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CASE STUDY

A CASE STUDY OF SOCIAL PHOBIA: SELF-PERCEPTION OF BEING UGLY

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This case study discusses the case of a 21 years old young man referred because of his problem of social anxiety and strong feelings of ugliness. The client fulfilled the DSM-IV-TR criteria of Social Phobia. His family background and academic history showed gradual development of his problem. The informal assessment (A-B-C chart, Mental Status Examination, categorizing the distortions in thinking and subjective ratings) and formal assessment (Rotter's Incomplete Sentence Blank, Beck Depression Inventory and Manifest Anxiety Scale) also confirmed the diagnosis of social phobia with the presence of depression as a secondary problem. Management plan included Behavior therapy (Relaxation Training, In vivo desensitization), Rational Emotive Behavior therapy (Disputing, Rational Emotive Imagery and Bibliotherapy), Cognitive Behavior therapy (challenging automatic thoughts), Assertiveness training, social skills training and self-esteem building exercises. Thirteen therapeutic sessions were conducted. There was marked improvement in the client's condition indicated by mid- and post-treatment assessment scores on BDI, MAS and Subjective ratings.

Our society is one of the societies which are very much governed by the rules and standards of external beauty of a person. This leads many of our youth to suffer inferiority complex. We usually believe that it is just girls who are mainly sufferer of this obsession and always want to look good but the present case study draws attention towards the young men of our society who also are the victim of this beauty syndrome. The purpose of reporting this case study is to show how the useless and illogical standards of beauty in our society bring the vulnerable youth at the edge of psychological breakdown. Especially, when they don't find any support at home as well. If the parents and siblings are also critical then this inferiority complex gets worse by the family's attitude along with society's rejection. This double rejection results in double breakdown within the sensitive teenage and thus resulting in an insecure and unsure youth. In this case report the detailed formulation of the case on the basis of client's history and psychological assessment is mentioned along with a successfully administered treatment plan.

M.Y. 21 years old male, student of B.Com., part I, was referred by his friend due to his problem of social

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anxiety. Clinical interview with the client generated complaints of panic like feeling while talking to people especially women, inability to maintain conversation, feeling that everybody is looking at him and laughing at him and a very strong belief that he is ugly. Client has had strict parenting and has a critical elder brother, who discourages him and keeps on telling him that he is young and stupid.

His school seems to have played the most crucial role in developing his present problems. According to the client his problem of social anxiety started when he was in class 6. He had difficulty in studying English due to which his class fellows laughed at him, which was very embarrassing for him. Since then he has been afraid of speaking in public. The client's problem of feeling ugly started when he reached puberty and different physical changes occurred in him. At that point his problem of poor English was no longer there but he began to see himself as ugly. His class fellows also made fun of his dark complexion. All these factors first initiated and then exasperated his feelings of inferiority and social anxiety. Client's problem affected his daily functioning very badly; he started to avoid socials and meeting others. He even avoided meeting his relatives.

In informal assessment A-B-C chart, Mental Status Examination, categorizing the distortions in thinking and subjective ratings of the client were used whereas for formal assessment Rotter's Incomplete Sentence Blank (RISB; Rotter & Rafferty, 1950), Beck Depression Inventory (BDI; Beck, 1996) and Manifest Anxiety Scale (MAS; Taylor, 1953) were administered.

Client's symptoms were initially pointing towards the social anxiety disorder. There were different antecedents to his problem at different times. He had harsh and strict parents and a critical elder brother, which seems to have obstructed the development of a positive self-image and self-esteem. According to Larson, Richards, Moneta, Hombeck, and Duckett (1996), if one is unable to develop an adequate bond with one's primary caretaker as a child, one may lack self-regulatory skills to calm down, focus and soothe oneself in situations one perceives as stressful or chaotic. Attachment specialists attribute this as a possible cause of social anxiety disorder and other anxiety, depression and stress-related disorders.

He got transferred to an English medium school when he was in class 6, where he had to face bullying attitude of students because of his poor English. Bullying causes all sorts of damage. Field (n.d.) believes that "girls become sad and boys become mad". The target can be affected emotionally, physically, academically and socially. They can experience poor self-esteem, physical health difficulties and anxiety disorders, including panic attacks, depression and post traumatic stress disorder. Bullying can lead to shyness, social isolation or social phobia. Later as he experienced rapid physical changes especially height burst, he began to feel ugly. This belief was facilitated by the bullying attitude of boys at school and college. According to Veale (2001), beliefs about being defective and the

importance of appearance drive varying degrees of social anxiety and avoidance. Thus, depending on the nature of their beliefs, patients will tend to avoid a range of public or social situations or intimate relationships.

Clinical observations of the client supported his presenting complaints as he did not make eye contact throughout the initial sessions. His scores on MAS were also very high which supported the information provided in presenting complaints and history. His scores on RISB also indicated maladjustment in different areas of life, which was in consonance with his history. His major conflict appeared to be in social environment; this went consistent with a history of bullying and automatic thought distortion of "mind reading". He had a generally regretful attitude towards his past and a pessimistic attitude towards the future, as indicated in RISB. This is supported by the errors of "regret orientation" and "fortune telling" in his self-assessment of automatic thoughts. Similarly, his characteristic traits on RISB showed a very self-damning attitude and self-image, which was consistent with the presenting complaints of client as well as with the automatic thought distortion of "labeling".

In the formal assessment, the client met all the criteria of social phobia (DSM-IV-TR; APA , 2000). He also had a very high score on BDI, which could be due to his underlying negative beliefs about his self and resulting social skills deficits. Lewinsohn (1974) proposed a more behaviorally based model that attributes depression to a reduction in reinforcement. People at risk for depression have social skills deficits that cause them to elicit negative responses from others (and other reinforcement), which, in turn, causes them to view the world negatively and withdraw, leading to depressive cognitions and maladaptive social behavior. Although he got high scores on BDI, he did not fulfill the criteria of DSM-IV Major Depressive Disorder and fell in the Not Otherwise Specified Category (DSM-IV-TR; APA, 2000).

The information produced by the history and psychological assessment were consistent with each other and provided a very clear picture of client's problems. M.Y.'s prognosis was good. He was very much motivated to receive treatment. He regularly completed his homework assignments. Although his problem was chronic, he had deep insight into his problems. This was a strong factor indicating the possibility of successful therapy.

Therapy

The client was first educated about the vicious cycle of anxiety and its possible management. 16 Progressive muscle relaxation (Jacobsen, 1938) was used to help the client relax. This was gradually reduced to the cue word "relaxation" in the last sessions. As a next therapeutic step, in vivo desensitization (Morris, 1991) was used in which the hierarchy of anxiety provoking situations was drawn up with the help of the client. The client was gradually exposed to the anxiety provoking situations in reality. For the exposure of situations involving interaction with women, therapist took the help of her female

colleagues and conducted group sessions with the client. Disputing (Ellis & MacLaren, 1998) was used at all four levels to challenge his irrational belief "it is awful, if someone rejects me". Rational emotive imagery (Ellis & MacLaren, 1998) was used to lower the client's anxiety in particular anxiety provoking situations. Verbal challenging (Beck, 1970) was used to help modify client's distorted beliefs of "regret orientation", "fortune telling", "labeling", "mind reading" and "catastrophizing". Assertiveness training (Wolpe & Lazarus, 1966) was used to teach the client to respond to other people's bullying assertively. Social skills training (Spence, 2003) was used to teach the client to initiate and maintain conversation. Self-esteem improving exercises (Fresh, 2003) and Bibliotherapy (Ellis & MacLaren, 1998) was also used to help improve his self-esteem.

Outcome

In mid and post treatment assessment, BDI and MAS scores showed a gradual decline for the client, which indicated that he had been able to control his anxiety and associated depression through the course of therapy. Figure 1 shows the client's scores on MAS which are falling in the category of severe in Pre (48) and mid (42) assessment whereas in post-treatment assessment client's score was 26 which was falling in the moderate category.

Figure 2 is the graphical representation of client's scores on BDI. These were representing the severe category (29) in pre-treatment assessment, moderate (22) in mid and mild (16) in post-treatment assessment. Thus it is showing a gradual transition from severe to mild category of depression

Figure 1

Graph Showing Pre, Mid and Post MAS Scores

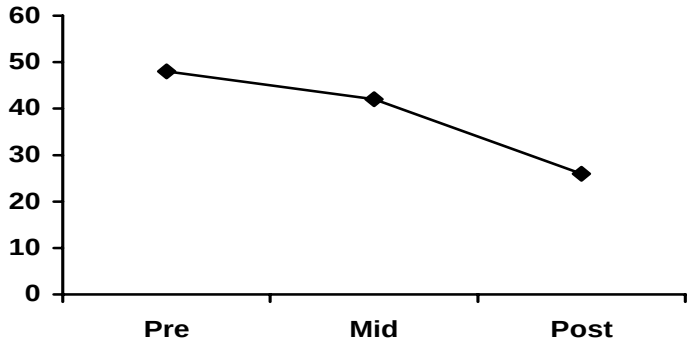
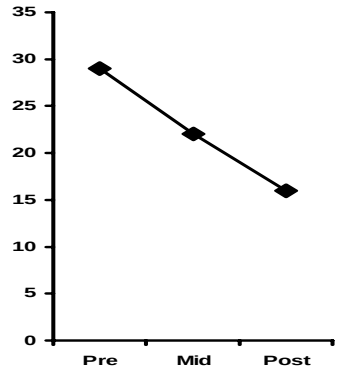


Figure 2

Graph Showing Pre, Mid and Post BDI Scores

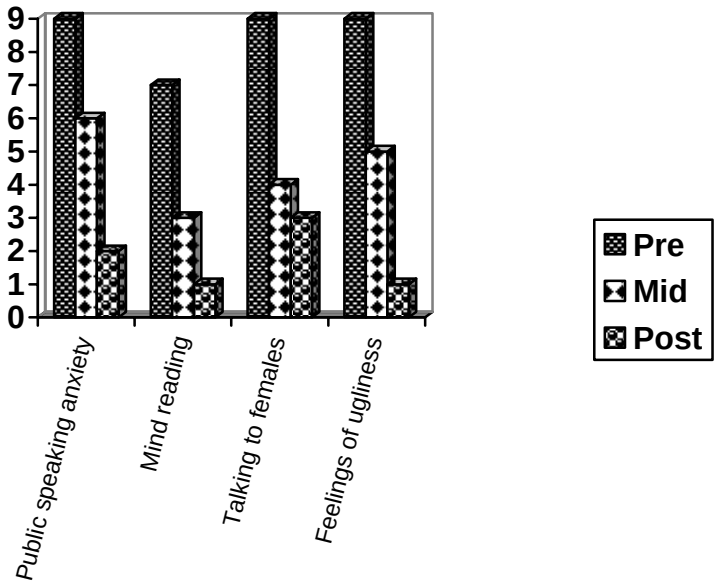


through the course of therapy.

Other than psychological assessment, his behavioral observation showed that he was more confident than before. He had started to make and maintain eye contact and talk confidently not only with the therapist but also with the other members who were included in the sessions for exposure purposes. In the exposure of last step of hierarchy, the client confidently spoke for about 20 minutes in front of 6 females. This showed the extent of improvement he made if we compare it with the first session in which he was even unable to make eye contact with the therapist. Figure 3 shows the Pre, Mid and Post subjective ratings by the client on his major complaints.

Figure 3

Graph Showing Pre, Mid and Post Subjective Ratings



This case report examined the probable etiology of social anxiety in a young man while describing the treatment plan for the client, which showed prominent improvements in the client having social phobia. The present case depicts that by using the combination of cognitive behavioral and emotive therapy, the therapeutic outcomes can be enhanced to manage the clients with social phobia.

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