History Research Journal

ISSN: 0976-5425
Vol-5-Issue-4-July-August-2019

Management of Low Self-Esteem and Social Interaction Anxiety Through Multimodal Therapy: A Case Study

Dr. Pankaj Singh
Assistant Professor Psychology,
School of Humanities,
Lovely Professional University, Phagwara, Punjab, India

Shaveta Tewari,
Ph D Research Scholar,
Lovely Professional University, Phagwara, Punjab, India

Abstract: Most of the times counsellors use therapeutic toolswithout a systematic method for analyzing the effectiveness of therapies. Multimodal Therapy (MMT), is a seven-fold model for assessing the individual and planning the treatment. Anxiety disorders are common in the general population and can have a damaging influence on the life of person having it. Self-esteem has prevalent and significant effect on personality and people with high self-esteem are happier than those in low self-esteem (Coopersmith, 1967). In this case study, MMT was applied to a 23-year-old male student having Low self-esteem and High Social Interaction Anxiety. This study aimed to check the role of Multi Modal Therapy in a student having Low self-esteem and High Social Interaction Anxiety. After assessing him on Social Interaction Anxiety Scale (SIAS) by Mattick and Clarke (1998) along with Rosenberg Self-Esteem Scale by Morris Rosenberg (1993), it was revealed that his score on SAIS were high and on Self-Esteem Scale his score was very low. Client scored 44 on SAIS and a score of 43 or more indicates traditional social anxiety. He scored 12 on Rosenberg Self-Esteem. A score of 15 or less than 15 indicates low self-esteem on Rosenberg Self-Esteem. So, the client was treated with Multimodal Therapy for ten weeks. The treatment consisted of 10 sessions for 12 weeks. The social interaction anxiety level and level of self-esteem was reassessed after twelve weeks. Results showed that Social Interaction Anxiety was reduced from 44 to 32, (72% reduction) and his levels of self-esteem were increased from 12 to 17 (70% gain). The research findings indicated positive improvement in self-report scores.

Keywords: Lazarus Multi Modal Therapy, Social Interaction Anxiety, Low Self-esteem.

Introduction

Anxiety disorders are pervasive in the general population (Kessler, et al., 1994) and may have inimical effect on the life of persons who go through any of anxiety disorders. Self-effacement and sheepishness are related wordsindicating a propensity for few people to fear and avoid the scrutiny of others. In few cases, these traits are so noticeable that the individual end up having most of socialinteractions with intense discomfort. Such people suffer from "social anxiety disorder" or "social phobia." Fewstudies found generalityof SAD as approximately 1% that showed slightly higher presence of anxiety in girls. Social anxiety was ignored by the medical fraternity, but now accumulating lot of attention as a serious but treatable condition (Stein, 1999 &1997). People having social anxiety feel deficient on self-esteem, difficulty dealing with people in authority, and are unable to speak in front of even small groups of people. Different age groups have different patterns: older adults go through social anxiety at a lower level but the level of their fear remains greater multitude of situations, while young adults has shown higher levels of social anxiety but in particular situations. Young adults constantly experience fear and dodging in comparison to young children. Few communities based studies researched on generality of Social Anxiety Disorder and found higher presence of SAD in girls than boys (Kashani&Orvaschal, 1990; McGee. et al., 1990). A person having social anxiety lives all his life in fear, apprehension, avoidance, hiding their inner feelings & putting up a shield to protect their secret. People with social anxiety disorder prefer staying alone because of the fact that everyday social environments give them a

ISSN: 0976-5425
Vol-5-Issue-4-July-August-2019

lot of anxiety. They find peace in that isolation. But isolation bring another challenges likemostly sufferers may turn to over eating, substance abuse, other addictions or even self-mutilation to handle their stress. Physical signs and symptoms of social anxiety disorder include: sweating, nausea, stomach upset, difficulty talking, blushing muscle tension, confusion, shaky voice palpitations, trembling or shaking hands and difficulty making eye contact.Related personality attributes in people with social anxiety disorder may involve: weak social skills, low self-esteem, trouble saying No, negative self-schema, low self-esteem, hypersensitivity to criticism and poor social skills. Lamentably, without right awareness, understanding medical/psychological care social anxiety continues to spoils the lives of patients having it.

The wordbook of psychological science defines self-esteem as the level to which one values oneself (Hartgill, 2003). According to Rosenberg, (1975 &1979) Individuals' negative or positive attitude of themselves, is called Self-esteem. Orth & Robins, (2014) defined Self-esteem as an individual's self-evaluation of his or her worth. As onemove forward in life, self-esteem inevitably increases and decreases. After years of discussion, a concord has appeared about the self-esteem that it develops across the lifespan. One's potential to achieve what they most desire is directly related to their self-esteem.Self-esteem has prevalent and remarkable effect on one's life. It was noted that people high in self-esteem were happier and more successful in having good social interactions than people with low in self-esteem (Coopersmith, 1967). It can influence how an individual will do academically and socially. (Erikson, 1968), a foremost developmental psychologist, identified that self-esteem is a function of identity development that is the consequence of successfully engaging in the tasks related to each developmental stage of life. Self-esteem is an aspect of personality that often serves as an indicator of what is significantly absent. Self-esteem draws most public attention when it is lacking entirely. Thus, self-esteem is often most obviously measured in its absence. But like a thermometer, it is an indicator of a problem, not a diagnosis and solution unto itself. A huge number of longitudinal and cross-sectional, studies have emerged with the evidence that (a) men showed the tendency to have higher self-esteem than women (b) that both men and women indicated to age-related improvements in self-esteem from late adolescence to middle adulthood. But for both genders, self-esteem is comparatively high in childhood, falls during adolescence, rises progressively throughout adulthood and shows to get decline in old age (Orth & Robins, 2014; Robins &Trzesniewski, 2005; Wagner, Gerstorf, Hoppmann, &Luszcz, 2013).

Lazarus (1976) developed The Multimodal Modal Therapy in response to research that the therapeutic success resulting from unimodal treatments generally was short-lived. Multimodal Modal Therapy involves seven apparent but interconnected dimensions as Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, Drugs/ Biologicals, the appropriate acronym BASIC I.D. comes from the first alphabet of each word. The multimodal therapy contributes counsellor a broad pattern. When a therapist, disparate sensations from emotions, separates images from cognitions, gives an emphasis on both intra-individualand interpersonal actions, and accentuates the biological part, the multimodal orientation is most far-reaching. By evaluating a client on BASIC I.D. therapistsattempt to do everything in their power.

A more detailed trouble findingpattern is obtained from the Multimodal Life History Inventory and Structural Profile Inventory. Usually after the initial sessionLife History Inventory, a 15-page inventory which accelerates treatment plan when carefully filled by clients as a homework assignment. SPI evaluates the range to which people are action-oriented (behavior),their emotionality (affect), sensory experiences (sensation), how much time they indulge with fantasy and day dreaming (imagery), analytical tendencies (cognition), importance of other people to them (interpersonal) and health related awareness (drugs/biology). Therefore, this study aimed to assess the efficacy of Multimodal therapy in managing Low Self Esteem and Social Interaction Anxiety.

METHODOLOGY

This is a case study of a university student who is 22 years old, doing B.Tech in Lovely Professional University, Phagwara, Punjab. He himself came for counseling with the complaint that he becomes anxious, angry, frustrated in social situations and most often feels low. After testing him on Social interaction anxiety inventory & Rosenberg Self Esteem Scale, it was revealed that his levels of social interaction anxiety were high and levels of the self-esteem was very low. After the initial assessment and as per the tradition of MMT with literate patients, attention was paid on filling out multimodal Life History Inventory (LHI). He was given Life History Inventory and Structural Profile Inventory as a home assignment. In second session, the inputs taken

ISSN: 0976-5425
Vol-5-Issue-4-July-August-2019

from the inventory were discussed. Plan of treatmentwas established. LHI revealed that the root cause of his issues lied in the childhood. His father was an alcoholic. During the initial interview, he revealed that he was the victim of physical abuse by his father. Several interconnected problems were brought to light. His mental images were full with the sad memories of his past; his cognition had statements of self-hatred. His social relationships were marked by unassertive behavior patterns.This student was treated with Positive Reinforcement, The Empty Chair Technique, Hypnosis, Bibliotherapy as he was suggested to read two books handed over by therapist, Positive Imagery, Social Skills Training and encouraged to maintain good health habits. The treatment consisted of 10 sessions for 12 weeks. The client's showed great improvement by the end of treatment based on self-report scales and questionnaires.

Interventions:The following interventions were given for twelve weeks.

(1) Positive Reinforcement (2) The Empty Chair Technique (3)Hypnosis (4) Bibliotherapy
(5) Positive Imagery (6) Social Skills Training (7) encouraged to maintain good health habits.

Results

The student was reassessed after twelve weeks. Results showed that Social Interaction Anxiety was reduced significantly (72%) from 44 to 32, on Social Interaction Anxiety Scale (SIAS) [Table 1].

Table 1: Score of Social Interaction Anxiety Scale Before and After Intervention

Score Range	Before	After	Reduction
(0-80)	44	32	72%

Whereas client's Self-Esteem was improved (70%) from 12 to 17 [Table 2].

Table 2: Score of Rosenberg Self-Esteem Scale Before and After Intervention

Score Range	Before	After	Improvement
(0-30)	12	17	70%

DISCUSSION

The purpose of the present study was to assess the effectiveness of Multi Modal Therapy on Social Interaction Anxiety and self-esteem. For the objective assessment of Social Interaction Anxiety, a psychometric scale, namely, Social Interaction Anxiety Scale (SIAS) by Mattick and Clarke (1998) was used. For the objective assessment of self-esteem, Rosenberg Self-Esteem Scale by Morris Rosenberg (1993) was used. To know the dominant information of the student, Life History Inventory (LHI) & Structural Profile Inventory (SPI) by Lazarus were used. A protocol of Multi Modal Therapy was maintained and used to treat the client. Before giving interventions client was tested on Social Interaction Anxiety Scale (SIAS) and Rosenberg Self-Esteem Scale. Scores of Social Interaction Anxiety Scale (SIAS) indicated high social interaction anxiety and scores of Rosenberg Self-Esteem Scale indicated low self-esteem. Client's dominant modality on Structural Profile Inventory (SPI) was found to be Imagery and Cognition. So, Client was given therapy as per his preferences on Structural Profile Inventory (SPI).Client was given intervention for twelve weeks with Positive Reinforcement, The Empty Chair Technique, Hypnosis, Bibliotherapy, Positive Imagery, Social Skills Training and encouraged to maintain good health habits. To bring the changes in Behavior, Positive Reinforcement was used.Positive reinforcement is a method to introduce a desirable reward to encourage the behavior that is desired. Client mentioned an outburst of temper in Life History Inventory. Empty Chair Technique was preferred to understand the reason of outbursts. Empty-chair technique is a psychotherapeutic techniqueused in Gestalt therapyin which the client takes part in a role-played conversation with a person with whom the client is having some sort of issue to resolve or to rehearse future encounters with that person. In sensations, client indicated that he often had watery eyes, sweating in palms and doesn't like to be touched. These sensations were dealt with Hypnosis. Hypnosis refers to a therapeutic tool used by therapists to make interactions with clients to bring them into a relaxed state of mind. Client's responded well to hypnosis. Bibliotherapy was introduced to the client. Bibliotherapy includes reading a book or books to enhance the effect of therapy. Client was suggested to read

ISSN: 0976-5425
Vol-5-Issue-4-July-August-2019

'The monk who sold its Ferrari' by Robin Sharma and few chapters of 'Many lives Many masters' by Brian Weiss. Positive Imagery was used to clear the images of unpleasant childhood and loneliness. The power of positive mental imagery for healing physical afflictions can help one cope with pain and it can induce a feeling of optimism while overcoming boredom (Lazarus,1978; Singer & Switzer,1980)

Whereas, through Social Training was aimed at fostering personality traits, such as, courage, confidence, optimism and the communication skills needed to enhance social communication for better self-esteem.

To deal with Drug/Biological part, client was motivated to main good health habits. This case study emerged with clearly pointing to the efficacy of the multimodal therapy. The client showed reliable and clinically significant change on Rosenberg self-esteem scale & Social Interaction Anxiety Scale (SIAS). Further research is needed to confirm the efficacy of MMT to compare its efficacy and effectiveness to alternative treatments.

Conclusion

The current case study focused on assessing the efficacy of Multimodal Therapy in the management of low self-esteem and Social Interaction Anxiety. A package of intervention according to Multimodal Therapy was introduced to the client and after the intervention his Social Interaction anxiety was reduced and self-esteem was enhanced with a gain score of 12 and 5 respectively.

References

Boer, J. A. (1997). Social phobia: epidemiology, recognition, and treatment. *BMJ* . 315. 796-800.

Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco: W. H. Freeman & Co.

Feingold, A. (1994). Gender differences in personality: A meta-analysis. *Psychological Bulletin, 116,* 429–456. http://dx.doi.org/10.1037/0033-2909.116.3.429

Hartgill, M. (2003). Increasing Self-esteem in the Therapy setting through the use of a workbook.Masters Research Report submitted to the University of the Witwatersrand.

Huang, C. (2010). Mean-level change in self-esteem from childhood through adulthood: Meta-analysis of longitudinal studies. *Review ofGeneral Psychology, 14,* 251–260. http://dx.doi.org/10.1037/a0020543

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., and Kendler, K.S. (1994). Lifetime and 12-month prevalence of DSM-III Psychiatric disorders in the United States. *Archives of general psychiatry*. 51, 8-1.

Kling, K. C., Hyde, J. S., Showers, C. J., &Buswell, B. N. (1999). Gender differences in self-esteem: A meta-analysis. *Psychological Bulletin. 125,* 470–500. http://dx.doi.org/10.1037/0033-2909.125.4.470

Lazarus, A. A. (1976). Multimodal behavior therapy. New York: Springer.

Lazarus, A. A. (1978). What is multimodal therapy? a brief overview. *Elementary School Guidance & Counseling.* 13 (1) 6-11.

Liebowitz, M. R., Gorman J. M., Fyer A. J., Klein, D. F. (1985). Social phobia: review of a neglected anxiety disorder. *Arch Gen Psychiatry*. 42, 729-36.

McGeown (Ed.), *Psychology of gender differences*. 131–143. Hauppauge, NY: Nova.

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science, 23,* 381–387. http://dx.doi .org/10.1177/0963721414547414

Robins, R. W., &Trzesniewski, K. H. (2005). Self-esteem development across the lifespan. *Current Directions in Psychological Science. 14.* 158–162. http://dx.doi.org/10.1111/j.0963-7214.2005.00353.x

Shaw, B. A., Liang, J., & Krause, N. (2010). Age and race differences in the trajectories of self-esteem. *Psychology and Aging, 25,* 84–94. http://dx.doi.org/10.1037/a0018242

Singer & Switzer (1980). Mind-Play: The Creative Uses of Fantasy. Prentice Hall Trade Englewood Cliffs, N.J.

Stein, M. B. (1996). How shy is too shy? *Lancet.* 347, 1131-2.

Stein, M. B.(1999). Coming face-to-face with social phobia. *Am Fam Physician.* 60. 2244-2247.

Trzesniewski, K., Donnellan, B., & Robins, R. W. (2013). Development of self-esteem. In V. Zeigler-Hill (Ed.), *Self-esteem.* 60–79. NY: Psychology Press, NewYork.

Twenge, J. M., & Campbell, W. K. (2001). Age and birth cohort differences in self-esteem: A cross-temporal meta-analysis. *Personality andSocial Psychology Review. 5*, 321–344. http://dx.doi.org/10.1207/

ISSN: 0976-5425
Vol-5-Issue-4-July-August-2019

Wagner, J., Gerstorf, D., Hoppmann, C., &Luszcz, M. A. (2013). The nature and correlates of self-esteem trajectories in late life. *Journal ofPersonality and Social Psychology. 105,* 139–153. http://dx.doi.org/10.1037/a0032279

Zeigler, H. V., & Myers, E. M. (2012). A review of gender differences in self-esteem. In S. P. http://dx.doi.org/10.1207/