By analyzing data from the National Comorbidity Survey epidemiological sample (NCS; Kessler et al., 1994), Mickleson, Kessler, and Shaver (1997) found that social anxiety was positively correlated with both avoidant and anxious attachment styles (as determined by Hazan and Shaver's (1987) attachment style measure). For both avoidant and anxious attachment types, the connection strength was same (b = 0.52). This could be as a result of the attachment measure used, since the Hazan and Shaver (1987) instrument has three descriptors that equate to anxious/ambivalent, avoidant, and tensed/

aggressive. responders are asked to choose the one that most accurately captures their emotions. According to Collins and Read (1990), this measure omits two crucial facets of attachment: beliefs about the responsiveness and availability of others and responses to caregiver/partner separation.

One meta-analysis examined 46 studies involving 8,907 children between 1984 and 2010. The results found an effect size of r:0.30, indicating that attachment was associated with moderate anxiety. Analyzes showed that ambivalent attachment was most strongly associated with anxiety. When this relationship was evaluated with attachment and anxiety scales in adolescence, it was seen that the child was a source of information, attachment was evaluated as internal working models, and it was stronger in cross-sectional studies and in cases where the study was conducted. No difference was found when the symptoms were measured as an anxiety symptom or illness and when different types of anxiety were taken into account.

Other studies showing a strong relationship between ambivalent attachment and anxiety suggest that theoretically ambivalent attachment is associated with internalizing symptoms, particularly anxiety. It was stated that the uncertainty in reaching the caregiver increases the risk of ambivalent attachment and may cause anxiety in the child. Similarly, Cassidy (1995) stated that childhood anxiety may result from a lack of confidence that attachment figures are available when and where they are needed.

Papini et al. (1991) stated that the perception of strong attachment to parents had a predictive value for less depression and social anxiety in early adolescence.

Warren, Huston, Egeland, and Sroufe (1997) classified infants as secure and insecure attachment. When the children reached 17.5 years of age, current and past anxiety disorders were reassessed using a standard interview method. Insecurely attached children had more anxiety disorders (extreme anxiety disorder, separation anxiety disorder, and social phobia) than securely attached children.

Muris, Mayer, and Meesters (1999) also found that insecurely attached children (avoidant and ambivalent) had higher levels of anxiety disorder than securely attached children. Muris et al. In 2000, they found that 91 12-year-olds and insecurely attached children showed higher levels of anxiety symptoms and depression than securely attached children. They stated that attachment style is associated with other anxiety disorders (such as panic disorder) and depression rather than

only socially related anxieties such as social phobia and separation anxiety. Again, supporting these findings, Muris et al. In another study conducted with insecurely attached adolescents, higher levels of anxiety and depression were found compared to securely attached adolescents (Muris et al. 2001).

Bohlin, Hagekull, and Rydell, in a study on social functioning and attachment in Sweden in 2000, found that 8-9 year old children with anxious attachment were much more severe than those with secure attachment.

Insecurely attached children are seen as socially less self-confident and less loved than securely attached children. Clark and Symons (2009) found that secure attachment is not only associated with the child's positive self-esteem, but also has more prosocial behaviors with others.

Rosnay et al. (2006) in their study with 12-14 month-old babies and their mothers, found that babies of mothers with social anxiety experienced more fear and avoidance behaviors when a stranger came into the room.

Brumaria and Kerns (2008), in a study of 74 children, found that low secure, high ambivalent attachment was most associated with high social anxiety.

Cunha et al. (2008), in their study on 180 adolescents aged 12-18, consisted of three groups: those with social phobia, those with other anxiety disorders, and the normal control group. 76 people had social phobia and 28 people had other anxiety disorders. A strong relationship was found between behavioral inhibition and social phobia. Al-Yagon (2008) revealed that the child's social loneliness was positively related to experiencing internalized problems and avoidant attachment. Raikes and Thompson (2008) showed that individuals with secure attachment have increased social problem solving skills and are associated with less loneliness.

Mayer, Muris et al. (2009) found that adolescents with high levels of eating problems were associated with higher levels of insecure attachment, social anxiety, depression, and low self-esteem.

It is thought that insecure attachment plays an important role in the etiology of social phobia, which is an anxiety disorder, and may be effective in the development of this disorder. At

this point, the few studies examining the relationship between social phobia and attachment in the literature are summarized above.

2.4. Analysis of research on attachment styles and its role in personality formation.

Attachment styles play a major role in personality formation, as shown in many studies. Many studies show that having a secure attachment makes more sense than having one of the insecure attachment types. Bowlby (1973) suggested that individuals with secure attachment cope better with difficulties than individuals with insecure attachment. Rice, Cunningham, and Young (1997) related attachment in adolescence with self-esteem, assertiveness, academic and emotional well-being, and social competence. A number of researchers have suggested that attachment is related to many emotional and social behaviors at different times of personal development.

Mary Ainsworth explained three main attachment styles, they are: secure, avoidant, and anxious-ambivalent. They suggested that each attachment style is related to caregiving (as cited in Colin 1996). This is why it is easy for children who are cared for with care and sensitivity to form secure bonds. Children who are given inconsistent care form an anxious-ambivalent attachment style. These children believe they are not worthy of consistent attention and act clingy or angry. Understanding the behaviors and beliefs of young children with secure, avoidant, and anxious-ambivalent attachment styles also opens up an avenue for understanding relationship patterns in adults.

Maladaptive response to stressors may manifest as engaging in risky behaviors.Brennan and Shaver's (1995) research established a correlation between attachment patterns in adolescents and their engagement in risky behaviors related to food consumption, alcohol consumption, and

sexual activity. Brennan and Shaver's study revealed that individuals exhibiting avoidant attachment styles frequently consumed alcohol in large quantities as a means of tension reduction. Individuals with avoidant attachment styles exhibited a higher tendency to engage in casual sexual encounters as a strategy to evade intimacy.

Individuals with anxious-ambivalent attachment style exhibited a higher tendency to engage in binge drinking as a coping mechanism for anxiety, and to display behaviors of clinginess and jealousy in their romantic relationships. Individuals who exhibit secure attachment tendencies are more prone to displaying moderate behavior. The current research posited that individuals with insecure attachments would engage in risk-taking behaviors as a means of coping with stress and due to a diminished sense of self-worth, as reflected in their internal working models.

Purvis and Matzenbacher's (1999) study emphasized that participants who remember their mothers were not in a warm relationship with them felt more insecure in their relationships, while participants who remembered their relationships with their mothers as warm felt more secure in their relationships. For this reason, in this study, it was thought that insecurely attached individuals would have negative ideas about the past. However, it is assumed that individuals with secure attachment have positive views about the past. It was assumed that the probability of having a negative view of the past with anxious-ambivalent attachment styles would be higher than participants with avoidant attachment. As a result of the research, it was suggested that the participants with secure attachment style had a positive perspective about their past because their memories included good memories of a warm relationship with their caregivers.

Collins and Read (1990) hypothesized that securely attached people have more positive experiences in their romantic relationships and also experience greater emotions than avoidant and anxious-ambivalent individuals. It is stated in the research that these individuals have a high sense of self-worth and control over their lives. In this study, it is also stated that securely attached individuals have control over their own lives, while insecurely attached individuals are not expected to feel in control over their own lives. Additionally, it has been suggested that people with anxious-ambivalent attachments feel little control over their own lives, as they consider feelings of anxiety to be equivalent to feelings of powerlessness.

In one of the studies, it has been shown that a strong enough sense of self-control is beneficial for stress management (Nowicki, 1974). In a study conducted by Kobak and Sceery (1988), individuals with avoidant attachment reported loneliness and hostility, while individuals with anxious and indecisive attachment reported anxiety and distress. On the contrary, researchers have stated that securely attached individuals have low feelings of anxiety and hostility. The difference in distress levels shown in many of the studies suggested that there may also be a difference in the way attachment styles cope with stressful situations in both adulthood and infancy.

Around the age of 2, the baby realizes that there is another outside of him and that he is not an extension of the mother. There are others out there, and there are stressful situations to experience with them. Situations and events outside of I cannot be controlled and a transformation is required to turn crisis into opportunity. Psychological resilience is the adaptation to these stressful situations. According to Özer (2013), psychological resilience is the individual's adaptation to changes in the face of negative and distressing situations with the interaction of risky and protective factors (Aktaran Bindal, 2018). When the secure bond established is considered as a protective factor, it actually supports the psychological resilience of the baby in the face of the problems that he will experience in his later years. Especially the adolescence period shows the importance of psychological resilience in terms of the complexity of the problems that may be experienced.

Adolescence is a period in which emotional independence from parents is experienced and the attachment style developed in infancy tends to others and is invested. Adolescents who turn outwards now have to cope with the stressful situations they will experience here, in their own way. According to a study conducted with high school adolescents, it was determined that there is a positive relationship between attachment and resilience, and that attachment has a significant effect on resilience (Atik, 2013).

CHAPTER 3. THE RELATIONSHIP BETWEEN SOCIAL PHOBIA AND ATTACHMENT STYLES IN ADOLESCENTS

3.1. Materials and methods used in the research

In order to collect the socio-demographic information of the participants, the personal information form developed by the researcher and the Liebowitz Social Anxiety Inventory, Social Anxiety Scale for Adolescents and Adolescent Relationship Scales Questionnaire were applied.

In the personal information form developed by the researcher, there are questions about the individual's age, gender, marital status, educational status, monthly income and the number of siblings.

Liebowitz Social Anxiety Scale (LSAS). The validity and reliability of the LSA scale, which was developed by Liebowitz (1987) to assess the severity of fear and avoidance in social environments and situations requiring performance, was demonstrated by Heimberg, Horner, Juster, Safren et al (1999). It was adapted into Turkish by Soykan et al. (2003). The validity and reliability results of the LSAS are satisfactory. There are a total of 24 questions in the scale, 11

questions evaluating social relations and 13 questions evaluating the behavior of the person in performance situations. After scoring, points are obtained in 6 areas. These;

1. The severity of fear in social situations;
2. The severity of the fear experienced in situations that require performance;
3. The severity of avoidance of social situations;
4. The severity of avoidance of performance-required situations;
5. total fear severity and;
6. total avoidance severity.

The severity of the fear and avoidance experienced in this scale, which was initially filled by the clinician, is questioned on a 0-3 likert type scale. The form used in our study was graded between 1-4. It is scored between 0-3 while scoring. There are 2 subscales that measure the degree of fear and avoidance. The participant evaluates 24 questions separately for both subscales. The range of points that can be obtained from each sub-dimension is 0-72. The range of points that can be obtained in total is between 0-144. The suggested cut-off score of the scale is 25 for each subscale and 50 in total. The total score for the whole scale is obtained by summing the subscale scores. 0= 0%, 1= 1-33%, 2= 33-66%, 3= 67-100% scores are used. It has been found that this scale can identify subtypes of SP. As a result, LSAS is thought to be a useful scale in this area.

In our study, fear and avoidance subscores of the LSAS were calculated and used in the statistical analysis.

Social Anxiety Scale for Adolescents (SASA). La Greca and Lopez developed the Adolescent version of the Social Anxiety Scale in 1998. This scale was found to be valid and reliable in measuring social anxiety.

The SASA consists of three 18-item subscales:

Fear of Negative Evaluation;

Social Avoidance and Anxiety in General Situations;

Social Avoidance and Anxiety in New Situations.

This 5-point Likert-type scale is scored as 1: Never 2: Rarely 3: Sometimes 4: Usually 5: Always. The score that can be obtained from the scale varies between 18-90. La Greca (1998)

suggested a cut-off value of 50 (clinically significant social anxiety) for the total score. Its Turkish validity and reliability were determined by Aydın and Sütçü in 2007.

Adolescent Relationship Scales Questionnaire. The Adolescent Relationship Scales Questionnaire (A-RSQ, Scharfe 2002) is a revised version of the Relationship Scales Questionnaire (RSQ, Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994). The adolescent form of the Adolescent Relationship Scale was translated into Turkish by Vedat Şar, and the Turkish validity and reliability for the adult form was performed by Sümer and Güngör (1999).

The Turkish form is a Likert-type scale consisting of 17 items. Participants mark the extent to which each item describes themselves and their general attitudes in close relationships on a 7-point scale. (1=doesn't suit me at all; 7=fits me a lot). Secure and dismissing attachment styles are measured with five items, while preoccupied and fearful attachment styles are measured with four items each. Terrible attachment 1, 4, 9, 14; indifferent appendix 2, 5, 12, 13, 16; secure link 3, 7, 8, 10, 17; obsessive attachment are questions 5 (reverse loaded), 6, 11, 15. One item (5th item) in the scale is used for both dismissive and preoccupied attachment styles. Reverse items in the scale are items 5, 7 and 17. Increasing scores in factors other than the secure attachment dimension indicate unhealthy attachment. Total points are not taken from the scale, factor scores are evaluated. The internal consistency of the scales is 0.82. The average score of each attachment style is calculated and the attachment type with the highest score is accepted. SPSS 21.0 program was used in the evaluation of the research data.

3.2. Analysis of the method results used in the research phases

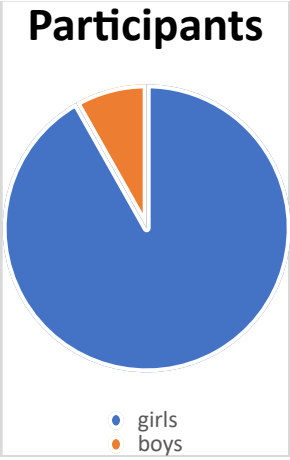
A total of 60 adolescents, 60% of whom were girls (n: 36) and 40% were boys (n: 24), were included in the study. The mean age of the cases was 14.63 ±2.04 (min:11, max:18). It was determined that 31.7% (n:19) were between the ages of 11-14 and 68.3% (n:41) were between the ages of 15-18. Considering the number of siblings with children, the rate of those with one child is 16.7% (n:10), the rate of those with two children is 46.7% (n:28), and the rate of those with more than two children is 36.7%. (n: 22). The child's shy behaviors were found to be 68.3% (n:41) before the age of 7, and 31.7% (n:19) at the age of 7 and after. When examining how many

close friends the child has, it was determined that 8.3% (n:5) did not have any, 56.7% (n:34) had one or two close friends and 35% (n:21) had no close friends. Sociodemographic characteristics of the cases are shown in Table-3.2.1:

Table 3.2.1. Sociodemographic Characteristics of the Cases

Sociodemographic characteristics		n	%
Gender	Girl	36	60%
	Boy	24	40%
How many children are you in the family?	Only child	10	16.7%
	Two kids	28	46.7%
	Two kids or more	22	36.7%
Age group	11-14 years	19	31.7%
	15-18 years	41	68.3%
When did the shy behavior start?	Before the age of 7	41	68.3%
	After 7 years	19	31.7%
How many close friends do you have?	There is none	5	8.3%
	One/two people	34	56.7%
	Three and more	21	35%
	Mean ± SD	Minimum	Maximum
Age	14.63 ±2.04	11	18

The participants in the study were noted in this pie:



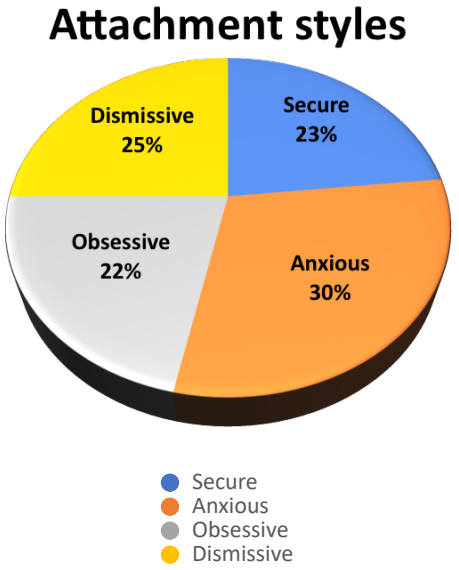
When the education levels of the mothers and fathers were examined, mother's education level was determined as 15% (n:9) illiterate/primary school graduate, 18.3% (11) high school graduates, 66.7% (n:40) university or higher education level. Father's education level was determined as 18.3% (n:11) illiterate/primary school graduate, 23.3% (n:14) high school graduate, 58.3% (n:35) university or higher education level. It was determined that 91.7% of the families lived together (n:55), and 8.3% were divorced or separated (n:5). When the income levels are examined, 23.3% (n:14) of the families are low (under 350 AZN per month), 61.7% (n:37) are at medium level (350 - 600 AZN per month), 9% (n:15) was determined as high level (over 1000 AZN). Sociodemographic characteristics of the families of the cases are shown in Table-3.2.2.

Table 3.2.2. Sociodemographic Characteristics of Families

Sociodemographic characteristics		n	%
Your family lives together?	we live together	55	91.7%
	we live apart	5	8.3%
Mother education level	Illiterate/Primary education	9	15%
	High school graduate	11	18.3%
	University or later	40	66.7%
Father education level	Illiterate/Primary education	11	18.3%
	High school graduate	14	23.3%

	University or later	35	58.3%
Family income level	low (350 AZN)	14	23.3%
	medium (350 - 600 AZN)	37	61.7%
	high (1000 AZN)	15	9%

When the adolescents' attachment styles were evaluated according to the results of the adolescent relationship scales questionnaire, 23.3% of the adolescents had secure attachment, 30.0% had anxious attachment, 21.7% had an obsessive attachment style, and 25.0% had a dismissive attachment style.



When our cases were divided into 4 groups according to their attachment styles and these four groups were compared in terms of sociodemographic characteristics, a statistically significant difference was found only between gender groups. While the rate of girls is higher in the anxious and obsessive attachment group, the rate of boys is higher in the dismissive attachment group.

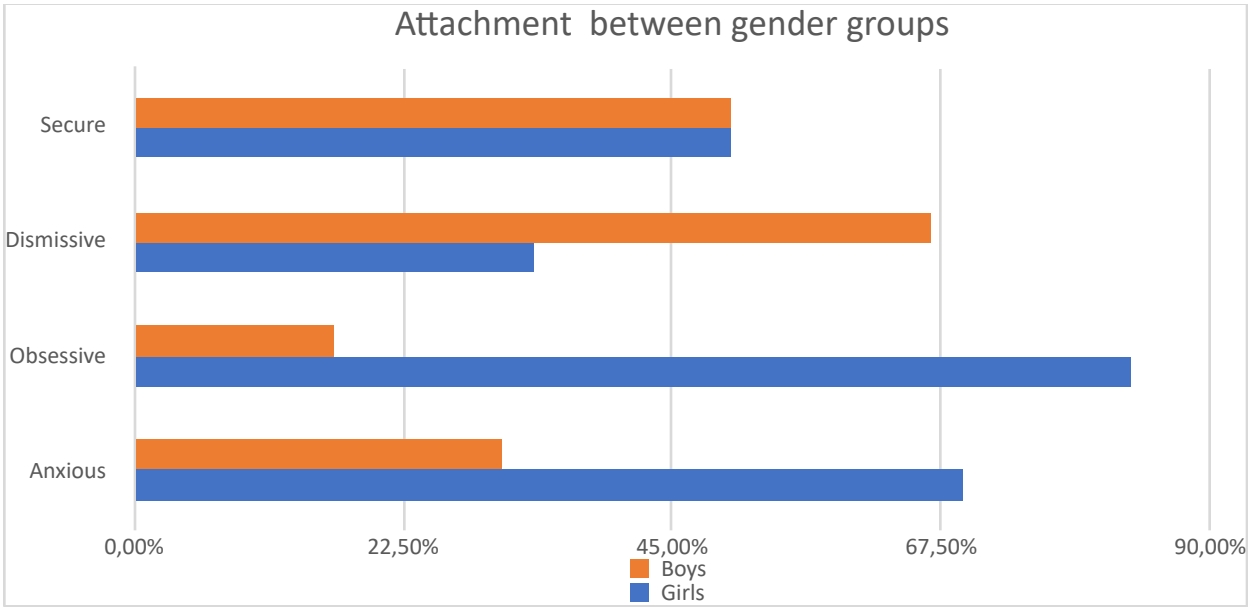


Table 3.2.3. Comparison of Attachment-Sociodemographic Characteristics

Sociodemographic characteristics		**Secure Attachment**	**Fearfull Attachment**	**Preoccupied Attachment**	**Dismissing Attachment**	**p***
		n(%)	**n(%)**	**n(%)**	**n(%)**	
Gender	Girl	7 (50.0%)	15 (83.3%)	9 (69.2%)	5 (33.3%)	0.023
	Boy	7 (50.0%)	3 (16.7%)	4 (30.8%)	10 (66.7%)	
How many children are you in the family?	Only child	1 (7.1%)	4 (22.2%)	2 (15.4%)	3 (20.0%)	
	Two kids	7 (50.0%)	6 (33.2%)	8 (61.5%)	7 (46.7%)	0.719
	Two kids or more	6 (42.9%)	8 (44.4%)	3 (23.1%)	5 (33.3%)	
When did the shy behavior start?	Before the age of 7	9 (64.3%)	15 (83.3%)	9 (69.2%)	8 (53.3%)	0.315
	After 7 years	5 (35.7%)	3 (16.7%)	4 (30.8%)	7 (46.7%)	
Age group	11-14 years	5 (35.7%)	3 (16.7%)	4 (30.8%)	7 (46.7%)	0.315
	15-18 years	9 (64.3%)	15 (83.3%)	9 (69.2%)	8 (53.3%)	

Mother education level	Illiterate/Primary education	1 (7.1%)	2 (11.1%)	4 (30.8%)	2 (13.3%)	0.163
	High school graduate	4 (26.8%)	1 (5.6%)	1 (7.7%)	5 (33.3%)	
	University or	9 (64.3%)	15 (83/3%)	8 (61.4%)	8 (53.3%)	
Father education level	Illiterate/Primary education	2 (14.3%)	3 (16.7%)	4 (30.8%)	2 (13.3%)	0.219
	High school graduate	4 (28.6%)	1 (5.6%)	5 (38.5%)	4 (26.7%)	
	University or	8 (57.1%)	14 (77.8%)	4 (30.8%)	9 (60.0%)	
Your family lives together?	we live together	14 (100%)	16 (88.9%)	12 (92.3%)	13 (86.7%)	0.582
	we live apart	0 (0%)	2 (11.1%)	1 (7.7%)	2 (13.3%)	
Family income level	low (350 AZN)	2 (14.3%)	3 (16.7%)	4 (%30.8)	5 (33.3%)	
	medium (350 - 600 AZN)	11 (%78.6)	13 (72.2%)	5 (38.5%)	8 (53.3%)	0.321
	high (1000 AZN)	1 (7.1%)	2 (11.1%)	4 (30.8%)	2 (13.3%)	

*Chi-Square test p value

Table 3.2.4. Comparison of Cases According to Liebowitz Scale Scores According to Adolescents' Attachment Characteristics

	Secure Attachment	Fearfull Attachment	Preoccupied Attachment	Dismissing Attachment	p*
	Mean±SD	Mean±SD	Mean±SD	Mean±SD	
Liebowitz Social Anxiety Scale Total Score	132,07±25,13	136,05±25,56	138,77±21,78	130,07±22,43	0.768
Liebowitz Social Anxiety Scale Total Anxiety Score	66,07±12,31	69,28±12,26	68,92±10,34	66,40±11,09	0.815
Liebowitz Social Anxiety Scale Total Avoidance Score	65,86±13,47	65,22±15,52	69,08±11,22	63,66±12,73	0.761

The comparison of the Liebowitz scale scores of 4 groups formed according to the adolescent's attachment style using the One Way Anova test is shown in Table 3.2.4. As can be

seen from the table, there was no statistically significant difference between the 4 groups (p>0.05).

In addition, when the groups were divided into two as secure and insecure attachment and when the Liebowitz social anxiety scale scores were compared, no significant difference was found between the groups. Similarly, when the groups with and without anxious attachment, with and without dismissive attachment were separately compared with the Liebowitz social anxiety scores, no statistically significant difference was found (p>0.05).

	Secure Attachment	Fearfull Attachment	Preoccupied Attachment	Dismissing Attachmen	p*
	Median (25 – 75%)	Median (25 – 75%)	Median (25 – 75%)	Median (25 – 75%)	
SASA – Total	57,0 (50,75-64,25	72.5 (53.75-77.5	75.0 (56.0-81.5)	57.0 (47.0-69.0)	0.037
SASA – Fear of Negative Evaluation (FNE)	18.5 (15.75-24.50	28.5 (20.0-33.0)	30.0 (18.0-34.0)	20.0 (15.0-26.0)	0.008
SASA – Social Avoidance and Restlessness in General Situations (SARGS)	16.0 (12.0-19.0)	17.0 (12.5-21.25)	20.0 (17.0-23.0)	13.0 (13.0-19.0)	0.084
SASA – Social Avoidance and Restlessness in New Situations (SARNS)	23.0 (20.75-25.25)	24.0 (20.25-26.5)	25.0 (21.5-28.5)	23.0 (19.0-29.0)	0.442

Table 3.2.5. Comparison of the Social Anxiety Scale for Adolescents Scale Scores According to Attachment Characteristics

The 4 groups formed according to the adolescent's attachment style were compared in terms of ASAS scale scores. Since the scale scores did not show normal distribution, this comparison was made with the Kruskal Wallis test, which is a non-parametric test. The results are shown in Table 3.2.5. As can be seen from the table, ASAS-Total (p=0.037) and ASAS-FNE scores (p=0.008) were statistically significant between the groups.

When we looked at which groups this significance was in Post Hoc analyzes, it was determined that the ASAS-Total score was between the dismissive and preoccupied attachment groups, and the ASAS-FNE score was statistically significantly different between the secure attachment group and the anxious attachment group attachment group and anxious attachment and dismissive attachment groups. ($p<0.05$).

The relationship between the scores of the Liebowitz social anxiety scale completed by the adolescents and the scores of the adolescent relationship scale is analyzed in Table 3.2.6. As can be seen from the table, a negative correlation was found with the total score of the Liebowitz social anxiety scale with the indifferent attachment subscale score of the adolescent relationships scale. It was observed that as the total scores of the adolescents' Liebowitz social anxiety scale increased, their dismissing attachment scores decreased (r: -0.265 p: 0.040). Liebowitz social anxiety scale total avoidance score and adolescent relationship scale indifferent attachment scores also showed negative correlations. It was observed that as the total avoidance scores of the adolescents in the Liebowitz social anxiety scale increased, their dismissing attachment scores decreased (r: -0.273 p: 0.035).

Table 3.2.6. Correlation between Liebowitz Social Phobia Scale and Adolescent Relationship Scales Questionnaire

Liebowitz Social Anxiety Scale		Adolescent Relationship Scales Questionnaire			
		Secure Attachment	Fearfull Attachment	Preoccupied Attachment	Dismissing Attachment
Liebowitz Social Anxiety Scale Total Score	r	–0.240	0.018	0.181	–0.265
	p	0.065	0.894	0.165	0.040
Liebowitz Social Anxiety Scale Total Anxiety Score	r	–0.180	0.039	0.190	–0.202
	p	0.169	0.766	0.147	0.121
Liebowitz Social Anxiety Scale Total Avoidance Score	r	–0.230	–0.007	0.177	–0.273
	p	0.077	0.959	0.176	0.035

Table 3.2.7. Correlation Between Adolescent Social Anxiety Scale and Adolescent Relationship Scales Questionnaire

Social Anxiety Scale for Adolescents		Adolescent Relationship Scales Questionnaire			
		Secure Attachment	Fearfull Attachment	Preoccupied Attachment	Dismissing Attachment
SASA – Total	r	–0.305	0.303	0.454	–0.050
	p	0.018	0.019	0.000	0.706
SASA – Fear of Negative Evaluation (FNE)	r	–0.299	0.400	0.443	–0.058
	p	0.020	0.002	0.000	0.658
SASA – Social Avoidance and Restlessness in General Situations (SARGS)	r	–0.272	0.158	0.339	–0.136
	p	0.036	0.227	0.008	0.301
SASA – Social Avoidance and Restlessness in New Situations (SARNS)	r	–0.203	0.099	0.342	–0.168
	p	0.119	0.454	0.007	0.19

As seen in the table, a negative correlation was found between the ASAS total score and the adolescent relationship scale secure attachment subscale score (r: -0.305 p: 0.018). It was observed that as the ASAS scale total scores of the adolescents increased, their secure attachment scores decreased. The ASAS total score and the adolescent relationship scales questionnaire anxious attachment scores showed a positive correlation. It was observed that as the ASAS total scores of the adolescents increased, their anxious attachment scores also increased (r: 0.303 p: 0.019). Adolescent relationship scales questionnaires were found to be positively correlated with ASAS total scores and preoccupied attachment scores. As the total ASAS scores increase, the preoccupied attachment scores also increase (r: 0.454 p: < 0.001).

When the relationship between ASAS fear of negative evaluation (FNE) sub-scores and adolescent relationship scale scores was examined, it was found that there was a negative correlation with the adolescent relationship scale's secure attachment sub-dimension score. As ASAS-FNE subscores increase, secure attachment scores decrease (r: -0.299 p: 0.020).

Adolescent relationship scales questionnaire anxiety-attachment scores were positively correlated with the ASAS-FNE subscore. It was observed that as the ASAS-FNE sub-scores of the adolescents increased, their anxious attachment scores also increased (r: 0.400 p: 0.002). Obsessive attachment scores of the adolescent relationship scales questionnaire were positively correlated with the ASAS-FNE subscores. As the ASAS-FNE subscores increased, it was observed that the preoccupied attachment scores increased (r: 0.443 p: < 0.001).

When the relationship between the ASAS general conditions social avoidance and restlessness (SARGS) sub-scores and the adolescent relations scale questionnaire scores was examined, it was found that there was a negative correlation with the secure attachment subscale scores of the adolescents. relationship scale. As ASAS- SARGS sub-scores increase, secure attachment scores decrease (r: -0.272 p: 0.036). Adolescent relationship scales questionnaire predisposed attachment scores were positively correlated with ASAS- SARGS subscores. As the ASAS- SARGS subscores increase, the preoccupied attachment scores also increase (r: 0.339 p: 0.008).

Social avoidance and irritability subscores of the ASAS in the new situations were positively correlated with the preoccupied attachment scores of the adolescent relationship scales questionnaire. As the ASAS–SARNS subscores increase, the preoccupied attachment scores also increase (r: 0.342 p: 0.007).

CONCLUSIONS

As a result, the following information was obtained in our study:

In our study, it was observed that the attachment styles of adolescents with social phobia were significantly different between genders, and anxious and preoccupied attachment were more common in girls, and dismissive attachment was more common in boys. It has been determined that the majority of adolescents with SP have one of the insecure attachment types. Adolescents' secure attachment scores and social phobia levels were found to be inversely proportional. Indifferent and securely attached adolescents have lower social phobia scores, while anxious and obsessively attached adolescents have higher social phobia scores.

In our study, insecure attachment styles may be a risk factor for the development of social phobia.

It has been observed that other studies in our country generally reflect the social sample of university students, and considering that the participants of our study consisted of adolescents between the ages of 11-18 and were taken from the clinical sample our results may perhaps overlap with these results to contribute to the literature on this subject.

We think that when working with children with social anxiety disorder, it may be beneficial to consider attachment characteristics and to make interventions in this direction in treatment planning.

When we look at the attachment styles of the adolescents, only 23.3% of the adolescents have a secure attachment style. While the majority (76.7%) of adolescents with SP have one of the insecure attachment types, approximately a quarter of them have secure attachment.

Although there was no control group in our study, it can be said that the rate of insecure attachment in adolescents with SP is quite high compared to studies involving the population. However, since we did not take a control group, we cannot say which binding was most observed in SP. Since our study is a cross-sectional study, it is not possible to establish a cause-effect relationship between social phobia and insecure attachment. Based on all this information, it can be said that insecure attachment is a risk factor for social anxiety.

While there was no significant difference between the attachment styles of the adolescents and the Liebowitz scale scores, it was found in the correlation analysis that the dismissive attachment scores of the adolescents were inversely proportional to the total scores and total

scores of Liebowitz scale social phobia. Avoidance scores showed that the child with avoidant attachment trying to cope with rejection may develop social phobia and separation anxiety in the future.

Our study findings show that attachment styles affect anxiety levels in cases with social phobia. Social phobia levels were found to be lower in securely attached cases.

The degree of social anxiety experienced by individuals can be influenced by a variety of factors, one of which is the nature of the parent-child relationship. Given that the process of attachment commences at birth, it may be advisable to strategize the provision of parental training during the gestational period. Furthermore, it is recommended that these concerns be incorporated into family education programs that are conducted in schools to address potential challenges during adolescence.

The study's findings suggest that insecure attachment styles could potentially increase the likelihood of developing social phobia. The findings are consistent with prior research in this area, and a study featuring a larger sample size and a control group would yield more dependable results.

When addressing social anxiety disorder in children, it is wise to take into account attachment characteristics and incorporate corresponding interventions into the treatment plan.

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Appendix A.

1. Name and Surname: _____
2. Gender:
   - Girl
   - Boy
3. Age:
   - 11 - 14 years old
   - 15 – 18 years old
4. Classroom:
   - 6th grade
   - 7th grade
   - 8th grade
   - 9th grade
   - 10th grade
   - 11th grade
5. What is the highest level of education your mother has ever completed?
   - Primary education (grades I-IV)
   - General secondary education (grades V - IX)
   - Upper secondary education (grades X-XI)
   - Undergraduate studies
   - Vocational education (first profession, technical profession, higher profession)
   - High education
   - I don't have a mother, she is dead
6. What is the highest level of education your father has ever completed?
   - Primary education (grades I-IV)
   - General secondary education (grades V - IX)
   - Upper secondary education (grades X-XI)
   - Undergraduate studies
   - Vocational education (first profession, technical profession, higher profession)

- High education
- I don't have a father, she is dead

7. How many children are you in the family?
   - I am an only child
   - 1
   - 2
   - 3
   - 4
   - 5 and more
8. When did the shy behavior start?
   - Before the age of 7
   - After 7 years
9. How many close friends do you have?
   - there is none
   - one/two people
   - three and more
10. Your family lives together?
    - we live together
    - we live apart
11. Family income level
    - low (350 AZN)
    - medium (600 AZN)
    - high (1000 AZN)

B. Liebowitz Social Anxiety Scale

	Fear or Anxiety				Avoidance			
	None	Mild	Moderate	Severe	Never	Occasionally	Often	Usually
					0	1-33%	33-67%	67-100%
Telephoning in public.	0	1	2	3	0	1	2	3
Participating in small groups.	0	1	2	3	0	1	2	3
Eating in public places.	0	1	2	3	0	1	2	3
Drinking with others in public places.	0	1	2	3	0	1	2	3
Talking to people in authority.	0	1	2	3	0	1	2	3
Acting, performing or giving a talk in front of an audience.	0	1	2	3	0	1	2	3
Going to party.	0	1	2	3	0	1	2	3
Working while being	0	1	2	3	0	1	2	3
Writing while observed	0	1	2	3	0	1	2	3
Calling someone you don’t know very well.	0	1	2	3	0	1	2	3
Talking with people you don’t know very well.	0	1	2	3	0	1	2	3

Meeting strangers.	0	1	2	3	0	1	2	3
Urinating in a public bathroom.	0	1	2	3	0	1	2	3
Entering a room when others are already seated.	0	1	2	3	0	1	2	3
Being the center of	0	1	2	3	0	1	2	3
Speaking up at a meeting.	0	1	2	3	0	1	2	3
Taking a test.	0	1	2	3	0	1	2	3
Expressing a disagreement or disapproval to people you don't know very well.	0	1	2	3	0	1	2	3
Looking at people you don't know very well in the eyes.	0	1	2	3	0	1	2	3
Giving a report to a group	0	1	2	3	0	1	2	3
Trying to pick up someone	0	1	2	3	0	1	2	3
Returning goods to a store	0	1	2	3	0	1	2	3
Giving a party	0	1	2	3	0	1	2	3
Resisting a high pressure salesperson.	0	1	2	3	0	1	2	3

---------- + ----------

Total----------

<54 (Normal)
55-65(Moderate)
65-80 (Marked)
80-95 (Severe)
>95- (Very severe)

Adolescent RSQ

Think about all of the people in your life. Now read each of the following statements and rate how much it describes your feelings using the 7-point scale, ranging from "not at all like me" to "very like me".

Not all like me Some what like me Very like me
1 , 2 , 3 4 , 5 ,6 7.
1. I find it hard to count on other people. _____
2. It is very important to me to feel independent. _____
3. I find it easy to get emotionally close to others. _____
4. I worry that I will be hurt if I become too close to others. _____
5. I am comfortable without close emotional relationships. _____
6. I want to be completely emotionally close with others. _____
7. I worry about being alone. _____

8. I am comfortable depending on other people. _____
9. I find it difficult to trust others completely. _____
10. I am comfortable having other people depend on me. _____
11. I worry that others don't value me as much as I value them. _____
12. It is very important for me to do things on my own. _____
13. I'd rather not have other people depend on me. _____
14. I am kind of uncomfortable being emotionally close to people. _____
15. I find that people don't want to get as close as I would like. _____
16. I prefer not to depend on people. _____
17. I worry about having people not accept me. ____

Social Anxiety Scale for Adolescents (SASA)

This is not a test. There is no right or wrong answer. Try to answer all items as sincerely as possible. Mark the appropriate number from the numbers next to each item.

1 = Never

2= Rarely

3= Sometimes

4= Usually

5=Always

1. I worry about what others say about me	1	2	3	4	5
2. I worry that others don’t like me	1	2	3	4	5

3. I worry about what others think of me	1	2	3	4	5
4. I'm afraid that that others will not like me	1	2	3	4	5
5. I worry about being teased	1	2	3	4	5
6. If I get into an argument, I worry that the other person will not like me	1	2	3	4	5
7. I feel that others make fun of me	1	2	3	4	5
8. I feel that my peers talk about me behind my back	1	2	3	4	5
9. I get nervous when I talk to peers I don't know very well	1	2	3	4	5
10. I feel shy around people I don't know	1	2	3	4	5
11. I get nervous when I meet new people	1	2	3	4	5
12. I feel nervous when I'm around certain people	1	2	3	4	5

13. I worry about doing something new in front of others	1	2	3	4	5
14. I only talk to people I know really well	1	2	3	4	5
15.I'm afraid to invite others to do things with me because they might say no	1	2	3	4	5
16. It's hard for me to ask others to do things with me	1	2	3	4	5
17. I'm quiet when I'm with a group of people	1	2	3	4	5
18. I feel shy even with peers I know well	1	2	3	4	5