Pakistan Journal of Clinical Psychology, 2014, 13, 2, 17-31 | PJCP

ANXIETY AMONG STUDENTS: COMPARISON ACROSS AGE, GENDER, AND SOCIO-ECONOMIC STATUS

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ABSTRACT

Objective: *The purpose of this study was to explore the manifestation of anxiety across gender, age and socio-economic status in school and college going children and adolescents.*
Research Design: *Cross-sectional study*
Place of Study: *Schools and Colleges of Karachi, Pakistan.*
Sample and Method*: The sample of 270 students (135 females & 135 males) of 6 to 19 years of age was randomly selected. The translated and adapted Urdu version (Ahmad & Mansoor, 2011) of Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2; Reynolds &Richmond, 2008) was used to estimate the level of anxiety among students.*
Result: *On the whole prevalence in problematic range of anxiety was 16.6 %. Results demonstrate that 11.1 % male and 22.2 % female students had problematic range of anxiety level. Students of age between 6-8, 9-12, and 13-19 years demonstrated 18.8 %, 22.2 %, and 8.9 % of problematic anxiety level respectively. 43.2% of the students' belonging to lower socio-economic status, while 4.4% students belonging to middle and 2.2% from upper socio-economic status were found to experience problematic range of anxiety.*
Conclusion: *The findings from the present results revealed the high prevalence of anxiety in female gender, age group of 9-12 years (especially in males), and lower socio-economic class. These estimates about the prevalence of anxiety exhibit the clear image of morbidity of anxiety among children and adolescents, and are beneficial in planning strategies to deal with anxiety problems.*

Keywords*: Manifest anxiety; students; age; gender; socioeconomic status*

INTRODUCTION

In modern society, no one is totally insulated from anxiety-producing events or situations. Anxieties and fears are a normal feature of childhood, just as they are a normal feature of adult life. Children face many fears and anxieties that seem normal because they are common and reflect natural cognitive developmental processes and developmental phases of life and they can also be victims of anxiety disorders. The prevalence rate of anxiety in children may continue to rise in past few decades because of significant improvement in the diagnostic criteria of anxiety disorders in children[1]. In one review of published studies of anxiety disorders in children below 12 years had 2.6-41.2 % prevalence, and separation anxiety disorder appeared to be the most prevalent anxiety disorder among children with rates of 3 % to 5 %, but only 0.01-2.4 % among adolescents[2] . There are different estimates for different types of anxiety disorders among children and adolescents[3].

Many epidemiological studies also focused on the prevalence of anxiety among children and adolescents in developing countries. Nader, Pynos, Fairbanks, Al-Ajed and Al-Asfoor[4] reported 70 % of Kuwaiti children with moderate to severe level of anxiety in Kuwait. Similarly Thaber and Vostanis[5]

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[1] Muris, P., & Broeren, S. (2009). Twenty-five years of research on childhood anxiety disorders: Publication trends between 1982 and 2006 and selective review of literature. *Journal of Child and Family Studies*, *18*, 388-395.

[2] Eisen, A. R., Brien, L. K., Bowers, J., & Strudlen, A. (2001). Separation anxiety disorders. In C. A. Essau & F. Petermann (Eds.), *Anxiety Disorders in Children and Adolescents: Epidemiology, Risk Factors and Treatment* (pp.111-142). NY: Brunner-Routledge.

[3] Silverman, W. K., & Carter, R. (2006). Anxiety disturbance in girls and women. In J. Worewell & C. D. Goodheart (Eds.), *Handbook of Girls and Women's Psychological Health* (pp. 60-68). NY: Oxford University Press.

[4] Nader, K. O., Pynos, R. S., Fairbanks, L.A., Al-Ajed, M., Al- Asfoor, A. (1992). A preliminary study of PTSD and grief among the children of Kuwait following the Gulf crises, *British Journal of Psychiatry*, *46*, 315-319.

[5] Thaber, A. A., & Vostains, P. (1998). Social adversities and anxiety disorders in the Gaza Strip. *Arch Dis Child*, *78*, 439-442.

reported the pattern of anxiety symptoms and disorders among children of Gaza Strip and found the prevalence of 21 % of anxiety related disorders in children. In Iran, Asadi, Basirani, Asadi, Mirshekar, and Amirshahi [6], found the prevalence of moderate anxiety 50.8 %, neurotic anxiety 22.8 % and severe anxiety 9.5 % among students. Research work[7] on morbidity of anxiety among adolescents of India explored that 20 % of boys and 17.9 % of girls suffering from high anxiety.

Like other developing countries many studies in Pakistan also highlight the pervasiveness of anxiety. As prevalence of anxiety was studied by Inam, Saqib and Alam[8] , in medical students of Karachi, Pakistan, results showed that 60 % students were suffering from anxiety disorders and females had high prevalence of anxiety as compared to males. These similar trends of anxiety were also revealed by the research work of Khan, Mahmood, Badshah, Ali, and Jamal[9] on the sample of students. Rab, Mamdou and Nasir[10], found that 43.7 % of female students reported anxiety in the city of Lahore, Pakistan. In Pakistan after

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[6] Asadi, S. A., Basirani, N., Asadi, B. E., Mirshekar, A., & Amirshahi, M. (2010). Prevalence of anxiety and its relationship with self-esteem among Zabol University students, Iran. *Educational Research*, *1*, 140-144.

[7] Deb, S., Chatterjee, P., & Walsh, K. (2010). Anxiety among high school students in India: Comparisons across gender, school type, social strata and perceptions of quality time parents. *Australian Journal of Educational and Developmental Psychology*, *10*, 18-31.

[8] Inam, S, N., Saqib, A., & Alam, E. (2003). Prevalence of anxiety and depression among Medical students of private university. *Journal of Pakistan Medical Association*, *53*, 44-47.

[9] Khan, H., Kalia, S., Itrat, A., Khan, A., Kamal, A., Khan, M, A., Khalid, R., Khalid, S., Javed, S., Javed, S., Umer, A., & Naqvi, H. (2007). Prevalence and demographics of anxiety disorders: a snapshot from the community health centre in Pakistan. *Annals of General Psychiatry*, *6*, 30. doi:10.1186/1744-859X-6-30

[10] Rab, F., Mamdou, R., & Nasir, S. (2008). Rates of depression and anxiety among female medical students in Pakistan. *East Mediteer Health Journal*, *14*, 126-133. Retrieved from http://www.ncbi-nih.gov/pubmed/18557460

two months of the earthquake, Bahadur[11] found the high rate of panic disorder among the children after the disaster. In study by Sarwat, Ali, and Ejaz[12] on the sample of two hundred adolescents of up to 14 years of age found 11% prevalence of anxiety in children of Karachi attending the psychiatry clinic.

The increasing rate of traumas to children, such as divorce and family breakdown, crime, violence, drug abuse, and recent terrorism is affecting the children and become cause of anxiety in many cases[13]. Pakistan has also been exposed to social and political instability, economic insecurity, and local conflict disarticulation for at least thirty years of the history. Increasing violence of all types like suicide bombing and other forms of terror, and its effect on educational institutes, all are the risk factors for psychological disorders in children. In this scenario the objective of current research is to provide the scientific evidence regarding morbidity of anxiety in children and adolescents between ages 6 to 19 years.

METHOD

Participants

The sample consisted of 270 (135 females & 135 males) school and college going students with the age range of 6-19 years. The data was collected randomly from different educational organizations of Karachi.

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11 Bhadur, M. H. K. (2005). *PTSD and Panic Disorder in Earthquake Survivors*. Sexual Health Institute, Pakistan. Retrieved from http://anxiety-panic.com/conference/coo6ae.cfm

12 Sarwat, A., Ali, S.M., Ejaz. M. S. (2009). Mental health morbidity in children: Hospital based study in child psychiatry clinic. *Pakistan Journal of Medical Sciences, 25,* 982-985.

13 Foxman, D. (2004). *The Worried Child: Recognizing Anxiety in Children and Helping them Heal.* USA: Hunter House Inc, Publishers.

Measures

Demographic and Personal Information Form

Demographic and personal information was obtained through items which focused on the participant's age, gender, education, parents' level of education & occupation, family structure, total members of family, total earning members of family, total monthly income of the family and residential area.

Revised Children Manifest Anxiety Scale, Second Edition (RCMAS-2)

The Revised Children's Manifest Anxiety Scale, Second Edition[14] was developed by Reynolds and Richmond. The RCMAS-2 was translated and adapted in Urdu by Ahmad and Mansoor[15].

The RCMAS-2, subtitled " What I Think and Feel " helps pinpoint problems in a child's life. This brief, objective self report inventory measures the level and nature of anxiety in children and adolescents of age range of 6 to 19 years. It has 49 items and it provides scores for total anxiety and six scales: one score measures Defensiveness, one score measures Inconsistent responding, and the remaining four scores include Total anxiety scores and scores for three anxiety related sub-scales consist of Physiological anxiety, Worry and Social anxiety. The reliability of original version of RCMAS-2 is .76 in test retest having the Cronbach's alpha of .92.[14]

RCMAS-2 is adapted and translated in to Urdu language with significant reliability. Reliability estimates of Urdu version of RCMAS-2 is .93 (for test-retest) and .828 (Cronbach's alpha).

Procedure

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14 Reynolds, C. R., & Richmond, B. O. (2008). *Revised Children's Manifest Anxiety Scale* (Manual) (2nd ed.). USA: Western Psychological Services.

15 Ahmad, R., & Mansoor, I. (2011). What I think and feel: Translation and adaptation of Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2) and its reliability assessment. *The International Journal of Educational and Psychological Assessment, 8*, 1-11.

The sample was gathered from the educational institutions of the urban areas of Karachi, Pakistan. The participants were approached through the assistance of teaching staff during the official timings of their schools/colleges. The consent form was filled by the participants, while for students less than age of 9 years the consent was taken from their parents or teachers. The demographic form related to personal information and family details along with RCMAS-2 was administered individually on students in the age range of 6 yrs to 9yrs, 4 months. For the age range of 9 yrs, 5 months to 19 years the test was applied in the group of ten participants under supervision of the examiner.

Scoring and Statistical Analysis

For the estimation of the level of anxiety, the instructions were followed as given in manual. The *t*-scores were calculated, with the mean of 50 and standard deviation of 10. Then these *t*-scores were categorized according to the descriptors of RCMAS-2 given in manual. These descriptors are shown below:-

Suggested Qualitative Descriptors for RCMAS-2 Score Ranges

Score range	Descriptor
61 and higher	Problematic
40 – 60	No more problematic than for most students
39 and lower	Less problematic than for most students

The Statistical Package for Social Sciences (SPSS, version 19.0) was used to analyze the data. The descriptive statistics including mean, standard deviations and percentages were used to analyze data.

RESULTS

Demographic Characteristics of the Sample

Demographic information of the whole sample consisting of 270 participants and the descriptive statistics of gender, age, and socioeconomic classes is illustrated in Table 1 and 2. Descriptive statistics of variable of anxiety and its sub-scales and anxiety in different age groups is also given in Table 3 and Table 4 respectively.

Table 1
Distribution of Grades across Age Groups

Age Groups	Gender	*f*	Grades	Frequency	Mean Age	*SD*
6-8 years	Male	45	Prep	8	6.95	.84
	Females	45	One	22		
			Two	45		
			Three	11		
			Four	4		
9-12 years	Male	45	Three	2	10.75	1.15
	Females	45	Four	21		
			Five	23		
			Six	36		
			Seventh	8		
13-19 years	Male	45	Eight-	45	15.46	1.71
			Tenth	45		
	Females	45	11^{th}-12^{th}			

Note, N = 270, n = 90 (in each age group)

Table 2
Distribution of Socioeconomic Status and Gender across Age Groups

SES	Age						Total
	6-8 years		9-12 years		13-19 years		
	M	F	M	F	M	F	
Lower SES	15	15	15	15	15	15	90
Middle SES	15	15	15	15	15	15	90
Upper SES	15	15	15	15	15	15	90

Note. SES =Socio-economic status, M = Male, F = Female, N = 270 (whole sample), n = 90 (in each socio-economic class)

Table 3
Descriptive Statistic of Anxiety on RCMAS-2 and its Sub-scales

Variables		LL	UL	*M*	*SD*
Total Anxiety		00	38.00	14.08	7.25
Subscales	**Physiological Anxiety**	.00	10.00	3.84	2.31
	Social Anxiety	.00	14.00	3.66	2.88
	Worry	.00	17.00	6.81	3.55

Note. LL= Lower limit, UL= Upper limit, *M*= Mean, *SD*= Standard Deviation

Table 4
Descriptive Statistics of Variable of Anxiety in Different Age Groups

Variables	Children (6-8 yrs)		Children (9-12yrs)		Adolescents (13-19yrs)	
	M	***SD***	***M***	***SD***	***M***	***SD***
Anxiety	13.10	7.83	16.01	6.73	13.14	6.81

Note. *SD*= Standard Deviation, and *M* = Mean, N = 270, n = 90 (For each group)

The prevalence of anxiety assessed among students across gender, age, and socio-economic status is illustrated in Tables 5, 6, and 7 respectively. For further understanding, prevalence of different dimensions of anxiety: Social Anxiety, Worry and Physiological Anxiety (sub-scales of RCMAS-2) were also calculated as shown in Table 8.

Table 5
Prevalence of Anxiety across Gender

Score Range	Total (N=270) *f (%)*	Male (N=135) *f (%)*	Female (N=135) *f (%)*
61and higher	45 (16.6)	15 (11.1)	30 (22.2)
40-60	190 (70.4)	97 (71.8)	93 (68.9)
39 and lower	35 (13)	23 (17.04)	12 (8.9)

Note. , N = 270 (whole data), n = 135 (for each gender)

Table 6
Prevalence of Anxiety in Different Age Groups across Gender

Age Range	Score Range	Total (N=270)		Male (N=135)		Female (N=135)	
		f	*(%)*	*f*	*(%)*	*f*	*(%)*
6-8 years	61and higher	17	(18.8)	4	(8.8)	13	(28.9)
n=90	40-60	52	(57.8)	29	(64.4)	23	(51.1)
	39 and lower	21	(23.3)	12	(26.7)	9	(20)
9-12 years	61and higher	20	(22.2)	9	(19.9)	11	(24.4)
n=90	40-60	64	(71.1)	32	(71.1)	32	(71.1)
	39 and lower	6	(6.7)	4	(8.9)	2	(4.4)
13-19 years	61and higher	8	(8.9)	2	(4.4)	6	(13.3)
n=90	40-60	74	(82.2)	36	(80)	38	(84.4)
	39 and lower	8	(8.9)	7	(15.5)	1	(2.2)

Note. , N = 270 (whole data), n = 90 (for each age group)

Table 7
Prevalence of Anxiety in Different Socio-economic Status across various Age groups

SES	Score range	Total	Age		
			6-9yrs	9 -12 yrs	13 -19 yrs
Lower	61and higher	39(43.2)	17(56.6)	16(53.2)	6(19.9)
	40-60	50(55.5)	13(43.3)	14(46.6)	23(76.6)
	39 and lower	1 (1.1)	0 (0)	0 (0)	1(3.3)
Middle	61 & higher	4 (4.4)	0 (0)	2 (6.6)	2 (6.6)
	40-60	76(84.4)	25(83.3)	27(90)	24 (80)
	39 and lower	10(11.1)	5 (16.6)	1(2.2)	4 (13.3)
Upper	61 & higher	2 (2.2)	0 (0)	2 (6.6)	0 (0)
	40-60	64(71.1)	14(46.6)	23(76.6)	27(90)
	39 and lower	24(26.6)	16(53.3)	5 (16.6)	3(10)

Note. , N = 270 (whole data), n = 90 (for each age group and socio-economic class), SES = Socio-economic status

Table 8
Prevalence of Anxiety in Different Socio-economic Status across Gender

SES	Score range	Total	Gender	
			Male	Female
Lower	61and higher	39(43.2)	13 (28.8)	26(57.7)
	40-60	50(55.5)	30(66.6)	20(44.4)
	39 and lower	1 (1.1)	0 (0)	1 (2.2)
Middle	61 & higher	4 (4.4)	2 (4.4)	2 (4.4)
	40-60	76(84.4)	36(80)	40(88.8)
	39 and lower	10(11.1)	7 (15.5)	3 (6.6)
Upper	61 & higher	2 (2.2)	0 (0)	2 (2.2)
	40-60	64(71.1)	31(68.8)	33(73.3)
	39 and lower	24(26.6)	14(31.1)	10(22.2)

Note. , N = 270 (whole data), n = 90 (for each age group and socio-economic class), SES = Socio-economic status

Table 9
Prevalence of Different Dimensions of Anxiety for Total Sample (Sub-scales of Anxiety in RCMAS-2)

Scores range	SOC	WOR	PHY
	f (%)	*f (%)*	*f (%)*
61 and higher	51 (18.8)	46 (17.1)	37 (13.7)
40-60	185 (68.5)	169 (62.6)	186 (68.9)
39 and lower	34(12.59)	55 (20.4)	47 (17.4)

Note. N = 270 (entire sample), SOC = Social Anxiety, WOR = Worry, and PHY = Physiological Anxiety.

DISCUSSION

Anxiety disorders are widespread in all the regions of the world. They comprise a substantial fraction of the global burden of disease, and are probable to form the second most common sources of disability and distress among humanity. This amplified significance of non-communicable disease like anxiety create a challenging situation for developing countries like Pakistan, where infectious diseases and malnutrition are still widespread and where only a low

percentage of gross domestic products are to be paid to health services. The research work in developing countries revealed that the prevalence of anxiety among children in many developing nations like Pakistan seems to be rising.

In Pakistan mostly research work on prevalence of anxiety is related to adults and limited research work deals with the anxiety in childhood and adolescence. In this study the prevalence of anxiety estimates for whole sample as shown in Table 5, demonstrates that the prevalence of anxiety in problematic range was 16.6 %. These results are supported by research work of Williams and Brisbane (2004), who had found nearly similar trends as mentioned above related to prevalence of anxiety in children of developing countries.

Results also demonstrate that in problematic range of anxiety females showed 22.2% prevalence as compared to 11.1 % in male gender. These gender differences in morbidity of anxiety are consistent with previous research literature in this specific area[16, 17, 18, 19, 20]. This trend of high prevalence of anxiety among females is also evident in all age groups as shown in Table 6. Previous research has emphasized that difference in anxiety scores of both males

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[16] Abe, K., Masui, T. (1981). Age-sex trends of phobic and anxiety symptoms. In H. Orvaschel, M. M. Weissman. (1986). Epidemiology of anxiety disorders in children: A review. In R. Gittelman (Eds.). *Anxiety Disorders of Childhood* (pp.58-72). USA: The Guilford Press Publications, Inc.

[17] Ali, N, S., Ali, B, S., & Azam, I, S. (2009). Post partum anxiety and depression in peri-Urban communities of Karachi, Pakistan: A quasi experimental study. *BMC Public Health*, *12*, 384. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19821971

[18] Farooqi, Y. N. (1981). Male-female differences in anxiety. *Pakistan Journal of Psychology, 12,* 37-42.

[19] Khan, H., Kalia, S., Itrat, A., Khan, A., Kamal, A., Khan, M, A., Khalid, R., Khalid, S., Javed, S., Javed, S., Umer, A., & Naqvi, H. (2007). Prevalence and demographics of anxiety disorders: a snapshot from the community health centre in Pakistan. *Annals of General Psychiatry, 6,* 30. doi:10.1186/1744-859X-6-30

[20] Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence and treatment of anxiety disorders in Pakistan: Systematic review. *British Medical Journal*, *328*, 87-94. doi:10.1136/bmj.328.7443.

and females is due to the fact that it is easier for girls to admit about their anxiety. So differences in anxiety do not reflect the innate difference, but only measures the differences in their attitude to admit to anxiety[21]. This gender difference in anxiety is attributed to females' lack of power in society, differences in gender role socialization in which it is acceptable for women to report about fears and anxiety[22]. Farooqi[18] described these gender differences from another point of view that females are highly responsive in attitude to the anticipated dangers induced by overprotective and over-restrictive parental attitudes or failure to acquire educational, social and vocational abilities or lack of assertiveness or dispositional timidity which acts to magnify their anxiety in relation to inner and outer threats. In the culture of Pakistan, females encounter more prolonged exposure to stressful situations due to inferior status and role conflicts. In our society male child is welcomed more warmly than a female so females from birth instill the feelings of inadequacy, inferiority and insecurity and all these factors play crucial role in predisposing females to anxiety.

In addition to these findings results also revealed the relatively high prevalence of anxiety of 22.2% (problematic range) in age groups of 9-12 years especially in male gender than 6-8 and 13-19 years that showed 18.8%and 8.9% respectively as illustrated in Table 6. These findings are supported by the relevant literature[23] [24]. These all researches support the fact that there is rapid increase in frequency of symptoms of anxiety at this age group of 9 to 12 years in males, while this trend is unstable for girls[21]. According to Campbell[25], it is

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[21] Lokare, V.G. (1984). Anxiety in Children: a cross-cultural perspective. In V. P. Varma (Eds.), *Anxiety in Children* (pp. 71-73). UK: Methuen, Inc.

[22] Arrindell, W. A., Eisemann, M., Richter, J., Oei, T. P. S., Caballo, V. E., Van der Ende, J. (2003). Masculinity-femininity as a national characteristic and its relationship with national agoraphobic fear levels: Fodor's sex role hypothesis revitalized. *Behavior Research and Therapy, 41*, 795-807.

[23] Eysenck, S. B. G. (1965). Manual of the Junior Eysenck Personality Inventory. In V. G. Lokare. (1984). Anxiety in children: A cross-cultural perspective. In V. P. Varma (Eds.), *Anxiety in Children,* (pp.71-73). UK: Methuen, Inc.

[24] Werry, J. S., & Quay, H.C. (1971). The prevalence of behavior symptoms in younger elementary school children. In H. Orvaschel, & M.M. Weissman. (1986). Epidemiology of anxiety disorders in children: A review. In R. Gittelman.(Eds.). *Anxiety Disorders of Childhood* (pp. 58-72). USA: The Guilford Press Publications, Inc.

unclear whether these increases in symptoms of anxiety in boys represent a true increase in the prevalence of anxiety or whether these high emergences of symptoms reflect the increase in behavioral disturbance.

The results demonstrate higher anxiety prevalence of 43.2% (problematic range) among the students related to lower socio-economic status than prevalence rates of 4.4 % and 2.2 % in the middle and upper socio-economic status respectively as shown in Table 7. These findings are supported by research work in sub-continent[26]. The lower socio-economic status children and adolescents are facing financial problems in all areas including education, food, living styles etc, which cause anxiety in them. In the lower socio-economic status, the parents having most of their energies allocated to earning, are unable to give much time to child rearing practices and due to this burden are mostly frustrated. This frustration and stress in family environment create a hindrance in developing useful personality traits in their children which in turn make them vulnerable to develop disorders[27]. The lower socio-economic status children are brought up in a less controlled manner and they also experience physical and verbal abuse. The future rests on the basic objectives of secure job, good pay, but they are no t oriented to ambition with clear aims [28](Stagner, 1961). As stated by Sadock[29]

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[25] Campbell, S. B. (1986). Developmental issues in childhood anxiety. In R. Gittelman (Eds.), *Anxiety Disorders of Childhood* (pp.24-49). USA: Gilford Publications Inc.

[26] Luni, F., Ansari, B., Jawad, A., Dawson, A. Baig, S. M. (2009). Prevalence of depression and anxiety in the village of Sindh. *Journal of Ayub Medical College Abbottabad, 21*, 69-72.

[27] Jahangir, F. (2006). Psycho-social Personality features among N.W.F.P. male population. *Pakistan Journal of Professional Psychology: Research & Practice, 1*, 19-24.

[28] Stagner, R. (1961). Psychology of Personality (3rd ed.).In F. Jahangir. (2006). Psycho-social personality features among N.W.F.P. male population. *Pakistan Journal of Professional Psychology: Research and Practice, 1*, 19-24.

[29] Sadock, B. J., & Sodock, V. A. (2000). Kaplan and Sadock comprehensive text book of psychiatry (7th ed.). In S. Deb, P. Chatterjee, & K. Walsh (2010). Anxiety among high school students in India: Comparisons across gender, school type, social strata and perceptions of quality time parents. *Australian Journal of Educational and Developmental Psychology, 10*, 18-31. Retrieved from

(2000), anxiety decreases with increasing socio-economic status. Students who belong to the middle class mostly facilitated by their parents due to high value of education in their lives for determining better future. So the parents as possible as they can, provide, financial and emotional support to their children in attainment of their educational goals. The students who belong to upper class generally attend higher quality of life and education. Also, if having individual difficulties, their parents more often have the resources to assist them[30]. So the availability of resources alleviates the difficulties and stresses that would otherwise cause mental health problems like anxiety. The prevalence rate of anxiety seems on the lowest level among children and adolescents belongs to upper socio-economic class supported by research of Deb, Chatterjee and Walsh[7], who attributed this least level of anxiety to their materialistic and financial secure future.

Further, the analyses were made for the different dimensions of anxiety given as sub-scales of anxiety in RCMAS-2, the prevalence of anxiety in these subscales as Social Anxiety, Worry and Physiological Anxiety in the whole sample, were estimated as shown in Table 9. The prevalence of social anxiety, worry and physiological anxiety among children and adolescents by covering the score range of (61 and higher), which comprises of problematic category is 18.8 %, 17.07 % and 13.7 % respectively. High prevalence in social anxiety among students indicate their concern about themselves, their abilities according to the expectations of significant others. As stated by the Muris[1] anxiety related to social evaluation mostly increase in middle childhood and adolescence. The high prevalence of social anxiety (sub-scale) among students of Pakistan might be due to the high competition and parental high demands in academic areas in middle and upper socio-economic classes[31]. High prevalence of worry indicates child's sensitivity to environmental pressures. As mentioned by Reynolds and

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http://www.newcastle.edu.au/Resources/Research%20Centres/SORTI/Journals/AJEDP/Vol%2010/V10_deb_et_al.pdf

[30] Rosenberg, M., Schooler, C., & Schoenbach, C. (1989). Self-esteem and adolescent problems: Modeling reciprocal effects. In L. E. Berk. (1996), Infants, Children, and Adolescents (2nd ed.). U. S. A: Allyn and Bacon.

[31] Reynolds, D. J. (1976). Adjustment and maladjustment. In J. F. Adams (Eds.), *Understanding Adolescence: Current Development in Adolescent Psychology* (3rd ed.) (pp. 334-368). Boston: Allyn and Bacon.

Richmond[14], high score on worry scale indicate the child internalizes much of his/her anxiety experience and thus overburdened with trying to relieve this anxiety. Such children and adolescents need to discuss and share their feelings with others who can provide support to them. There is relatively less prevalence of physiological anxiety which is the child's experience of physiological responses that often accompany anxiety as compared to social anxiety and worry which are other two sub-scales of RCMAS-2

To sum up, prevalence of anxiety was analyzed in difference aspects across gender, age and different dimensions of anxiety. The morbidity of anxiety in problematic range is high in females. The differences in anxiety (problematic range) across age revealed high level in 9 to 12 years of children especially these differences seemed prominent in male gender as compared to other age groups of 6-8 and 13-19 years. Prevalence of social anxiety (sub-scale) is relatively high as compared to worry and physiological anxiety (sub-scales). Anxiety across socio-economic status showed that student's belonged to lower socio-economic status showed high level of problematic anxiety than other socio-economic classes. These estimates about the prevalence of anxiety exhibit the clear image of morbidity of anxiety among school and college going children and adolescents, and these findings enables us to develop better treatment, planning and preventative measures for children suffering from anxiety and facilitate these school going children and adolescents to deal effectively with the developmental challenges, their ability to be productive and to use cultural resources to maximize growth.