CHAPTER - I

Introduction
Man is inextricably linked with others. Although at birth the umbilical cord connecting the infant with the mother is severed, he continues to draw sustenance from her and through her. The survival arranged bonds the child to an external human entity from the very beginning and as his journey of life continues, this connection to others become enlarged and richer. The acquisition of psychogenic needs are a part of this interaction and these social forces become so powerful that they sometimes gain precedence over our biological existence.

The human identity is acquired by the homosapien through the process of socialization. The need to communicate with others gives birth to language, social behaviors and a system of group and community existence. As an individual and as a group, humans have survived the onslaughts of nature, calamities and crises through interactions, integrated endeavors and a group life.

Individuals may vary in their personality characteristics of sociability and enjoyment of group activities, but withdrawal from others is viewed with serious concern by health psychologists and society. It may be indicative of full-blown pathology or a symptomatic precipitating factor of a behavior problem. Depression and schizophrenia are highlighted by an aloof, withdrawn behavior. The desire to understand the dynamics of loneliness is evident in recent psychological research and literature. To understand it fully, its relationship with personality and socio psychological factors is necessary. Some of these factors may be those, which encourage or lead to loneliness.
and some may be the outcomes of that experience. It is important to review the current position about the concept of loneliness and research findings in the area in order to focus on factors, which should be studied in its context to elicit maximally useful information.

Loneliness is a painful awareness of feeling not connected (detached or unconnected) with others and a realization that important needs are not being met. These needs may be the need to develop a circle of friends or a special relationship. People need people. Mutual relationships are essential to health. The Swiss psychiatrist Paul Townier (1998) said, "Loneliness is the most devastating malady of this age".

Loneliness restricts the opportunities for warmth, understanding and sharing of feelings and thoughts with others. Loneliness can mean:

a) Feeling that one is unacceptable, unloved by those around, not worthwhile (even if others don't share these perceptions).

b) Feeling alienated from one's surroundings; lacking the attachments which one had in the past.

c) Feeling that there is no one with whom to share personal concerns and experiences.

d) Feeling that one is alone and the choice otherwise is not there. One finds it difficult to make friends and go beyond mere acquaintance.
Loneliness should be differentiated from solitude. Solitude may be good, one sometime needs to be alone, in fact enjoys being alone but this is an example of being alone without being and feeling lonely. Situation like enjoying a good book, writing poetry, relaxing in the garden are also examples of aloneness without loneliness. Loneliness is not just isolation, it is insulation, the feeling of being cut off. It is a feeling of being unnoticed, unloved, uncared for, unneeded, maybe even unnecessary. That is loneliness. Everybody needs somebody to love and share intimacy with. Everybody needs someone who can understand them and their feelings. Everybody needs to be needed and wanted.

Loneliness is considered a serious problem in today's society (Peplau and Perlman, 1982; Rotenberg, 1994). It has been linked to depression, suicide alcoholism, substance abuse, and dropping out of school (Rotenberg, 1994). Marshall (1989) has observed that parental behaviors which exclude secure emotional attachments, that is encourage emotional loneliness, lead to delinquent and aggressive behaviors in adolescence and adulthood. Seidman, Mashal, Hudson and Robertson (1994) suggested that poor quality of childhood attachments may lead to deficiencies in adult intimacy and consequently to loneliness. Berg and Peplau (1982) found that lonely people frequently report that their relationships with others are not only superficial, but that others do not understand or seem to care about them. Focusing on the negative implications of loneliness; Marshall (1982) saw alienation and lack of intimacy as critical in the development of criminality in general and
sexual offending in particular. Calabrese and Adams (1990) even suggested that alienation has long been used to explain deviant behavior, be it sexually oriented or otherwise.

The findings of Renshaw and Brown (1993) connect loneliness with low peer acceptance and internal-stable attribution style. Chronic feelings of loneliness appear to have roots in childhood and early attachment processes (Ernst and Cacioppo, 1999). Lonely individuals are more likely to be high in negative affectivity, act in a socially withdrawn fashion, lack trust in self and others feel little control over success or failure and generally be dissatisfied with their relationships. Loneliness has been associated with a variety of individual differences and is also a concomitant of more severe disorders.

Rokash and Brock (1997a) conducted a study, which probed into the multidimensionality of loneliness. Five factors, emerged as components of the experience of loneliness:

1. Emotional distress, which accounted for 19% of the variance, addressed the intense pain, inner turmoil, hopelessness, and feeling of emptiness associated with loneliness.

2. Social inadequacy and alienation accounted for 7% of the variance, and highlighted the social alienation and concomitant self generated social detachment.

3. Growth and discovery accounting for 4% of variance, focused on the positive, growth-enhancing and enriching aspects of the
loneliness experience and the subsequent increase in feelings of inner strength.

4. Interpersonal isolation 3% variance, addressed feelings of alienation, abandonment and rejection, which were reported to relate to a general lack of close relationships, or absence of a primary romantic relationship.

5. Self-alienation 3% variance, focused on the detachment from oneself characterized by numbness, immobilization and denial.

In all, these factors accounted for 36% of the common variance, with the remaining variance being attributed to personal factors, characteristics and experiences.

Loneliness has been shown to consist of at least two distinct dimensions that are referred to by Weiss (1987) as emotional isolation – seen as the absence of an attachment figure in one's life and social isolation – regarded as the absence of a place in an accepting community. The distinction between social and emotional loneliness is based on the nature of the social deficit and is clearly one of the most influential distinctions in loneliness literature. Peplau and Perlman (1982) examined and viewed loneliness as an affective state in which the individual is aware of being apart from others and apart from familiar support networks (or) systems. Still others (e.g. Sadler and Johnson, 1980 and Ellison, 1978) have discussed such types of loneliness as self-estrangement and / or existential loneliness. Existential
loneliness may be more tied to the lack of religion (or) meaning in life than to a lack of interpersonal bond. It would perhaps overlap with ‘noogenic neurosis’, which has been emphasized by Frankl (1950).

Polansky (1985) has opined that “loneliness is a nearly universal human emotion – where all, but the most fortunate – are subject to it”. Young (1980) defines loneliness as the absence of satisfactory social relationships. Russell, Peplau and Cutrona (1980) consider loneliness as reflecting interpersonal and social relationships.

Cacippo, Ernst, Burleson and Mc-Clintock (2000) explain loneliness as a complex set of feelings encompassing reactions to unfulfilled intimate and social needs. Although transient for some individuals, it can be a chronic state for others. The authors examined differences between lonely and socially embedded individuals that might explain differences in health outcomes. Satisfying social relationships were associated with more positive outlooks on life, more secure attachments and interactions with others, more autonomic activation when confronting acute psychological challenges. The more chronically lonely were characterized by elevated mean salivary cortisol levels across the course of a day, suggesting more discharges of corticotrophin-releasing hormone and elevated activation of the hypothalamic pituitary-adrenocortical axis. An experimental manipulation of loneliness further suggested that the way in which people construe their self in relation to others around them has powerful effects on their self-concept and possibly on their physiology.
There are two main types of loneliness:

1. Emotional Loneliness, which is defined as the lack of intimate relationships leading to over sensitivity and restlessness.

2. Social Loneliness which deals with the lack of an available social network giving rise to feelings of meaningless, worthlessness and boredom.

Loneliness is often associated with emotional disorders such as depression or anxiety. In fact, there is a very thin line separating chronic loneliness and mild depression. The symptoms a lonely person might feel are separation or isolation from others, alienation by others, a sense of being unloved or uncared for, and the need for friendship.

According to Lake (1980) there are certain negative effects of loneliness. Lonely people often report feeling depressed, angry, afraid and misunderstood. If one is lonely one may become highly critical of oneself, overly sensitive or self-pitying, or critical of others. There is a tendency to engage in behaviors such as the following that perpetuate the problem:

- Perceiving one’s self in a negative way. For example, one may become overly critical of one’s physical appearance.

- Blaming one’s self and others for poor social relationships and falsely assuming that one is not liked by anyone.
- Not making any attempt to get involved in social activities, but expecting that everyone admired and liked will include you in their activities and conversations.

- Tendency to see things out of proportion or over react to situations.

- Becoming self-conscious and worrying unnecessarily about being evaluated by others.

- Avoiding social risks, meeting people and new situations. One has difficulty introducing one's self, making telephone calls and participating in group activities.

Loneliness is a feeling of being left alone. This feeling has its basis in interpersonal dissatisfaction or breakdown. Loneliness can also be based on distortion and relationships i.e., one does not get what one expects out of the relationship. 'Peplau and Perlman (1979)' are of the opinion that there is a discrepancy between one's desired and one's actual relationship which lead to loneliness. The distortion and discrepancy of relationships is based on the classical fact that human beings have a need for intimacy. This need is projected of various social contact levels. When this need is not fulfilled due to cognitive processes of attribution, interpersonal deficiency and heightened emotional response to this deficiency, the result and feelings, thoughts and behavior is loneliness.
Peplau and Perlman go on to say that there are four approaches in typing out the forms of loneliness:

1. Loneliness can be first manifested as an anxiety, which has aversive results. Maustakes (1961) is of the opinion that this is a basic "alienation" among human beings. However loneliness as the existential concept can be positively forced isolation leading to self-growth. Loneliness hence can lead to destructive and constructive activities.

2. Loneliness can also be temporary. Shifting into new environment leads to loneliness, which is ended as soon as one settles and adapts to the environment. It can be permanent or chronic where the person finds solace and satisfaction in his or her lonely state.

3. Social deficiency loneliness has to be differentiated from emotional loneliness. According to Weiss (1971) the former refers to a sense of community, which is lacking in lonely people; and the latter refers to a lack of personal relationship.

4. Loneliness is not just an intense emotion rather it is a behavior. This approach takes into account the fatalism and lack of assertive behavior in a lonely person. Loneliness is also characterized by severe lack of communication skills. The lonely person just cannot communicate what he / she feels to others.
Loneliness in the elderly is generally characterized by emptiness, isolation and alienation. The causes of loneliness are numerous, of which a few according to Perien et. al. (1970) are widowhood, housing dissatisfaction, decreased income, having fewer close friends and contacts. There is a marked decline in life satisfaction also. These factors coupled with marked physical decline lead to loneliness. Loneliness is rather a personal and social problem. Techniques for alleviation include finding newer areas of social interaction and arranging new activities to overcome loneliness. However, the loneliness to which the elderly are subjected appears to be related more to the compulsion of circumstances than to a preference exercised by them. But the search for strategies to alleviate it is a priority concern of civilized and compassionate societies.

An area of great importance for the psychologist is to study the individual's socio psychological repertoire of behaviors, which may contribute to phenomena like loneliness. If certain factors are found to encourage withdrawn, lonely behavior and these factors can be modified or influenced it would serve as an importance purpose.

Therefore study of factors, which would in all likelihood enhance loneliness, should be undertaken.

The factors of anxiety sensitivity, Competence and Anger directions may have great relevance in the experience of loneliness. To understand how anxiety sensitivity may influence loneliness, it is necessary to explain the phenomena, particularly since it is a relatively new concept.
Research over the last seventeen years had led to the discovery of a psychological factor called anxiety sensitivity. Anxiety sensitivity is the fear of anxiety sensations, which arises from beliefs that these sensations have harmful somatic, social or psychological consequences. However, there is a lot of difference between anxiety (frequency of symptom occurrence) and anxiety sensitivity (beliefs that anxiety experiences have negative implications).

Fenichel (1945) observed that some people with anxiety disorders "develop a 'fear of anxiety ' and simultaneously a readiness to become frightened very easily...." Evans (1972) reported the case history of a woman who feared recurrent panic attack whenever she had to eat in the presence of others.

Concepts of the fear of fear have been proposed by Goldstein and Chambless (1978) and by Reiss and Mc Nally (1985). Reiss and Mc Nally (1985) have analyzed the fear of fear into two component processes called anxiety expectancy and anxiety sensitivity. Anxiety expectancy is primarily an associative learning process in which the individual has learned that a given stimulus arouses anxiety or fear. Anxiety sensitivity is an individual difference variable consisting of beliefs that the experience of anxiety or fear causes illness, embarrassment or additional anxiety. For example, the person may believe that a pounding heart is a sign of an impending heart attack of that it can be terribly embarrassing to have a growling stomach. Anxiety sensitivity should increase alertness to stimuli signaling the possibility of becoming
anxious, increase worry about the possibility of becoming anxious, and increase motivation to avoid anxiety-provoking stimuli.

The Reiss and McNally position build upon the prior Goldstein and Chambless position but also departs from it. One difference concerns the role of panic experience in the fear of fear. Goldstein and Chambless regard the fear of fear as the consequence of panic experiences, whereas Reiss and McNally regard the fear of fear as the consequence of several factors, which include panic experiences, but also other factors like biological constitution and personality needs to avoid embarrassment, to avoid illness or to maintain control. A history of panic attacks may strengthen anxiety sensitivity by providing examples of frightening anxiety experiences. However, a history of panic experiences is not necessary for the acquisition of negative belief about the effects of anxiety.

Reiss and McNally (1985) first proposed the concept of anxiety sensitivity. Many researchers viewed the fear of anxiety as a secondary consequence of panic attacks. For example, many researchers accepted the hypothesis of introspective conditioning, which holds that a fear of anxiety develops when people who have initial panic attacks learn to fear the recurrence of those attacks (Goldstein and Chambless, 1978). In contrast, Reiss and McNally (1985) proposed that the fear of anxiety (anxiety sensitivity) might constitute a cognitive risk factor for the development of panic disorder. The anxiety sensitivity position holds that the fear of anxiety can precede panic disorder, at least in some cases.
Although there are overlapping and similarities in the concept of anxiety sensitivity and panic disorder, and anxiety sensitivity and anxiety disorder, if we look at the picture critically we find that anxiety sensitivity has certain distinctive features, which set it apart from panic disorder and anxiety disorder. It may be a predisposition for both, it may come into existence as a part of the experiential impact of anxiety and panic but the cognitive component, which is so vitally related to anxiety sensitivity, sets it apart.

It is possible that the anxiety sensitivity is causally related to the development of anxiety disorders. Anxiety sensitivity should increase the negative valence (aversive ness) of anxiety experiences. For examples, anxiety should be more likely to grow in magnitude for an individual who believes that anxiety causes heart attack than for someone who does not share this belief. Beck and Emery (1979) observed that, "as anxiety attacks recur, the victim becomes to dread the unpleasant symptoms of anxiety almost as much as the precipitating causes...."

Reiss and Mc Nally (1985) outlined an expectancy model of fear based on a new concept of the fear of fear, called anxiety sensitivity. Because anxiety sensitivity was defined as a personality factor that enhances the person's conditionability for fear, the concept has similarities to Eysenck's concept of neuroticism (Rachman, in press). Because anxiety sensitivity was defined in terms of irrational beliefs, the concept has similarities to Ellis's (1979) concept of discomfort anxiety and to Clark's (1986) theory of panic. There also is some similarity between the concept of anxiety sensitivity and
Rescorla and Wagner's (1972) concept of the "reinforcing effectiveness" of an Unconditional Stimulus (UCS). Specifically anxiety sensitivity is seen as enhancing the reinforcing effectiveness of the sensations of anxiety.

The expectancy theory, developed in 1985 by psychologists Reiss, and McNally in collaboration with George Washington University psychologist Peterson argues that the person does not need to have a panic attack to develop a fear of anxiety symptoms.

Reiss expectancy theory holds that human motivation to avoid a feared object is a function of two classes of variables, called expectation and sensitivity. Expectation refers to what the person thinks will happen when the feared object / situation is encountered (example, "I expect the plane will crash," "I expect to have a panic attack during flight," "I expect other people will notice my fear of flying"). Sensitivity refers to the reason that a person holds for fearing the anticipated events (example, "I can't stand the thought of being handicapped," "panic attacks cause heart attacks"). Expectations (what one thinks will happen) and sensitivities (why one is afraid of the anticipated event) theoretically provide the key for understanding human fears.

Reiss expectancy model holds that there are three fundamental fears (called sensitivities): the fear of injury, the fear of anxiety, and the fear of negative evaluation. Thus this model has focused on the fear of anxiety (anxiety sensitivity). The model recognizes a wide range of individual differences in explanations regarding a particular object or situation (Gursky and Reiss, 1987; Rachman and Lopatka, 1986). For example, some people
boarding an airplane will think that there is a chance that the plane will crash, whereas others think there is virtually no chance of a crash. Some people think there is a substantial likelihood that an airplane flight will cause them to have a panic attack, experience an upset stomach, or vomit; others dismiss the probability of such events as negligible.

The model also recognizes a wide range of individual differences in people's sensitivities to fear-outcome events. Some people are terrified by fear-outcome events, whereas others do not care. Some people who expect to become anxious and stressed while flying in airplanes dismiss the bodily sensations of anxiety as harmless; other people think that anxiety experiences cause heart attacks and/or mental illness. Some people who anticipate the possibility of a plane crash dismiss the likely consequences of death or injury by telling themselves that God's will is not to be feared. After the plane hijackings and crashes into the WTC building in New York, which brought imaginable tragedy, both immediate, and also future projections of it, it is likely that anxiety sensitivity.

Anxiety sensitivity is a pattern of thinking that can affect health," said Norman Schmidt (1998) associated professor of psychology at Ohio State University. Just having this type of thinking pattern puts a person at greater risk for developing physical or mental impairment. Schmidt conducted the study with Darwin Lerew (1998) in addition to anxiety-sensitivity; the researchers evaluated two other psychological risk factors body vigilance and discomfort intolerance that could lead to psychological or physical impairment.
Body vigilance is the attention people give to bodily sensations, such as symptoms that may indicate health problems. Discomfort intolerance is the degree to which a person can accept unpleasant physical sensations. It goes beyond pain to include all type of unpleasant physical symptoms, such as pressure and numbness.

Someone who is more sensitive to internal bodily changes is going to be at greater risk for identifying a benign internal symptom as dangerous, Schmidt said that someone who doesn’t tolerate unpleasant bodily sensations very well could be at risk for developing an anxiety disorder. Schmidt said the fact that anxiety affected women more than men may have something to do with how males and females interpret stress. Women are at greater risk for anxiety disorders than men and there is some evidence to suggest that gender difference in this particular type of thinking pattern (anxiety sensitivity) may be part of the reason.

Anxiety sensitivity has been reported as fear of anxiety-related sensations or arousal, based on beliefs in harmful consequences of bodily symptoms (Reiss and McNally, 1985). It has been characterized as a heightened anxious response to the perception of physiological sensations caused by a hypervigilant self-monitoring and attention focused on internal physical cues. According to this theory, individuals with a higher level of anxiety sensitivity show a greater proneness in assessing anxiety-related symptoms of threatening, alarming and dangerous. High anxiety sensitivity has also been discussed as a predisposing factor in the development and
maintenance of anxiety disorders and it has shown a strong relationship especially to panic disorder (Schmidt, Lerew, Jackson, 1997; Taylor, Koch, McNally, 1992). Since individuals with higher anxiety sensitivity seem to be more vigilant to subtle changes in physiological sensations, an induction of intense bodily sensations should cause more anxious responding in people who are higher in this trait. Biological challenge producers such as inhalation of carbon-dioxide enriched air as a panicogen trigger are widely used methods in physiological research to investigate physiological and psychological responses in individuals with elevated levels of anxiety sensitivity (Zvolensky, Eifert, Lejuez, McNally, 1999), as well as underlying pathogenic mechanism between different anxiety disorders (Papp et al, 1993).

Anxiety is a part of our lives. It is a normal and protective response to events outside the range of everyday human experience. It helps us to concentrate and focus on tasks. It helps us to avoid dangerous situations. Anxiety also provides motivation to accomplish things that we may otherwise tend to put off.

Since anxiety and anxiety disorder is a very common term, and anxiety sensitivity is a new term so it would be apt to discuss the difference between anxiety and anxiety sensitivity.

Anxiety is a feeling of tension, fear or dread that occurs in response to a real or imagined threat. Anxiety sensitivity refers to individual differences in what people think will happen to them when they actually experience anxiety. Anxiety can be viewed as a momentary emotional response to life situations.
Anxiety sensitivity is a fear of anxiety sensations, which arises from belief that these situations have harmful somatic, social, psychological consequences. The degree of anxiety depends on how serious or severe the person thinks a real or imaginary threat is. Anxiety sensitivity is an individual difference variable consisting of beliefs that the experience of anxiety/fear causes illness, embarrassment or additional anxiety.

Anxiety experience is related primarily with an anxiety provoking stimulus situation, anxiety-sensitivity is related to a cognitive framework which one has acquired, which can provoke a reaction of anxiety in absence of sufficiently powerful stimulus. Anxiety varies in intensity from mild to strong feelings of uneasiness and nervousness. Anxiety sensitivity is not the experience of anxiety, it is an increased alertness to stimuli, (signaling the possibility of becoming anxious, increasing worry about the possibility of becoming anxious and increasing motivation to avoid anxiety-provoking stimuli). Anxiety is associated with a wide range of physical illness. On the other hand, anxiety-sensitivity may be a risk factor for the occurrence of anxiety disorders, particularly panic disorders. Therefore its relation to physical illness may be indirect. It is important to distinguish anxiety sensitivity from trait anxiety. Anxiety sensitivity is defined as the tendency to respond fearfully to anxiety symptoms. This is different than the concept of trait anxiety, which is a tendency to respond fearfully to stressors in general. The distinction becomes less marked if we see the new theory of trait anxiety given by Eysenk, which appears to be inspired by the concept of anxiety-
sensitivity, in fact it has tried to assimilate anxiety-sensitivity in the new version of trait anxiety.

Eysenck (1997) proposed a new theory of trait anxiety, this being a 4-factor theory of anxiety. According to this unified theory, there are four sources of information, which influence the level of anxiety experienced. 1) External stimulation. 2) Internal physiological activity. 3) Internal cognitions. 4) One's own behavior. The unified theory is essentially based on cognitive biases, and is more reflective of the concept of anxiety sensitivity (without actually using the term) than anxiety disorder as such.

According to McNally (1994), anxiety is similar to catastrophic misinterpretation. However, anxiety sensitivity is different because the person does not have to misinterpret anxiety symptoms such as rapid heart rate as something else like a heart attack for panic to occur. They simply must believe that their arousal from anxiety can lead to heart attacks or insanity. In addition, anxiety sensitivity is dispositional, while catastrophic misinterpretation is episodic (Fridhandler, 1986). The concept of anxiety sensitivity was established due in part to observations that intense bodily sensations do not always lead to panic attacks. This fact is demonstrated in studies that found hyperventilation challenges and carbon dioxide inhalation to elicit responses from participants that ranged from terror to pleasure (Clark and Helmsley, 1982).

Anxiety sensitivity is a cognitive, individual-difference variable characterized by fear of anxiety-related sensations. Anxiety
sensitivity is thought to arise from the belief that anxiety-related sensations have harmful physical, psychological, or social consequences. A person high in anxiety sensitivity might worry that an inability to concentrate on a task is a sign of mental illness or that a rapid heartbeat is a sign of an impending heart attack. Cross-sectional and longitudinal studies have suggested that Anxiety sensitivity is central in the development of panic disorder, which has been repeatedly shown to be characterized by elevated anxiety sensitivity levels. As such, researchers see anxiety sensitivity as the cognitive vulnerability factor for panic attacks and panic disorders.

Research on the role of gender in anxiety-sensitivity has revolved around the factorial structure of a popular self-report measure of anxiety sensitivity, the anxiety sensitivity Index (ASI). Factor analyses of the ASI indicate that it comprises of three factors and that these factors are the same across genders.

1. **Physical concerns:** describe the fear of physical symptoms due to the belief that arousal-related bodily sensations are indicative of physical illness.

2. **Psychological concerns:** describe fears of cognitive dyscontrol due to the belief that sensations such as depersonalization are signs of mental illness.

3. **Social concerns:** describe fears of publicly observable, arousal-related experiences due to the belief that displays of anxiety will lead to public
ridicule, embarrassment, and social censure. Although the factorial structure of the ASI is invariant across genders, female's scores higher than males on physical concerns, where as males scores higher on psychological and social concerns.

These findings are supported to some degree by research into gender differences in panic disorder which reveals that the clinical features of panic disorder are similar across genders, although diagnosis of the disorder occurs more than twice as often in women as in men. There is some evidence that pharmacotherapies have yielded better outcomes for females although other studies have found no differences between the genders. At the end of treatment, men and women undergoing cognitive-behavior therapies, such as in vivo exposure, tended to be similar in terms of symptoms and severity. Both genders had approximately equal reductions in panic over the course of therapy. However, women had more frequent panic attacks than men at the beginning and end of treatment. However, although the cause of anxiety-sensitivity has received some empirical attention, limited work has been done on the etiology of gender differences.

A recent behavioral genetic study of the ASI estimated significant heritability on the physical and social concerns factors and on the total ASI scores. The study detected no heritable influences for psychological concerns. Family and twin studies of panic confirm the familial and heritable nature of anxiety sensitivity. Watt and colleagues studied the childhood learning history associated with anxiety sensitivity. Their results suggested
that above-normal levels of anxiety sensitivity may arise from learning to "catastrophize" about an occurrence in bodily symptoms rather than anxiety related symptoms because bodily symptoms elicit greater attention form parents. Unfortunately, the study did not examine gender differences. These studies suggest, however, that both genetic and environmental factors influence anxiety sensitivity.

Understanding of anxiety sensitivity has been greatly advanced due to development of a measure of anxiety sensitivity and evaluation of its psychometric properties. Reiss Peterson, Grusky and Mc Nally (1985) evaluated the relevance of the measure for the psychopathological conditions such as agoraphobia and other anxiety disorders. The relationship between anxiety (frequency of symptom occurrence) and anxiety sensitivity (beliefs that anxiety symptoms have negative effects) were also evaluated by them. Through this effort demonstrated that the measure of anxiety sensitivity is not just another measure of anxiety but actually predicts an important outcome namely fearfulness that cannot be predicted as well by anxiety scales. There is definitely a need to study this variable further and researches, which explore it in the context of various relevant situations, would in fact add to an understanding of the variable itself. Loneliness is one of the dimensions, which may yield information likely to enlarge understanding of anxiety-sensitivity.

As pointed out earlier, loneliness is a precursor, often a symptom of pathology and even if pathology does not occur, it reflects behavior that is not
highly desirable. Therefore if we understand factors that contribute to loneliness, it may help us to manage loneliness. Many conjectures can be made. Perhaps people who are competent are so because they possess interactive skills, which help them to perform better and perhaps people, who are not highly competent or perceive themselves as being so, may withdraw and express behavior that is termed lonely.

Competence is a synthesis of skill, knowledge, and performance. The ability to transform learning into effective and appropriate action is evidence of such competence. Competence is the ability to continue to demonstrate competence throughout one's career. According to the Webster's Collegiate Dictionary, being competent is to possess the quality of having a clear decisive relevance to the matter in hand. According to this definition, a statement saying that an individual is incompetent or competent is not complete because, competent refers to competence for a particular act or task. Thus, just because I do not know how to cook, does not mean I an incompetent person. Competency determination then becomes a determination of a particular person's capacity to perform a particular decision-making task at a particular time and under specified conditions. This decision making competency may involve other factors such as capacity for communication and understanding, the capacity for reasoning and deliberation, and the possession of values or a conception of good, depending upon the nature of the ability which we are talking about. Competence is a concept of great importance in the professional sphere where development in
concept and technique is going on, and a worker has to demonstrate continued competence in order to be useful to organization. Thus, competence is not a static position of achieving something or being something, it is a process towards which the individual has to proceed all the time.

Whites (1959, 1960, 1963) clarifies the concept of competence, and says that it is an effectance motive to "explore the properties of the environment", it leads to an accumulating knowledge of what can and cannot be done with the environment, its biological significance lies in this very property of developing competence.

Smith (1969) has penetratingly analyzed and summarized the theoretical positions and research in the area. The traits which have been cited as indices of competence are also those generally ascribed to psychological health. Self-confidence, self-esteem, assertiveness, self-reliance, self control, buoyancy, affiliativeness, realistic openness to experience, tolerance, principled responsibility, initiative, feelings of control over impulses, clarity about identity, determination, problem solving attitude are traits through which research and theory define competence.

Smith (1968) believes that central to the concept of Competence, is a constellation of attitudes towards one's self based on the belief that one has control of one's own life, that one is an "origin" and not a "pawn" to use De Charms distinction (1968). Clausen (1968) says, "I.... expect that highly competent persons would, in general, be characterized as self-confident,
dependable, and responsible, open to experience, and tolerant and understanding. White (1971) identified competent preschool children as those who anticipate consequences, plan and take the perspective of another, traits similar to those predicted by the model of maturing.

White (1959, 1960, 1963) competence refers to effectiveness in relating to some specific environmental expectation or task. To identify competence requires that we evaluate a person’s level of skill in relation to what is required by the task. What Smith (1969) calls a core competence factor turns out for empirical and theoretical reasons, to be similar to his definition of maturity. The best predictor of the rated competence of men in their early thirties, whether as husbands, fathers or workers, was their psychological maturity. While not equivalent, maturity and competence are not exclusive of each other. To function competently requires some developed skills, motives, ideas about one’s capabilities and or interpersonal skills. Different roles and tasks differ widely in the degree to which they require different levels and patterns of maturing for their effective accomplishment.

Smith (1969) goes on to say that the competent self, is a core of interrelated traits that mediate effective adaptation over a very wide range of different task roles and this he proposes may be transculturally universal. Smith’s emphasis on autonomy may neglect the importance of values as well as types of mature adaptative skills. The process of adaptation that effectively defines competence may be systematizable, deeply general, and hold across many different tasks as well as situations and culture. The model of maturing,
therefore, may provide a systematic basis for Smith's idea of a "competent self." An important implication is that to further a person's competence one should find ways to enhance his maturity.

White (1959, 1960, 1963) has noted that competence enhances one's self-esteem as well as facilitates the shift in dependence on others for approval to one's own (autonomous) judgment or self-approval. Competence has been used as a motive by White to refer to the desire to be efficacious and create effects on the environment. Competence has also been used as a behaviorally evaluative term referring to the effectiveness with which a person functions. Competence as an evaluative term becomes useful to a scientific theory of personality only as it becomes determined less by situational and more by stable personality traits.

The theoretical status of competence and its relation to the model of maturing however remains unclear because, although competence is defined by several referents, nowhere it is operationally defined.

Competence is not a probability of success in the execution of one's job; it is a real and demonstrated capability. It is a social construction of significant, useful lessons for the productive performance in an actual working situation, which is attained not only through instruction, but also and to a great extent through learning by experience in specific job situations. Competencies define the effective exercise of capabilities that allow for the performance of an occupation, with regard to the levels required for the job. It is more than the technical knowledge, which makes reference to informational knowledge and
know-how. The concept of competence encompasses not only the abilities required for the exercise of a professional activity, but also the set of behaviors, faculty of analysis, decision-making, transmission of information etc, considered necessary for the full performance of an occupation. Competence is the set of socio-affective conducts and cognitive, psychological, sensorial and mobile abilities that permit one to adequately carry out a role, a function, an activity or a task.

A person who possesses professional competence has at his or her availability knowledge, skills and aptitudes needed to exercise a profession, can solve professional problems in an autonomous and flexible way, is able to collaborate in his or her professional environment and the labor organization.

Anger is a feeling of being irritated, annoyed or furious. It usually occurs if our freedom is limited or impinged on in some fashion. Anger experience is not limited to unexpected negative stimuli, it can come about in everyday situations also.

Anger like all emotions is a phenomenon which manifests itself, at the overt level but also exists within the individual in terms of feelings. Many explanations of emotions are concerned with formulating relationships between the bodily changes which occur during emotions and the feeling aspect. James Lange theory opines that bodily changes occur first and felt emotion is the perception of bodily changes. Cannon Bard theory emphasizes that activation of hypothalamus and other brain areas is the primary reaction of emotion (anger) provoking stimuli which triggers two reactions independent
of each other, internal body and muscular changes which cause bodily expressions in emotions and pattern of discharge to the cerebral cortex which is perceived as felt emotion. With more sophisticated techniques for experimentation now available, the role of various brain structures is being understood in a more in-depth manner.

Kluver and Bucy (1937; 1938; 1939) made lesions in the temporal lobe and observed an increase in emotionality by ablation of the amygdaloid complex and or cingulated gyrus. Some studies for example, Bard and Mountcastle (1948) show that there is an increase in emotional activity following amygdaloid lesions. Similar findings have been obtained for aggression and dominance although unequivocal evidence is not there. However, each of the studies on the amygdaloid complex suggests that this area is sensitive for emotional reactivity. Electrical and chemical stimulation of the hippocampus facilitates emotional responses and autonomic reactions similar to those which are found during normal emotion (MacLean 1954; 1957). Also the hippocampus influences hormonal mechanisms which may affect emotional behavior.

Some studies (for example Kennard 1955) report an immediate but transient increase in emotionality following bilateral damage to the cingulate gyrus – there is an increased aggression and viciousness. Lesions in the cingulate gyrus have often been used in attempts to combat clinical problems of anxiety neurosis and obsession. Septal region has been concerned with avoidance behavior. Its beginnings can be found in Brady and Nauta (1953;
1955) and Brady (1958; 1960), who made lesions in the ventral portions of this area. Their general findings were quite clear, namely, increases in general emotional reactivity and in the startle response to loud auditory stimuli. The frontal lobes are mainly neocortex, they are clearly implicated in emotions. There is a straightforward anatomical and functional relationship between them, the limbic system proper and the relevant subcortical structures. The frontal lobes are important to emotion, but how important or in what way is unknown. Arnold (1950) suggests that they are concerned with the sympathetic side of emotion, and (1970) with emotional appraisal.

Often enough we can feel the flush enter and move up our neck and out the top of our head. Depending on the severity of the feeling, our body may twitch in response to the feeling. The feeling turns violent, if we actually strike out at someone, or if we plan and strategize to harm someone, then we move from an emotion, that is quite normal to an emotion that has turned evil and become a sinful activity.

We often observe strong, uncontrolled attacks of anger in some person. According to Fava and Rosenbaum (1999), anger attacks are sudden intense spells of anger that resemble panic attacks but lack the predominant affects of fear and anxiety associated with panic attacks. They typically occur in situations in which an individual feels emotionally trapped and experiences outbursts of anger that are later described by the patient as being uncharacteristic and inappropriate to the situation at hands. Anger attacks consist of both behavioral and autonomic features, and various criteria. An
anger attack is a combination of predisposition or some enduring state of vulnerability- and provocation. Anger and irritability may be part of a depressive symptomatology. Irritable mood is a core symptom of major depressive disorder in children and adolescents but is emphasized less as a symptom of depression in adults. Snatch and Taylor (1999) report that 37% of depressed inpatients had moderate- to severe outwardly directed irritability, and findings from the Epidemiologic Catchment Area surveys indicate that depression is related to violent behavior in samples taken from the community.

The criteria adopted to define anger attacks include 1) irritability during the previous six months, 2) overreaction to minor annoyances with anger, 3) occurrence of one or more anger attacks during the previous month and, 4) inappropriate anger and rage directed at others during an anger attack.

Anger attacks were not unique to panic disorders, and similar rates emerged for patients with other anxiety disorders. Depressed patients were twice as likely to report anger attack as patients with anxiety disorders. Additionally, anxiety disorder patients with anger attacks were significantly more depressed than anxiety disorder patients without anger attacks. Anger attacks have also been reported in women with eating disorders. Women with eating disorders with anger attacks had more depressive symptoms than women with eating disorders without anger attacks.

Broody, Haaga, Kirk and Solomon (1999) studied the concept of fear of expressing anger and its relations with self-silencing and anger attacks was
explored. The major depression group significantly exceeded the never-been depressed group in the degree of reported holding anger-in and being afraid to express it. Also major depression subjects were more likely to endorse attitudes consistent with silencing the self-theory, believing they must hide their feelings to preserve relationships. They were also more likely to have experienced an anger attack. Both silencing the self and a history of anger attacks were significantly correlated with fear of anger expression.

It is difficult to distinguish anger with rage, that rage and anger is distinct. The distinction lies primarily in how each is experienced as an emotional state of being. Anger is an experience that can be more easily intellectualized than rage. Further, the term rage has connotations of low social desirability as compared to anger. We minimize the intensity of our rage by calling it anger. We do this to stay in control because we fear the raw truth of our bodies. This rational desire to mentally deal with this powerful, somatic emotion is what interferes with our healing; we unconsciously intellectualize our experience of rage by rationalizing it as anger. Rage and anger may be concerned of as falling on a continuum, with rage being an accumulation of unresolved anger. It is also suggested that anger is more often associated with the present, and rage more often associated with an unresolved past. These beliefs make rage an older, more intense emotion than anger. Anger is more of a mental, heady experience and rage as more of a somatic experience.
Anger is usually considered one of the primitive emotions, closely associated with fear, and is thought to have arisen in connection with the reactions of defense, which situations of fear would call out. In order to clarify what is meant by anger, it is necessary to distinguish it from terms akin to it and often used interchangeably like aggression and hostility.

Aggression: Anger is a situational aggression, so anger frequently accompanies aggression but Berkowitz (1964, 1965) has shown that anger always leads to aggression, but requires the presence of appropriate cues. Other studies by Scott (1958) and Buss (1971) have demonstrated aggression in the absence of anger. Kaufman (1965) presumes anger to be neither a sufficient nor a necessary condition for the production of aggressive behavior. Anger is therefore not synonymous with aggression.

Hostility: Hostility consists of the mulling over of past attacks on oneself; rejection and deprivation (Buss, 1961). This suggests perhaps that hostility is the result of punishment; repeated punishment and sufferings at the hands of others may lead to a generalized dislike of humanity, and a tendency to perceive the pain and discomfort of people as reinforcing. Buss (1961) suggest that hostility “involves negative evaluation of people and events ...(and) may be inferred when the attack is reinforced more by injury than by attaining the “extrinsic reinforcer”. It is evident that anger is not synonymous with these terms. This difference has been found on conceptual level. (Scott, 1958; Buss, 1971; and Coleman, 1979) and on hormonal differences have been found between anger and aggression.
Hormonal differences have also been found between fear and anger; anger reaction indicates the presence of epinephrine and norepinephrine, whereas in fear only epinephrine seems to be present (AX, 1953; Schachter, 1975).

Earlier, anger was conceptualized as a single dimension with anger expression and anger expression being two poles. It is now seen that there are two major, well-recognized dimensions of anger, anger-in and anger-out. Anger-in refers to how often angry feelings are experienced but not expressed. Whereas anger-out, refers to the extent that an individual engages in aggressive behaviors when motivated by angry feelings. Traditionally, it has been customary to conceptualize anger as a dimension, but in recent years, the concept of anger-in and anger-out has entered psychological literature.

Spielberg, Johnson, Jacobs and others (1985) analyzed results obtained on their Anger Expression (AX) scale and found that anger-in and anger-out sub scales were empirically independent as well as factorally orthogonal. These two sub scales assess two independent anger expression dimensions.

In addition to anger-in and anger-out, two other dimensions of anger are recognized, that is, anger-control which may be defined as a tendency not to become angry even in anger provoking situations. Anger-total reflects a configuration of all the anger dimensions. Two-dimensions of anger, anger-in and anger-out are being extensively studied vis-à-vis their role in physical and psychological health. Anger, both suppressed and expressed, can easily
result in psychosomatic reactions, including high blood pressure (Gentry et al. 1982; Spielberger et al. 1985) heart problems (Wood, 1986; Hecker et al. 1988), ulcer and various other physical conditions. We often dramatize the effect of unexpressed anger in these respects; evidence seems to show that expressed anger also encourages physical pains and dysfunctions. It has been found that suppressed anger is linked to evaluation in blood pressure (Gentry et al. 1982; Feshback, 1986; Spielberger et al. 1986). While frequently expressed anger is linked to coronary malfunctioning (Feshback, 1986; Mendes de Leon, 1992).