

Social phobia and perfectionism: theories, types and models



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Abstract

Derived from the Greek word for ‘fear’, a phobia represents a ‘fight or flight’ response that is described by the American Psychiatric Association as “... an uncontrollable, irrational and persistent fear of a specific object ... situation ...activity” (Phobia King, 2006). Social phobia, which is known as ‘phobia des situations sociales’, was first termed by Pierre Janet (1903) whereby he described patients that demonstrated and or had a fear of being observed as they were either speaking, writing or performing other functions.

Hurka (1993, p. 3) tells us that perfectionism is a “... moral theory (that starts from an account of the good life ...” Hurka (1993, p. 3) goes on to add that the ‘good life’ develops humanity properties to a high degree and or thus realizes what is important as well as central to human nature. The history of perfectionism can be traced back to Aristotle’s conception of eudaimonia, the good life, and his belief that political structures and politics should thus promote this in its individuals (Aristotle and Irwin, translator, 1999, pp. 1-4). Other notable individuals throughout history noted for their

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devotion to perfectionism in varied forms are Thomas Aquinas, Francis of Assisi, Clement of Alexandria as well as Jesus who stated in his Sermon on the Mount said “ Be ye therefore perfect, even as your Father which is in heaven is perfect” (MainBelieve. com, 2006).

The dictionary defines ‘ perfectionism’ as “ a tendency to set rigid high standards of personal performance” (free dictionary. com, 2006). In psychology, perfectionism represents the belief that this is something which should be strived for and in its pathological sense it represents the unhealthy belief anything that is not perfect is unacceptable (coping. org, 2006). It also represents not making mistakes and striving to be the best, as well as the attitude that what one attempts needs to be done perfectly and a habit that is developed in one’s youth keeping one consistently alert to imperfections as well as weaknesses and failings in one’s self as well as others (coping. org., 2006).

This paper shall examine these two areas, delving into their individual specificities as well as linkages and commonalities, revealing opposing views concerning the diagnosis and causes of these afflictions and the views which seemingly share many similar aspects.

The term, phobia, is generally classified by psychiatrists and psychologists into three basic categories (Bourne, 2005, pp. 33-42) (Kessler et al, 2005, pp. 629-640):

- Social Phobias
- Specific Phobias
- Agoraphobia

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Isaac Marks (1969, p. 362) advises that the syndromes representing shyness, social anxiety along with social avoidance had been described as early as Hippocrates. Marks (1969, p. 362) reported that individuals with this affliction "... through bashfulness, suspicion, and timorousness, will not be seen abroad, ... he dare not come in company, for fear he should be misused, disgraced, overshoot himself in gestures of speeches ... he thinks every man observed him ..." Mark's (1969) views and analysis is amplified by Heimberg et al (1995, p. 96) who state that individuals having this affliction "... experience excessive fear of being humiliated or judged negatively in social or performance situations."

Juster et al (1996, pp. 403-410) state that perfectionism is linked to social phobia and is also related to anxiety as well as depression. Frost et al (1990, pp. 449-468) ' Multidimensional Perfectionism Scale assesses perfectionism in terms of it being a phenomenon that consists of three segments:

- Self oriented,

is described as the tendency for a person to seek as well as set high self standards concerning performance,

- Other oriented,

is the tendency for a person to expect others to be perfect in their performance(s),

- Socially prescribed

represents the tendency that a person expects others to think and or believe others expects them to be perfect in their performance.

Frost et al (1990, pp. 449-468) define perfectionism as a malady that entails excessive self criticism that is associated with the setting or belief in higher personal standards and the allied concern of meeting expectations on a social level. The preceding also includes the tendency for excessive self criticism that is associated with their higher personal standards as well as their concerns for meeting what is, in their internal view, social expectations, along with the excessive focus concerning organization as well as neatness and doubts with regard to their effectiveness in their actions (Frost et al, 1990, pp. 449-468).

The preceding describes the inter relatedness between social phobia and perfectionism that will be explored herein which shall examine each aspect and their links. Perfectionism has roots in aspects of social phobia, as well as the reverse being true. These two afflictions sometimes are present in individuals having social anxiety and are generally conditions that have their roots in early childhood. In examining these two areas, attention shall be paid to their individual diagnosis areas, signs, conditions and foundations, as well as the linkages between the varied forms of social phobia and perfectionism. This examination has been organized to set forth the preceding via segmenting the foregoing into areas that identify and explain the aspects of social phobia as well as perfectionism revealing the foregoing linkages and commonalities.

The Diagnostic and Statistical Manual of Mental Disorders (2000, pp. 154-156) defines social phobia as a persistent and marked fear of one or more performance and or social situations whereby an individual is exposed to people that are unfamiliar and thus subject to scrutiny by others whereby <https://assignbuster.com/social-phobia-and-perfectionism-theories-types-and-models/>

the person in question thus feels (fears) that they might or will act in such a manner, and or exhibit anxiety, which will either be embarrassing and or humiliating. The preceding concurs with Heimberg et al (1995, p. 96) who stated that individuals having this affliction "... experience excessive fear of being humiliated or judged negatively in social or performance situations." Social Anxiety Disorder represents the third highest mental health care problem globally and afflicts an estimated seven percent of the world's population at any given point in time, with a thirteen percent chance that it will affect any one of us during our lives (Social Phobia / Social Anxiety Association, 2005).

The Diagnostic and Statistical Manual of Mental Disorders (Social Anxiety Institute, 2006) defines social phobia as:

- A persistent fear of either one or more performance and or social situations whereby an individual is exposed to potential scrutiny by unfamiliar people and that they, the person in question, will act in a manner, and or show anxiety symptoms, which will be either humiliating and or embarrassing.
- That the exposure to the situation in almost all situations results in anxiety that can and usually does take the form of what is termed as being based upon situations and thus pre-disposed or bound Panic Attack.
- The individual experiencing the symptoms of social anxiety recognizes that they have a fear that is excessive and or unreasonable.
- The feared situations are thus avoided by this type of individual or are endured under intense distress and anxiety.

- The individual's avoidance, distress and or anticipation of the feared situation thus significantly interferes with this person's normal routine, functioning and an occupational and or academic manner, their social activities /relationships, and or they experience a marked distress concerning having the phobia.
- In those persons 18 years of age or less the general period of the duration of such an experience is generally six months.
- That the fear and or avoidance of the aforementioned is not due to the direct physiological effects of either drugs or medications, and or a general medical condition which could be accounted for by virtue of another mental disorder.

The preceding diagnostic criteria provide a guideline, however they do not substitute an analysis and or visit to a mental health practitioner (Ohio State University, 2005). Examples of diagnostic criteria historical facets are described as (The Diagnostic and Statistical Manual of Mental Disorders (2000) :

- patients having a hypersensitivity to criticism, along with a difficulty in being assertive, and or low self esteem as well as potentially inadequate social skills.
- They avoid speaking in front of groups of people, with the preceding potentially leading to difficulties in either work or education.
- In order to reach a diagnosis concerning social phobia in children the situation calls for observing their interactions with peers as opposed to observing them with adults, which represents a different context.

- In reaching and or considering a diagnosis, clinicians should seek to consider what is termed the co-morbid diagnosis represented by avoidant personality disorder when an individual exhibits generalized social phobia.
- It has been determined that a high percentage of individuals with social phobia have or have developed alcohol and or sedative abuse that aids them in tolerating social situations, however the preceding is not universally true.

Symptoms and characteristics of social phobia consist of one, some or all of the following (Helpguide. org, 2006):

- Avoidance,

Whereby an individual will go to great lengths to avoid the prospect of socializing based upon the fear that they will be either perceived in an adverse manner or be humiliated. If left untreated this condition can accelerate or develop into the condition known as agoraphobia.

- Low Self Esteem,

Represents a condition which most individuals who are afflicted with social phobia experience and it is marked by the fact that the longer one remains in this condition the more it affects one's sense of self worth.

- Depression,

A common outgrowth of having a social anxiety disorder is that the feelings of extreme anxiety as well as the sense of the lack of control over one's life can very well lead to depression.

- Alcohol and or Drug Abuse,

It has been estimated that one fourth of the individuals with this condition abuse either alcohol and or drugs usually starting to alleviate the pain and then accelerating into wholesale abuse.

- Academic and Occupational Difficulties,

The condition has been known to interfere with one's ability to function at work as well as academically and can as well as has presented obstacles in these regards.

- Interpersonal Difficulties,

Statistics and studies have determined that as a result of this condition, individuals are prone to be less likely to marry and also have fewer friends as well as social support.

The symptoms represented by social phobia defer in respect to children and adults as generally represented by the fact that in the earlier stages children tend to fail to achieve their levels, and adults show declines from prior functioning levels (Biederman et al, 2001, pp. 49-57) (Stein, 2001, pp. 28-39). The symptoms as manifested by children frequently are observed as temper tantrums, clinging to parents, crying and interactive aspects such as the refusal to talk to others (Biederman et al, 2001, pp. 49-57). In adults, the symptoms include a number of physical anxiety signs along with behavior and attitude manifestations (Bruce and Saeed, 1999, pp. 2311-2322):

- blushing, nausea, dry mouth, sweating, tremors and other similar types of anxiety indicators,

- difficulty as represented with self assertion,
- an extreme sensitivity concerning criticism, negative evaluations and or rejection,
- an intense preoccupation and concern regarding the responses as well as reactions of other individuals,
- increased fears regarding the prospect of being either humiliated and or embarrassed,
- and the avoidance of situations that cause or create fear and or anxiety

Olfson et al (2001, pp. 521-527) advise that the diagnosis of social phobia is generally based upon the history of the patient, along with reported symptoms. In keeping with an accurate diagnosis the physician may also utilize what is termed a diagnostic questionnaire which aids in ruling out other possible phobias, anxiety disorders as well as major depression (Olfson et al, 2001, pp. 521-527). Screening and testing procedures for adults suspected of suffering from social phobia represents a problematic assessment as some general screeners, for example the Structured Clinical Interview does not include questions that are related to social phobia and such a test can take upwards of twenty-five minutes (Bruce and Saeed, 1999, pp. 2311-2322). In addition to the foregoing there are instruments such as the Fear of Negative Evaluation Scale as well as the Social Avoidance and Distress Scale which are long and in general are useful more in the measurement of therapy progress (Bruce and Saeed, 1999, pp. 2311-2322). Interestingly, physicians have found that the utilization of a selected group of questions added to a general screening questionnaire has proved helpful in

their detection of this condition; examples of the preceding are as follows (Olfson et al, 2001, pp. 521-527):

- Are feeling embarrassed or feeling as if you look stupid among your worst fears?
- Does the fear of embarrassment cause you to avoid doing certain things and or speaking to people?
- Do you avoid situations where you could be or are the center of attention?

The diagnosis of children takes into account additional factors as a result of their age. Such includes the fact that they do not have the options of avoiding most situations which frighten them (Bogels and Zigterman, 2000). The preceding provides an explanation as to why children are less likely to be able to provide why they are thus anxious. Bogels and Zigterman (2000) advise that thus it is important for physicians to therefore evaluate their capacity concerning social relationships with individuals the child knows, as well as assess their interactions with those in their peer group for signs of social phobia indications in addition to their behavior with and around adults. Examples of the procedural aspects for the preceding entail the utilization of what are termed the Anxiety Disorders Interview Schedule for Children, the Liebowitz Social Anxiety Scale for Adolescents and Children, the parent completed Child Behavior Checklist and the Teacher's Report Form (Bogels and Zigterman, 2000).

Social phobia differs from shyness in that the former condition causes individuals to avoid the anxiety producing situations by all means, whereas shyness can be attributed to a number of broad classifications as it

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represents different things to differing individuals. Crozier (1990, p. 2) states that "... shyness is not a precise term. It refers to feeling awkward or uncertain in social situations." Crozier (1990, p. 2) continues that shyness is associated with being and or feeling self conscious, the "... excessive monitoring of one's behaviors and over rehearsal of potential utterances" "The shy person feels anxious and often ... appears anxious to others" (Crozier, 1990, p. 2). Berent and Lemley (1994, p. 9) state that the word itself is "... too general to be of much help in identifying a problem and solving it" and that shyness has varied degrees of complexity and intensity from extremely mild and applicable in a few situations, to more perverse whereby it can thus be termed as a social phobia. Berent and Lemley (1994, p. 10-11) advise us that shyness and social anxiety are closely related and in both instances as they represent a "... learned response to social interaction". They go on to explain that shy and or socially anxious individuals "... may hesitate to pursue the things he or she is interested in, or even begin to avoid situations that cause nervousness or anxiety". Thus, the spectrum entailing shyness ranges from relatively few instances to actual social phobia. Shyness is not necessarily a criterion for social phobia in that individuals having a social anxiety disorder can be comfortable with certain types and or many differing people; however, they feel intense regarding certain specific situations (CNN. com, 2006).

Social anxiety disorder is termed as a social phobia, and or as a psychiatric anxiety disorder which entails overwhelming anxiety as well as excessive self consciousness concerning everyday situations (Crozier and Lynn, 2001, pp. 18-24). Individuals with this affliction often exhibit an intense, chronic as

well as persistent fear that they are being watched along with being judged by others, thinking that they might be either humiliated and or embarrassed as a result of their own actions (Crozier and Lynn, 2001, pp. 18-24). The distinction between generalized and specific social anxiety is indicated as those having the generalized type have significant distress with most, if not all social type situations, whereas specific, as the word implies, refers to such situations with specific connotations. Examples of the preceding are evidenced by glossophobia, which is the fear of speaking or performing in public, scriptophobia, which is the fear of writing in public, or paruresis, the fear of utilizing public restrooms (Bruch, 1989, pp. 37-47).

Sometimes referred to as anxious personality disorder, avoidant personality disorder is recognizable as a result of a pattern of social inhibition that is pervasive (Mental Health Matters. com, (2006). The foregoing description includes feelings of inadequacy as well as an extreme sensitivity regarding negative evaluation, and people with this affliction very often consider that they are socially inept and or unappealing on a personal level, thus they avoid situations entailing social interaction due to a fear of either being humiliated and or ridiculed. In general, avoidant personality disorder is usually first noticed in one's early childhood and is usually associated with either a real or perceived rejection by one's parents and or peers in that period (Dayhoff, 2000. pp. 29-38). The Diagnostic and Statistical Manual of Mental Disorders (2000) is widely utilized in diagnosing avoidant personality disorder and is identifiable by four or more of the following (Rettew, 2006):

1. Avoidance of occupational activities which involve degrees of significant interpersonal contact as a result of fears regarding criticism, rejection and or disapproval.
2. Being unwilling to get or be involved with someone unless being certain that one will be liked.
3. Through showing restraint in intimate relationships as a result of fearing shame or ridicule.
4. Being preoccupied in social situations with being criticized and or rejected.
5. By being inhibited in new situations entailing interpersonal relationships due to feelings of being inadequate.
6. Viewing one's self as inept socially, being unappealing and or inferior to other people.
7. Being reluctant to take on personal risks and or to engage in new activities as such could or might thus prove embarrassing.

Comorbidity is defined by the American Heritage Dictionary (2006) as “ A concomitant but unrelated pathological or disease process” with in the context of social phobia means the presence of either one or more such disorders as well as the primary disorder. Schuckit et al (1990, pp. 34-41) state that it represents the disorder that occurred first or the one representing the symptoms that are most dominant, which Klerman (1990, pp. 13-17) refers to as the primary disorder. The critical issues in dealing with comorbidity represents the proper and correct analysis of the varied disorders and understanding which one is the prevalent or primary one as well as the order, and impact of the associated disorders in which there are

combination and their influences on the patient. Biederman et al (1991, pp. 565-577) indicates that there are several hypotheses which may be utilized to account for the true patterns of comorbidity and critical issues:

1. that comorbid disorders are not distinct entities, they represent expressions termed phenotypic variability in the same disorder,
2. that each comorbid disorder is a distinct as well as separate entity,
3. that these disorders share vulnerabilities that are common, represented by genetic and or psychosocial,
4. that these disorders have a distinct subtype, or genetic variant, and a heterogeneous disorder,
5. that one syndrome represents what is termed an early manifestation, and
6. that the development as represented by one syndrome can increase the risk of comorbid disorder.

Caron and Rutter (1991, pp. 1063-1080) advise that the failure in understanding and attending to comorbidity patterns can thus cause researchers and physicians to come to misleading conclusions thereby creating negative intervention results. Achenbach (1990. pp. 271-278) warns us that the appearance of comorbidity might develop as a result of varied conceptual and or diagnostic models which can result in boundaries between disorders that are inappropriate and can potentially lead to the tendency for comparison of one diagnosis against normal individuals as opposed to other diagnosis. He warns that there is a need for well defined diagnosis in the instance of this occurrence, comorbidity (Achenbach, 1990. pp. 271-278).

Chapter 2 – Epidemiology of Generalized and Specific Social Phobia

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Termed the study of the scientific factors which affect the illness and health of populations, epidemiology serves as the logic and foundational basis for interventions that are made in the interests serving public health, along with preventive medicine (Rothman and Greenland, 1998, p. 29). The field is regarded as a cornerstone in the methodology of health research for the public sector and has the reputation of being highly regarded in the field of what is termed evidenced based medicine for the identification of disease risk factors and the determination of optimal treatment in the approaches representing clinical practice (Rothman and Greenland, 1998, p. 29). Morabia (2006, p. 3) explains that epidemiology, in terms of the public, represents a medical discipline dealing with the "... large scale outbreaks of infectious diseases". Chronicled in "Epidemiologia Espanola" spanning a period of thirteen centuries, Villalba, a Spanish physician, compiled a listing of epidemics as well as outbreaks which helped to define the term (Morabia, 2006, p. 3). Even though the practice extends back to the 16th century, as a scientific discipline it is relatively recent. The mission of epidemiology has "... historically been to identify determinants of human diseases ... mostly at the population level" (Morabia, 2006, p. 3), and this holds true today.

Epidemiology is prevalent in today's communities under the term 'Community-oriented primary care', or COPC) and represents a systematic health care approach that is based upon principles of epidemiology (Rhyne et al, 1998). Usage has demonstrated that COPC, representing primary care, health promotion and preventive medicine has positive community benefits on a global basis (Rhyne et al, 1998). The methodology, 'Community-oriented primary care', entails the process of seeking to improve the health

of a community utilizing the aforementioned principles, public health, primary care and epidemiology, which traditionally has been used to describe the health care system whereby a community and or targeted population is thus the focus (Wright, 1993). The American Public Health Association description of Community-oriented primary care states that it represents a “... systematic process ... identifying and addressing ... health problems of a defined population” and that it thus can be implemented via the resources which are already available within most communities (Rhyne et al, 1998). It, COPC, represents a team comprised of health professionals, along with community members, who work in partnership over a long duration in treating and diagnosing patients in a community in a similar manner as does a primary care doctor, and while primary care physicians are not needed for or in every project, they nevertheless need to be involved in the process (Rhyne et al, 1998).

The availability of epidemiologic studies from Europe, Asia and the United States over the past twenty years has permitted a clearer and sharper picture of social phobia with respect to its incidence, severity, prevalence and other correlations (Zucchi et al, 2000, pp. 17-24). The preceding historical base of epidemiologic information helps to provide a comprehensive reference point concerning the age of onset and incidence of social phobia from a broad population cross section. Studies conducted indicate that social phobia is the most prevalent of anxiety disorder (Carta et al, 2004), as shown by the following:

Table 1- Lifetime Prevalence of Social Phobia in the

General Populations of Europe and the United States

(Carta et al, 2004)

Country	Diagnostic Criteria	Lifetime Prevalence	Lifetime		Total
			Male	Female	
Italy	DMS-III-R	1110	-	-	1.0
USA	DIS	18571	2.0	3.1	2.4
Iceland	DSM-III	862	2.5	4.5	3.5
Switzerland	DSM-III	591	3.1	5.7	4.4
Germany	DMS-III	3021	2.2	4.8	3.5
Spain	DIS	237		8.9	
Netherlands	DSM-III-R	5.9	9.7	7.8	
France	DSM-IV				7.3

The preceding show the lifetime prevalence of Social Phobia of 2.2% across the board, representing 1.5% for males and 2.8% for females.

Table 2 – Lifetime Prevalence of Social Phobia According to Age and Sex

(Carta et al, 2004)

Age	Male	O	Female	OR	Total	OR
Under 25	1 (1.3)	0.9	4 (5.0)	2.3	5 (3.4)	1.7
25-44	4 (2.5)	2.5	4 (2.1)	0.7	8 (2.2)	1.1
45-64	1 (1.07)	0.4	4 (2.4)	0.8	5 (1.6)	0.6
65 and older	1 (1.1)	0.7	4 (2.8)	1.1	5 (2.2)	0.9

The preceding Table represents studies conducted in Europe and the United States for the countries indicated with OR representing the degree of associated disorders that were observed regarding frequency in the populations that were not affected by social phobia.

Table 3 - Lifetime Comorbidity of Social Phobia

(Carta et al, 2004)

Condition	Lifetime Prevalen	OR	X2*
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	ce	%		
Depressive Episode (DE)	9 (39.1)	4.3	11.3	1*
Dysthymia (DD)	5 (21.7)	7.1	14.3	1*
Generalized Anxiety Disorder (GAD)	10 (43.4)	6.5	20.9	9*
Panic Attack Disorder (PAD)	2 (8.7)	3.3	1.1	
Specific Phobia	1 (4.3)	8.6	1.6	

* Where p is less than 0.001

The preceding Table represents the rate of comorbidity concerning major psychiatric disorders which were observed in the overall general populations of Europe and the United States, along with the degree of associated disorders (OR) in the reported populations which were not affected by social phobia. The mean age representing the onset of comorbid DE represented 6.5 plus or minus 6.6 years, whereas GAD represented a mean of 4.3 plus or minus 7.8 years later (Carta et al, 2004).

In a study conducted by the Johns Hopkins Medical Institute, they found six regions in the human genome that very well could play a role with regard to the susceptibility of obsessive compulsive disorder (Johns Hopkins Medical Institute, 2006). The study added to the growing evidence of a genetic basis for obsessive compulsive disorder and thus its inheritability through the finding of genetic markers, or what are termed similarities, in the genomes of individuals with obsessive compulsive disorder as represented by six significance regions within the genome that are on five differing chromosomes which appeared to be linked to obsessive compulsive disorder (Johns Hopkins Medical Institute, 2006). Dorak (2006) advises us that genetic epidemiology is related to and overlaps molecular epidemiology and that the epidemiological evaluation aims to seek the detection of the inheritance pattern regarding a disease, localize it and find the marker that is associated with its susceptibility. Dorak (2006) states that the steps in genetic epidemiologic research are:

- the establishment of the fact that there is a genetic component concerning the diso