International Journal of Psychology , Social and Educational Sciences
Vol.2, NO.1 , P: 17 - 26
Received : 15 January 2020
Accepted : 20 March 2020

Relationship between body dysmorphic with social anxiety in women teachers in Abdanan city

Mehdi Yaseminia
Master of Personality Psychology from Islamic Azad University, Dezful Branch.
mzmz1363@gmail.com

Nasser Saraj Khorami
PhD in Clinical Psychology, Faculty Member, Islamic Azad University, Dezful Branch.
dr_sarraj@yahoo.com

Abstract
The purpose of this study was to investigate the relationship between body dysmorphic with social anxiety in women teachers in Abdanan city. The present research has been applied in based on the objective, according to the method of data collection, descriptive, based on type, correlation and based on the type of data, quantitative data. The statistical population of this study was all female teachers in Abdanan city in the academic year of 2017-2018, with 501 people. The sample size was 217, according to the sample size set for Krejcie and Morgan and sampling method was stratified random sampling. Method and tools for data were the SPIN test-Conor (2000), YBOCS_BDD test for Dysmorphic Disorder-Sadock et al (2005). To test the hypothesis of the research, SPSS software was used for Pearson correlation and multiple regression. The results showed that at 95% confidence level, Body dysmorphic have a significant relationship with social anxiety. Also research findings indicate that body dysmorphic variable in the significance level of 5% is a predictor of social anxiety in Abdanan female .

Key words: social anxiety, body dysmorphic, women teachers.

Introduction

One of the most important psychological problems and disorders, along with the ever-increasing changes in society that have manifested themselves more than ever, is social anxiety disorder. Social anxiety is a anxiety or fear that arises in interpersonal or functional situations, and people with high social anxiety are afraid of negative self-esteem or doing something that causes embarrassment. Research suggests that anxiety is associated with feelings, behaviors, and symptoms of dissatisfaction with others (Abbasi Asl et al., 2016). Social anxiety disorder is characterized by dysfunction in cognitive, interpersonal, academic, and occupational areas (Kashedan, 2002). In recent years, numerous studies have examined the prevalence, etiology, and treatment of this clinical problem, with demographic studies showing that the prevalence rate of social anxiety during life was 13.3% (Abbasi Asl et al., 2016). As the prevalence of this anxiety disorder increases, researchers are looking for factors that contribute to this type of anxiety. This disorder is one of the types of fears that are characterized by constant fear of negative evaluation from the perspective of others and severe distress or avoidance of situations in which others scrutinize people (Ganji, 2016). In terms of prevalence, social anxiety is one of the

three most common psychiatric disorders after depression and alcoholism (Moitra et al., Quoted by Hassanvand, Amozadeh et al., 2013). Social anxiety is known by some physiological characteristics (redness of the cheeks, sweating, dry mouth, and trembling when confronted with worrying situations), behavioral characteristics (withdrawal, avoidance of eye contact, fear of expression, and fear of public speaking or addressing) It is clear (Stravinsky, Bond and Amado, 2004).

One of the most influential variables related to social anxiety is Body dysmorphic disorder (BDD) (Angela Feng and Stephen G. Hoffman, 2011). The persistence of a perceived defect in one's appearance, which is insignificant to others, and the accompanying repetitive behaviors (such as mirror examination). The disorder generally begins in adulthood, but is often overlooked and severely underestimated (Georgia Karbes et al., 2017). Social, cultural, and political changes in the late twentieth century, the emergence and spread of new technologies such as gene therapy, medical interventions in the body, cosmetic surgery, and the growth of consumerist culture in modern societies have attracted too much attention (Jafari, M. et al., 2017). Women who do cosmetic surgery have significantly higher scores than women who do not have cosmetic surgery in terms of body dysmorphic disorder and social anxiety (Deh Kiani and Mardpour, 2009). Even mental health has had a significant positive relationship with the evaluation of the deformity of the body in women seeking surgery (Fattahi, et al., 2017). The term mischief was first used in 1886 by Morsley, an Italian psychiatrist, to describe the abnormal occupations associated with body beauty. It is still used in some cases. Dysmorph is a Greek word meaning unusual and abnormality

In general, dysmorphia or dysmorphia means ugliness. The ancient Greek historian Herodotus used the word to refer to the legend of Sparta's ugliest daughter. The girl may also have had a birth defect because her parents had strictly instructed her nurse not to show her to anyone. Every day, the nurse would take Dysmorphia to Helen's temple and pray that Helen would save her from ugliness. After a long time, Helen responded positively to this request, turning Dysmorphia into Sparta's most beautiful daughter. Morselli's description of phobia included an individual's sense of unattractiveness or physical disability despite his or her natural appearance (Sabansky et al., 2000). In addition, he explained the similarities of Body dysmorphic disorder and obsessive-compulsive disorder and identified the tendencies of obsessive-compulsive disorder for Body dysmorphic disorder (Phillips et al., 1993). Also, at the beginning of the twentieth century, malformations were described by two European psychiatrists, Janet (1903) and Karplin (1909). Janet also described obsessive-compulsive disorder and the severity of Body dysmorphic disorder and believed that the disorder was detected under the same symptoms. Emile Karplin believed that phobia should be considered an obsessive-compulsive disorder (Phillips, 1991; Sabansky et al., 2000). Pierre Jeanne called it an obsession with body shape. Freud wrote about this disorder in his description of Wolf-Man, who was very worried about his nose. Although Body dysmorphic disorder accounts for a significant amount of European literature, this disorder was not described in a psychiatric text until the publication of the tenth review of the 1992 International Classification of Diseases and Related Problems. Diagnosis of Body dysmorphic disorder is allowed only if the symptoms cause severe damage to the patient's function for at least 6 months.

In addition, a distinction must be made between delusions and the non-delusional type of body dysmorphic disorder (World Health Organization, 1994). Body dysmorphic disorder was first identified in the DSM_III in 1980 as

malformations, which are classified as a type of physical disorder. Although research on body dysmorphic disorder has been limited, many people have been affected by the disorder and have been affected in several aspects of their daily lives. The term Body dysmorphic disorder was first introduced in DSM_III_R in 1987 and replaced the term malformation, in which thoughts related to body deformity were more important than avoidance fears. In addition, the disorder was classified as a separate classification and a distinction was made between delusional and non-delusional characteristics of bodily dysmorphic disorder (Phillips, 2002). Because DSM editors believe that "fear of mischief" incorrectly implies the existence of a behavioral pattern of phobic avoidance. Body dysmorphic disorder was classified in the DSM-IV and DSM-IV-R group as a form of physical disorder, and according to the new DSM-V classification it is in the group of obsessive-compulsive disorder and related disorders.

BDD is a mental disorder characterized by widespread anxiety with a perceived apparent defect. People with BDD often spend many hours a day thinking about their appearance and attending ceremonies regularly to improve or hide worrying areas of the body. Also, most of them are disrupted due to social and occupational or academic performance and lead to low quality of life (Matthias Kels et al., 2015). BDD describes repetitive and time-consuming behaviors such as looking in the mirror too much, cleaning, meditating, reassuring, touching or measuring body parts, researching methods to improve one's appearance, and comparing one's appearance with others (Phillips, Menard, Fei and Weisberg, 2005). The most common concerns include skin, hair and nose (Phillips, Menard, Fi and Weisberg 2005). In severe cases, people with BDD become housewives for fear of being seen by others (Phillips, McElroy, Cock and Pop, 1993). Studies show that social anxiety disorder (SAD) and Body dysmorphic disorder (BDD) show the same age, have a unique path, and show similar cognitive approaches to interpreting vague social information in a negative way. Intercultural research findings suggest that BDD may be considered a subset of SAD in some Eastern cultures (Angela Feng and Stephen G. Hoffman, 2011). Large epidemiological studies have shown that SAD is more common in women (Kessler, Jay O, and Nelson, 1994). A demographic study found the prevalence of BDD in an age group of 34- to 36-year-old women was higher (Otto, Wilhelm, Cohen, & Harlow, 2001).

BDD is characterized by mild or excessive concern, or the perception and fear of negative evaluation by others that is at the core of SAD characteristics. In addition, in some Eastern cultures, BDD is thought to be a form of SAD (Angela Feng and Stephanie, J. Hoffman, 2011). Having BDD with anxiety disorder is more likely than not having BDD alone is more associated with being unemployed, staying home, and having suicidal thoughts and attempts (Coles et al., 2006). Among people with BDD, 12 to 68.8 percent have SAD, and those with SAD have 4.8 to 12 percent who have BDD (Coles et al., 2006). Another study of a sample of patients with anxiety and depression disorders found that the prevalence of BDD was 11% in people with SAD and 8% in OCD (Brooman 1995). Some evidence suggests that BDD may be more closely related to different subtypes of SAD, with studies showing that BDD is highly correlated with avoidant personality disorder (Will, Bock, Jorney, & Drydon, 1996). Evidence suggests that BDD and SAD are similar in phenomenology, clinical features, cognitive errors, and treatment outcomes, and are even accepted as variables of a disorder in certain cultures (Angela Feng and Stephen G. Hamann, 2011). People with BDD and SAD appear to use similar methods, such as serotonin reuptake inhibitors, as well as cognitive-behavioral therapies (Pinto and Phillips, 2005). All of this

indicates that body deformity is one of the most important variables associated with social anxiety. Therefore, this study seeks to ask whether body deformity is related to social anxiety of female teachers in Abdanan city or not.

Research Hypothesis: There is a significant relationship between body deformity and social anxiety in female teachers in Abdanan city.

Method

The present study examined the relationship between body deformity and social anxiety in female teachers in Abdanan city. Therefore, the present study was descriptive applied correlational and quantitative. The statistical population included 501 women teachers in Abdanan city in the academic year of 1996-97. The number of samples of the present study was selected based on the Krejcie & Morgan sample size determination table. According to the Education Department of Abdanan, the number of female teachers working in the three levels of the city was 501, of which 279 were in primary school, 104 in secondary school and 118 in high school. The statistical sample size was 217 people according to the table of sample size of Karajsi and Morgan. The sample selection method was stratified random sampling, so we must first determine the number of sample individuals and then determine the ratio of each subgroup according to the volume of each group of the community multiply by the sample size (i.e. 217). The sample size of the groups was calculated and determined as follows:

Primary schools: $\frac{279}{501} \times 217 = 120$

Secondary school $\frac{104}{501} \times 217 = 45$

High school $\frac{118}{501} \times 217 = 52$

The method of selecting the samples for the implementation of the questionnaires was such that samples were selected from almost all schools, that is, from each school, one to several people were randomly selected and after presenting and explaining the questions of the questionnaires, they completed and answered them.

Measurement instrument

A. Social phobia inventory

This questionnaire was first developed by Connor et al. (2000). Social phobia inventory is a 17-item self-assessment scale that has three subscales of fear (6 items), avoidance (7 items), and physiological discomfort (4 items), in which each item is based on a five-point Likert scale (0 = not at all, 1 = Low, 2 = to some extent, 3 = high, 4 = very high). The scores of each subscale are obtained by summing the scores of the materials related to that subscale. Based on the results obtained for the interpretation of the scores, the 40-point cut-off with 80% detection accuracy and the 50-point cut-off efficiency of 89% detection distinguishes people with social phobia from non-suspicious individuals (Connor et al., 2000, quoting Fathi, Ashtiani et al., 2009).

Reliability and validity:

The reliability of this questionnaire was tested by retesting method in groups with social anxiety diagnosis and was 78 to 89% (Connor et al., 2000, quoted by Hassanvand Amouzadeh, 2013). Hassanvand Amouzadeh (2012) in a non-clinical sample in Iran, obtained the validity and reliability of this scale. The alpha coefficient of the questionnaire in the first half of the test was 82%, for the second half of the test was 76% and also the correlation of the two halves of the test was 84%. According to Fathi Ashtiani (2009), its internal coefficient (alpha coefficient) has been reported in a normal group to be 94%, and for the subscales of fear was 89%, 91% for avoidance and 80% for physiological discomfort. The validity of the structure was compared in two groups of subjects with social phobia and normal subjects without psychiatric diagnosis, which showed a significant

difference, which indicated the validity of the structure (Fathi Ashtiani, 2009).

B. Yale brown obsessive compulsive scale for dysmorphic disorder (YBOCS_BDD) (for assessing body deformity):

The questionnaire was developed in 2005 by Sadok et al. The test has 31 questions and aims to assess the dimensions of the body's deformity metacognition, metacognitive control strategies, thought-practical or fusion of thoughts, positive and negative metacognitive beliefs, and safety behaviors. The response spectrum is of the Likert type, where the score for each option is presented in the table below:

To get points for each dimension, you must add the sum of the scores of the questions related to that dimension. To get the overall score of the questionnaire, the total score must also add up all the questions.

Low score: 31

Average score: 93

High score: 155

Rating between 31 and 62: The rate of body deformity is low.

Rating between 62 and 93: The rate of body deformity is moderate.

Score above 93: The rate of body deformity is high.

Reliability and Validity:In the study of Rabiee et al. (2011), a simultaneous validity study of 200 students showed that Yale-Brown's questionnaire assessing the deformity of the body and its factors had a positive and significant correlation of 74% with a modified scale of Yale-Brown's obsessive-compulsive disorder for Body dysmorphic disorder (YBOCS-BDD) (Rabiee et al., 2011). In general, studies have shown that this scale has good validity and reliability in the sample of Iranian students, so that the range of alpha coefficient in 87% was obtained for the cause of obsessive behaviors and thoughts. In factor analysis, obsessive-compulsive disorder control thoughts and behaviors explained a total of 66% of the questionnaire variance, and the overall results showed that the modified Yale-Brown Obsessive-Compulsive Scale for Body dysmorphic disorder in the Iranian sample had appropriate validity and reliability. It can be used in diagnostic and therapeutic cases (Rabiee, Khorram Del, Kalantari and Molavi, 2009).

Findings

The descriptive findings of this study include statistical indicators such as mean, standard deviation and number of sample subjects that are presented in the following tables for all variables studied in this study.

Table 1: Central and Distribution Indicators of body deformity and social anxiety in female teachers of Abdanan city

Descriptive statistics						
Max	Min	SD	M	n	items	
56	0	9/77	18/51	217	17	social anxiety
139	31	21/13	64/36	217	31	Body deformity

As can be seen in Table 1, the mean and standard deviation of the social anxiety score in female teachers of Abdanan city was (18/18 and 9/77) and body deformity in female teachers of Abdanan city was (64/36 and 21/21).

Inferential findings related to the hypotheses of this study included Kolmogorov-Smirnov test, Pearson correlation and repeated linear regression, which are presented for all variables in the following tables with error level of 0.05.

Table 2: Kolmogorov-Smirnov test to assume the normality of body deformity and social anxiety scores in female teachers in Abdanan city

Kolmogorov-Smirnov test			Variable
results	Sig	Value z	
accepted) H_0 normal(	0/12	1/17	social anxiety
accepted) H_0 normal(	0/60	0/766	Body deformity

** Significance at the level of 0.01

* Significance at the level of 0.05

In order to compare the distribution of the obtained data from the obtained research with the normal distribution, the Kolmogorov-Smirnov test was used.

According to the information obtained from the above table and with emphasis on z obtained, the score of body deformity and social anxiety in female teachers of Abdanan city at the level of 0.05 is not significant. Therefore, it can be concluded that the distribution of data related to research hypotheses is normal and parametric tests such as Pearson correlation and repeated linear regression can be used to determine the relationship between personality traits and body deformity, social anxiety in female teachers in Abdanan.

Table 3: Pearson's correlation between body deformity and social anxiety in female teachers in Abdanan city

social anxiety						Dependent var () Independent var ()
Test results	n	Error level (α)	sig (P)	Coefficient of determination (R^2)	Pearson (r)	
rejected H_0	217	0/05	0/001	0/199	0/447**	Body deformity

** Significance at the level of 0.01

* Significance at the level of 0.05

Investigating the research hypothesis: According to Table 3, it can be seen that the amount of Pearson correlation test between body deformity and social anxiety in female teachers of Abdanan city at the level of 0.05 was significant. Therefore, the null hypothesis is rejected and the test is significant, and since the correlation value is positive, we accept the existence of a direct relationship.Therefore, with 95% confidence, we conclude that the higher the body deformity in female teachers in Abdanan, the more social anxiety will accompany them. According to the value of the coefficient of determination (R2), it has been determined that 20% of social anxiety variance in female teachers of Abdanan city can be explained by predictive variables (body deformity). Therefore, the research hypothesis (there is a relationship between body deformity and social anxiety in female teachers of Abdanan city) is confirmed.

Discussion

In this study, the hypothesis was analyzed that there is a significant relationship between body deformity and social anxiety in female teachers in Abdanan city. The results of the research hypothesis are as follows:

Table 3 shows that 0.447 percent of the Pearson correlation coefficient between body deformity and social anxiety is significant in female teachers in Abdanan city at the level of 0.05. Therefore, the null hypothesis is rejected and the test is significant, and since the correlation value is positive, we accept the existence of a direct relationship. Therefore, with 95% confidence, we conclude that the higher the body deformity in female teachers in Abdanan, the more social anxiety will accompany them. According to the coefficient of determination (R2), it has been determined that 20% of social anxiety variance in female teachers of Abdanan city can be explained by predictive variables (body deformity). Therefore, the second hypothesis of the study (there is a relationship between body deformity and social anxiety in female teachers in Abdanan city) is confirmed. The results of this hypothesis is consistent with the results of research by Mohammadi and Sajjadinejad (2007), Zanjani et al. Jafari et al. (2017) Ismail Nia et al. (1397), Angela Feng and Stephen Hoffman (2011), Koles et al. (2006), Hollander and Aronovitz (1999), Will et al. (1996), Clark and Arkowitars (1990) , Ivarson et al. (2005), Atalay and Gunks (2008), Chao and Cheng (2012), Phillips et al., 2006), Cubra et al. (2007), Liu et al., (2010), Fang et al. (2010) , Matthias Klees et al. (2020) and so on.

One of the most comprehensive studies in this field, entitled "The Relationship between Social Anxiety Disorder and Body Dysmorphic Disorder" by two American psychologists, Angela Feng and Stephen Hoffman, was published in 2011 by the Department of Psychology at Boston University. The study found that there was a significant relationship between the two disorders, with BDD and SAD showing the same age, having a unique path, similar cognitive methods for interpreting ambiguous information in a negative way, and that in some Eastern cultures, BDD is considered as a subset of SAD. Based on the results of this hypothesis, it can be concluded that the more people are dissatisfied with their body or the so-called people with body deformity, the more social anxiety they have or the more likely they are to have social anxiety. Although Body dysmorphic disorder was almost non-existent or significant in the study population, it is better to educate people with proper education so that they realize that instead of focusing too much attention on their imaginary or real minor defects and be aware that this will help prevent social anxiety. Awareness of people in this field can also be effective in preventing the unnecessary procedures of cosmetic and facial surgeries, because many people without special and real defects in their face and appearance, are always

anxious and some repeat a cosmetic surgery several times.

Based on the results of this hypothesis, it can be concluded that body deformity is a good predictor for diagnosing social anxiety and can be measured using standard SPIN questionnaires and YBOCS_BDD (for assessing body deformity) corrective scale. The deformity of the body examined people's perceptions of their appearance. Therefore, it is appropriate to create a suitable and stress-free environment in the community of teachers, so that they consider themselves conscientious and responsible and instead of paying attention to their imaginary defects to their positive activities, one can expect fewer people to be involved in social anxiety. To do this, it is necessary to strengthen and highlight the positive characteristics of personality and correct and improve the negative characteristics of personality by relying on one's own abilities, through formal, implicit and cultural education, and even with the help of **psychologists and counselors.**

The present has some limitations:

- The inability to control all interfering and disturbing variables
- Due to the closure of schools from June onwards, it was difficult to communicate with teachers. The body's deformation questionnaire may not be very accurate because of the few questions.
- Women's sensitivity to their appearance may have led to dishonesty in answering questions.

Research suggestions

According to the findings of research hypotheses and also due to the sensitivity of the functions of the education system and the key role of teachers in the education and scientific and practical progress of the young generation, the esteemed officials and all those involved in the holy system of education are recommended to create a healthy psychological environment in the community (especially the teachers' community) and should consider the following points

- The use of psychologists and psychiatrists in schools.
- Informing teachers that their imaginary or minor flaws are not insignificant, and that what is valuable is their high human abilities, talents, and values, especially the beautiful and sacred work of teaching and learning, so it is better to pay too much attention to appearance and limbs. Give way to focus and boast of abilities and values.
- Use longer questionnaires to measure social anxiety.
- It is better to do research on the community of teachers in the first 6 months of the school year (autumn and winter) so that it is not difficult to access them. -

This research should also be done on the community of male teachers.

- Use interviews, observations, etc. in research. It is better to have a more detailed questionnaire with more questions to assess the body's deformity. -

Research on women's society (non-teachers), something that may make them pay attention to cosmetic surgeries, etc., or show the prevalence of malignant disorders in society.

References

1. Ismail Nia, M., Dosti, Y and Mirzaeian, B, (2018), Structural Relationships of Primary Inconsistent Schemas and Body dysmorphic disorder mediated by anxiety and transgression, Social Health Journal, Volume 6, Number 1, Winter 97, Pages 80-89

2. Jafari, M, Narimani, M, Bashpour, S. and Hojlu, N, (2017), Comparison of the effect of individual intelligence and physical intelligence on the symptoms of social anxiety applicants for body beauty, Journal of Nursing Psychology, Volume 3, Number 5, Pages 37-47

3. Hassanvand Amouzadeh, M., (2012), Relationship between shyness, self-esteem, self-efficacy and daring with social anxiety. New Findings in Psychology, No. 24, pp. 35-56.
4. Rabiee, J .; Kalantari, Molavi, H. (2010). Identifying and prioritizing standardized educational needs for teaching skills of faculty members based on the job and employment model of the case study: Shiraz University. Research in Curriculum Planning, Year 10, Issue 11 (Series 38), 102-86.
5. Rabiee, M., Salahian, A., Bahrami, F and Palahang, H., (2011), "Construction and Credit of the Body Transformation Evaluation Questionnaire" Journal of Mazandaran University of Medical Sciences, (43-52) Volume 21, Number 83, August 2011
6. Abbasi Asl, R., Naderi, H. and Akbari, A., (2016), Social anxiety prediction of female students based on personality traits. Journal of Principles of Mental Health, 18, November and December, pages 343-349.
7. Fattahi, A., Eftekhari, S., Ahmadi, S. and Hamzeh, B, (2018): National Publications Database
8. Fathi Ashtiani, M. (1388). Information needs assessment. Tehran: Iran Scientific Information Center
9. Kiani Deh Kiani, M. and Mardpour, A., (1398), Body dysmorphic disorder and social anxiety among women undergoing cosmetic surgery and non-acting women; A Comparative Non-Intermediate Study, Journal of Health Research, Volume 4, Number 3, Spring 2017, Pages 152 to 158.
10. Ganji, Akbar 2017) Relationship between corporate entrepreneurship, market orientation, organizational flexibility, job satisfaction, end of master's degree, School of Management, University of Tehran
11. Brawmann,bil, (1995).tegrating knowledge management technolgiesinorganizational business processes: getting real enterpiisesto deliver real business performance. Journal of knowledge management vol. 9, no. 1, pp. 7-28.
12. Coles et al,hoft (2006) advantage in an entreprise, international. Journal of information management , vol. 21issue. 2, pp. 151-165.
13. Fang,A. &G.Hofmann,S. , 2011, Relationship between social anxiety disorder and body dysmorphic disorder, Boston Univercity Psychology Clinic, 30(8), 1040-1048
14. Georgina Krebs, Lorena Fernández de la Cruz, David Mataix-Cols (2020) Recent advances in understanding and managing body dysmorphic disorder ، Evid basd normal health , August 2017 Vol 20 No 3
15. Hollander &Aronowitz, S. (1993). Dinensioncknowledeg and its management.Rerrieved from http://www.insighting. co. uk.
16. Kashdan, j. c. (2002) if only we knew what we know: Identification and transfer of Internal Best practices,colifornia management Review,4. (3), 74-154
17. Kesler, Zhao &Nelson,dell(1994) advantage in an entreprise, international. Journal of information management , vol. 21issue. 2, pp. 151-165.
18. Kessler, R.C., Berglund, P., Demler, O., Jin, R., & Walters, E.E. (2005).Lifetime prevalence and ageof-onest distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62 (6), 593-602.
19. Mataix-Cols D, de la Cruz LF, Isomura K, Anson M, Turner C, Monzani B, et al. A pilot randomized controlled trial of cognitive-behavioral therapy for adolescents with body

Dysmorphic disorder. J Am Acad Child Adolesc Psychiatry. 2015;54:895–904

20. Otto, Wilhelm, Kohen&Harlow,math(2001) advantage in an entreprise, international. Journal of information management , vol. 21issue. 2, pp. 151-165

21. McElroy,Keck& Pop, p. (1993), the knowledge factor, CIO, 15 december: pp. 1-90

22. Pillips, Menard, Fay & Weisberg, G. T. (2005) :Poactiveness versus competitive aggessiveness: teasing apart key dimentions of an entrepreneurial orientation, Wellesley, MA, pp. 47-58.

23. Pinto &Philips,math(2005) advantage in an entreprise, international. Journal of information management , vol. 21issue. 2, pp. 151-165.

24. Pinto A, Phillips KA.Social anxiety in body dysmorphic disorder. Body Image 2005; 2: 401-405.

25. Phillips,K. 2004, Psycosis in body dysmorphic disorder, Jornal of Psychiatric Research, 38_6.

26. Stravynski, A, Bond, S, Amado.D. (2004). Cognitive causes of social phobia: Acriticalappraisal. ClinPsycholRev, 24(2), 421-440

27. Veal, Boocock, Gournay&Dryden,ghaziri,(1996) advantage in an entreprise, international. Journal of information management , vol. 21issue. 2, pp. 151-165.

28. Veale, D. (2004). Advances in a cognitive behavioral model of body dysmorphic disorder.Body Image.Vol. 1.No. 1.113-125.