EFFECTIVENESS OF MULTIMODAL THERAPY ON PUBLIC SPEAKING ANXIETY, SOCIAL-ANXIETY AND LOW SELF-ESTEEM

A Thesis

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By

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CERTIFICATE

This is to certify that **Ms Shaveta Tewari** has completed this piece of research of work entitled **"Effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem"** for the degree of Doctor of Philosophy under my supervision in School of Humanities, Lovely Professional University, Phagwara. To my best of my knowledge, this thesis is result of her own investigation and has not been submitted elsewhere for any degree or any other distinction.

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I, hereby declare that the thesis entitled **"Effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem"** is a result of original investigation conducted by me under the supervision of Dr. Pankaj Singh, Assistant Professor, School of Humanities, Lovely Professional University and under co supervision of Dr. /Prof. Pavitar Parkash Singh, Professor & Associate Dean School of Humanities, Lovely Professional University Punjab. This thesis or any part thereof has not been submitted by me for the award of any research degree to this University or any other institution.

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ABSTRACT

The purpose of study was to examine the effectiveness of multi modal therapy on public speaking anxiety, social-anxiety and low self-esteem. This study has one independent variables and three dependent variables. Multi modal therapy is the independent variable and public speaking anxiety, social-anxiety and low self-esteem are the dependent variables. The participants drawn from a private university consist of 60 young adults. Age range of the patients was 18-25 years. The participants consist of 20 respondents with high public speaking anxiety, 20 respondents with high social-anxiety and 20 respondents with low self-esteem. These 20 respondents from each group were further divided into experimental group and control group. Three scales were used for data collection in the study: Personal report of public speaking anxiety (PRPSA) by McCroskey (1992), Social Interaction Anxiety Scale (SIAS) by Mattick and Clarke in 1998, Rosenberg self-esteem scale by Morris Rosenberg in 1965. To study the effect of multi modal therapy the respondents were put into two conditions first before multi modal therapy and second after multi modal therapy i.e. all the subjects were first tested on public speaking anxiety, social-anxiety and low self-esteem scores. They were given therapy using multi modal therapy and then again they were tested for their scores in Public Speaking Anxiety, Social-anxiety and low Self-esteem, which provided the scores of respondents before and after intervention. Descriptive statistic i.e. mean, standard deviation, t-test, regression and multiple correlation were applied. Result showed that multimodal therapy made a significant effect on public speaking anxiety, social-anxiety and low self-esteem. Self-esteem and public speaking anxiety were moderately ($r = -.417$) but negatively related to each other. There was average correlation between public speaking anxiety and social-anxiety ($r = .422$). There was a significant positive relationship between self-esteem and social-anxiety ($r = -.574$) but both the variables were also correlated negatively with each other.

This study also revealed that self-esteem significantly predicted social anxiety (R square = 0.32) and self-esteem also predicted public speaking anxiety (R square= 0.17). Hence, it can be concluded that the psychologists/ therapist can help individuals to develop more useful and effective methods of coping with public speaking anxiety, social-anxiety and low self-esteem.

Keywords: Multimodal Therapy, Social-anxiety, Public Speaking Anxiety, Self-esteem

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Chapter 1

Introduction

1.1Introduction

According to evolutionary psychology, in the modern age, human beings feel a compulsive need to be appreciated and valued. They seek constant approval from the people around them to ensure parental investment, to attract desirable partners, for successful social engagements and to maintain supportive relationships in general. Modern humans are heavily dependent on social support especially during stressful times. Avoiding social interactions or hesitating to be an active part of various social groups takes a toll on people/s self-esteem and affects them negatively. It hampers their sense of belonging.

History is replete with examples of how fear of performing in social situations affects human beings. The emotional response to a real or perceived threat is known as 'fear' whereas the anticipation of a future threat is known as 'anxiety'. Public speaking is considered one of the most prevalent form of anxiety. It is counted as a social phobia with great social significance. Modern life involves ample such situations where we are required to speak in public, be it our personal or professional lives. It has been established that mild anxiety generated by communicating in front of a number of individuals collectively is both normal and captivating till the individual has complete mastery over the activity of speaking front of people. The career choices and avenues get limited for those young adults who fear public speaking which often results in a considerable amount of distress, frustration and depression. Similar effects have been witnessed in those with low esteem. It is inevitable for one's self esteem to waver through life. It is directly linked to one's potential to achieve what they desire. A consensus about

how self-esteem develops across the lifespan is finally emerging after years of constant debates.

1.2Anxiety

Anxiety influences our entire being. It influences how we feel, how we carry on and has genuine physical side effects. Anxiety is frequently activated by worry in our lives (Bettina, 2012). There is diversity and presence of anxiety disorders in our society that can have a damaging effect on people's lives. Diagnostic and Statistical Manual for Mental Disorders, (5th ed.; DSM-5) defined the variation of anxiety disorders like agoraphobia, panic disorders, specific and social phobia.

In Latin Anxiety means 'anxietas', from anxius ("anxious, solicitous, distressed, and troubled"). Anxiety produces apprehension, worry, uneasiness, and dread. Anxiety at optimum level helps people to deliver or cope with challenging situations and enhances the performance, thus also called as 'functional anxiety'. However, when anxiety exceeds the optimum level and hampers daily activity, then it is classified under anxiety disorders. Anxiety disorder, consist of disorders that includes extreme fear and anxiety leading to behavioral problems. Fear is a reaction to an actual or apparent threat, whereas anxiety is indication of threat that has some connection with future. Where fear is coupled with autonomic stimulation, on the other hand anxiety is related with muscle strain and vigilance for future threat. Once in a while the level of dread or uneasiness
is diminished by unavoidable evasion practices. Neurotic disorders vary from each other in the circumstances that instigate dread, nervousness, or shirking conduct, and the related cognitive speculation.

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) specified that even though neurotic disorders have a tendency of becoming exceptionally co-morbid with each other, they can be separated by close examination of the circumstances that are dreaded or evaded and associated beliefs

1.3 Public speaking anxiety

Cicero (1942) acknowledged the intensity of public speaking anxiety in the following lines

''I turn pale at the outset of a speech and quake in every limb and in my soul''

1.3.1 Concept of Public speaking anxiety

This statement of Cicero very clearly defines the impact Public speaking anxiety has on one's life.

public speaking anxiety, has been labelled as "stage fright," and considered a subgroup of communication apprehension and this could be so stern that it entitles as a social phobia. Public speaking anxiety has also been categorized as situational type or state anxiety. Fear of public speaking is also known as glossophobia, this term took its existence from two Greek words "glossa" and "phobos." "glossa" has a meaning in english "tongue or language," and in Greek mythology "phobos" has the characteristics of fear. This has been asserted by researchers that speech or oration is an oral dialogue on a dignified and important theme, suitable to the average audience and who has an aim to impact the intention of that audience. Research has proven that some people give better outcome when they go through little anxiety. This approach has arisen from the research called "inverted- U" (Allen et al., 1982; Yerkes & Dodson, 1908). Figure 1 illustrates that when the level of stress is minimum, the chances of giving good performance gets low (Nakatumba & Wil 2009*)*. But if the stress level mounts up to a certain expected level then the performance starts dropping.

Figure 1: Yerkes-Dodson Law modeled as U-shaped Curve

Similarly, through "inverted-U" research it had been demonstrated that optimum level of stress can improve performance although too little or too much anxiety can hinder performance of the speaker. If performance is noticed opposite to the level of stress on graph, the bell-shaped curve or "inverted-U" is examined in most people. As a result of too little or too much anxiety, the person may feel confusion or mental barrier (not able to recall or remember the content).

The original definition of Public Speaking Anxiety was given by McCroskey (1972), he stated

"PSA was a broadly based anxiety related to oral communication".

McCroskey (1977) redefined his statement as "an individual's level of fear or anxiety associated with real or anticipated communication with another person or persons".

McCroskey (1977) also defined public speaking anxiety as "a transitory emotional reaction triggered by a specific situation, such as performing before an audience".

Other definitions or writings about public speaking anxiety were minor modifications of McCroskey's definition.

Beatty and McCroskey (1998), came up with a paradigm of communibiological and have re-conceptualized public speaking anxiety as neurotic introversion. Neuropsychological

research investigated the connection between communication anxiety and biological predisposition. Evidences have suggested that a person's tendency to acknowledge anxiety during communication has direct link to certain biological traits of personality (e.g. introversion or neuroticism).

Kirkwood and Melton (2002) advocated that mostly public speakers encounter issues related to anxiety and fall under the most popular category of psychological disorders.

Bourne and Garano (2003) defined public speaking anxiety as "an exaggerated fear of embarrassment or humiliation in situations where you are exposed to the scrutiny of others or must perform".

Daly et al. (2009) defined anxiety while speaking in public, as "a specific, anxiety in which individuals experience physiological arousal, negative cognitions, or behavior responses to real or anticipated presentations".

Bodie (2010) claimed that public speaking fear exists because of "the threat of unsatisfactory evaluations from audiences" and it is cited as one of the chief apprehensions for Americans.

1.3.2 Prevalence of Public speaking anxiety

Globally, fear of speaking in front of people has been considered the only most feared situation among people. According to Hollingsworth (1935), public speaking anxiety is being studied and investigated since the mid-1930s. In 1973, the Bruskin's Report, indicated that fear of speaking in public was the top most fear among American people. Its wide and powerful prevalence was first realized by scholars and researchers by publication of a book named The *Book of Lists* written by Wallechinksy et al. (1977). This book revealed and rated delivering a speech in public settings as topmost fear of Americans.

In 1973, Bruskin's assistants conducted a survey using telephone on 2,543 adult males and females. The associates read a list of 14 situations to the respondents and asked everyone to specify if each situation from the list carries their personal experience of fear. The list predominantly concluded all the possible fears along with public speaking. In 2010, a similar research was conducted, including 815 university students, out of which 372 were male and 416 were female. The study had three prime statements. It first asked

the respondents to mark items from a list of 14 similar items as in the Bruskin survey that induced fear or anxiety in their minds. The second statement was to rank their top three top fears using the same list of 14 statement. The third question in that study focused on fear of speaking in front of people. As a result of the study revelation took place that public speaking was the topmost fear among all other common fears. 61.7% of the respondents marked public speaking the top fear in the 2010 survey, as compared to 40.6% in the 1973 Bruskin survey. The results of the second statement revealed that public speaking ranked second (18.4%) right after death which was number one (20%). The third statement of this study proved that those who had a high level of public speaking anxiety, also ranked public speaking as their top fear.

Even Motley (1988) verified the conclusion that speaking in front of a group/people was considered top most fear. Blöte et al., (2009) considered it as a debilitating and an expensive fear (Lépine, 2002) with 21%

prevalence rates (Pollard and Henderson, 1988) to 33% (D'El Rey & Pacini, 2005; Stein et al., 1996) in community samples. In university and community samples public speaking anxiety has been declared to be the single most frequently feared situation (Pollard and Henderson, 1988; Stein et al., 1996; Tillfors & Furmark, 2006). Wittchen and Fehm (2003) added that public speaking anxiety always has its onset in adolescence.

While taking up higher education, most of the students exhibit many different disturbed symptoms at just a thought of giving any presentation in front of people and their mental status become negatively upset. They witness increment in their usual anxiety and find it difficult to manage their fear in classes that require oral presentations. Public speaking anxiety has been found most usual issue in both college going students and general population. It is estimated that when people are asked to speak in public 20-85% of people experience anxiety. Spijck (2011) researched and revealed that almost 80 out of every 100 people tried to overcome public speaking anxiety at a large or small scale.

1.3.3 Theories of public speaking anxiety

1.3.3.1 Communibiological paradigm

Beatty and McCroskey (1998) developed the Communibiological paradigm as an interpersonal communication theory. Beatty, McCroskey and Heisel's theory is based on the study of many other researchers of psychobiology and temperament. In communibiological paradigm, two theories found to be central those are Eysenck's (1986 and 1990) and (Eysenck and Eysenck, 1985) personality theory and Gray's (1982, 1990 and 1991) theory of the neuropsychology of temperament. Eysenck and Eysenck (1985) proposed a theory explaining the structure of personality, two components of which Beatty et al. (1998) view as basic to communication apprehension.

1.3.3.2 Personality theory

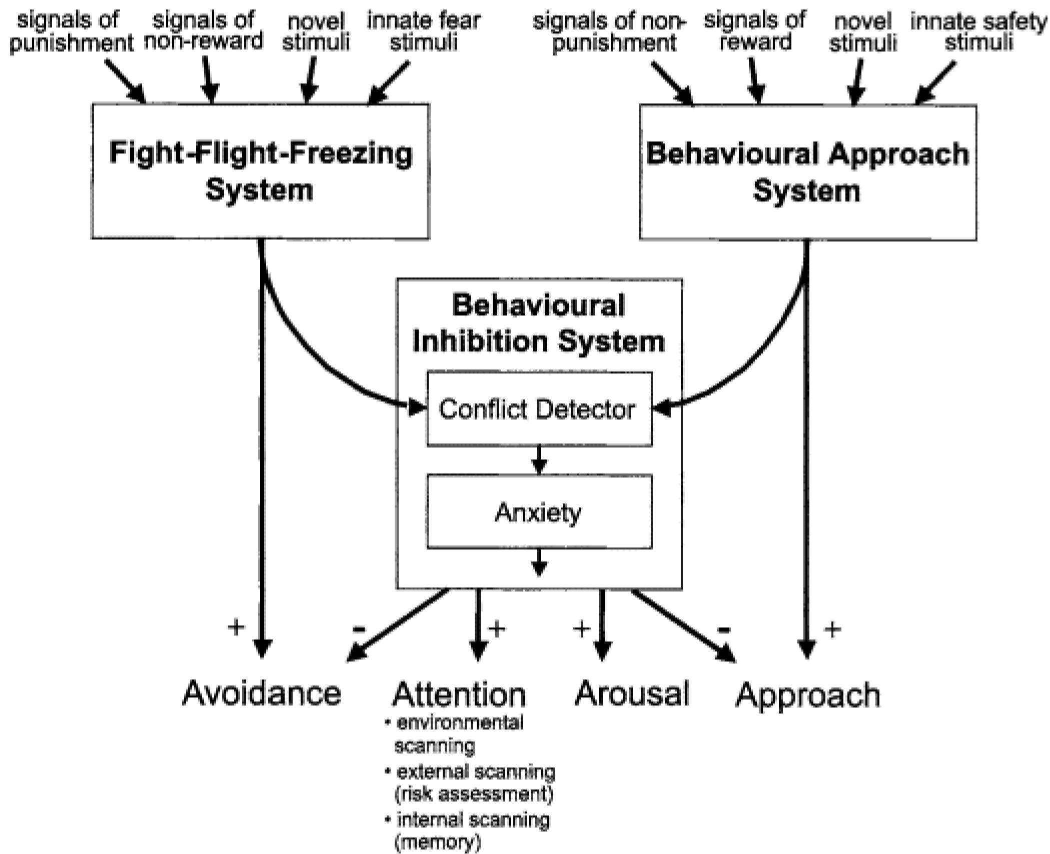
Eysenck and Eysenck (1985) suggested that temperament and intelligence, both are two major aspects of personality. In essence, they suggested that the three "super factors" or personality types are: neuroticism, extraversion and psychoticism. Eysenck and Eysenck (1985) defined these three types of traits are "correlated behavioral acts or action tendencies". The traits that together construct extraversion are venturesome, active, lively, assertive, carefree, sensation-seeking, dominant and sociable. The traits that comprise neuroticism are emotional, depressed, low self-esteem, guilt feelings, under stress, shy, illogical, melancholic, anxious and symptoms of psychosis have the characteristics of tough-minded, impersonal, narcissistic, tend to act without thinking, creative, unempathetic, unsocial, and aggressive. Eysenck's personality theory has significance because according to Beatty et al. (1998), the primary components of communication apprehension, are introversion and neuroticism. Beatty et al. (1998) stated that the confused perceptions, tendency to avoid, behavioral turmoil, and undesirable emotions were directly connected to higher trait speech anxiety and represented the proof of neurotic introversion.

1.3.3.3 Theory of the Neuropsychology

Gray's (1982, 1990, 1991) suggested that a Behavioral Inhibition System (BIS) and Behavioral Activation System (BAS), which Beatty et al. (1998) described that people

with high trait speech related apprehension go through anxiety, behavioral inhibition and avoidance. Sawyer and Behnke (1999), and Freeman et al. (1997) also used theory of Gray to describe public speaking anxiety in a similar way. The Behavioral Inhibition System gets activated by some original stimuli and sensed danger of suffering and blocking of reward; the stimulation of Behavioral Inhibition System was sensed as anxiety. People have such an inherited verge for Behavioral Inhibition System activation and found that some people get easily and frequently stimulated than others. Thus stimulation of the Behavioral Inhibition System is directly connected to anxiety, and most of times related with heightened attention to threatening or negative facet of social settings (Beatty et al., 1998). "Activation of the BIS inhibits ongoing behavior when triggered by novel stimuli, punishing stimuli, or those associated with loss of reward. When flight is impossible, inhibition results. Therefore, high apprehensive communicators to exhibit verbal inhibition in the presence of strangers, when negative feedback is expected, or when talking might result in loss of reward". Beatty (1998) also claimed that people with higher levels of communication related anxiety are introverts and their personality and temperament are neurotic. Beatty and McCroskey (1998) understood that treatment may bring mild changes in communication anxiety, although "changing one's communication anxiety level typically is very difficult, and for some, impossible". Environment does impact the development of speech related anxiety and researcher highly recommend that one should not avoid taking solutions for it. Beatty and McCroskey (1998) understood that treatment may bring mild changes in communication anxiety, although "changing one's communication anxiety level typically is very difficult, and for some, impossible". Environment does impact the development of speech related anxiety and researcher highly recommend that one should not avoid taking solutions for it. Beatty et al., drawn from Eysenck and Eysenck (1985) and argued that genes contribute 80% and surroundings passes on 20% in the anatomy of neuroticism and introversion which we already understand as the two components of communication apprehension. In actual, the public speaking situation doesn't carry real danger of physical harm but only perceived danger or threat. Fig. 2 demonstrates the neuropsychological model of temperament (Steckler, 2005).

Figure 2: Neuropsychology Model



In the situation where human beings communicate, the outcomes they fear and as a reward they look forward teach people to manage few of their negative aspects of that particular attitude. to have approval and evaluation by others and to confirm their concept of self (Beatty et al., 1998). They also claimed that therapies do not bring much difference in one's basic attitude, but therapies or interventions

1.3.3.4 Self-efficacy theory

Since public speaking anxiety is found to be rooted in both learned behavior and cognition. Lucchetti et al. (2003) had suggested that fear of speaking in public speaking has connection with cognitive aspects such as self-efficacy. As per the self-efficacy theory, people who have opinion that they will perform confidently on public platforms may face less worry and anxiety and hence they will experience less anxiety than people

who think they will perform adversely. Additionally, a person having high levels of anxiety may skip opportunities that come due to public speaking, which steals them of acquiring their fears to enable them to upgrade the level of low self-efficacy. Self-efficacy theory describes that fear of judgments may have an adverse effect on individual's level of public speaking anxiety.

Figure 3: Self-efficacy Model

Brockner's (1988) theory of plasticity in behavior described that individuals having low levels of self-efficacy or self-esteem (Eden & Zuk, 1995) are vulnerable to extraneous impact than people with higher self-efficacy. Evidently, if self-efficacy is low, person do not feel confident, so the chances of getting influenced by other people's behaviours and experiences are higher. Individuals having higher levels of self-efficacy are presumably to be more self-assured, they find all the approvals inside them, and mostly keep external sources aside. So, people with low level of self-efficacy should be treated with more self-efficacy enhancing treatment plans. Tucker and McCarthy (2001) confirmed this by providing the results, verifying this diminished role of primary self-efficacy levels that are generally supportive.

1.3.3.5 Component Theory

Another theory regarding communication apprehension came from Ayres and Ayres (1997) Component Theory, which stated that communication apprehension manifested

itself through an interplay that occurred among negative evaluations, competence, motivation and the nervous system sensitivity factor. Negative thoughts of being evaluated by others are perhaps the leading cause of communication apprehension that propels such behaviors.

1.3.4 Clinical features of Public Speaking Anxiety

Anxiety is a feeling portrayed by sentiments of strain, stressed considerations and physical changes like expanded pulse. A study by Gibson et al. (1980) found that around 85 percent of people reported encountering one or the other form of anxiety while talking with the public. Individuals with anxiety may keep away from specific circumstances out of stress. Pull (2012) gave the statement that public speaking anxiety causes distress in clinical terms and deterioration in social, occupational, and other operational areas and it may block career related aspirations as well as overall level of contentment in life (Emanuel, 2005). Highly anxious people may have some disturbing responses in their bodies when they're asked to give a speech in front of a group. These responses can show up as a very fast or slow rate of breathing, trembling, nausea, cold and sweaty palms, heart pounding, tensed muscles, irrelevant laughter, fainting and blacking out (McCroskey, 1977; Beatty, 1998; Clevenger 1959). Some people have biological issues, such as palpitations in heart, vertigo, dry mouths, sweating, hand trembling and few people report effects like forgetfulness, night-mares, or unknown fear that forces them to leave education in or in worst cases committing suicide (DeFleur et al. 1992).

1.3.5 Functional impairments caused by Public Speaking Anxiety

McCroskey (1977) found that at the heart of communication, apprehension was a psychological reaction to the evaluation of self by others. Unfortunately, this psychological reaction to evaluation quickly turns into a physical reaction as the human body responds to the threat of assessment that the human mind perceives. At this moment when the human body perceives a threat posed by others, it becomes challenging for the body to differentiate between psychological and physical risks, thus prompting the body to respond as if it was a physical threat that was directed to an individual (Nicholson et al. 2014).

Menzel and Carrell (1994) documented that Public speaking anxiety may leave negative effect on the execution of the classrooms. Students who encounter abnormal state of public speaking anxiety may show avoidant open conduct later on. In order to measure speaking anxiety among the students a study conducted by Yahya (2013) examined the elements that contribute to uneasiness among the students. Almost one third of the population reported public speaking anxiety as debilitating disorder with negative social, academic, occupational consequences. In teenage and adulthood, public speaking anxiety has the connection with heightened chances of progressing into social-anxiety disorder. Approximately, 30% of individuals may experience high levels of communication apprehension that causes major anxiety while communicating in social settings and this anxiety further creates relational (Miller & Stone, 2009), academic (Hassani & Rajab, 2012), professional, intrapersonal (Lian & Budin, 2014), and interpersonal communication scenarios (Shabani, 2012; and Shi et al. 2015). According to Kant (2000), mostly humans have the tendency to negatively judge and evaluate those who openly show their fears of speaking in front of public and are unsuccessful to make a powerful impact through their confident expressions. According to Pertaub et al. (2001) this has always been an expectation from professionals to present various talks to various size of gatherings/groups at distinct stages of their professional tenure and if any of them start becoming sufferers of public speaking anxiety, they go through some adverse results and this anxiety can give severe negative effect on their career. This has been proved by their research that social-anxiety in people has direct relation to the many responses received from the crowd. It has been also explained that the confidence of the speaker creates a strong positive influence and it significantly shows up into their public appearances and presentations.

Students with apprehension of public speaking frequently go through diverse symptoms in a public situation, which include trembling, perspiring with sweat, diarrhea, uneasiness in stomach, muscle tension, and disoriented state of mind.

Kearns and Engelhart (2015) found that hormonal and physical reactions to public speaking, similar to when a threat was perceived, known as fight-or-flight reaction, occur in people who fear public speaking. This intense physical reaction leads to presenters failing to perform well, necessitating specialized training of first-year students to

overcome or manage communication, also known as stage fright or reticence (Nash et al., 2016).

Conclusion: Public speaking anxiety as per McCroskey (1977) was a transitory emotional reaction triggered by a specific situation, for example performing before an audience or a group of people. It was considered the top most fear with wide and powerful prevalence. In university students public speaking anxiety had been declared to be the single most frequently feared situation. It is estimated that when people are asked to speak in public 20-85% of people experience anxiety. Many theories had been given on public speaking anxiety like communibiological paradigm, theory of personality, theory of neuropsychology, self-efficacy theory, and component theory. As per the research different people show different symptoms of public speaking anxiety people like palpitations in heart, vertigo, dry mouths, sweating, hand trembling and few people report effects like forgetfulness, night-mares, or unknown fear that forces them to leave education in or in worst cases committing suicide. Almost one third of the population reported public speaking anxiety as debilitating disorder with negative social, academic, and occupational consequences.

1.4 Social-anxiety

1.4.1 Concept of social-anxiety

The definition of social phobia was initially explained by Marks and Gelder (1966) as a situation in which an individual gets highly anxious when subjected to be scrutinized by others while operating a specific task. But this definition did not become a part of psychiatric nomenclature until the DSM 3 was published. Since then, there has been a steady increase in the interest in psychopathology and its treatment.

Barlow's (2002) model of anxiety disorders relies on the hypothesis that some sensitive people who unusually have a feeling of constant but intense fear with panic attacks may later in life develop anxiety issues and this response may redevelop in an uncontrolled way. Consequently, even though an individual who never had any issue in social settings can cultivate anxiety in social environments after any instance which triggered some circumstantial panic attack.

Colman (2007) characterizes anxiety as a condition of uneasiness, associated with dysphoria and physical signs and side effects of stress, inclined towards probable threat or failure. As the body gets ready to manage a risk, pulse, heart rate, sweat, and blood flow increases while insusceptible and stomach related capacities are restrained. These sensations are called alarm reaction, which happens when the body's biological alarm system gets stimulated. Nervousness does not just influence physically, it additionally influences our thoughts and conduct. Hence there are three sections of nervousness: physical side effects (how our body reacts), automatic thoughts (what we say to ourselves) and practices (what we do). Figuring out how to perceive these indications of uneasiness can help you to be less apprehensive. Physical indications of anxiety may incorporate quick heart-beat and fast breathing, queasiness and stomach disturbance, sweating, feeling tipsy or unsteady, tightness in the chest and shivering sensation. In addition, people get hot and chilly flashes, frosty or sweat-soaked hands/feet and dry mouth. The cognitive impact of anxiety may incorporate negative and self-harming thoughts, associated with hampered memory. Though, the behavioral impact of anxiety may incorporate withdrawal from circumstances which have incited tension previously. Anxiety further can be behaviorally observed in disturbed sleep pattern, twitching movements and restlessness. As per Morreale et al. (2006) classroom situations were considered the most difficult situations for people with social-anxiety, especially the experience of introducing communication course. Moreover,
research indicates that students having communication anxiety could not be made to interact irrespective of the multiple interventions; however, non-communication apprehensive students did benefit from the skills training session (Kelsey, 2000).

People with high levels of social-anxiety disorder may be diverse with the intensity and situations of social surroundings which cause fear for them. For example, few individuals fear just one or two feared circumstances but they may have more than one feared outcomes like ‘I shall perspire’, ‘I shall look unqualified’, ‘I shall sound boring’, ‘I shall appear silly’, ‘I shall blush’ or ‘I shall look tensed’. Many people may fear multiple situations but they may come up with only one feared statement like ‘I shall appear incompetent’. Because of its volatility, researchers and psychologists have always advised to categories social-anxiety disorder into subcategories. They recommended

several subcategories, a few of which are illustrated by particular consequences like fear of sweating, fear of blushing and list goes on. The most usual differentiation has been found between generalized social-anxiety disorder and non-generalized social-anxiety disorder. In generalized anxiety disorder people fear most social situations whereas in non-generalized anxiety disorders, individuals face more limited number of situations which often include performance based functions such as public speaking. Some researchers came up with the approach that the distinction between these subcategories is a difference in the degree only. Kessler et al. (1994) stated that the generalized subcategory has direct connection with higher chances of comorbidity and greater impairment with other psychological disorders. The generalized subcategory also has an earlier age of onset, a stronger familial aggregation, and more chances of getting chronic. Although, most psychological interventions are applicable to both these subcategories, assessments of pharmacology have been mainly implicated in disorder of social-anxiety.

1.4.2 Prevalence of social-anxiety

Social-anxiety Disorder is considered immensely impairing and disabling disorder. It impacts the scholastic consequences, and has negative effect on occupational, social and good quality of life. Fehm et al., (2005), Stein et al. (2000), Dams et al. (2017) proved that directly and indirectly social-anxiety has great societal costs. Social phobia carries minimum 5% of lifetime prevalence (depending on the intensity of impairment and distress). In psychological documents, social-anxiety comes on number three on the terms of commonality among adults all over the world. As per the bible of psychology DSM-5, social-anxiety disorder affects 50-80% of adolescents. Stein and Stein (2008) quoted its lifetime prevalence of 12%-16% in the general population. Mehtalia and Vankar (2004) conducted a study on Indian students and revealed that 12.8% high school going students were affected with social-anxiety disorder, with impaired academic functioning and comorbid major depression. United States of America showed up approximately 7% prevalence of social-anxiety disorder for over 12-months. Lower than 12-month existence was witnessed in most of the world using the similar diagnostic tool, median prevalence in Europe is 2.3% clustering around 0.5%-2.0%. The 12-month prevalence rates showed high level of social-anxiety in young people in comparison to the middle age adults. In the general population of the world, it is found that females in comparison to males had

higher rates of social. This inequality among male and female in the terms of prevalence is more prevailing in young adults. Internationally, many researchers had worked on the existence of social-anxiety in university students. Izgiç et al. (2004) found 9.6% in Turkey, and Bella and Omigbodun (2009) claimed 8.5% in Nigeria. Kessler *et al.* (2005) majorly worked in different countries to find out its existence and found that the population of USA had 6.8%, and New Zealand had 9.4% social-anxiety. Stein et al. (1996) found 11.8% existence of this disorder among the population of Brazil. Ruscio et al. (2008), Stein et al. (1996), Wacker et al. (1992) and Brunello et al. (2000) have frequently associated social-anxiety with drug or drinking dependence, Brunello et al. (2000) associated with depressive symptoms, Mehtalia and Vankar (2004), Stein et al. (1994) linked with increased suicide risks and impaired relationships, Evans et al. (2004) and Schneier et al. (1994) with lower educational and work attainment, Schneier et al. (1994) related with lower wage rates. Lipsitz and Schneier (2000) claimed social-anxiety disorder as a chronic and debilitating psychiatric disorder, which is very costly and later becomes burden for public health. A review of 43 epidemiological studies surveyed by Furmark (2002) from 1980 to 2002 stated that in Western countries the existence of any kind of social-anxiety falls between 7% and 13%. It is more prevalent in American Indians in the US and lower in people of Latino, African American, Asian and Afro-Caribbean descent than non-Hispanic whites.

Based on various scales available, it was observed that in general population this disorder had the existence of 4.9%-80% worldwide (Wittchen, 1999; Stein, 2008). In India, the phobic anxiety disorders have a prevalence rate of 1.9% as per the National Mental Health Survey 2015– 2016 among all the age groups. Morrison et al., (2016) stated that because of an unacceptable prognosis and process of the disorder, professionals from psychology and psychiatry have currently begun to pay their attention on this particular anxiety. The ideological researches too had shown up 13.3% presence of social-anxiety in a lifetime. Previous researches had identified that by the age of 11 years approximately 50% and by the age of 20 years approximately 80% of people showed existence of this disorder. It is considered that risk factor for related illnesses like drug abuse, alcoholism and depression increases in people with social-anxiety disorder.

All over the world researchers had always worked on the large surveys consisting of general population to find out the existence of social-anxiety disorder. Prevalence estimates had shown variance and fluctuation may be because of differences in the assessment tools used to confirm the diagnosis. Yet, it has always been certain that social-anxiety disorder is one of the mostly found disorder of all the existent anxiety disorders. Kessler et al. (2005) stated the lifetime prevalence rates of nearly 12% as compared to the lifetime prevalence estimates of other anxiety disorders and found that generalized anxiety disorder had 6%, post-traumatic stress disorder (PTSD) had 7%, panic disorder 5% and obsessive-compulsive disorder (OCD) had 2% prevalence rate (Kessler et al., 2005). Grant et al. (2005) conducted a survey to find out the yearly and lifetime prevalence rate in the citizens of America, the basis of investigations were face-to-face interviews, results halved into 5% and 3%, respectively. The results of this survey concluded that social-anxiety disorder was still more common than the major autoimmune diseases like uveitis, ulcerative colitis, type I diabetes, multiple sclerosis, rheumatoid arthritis, Crohn's disease, hypothyroidism and hyperthyroidism and American autoimmune related diseases association (2011) confirmed this statement. Kessler et al. (2005) validated this point with the data from the National Comorbidity Survey that after major depression and alcohol dependence, social-anxiety disorder was considered the third most common psychiatric condition.

Kessler et al. (2005) also proved that male and female both were equally interested in taking the treatment for social-anxiety disorder, but there was indication through community surveys that females were more vulnerable to have the condition. Turk et al. (1998) reported that in a clinical sample, women demonstrated high on social-anxiety measures. It also indicated that even though females were more likely to have social-anxiety but males showed more interest in finding solutions even though with less severe symptoms.

Many countries examined the existence of social-anxiety disorder among children and young adults in their population. A variety of techniques had been used for the assessment in adult studies, which probably explained the wide fluctuations in prevalence estimates. Feehan et al. (1994) conducted a study in New Zealand and reported that

11.1% of individuals met the criteria for social-anxiety disorder by 18th year of age. Ford et al. (2003) presented a large British epidemiological survey that revealed just 0.32% prevalence of social-anxiety among 5 to 15-year-olds. This rate was higher than post-traumatic stress disorder, panic disorder and obsessive compulsive disorder but these prevalence rates were lower than specific phobia, disorder related to generalized anxiety and separation anxiety disorder. Costello et al. (2003) concluded through a British study that the rates of social-anxiety were higher in men than women, and noticed slight expansion of social-anxiety with age. Wittchen et al.(1999) reported through a study that was conducted in German of 4% prevalence in individuals of age 14 to 17 year.

1.4.3 Clinical features of Social-anxiety

Some of the common clinical features of Social-anxiety can be summarized as follows:

1. Marked anxiety or fear about one or more social settings in which the person is possibly scrutinized by others. For example, social interactions (e.g. meeting unknown people or having conversations), performing in front of others (e.g., giving a speech) and being judged (e.g., while eating or drinking).

Note: In kids, there should be anxiety in peer settings and while interacting with adults.

2. The person carries irrational fear that he/she may show symptoms of anxiety that will be negatively evaluated (It will be embarrassing or humiliating and will lead to rejection or be offensive to others).

3. The social settings almost every time invoke anxiety or fears.

Note: In the case of children, the anxiety of fear may be expressed by failing to speak, clinging, crying, freezing, tantrums, shrinking in social settings.

4. The presence in social settings are dodged or tolerated with extreme anxiety or fear.

5. The anxiety or fear is out of proportion to the real threat posed by the social setting and to the sociocultural context.

6. The fear, anxiety, or avoidance is consistent, typically lasting for more than 6 months.

7. The fear, anxiety, or avoidance causes clinically significant distress or impairment in occupational, social or other important areas of functioning.

8. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

9. The fear, anxiety, or avoidance is not better explained by the symptoms of some other mental disorder, such as body dysmorphic disorder, panic disorder or autism spectrum disorder.

10. If another medical condition (e.g., obesity, Parkinson's disease, disfigurement from bums or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is present in excess.

1.4.4 Functional Impairments caused by social-anxiety

Faravelli et al. (2000) described that having fear of speaking in front of a group or people has been the considered common symptoms of social-anxiety disorder. Their study showed that 89.4% of people who had social-anxiety also had intense fear and high public speaking anxiety which is also considered the top common factor of fear in people having social-anxiety.

In previous years numerous researches had been conducted those studies demonstrated a significant relationship between social-anxiety disorder and other conditions, like alcohol and drug/substance abuse disorders. Especially, in college years, it becomes more important for a boy or girl to communicate comfortably in social settings and to actively participate in social activities more frequently. Actually, college or university times are the final age of adolescence, therefore, other people's viewpoints carry more relevance for adolescents. It becomes the cause that individuals with high expectations from themselves experience heightened anxiety if their expectations are not accomplished. Having social-anxiety and fear of speaking in public may negatively affect performance in studies, by avoiding the situations which demand interaction with others which is one of the essential attributes of educational organizations; and when a student having social-anxiety is pushed to communicate in social situations, that person may attempt to adopt avoidance behaviors such as avoiding eye contact and fast talking. These issues carry a bad effect on students' performance in classes, verbal examinations and oral presentations.

Social-anxiety disorder may have bad consequences on lives of students who have the planning for future jobs especially as teacher, because then it will be mandatory for them to speak in front of people/students almost every day.

People having social-anxiety disorder show insufficient assertiveness or extremely accommodating or may try to control any discussion. They may have very firm posture of body or may have zero/ poor eye contact, or interact with an extremely soft voice. They may be withdrawn or shy, and they may not be very open in conversations and may not share about them. They compromise their caliber by seeking only those jobs which does not need any social contact. They may spend their lives in home for longer hours. Male may avoid or delay marrying and whereas females who has the desire and capability to work may compromise their dreams and spend all their lives as a housewife. Self-medication with substances is also somewhere connected to social-anxiety such as to hide the anxiety drink alcohol before attending any social event. Social-anxiety in old adults can also aggregate the symptoms of many medical issues like increased tremor or tachycardia. Blushing has been also considered classic physical symptom of social-anxiety disorder. There are studies proving the relationship of alcohol and other substances frequently used by people having social-anxiety.

There is comparatively a significant relationship between body dysmorphic disorder, alcohol or substance abuse and depression. The existence of social-anxiety disorder may also depend on the context of different cultures. For example, in Western cultures, when patients meet surgeons for treatment or surgery, they show up similar symptoms like excessive blushing or sweating. In Japanese culture, social-anxiety is demonstrated as an extreme fear of offending other people, and is known as taijin kyofusho. The psychology of the sufferers of this disorder may have strong fear about blushing, making eye contact, imaginary defects in their body appearance or their body stink would be invasion to other people. Very few number of individuals having social-anxiety disorder get appropriate attention and psychological therapies.

Ford et al. (2003) stated that there are high chances of combining other anxiety disorders with social-anxiety, just like high chances of comorbidity in anxiety and mood and behavioral disorders. Most importantly, the specific comorbidities of anxiety related to social settings had been less explored in children and young adults. Wittchen et al.

(1999) researched and revealed that 41.3% respondents who had social-anxiety disorder were also diagnosed with substance misuse (including nicotine), 31.1% also had any of mood disorder and 49.9% any other kind of anxiety disorder. Sonntag et al. (2000) demonstrated that social-anxiety disorder is a significant predictor of nicotine use especially in young adults.

Conclusion: In Social anxiety, people have a feeling of constant but intense fear with panic attacks in social settings. In psychological documents, social-anxiety comes on number three on the terms of commonality among adults all over the world. As per DSM-5, social-anxiety disorder affects 50-80% of young adults. Mehtalia and Vankar (2004) revealed that in India 12.8% high school going students were affected with social-anxiety disorder, with impaired academic functioning and comorbid major depression. Same study showed the comorbidity of social-anxiety and public speaking anxiety. Atoner studies revealed its relationship with substance misuse (including nicotine), mood disorder and any other kind of anxiety disorder.

1.5 Self-esteem

> *"No psychological health is possible unless this essential care of the person is fundamentally accepted, loved and respected by others and by himself" (Maslow, 1968).*

1.5.1 Concept of Self-esteem

The psychological literature relating to self-esteem has an extensive past indeed, the idea of the self is an ancient phenomenon. When one uses the term 'Self-esteem', it refers to a person's appraisal of her/ his value. Global self-esteem indicates towards a global value judgement about the self, whereas domain-specific self-esteem involves appraisals of one's value in particular area like intellectual, social and physical dimensions. The most famous work is of Maslow (1943) who includes self-esteem in his needs of hierarchy. Cooley (1902) tagged this at first as the "looking glass self" and Mead (1934) Festinger (1954) gave back to this explanation. Numerous researches by psychologists and sociologists also have come up with factual evidence.

Rogers (1951) viewed the self as a discerned part of the substantial field, which subsists of a model of conscious values and perceptions of the "I" or "me". According to Rogers' view, the self is the essential element of person's character and personal modification. Rogers represented the self as a product of society, cultivating personal relationships and striving for regularity. He further supported that there is an elemental human requirement for positive perspective in regard to both from others and from oneself. He also concluded that there is an inclination towards self-actualization and growth in every individual when they get encouragement and support by the pleasing and a supportive atmosphere (Purkey & Schmidt, 1987).

Erikson (1968), a foremost developmental psychologist, described self-esteem as an act of identity development that rises up from successfully addressing the tasks related with every developmental stage of life.

The Dictionary of Psychology defines self-esteem as "the degree to which one values oneself" (Hartgill, 2003).

(Krasner et al., 2000) cited in (De Reuck, 2002) purports that self-esteem levels represent people's general or typical feelings of global self-worth and liking.

Coopersmith (1967) "Probably the most important requirement for effective behaviour, central to the whole problem, is self-esteem".

"Self-esteem has pervasive and significant effect, persons high in self-esteem are happier and more effective in meeting environmental demands than are persons' low in self-esteem" (Coopersmith, 1967).

Given its lengthy and divergent history, this term has many definitions, each of the definition has generated its own established practice of research, practical applications and findings.

Rosenberg, (1960) defined self-esteem, in the terms of a stable sense of personal worth or worthiness. This definition by Rosenberg became the most widely used introduction of self-esteem for research purposes. But, this definition had an issue of defining boundaries, self-esteem couldn't be distinguished from personality factors like narcissism or simply boosting.

Coopersmith (1967) defined the phenomena of self-esteem as, “By self-esteem a person means to refer the assessment which an individual forms and habitually cultivates with the regard to herself/himself.

Branden (1987) concisely illustrated self-esteem as the occurrence of being adequate to handle the essential challenges of life and deserve happiness. This two-factor approach accommodates a balanced description that looks accomplished of dealing with the disadvantages of explaining self-esteem majorly in terms of personal worth or proficiency alone.

Branden’s (1991) explanation of self-esteem incorporates the following fundamental features:

1. Self-esteem as an essential requirement of a human, it means that "self-esteem generates an important benefaction to the process of life, it is necessitous for healthy and normal self-development, and carries a weightage for survival”.
2. Self-esteem occurs as a natural and inescapable consequence of the total of one's preferences in utilizing their awareness.
3. Something experienced as a component of, or backdrop to, all the thoughts, feelings and actions of a human.

Self-esteem is also defined as a thought that an individual is acknowledged, approved of, associated, unique, dynamic, and proficient.

Self-esteem is an approach connected to personality, for its progress, one’s basic requirement to have worth of self, and this worth can be constituted from taking up the challenges that culminate in the uncovering of accomplishments.

Conley (1984) influentially reviewed the stability of personality with the statement “self-esteem cannot be considered a stable individual-differences construct” for the reason that it cannot provide long lasting balance in life. According to him, self-esteem is mostly persuaded by a person’s surroundings, which actually undermines its stability and prevents it from predicting future behavior. It had been also concluded by researchers that self-esteem can be called stable trait that has the capacity to predict future behavior (Harter, 1998; & Rosenberg, 1965).

Branden (1987) summarized the duality of self-esteem in identifying its two components as

(a) a feeling of personal competence

(b) a feeling of personal worth.

Thus, says Branden, self-esteem includes both self-efficacy and self-respect. He asserted that higher level of self-esteem allows a person to confront life's adversities in a better way, express more creatively, accomplish more ambitions and more probably find wholesomeness in the relationships.

National Association of self-esteem (2000) defined self-esteem as,
"Self-esteem refers to evaluation a person makes and maintains with regard to him or herself. It is the global evaluation reflecting our accomplishment and capacities, our values, our bodies, others response to us and our possessions."
Self-esteem remains an indicator of ephemeral and impermanent beliefs regarding one's value as compared to other people (Leary & Baumeister, 2000). It showed that self-esteem levels are hugely responsive to the evaluations done by society and are hence, constantly change in reaction of feedback from others. Another theoretical issue concerns whether self-esteem fluctuates and if there is any time in life when it is very low, stable or very high. According to Erickson's stage theory, the most critical periods in life, in the terms of flourishing self-esteem is adolescence, in this particular period of age one gains a firm sense of identity (Carwell et al., 2001). Most of the young adults develop a kind of "delusion of uniqueness" that consists of such thoughts as "No one feels the way I do about anything", "My problems are larger than life, unlike those of anyone else," and "No one cares about me." In short, the search for identity - one of the principal tasks of adolescence - leaves many young people feeling alone and without hope. How people feel about themselves can have a pervasive effect on their lives. It can influence how an individual will perform academically and socially. On the other hand, failure is much more likely when one suffers from low self-esteem because that person may believe others when they may tell, why the person cannot succeed. Low self-esteem can affect motivation and make the person more likely to give up on anything that seems difficult. Self-esteem is one aspect of personality that often serves as an indicator of what is

significantly absent. By definition, Self-esteem is a subjective judgement, it does or does not clearly reveal one's talents or achievements. Self-esteem draws most public attention when it is lacking entirely. Thus, self-esteem is often most obviously measured in its absence. But like a thermometer, it is an indicator of a problem, not a diagnosis and solution unto itself.

Students hold a particular pertinence with the issues of self-esteem while learning or paying attention because self-assessment of this concept needs the ability to evaluate and compare. Sometimes, students find themselves inadequate to correctly evaluate their own self-esteem. May be because of the fact considered by researchers that self-esteem is a feeling - not a skill - it can only be calculated by being observant to the way in which an individual acts or behaves. It is always advisable for parents and teachers to become interested and insightful observers of their children in order to evaluate and measure the self-esteem.

1.5.2 Historical conceptions of "Self"

Western societies commonly value goals related to growth of character and personal development of self-constructs and mostly take these goals for granted as desirable. Still, it is to some extent a recent phenomenon: between 700 and 1500, the concept of the "self" attributed to only the indecent, sinful, weak "selfish" nature of humans. The immoral "self" was compared with the divinely perfect nature of a Christian soul. It is believed that 800 years ago, the concept of an independent, self-directed "self" started coming in light. In medieval times, community used to direct values ("do what you are told to do"). So, the phenomena of "self" can be considered relatively latest idea which has gained importance. In modern times, "self" theory says that every person is expected to take the decision about what is right (almost by magic and without much dependence on the accumulated knowledge of the culture) and to understand him/her well enough to decide what courses of action "seem right." Briefly, it is expected that everyone must know themselves, so they can set their goals of life and self-actualize themselves. The cultures of 1200 and 2000 are two entirely very different worlds. (Tucker & Clayton, 1996). During the beginning of the twentieth century studies of the self-disappeared as the prevailing style in psychology was behaviorism. After the end of World War II

however, the concept of self was once again brought into importance and by 1980 self-esteem as a topic of study had been highly popularized (Walz & Bleuer, 1992). Most modern psychologists and sociologists would agree with Markus' (1980) statement that "assumption that a person will go to great lengths to protect his/her ego or preserve their self-esteem is an old, respected and when this is said and done, probably one of the great psychological truth". Indeed, self-esteem ranks among the most extensively studied conduct in behavioural science.

1.5.2.1 "Self" in the 20th century

Prior to the 20th century, social establishments, including psychology (which even didn't exist in that period) and educational institutes did not focus on the growth of positive beliefs about "self". Great prominence was being given, on constructing relationship with organized systems of government and divinities. With the evacuation of religion as the controlling organizational culture in the Western society, and the rise of capitalism with its significance, particularly in North America, on expression and reverence of personal independence, a 'cult of the self' come in light. Certainly, self-constructs had been positively linked with other desirable aspect of humans like improved quality of life, better educational performance, and list goes on. But there has always been an argument about whether an enhancement in self-concept or self-esteem becomes the reason for one's performance to be improved, or vice-versa. There is also a confirmation that high level of self-esteem when united with prejudice may take lead to heightened anger among humans. In North America, education and parenting has been condemned for overly emphasizing on affirmations and praise of kids. It has been a matter of dispute that merely boosting self-esteem without boosting personal skill, creates empty beliefs about self that become the root cause of more serious issues arising from self-deception.

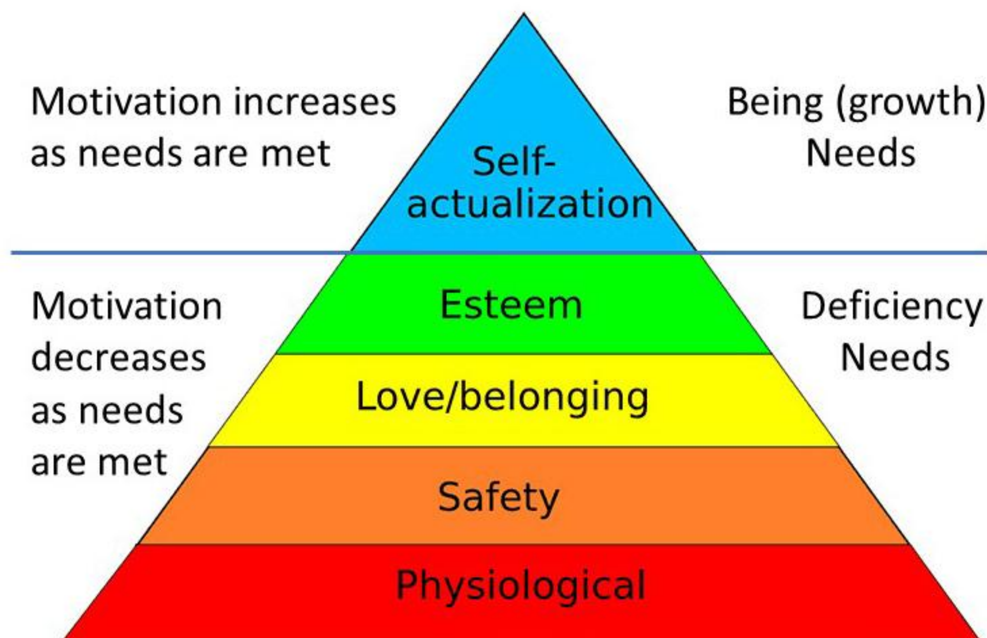
1.5.3 Theories of Self esteem

1.5.3.1 Self-actualization

Maslow (1943) rationalized the concept of requirement for self-actualization. He matured the extensively used concept of a hierarchy of needs, a pyramid model intended toward demonstrating the sequence of needs that individuals struggle to gratify.

Maslow's model rests on five levels, the lowest level addresses vital physiological requirements like food, water, and sleep that are requisite for human endurance. The second level have the requirement for security. If individuals have the sense of security in financial, health and personal sphere they can access the next level- a level that contains of psychological needs, such as friendship or a feeling of belonging. Human beings have a requirement to associate, to feel linked with friends, partner and family.

Figure 4: Self-actualization Model



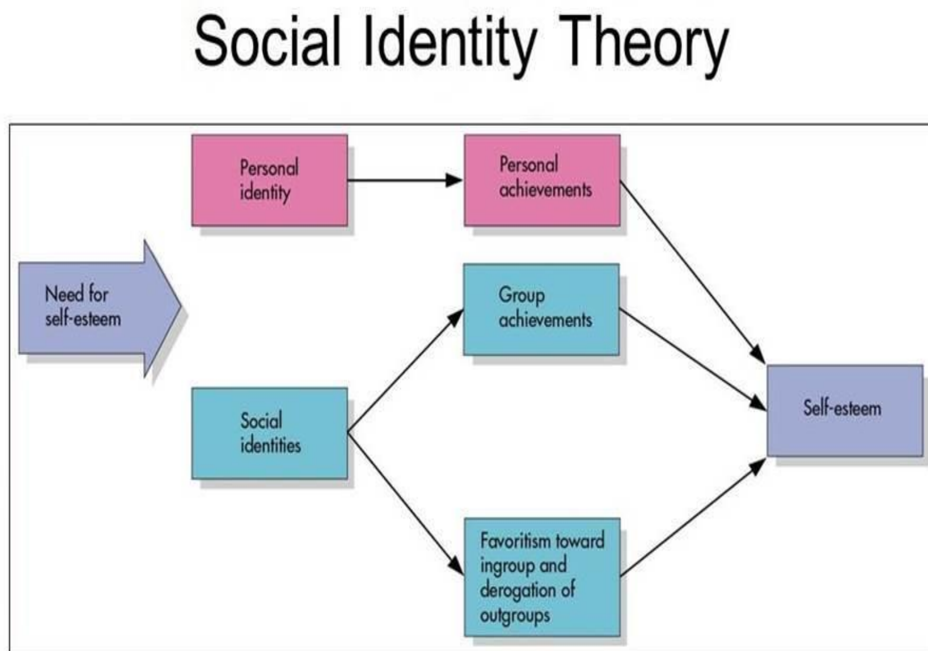
The fourth level specifies the requirement to feel valued, propounds that when individuals are acknowledged and accepted by society they become suitable of reaching to the final level, self-actualization. In spite of Goldstein (1939) understood self-actualization as an intrinsic effort that pushes people to accomplish their maximum

achievement, Maslow explained self-actualization fairly as a propensity for individuals to grow into actualized in what they are proficient of being. Furthermore, a highly improved self-actualization can increase your self-esteem.

1.5.3.2 Self-Categorization (Social Identity) Theory

Tajfel et al. (1978, 1979) proposed Self-Categorization or Social Identity Theory in social psychology. Social identity [Fig. 5] states the idea that individuals' self-concepts rely on their association in social settings. Examples include sports teams, religious or spiritual groups, nationalities, occupations, sexual orientation, ethnic groups, and gender. Social identity theory explains that social identification affects one's opinions and the way they behave in group and the outgroup settings. Social identities are mostly affective when a person consider membership in a particular group to be central to their self-concept and they feel strong emotional ties to the group. Affiliation with a group confers self-esteem, which helps to sustain the social identity. Theory and research on social identity complemented psychology's historical emphasis on personal identity (Erikson, 1963; Marcia, 1980).

Figure 5: Social Identity Theory Model



Whereas social identity refers to people’s self-categorizations in relation to their group memberships (the “we”), whereas (the “I”) refers to the unique ways that people define themselves as individuals. That is, people’s self-concepts (i.e., self-categorizations) comprise both personal identity and social identity (Hewstone et al., 2002).

1.5.3.3 Terror Management Theory

Terror management theory was considered one of the most controversial explanation of self-esteem. As per this theory, high self-esteem protects people from the pragmatic fear they had for their own death and utter destruction (Greenberg et al.1997; Solomon et al. 1991). Humans were motivated to nurture self-esteem because it helped them to stay away from the debilitating terror they may otherwise had. Consistent with terror management theory, experimental guidance that make fatality pertinent, do increased people's concerns with self-esteem. Greenberg et al., (1997) claimed that high self-esteem lowered people's anxiety about death. Sowards et al., (1991) argued that there exists strong support for this theory, but no research has been done to prove that self-esteem functions to buffer existential anxiety.

1.5.3.4 Sociometer Theory

Human being is defined by a basic requirement to belong, an elementary motivation to form and sustain a minimum but a number of meaningful social connections. Certainly, when something is extremely vital for an organism's well-being, internal structures tend to grow for observing it. The central tenet of socio meter theory is that the self-esteem system monitors the standards of human’s actual and potential relationships specifically the degree to which people value their relationships with the individual. In an evolutionary analysis of friendship, Tooby and Cosmides (1996) made a point, suggesting that "adaptations should be designed to reply to signs of waning affection by increasing the desire to be liked, and mobilizing changes that will bring it about". In our view, self-esteem may be a familiar, affectively potent response because it is the variation that performs the essential job of monitoring and reacting to social acceptance and rejection.

1.5.4 Functional impairments caused by Low Self-esteem

The book titled *The Hidden Face of Shyness* explained that apprehension has "long-term consequences" that can dampen an individual's self-esteem leading to communication incompetence (Schneier and Welkowitz, 1994). Concept of self has been studied under many labels like self-image, self-evaluation, self-concept, self-esteem and self-acceptance (Wylie, 1966). Self-esteem has been the core to the theories based on personality (Mead, 1934; Lewin, 1936; Allport,1937; Murphy, 1948; Cattell, 1950; Secord & Backman, 1965), intervention approaches in counseling services (Freud, 1943; Horney, 1950; Rogers, 1951; Sullivan, 1953; Maslow, 1954), and approaches of interpersonal behavior (James 1950; Combs & Syngg, 1959; Goffman, 1961; Bales, 1970). Low levels of self-esteem have been associated with a number of problematic results, such depressive symptoms (Block et al. 1991; Reinherz et al., 1993; Roberts et al., 1996; Whisman & Kwon 1993), health issues (Antonucci & Jackson, 1983; O'Connor & Vallerand, 1998; Vingilis et al.1998), and antisocial behavior (Donnellan et al. 2002; Owens, 1994; Rosenberg et al. 1989). Considerable amounts of research have been conducted to understand the various correlative factors of self-esteem. Such as Jourard (1971) has deduced that who had high self-esteem will associate in higher levels of self-disclosive behavior. Consistently it has been said that low self-regard had connection with a number of maladaptive and neurotic behaviors (Brownfain, 1952: Crandall & Bellugi, 1954; Cooper & Worchel, 1970; Leary, 1957). Persuasibility also had been correlated with low self-esteem (Hovland & Janis, 1959; Cooper & Worchel, 1970; Helmreich et al., 1982; Deaux, 1972) and influence attempts (Cohen, 1956), as well as liking for themselves (Walster, 1965) and inspiration (Korman, 1970; Deci & Ryan 1975).

Conclusion: Self-esteem refers to a person's appraisal of her/ his value. As per the definition, self-esteem was considered as a subjective judgement, it does not clearly reveal one's talents or achievements. So, self-esteem is mostly measured in its absence. It has been a matter of dispute that merely boosting self-esteem without boosting personal skill, creates empty beliefs about self that become the root cause of more serious issues arising from self-deception. Many theorists summarized self-esteem through self-actualization theory, self-categorization or social identity theory, sociometer theory and

terror management theory. Concept of self has been studied under many labels like self-image, self-evaluation, self-concept, self-esteem and self-acceptance. Low levels of self-esteem have been associated with a number of problematic results like depressive symptoms, health issues, antisocial behavior and neurotic behaviors.

1.6 Multimodal Therapy

1.6.1 Historical perspective

During the 1950s and 1960s "unimodal" solutions to mental and emotional suffering were predominant. "Make the unconscious conscious!" "Change maladaptive behaviors!" "Modify faulty cognitions!" Lazarus (1964) elaborated a multidimensional way to the treatment of substance abuse, displayed the start of a break from almost hollow forces of rigid behaviorism, approached to a more all-encompassing procedure. Lazarus was not satisfied regarding the limitations which behavior therapist had, which was clearly shown up in following statement,

> **"....** in their zeal for experimental rigour, and their desire to
> circumvent the quagmire of internal or subjective phenomena,
> many therapists have limited themselves to a rather narrow
> range of human experience."

Lazarus (1976) kept on progressing to the mission of creating concepts, and on his approach of treatment for agoraphobia which he published as a paper on the "Broad Spectrum Behavioral approach". Lazarus (1966) confronted the limited stimulus feedback approach of traditional behavior therapists. This generally extensive approach further took the shape as the publication of "Behavior Therapy and Beyond". Lazarus (1971) an advanced spectrum behaviorist, insisted on the usage of reinforcement agendas and the behavioral contingencies functioning in almost every circumstance, consideration of the interpersonal mechanism, personal attitudes, perceptions and environmental factors which may be operating. Studies regularly revealed that follow up of respondents were showing up high relapse rate specially who were purely exposed to behavioral techniques. In cases where showed up significant change, consistently related to somewhat more ambiguous statements of the participant having "an enhanced range of interpersonal and behavioral skills" and "increased self-esteem", and there was a

persistent notion of harmony between more obvious cognitive and behavioral approaches. There were two probable and clear filaments to Lazarus' flourishing concepts. On one side, there was a strong dogma that the evolution of advantageous and reliable treatments with people needs accurate and broad data of follow up. As Paul (1967) had previously expanded this point that the counselor should have to frequently has to interrogate about treatments, of problems, and under which set of situations, treatments will show its efficacy. Thus, the straight implementation of behavioral interventions is not sufficient. He claimed that it is necessary to understand the uniqueness of a person. A therapist should try to match their needs with the assortment of distinct and adeptly available treatment plans. At that time Lazarus was also very keen in expanding a structure, which would allow for the precise and comprehensive assessment of a person.

Finally, Lazarus (1976) developed The Multimodal Model in response to research that the therapeutic success resulting from unimodal treatments generally short-lived. Initially, Multimodal Therapy also called Multimodal Behavior Therapy. It relies on the perception that on ground level, everyone is biological organism (neuro physiological/biochemical creatures) who behave (act and give reaction), sense (respond to material, olfactory, visual, and auditory beings), emote (experience feelings), imagine (implore up sounds, sights and in our mind's eye create other events), think (make beliefs, values, opinions, and attitudes) and interact with others (entertain interpersonal relationships). When these seven different but interconnected modalities or dimensions are referred they conclude to Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, Drugs/ Biological, the convenient acronym BASIC I.D. comes out from the first letter of each word. Most importantly, this model covers a broad range of interrelated modes, all of which influence the client's functioning (Lazarus, 1976). The multimodal therapist insists that a complete estimation and intervention plan must be considered for every modality of BASIC ID. In this manner, the BASIC ID is a cognitive directive plan that makes sure that every facet of personality gets systematic and precise attention (Lazarus, 1989). Ayers and Hopf (1993) stated that it becomes quite tough to claim why an intervention works for an individual but not for other.

Lazarus claims that if we use this approach, our results will be rapid and long. And if we don't cover all seven of the modes, in the premise of BASIC ID, we are doing a half-baked, incomplete job. People will relapse! If you don't deal with all seven, "it's like an earthworm that regenerates" (Lazarus 1977). Another way to use this approach is the BASIC ID model as a kind of lens, view piece or pair of eyeglasses through which you zoom in on the modes that you are investigating in order to determine where to intervene. The BASIC ID is the head profile, compass or personal chart that guides your gaze into these "Pillars of Personality" (Lazarus 1977). By assessing a client's BASIC I.D. one endeavors to "leave no stone unturned."

Multimodal behavior therapy generally proceeds through the following four stages:

(a) Assessment of client's current functioning.
(b) Establishment of goals and objectives.
(c) Development of treatment plans aimed toward altering deficits or difficulties.
(d) Evaluation of effect of treatment (Seligman, 1981).

Multimodal therapy tries to combine different perspectives and also seeks to adapt treatment with individuals' problems and pays specific attention to the individual differences in the treatment. This systemic approach to an individual and his/her problem and treatment of problems with the Multimodal method has more consistency with humans' nature. This intervention is an organized and extensive psychology based therapy which has a holistic way with the purpose of constructing a viable change. Lazarus (2005) stated that emotions are important for shaping and keeping social relations interactions. Lazarus (1981) analyzed three theory based factors that would be an active side of human conduct.

a. Social learning

Lazarus noticed that conduct of an individual as grows through the dynamic connection between human genes, social communications and physical surroundings. Apparently, Lazarus balanced his work with the social learning theory (Bandura, 1977).

b. Private events

Even though, Lazarus stressed on the prominence of social learning, he acknowledged that private events, images, thoughts, and sensations and feelings too play a vital aspect in giving shape to one’s personality. Ellis (1962) pointed out that mostly people give

response to their perceived surroundings and not the actual environment. So Lazarus (1981) suggested that these perceived surroundings may be a reason of both unconscious and conscious mechanisms. Moreover, Lazarus claimed that an awareness of unconscious acts cannot be necessarily implied as a belongingness to any theoretical line - Freudian, for example. It was observed by Lazarus (1981) as an awareness of the evidence that individuals are adequate enough of eliminating their own awareness, losing touch with themselves and mistaking their emotional reactions.

c. Social Systems

Environmental and contextual factors are also considered significant determiners of behavior. Lazarus (1981) was convinced with the fact that every human functions as part of a social organization and as a fundamental of culture and society. So, while constructing client's modality profile across the BASIC ID, the situation in which one's mindset is working out has to be kept in attention, specially at the time of devising therapeutic techniques. Finally, when time comes to applying interventions across the BASIC ID, the multi modal therapist does not have any restriction to pick any specific school of thought. Lazarus briefly summarized the basic principles of multimodal therapy as follows:

1. Human psychology can be understood through seven interconnected process of the BASIC ID.
2. A comprehensive and all-inclusive model is provided by BASIC ID analysis.
3. The effective interaction of social learning theory, contextual factors and private events are the theoretical foundation of human behaviour.
4. The therapist practicing multimodal therapy embraces a treatment relies on utilitarian technical eclecticism, in which the adequacy of a treatment plan is predominant just opposite to its theory based origin.
5. This model provides an authentically useful holistic structure for understanding the psychological functioning of an individual.

1.6.2 Techniques used in Multimodal Therapy

Lazarus stated that every individual has multiple layers of the personality. All human beings carry out the similar functions, it could be emotions, biological, or mental even

though every individual remains different in their own individual way. Lazarus concludes that every person requires a unique way in therapy and counseling. Reason being that each individual is exclusive. Lazarus' list of interventional techniques constitutes only of those techniques which were already proved their efficacy in research (Dryden & Mytton, 1999; Lazarus, 1989; Corey, 2001).

1.6.2.1 Behaviour

I. Behavior rehearsal
II. Modeling
III. Nonreinforcement
IV. Positive reinforcement
V. Recording and self-monitoring
VI. Stimulus control
VII. Systematic exposure
VIII. The empty chair

1.6.2.1.1 Behavioral Rehearsal

Behavioral rehearsal, a therapeutic intervention through which social skills, responses and behaviors are imagined and practiced to prepare for when they will actually be implemented. People who are unable to conduct themselves appropriately in specific situations, or who cannot cope with particular interactions, are rehearsed much like a character actor mastering a role. For example, if a student is intelligent but is at a loss for words when confronting his teacher for clarifications. In that case counselor will commence by playing the part of the teacher; the student practices his encounter with the teacher. They later reverse roles- the student will play the role of teacher and counselor will act like student until the student is satisfied with his performance and client is encouraged to test his skills in the actual situations. Other example could be just like the actors rehearse their lines and stage actions before actually performing in front of the crowd. This intervention technique helps to enhance social interactions skills. There are many other ways to practice rehearsing behaviours.

- First way covers a persons' thinking or imagining about themselves as acting, responding and performing properly the desired behaviour with others.
- A second way constitutes practicing and describing oral social conversations to others.
- Role-playing is considered the method.

All these methods, constitute eloquence through repeated rehearsal and that becomes the utmost significance for accomplishing success and improving appropriate interpersonal skills.

1.6.2.1.2 Modeling

Modeling is a technique in which behavior is learned by observation, mostly known as social learning or observational learning. When an individual notices the actions of others and then tries to imitate that particular behavior, that person is referred to be imitating or modeling the behavior. In this technique, either therapist provides a role model or serves as a model for that particular behavior which the person is motivated by therapist to imitate. For example, in the case of public speaking fear the counselor can invite the respondent to accompany him or her to an event and initiates an interaction with main speaker before the event starts. There are four sub processes that must exist prior to modeling being demonstrated:

1. Attention
2. Retention
3. Reproduction
4. Motivation.

Attention is the first sub process. Before a particular behaviour can be imitated, respondent must give serious attention to the behaviour. Retention becomes the next sub process. An individual should be able to remember and retain the noticed behaviour. In the journey of modeling behaviour, reproduction becomes the next and third stage. The client should be potent enough to convert the images of other's behaviour into his/her own behaviour. In short, client should have the capacity to reproduce other's behaviour into their personality. Motivation is considered the last stage. Respondent should be

motivated enough to imitate the behaviour. The counselor explains the steps along the way and may assign homework to the client for practice. This technique is used to get rid of self-defeating thoughts, reducing stress and practicing social skills (Bandura, 1977, 1989; Sprafkin et al., 1975).

1.6.2.1.3 Non-reinforcement

In non- reinforcement, a response or behavior is elicited by stopping, removing, or avoiding a negative outcome or a stimulus that evokes aversion. In negative-reinforcement, response is strengthened by the fear of punishment or the anticipation of reward**.** Non reinforcement happens when the target behavior is exhibited and there is no response from the environment. These acts produce neutral results and neither rewards nor punishment are brought. However, if an act has been consistently followed by a reward in the past, but does not manage to elicit the expected reward, it leads to frustration. If multiple repetitions of the act fail to result in the expected reward, the act will grow less and less frequent and will eventually die out.

Many problems are maintained by attention (social reinforcement) from other people. By not attending to the behavior, by not rewarding or reinforcing it, a therapist or other individuals in client's social environment may facilitate its extinction. Reward those behaviors you wish to encourage; ignore those you wish to discourage.

For Example, a child will cease to stick out his/her tongue if you pretend like you did not see it

1.6.2.1.4 Positive reinforcement

Positive reinforcement is used to get desired or wanted behavior by introducing a desirable response to motivate the behaviour. For example, giving child a reward when he or she is behaving well in social settings. In psychotherapy, there are four types of positive stimulus—also known as a reinforce.

1. Natural reinforcers that happen directly as a result of the behavior. For example, a student studies hard and tops in the class.
2. Token reinforcers are given for acting certain behaviours and can be exchanged for some valuable thing. For example, parents usually make out a reward system in which the child can earn points, some other token or stars that they can use later and turn those points into some desirable reward.
3. Social reinforcers involve others communications as the approval of their behavior. For example, a parent, teacher, or boss saying, “Good job!” and “Excellent work!”.
4. Tangible reinforcers are in actual tangible or materialistic rewards. For example, treats, increments, cash or toys, (Cherry, 2018).

A positive reinforcement is a technique that defines how a person will be encouraged for acting certain
behaviour.

1.6.2.1.5 Recording and Self-monitoring

Self-directed change often rests on the client’s willingness to engage in the systematic recording, charting and/or quantifying of target behaviors. For example, the person on a weight reduction program who accurately computes daily caloric intake has a better chance of achieving a desired weight than the individual who will not engage in self-monitoring. The very act of counting and keeping notes tends to give clients a greater degree of self-control.

1.6.2.1.6 Stimulus Control

The presence of certain behaviours has the tendency to multiply the frequency of certain stimuli. For example, the presence of good or junk foods is likely to increase eating. An individual who wants to lose weight may implement “stimulus control” by keeping snacks, deserts or junk food out of the house. An individual who wants to quit smoking, may light up a cigarette only under specified stimulus-conditions. Those who practice

stimulus control to bring a desired change may arrange environmental cues as a trigger of those responses.

1.6.2.1.7 Systematic Exposure/desensitization

Efficient exposure is a behavioral strategy whereby a man is bit by bit presented to a nervousness arousing stimulus, occasion, or place while being occupied with some kind of unwinding, in the meantime keeping in attention the last goal to diminish the side effects of tension.

Refusal to take emotional risks and avoidance of fearful or unpleasant situations are two of the most common characteristics of troubled individuals. Clients are encouraged, step by step, to expose themselves to their feared situations. Clients may first use goal-rehearsal or coping imagery to ease their actual excursions into unpleasant situations. Many other techniques may be employed to achieve the all-important non avoidance or systematic exposure objectives- modeling, positive imagery, relaxation training and self-instructional training.

Wolpe (1969) emphasized on assertiveness to treat anxiety pertaining to interpersonal relations but due to its infectiveness in other forms of anxiety, swayed towards the benefits of deep muscle relaxation. Researchers also found that practicing muscle relaxation reduces pulse rate, blood pressure, rate of respiration and increases the skin resistance (Jacobson, 1938; Clark, 1963).

Wolpe designed treatment programs in which anxious person were subjected to gradual exposure of anxiety provoking stimulus from mild to severe, by making use of both in vivo and imaginary situations. The idea behind this was once a weak anxiety provoking stimulus ceased to arouse any anxiety then it is possible to present a stronger anxiety provoking stimulus to a fully relaxed person.

1.6.2.1.8 The empty chair

The empty-chair intervention or chair-work is a psychotherapeutic plan. The empty chair is predominantly practiced in Gestalt therapy, which constitutes the client in a role-played interaction with an imaginary individual. Originally, Gestalt techniques were a part of psychotherapy. But in recent times it is being used in counseling, for encouraging patients to act out their negative feelings helping them to prepare for positive and changed behaviour. (Schacter et al. 2012; Nichol, 2008). The patient imagines that a specific person or family member is sitting in front of patient on that empty The patient communicates with that person, about the things they could say or convey real life and to practice how patient will communicate with that person in future. Most of people open up by blaming, hitting, beating, attacking, requesting or forgiving something of the imagined occupant of the empty chair. The client then moves into the empty chair and becomes the other person, who then directs all remarks to the chair that the client had occupied, as if talking to the client. Again the client changes chairs and becomes himself or herself and continues the dialogue. Switching to the other while assuming the role of the significant other and then oneself is usually continued until some resolution is reached. The therapist may offer prompts while the client is playing either role. This procedure provides diagnostic insights and also has a variety of therapeutic effects. It is especially useful in permitting clients to appreciate the other person’s point of view. Some other person or even the client himself too can take up the role of the person on the empty chair.

1.6.2.2 Affect

- **I.** Anger-expression
- **II.** Anxiety management
- **III.** Feeling-identification

1.6.2.2.1 Anger expression

Many clients have difficulty in recognizing their anger; others are afraid of it. Once the anger is owned, it can be eliminated through rational disputation or channeled into appropriate assertive expression. Coaxing the client, especially in group settings, to state

"I am angry!" over and over, louder and louder, is well known method of bringing the person in touch with his or her anger. Pounding foam rubber cushions and staging pillow fights are other well-known means of eliciting anger.

1.6.2.2.2 Anxiety management training (AMT)

The basic characteristics of AMT includes implementation of relaxation for self-trained anxiety minimization, guided imagery, anxiety arousal. During sessions anxiety is dissolved and clients get the advantage to be more mindful of the causes behind the elevation of their anxiety levels. Clients also become aware of the early cautionary signs and learn to use relaxation techniques those would actually decrease their levels of anxiety. Firstly, patients learn to control their anxiety in a clinical setting. When they learn self-control of anxiety, the anxiety provoking scenes are exaggerated and the amount of support by the counselor in relaxation retrieval is reduced. The patient also gets homework assignments to use relaxation in their personal surrounding. When anxiety is experienced at home they are trained to employ the transfer of skills to in vivo settings. An emphasis is levied on awareness of stress which is combined by giving instructions to clients for paying attention to the feelings induced by tension in muscles and to carefully observe the difference between the tensed and relaxed sensations. Progressive relaxation and relaxation scene visualization training are also provided by therapist. Patients are also motivated to regularly monitor anxiety symptoms every day.

1.6.2.2.3 Feeling-identification

The cornerstone of psychological health is communication. That's why psychotherapy is considered as the "talking cure," or the process by which a person reveals themselves to an empathic professional. It's a two-stage process — opening up to oneself and then learning how to speak about those feelings to another. However, given how effectively our defense mechanisms work to hide emotions from consciousness, it's often a challenge to know what one feels. By using the tools one can get help to identify what feelings are cooking beneath the surface. Ask:

- What feelings am I aware of having? (There are often many.)
- What is the most prominent? (Try to describe it to yourself. Also, don't be afraid to push yourself past answers like "fine" or "okay." Continue by asking what "fine" means. We often resist even our own probing.)
- When did I become aware of this feeling?

Identify stressors.

Ask : What might be triggering this feeling?

What's happening (or not happening) in my daily life? (It helps to deconstruct one's day, week, month. Pay particular attention to events, thoughts, or dreams that you have no control of and perhaps have decided 'not to pay attention to' because you cannot change them. This is a common pitfall. The fact that we have no control itself brings an emotional reaction). Perhaps your answer is, "I don't even know how I feel." One direction to take in that situation is to examine your behavior and daily life. This can help to tease out feelings not recognized initially. So, ask:

- How is my home life?
- Am I getting along with my partner? My children? My parents and siblings?
- How am I doing at work? Am I enjoying my work? Am I getting along with my co-workers? My boss? What are they telling me about me and their feelings about me? Can I see validity in what they're saying?

Look for patterns that may be forming. Explore them. What do they tell you?

Notice if you start judging what you feel.

"I don't have any reason to feel bad (anxious, depressed)," you may say. Wait for an outcome before assuming the worst. We tend to chastise ourselves (as if feelings follow reason!). The reality is that life events generate feelings. They simply are. Though we

may decide which feelings to attend to, we don't decide to feel or not feel. It's our project to identify them and give them room to breathe.

1.6.2.3 Sensation

I. Bio-feedback
II. Focusing/ Meditation
III. Hypnosis
IV. Relaxation training
V. Threshold training

1.6.2.3.1 Biofeedback

A variety of procedures exists that systematically monitor specific areas of a person's physiological functioning and transmit that information, usually in the form of a visual or auditory signal. Biofeedback is a technique that involves the mind and the body, using auditory or visual feedback to have control over involuntary physical activities. The aim of biofeedback is to bring about a desired change in these autonomic or physiological functions. For example, a client suffers from twitches in jaws. Using a machine designed to give electromyographic (EMG) feedback, the therapist attaches electrodes to the client's jaw muscles so that the minute contractions are registered, amplified and connected to an auditory signal. The tonal feedback would vary with the degree of muscular tension- the more the tension, the louder the sound. The individuals are trained to maintain a low decibel level or to dispose of the tone together. By learning how to control different bodily responses to stress, biofeedback clients become able to relax their bodies, minds and better coping with the signs of stress.

1.6.2.3.2 Focusing/ Meditation

This is an introspective technique adapted from the work of Eugene Gendlin. When in a quiet, relaxed state, the client is encouraged to enter contemplative mood and is gently coaxed into examining spontaneous thoughts and feelings until one particular feeling emerges at the focus of his or her full experiential awareness. After several minutes of intense focusing, the client is

asked to try to extract something new from sensations, images and emotions. By shifting the emphasis from talking and thinking about problems to their felt bodily expressions, the client is often able to circumvent cognitive blocks, with the result that important material may be brought to light. Focusing exercises also tend to have a desensitizing effect in some cases.

1.6.2.3.3 Hypnosis

Merger of hypnosis and behavior therapy has been found in Wolpe's work. In 1958, Wolpe developed an imagery-based technique for the treatment of phobias and fears known as Systematic desensitization. Originally, Wolpe (1958) used hypnosis for overcoming anxiety along with Systematic Desensitization. Because most of his patients were not comfortable to get hypnotized he shifted to Jacobson's (1929) progressive relaxation technique. Nevertheless, Wolpe and Lazarus (1966) used hypnosis with Systematic desensitization in many of their cases. The earliest definition of hypnosis was given by Braid, who coined the term "hypnotism" as an abbreviation for "neuro-hypnotism", or nervous sleep, which he opposed to normal sleep, and defined as:

"A peculiar condition of the nervous system, induced by a fixed and abstracted attention of the mental and visual eye, on one object, not of an exciting nature."

According to the Kirsch et al., (1993), American Psychological Association, "Hypnosis involves learning how to use your mind and thoughts in order to manage emotional distress (e.g., anxiety, stress), unpleasant physical symptoms (e.g., pain, nausea), or to help you change certain habits or behaviours (e.g., smoking, overeating)".

Orne (1971) defined hypnosis as an existence where suggestions from one person seemingly modify the memories and perceptions of other.

Erickson et al. (1976) stated hypnosis a procedure of creating a trance clinically as "a free period" so that a person's individuality can be enhanced.

Kaplan et al. (1998) described hypnosis as a state which is dissociated, a state where a person can regress and altered state of consciousness.

Hypnosis is an intervention used by therapists to develop communications to respondents who have been subjected to trance like state. The concept of hypnosis in psychology comes from the reactions of respondents in relaxed state, which is considered to be a

solution to many physical conditions like pain. To attain this state of mind, the therapist induces a repetitive session of images and words, with the intention to attain a sleep-like state of mind. Hypnosis is considered a temporary state of mind, where an intense suggestibility and relaxation exist. In this state, some (not every) clients become so concentrated that they experience imaginary manifestations like those situations were happening in reality.

1.6.2.3.4 Relaxation training

Deep muscle-relaxation tends to go beyond mere physical comfort and can produce profoundly calming feelings in many people. There are two main varieties- total relaxation and differential relaxation. Total relaxation is performed while lying down on a comfortable bed or couch, or while sitting on a large, upholstered chair that fully supports the back and head. This mode of therapy targets to assist individuals to have an improvised and relaxed state of mind resulting in the positive perspective. Step to be followed for relaxation training:

In deep breathing training, the clients sit straight, with their palms on the lap, the head straight and feet folded or kept on the floor, therapist guides them to breathe slowly on the count of 4 and breathe out more slowly on the count of 6. This is repeated for 5 times with the client's eyes open and 5 times with the client’s eyes closed. The following instructions were given:

“Breathe in slowly.......Breathe out gradually” (repeated 3 times). “Now concentrate on the top of the head Breathe in slowly.........Breathe out gradually.... Top of the head... Relax” (repeated 3 times). The following instructions were also given: “Now the top of the head is light and relaxed, no thoughts, no fears, no worries, no stress, and no pain. Top of the head is light and refaxed. Top of the head is completely relaxed. Breathe in slowly... Breathe out gradually”. Same instructions were used for rest of the body parts in the order given below:

Forehead, Mouth, Eyes, Neck, Back of the head, Back, Shoulders, Chest, Stomach, Legs and Hands.

After bringing them into the relaxed, the following instructions were used:

> Inhale good health. Exhale all the pains and illnesses from your physical body.

> Inhale happiness. Exhale all the stress from the body.

> Inhale positive thoughts. Exhale all the useless and negative thoughts from your body.

> Inhale courage and confidence. Exhale fears from your body.

> Inhale success. Exhale fear of failures from your body.

> Inhale strength. Exhale the weaknesses that your body is having.

> Inhale love. Exhale all the hatred, frustration and anger from your body.

1.6.2.3.5 Threshold training

Psychology defines the absolute meaning of threshold as the smallest amount of intensity recognized by a person's senses. Each sense a person carries its own level of absolute threshold and it differs from person to person. The statement infinite threshold is mostly applicable in neuroscience and experimental research. The main concept of absolute threshold revolves around five senses include vision, hearing, taste, touch and smell. As an example of infinite threshold for hearing is the faintest tone that is a human can detect without any other nuisance. The infinite threshold for vision is the little amount of light that can be seen by the eye of a human. An example of infinite threshold for touch is the point in which an individual start to feel the heat from fire. For smell, it is the slightest hint of a perfume a person is able to detect when in a room. In reference to taste, the infinite threshold is the minimum level of flavor a person can detect.

1.6.2.4 Imagery

I. Anti-future shock imagery
II. Associated imagery
III. Aversive imagery
IV. Goal-rehearsal or coping imagery

V. Positive imagery
VI. The step-up technique
VII. Time projection

1.6.2.4.1 Anti-future shock imagery

Apart from helping clients solve their ongoing problems, it is important to prepare them for changes that are likely to occur within the coming months and years. So many people are taken unaware by events in their lives that could readily have been anticipated. One asks, what are the prevailing conditions in the work setting and in the home? What changes are likely to occur? By taking stock of the most probable changes that are likely to occur, and by encouraging the client to visualize himself of herself coping with these changes, you facilitate the client's acceptance of the inevitable. These "emotional fire-drills" tend to reduce relapse rates.

This technique prepares clients for changes that are likely to occur within coming months and years. By taking stock of most probable changes that are likely to occur and encouraging the client to visualize himself or herself coping with that changes, therapist facilitate the client's acceptance of the inevitable. These "emotional fire-drills" tend to reduce relapse rates.

1.6.2.4.2 Associated imagery

The value of dipping into and tracking ongoing thought processes has been underscored by William James in his writings on the "the stream of consciousness" and by Freud's method of free association. Clients frequently experience unpleasant sensations and emotions that they are unable to account for. While experiencing an untoward emotion, they are asked immediately to pay attention on any picture that came in their mind, to see vividly as possible. Other images may begin to take its place. If so, each one is to be visualized as clearly as possible. If new images do not come to mind, the original image is to be magnified as through a zoom lens. As each image may begin to take shape and some clients will come up with significant self-revelations.

1.6.2.4.3 Aversive imagery

There is long history to the technique of associating unpleasant thoughts and feelings with behavior that is undesirable but self-reinforcing (e.g., alcoholism or over eating). Instead of using emetic drugs and electric shocks to discourage undesirable behavior, the use of extremely unpleasant mental pictures sufficient. For instance, an obese individual who is tempted by rich deserts, can be trained to imagine that someone has vomited over the desert.

1.6.2.4.4 Goal rehearsal or coping imagery

Most people tend to rehearse upcoming events in their minds, but goal-rehearsal refers to a meticulous and thorough visualization of every step in the process. The purpose was that the deliberate picturing of oneself coping with situations will enhance transfer to the actual events. Clients are told, “If you practice something in imagination, it is bound to have an effect on the real situation”. The realistic expectation enables a client to experience the actual event with minimal discomfort.

1.6.2.4.5 Positive imagery

The picturing of any pleasant situation, whether imagined or real, it could be from one’s history, present or future has many benefits. As a tension-reducer, as an anxiety-inhibitor and as a direct enjoyment enhancer, positive imagery can play a vital role. The power of positive mental imagery for healing physical afflictions can help one cope with pain and it can induce a feeling of optimism while overcoming boredom (Lazarus, 1978; & Singer & Switzer, 1980).

1.6.2.4.6 The step up technique

Many people are unduly anxious about their upcoming event- a public speech, a job interview, a dinner party and so forth. This technique consists of imagining the possible worst thing that can happen and later in therapy picturing oneself handling in that same situation and surviving even if some negative outcome occurs. When an individual clearly imagines himself or herself managing with horrors that were deliberately called

into fantasy, anticipatory anxiety tends to recede. When things happen in reality, they give little threat.

1.6.2.4.7 Time projection

Clients with fairly vivid imagination can readily picture themselves going forward or backward in time. Some clients experience immense relief after reliving and working through past events. By going several months into the future and picturing themselves adding more and more rewarding events to their daily lives, some depressed individuals experience a diminution in negative affect. Mostly, an issue which creates intense distress or anger can be considered with detachment.

1.6.2.5 Cognition

I. Bibliotherapy
II. Correcting misconceptions
III. Ellis' A-B-C-D-E paradigm
IV. Problem-solving
V. Self-instruction training

1.6.2.5.1 Bibliotherapy

Bibliotherapy suggests the use of literature to help individual cope with mental illness, emotional issues, or other positive changes in their lives (Pardeck, 1993), or to bring the required positive change and boost up personality development and grooming (Lenkowsky, 1987; Adderholdt-Elliott and Eller, 1989) by giving relevant literature for their personal events and developmental requirements at required times (Hebert and Kent, 2000). Historically, Bibliotherapy started in 1930s when librarians started arranging lists of books that helped people change and improve their feelings, behaviors or thoughts for therapeutic aims. Psychologists created an association with librarians to suggest selected literature for patients who were going through different psychological issues (Pardeck,

1994). In clinical Bibliocounseling and Bibliotherapy, skilled psychologists use techniques to guide people having serious emotional disturbances. To bring out desired change, it provides to help patients respond directly to the contents that they were given. Usually, that change occurs through a catharsis, insight, or the "copying of character behaviors" (Gladding & Gladding, 1991).

1.6.2.5.2 Correcting misconceptions

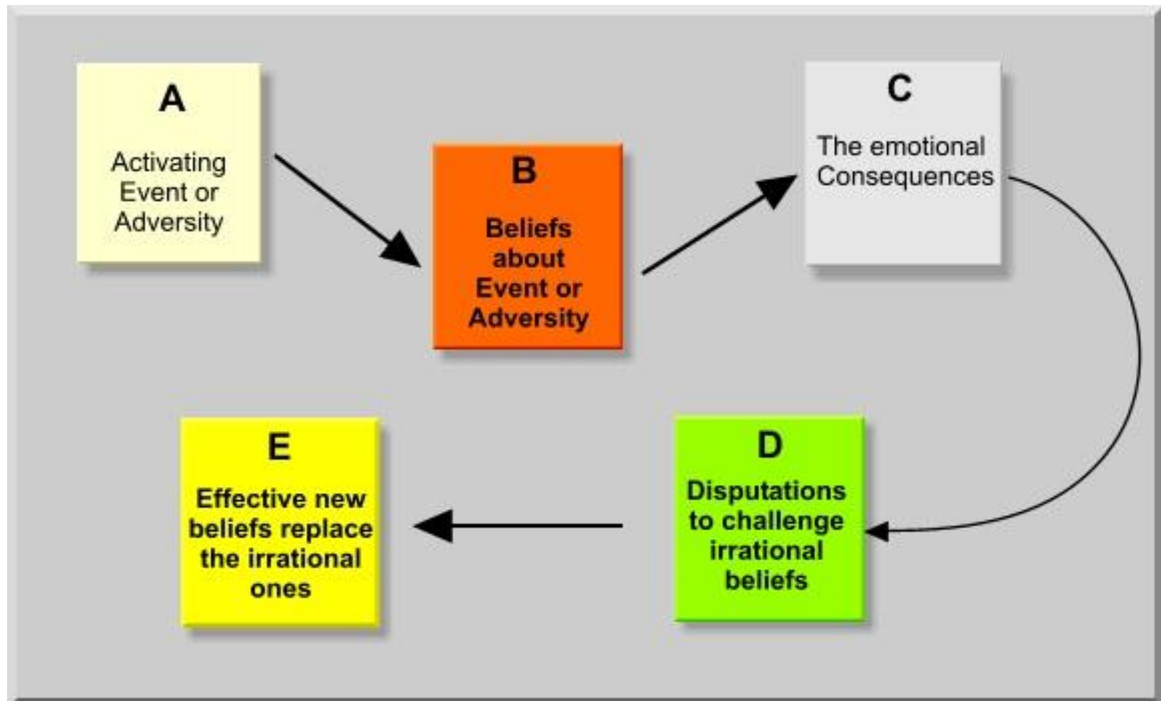
Clients often arbor mistaken attitudes about society, about particular people, or about themselves. Psychotherapy as an education has a purpose that one's clients should be given facts, not myths or superstitions, to cope with their daily life related issues. Correcting misconceptions is a vital phenomenon after conducting the 'Thought Stopping' technique as it becomes important to shift the negative thoughts with self-improving positive cognitions. Through correcting misconception technique, respondents were told to inhale slowly and pick one of the following positive thoughts and exhale with a smile on their face.

"I can face my problems boldly and solve them successfully"
"I can study well"
"I am intelligent"

1.6.2.5.3 Ellis' ABCD paradigm

Albert Ellis developed Rational emotive behavior therapy (REBT) in 1955. In his numerous writings, Albert Ellis has emphasized that people disturbs themselves with their personal belief systems. Clients were showed that how they wrongly connect their own troubles to external or activating events. Rational emotive behavior therapy explains that when a person feels disturbed it becomes important to check out their beliefs instead of accusing the activating events. As Matei (2014) explained through a model [Fig. 6] that virtually everyone is consciously and unconsciously develop themselves to be emotionally perturbed at some point.

Figure 6: Model of Ellis' ABCDE paradigm



The instructions that frequently create dysfunctional emotions and behaviors can be following:

(a) "I absolutely must perform well at important tasks and be approved by significant others—or else I am an inadequate person!"

(b) "Other people absolutely must treat me kindly, considerately, and fairly—or else they are bad individuals!"

(c) "Conditions under which I live absolutely must provide me with what I really want—or else my life is
horrible, I can't stand it, and the world's a rotten place!"

The main therapeutic procedure of Ellis's concept is to explore how patients feel, think and act to refrain themselves from achieving their own goals and desires. Albert Ellis didn't find self-esteem a worthy goal because it has components of evaluation. If an individual says that his or her "high self-esteem" is based on high levels of IQ, or on looking good, muscular, being famous, and being rich then they carry the risk of having

"low self-esteem". Self-acceptance entails an understanding that everybody has some error.

1.6.2.5.4 Problem-solving

In psychological terms, Problem solving means to a process of looking for solutions to issues faced in general life (Brandell, 1997). Most problem-solving situations call for a modicum of logic and a fairly coherent or scientific progression. It is often impossible to reach solutions without first generating plausible hypotheses that can be strengthened or weakened by gathering relevant data. Clients who do not apply these elementary but fundamental principles to their ongoing problems tend to feel bewildered and overwhelmed. Psychologists use behaviorism, simulation, introspection, computer modeling, and experiment to study the human problem solving processes (Goldstein & Levin 1987).

1.6.2.5.5 Self-instruction training

Self-instructional training developed by U. S. psychologist Donald Meichenbaum in 1940 is a cognitive technique which is aimed at giving patients complete authority over themselves through self-talk guided by a therapist that becomes self-generated with time. It is well documented that what we think and imagine will influence the way we feel and what we do. Our perceptions, evaluations and anticipations will determine our self-regulation processes. The many writings of Albert Ellis and the experiential studies by Meichenbaun (1977) have shown that negative talk about self becomes reason of many people's anxiety-ridden reactions and failures, whereas the intentional use of positive, self-creative statements can facilitate successful coping.

1.6.2.6 Interpersonal

I. Communication training

II. Social skills and assertiveness training

III.

1.6.2.6.1 Communication training

Communication skills training is implemented when someone's communication skills are lacking or poor, it could be because of communication disorders. Thousands of books and articles based on effective communication are published every year. It is often lamented that our society rarely provides opportunities for people to acquire information on how one should share thoughts and feelings with another person, the result of which takes the shape of isolation and alienation. Communication training is comprised of sending skills and receiving skills. When expressing ideas or conveying feelings, many people send messages that are vague, ambiguous, contradictory and difficult to follow. The client learns about the importance of eye-contact, the use of simple, concrete terms, voice projection, body posture, the avoidance of blaming and pejorative remarks, forthright rather than manipulative intent, and statements of empathy for the purpose of improving sending skills. Good skills of receiving have active listening, verification and acknowledgement, and rewarding for good communication.

1.6.2.6.2 Social skills and Assertiveness Training

Assertiveness refers to the capability to take stand for own rights without getting offended or creating any harm to others' rights. Most of people need to understand that how to express their thoughts, feelings, how to take stand for the personal rights, beliefs in direct, appropriate and honest methods without disrupting other individual's authorities. Assertive behavior has been summarized in four particular patterns of response: the ability to say "no", the skill to communicate about positive or negative feelings, the capability to ask for service or to make requests and the capability to initiate, continue and terminate conversations. This training has the aim to foster positive personality characteristics like determination, confidence, idealism and the communication skills required for the implication of assertiveness.

1.6.2.7 Biological/ drugs

This modality is more than drugs, through this modality therapist talks about one's nutritional habits and exercise routines. Mostly therapist asks these questions: 'Are you physically fit and conscious about health?', 'Do you have any concerns regarding your health?', 'Do you take medicines for any issue?'. 'Discussed diet, exercise, and physical fitness?' Referral to physicians when organic problems were noticed or biological interventions are indicated. Encouragement of health habits- good nutrition, exercise & recreation remains important part of multimodal therapy.

Conclusion: Lazarus' Multimodal therapy came in existence as a result based on the research that therapeutic success which comes from unimodal treatments was generally short-lived. He stated that all human beings carry out the similar functions, it could be emotions, biological, or mental even though every individual remains different in their own individual way and every individual has multiple layers of the personality. So, every person requires a unique way in therapy and counseling. Reason being that each individual is exclusive. Lazarus had given seven different but interconnected modalities or dimensions: Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, Drugs/ Biological, the convenient acronym BASIC I.D. comes out from the first letter of each word. Most importantly, this model covers a broad range of interrelated modes, all of which influence the client's functioning. Lazarus recommended multimodal approach for rapid and long lasting impact of therapy.

1.7 Need for the study

In spite of a number of studies on public speaking anxiety, social-anxiety and self-esteem, majority of young adults still experience the problem, and thus, the research to find out a package of intervention having impactful effect in the overcoming of public speaking anxiety, social-anxiety and self-esteem is justified. Even though many students and young adults experience public speaking anxiety, social-anxiety and low self-esteem, which are complex in nature and difficult to comprehend. As a result, it mounts anxiety among students.

Most young adults find difficult to handle their issues due to past experiences and develop a negative attitude towards them. The negative experiences caused due to aforesaid causes leads to avoidance which further deteriorates the quality life of the students, resulting into anxiety towards social situations and about self. This causes a feeling of dread instead of enjoying their life. These form a valid ground for this study.
The present study aimed at introducing a package of interventions used under multimodal therapy. Systematic exposure proved to be the best available intervention for public speaking anxiety and social-anxiety management. Hypnosis not only reduces the anxiety level but also integrates both the hemispheres. Positive reinforcement helps in improving a directly observable behaviour and a cognitive restructuring neuro-cognitive model helps to sustain the change. Hence a package of interventions was used.

1.8 Statement of the problem

To evaluate the effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem.

1.9 Significance of the study

Communication is a pillar of our society. It enables us to form connections, influence decision making and motivate change. People across the globe consider public speaking to be one of the dreaded forms of communication. Communication skills hold key importance in our lives as they enhance our ability to progress in our workplace and in life in general. Students manage to dodge the opportunities to speak in front of others by occupying the back benches in classrooms and hence it is easier to get through the schooling years by using such avoidance strategies. But in a work environment, public speaking is an important skill to have. Having public speaking anxiety can have many issues that requires attention and most of which have negative impact on the body, mind and general well-being of a human. The fear of ridicule by a large number of people, even if these people are complete strangers, terrifies many people (Stein et al., 1996). Many students choose college coursework in a way where they can avoid public speaking, rather than seeking the help that they want. At work, they let go of promotions

and assignments which would require speaking or giving oral presentations. The fear of public speaking may even lead to people choosing a career that doesn't require public speaking. This is often the case with people who started fearing public speaking at a very young age. Even if they become successful in their career, when they are called upon to share their expertise and experiences with colleagues and juniors, they become apprehensive because of their public speaking anxiety. (Bourne, 2003) conducted a survey of the literature pointing that PSA is experienced virtually by all the students in their lifetime. From giving presenting in colleges to presenting tasks and pitches to the bosses or clients, public speaking is a much needed element of a successful career.

If we consider the physiological impact then the person's heightened sympathetic arousal becomes a dreadful outcome of public speaking anxiety (Asterita, 1985; Wolpe, 1958). It refers to the response which becomes the reason for the fight or flight mode in human body. The degree of sympathetic arousal and anxiety is elevated further in altered or unavoidable situations (Selye, 1976). As a consequence of too little or too much anxiety, the individuals may go through a feeling of mental block, forgetting the content or having confusions while giving speech. If a person is frequently experiencing high anxiety in most of the situation, he or she may develop a variety of psycho physiological disorders, right from peptic ulcers (Mirsky, 1958) to cancer (Everly & Rosenfeld, 1981; Riley, 1975). Past research has proven that people who had high levels of apprehension in speaking front of public were labelled by their peers and supervisors as less credible, less intelligent and less attractive (McCroskey & Richmond, 1975, 1976).

Unlike other psychological problems, social-anxiety is not properly understood by the general public. Wittchen et al. (1999) conducted a research on young adults aged 14-24 years and claimed prevalence of lifetime in cases of Social-anxiety Disorder. Mehtalia (2004) stated that there are no such data available in India in the case of social-anxiety disorder among adults or adolescents. Social-anxiety continues to have a profound and worse effect among relationships, on good living, family relations and majorly on social connections. Tillfors et al., (2008) study revealed that even in Western cultures, social-anxiety is considered the lifetime prevalent disorder. In spite of the pervasiveness of this disorder, very few people having social-anxiety get appropriate interventions. The

individual having social-anxiety goes to greater heights and come up with various explanations to stay away from giving presentations and attending public events. A heightened amount of withdrawal into social seclusion negatively and adversely impact relationships in every aspect like personal or professional life of a person. People who go through social-anxiety disorder are not just introvert in their nature but their preference for solitude and isolation sometimes start creating actual bodily symptoms when they are compelled to encounter their fears. And situation gets worse when sufferers of this issue start suppressing the effect of their problems through the use of addictions, prescription drugs or even through binge eating or bulimic behaviour. Social-anxiety does not come and go like some other physical and psychological problems. People having social-anxiety disorder make most of their life decisions to accommodate and make their own space with their illness that's why this is also known as a disorder of lost opportunities. If one has social-anxiety one day, he/she has it every day for the rest of the life, unless that person receives appropriate therapy from an experienced therapist/counsellor.

In addition, with social-anxiety disorder and public speaking anxiety, self-esteem also requires the consideration because the Diagnostics & Statistic Manual, DSM – the Bible for diagnosis in psychiatry, provided no diagnostic criteria for self-esteem. Till today, its more focus remained on the more specific diagnosable illnesses that have medications to treat them. That's why there's no pill to prescribe to someone who has low self-esteem because chances of generating revenue for pharmaceutical companies becomes almost nil through a person having low self-esteem. It is an important aspect in the sphere of psychology and has been related to virtually every other psychological domain, for example personality, behavioral, cognitive and clinical concepts like anxiety and depression (Beery,1975). According to Burka and Yuen (1983) few people perceive their worth only when they have the capability to perform in their own eyes. Due to low self-esteem some students get into the habit of procrastination. This means one does not have to bother performing any task and hence the question of their self-image being threatened does not arise. When students have low self-esteem, their emotional welfare is put at stake. Most importantly, in handling the challenges of student life a high self-esteem plays a vital role. Morreale et al. (2006) conducted a survey of communication departments across the nation, over half of the respondents indicated that the basic

communication course was a general education requirement at their college or university. When the question arises for the solution of these life wrecking disorders, most of the psychologists are using traditional cognitive behavioral therapy for these issues but ending up with reoccurrence of the issues to the point from where they started. The cause for the reoccurrence could be that the therapy was not comprehensive. There is a distinct key area that it becomes the cause of dysfunction or problem and this leaves them more susceptible after the treatment ends. Multimodal therapy is a "broad-spectrum" treatment approach. Multimodal therapy has proven its contribution to the young adults, facing social or public speaking and had problem in the area of self-esteem. The multimodal approach helps clinicians by providing them with an all-inclusive pattern. By distinguishing emotions from sensations, delimiting between cognitions and images, giving priority to both interpersonal and intra individual behaviors and emphasizing on the physical part, the multimodal therapy contributes for the most far-reaching results. This study is valuable because it contributed young adults an opportunity to deal with their fear, considered to be number one fear of the world i.e. public speaking fear. This study offered an opportunity to overcome social-anxiety. Furthermore, this research proved to be beneficial, as young adults had improved communication skills and a positive self-esteem. This research had an inclination to concentrate on treatment intervention for social-anxiety, public speaking anxiety and low self-esteem through multimodal therapy. A growing body of evidence demonstrated that multimodal programs, such as skills for adolescence, can prevent the kind of youthful alienation associated with inappropriate behavior, poor performance, alcohol, drug abuse and related problems. As a psychologist, it is important to monitor the self-worth of students and help improve their self-esteem. By giving right help on right time can ameliorate their living standards. This research was all about to study the effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem.

Chapter 2
Review of literature

2.1 Review of literature

Literature belonging to the study on "Effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem" has been reviewed and presented under following categories:

- Effectiveness of multimodal therapy
- Interventions for public speaking anxiety
- Interventions for social-anxiety
- Interventions for low self esteem

2.2.1 Effectiveness of Multimodal Therapy

Shahrabad et al., (2018) investigated the effectiveness of Lazarus's multimodal therapy on coping with the symptoms of depression, anxiety and glycemic control in women with type 2 diabetes. The study was conducted on 24 women who were high on depression, anxiety and glycosylated hemoglobin (HbAIC) level was more than 7%, with an age range of 20-40 years. 24 cases were selected and divided into experimental and control with 12 cases in each group. The results of this study exhibited that Lazarus' multimodal therapy significantly reduced anxiety, depression and glycosylated hemoglobin levels in women with type 2 diabetes compared to the control group of 12 candidates.

Arani and Mosiri (2018) examined the effectiveness of Lazarus' approach-based group consultation in solving social problem and emotional maturity of female adolescences living in Kashan, Iran. Through cluster random sampling 36 members were selected as sample and 18 subjects were randomly allocated to experimental group and 18 subjects were allocated to control group. Detailed results indicated significant effect of Lazarus approach-based group consultation on solving social problem of adolescent girls.

Moreover, Lazarus approach-based group consultation had a significant effect on emotional maturity of adolescent girls.

Khazaei et al. (2017) aimed to examined cognitive emotion regulation in students having attention deficit/hyperactivity disorders (ADHD) with the effectiveness of Lazarus' multimodal therapy. 30 children from elementary school ages between 9-12 years with ADHD were selected by purposive sampling. Results revealed that Lazarus multimodal therapy had a significant improvement on the regulation of cognitive emotion in students with ADHD. There was significant reduction in the mean scores of students in the negative strategies and in positive strategies for emotional regulation of experimental group.

Mhtare et al., (2017) studied the effect of multimodal intervention i.e. medication along with behavioral modification therapy and occupational therapy given to children with ADHD. This was a longitudinal, prospective study, in which children coming to pediatric neuro-developmental centre and diagnosed as ADHD were included. Cognitive behavior therapy was given along with required medications. 41 ADHD children were the part of study. Multimodal intervention was found effective in treating children with ADHD. Researchers of this study concluded that Multimodal treatment is the most effective form of treatment which includes multiple elements like parent and child education about diagnosis and treatment, specific behaviour management techniques, medications and appropriate educational programs.

Kheirandish (2016) anticipated to explore efficacy of Lazarus' multimodal therapy on well-being and hope among older adults living in the nursing homes. This study had a sample of 30 older adults from nursing homes. The results verified the efficacy of Lazarus' multimodal therapy in treating psychological issues, bettering health, wellbeing and generating hope in the natives of nursing homes.

Habibzadeh (2016) conducted a study aiming to analyze the efficacy of multimodal therapy on reducing test anxiety. Data for this study was randomly selected. 24

individuals were divided into two groups. The results confirmed that interventions given with multimodal therapy has been adequate on lessening the levels of test anxiety in students.

Mohammadi and Akbari (2015) investigated the efficiency of Lazarus' multimodal therapy on women with obsessive-compulsive disorder to improve their self-efficacy. The population for the study included, 30 female patients having obsessive-compulsive disorder who were referred to psychiatry clinics. Results showed that multimodal counselling therapy significantly increased the level of self-efficacy among women having OCD.

Mikaeili et al. (2015) cross examined the effectiveness of spiritual-religious multimodal and multimodal therapy on patients with functional dyspepsia to improve specific physical symptoms and quality of life. The sample size included 54 subjects. The findings showed a significant variation in the quality of life and body related symptoms of test group.

Tehrani and Heidari (2015) presented a study to check the impact of multimodal therapy in group settings on happiness among females. The data included 24 females prescribed to social working centers. Treatments based on Lazarus' mode of therapy were given to the experimental group. Research results provided evidence that multimodal therapy in group settings was a beneficial method for improving happiness in females. Therefore, multimodal therapy was found effective in order to enhance the happiness of females.

Filaire et al. (2013) investigated the perceived stress in patients with multiple sclerosis (MS) and also checked the capability of multimodal psychotherapy, 40 patients were selected by convenient sampling from Iran. Results showed that multi modal psychotherapy had a significant response on perceived stress. Multimodal psychotherapy could significantly reduce negative perception and escalate positive perception. In experimental group, negative perceived stress had remained low in follow-up sessions, but both experimental and control group did not show much variance in positive perceived stress in follow up testings.

Ojo (2010) conducted a study on multimodal counselling therapy for the learners support services provider to help the open and distance learning students to overcome issues that they faced during their study time in an open and distance learning institution. The paper indirectly revealed that eclectic approach as another option for solving many issues of students.

Burgener et al. (2008) researched on the impact of a multimodal intervention on dementia. The treatment group included 24 persons with dementia and control group included 19 persons with dementia. The results indicated testing of the more therapeutic interventions along with the probability for acquiring positive results in early-stage dementia.

Conclusion drawn: The effectiveness of MMT was proved on issues like depression, anxiety, social problem and emotional maturity, attention deficit/hyperactivity disorders (ADHD), well-being and hope, test anxiety, OCD, functional dyspepsia, enhance the happiness, negative perceived stress in patients of multiple sclerosis (MS), dementia by Shahrabad et al., (2018), Arani and Mosiri (2018), Khazaei et al. (2017), Mhtare et al., (2017), Kheirandish (2016), Habibzadeh (2016), Mohammadi and Akbari (2015), Mikaeili et al. (2015), Tehrani and Heidari (2015), Filaire et al. (2013), and Burgener et al. (2008).

2.2.2 Interventions for Public Speaking Anxiety

Takac et al. (2019) studied the efficacy of virtual reality exposure (VRE) as therapeutic intervention for public speaking phobia highlighting on distress arousal instead of distress habituation. To observe distress habituation, this study used within-speech repeated measures in three brief public speaking scenarios. 19 respondents participated in the study. Virtual reality exposure successfully evoked substantial stress in all the scenarios. High stress was noticed in second scenario and it demonstrated that in sequence three speech performances were critical in gaining habituation.

Bueno and Carinan (2019) investigated the main factors that lead to communication apprehension in the first-year college students in a teacher education institution and

suggested some solutions to cope with the students' apprehension in communication and enhance their ability of communication. The participants of the study were the 17 first-year college students in a teacher education institution. The data on the students' level of oral CA were gathered using the McCroskey's personal report of communication apprehension (PRCA-24). Findings divulged that first-year college students demonstrate varying degrees of oral apprehension.

Ebrahimi et al. (2019) presented a meta-analysis on fear of public speaking and social-anxiety and observed the short and long-term results of therapies in psychology. Main aim of this paper was to investigate whether differences in effect exist between theory frameworks, technology based delivery medium such as Internet based interventions and traditional ways of giving intervention (e.g., in person therapies). This study also examined the effects of psychological therapies in treating fear of public speaking on other measures like depression and whether a "sleeper effect" was present in public speaking anxiety and social-anxiety. The result clarified that most of the researches reviewed the effectiveness of cognitive or behavioral related techniques. Moreover, psychological based therapies for public speaking anxiety had a mild to average effect on SAD. Cognitive and behavioral interventions were found to have sleeper effect. This revealed that clients continued to improve after leaving the therapy sessions. In reducing public speaking anxiety, internet based modes of therapy proved to be as effective as traditional in-person interventions. This study also found an evidence that psychological interventions used for public speaking anxiety have an effect on generalized social-anxiety.

Leath (2019) examined the effectiveness of basic level public speaking related courses in improving student communication competence. The target of this quantitative correlational research was to study the effect of introductory public speaking related courses. The data was collected from 414 participants responding to the survey, information collected from 244 responders, 84 identified as completing the survey for a 36% completion rate. A total of 78 participants answered the four questionnaires. The result showed that only public speaking was a significant predictor of public speaking

anxiety. Results showed that an increase in the public speaking level results in the public speaking anxiety score of participants. There were two main findings in the study: The increase in the public speaking level results in an increase in the public speaking anxiety of participants. Communication competencies do not significantly increase the employability of participants. These findings were unexpected leads to the conclusion that universities and colleges need to focus on improving the communication skills of their students, to ensure that they are preparing them for their future. Students must also be more proactive in ensuring they have the skills that employers find necessary to be successful.

Chowdhury and Mete (2018) investigated the effectiveness of behavior modification in improving public speaking anxiety and enhance self-esteem among students. 80 students took part in the study. Behavior Modification techniques were used for the study and the results revealed that significantly less anxiety was experienced by the students. The levels of self-esteem increased and level of Subjective unit of distress scale came down.

Arnold (2018) studied the perceived leadership potential and phenomenality of public speaking anxiety. 151 students who were studying MBA participated in this research. The level of public speaking anxiety was measured as both on trait and state dependent situation, for five performances, sex, age, and perceived qualities of leadership. The conclusion revealed no outstanding relationship between perceived leadership and public speaking anxiety.

Jangir and Govinda (2017) also conducted a study in Indian students to researched to find out effect of behavior modification in improving public speaking anxiety and enhance self-esteem. This was a study of 50 students. The results concluded that the students were able to experience significantly less level of anxiety. This study proved that public speaking anxiety can be reduced effectively by using techniques based on behavior modification.

Kumar et al. (2017) conducted a study to know the different demographic factors like gender, age, family type, residential type, educational level, socio-economic status in relation to public speaking anxiety. The sample of the study was 300 school and college students between the age group of 14-28years. The objectives of the study were to investigate the gender differences, differences in age groups, educational streams in public speaking anxiety, socioeconomic levels, residential areas and family structures. The end result showed no significant gender difference, age difference, educational stream differences, residential differences in public speaking anxiety. However, the study emerged with a clear difference in public speaking anxiety among students from different socioeconomic levels.

Spieler and Miltenberger (2017) conducted a study to find out the efficacy of awareness training for reducing three nervous traits occur during public speaking. These are tongue ticks, filled gaps, and irrelevant application of the word "like". Four students studying in university participated in the study. All participants showed meaningful reductions in target behaviors after giving awareness training. Booster awareness training sessions were also given to maintain further. After the treatment, scores of social validity showed that the treatment was adequate, and students not only improved their overall ability of public speaking but the use of verbal fillers was also decreased. College students who find expressing their opinions and feelings difficult when dealing with employers and have trouble with public speaking may experience challenges when seeking employment opportunities.

Kumar et al. (2017) studied a model to find out the effect of mindfulness-based therapies on low self-esteem and public speaking anxiety. 227 executives studying management were the subjects of this study. The study indicated that the impact of mindfulness-based therapies on public speaking anxiety could be better implied by studying self-esteem as mediating variable. Researchers of this study suggested to include Mindfulness based therapies to overcome public speaking anxiety and also suggested that public speaking courses should work on enhancing self-esteem.

Raja (2017) studied the causes behind the levels of anxiety in undergraduate students of a public speaking class and suggested techniques to come out of this anxiety. The study consists sample of 50 students. The results directed that with the use of certain techniques students having public speaking anxiety can perform well. 75% students confirmed that they have fear of speaking in front of public. 95% students admitted that right guidance, counseling and coaching can possibly help them to reduce this fear. Study revealed that virtual environment exposure can enable students to face audience regardless of the size and enhance student's confidence.

Lihui (2016) researched the effectiveness of merging psychotherapies on advance level with skill-training-based speech instruction in reducing college students' public speaking anxiety. Three prevalent psychotherapies acceptance and commitment therapy, stomach breathing with muscle relaxation method and exposure therapy were utilized to treat public speaking therapy. The results of pre and post therapy clearly showed that combined instructions helped college going students to drastically reduce public speaking anxiety.

Nash et al. (2015) demonstrated through his research that whether first year students have a fear of public speaking appraisals and how the educators help to lighten fear of speaking in front of public. The subjects included 25 individuals. This study paid attention on understanding the perceptions experiences and emotions of students. Skill development strategies were designed to overcome public speaking anxiety and assessment task. The study found that public speaking appraisal should be adjusted with the learning exercises. Results indicated that students experienced significant reduction in fear, confusion and indecision after taking public speaking desensitization and assessment sessions.

Niles et al. (2015) studied if affect labeling intensifies exposure efficacy in respondents having fear of public speaking. 102 subjects were randomly participated to exposure with or without affect labeling. Results showed that treatment plan which have behavioural strategies majorly focusing on prefrontal-amygdala circuitry can enhance efficacy in

treatment for anxiety. Those who showed greatest deficiency in emotional regulation, effects for them were particularly pronounced.

Chollet (2015) devised a platform for audience that was virtually interactive for public speaking training. Multi modal sensors, generic visual widgets depending on the respondent's behavior and Multi modal feedback was created by virtual characters to analyze automatic public speaking behavior. Results showed that experts who were judging noticed increased engagement and challenge as well as enhanced skills of public speaking. They concluded that interactive virtual audience brings together the best results.

Kamridah et al. (2015) demonstrated that there was no significant relationship found between the level of public speaking execution and anxiety. This was expected that systematic learning process may help in overcoming their problems related to the capacity to speak with confidence in public. There were 135 participants in this study. Results indicated that there was significantly no correlation between the level of public speaking performance and anxiety. This proved that even though the subject had mild levels of anxiety, it doesn’t prove that subject will have good public speaking skills, or vice versa. This study proved that the systematic learning process verified accurate results on public speaking performance of the participants.

Laio (2014) found that community oriented learning added to student learning. The observation of the study showed that Hispanic American students, African American students, and students whose mother had close to a secondary school training benefited the most from collective process of learning. As far as speech anxiety and speech efficacy was concerned it was demonstrated that community learning sessions were not that effective. This study also demonstrated that public speaking course increased speech efficacy and reduction in speech anxiety throughout the semester.

Price and Anderson (2012) conducted a study to verify the efficacy of CBT for fear of speaking in public along with social-anxiety disorder. This study evaluated the effectsof

outcome expectancy as a predictor of intervention response for public-speaking anxiety across bothgroup-based cognitive– behavioral therapy and individual virtual reality therapy. The results verifyoutcome expectancy as a predictor of bringing change in public-speaking anxiety during bothgroup CBT and individual VRET. Moreover,there was no proof found that suggests the impact of outcome expectancy was different in both group or virtualreality treatments.

Docan-Morgan and Schmidt (2012) examined the effect of skills training, systematic desensitization, and cognitive restructuring as an hour training session for public speaking anxiety on non-native and native English speakers. The results indicated that just an hour of training may decrease public speaking anxiety substantially.

England et al. (2012) examined the utility, reliability and foundation effect of acceptance-based exposure intervention for standard habituation-based exposure compared to public speaking anxiety compared to the clinical population. There were 45 adult participants. As per the findings, in directing participants to achieve diagnostic exemption by 6-week follow-up, the acceptance-based treatment had significant effect than exposure with a habituation rationale. Moreover, participants evaluated acceptance-based exposure as equally reliable and useful in contrast to the other therapies.

Tse (2011)investigated with the aim to check the efficacy of teaching affective learning strategies to decrease public speaking anxiety. The chosen data was a total of 202 university students. The results showed that university students noticed that after learning how to manage stress they experienced considerably less levels of public speaking anxiety.

Warren (2011) explored the role of service learning in enhancing students' self-efficacy in public speaking course. 328 students were traditionally taught public speaking courses and 274 students in service learning public speaking courses. Additionally, it also checked the association between public speaking skill and their self-efficacy. Results showed that public speaking skill and self-efficacy and skill had weak correlation. Additionally, non-service learning and service-learning students did not differentiate on

the scale of public speaking skill or self-efficacy. Moreover, in comparison to non-service learning students, the experiences of mastery seemed to have better impact of public speaking self-efficacy for service learning students.

Botella et al. (2007) presented a treatment for public speaking anxiety based on self-help and internet-based telepsychology program. The protocol of treatment was based upon cognitive-behavioral therapy that gave exposure to the most feared settings using videos of real audiences. 12 respondents having social phobia participated in the study. Results supported the effectiveness of program based on telepsychology for overcoming from the public speaking anxiety.

Wallach et al. (2009) examined that if instead of cognitive behavioural therapy, virtual reality cognitive behavioural therapy (VRCBT) can be other alternative to decrease public speaking anxiety. 28 respondents having public speaking anxiety were randomly allocated to virtual reality cognitive behavioural therapy 30 respondents were allocated to cognitive behaviour therapy, 30 allocated to control group. This study proved the significant effect of CBT and VRCBT in comparison to control group in reducing the level anxiety. Results revealed that virtual reality cognitive behavioural therapy was a practical and brief regimen of treatment at par with cognitive behaviour therapy.

Duff et al. (2007) investigated public speaking anxiety treatments and the efficacy of systematic desensitization and multiple intervention techniques containing visualization therapy against no-treatment and placebo control group. Data for the study consisted of 238 participants. Study reported that anxiety reduced over time, but none of the intervention beaten the placebo control group. Short-term gains were noticed for the multiple treatment group. Results of this study revealed that there was no evidence of lasting improvement of systematic desensitization or multiple interventions in comparison to control group.

Cunningham et al. (2006) investigated the ability of a novel psychological therapeutic interventions to reduce public speaking anxiety. 40 subjects took part in the study. The

interventions were designed specially to terminate irrational beliefs and decondition stimuli that become cause of emotions and dysfunctional behaviors. After participating in an actual experience of public speaking, respondents revealed substantial decrease in bodily sensations, apprehension, and thought processes related with public speaking. The study provides strong evidence that public speaking anxiety was virtually eliminated.

Schmidt (2006) investigated that public speaking apprehension can be reduced using self-administered tactile therapy. 73 undergraduate students were randomly assigned to three groups. self-administered tactile therapy was compared with visualization intervention and an intervention group that combined both self-administered tactile therapy and visualization intervention. Results indicated the self-administered tactile therapy helped in reducing public speaking anxiety. The visualization intervention also improved apprehension.

Anderson et al. (2005) conducted a research on reducing fear of public speaking through cognitive-behavioral intervention based upon virtual reality as a substitute for exposure therapy. 510 participants completed the treatment. Results showcased the reduction of public speaking anxiety on all measures of self-report. This study claims that virtual reality exposure used along with cognitive-behavioral therapy may improve public speaking anxiety.

Sandra et al. (2002) examined the effectiveness of virtual reality therapy (VRT) in reducing public speaking fear among students of university. 14 subjects with the division of experimental and control group participated in the research. Results revealed that virtual reality therapy clearly was beneficial for the students to overcome their public speaking anxiety.

Kostić-Bobanović (unpublished) investigated if the teaching of affective strategies can provide a help for students to combat their fear of speaking in public. Results of this study showed that there is significant reduction in student’s anxiety with the use of affective strategies.

Kirsch et al. (1997) investigated the efficacy of multi-dimensional cognitive behavioural intervention plan along with hypnosis for reducing public speaking anxiety. 62 individuals too part in the study. Results clearly revealed improvement in respondents' level of public speaking anxiety.

Robinson (1997) researched with a question to find out which of the major interventions were used into the course of public speaking. He demonstrated it through a survey and found that only 13% courses offer a special program for overcoming public speaking anxiety, and half of respondents mentioned that the program ran as a module. Results indicated that skill training was being used 96%, cognitive modification was used 63%, visualization techniques 59% and only 25% used systematic desensitization to reduce public speaking anxiety.

Herman et al. (1985) reviewed a statement of Shapiro and Shapiro (1982) that systematic desensitization was less effective that CBT. Observations directed to the point that (a) both systematic desensitization and cognitive behavioural therapy were approximately similar in effectiveness, and (b) Shapiro and Shapiro's stated that only because maximum studies they explored were conducted by researchers with their adherence to cognitive behavioural therapy. This study also provided a statement that interventions clubbing both systematic desensitization and cognitive behavioural therapy were not very effective than one of the intervention alone.

Arden and Carley (1983) compared Albert Ellis's rational emotive therapy (RET), with other treatments for communication apprehension, 52 high communications apprehensive, individuals were placed in three treatment groups. Group 1 supplemented the development of communication skills with RET training; group 2 used skill, training and systematic desensitization, the relief of anxiety through relaxation techniques; and group 3 worked only on building students' communication skills. Comparisons of pretests and posttests revealed that while all three groups showed significant decreases in speech

anxiety after the 4-month program, no group's results differed significantly from any of the others. In other words, all methods worked equally well.

Conclusion drawn: Lihui (2016) researched the effectiveness of merging psychotherapies on advance level with skill-training-based speech instruction in reducing college students' public speaking anxiety. Kamridah et al. (2015) demonstrated that there was no significant relationship found between the level of public speaking execution and anxiety.A number of studies found that through different interventions for public speaking anxiety, social anxiety and self-esteem can be managed. For public speaking anxiety interventions based on virtual reality exposure (VRE), behavior modification, awareness training, mindfulness-based therapies, acceptance and commitment therapy, stomach breathing with muscle relaxation method, group-based cognitive behavioral therapy, skills training, systematic desensitization, cognitive restructuring, exposure therapy, acceptance-based exposure intervention, self-help, Albert Ellis's rational emotive therapy (RET), and internet-based telepsychology program were conducted in studies by Takac et al. (2019), Chowdhury and Mete (2018), Spieler and Miltenberger (2017), Kumar et al. (2017), Nash et al. (2015), Raja (2017), Chollet (2015), Price and Anderson (2012), England et al. (2012), Botella et al. (2007), Wallach et al. (2009), Duff et al. (2007), Cunningham et al. (2006), Anderson et al. (2005), Sandra et al. (2002), Arden and Carley (1983) and Kirsch et al. (1997).

2.2.3 Interventions for Social-anxiety

Wechsler et al. (2019) systematically researched of studies published till June 2019. Criteria to include a study was to cover the examination of specific phobia, agoraphobia, social phobia, and a randomized-controlled design with exposure in virtual reality and in person therapies. It provided an evidence that for social phobics, a mixture of cognitive techniques and virtual reality exposure and the understanding of virtual social interactions mainly focusing on central fears might be beneficial.

Lin et al. (2019) attempted a study to check the effect of exposure therapy on arousal feedback in young adults having symptoms of social-anxiety. A data of 50 young adults

participated in study. Results showed that most of the participants found the treatment beneficial. Respondents in the treatment group also showed positive changes on all measures of public speaking anxiety.

Matsumoto et al. (2018) aimed a study to look over the utility of video conference-delivered cognitive behavior therapy in patients having obsessive compulsive disorder, social-anxiety disorder, and psychotic disorder. 30 participants from Japan having OCD, SAD, or PD took up individual sessions of video conference-delivered cognitive behavior therapy with the actual support of a counselor. Results proved a significant improvement in the patients having OCD. Moreover, general anxiety and general anxiety also showed significant improvement.

Abbasi and Abdi (2018) administered a study with the determination to verify the effects of teaching assertiveness in group on social-anxiety and social skills in students. The sample consisted of 30 male students. According to the results of this study teaching assertiveness increased social skills, and decrease in social-anxiety in male students.

Kampmann et al. (2016) conducted a study targeting different social fears in participants with social-anxiety disorder and checked the effectiveness of virtual reality exposure treatment comprising verbal conversation with virtual humans. 60 patients having social-anxiety disorder were randomly allocated to individual in vivo exposure therapy (iVET), individual virtual reality exposure therapy (VRET) and control group. The study showed significant improvement on the symptoms of social-anxiety, avoidant personality disorder related beliefs perceived stress and duration of speech, in comparison to control group. Respondents who received in vivo exposure therapy, but not virtual reality exposure therapy, showed significant improvement on general anxiety, fear of negative evaluation, depression, speech performance, and quality of life when compared to control group. Virtual reality exposure therapy which contains comprehensive verbal exchange without any cognitive factors may adequately lessen the complaints related generalized social-anxiety disorder.

Holzman et al. (2014) conducted a study on social interaction anxiety and social performance anxiety to check the roles of self-focused attention and post-event processing. 101 participants who were students of college took part in the study. The relationship among social interaction anxiety and social performance anxiety were not significant after controlling for social performance anxiety. As a result, this study found no significant evidence that the relationship of post-event processing with social performance anxiety and interoceptive self-focused attention was statistically mediated by unconditional beliefs about self, high standards and conditional beliefs about self.

Priyamvada et al. (2009) presented a case study of a man who was 27 years old and was diagnosed with social phobia. The subject was given intervention based on cognitive behavioral therapy. Result showed that guilt feeling and the level of anxiety decreased. His negative cognition about self were modified, able to attend social get together and self-esteem also increased. This case study provides the fact that merger of cognitive, emotional and behavioral techniques might be effective and clearly reveals that CBT is the initial choice in treating the social phobia.

Kristy (2005) established a study to check the efficacy of cognitive-behavior therapy for social-anxiety disorder. The interventions also implemented protocols of mindfulness and acceptance techniques within a standard exposure-based treatment. Results revealed significant improvement in observer-rated social skills, self-reported and clinician-rated social-anxiety symptoms. Study also showed significant change on ACT-specific measures of valued action, willingness, and experiential avoidance. The evidence clearly showed that acceptance techniques and incorporating mindfulness within traditional behavior therapy like acceptance and commitment therapy (ACT), might be beneficial for major disorders.

Heimberg (2002) reported an article explaining the data on the effectiveness of cognitive behavioral therapy for the treating impaired quality of life in patients having social-anxiety disorder. Main focus was to compare cognitive behavioural therapy with

medicine. Results showed significant change using CBT and pharmacologic treatment methods in social-anxiety disorder.

Mattick et al. (1989) conducted a study to check effectiveness of systematic exposure and cognitive restructuring for social phobia. 43 social phobic were given therapy of exposure, cognitive restructuring without exposure and combined techniques. Within group analysis reported that combined techniques group and cognitive restructuring group showed significant improvement. Between group analysis indicated combined techniques to be superior.

Conclusion drawn: While working on interventions used for social anxiety mostly virtual reality exposure, video conference-delivered cognitive behavior therapy, assertiveness, interoceptive self-focused attention, acceptance and commitment therapy, systematic exposure and cognitive restructuring by Wechsler et al. (2019), Lin et al. (2019), Matsumoto et al. (2018), Abbasi and Abdi (2018), Kampmann et al. (2016), Holzman et al. (2014), Priyamvada et al. (2009), Kristy (2005), Heimberg (2002), Mattick et al. (1989) were found.

1.6.2 Interventions for self-esteem

Randal et al. (2013) critically reviewed to incorporate studies who investigated (a) the relationship between self-esteem and mindfulness (b) the effect of mindfulness-based treatments on self-esteem. 32 studies were included in the study. 15 studies studied the relationship between self-esteem and dispositional mindfulness, and 17 studies checked the changes in self-esteem after using mindfulness-based treatments. There were significant positive correlations between self-esteem and dispositional mindfulness in cross sectional studies, while the most of the mindfulness-based studies showed significant gain in self-esteem.

Pepping et al. (2013) presented two studies on self-esteem and mindfulness. First study, checked and proposed a theory based model to check the role of mindfulness in the predicting the life satisfaction and self-esteem. Second study tested the effects of a brief mindfulness induction on state self-esteem. Results clearly showed that enhancing

mindfulness enhanced self-esteem. These studies visibly demonstrated that self-esteem and mindfulness have connection. Moreover, mindfulness based training had shown good effect on enhancing the level of self-esteem.

Waite et al. (2012) conducted a pilot study using Fennell's cognitive conceptualization and trans diagnostic treatment approach along with cognitive behavior therapy (CBT) for low self-esteem. 22 participants were the part of study. Results showed significant improvement than the control group on measures of low self-esteem.

Rasmussen and Pidgeon (2011) measured the relationships between self-esteem, social-anxiety and dispositional mindfulness using self-report scales. 205 Australian undergraduate students participated in study. Low levels of social-anxiety and high levels of self-esteem were significantly predicted by mindfulness. Mediation analysis was also conducted to support that self-esteem plays the role of a partial mediator between social-anxiety and mindfulness.

Guindon (2010) analyzed more than 14,000 dissertations and theses since 1900 to 2008 on self-esteem. This meta-analysis revealed that just 23.1% actually addressed treatments, therapies or interventions. Study concluded that he found 3490 dissertations in this century, just 807 studies focused on intervention plans or strategies. Researcher regrettably reported with the evidence that interventions actually affect levels of self-esteem was not particularly encouraging. He stated that attempts to improve self-esteem were inconsequential, mixed, or inconsistent.

Singh and Rohatgi (2011) observed the impact of behavioral interventions on self-esteem of adolescents. It was hypothesized that behavioral interventions would enhance their self-esteem positively. For this purpose, 250 students were identified. The results confirmed that adolescents showed a significant change in the post-test comparisons of the self-esteem scores.

Michalak et al., (2011) administered a research to understand a non-judgmental acceptance and relationship between self-esteem and depression. 216 undergraduate students participated in the study. Results revealed that acceptance that is non-judgmental mediates the relationship between depression and self-esteem. Individuals who had low mindful acceptance, self-esteem was much more closely related with depression than in individuals with high mindful acceptance.

Marigold et al. (2010) studied the efficacy of a theoretically driven intervention on low self-esteem's relationship-destructive responses to threats. 76 undergraduate students who were in relationship became part of the study. In first Study, the abstract reframing intervention prevented low self-esteem from increasing the significance of self-protectively and relationship threats derogating their relationship. In second study, the abstract reframing intervention reduced low self-esteem's critical and negative behaviors towards their partners.

Borras et al. (2009) researched on to check the effectiveness of a self-esteem program on 54 schizophrenic patients. Results showed that there were relevant positive effects on self-assertion, active coping and self-esteem. The results showed no significant difference for those who received traditional care.

McManus (2009) demonstrated through a case study, the formulation, assessment, and cognitive behavioral therapy for an individual who had low self-esteem, symptoms of depression, and anxiety symptoms. After the completion of therapy sessions client did not meet diagnostic criteria for low self-esteem, depression, and anxiety symptoms. Moreover, patient showed clinically significant and reliable change on all inventories.

Shen and Armstrong (2008) conducted a research to verify the impact of sandtray therapy in group settings. 37 young adolescent females who were diagnosed with low self-esteem participated in the study. Result showed statistically significant differences between females of control and experimental groups in the terms of self-esteem.

Wanders et al. (2008) compared cognitive–behavioral therapy with eye movement desensitization and reprocessing on children having behavioral problems and low self-esteem. 29 children with behavioral issues were selected randomly. CBT and EMDR had significant effects on self-esteem and behavioral problems. Results supported the usage of EMDR, to bring significantly sustained and positive effects on the self-esteem of children.

Ventegodt et al. (2007) conducted a study in clinical setting to understand low self-esteem, treatment plansand follow-up. 43 patients who had low self-esteem were became the part of this study. Respondents were given psychodynamic short-term therapy along with bodywork. The bodywork was used to confront old emotional pain which they were carrying as childhood trauma repressed in mind-body. This study showed that most of the aspects of life like quality of life, physical health, mental health, and capability to respond in major areas (friends, partner, sexually, and social gatherings) also enhanced. Study claimed that recovery rate can be compared to other successful treatments with psychiatric treatment and psychological interventions. Researchers proved that clinical holistic therapies had many benefits like low cost, efficiency, no side effects, long lasting outcomes and above all saves a person from the side effects of psychopharmacological drugs.

Thompson and Waltz (2007) explored the relationship between self-esteem, mindfulness, and unconditional self-acceptance. A data of 167 university students was taken for study. Study found positive correlations among mindfulness, self-esteem, and unconditional self-acceptance.

Whelan et al. (2007) described a self-esteem of adults with learning disabilities using cognitive behavioural therapy. 5 members became the part of group study. Results of the study demonstrated an adapted cognitive behavioural intervention that targeted self-esteem and showed promising outcomes for people with learning disabilities and mental health problems. This group showcased helpful change due to both cognitive behavioural therapy and the group dynamics.

Chatterton et al. (2007) worked on developing an effective but brief therapy plan to overcome low self-esteem in psychotic patients. Results demonstrated that this treatment plan may also bring positive outcomes in old adults having depression. This was a case study in which, the treatment was given to 79-year-old female who had suicidal thoughts, symptoms of depression and anxiety. Post treatment significant improvements were observed.

Conclusion drawn: As per the literature reviewed to conduct this study, Randal et al. (2013) found significant positive correlations between self-esteem and dispositional mindfulness in cross sectional studies, whhile the most of the mindfulness-based studies showed significant gain in self-esteem. Guindon (2010) analyzed more than 14,000 dissertations and theses since 1900 to 2008 on self-esteem. This meta-analysis revealed that just 23.1% actually addressed treatments, therapies or interventions. Study concluded that he found 3490 dissertations in this century, just 807 studies focused on intervention plans or strategies. Studies conducted on self-esteem revealed that mindfulness-based treatments, cognitive behavior therapy, behavioral interventions, non-judgmental acceptance, sandtray therapy, eye movement desensitization, psychodynamic short-term therapy given by Randal et al. (2013), Pepping et al. (2013), Waite et al. (2012), Singh and Rohatgi (2011), Michalak et al., (2011), Marigold et al. (2010), Borras et al. (2009), McManus (2009), Shen and Armstrong (2008), Wanders et al. (2008), Ventegodt et al. (2007), Thompson and Waltz (2007), Whelan et al. (2007), and Chatterton et al. (2007) effectively brought change in the levels of self-esteem.

CHAPTER 3
Methodology

3.1 Methodology

3.1.1 Objectives of the study

The present research study had an aim to examine the effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem. Bearing in mind gaps and limitations mentioned in the review, the existing research put forward the following major objectives to attain:

1. To investigate the effectiveness of multimodal therapy on public speaking anxiety among young adults.
2. To investigate the effectiveness of multimodal therapy on social-anxiety among young adults.
3. To investigate the effectiveness of multimodal therapy on self-esteem among young adults.
4. To examine whether self-esteem predicts public speaking anxiety among young adults.
5. To examine whether self-esteem predicts social-anxiety among young adults.
6. To examine the relationship among public speaking anxiety, social-anxiety and self-esteem among young adults.

3.1.2 Hypotheses

1. There exists statistically significant difference between experimental group and control group in relation to public speaking anxiety, social-anxiety and self-esteem among young adults.
2. There exists statistically significant difference between pre and post intervention of experimental group in relation to public speaking anxiety, social-anxiety and self-esteem among young adults.

3. There exists statistically significant difference between experimental and control group after intervention in relation to public speaking anxiety, social-anxiety and self-esteem among young adults.
4. Self-esteem is a significant predicator of public speaking anxiety among young adults.
5. Self-esteem is a significant predictor of social-anxiety among young adults.
6. There exists a significant relationship between public speaking anxiety, social-anxiety and self-esteem among young adults.

3.1.3 Research design

Research design taken up for the study was pre and post quasi-experimental design with control group. For this study young adultsstudying in university from Jalandhar, Punjab, India were selected as sample through purposive sampling method. A survey was conducted on 373 young adults. Screened samples were divided into experimental and control group. 30 respondents became the part of experimental group and 30 respondents were assigned into control group. The mean age of respondents was 20.7 in experimental and control group. They were measured on personal report of public speaking anxiety, social interaction anxiety scale, and Rosenberg self-esteem scale, which served as base line data. Then as intervention multimodal therapy was administered for ten weeks to the experimental group only, control group was not given any therapy sessions. After therapy sessions to experimental group, they were again measured on personal report of public speaking anxiety, social interaction anxiety scale, Rosenberg self-esteem scale. The data was statistically treated and conclusions were drawn.

3.1.4 Research out line

TOPIC

EFFECTIVENESS OF MULTIMODAL THERAPY ON PUBLIC SPEAKING ANXIETY, SOCIAL-ANXIETY AND LOW SELF-ESTEEM

FIRST PHASE: A SURVEY ON 373 YOUNG ADULTS WAS CONDUCTED TO CONSTRUCT EXPERIMENTAL GROUP AND CONTROL GROUP BY USING

PERSONAL REPORT OF PUBLIC SPEAKING ANXIETY, SOCIAL INTERACTION ANXIETY SCALE AND ROSENBERG SELF-ESTEEM SCALE

SAMPLE

CONTROL GROUP (N=30)EXPERIMENTAL GROUP (N=30)

SECOND PHASE: IN THE SECOND PHASE OF RESEARCH, FORMATION OF EXPERIMENTAL GROUP AND CONTROL GROUP WAS DONE. THERAPY SESSIONS WERE CONDUCTED ON SELECTED DATA.

THIRD PHASE: AFTER GIVING THERAPY SESSIONS TO YOUNG ADULTS, THEY WERE GIVEN THE SAME QUESTIONNAIRES OF PERSONAL REPORT OF PUBLIC SPEAKING ANXIETY, SOCIAL INTERACTION ANXIETY SCALE AND ROSENBERG SELF-ESTEEM SCALE

FINAL PHASE: FINDINGS WERE TABULATED, ANALYSED AND CONCLUSIONS WERE DRAWN

3.1.5 Inclusion criteria

- Clinically diagnosed patients with anxiety disorder based on DSM V diagnostic criteria.
- Co-morbid depressive disorder was included in the sample.
- Gender: Both males and females.
- Education: Literate individuals.

3.1.6 Exclusion criteria

- Persons with functional psychiatric disorders, and major physical illness.
- Persons with other neurotic disorders such as somatoform and dissociate disorders.
- Patients having long treatment history.
- Illiterate individuals.

3.1.7 Sample

For this study, data was collected from young adults studying in university, a survey on 373 young adults was conducted to find out sample. Sample of this research consisted of 60 (30 = Experimental group and 30 = Control group) young adults. Both experimental group and control group were further divided into three groups. These three groups had ten respondents in each group. The age range of young adults was 18-25 years. The mean age of the study participants was 20.7 years. Purposive sampling method was used to obtain data.

3.1.8 Variables

3.1.8.1 Independent variables

These are called stimulus or input variables. They operate either within a person, or within his environment to influence his behavior. These are those components, which are

measured, and selected by the researcher to investigate their connection on a recognized phenomenon. In the present study the independent variable was multimodal therapy.

3.1.8.2 Dependent Variables

These are also known as response or output variables. These are those components, which are measured and observed to determine the impact of the independent variable. There were three dependent variables public speaking anxiety, social-anxiety and self-esteem.

3.2 TOOLS

Allen (1989) advocated the fact that when change is measured through self-report data, followed by observer ratings, and then physiological assessments only then therapies can show their effectiveness. This research used following tools for data collection.

I. Personal report of public speaking anxiety (PRPSA)
II. Social interaction anxiety scale (SIAS)
III. Rosenberg self-esteem scale
IV. Life history inventory (LHI) & Structural profile inventory (SPI)
V. Subjective unit of distress.

Description of the Tools used

This research utilized self-report data drawn from college/university students.

> "Self-report measures can help in developing a better understanding of the impact of communication (McCroskey & McCroskey, 1988)".

3.2.1 Personal Report of Public Speaking Anxiety (PRPSA)

McCroskey (1970) developed personal report of public speaking anxiety scale (PRPSA-34) to access accurate assessment of communication related fears. It is a uni-dimensional inventory with 34 statements related to giving a presentation and a speech in the public. Each statement articulates the severity of anxiety that occurs while speaking in public. PRPSA-34 is a likert-type scale that contains five options for one statement. Those five options are *strongly disagree, disagree, neutral, agree, and strongly agree*. Initially, the

PRPSA-34 was developed and used to diagnose students with high anxiety. Additionally, this scale gives heavy weightage to items related to public speaking anxiety. The reliability level of this scale is high (alpha estimates > .90).

Instructions given.

Before administration of the scale necessary instructions was given to the subjects and proper rapport was established with them. No time limit was imposed for completion of the tool. Personal Report of Public Speaking Anxiety scale have 34 statements that respondents make about themselves. Respondents indicate at which option each statement applies to them on likert scale *(1) strongly disagree, (2) disagree, (3) neutral, (4) agree, (5) or strongly agree* with each statement.

Table 1: Items of the Personal Report of Public Speaking Anxiety (PRPSA)

_____1. While preparing for giving a speech, I feel tense and nervous.

_____2. I feel tense when I see the words "speech" and "public speech" on a course outline when studying.

Scoring

To get final scores on the Personal Report of Public Speaking Anxiety scale practice the following way:

Step 1- Calculate scores for statements 1, 2, 3, 5, 9, 10, 13, 14, 19, 20, 21, 22, 23, 25, 27, 28, 29, 30, 31, 32, 33 & 34

Step 2- Calculate scores for statements 4, 6, 7, 8, 11, 12, 15, 16, 17, 18, 24 & 26

Step 3. Complete the following formula:

PRPSA = 72- step 1 + step 2 = final scores.

Interpretation

McCroskey and Richmond (1992) scored this scale into five levels of anxiety: a score of A "high" score signify more of anxiety and a "low "score means less anxiety. If the score of any respondent is below 34 or above 170 shows a mistake in computing the results.

Table 2: Interpretation of Personal Report of Public Speaking Anxiety

Below 98	Mild anxiety
98-131	Moderately high anxiety
131 and above	Very high anxiety

3.2.2 Social Interaction Anxiety Scale

Social interaction anxiety scale (SIAS) was designed by Mattick and Clarke (1998). The social interaction anxiety scale was discovered due to the lack of valid assessment tools that actually designed to assess interaction related fears and the more generalized social interaction anxieties like communicating with friends and strangers or attending a social gathering/party, which were considered as the main features of social phobia in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM–IV; American Psychiatric Association, 1994). This scale was used for the purpose of assessment before the in-person interview. It is a 20 statement scale that rates from 0 to 4, where 0 indicates that the item is not characteristic of the individual and 4 indicates that the item is extremely characteristic of the individual. The SIAS possesses a high internal consistency and test-retest reliability (Cronbach's alpha .93 and r =0.92 respectively) (Mattick & Clarke,1998).

Instructions given.

Before administration of the scale necessary instructions was given to the subjects and proper rapport was established with them. No time limit was imposed for completion of the tool. Subjects had to circle a number to show the relevance for them.

Table 3: Items of the Social Interaction Anxiety Scale

	Characteristic	Not at all	Slightly	Moderately	Very	Extremely
01.	I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
02.	I have difficulty making eye contact with others.	0	1	2	3	4

Scoring.

The social interaction anxiety scale is a self-report tool consisting 20 statements that each respondent rates as characteristic of them using a 5-point scale. The statements demonstrate the level of general anxiety related with the starting and maintain interactions in social settings like communicating with strangers, friends, or individuals of the opposite sex. Subjects marked according to their choices from 0 to 4 points for each of the 20 statements on the scale. Norms of the scale indicated reversing of the scores on statements 5, 9, and 11. A maximum score on this scale can be 80 points (4x20). A score of 43 or more indicates traditional social-anxiety (generalized irrational fears across numerous social situations with avoidance and impairment). A score of 34 to 42 indicates what is sometimes called social phobia (specific situations of irrational social fears with avoidance and impairment).

Table 4: Interpretation of Social Interaction Anxiety Scale

Scoring	Total Score:		Reserve Items: 5, 9, 11
	Interpretation:	34+ Social Phobia is probable.	
		43+ Social-anxiety is probable.	

3.2.3 Rosenberg Self-esteem Scale

Morris Rosenberg (1965) developed the Rosenberg Self-esteem Scale. It is one of the most famous scale for diagnosing self-esteem. It is a free scale and one does not require any permission from the author to use. Glaus (1999), stated that Rosenberg self-esteem scale is short and requires no effort to implement. Blascovich and Tomaka (1991) checked its reliability and validity. This is 10-statement scale that measures self-worth globally and checks negative and positive feelings about the self. Five items out of ten are negatively stated and five are positively stated. But both positive and negative feelings are presented in random order to lessen the effect of respondent set. The scale has a Guttman scale coefficient of reproducibility of .92, indicating excellent internal consistency. Two studies of two-week test-retest reliability showed correlations of .85 and .88, indicating excellent stability (Rosenberg, 1965).

Instructions given

Before administration of the scale necessary instructions were given to the subjects and proper rapport was established with them. No time limit was imposed for completion of the tool. The scoring was done with the standard key.

Table 5: Items of the Rosenberg Self-esteem Scale

Characteristics	Strongly agree	Agree	Disagree	Strongly disagree
1. On the whole, I am satisfied with myself.				
2.* At times, I think I am no good at all.				
3. I feel that I have a number of good qualities.				

Scoring

Rosenberg Self Esteem Scale had been widely used as self-report instrument for evaluating self-esteem of an individual. The scale has got 10 items with a single dimension. Graded item responses were used in the measurement process. People who performed the test respond on a 4-point Likert scale format ranging from *strongly agree, agree, disagree and to strongly disagree.*

Table 6: Interpretation of the Rosenberg Self Esteem

Nature of Items	Items Number	Total Number of Items Positive Items
Positive items	1, 3, 4, 7, and 10	5
Negative items	2, 5, 6, 8, and 9	5

3.2.4 Life history inventory

Life history inventory was used to get detailed picture of one's life. By completing all the questions accurately will facilitate the therapeutic program further. Lazarus, (1981) claimed, "It provides an organized structure that assures entirety without sacrificing minute details. It provides a compass, a cognitive map, and a continuous cross check that promotes diagnostic accuracy and therapeutic efficiency. It encourages treating the whole person, and above all, it provides specified procedures for assessing and remediating intra-individual and interpersonal problems".

Life history inventory is a comprehensive way to identify problems based upon client's complete information (Lazarus & Lazarus, 1989).

This 15-page questionnaire helps in planning treatment:

• By motivating clients to concentrate on particular issues, their origins and what solutions were undertaken to come out of the problem

• By giving complete attention to family history, current issues, and important data

• By developing a helpful outlook in the terms of a client's style and anticipation regarding treatment.

After the initial session, this questionnaire was given to subjects as a homework assignment. This exercise provided complete history of the subject with BASIC I.D. analysis, and helped in generating a viable treatment plan.

Structural Profile Inventory (SPI)

Lazarus composed and provided research using Structural Profile Inventory (SPI). This inventory was based upon quantitative rating of the extent to which clients favor specific BASIC I.D. areas. This tool measured behaviour based inclination, (Affect) the extent of emotionality, (Sensation) the value of sensory feelings, (Imagery) the time spent on fantasizing or day dreaming, (Cognition) logical capacity to solve problems, (Interpersonal) the value of social interactions, and (Drugs/Biology) the degree to which a person is health conscious (Herman, 1992; Landes, 1991).

3.2.5 Subjective Unit of Distress

Subjective Unit of Distress Score sheet was developed by the researcher herself in accordance with the variable taken for the study. The sheet included questions based on Life History Inventory marked by the students. Respondents gave a subjective score between 1-10 as per the level of distress experienced by them. The individual was asked to mentally mark most anxious situation as 10 and totally relaxed state as 1.

3.3 Intervention plan

Study included the following interventions plan:

First session: The treatment began with the distribution of the life history inventory, acknowledging respondent's fears and providing information about multimodal therapy and discussed strategies as per the requirement of every respondent.

Second session: All required methods of multimodal therapy briefly described and drawn
seven aspects of personality with structural profile inventory.

Third session: This session focused on respondent's behavior and strengthening good behaviors.

Fourth Session: Encouraged respondent to create positive imaginations about life incidents or changes that may occur.

Fifth session: Addressed cognitive features. Counseled for the replacement of thoughts. Elaborated on logical and illogical thoughts and cognitions and their effects on feeling.

Sixth session: Worked on the emotions of respondents. Training of emotional discharge, focused on emotions, taught relaxation techniques.

Seventh session: Assisted to understand physical sensation through a session of hypnosis.

Eighth session: Interpersonal skills were discussed with the respondents.

Ninth session: Discussion regarding the importance of proper nutrition, exercise and sleep.

Tenth session: Feedback and evaluation. At this time, individuals review therapy sessions and gave feedbacks. Finally, posttest was performed.

3.4 Need for the study

In spite of a number of studies and work on public speaking anxiety, social-anxiety and low self-esteem majority of students still experience the problem, and thus, the research is to find out a package of effective therapeutic intervention is justified.

Many young adults experience public speaking anxiety, social-anxiety and low self-esteem. As a result, it mounts anxiety among students. Most young adults or adolescents find difficult to overcome social-anxiety and public speaking anxiety. Spijck (2011) researched on hundred people and claimed that almost eighty people had public speaking anxiety at a lower or higher level. Another study conducted by Mehtalia and Vankar (2004) on Indian students, and revealed that 12.8% students had social-anxiety disorder in combination with major depression and debilitated educational functioning. According to the above-mentioned issues in life in terms of emotional, behavioural, social problem solving skills, it is essential to have technical skill (enough and update knowledge), perceptual skills (correct understanding of issues and problems) and human skill (ability to make good relationship with others). Bodie (2010) claims that sufferers of public speaking anxiety can avoid public speaking to any extent possible, even on the cost of their jobs or better opportunities. Lazarus' multimodal therapy is one of those methods (Rahmani et al., 2010). In many cases, due to past experiences of failure adolescents develop a negative attitude towards their psychological issues. These negative experiences are caused due to embarrassments in the social settings. Parents who have the history of psychological issues pass that on to their children. Parent's expectation also

causes stress and instills anxiety in their children. This causes a feeling of dread instead of enjoying their youth. These formed a valid ground for this study.

The present study aims at investigating the effectiveness of multimodal therapy on public speaking anxiety, social-anxiety and low self-esteem. Positive reinforcement proved to be the best available intervention for anxiety/phobia management. Cognitive restructuring not only reduces the anxiety level but also integrates both the hemispheres for optimum utilization of the resources. Behaviour therapy helps in improving a directly observable behaviour and cognitive restructuring being a neuro-cognitive model helps to sustain the change. Hence a package of intervention is introduced.

Research question

Whether multimodal therapy will improve public speaking anxiety, social-anxiety and self-esteem among young adults.

Statement of the problem

To evaluate the effectiveness of multimodal therapy in the management of public speaking anxiety, social-anxiety and self- esteem among young adults.

3.5 Implications

The effect of multimodal therapy has been documented in the earlier researches done mainly in foreign countries. There is dearth of such studies in Indian context. The attempt which has been initiated in the form of present research study to improve the self-esteem and decrease public speaking anxiety and public speaking anxiety in India, for the first time to the best of my knowledge, has strongly established the usefulness of multimodal therapy for the young adults who were the part of this study. Youth is the critical age where inculcation of high self-esteem can help in making the lives of young adults, the lack of it can put their lives in turmoil. Youth is the asset of any nation and of utmost importance in their wellbeing. The youth or the adolescents who are the future of the country can contribute their best in the building of any nation if they are having high self-esteem. The outcomes of this research are clearly indicative that taking multimodal therapy in issues like public speaking anxiety, social-anxiety and low self-esteem may

play a powerful role especially for adolescents, helps them to channelize their strengths and potential in constructive way by being in sound cognitive - affective and behavioral state instead of being engrossed in destructive revengeful thoughts, emotions and acts. The valuable asset of the nation can be protected psychologically. The present study can be helpful in training, adoption and implementation of such policies consisting of psychological intervention programs to overcome public speaking anxiety, social-anxiety and low self-esteem.

Present study also provided an opportunity for the counselors to use these techniques in their clinical settings for their clients to manage public speaking anxiety, social-anxiety and low self-esteem in adults. Hypnosis was also used as an intervention in this study and it also reduces anxiety. Moreover, most young adults have stigma pertaining to meeting a psychologist and thus these anxiety disorders prevail. Whereas innovative interventions like anxiety management, relaxation training used in this study are in the form of brief exercises and can be used in personal settings. Few of the interventions used in the present study can also be instructed and practiced in a group and thus can save precious time. A comprehensive package of interventions proved to be effective in the management of public speaking anxiety, social-anxiety and self-esteem.

3.6 Limitations

1. The sample size could have been larger.

2. There was also limited access to a wider sample. Therefore, it is suggested that other researchers consider these issues in their future research.

3.7 Recommendations

1. It is recommended to study effectiveness of multimodal therapy in group settings for improving public speaking anxiety, social-anxiety and self-esteem.
2. Considering the importance of communication in the life of young adults, it is recommended to educators that hold educational workshops based on the multifaceted approach like multimodal therapy at the beginning of each semester in order to increase awareness regarding in students.

3. It is suggested to hold several group sessions at all educational grades, welfare organization and recreation centers for young adults in particular those who suffer from severe social dilemmas. Meanwhile, these sessions can prevent from illogical beliefs in life that may cause mental and physical disorders.
4. Future research should continue to explore the efficacy of multimodal therapy in various instructional settings such as workshops.
5. Further research should also examine the long term effectiveness of multimodal therapy.

CHAPTER 4

RESULT & DISCUSSION

4.1 Results

The objectives of the study aim to assess the efficacy of multimodal therapy on public speaking anxiety, social-anxiety and self-esteem among young adults. Thirty young adults formed the experimental group and another thirty young adults served as control group. As this research's main cause was to check the effectiveness of independent variable on dependent variables. tTest, correlation and liner regression were conducted on the data in SPSS. tTest was conducted to find out the pre and post therapy differences. Correlation was attempted to find out whether there was any relationship among public speaking anxiety, social-anxiety and self-esteem.

The results of the study were analyzed tabulated and discussed below.

Table 7: Mean Scores of Experimental Group and Control Group Before Intervention with regard to Public Speaking Anxiety, Social-anxiety and Self-esteem (N=60)

Variables	Experimental group Mean (SD)	Control group Mean (SD)	Mean difference	Critical Ratio	p value
PUBLIC SPEAKING ANXIETY	123.40 (11.80)	120.70 (9.40)	2.40	.57	0.58
SOCIAL-ANXIETY	48.80 (9.32)	42.80 (6.32)	6.00	1.68	0.10
LOW SELF ESTEEM	11.40 (2.59)	12.10 (2.51)	-0.7	0.61	0.54

Table 7 illustrates the mean score of the experimental and control group before the intervention. Table articulates that there exists no significant difference between experimental group and control group before the intervention. Experimental group of

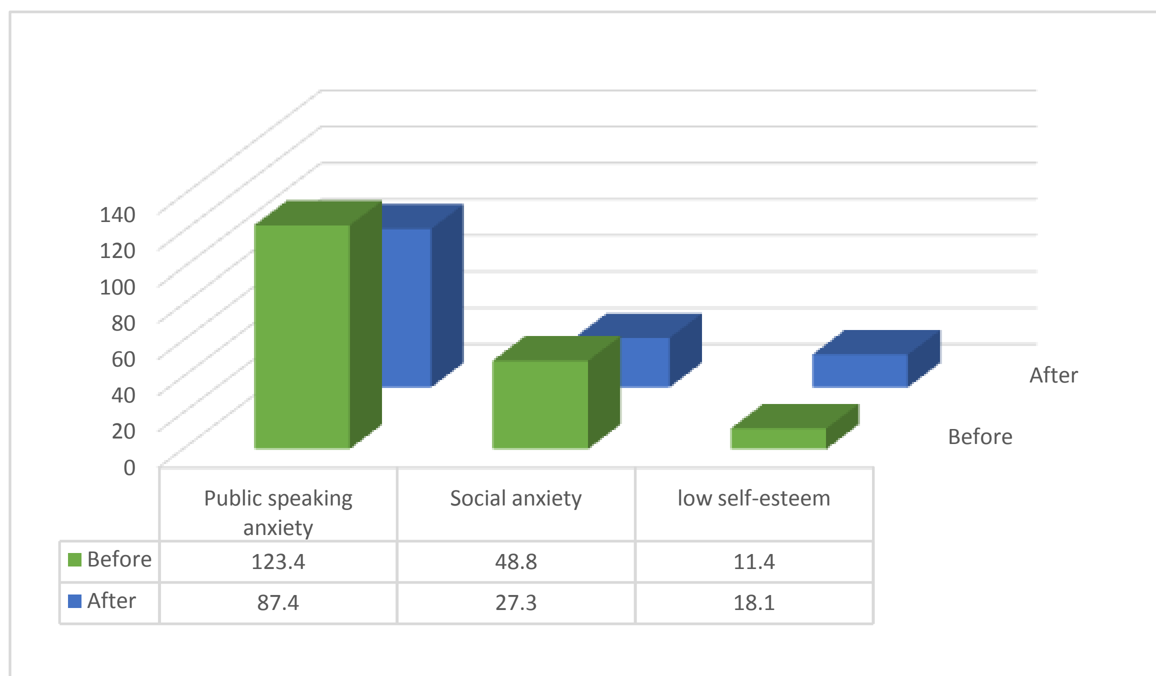
public speaking anxiety had the mean score of 123.40 before the intervention and control group of public peaking anxiety had the mean score of 120.70 before the intervention which indicated no significant difference among both experimental and control group before the intervention. Experimental group of social-anxiety had mean score of 48.80 before the intervention and control group had the mean score of 42.80 before the intervention which propounds that before intervention both the groups didn't differ significantly. Similarly, experimental and control group of low self-esteem with the mean scores of 11.40 and 12.10 showed no major difference before the intervention. A conclusion can be made that both the groups showed no significant difference before the introduction of intervention. Respondents for experimental and control group were selected on the basis of presence of public speaking anxiety, social-anxiety and self-esteem and both the groups were homogenous in nature. Thus, the Hypothesis H.1 which states that "**There exists statistically significant difference between experimental group and control group before intervention in relation to public speaking anxiety, social-anxiety and self-esteem among young adults**" is rejected.

Table 8: Mean scores of the Experimental Group Before and After Intervention with regard to Public Speaking Anxiety, Social-anxiety and Self-esteem (N=60)

Variables	Before intervention Mean (SD)	After intervention Mean (SD)	Mean Difference	Critical ratio	p value
PUBLIC SPEAKING ANXIETY	123.40 (11.80)	87.40 (24.37)	36.0	4.20	0.0005
SOCIAL-ANXIETY	48.80 (9.32)	27.30 (10.77)	21.5	4.77	0.0002
LOW SELF ESTEEM	11.40 (2.59)	18.10 (2.56)	-6.7	5.81	0.0001

Table 8 illustrates the average scores of public speaking anxiety, social-anxiety and low self-esteem of experimental group in before and after intervention. Table 8 enunciates that there prevails a significant difference between before and after intervention of the experimental group at 5 per cent level of significance as far as public speaking anxiety is

concerned. The mean of experimental group of public speaking anxiety before intervention was 123.40 which later reduced down to 87.40 after intervention. As lower score indicates improvement hence, intervention improved public speaking anxiety of the subjects. Similar results were observed on social-anxiety and low self-esteem where null hypothesis favoring no significance difference observed due to intervention in the respondents. Average value of social-anxiety was 48.80 with standard deviation 9.32 and after intervention this values stood at 27.30 with standard deviation of 10.77. Social-anxiety reduced drastically after the intervention among experimental group at 5 per cent significant level. The mean score of experimental group of low self-esteem before intervention was 11.40 which later increased up to 18.10 after intervention. As higher scores indicate improvement hence, it can be concluded that intervention improved self-esteem of the respondents.



	Public speaking anxiety	Social anxiety	low self-esteem
Before	123.4	48.8	11.4
After	87.4	27.3	18.1

Figure 7: Experimental Group Before and After Intervention with regard to Public Speaking Anxiety, Social-anxiety and Self-esteem (N=60)

The result shows that the levels of public speaking anxiety, social-anxiety, and self-esteem score of experimental group before and after intervention differ significantly.

Thus, the hypothesis H2 which states that "**There exists statistically significant difference between pre and post intervention of experimental group in relation to public speaking anxiety, social-anxiety and self-esteemamong young adults"** is accepted here.

Table 9: Mean scores of Experimental Group and Control Group After Intervention with regard to Public Speaking Anxiety, Social-anxiety and Self-esteem (N=60)

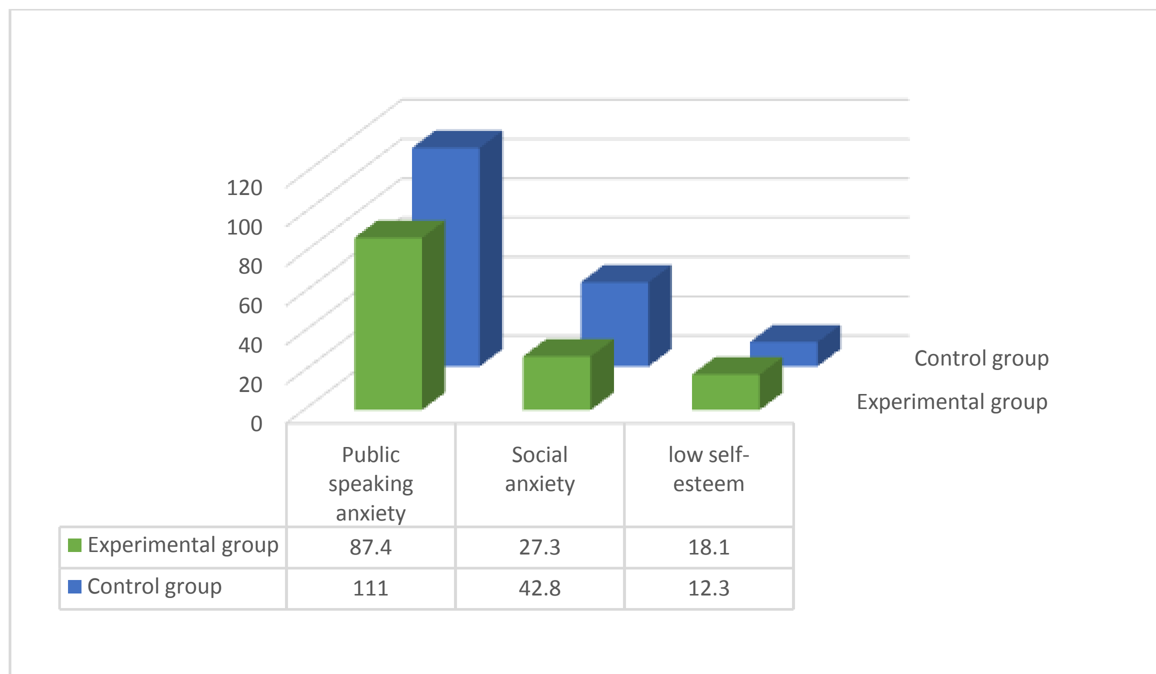
Variables	EXPERIMENTAL GROUP MEAN (SD)	CONTROL GROUP MEAN (SD)	MEAN DIFFERENCE	CRITICAL RATIO	P VALUE
PUBLIC SPEAKING ANXIETY	87.40 (24.37)	111.0 (12.11)	-23.6	2.74	0.01
SOCIAL-ANXIETY	27.30 (10.77)	42.80 (7.11)	-15.5	3.79	0.001
LOW SELF ESTEEM	18.10 (2.56)	12.30 (4.06)	5.8	3.82	0.001

The post-intervention score of the experimental group in public speaking anxiety is 87.40 with a standard deviation of 24.37. The post-intervention score of the control group in public speaking anxiety is 111.0 with a standard deviation of 12.11 mean difference is -23.6.

The post-intervention social-anxiety score of the experimental group is 27.30 with standard deviation of 10.77. The post-intervention social-anxiety score of the control group is 42.80 with a standard deviation of 7.11 mean difference is -15.5.

The post-intervention score of self-esteem of the experimental group is 18.10 with a standard deviation of 2.56. The post-intervention score of self-esteem of the control group is 12.30 with a standard deviation of 4.06 mean difference is 5.8.

Figure 8: Experimental Group and Control Group After Intervention with regard to Public Speaking Anxiety, Social-anxiety and Self-esteem (N=60)



The result shows that the score of public speaking anxiety, social-anxiety and self-esteem in experimental group and control group after intervention differ significantly. A conclusion can be made that experimental and control group had significant difference after the intervention. Young adults for experimental and control group were selected on the basis of presence of public speaking anxiety, social-anxiety and self-esteem and both the groups were significantly different after the intervention. Thus the Hypothesis H.3 which states that "**There exists statistically significant difference between experimental and control group after intervention in relation to public speaking anxiety, social-anxiety and self-esteem among young adults**" is accepted.

Table 10: Model summary of Self-esteem and Public Speaking Anxiety

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.417[a]	.174	.171	18.840	1.930

a. Predictors: (Constant), self-esteem

b. Dependent Variable: public speaking anxiety

The simple regression analysis was performed to understand the strength of the relationship of self-esteem and public speaking anxiety. To predict its relationship, public speaking anxiety was considered dependent variable and self-esteem was considered independent variable. Table 10 depicts the model summary, here R square which represents the proportion of variation in the dependent variable that can be explained by independent variable. Critical value of R square should be between 0 to 1. A higher value is considered good value. In Table 10 R square is .174 which means that only 17% of variance in public speaking anxiety can be predicted by self-esteem.

Table 11: ANOVA analysis summary of Self-esteem and Public Speaking Anxiety

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	27654.456	1	27654.456	77.910	.000[b]
	Residual	131687.775	371	354.954		
	Total	159342.231	372			

a. Dependent Variable: public speaking anxiety

b. Predictors: (Constant), self-esteem

From Table 11 ANOVA analysis summary depicts that whether the model as a whole has statistically significant predictive capabilities p =.000 established the significance of the relationship between self-esteem and public speaking anxiety. As per the p value is less than .05 it indicates that regression model is fit.

Thus the Hypothesis H.4 which states that **"Self-esteem is a significant predictor of public speaking anxiety among young adults"** is accepted.

Table 12: Model Summaryof Self-esteem and Social-anxiety

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.574[a]	.329	.327	10.751	.964

a. Predictors: (Constant), self-esteem

b. Dependent Variable: social-anxiety

To understand the strength of the relationship of self-esteem and social-anxiety, the simple regression analysis was performed in order to predict the dependent variable from the independent variable (predictor) where social-anxiety was dependent variable and low self-esteem was considered independent variable forstudying this aspect. Table 12 depicts the model summary, which indicates that R square is .329 which means that 32% of variance in social-anxiety can be predicted by self-esteem.

Table 13: **ANOVA analysis summary of *Self-esteem and Social-anxiety***

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	21035.090	1	21035.090	181.982	.000[b]
	Residual	42883.500	371	115.589		
	Total	63918.590	372			

a. Dependent Variable: social-anxiety

b. Predictors: (Constant), self-esteem

ANOVA results depicts whether the model as a whole has statistically significant predictive capabilities. With the establishment of value p =.000 the significant relationship between self-esteem and social-anxiety is found. As the p value is less than .05 it indicates that regression model is fit. From Table 13 it can be derived that the

regression model in which social-anxiety was the dependent variable and self-esteem was the independent variable has been found fit.

Thus the Hypothesis H.5 which states that **"Self-esteem is a significant predictor of social-anxiety among young adults"** is accepted.

Table 14: Correlation between Public Speaking Anxiety, Social-anxiety and Self-esteem

		Public speaking anxiety	Social-anxiety	Self-esteem
Public speaking anxiety	Pearson Correlation	1	.422**	-.417**
	Sig. (2-tailed)		.000	.000
	N	373	373	373
Social-anxiety	Pearson Correlation	.422**	1	-.574**
	Sig. (2-tailed)	.000		.000
	N	373	373	373
Self-esteem	Pearson Correlation	-.417**	-.574**	1
	Sig. (2-tailed)	.000	.000	
	N	373	373	373

**. Correlation is significant at the 0.01 level

The Pearson product-moment correlation coefficient is a measure of the strength of the linear relationship between two variables. It is known as Pearson's correlation or simply as the correlation coefficient. In Table 14 results of the Pearson correlation indicated that there was a significant negative association between self-esteem and social-anxiety ($r = -.574$) and showed moderate correlation between these two variables.

Self-esteem and public speaking anxiety were moderately (r = -.417) but negatively related to each other.

There was average correlation between public speaking anxiety and social-anxiety (r = .422) and this correlation was extremely statistically significant at .01 level which means that adolescents having social-anxiety had greater chances to have public speaking anxiety.

Thus the Hypothesis H.6 which states, **"There is significant relationship between public speaking anxiety, social-anxiety and low self-esteem among young adults"** is accepted.

4.2 Discussion

The purpose of this research was to study the effectiveness of Lazarus' multimodal therapy on decreasing the levels of public speaking anxiety and social-anxiety and increasing the levels of low self-esteem among young adults. The results indicated that participation in Lazarus' multimodal sessions reduced the levels of public speaking anxiety, social-anxiety and increased the level of self-esteem. Lasting outcome has been witnesses as a function of combined tactics and strategies.

All Studies were reviewed inside and outside of India and found very limited studies using Lazarus's multimodal therapy on the combination of public speaking anxiety, social-anxiety and self-esteem.

It has been already realized by many counselors and clinicians that single authentic procedure to understanding and correcting human problems does not prevail, no anyone orientation has all the resolutions (Garfield & Kurtz, 1975; Patterson 1980). In addition to offering rapid and effective treatment of the common anxieties, affect disturbances, other psychological and psychobiological disorders addressed by most clinicians, multimodal therapy has proved successful with problems that are generally considered "difficult" and the prognosis was often guarded (Eimer, 1988; Kwee et al., 1985; Rudolph, 1985; Shaughnessy & Slowinski, 1985).

In this study, as the Table 8 enunciates the efficacy of multimodal therapy on public speaking anxiety, social-anxiety and self-esteem. Similar results were verified through

other studies. To cite a few noteworthy reports (Sank, 1979) showed that the BASIC I.D. had clear-cut virtues when dealing with community disasters. Shaughnessy and Hirschhorn (1981) used art therapy as an adjunctive aid to multimodal therapy in the treatment of a severely retarded adult. Greenburg (1982) used the multi modal approach as a frame- work for eclectic counselor education. Gerler (1982, 1984) applied the multimodal approach in educational settings. Ridley (1984) found multi modal methods most valuable when confronted by the non-disclosing black clients. Ponterotto and Zander (1984) discussed a multimodal approach for counselor supervision. Brickner (1984) found value in multimodal therapy as a frame- work for the employee assistance program (EAP). Edwards and Kleine (1986) presented a multimodal model for the development of gifted adolescents. Ponterotto (1984) concluded that the multimodal framework "provides maximum opportunity to develop culturally relevant clinical case conceptualizations for Mexican Americans". Neland (1988) used multimodal therapy with adult female incest victims. Several dissertations have been devoted to the clinical utility of the multimodal approach (Aigen, 1980; and Ferrise, 1978. Allen (2002) used multimodal therapy to treat dementia. Biabangard (2002) improved students' test anxiety by demonstrating the impact of multimodal therapy in comparison to relaxation therapy and rational emotive therapy. Brunell (1978) provided a multimodal treatment model for a mental hospital. Dabbaghi (2002) worked on reducing anxiety through a comparison between multimodal therapy and progressive relaxation training. Halmi (2005) evaluated the effectiveness of multimodal therapy on bringing up a change among individuals having eating disorders and concluded that treatment using multimodal therapy brought significant improvement in eating disorders. Khazraei and Vijehfar (2010) analyzed the outcomes of multimodal therapy, and demonstrated influential improvement in general health. Abazari (2007) studied the impact of multimodal therapy among women to decrease the levels of depression and proved its efficacy in lowering the depression. Bahramkhani (2010) also stated that multimodal therapy had been found influential on improving mental health and stress.

Results of this study substantiated the results of Lotfi and Farkhondeh (2016), who carried out a study using multimodal therapy and showed significant improvement in anxiety and physical symptoms. The results were congruent with the study conducted by

Rahmani et al. (2010) using multimodal therapy which resulted in bringing change in positive affection, and relationship. Bahramkhani et al. (2010) demonstrated that multifaceted therapy led to a significant reduction in perceived negative tension and increased perceived positive stress in test group. Etemadi and Golmohammadian (2014) revealed a difference that was significant among experimental and control groups in terms of self-concept and negligence. Finally, Golshan and Sobhi (2017) proved that teaching group consultation through mutual behavior analysis could significantly reduce depression in experimental group so that there was a significant difference between pretest, posttest and follow-up. Dawyer (2000) designed and studied multidimensional model for students to treat their high speech anxiety. His study demonstrated that skill training via public speaking course helped individuals with high communication apprehension to reduce their anxiety, thus proved multidimensional model had a significant effect. Lazarus and Abramovitz (2004) researched on multimodal therapy and showed a persuasive impact on improving anxiety. It seems that this method not only has therapeutic role but also plays a preventive role. Studies that have conducted in the field of effectiveness of Lazarus' multifaceted approach outside of India have indicated effect of this approach on matters like mental health, reconstruction of relationships, negligence, depression, dementia, relationships, anxiety, and physical symptoms. Lambert and Neber (2004) reported that major component of Lazarus' treatment plan was to enhance the quality of life and general welfare. Although, researchers in the field of treatment planning had clearly stated that counselors employ multidimensional intervention techniques, but they fail to provide valid outcome of their work. It is significantly proven that unimodal or bimodal techniques are bound to leave significant areas untouched (Garfield, 1978; Goldstein et al., 1966; Kiesler, 1966, 1971; Strupp, 1964; Urban & Ford, 1971).

Table 9 discussed the mean difference of experimental and control group after the intervention. As per the protocol of this study, experimental group was tested after giving ten therapy sessions and control group was tested without giving any therapy sessions after ten weeks. Through Table 9, it has been clearly demonstrated that multimodal therapy effectively helped young adults to overcome public speaking anxiety, social-anxiety and enhance their self-esteem.

Table 10. discusses the strength of self-esteem and public speaking anxiety, value of R square = .174 directs towards the point that only 17% of variance in public speaking anxiety can be predicted by self-esteem Similarly, Faria and Vijaya (2019) researched to find out the relationship between distress and self- esteem on public speaking anxiety in teachers. The results revealed that self- esteem and public speaking anxiety are negatively correlated that means reduced level of self- esteem results in increased public speaking anxiety and vice versa. Moreover, the findings of Philips et al., (2004) study displayed a complete different perspective that even people with high levels of self- esteem are quite likely to be inhibited by their fear of speaking though they are familiar with the topic of discussion or interested in the topic.

Masoudnia (2009) through a study confirmed that the self-esteem explained 16.1% of the variance in social-anxiety. According to the study, self-esteem was found valuable predictors of social-anxiety in young adults. As depicted in Table 12. value of R square = .329 indicates 32% variance between social-anxiety and low self-esteem. The findings of current study demonstrated that adolescents with low self-esteem experience greater social-anxiety. The major cause lied in the fact that people having social-anxiety have fear of judgement by others and they show avoidance behaviour, which in the end takes the shape of social-anxiety. Schreiber et al., (2012) reported similar results that self-esteem has direct relationship with social-anxiety. The results are in line with the study of De Jong (2002) that self-esteem plays an important role in adolescent social-anxiety.

In order to check whether the two variables predictor and criterion doesn't have zero relation between them. Therefore, Table 11 and Table 13 indicating ANOVA analysis, reveals that there is significant difference between explained variance and residual variance. As the p value of both the tables is 0.00 that is less than the value .05 (level of significance) which means that the regression model is formed to be fit.

As per the values of Table 14. indicate (r = -.574) that there was a significant negative association between self-esteem and social-anxiety and moderate correlation between these two variables. Self-esteem and public speaking anxiety were moderately (r = -.417) but negatively related to each other.

There was average correlation between public speaking anxiety and social-anxiety (r = .422) and this correlation was statistically significant at .01 level which means that adolescents having social-anxiety had greater chances to have public speaking anxiety. Literature also supported that there is relationship between low self-esteem and social-anxiety. Such as, Kocovski and Endler (2000) indicated through their study that students who showed higher fear of negative evaluation had low self-esteem which was later diagnosed as social-anxiety. Izgic et al. (2004) stated that a group of university students with low self-esteem showed highest pervasiveness of social-anxiety and a group with lowest levels of social-anxiety in the group of students showed high self-esteem. Nordstrom et al., (2014) predicted that students having high levels of social-anxiety may show low levels of self-esteem and concerns regarding mental health. Stopa et al.,(2010) revealed through their study that students who had high levels of social-anxiety reported lower levels of self-esteem in comparison to the students with low social-anxiety. But also stated through this study that the reason of the connection between self-esteem and social-anxiety was not clear. In summary, multifaceted psychotherapy of Lazarus is a comprehensive method in this field (Lotfi & Farkhondeh, 2016). Fundamental assumption of this type of therapy is that patients have specific problems that should be solved using several methods (Prochaska & Norcross, 2007).

In present study, according to the results there is moderate relationship among low self-esteem and social-anxiety. Current study also indicated that comorbidity between low self-esteem and social-anxiety requires a close examination in the direction of their relationship as well as further study into their consequences on the students. As, in this study the size of sample was not elaborated enough due to some limitations. It is suggested to conduct a further research with a larger sample size.

Lazarus' seven dimensions are defined separately but are interacting together so that any experience of human may be determined by a dimension that is in relation with other dimensions and any change in one dimension can affect other dimensions (Bahramkhani et al., 2012). Accordingly, these seven dimensions were evaluated individually but in relation with each other in this therapy. Lazarus (2005) emphasized that integration of psychotherapy should not be essentially relied on theoretical combination and clinical

experts (Panahi et al., 2014). Major implication of the present study was that multimodal therapy may be although long and difficult but it could be stable due to depth of consultation process.

As per the protocol of multimodal therapy, 'B' modality stands for Behaviour, to bring change in behavior positive reinforcement, the empty chair technique, systematic exposure, behavioural rehearsal and self-monitoring were used. Veritas (2017) stated thateveryone can be benefitted from reinforcement but especially teenagers.MacPherson et al. (2010) proved the efficacy of positive reinforcement in risky behaviours among adolescents. In the empty chair technique, an emotional dialogue takes place. Mostly respondents imagined their parents, siblings sitting in an empty chair in the safe place of their imagination, then switching chairs and speaking for the person sitting opposite also helped respondents to clear their issues. Greenberg and Malcolm (2002) demonstrated that empty chair technique proved as an excellent way of resolving unfinished issues with parent. The empty-chair task was the basis of Gestalt principle that significant unmet needs do not get erased fully from memory (Perls et al., 1951; Polster & Polster, 1973). Perls et al., (1951) also established a statement that empty chair technique was a therapeutic way of confronting the unresolved issues in imagination, especially if the other person was not available. (Finn et al. 2009; Duff, et al., 2007; Kirsch, et al., 1977) demonstrated the effectiveness of systematic exposure in treating public speaking. Mayo-Wilson et al., (2014) compared CBT and systematic exposure in treating social-anxiety and found statistically no difference between exposure and cognitive therapy. Hence, proven that systematic exposure was equally potent in treating public speaking anxiety and social-anxiety. The results are in cue with results of the study by Friedrich (1997), who reported that systematic desensitization has proved its effectiveness in treating communication related anxiety, especially public speaking anxiety. Systematic desensitization remained the first choice of treatment for treating anxiety/ phobias and can be used with extreme anxious cases. Meichenbaum et al., (1971) compared RET, systematic desensitization, and a combined desensitization and found that systematic desensitization works more effectively with people having issues from low general social distress. McCroskey (1980) provided evidence after the extensive research of 15 years that techniques related systematic desensitization significantly reduces public speaking

anxiety. This study also came up with a strong statement that courses related to communication not involving the factors which especially address the emotional (affect) feature of public speaking were not capable of decreasing public speaking anxiety. Studies conducted on public speaking anxiety revealed that three intervention strategies: assertiveness training, systematic desensitization, and cognitive restructuring might be beneficial in overcoming public speaking anxiety.

‘A’ modality stands for affect, it included techniques like anger-expression, anxiety management and feeling-identification. In this research, in sessions young adults responded well to anger expression and anxiety management. Most of them scored highon anger, depression, anxiety and loneliness on Subjective unit of distress scale. Research done by Butler, et al. (1984) also indicated through their study that the combination of exposure and anxiety management was showed better efficacy than the merger of exposure and the nonspecific associative therapy and also claimed that anxiety management could teach skills that can be used in many situations in life. Blake and Hamrin, (2007) clearly stated that anger and the expression of anger depict a major public health issue especially for adolescents. Nasir and Ghani (2013) concluded that when anger failed to be controlled it ends up turning up to aggression. In current study, anger expression technique was used on respondents who rated high score on anger. Expressing anger technique helped individuals feel more in control and other adverse emotions, such as fear, sadness, and guilt. Clay, et al. (1993) summarized that analyzing both stressful events of life and anger expression may decrease client’s risk for depression and suggested to use multimodal counseling techniques that are personalized in nature.

‘S’ modality stands for sensation and included bio-feedback, focusing/ meditation, hypnosis, relaxation training, threshold training. Almost every respondent of experimental group was given a session of hypnosis. All the troublesome sensations were addressed in personalized session of hypnosis. As, most of the inductions used in hypnosis had similar instructions used for relaxation. Hypnosis session was also reimbursed as relaxation training. Kirsch et al. (1995) had given the authority by stating that progressive relaxation training can be used as hypnotic induction. Allen et al. (1989) also supported the base of current research that the broadest possible combination of

treatment plans was the most effective way of treating communication related anxiety. The research outcome also concluded that interventions based on hypnosis and systematic exposure are effective in alleviating public speaking anxiety. Kirsch et al. (1995) proved that application of hypnosis along with cognitive behavioural therapies improved results extensively in treating most of the psychological disorders.

'I' modality stands for imagination and it contained maximum number of options for therapy such as associated imagery, time projection techniques aversive imagery, anti-future shock imagery, positive imagery, the step-up technique, and goal-rehearsal or coping imagery. Most of the respondents scored high on imaginations like being talked about, being hurt, being laughed at, being helpless, failing, sad images from childhood, negative body image, unpleasant sexual images and images of loneliness. Any one or two techniques were implicated on the respondents of this research to employ change in their imaginations. To support the efficacy of imagery techniques, Rees (1995) demonstrated that guided imagery was effective in coping with issues like anxiety, depression and specific stress and in addition increases self-esteem. Negative self-images played an important role in having social-anxiety disorder and participants holding positive self-images showed higher levels of self-esteem (Hulme et al., 2012).

'C' modality, stands for cognition and Lazarus provided bibliotherapy, correcting misconceptions, Ellis' A-B-C-D-E paradigm, problem-solving and self-instruction training for altering disoriented cognition. Marrs (1995) presented a meta-analysis comparing bibliotherapy with therapist administered treatments and found that bibliotherapy works best when used with other modes of therapy and give better results in reducing anxiety. Even in current research, it has been noticed that it couldn't fulfill the requirement of immediate gratification. Lidren et al., (1994) demonstrated the efficacy of bibliotherapy with cognitive therapy based techniques on people having panic disorder. Mattick et al., (1989) proved the efficacy of exposure therapy and cognitive restructuring on social phobics to bring change in fear of negative evaluation and irrational beliefs. According to Corey (1991) Comprehensive therapy proved its efficacy in correcting irrational beliefs, abnormal behaviour, undesirable feelings, stressful associations,

negative sensations, and physical imbalances. Rational emotive therapy was proved its efficacy particularly in short-term relieve from specific emotional issues.

Kelly (1982) advocated CBT in cases where the assumption of actual cause originated from irrelevant thoughts about self and communication. Mostly, cognitive therapy is based upon the exchange from myths to facts. There are countless self-help books that address harmful misconceptions that people carry, and the writers of self-help books try to cater truths and facts that may embellish the quality of life whosoever reads it. These insights enable clients to solve their personal problems.

‘I’ modality stands for interpersonal relations and to enhance the social relationships of respondents communication training, social skills and assertiveness training techniques were implemented. While living in society produces number of interpersonal pressures. Central component of social skills training session was to make respondents aware about how to give and take in social settings and how to deal effectively with significant others. As, unassertive individuals are apt to suffer when unable to divert inappropriate requirements that may be placed on them by others. This aspect is directly connected to self-esteem and many researchers are convinced that high self-esteem generates beneficial consequences and low self-esteem has been found as a root cause of personal and social problems. Van der Molen et al., (2004) exhibited an ample change in behaviour by using communication skills training on students. Beidel et al., (2015) proved the efficacy of exposure therapy and social skill training on individual having social-anxiety. Eslami et al., (2016) demonstrated that assertive training decreased anxiety, stress, and depression of students. Even in the case of public speaking anxiety, as Kelly (1982) suggested that everyone has different causes for public speaking anxiety so, everyone requires different modes of treatments. Skill training program is supported, If the problem was assumed to be rooted in insufficient communication skills. Relaxation therapy is usually the proposed solution, If the issues is anxiety based.

In multimodal therapy, the ‘D’ modality goes further drugs and plays a significant role by indicating neurophysiological and biological factors. When medical issues were noticed, respondents were asked to consult appropriate physicians. Beyond medication, the

‘D’modality also targeted on issues such as relaxation, exercise, nutrition, and the avoidance of toxic substances like alcohol, smoke, and recreational drugs.

In addition to offering rapid and effective treatment of the common anxieties, affect disturbances, other psychological and psychobiological disorders addressed by most clinicians, multimodal therapy has proved successful with problems that are generally considered "difficult" and the prognosis is often guarded (Eimer, 1988; Kwee et al.,1985; Rudolph, 1985; Slowinski, 1985).

Palmer and Dryden (1991, 1995) verified multi modal approach and stated that it appeared to offer a diagnostic tool and intervention plan that could effortlessly fit to the area of counseling and stress management.

It seems that multimodal assessment and therapy often succeed when less comprehensive/systematic approaches fail.

CHAPTER 5
SUMMARY

5.1 Summary

In the present study public speaking anxiety, social-anxiety and self-esteem along with interventions based on multimodal therapy among young adults had been studied. It was found that public speaking anxiety, social-anxiety and self-esteem develop due to various reasons. The relationship of self-esteem with public speaking anxiety and social-anxiety had been also studied. This helped to gain in depth knowledge about the factors influencing these issues and also ways to treat it. It was followed by the experimental study which included an intervention treatment plan.

5.2Conclusions

1. The results revealed that the score of public speaking anxiety, social-anxiety and self-esteem of the experimental group and control group before intervention were almost homogeneous. No significant difference was found among the variables pertaining to experimental group and control group.

2. On account of the intervention given to the experimental group the mean score of public speaking anxiety and social-anxiety had significantly reduced. The mean score of self-esteem had also improved significantly.

3. No significant differences were found among the control group of public speaking anxiety, social-anxiety, self-esteem score between the pretest and posttest. This validates the earlier conclusion that on account of the intervention there was a significant reduction in the scores of public speaking anxiety and social-anxiety and improvement in self-esteem among the experimental group.

4. The mean score of public speaking anxiety, social-anxiety and self-esteem between experimental group and control group after intervention shows a significant difference. The mean score of experimental group public speaking anxiety and social-anxiety is

significantly low and score of self-esteem is higher than the control group in the post test. This shows the effect of intervention among the experimental group.

5. As per the findings of this research 17% of variance in public speaking anxiety can be predicted by self-esteem among young adults.

6. Research findings revealed 32% of variance in social-anxiety can be predicted by self-esteem among young adults.

7. Statistically significant association between self-esteem and social-anxiety but both the variables were also correlated negatively with each other. Self-esteem and public speaking anxiety were moderately but negatively related to each other. There was average correlation between public speaking anxiety and social-anxiety and this correlation was extremely statistically significant which means that young adults with high levels of social-anxiety have greater chances to have public speaking anxiety.

Table 15: Conclusion of Research

Sl.No.	HYPOTHESIS	SIGNIFICANT/ INSIGNIFICANT	ACCEPTED/ REJECTED
01	There exists statistically significant difference between experimental group and control group in relation to public speaking anxiety, social anxiety and self-esteem among young adults.	Significant	Rejected
02	There exists statistically significant difference between pre and post intervention of experimental group in relation to public speaking anxiety, social-anxiety and self-esteem among young adults.	Significant	Accepted
03	There exists statistically significant difference between experimental and	Significant	Accepted

	control group after intervention in relation to public speaking anxiety, social-anxiety and self-esteem among young adults.		
04	Self-esteem is a significant predictor of public speaking anxiety among young adults.	Significant	Accepted
05	Self-esteem is a significant predictor of social-anxiety among young adults.	Significant	Accepted
06	There is significant relationship between public speaking anxiety, social-anxiety and self-esteem among young adults.	Significant	Accepted
Conclusion: It is concluded from the findings that multimodal therapy is useful in treating public speaking anxiety, social-anxiety and self-esteem among young adults. Self-esteem significantly predicts public speaking anxiety and social-anxiety. There is statistical significant correlation exists among public speaking anxiety, social-anxiety and self-esteem.			

CHAPTER 6

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Appendice

I . Consent form

DATE:______________

NAME:_________________________________ AGE: _____________ SEX: ________________

ADDRESS:____
____
____

CITY:___________________________ STATE_____________ COUNTRY - _______________________

CONTACT NO. _________________ EMAIL ID :____

I…………………………………………………………...hereby discharge the therapist/counsellor…………………………………………………..….of any contractual obligation. I am completely aware of the modalities of therapy and I am giving the therapist the authority to work on me. I have been explained in detail how the therapy works and I have been duly informed about the modality and the functioning of the therapy. I understand the limitations of the therapy and understand that the result of the therapy also depends upon a lot of external factors and my efforts.

I am also giving the consent to document my case and use it as a part of research work.

SIGNATURE:__________________________

II. Personal Report of Public Speaking Anxiety (PRPSA)

Directions: Below are 34 statements that people sometimes make about themselves. Please indicate whether or not you believe each statement applies to you by marking whether you:

1=Strongly Disagree

2=Disagree

3=Neutral

4=Agree

5=Strongly Agree

_____1. While preparing for giving a speech, I feel tense and nervous.

_____2. I feel tense when I see the words "speech" and "public speech" on a course outline when studying.

_____ 3. My thoughts become confused and jumbled when I am giving a speech.

_____ 4. Right after giving a speech I feel that I have had a pleasant experience.

_____ 5. I get anxious when I think about a speech coming up.

_____ 6. I have no fear of giving a speech.

_____ 7. Although I am nervous just before starting a speech, I soon settle down after starting and feel calm and comfortable.

_____ 8. I look forward to giving a speech.

_____ 9. When the instructor announces a speaking assignment in class, I can feel myself getting tense.

_____ 10. My hands tremble when I am giving a speech

_____ 11. I feel relaxed while giving a speech.

_____ 12. I enjoy preparing for a speech.

_____ 13. I am in constant fear of forgetting what I prepared to say.

_____ 14. I get anxious if someone asks me something about my topic that I don't know.

_____ 15. I face the prospect of giving a speech with confidence.

_____ 16. I feel that I am in complete possession of myself while giving a speech.

_____ 17. My mind is clear when giving a speech.

_____ 18. I do not dread giving a speech.

_____ 19. I perspire just before starting a speech.

_____ 20. My heart beats very fast just as I start a speech.

_____ 21. I experience considerable anxiety while sitting in the room just before my speech starts.

_____ 22. Certain parts of my body feel very tense and rigid while giving a speech.

_____ 23. Realizing that only a little time remains in a speech makes me very tense and anxious.

_____ 24. While giving a speech, I know I can control my feelings of tension and stress.

_____ 25. I breathe faster just before starting a speech.

_____ 26. I feel comfortable and relaxed in the hour or so just before giving a speech.

_____ 27. I do poorer on speeches because I am anxious.

_____ 28. I feel anxious when the teacher announces the date of a speaking assignment.

_____ 29. When I make a mistake while giving a speech, I find it hard to concentrate on the parts that follow.

_____ 30. During an important speech I experience a feeling of helplessness building up inside me.

_____ 31. I have trouble falling asleep the night before a speech.

_____ 32. My heart beats very fast while I present a speech.

_____ 33. I feel anxious while waiting to give my speech.

_____ 34. While giving a speech, I get so nervous I forget facts I really k

III . **Social Interaction Anxiety Scale**

Instructions

In this section, for each item, please circle the number to indicate the degree to which you feel the statement is characteristic or true for you.

	Characteristic	Not at all	Slightly	Moderately	Very	Extremely
01.	I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
02.	I have difficulty making eye contact with others.	0	1	2	3	4
03.	I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
04.	I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
05.	I find it easy to make friends my own age.	0	1	2	3	4
06.	I tense up if I meet an acquaintance in the street.	0	1	2	3	4
07.	When mixing socially, I am uncomfortable.	0	1	2	3	4
08.	I feel tense when I am alone with just one person.	0	1	2	3	4

09.	I am at ease meeting people at parties, etc.	0	1	2	3	4
10.	I have difficulty talking with other people.	0	1	2	3	4
11.	I find it easy to think of things to talk about.	0	1	2	3	4
12.	I worry about expressing myself in case I appear awkward.	0	1	2	3	4
13.	I find it difficult to disagree with another's point of view.	0	1	2	3	4

Characteristic		Not at all	Slightly	Moderately	Very	Extremely
14.	I have difficulty talking to attractive persons of the opposite sex.	0	1	2	3	4
15.	I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4
16.	I am nervous mixing with people I don't know well.	0	1	2	3	4
17.	I feel I'll say something embarrassing when talking.	0	1	2	3	4
18.	When mixing in a group, I find myself worrying I will	0	1	2	3	4

	be ignored.					
19.	I am tense mixing in a group.	0	1	2	3	4
20.	I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

TOTAL SCORE ________

III. ROSENBERG SELF-ESTEEM SCALE

Instructions: Below is a list of statements dealing with your general feelings about yourself.

Characteristics	Strongly agree	Agree	Disagree	Strongly disagree
1. On the whole, I am satisfied with myself.				
2.* At times, I think I am no good at all.				
3. I feel that I have a number of good qualities.				
4. I am able to do things as well as most other people.				
5.* I feel I do not have much to be proud of.	Strongly agree	Agree	Disagree	Strongly disagree
6.* I certainly feel useless at times.				
7. I feel that I'm a person of worth, at least equal to.				
8.* I wish I could have more respect for myself.				
9.* All in all, I am inclined to feel that I'm a failure.				
10. I take a positive attitude toward myself.				

TOTAL SCORE ____

V. LIFE HISTORY QUESTIONNAIRE

GENERAL INFORMATION

DATE______________

Name:____

____

Address:____

____

ContactNo._____________Age:_______

Occupation:_____________________________

Date of birth: ___________ Religion: ______________

Height: ______ Weight: ___ Does your weight fluctuate? __No __Yes.

Relationship status (check one) ____ Single ___ Committed ___ Married

Do you live in: ___ House ___ Room ___ Apartment________ Others

With whom do you live? (Check all that apply) ___Self ___Parents ___ Spouse ___ Roommate____Friend(s) _____________________Others

What are you studying now? _____________________________

Are you satisfied with your present study? ____ Yes ____ No

If no, please explain the reason: ____

Have you been in therapy before or received any professional assistance for yourself?

Yes ___ No ___

Have you ever been hospitalised for psychological/psychiatric problems? Yes ___ No ____

If yes, then when and where? ____

Have you ever attempted suicide? _____ Yes ____ No

Does any member of your family suffer from an "emotional" or "mental" disorder? ____Yes ___No

Has any relative attempted or committed suicide? ___Yes ___ No

PERSONAL & SOCIAL HISTORY

Father's Name: ____ Age: __________

Occupation: __________________________________ Health: ___________________________

If deceased, give his age at time of death: ___________ How old were you at that time? ______

Cause of death: ____

Mother's Name: ____ Age: _________

Occupation: __________________________________ Health: ____________________________

If deceased, give his age at time of death: ___________ How old were you at that time? ________

Cause of death: ____

Sibling(s): Age(s) of brother(s)______________________ Age(s) of sister(s) _______________

Give a description of your father's (or father's substitute) personality and his attitude towards you (past or present)?

Give a description of your mother's (or mother's substitute) personality and her attitude towards you (past or present)?

____
____

In what ways were you disciplined or punished by your parents?

Give an impression of your home atmosphere (i.e. the home in which you grew up). Mention state of compatibility between parents and between children.

____
____

Were you able to confide in your parents? ____Yes ____No

Basically, did you feel loved and respected by your parents? ____Yes ____No.

Scholastic strengths:

____
____
____

Scholastic weaknesses:

____

-

____

____

Check any of the following that applied during your childhood/adolescence

-- Happy childhood -- Not enough friends -- Sexually abused

-- Unhappy childhood -- School friends --Severely punishes or teased

-- Emotional/behaviour problems -- Financial problem -- Eating disorders

-- Legal trouble --Strong religious convictions

-- Death in family -- Drug use

-- Medical problems -- Used alcohol

-- Ignored -- Severely punished

Others _______

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problems:

____

____

____

____

On the scale below, please estimate the severity of your problems:

__Mildly upsetting __Moderately upsetting __Very severe __Extremely severe __Totally in capacitating.

When did your problem begin?

____

____

____

What seems to worsen your problems?

____

_____________What have you tried that has been helpful?____

How satisfied are you with your life, as a whole, these days?

Not at all satisfied 1 2 3 4 5 6 7 Very satisfied

How would you rate your overall level of tension during the last month?

Relaxed 1 2 3 4 5 6 7 Tense

EXPECTATIONS REGARDING THERAPY

In a few words, what do you think the therapy is all about?

____

____

____

How long do you think your therapy should last?

____

____

____

What personal qualities do you think the ideal therapist should possess?

____

____

____

MODALITY ANALYSIS OF CURRENT PROBLEMS

BEHAVIOURS

Check any of the following behaviours that often applies to you.

-- Over-eat	-- Loss of control	-- Phobic avoidance
-- Take drugs	-- Suicidal attempts	-- Spend too much money
-- Odd behaviour	-- Outbursts of temper	-- Smoke
-- Drink too much	-- Withdrawal	-- Take too many risks
-- Work too hard	-- Nervous ties	-- Lazy
-- Procrastination	-- Concentration difficulties	-- Eating problems
-- Impulsive reactions	-- Sleep disturbance	-- Aggressive behaviour
-- Insomnia	-- Unassertive	-- Crying
-- Can't keep a job	-- Compulsions	Others______________

What are some special talents or skills that you feel proud of?

____

____

____

What would you like to start doing?

____

____

____

What would you like to stop doing?

____

____

How is your free time spent?

____

____

____

What kind of hobbies or leisure activities do you enjoy or find relaxing?

____

____

____

Do you have trouble relaxing or enjoying weekend and vacations? __Yes __No

If yes, please explain:

____

____

____

____

If you could have any two wishes, what would they be?

1.)____

____________2.)____

____

FEELINGS

Check any of the following that often apply to you?

-- Angry -- Energetic -- Hopeless -- Restless

-- Annoyed -- Envious -- Hopeful -- Lonely

-- Sad -- Guilty -- Helpless -- Contented

-- Depressed -- happy -- Relaxed -- Excited

-- Anxious -- Conflicted -- Jealous -- Optimistic

-- Fearful -- Shameful -- Unhappy -- Tense

-- Panicky -- Regretful -- Bored

Others________________________

List your five main fears:

1} ____

2} ____

3} ____

4} ____

5} ____

What are some positive feelings you have experiences recently?

____

____

____

When are you most likely to lose control of your feeling?

____

____

____

Describe any situation that makes you feel calm or relaxed.

____

____

____

PHYSICAL SENSATIONS

Check any of the following physical sensations that often apply to you.

-- Abdominal pain -- Bowel disturbances -- Hear things
--- Blackout -- Pain or burning with urination -- Tingling

-- Watery eyes -- Excess swearing -- Visual

-- Menstrual difficulties -- Numbness --
Nausea -- Flushes disturbance -- Headaches
-- Stomach trouble

-- Hearing problems -- Tics -- Skin
problems

-- Dizziness -- Palpitations -- Fatigue

-- Dry mouth -- Muscle spasms -- Twitches

-- Burning or itching skin -- Tension -- Back
pain

-- Chest pains -- Sexual disturbances -- Tremors

-- Rapid heartbeat -- Unable to relax -- Fainting spells

-- Don't like to be touched Others____________________________

What sensations are:

Pleasant for you?

____

Unpleasant for you?

____

IMAGES

Check any of the following that applies to you.

I picture myself:

-- Being happy -- Being talked about -- Being trapped

-- Being hurt -- Being aggressive -- Being laughed at

-- Not coping -- Being helpless -- Being promiscuous

-- Succeeding -- Hurting others

-- Losing control -- Being in change

-- Being followed -- Failing

Others:______________________

I have:

-- Pleasant sexual images -- Seduction images

-- Unpleasant childhood images -- Images of being loved

-- Negative body image -- Unpleasant sexual images -- Lonely images

Others: ___________________________

Describe a very pleasant image, mental picture or fantasy.

____

____

____

Describe a very unpleasant image, mental picture or fantasy.

____

____

____

Describe your image of a completely "safe place".

____

____

____

Describe any persistent or disturbing images that interfere with your daily functioning.

____

____

__________________________How often do you have nightmares?

____

THOUGHTS

Check each of the following that you might use to describe yourself.

-- Intelligent	-- A nobody	-- Inadequate
-- Concentration difficulties	-- Lazy	-- Confident
-- Useless	-- Confused	
-- Memory problems	-- Untrustworthy	-- Worthwhile
-- Evil	-- Ugly	-- Attractive
-- Dishonest	-- Ambitious	-- Crazy
-- Stupid	-- Can't make decisions	-- Sensitive
-- Morally degenerate	-- Naive	-- Suicidal ideas
-- Loyal	-- Considerate	-- Honest
-- Persevering	-- Horrible thoughts	-- Hard working
-- Trustworthy	-- Unlovable	-- Incompetent
-- Good sense of humour	-- Conflicted	-- Undesirable

-- Full of regrets -- Unattractive -- Worthless

What do you consider to be your craziest thought or idea?

____

____

____

____

Are you bothered by thoughts that occur over and over again? __Yes __No

If yes, what are these thoughts?

____

____

____

What worries do you have that may negatively affect your mood or behaviour?

____

____

____

On each of the following items, please circle the number that most accurately effects your opinion?

Strongly disagree(1), disagree(2), neutral(3), agree(4), strongly agree(5)

I should not make mistakes. 1 2 3 4
5

I should be good at everything I do. 1 2 3 4
5

When I don't know something, I should pretend that I do. 1 2 3 4
5

I should not disclose personal information. 1 2 3 4
5

I am a victim of circumstances. 1 2 3
4 5

My life is controlled by outside forces. 1 2 3
4 5

Other people are happier than I am. 1 2 3 4
5

It is very important to please others. 1 2 3 4
5

Play it safe; don’t take any risks. 1 2 3
4 5

I don’t deserve to be happy. 1 2 3 4
5

If I ignore my problems, they will disappear. 1 2 3 4
5

It is my responsibility to make other people happy. 1 2 3 4
5

I should strive for perfection. 1 2 3 4
5

There are two ways of doing things-the right and the wrong ways. 1 2 3
4 5 I should never be upset.
1 2 3 4 5

INTERPERSONAL RELATIONSHIPS

FRIENDSHIPS

Do you make friends easily? __Yes __No Do you keep them? __Yes __No

Did you date much during your high school? __Yes __No College __Yes __No

Were you ever bullied or severely teased? __Yes __No

Describe any relationship that gives you:

JOY:

____

____

____

____

GRIEF:

____

____

____

Rate the degree to which you generally feel relaxed and comfortable in social situations.

Very relaxed 1 2 3 4 5 6 7 Very anxious.

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts? __Yes __No

How do you get along with your partners' friends and family?

Very poorly 1 2 3 4 5 6 7 Very well.

Do you have any sexual concerns?

____

_____________Please complete the following:

One of the ways people hurt me is:

____

____

____

My best friend (or boyfriend/ girlfriend) would describe me as:

____

____

____

My best friend thinks I am :

____

____

____

People who dislike me:

____

____

____

Are you troubled by any past rejections or loss of a love relationship? __Yes __No

If yes, please explain:

____

____

____

Biological factors

Do you have any current concerns about your physical health? __Yes __No

If yes, please specify:

____

____

____

Please list any medications you are currently taking:

____

____

____

Do you eat three well balanced meals every day? __Yes __No

Do you get regular physical exercise? __Yes __No

Is yes, what type and how often?

____

____

____

Please list any significant medical problems that apply to you or to members of your family.

Structural Profile Inventory

Name……………………………………………...…….   Date……………….

1.) BEHAVIOUR

On the scale below, circle the number that best reflects that how much of a doer are you?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

In the space below, try to make a note of at least one specific behaviour that you would like to do less of, and also one specific behaviour you would like to do more of.

 I would like to do less (or stop):

 I would like to do more (or start):

2.) AFFECT

On the scale below, circle the number that best reflects that how emotional are you? How deeply do you feel things?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

In the space below, try to make a note of at least one emotion you would like to feel less of, and at least one emotion you would like to experience more often.

 I would like to feel less:

 I would like to experience more:

3.) SENSATION

On the scale below, circle the number that best reflects that how aware are you of your bodily sensations?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

Below, make a note of some sensations you would like to experience less of and more of:

 I would like to experience less:

□ *I would like to experience more:*

4.) IMAGERY

On the scale below, circle the number that best reflects that how much fantasy or daydreaming do you engage in? how imaginative are you?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

Make a note below of at least one thing, event or situation you would like to imagine less of and at least one thing you would like to imagine more.

□ *I would like to imagine less:*

□ *I would like to imagine more:*

5.) COGNITION

On the scale below, circle the number that best reflects that how much of a thinker are you?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

Below, try to make a note of some cognitions you would like to have less often and some thoughts you would like to have more often.

□ *I would like to think less:*

□ *I would like to think more:*

6.) INTERPERSONAL RELATIONSHIPS

On the scale below, circle the number that best reflects that how important are other people to you? How important are close friendships to you? How important is the desire for intimacy?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

Below, try to note some interpersonal or social activities you would like to decrease and others you would like to increase.

 I would like to decrease:

 I would like to increase:

7.) DRUGS / BIOLOGAL / HEALTH FACTORS

On the scale below, circle the number that best reflects, what extend are you health conscious? Do you avoid bad habits like smoking, too much alcohol or caffeine, overeating etc.? Do you exercise regularly, get enough sleep, limit junk food and generally take care of your body?

Very little			*Moderately*			*Very much*
1	*2*	*3*	*4*	*5*	*6*	*7*

Below, note some things concerning biological factors that you would like to decrease and some things relating to biology you would like to increase.

 I would like to decrease:

 I would like to increase:

VI. Sample of Subjective Unit of Distress

BEHAVIOUR

• Procrastination	1 2 3 4 5 6 7 8 9 10
• Concentration difficulties	1 2 3 4 5 6 7 8 9 10
• Phobic avoidance	1 2 3 4 5 6 7 8 9 10
• Lazy	1 2 3 4 5 6 7 8 9 10
• Outbursts of temper	1 2 3 4 5 6 7 8 9 10
• Impulsive reactions	1 2 3 4 5 6 7 8 9 10
• Crying	1 2 3 4 5 6 7 8 9 10

AFFECT

• Angry	1 2 3 4 5 6 7 8 9 10
• Annoyed	1 2 3 4 5 6 7 8 9 10
• Sad	1 2 3 4 5 6 7 8 9 10
• Depressed	1 2 3 4 5 6 7 8 9 10
• Anxious	1 2 3 4 5 6 7 8 9 10
• Guilty	1 2 3 4 5 6 7 8 9 10
• Regretful	1 2 3 4 5 6 7 8 9 10
• Helpless	1 2 3 4 5 6 7 8 9 10
• Bored	1 2 3 4 5 6 7 8 9 10
• Lonely	1 2 3 4 5 6 7 8 9 10
• Tense	1 2 3 4 5 6 7 8 9 10

SENSATION

• Watery eyes	1 2 3 4 5 6 7 8 9 10
• Rapid heartbeat	1 2 3 4 5 6 7 8 9 10
• Tics	1 2 3 4 5 6 7 8 9 10

IMAGERY

• Being hurt • Being helpless • Failing • Being laughed	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

COGNITION

• Lazy • Unlovable • Ugly • A nobody	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

VII. FEEDBACK FORM

NAME: ____

1.) My counsellor accepted what I said without judging

Strongly disagree 1 2 3 4 5 Strongly agree

2.) My counsellor listened to me effectively.

Strongly disagree 1 2 3 4 5 Strongly agree

3.) My counsellor fostered a safe and trusting environment.

Strongly disagree 1 2 3 4 5 Strongly agree

4.) The sessions with my counsellor helped me with whatever originally led me to seek counselling.

Strongly disagree 1 2 3 4 5 Strongly agree

5.) I am satisfied with the quality of service provided.

Strongly disagree 1 2 3 4 5 Strongly agree