Case study on social anxiety and depression

Jim is presenting several problems all of which appear to be caused by an extreme fear of being rejected in social situations. The main problems targeted in this formulation are social anxiety, depression, and social withdrawal behaviours as they appear to perpetuate each other through a vicious circle due to underlying dysfunctional cognitions regarding his self with respect to social interactions (Clark & Wells, 1995). By treating these key issues, Jim's other problems including worry thoughts, self-harm ideation and insomnia are implicitly addressed as they appear to be symptoms of his anxiety, depression (DSM-IV; American Psychiatric Association, 2000), and social perfectionism (Hewitt, Flett, & Weber, 1994).

(2) A description of the scientific background of the formulation you develop (this is where you present the theoretical justification for your formulation

Cognitive therapy (CT) has been chosen for this formulation as it illustrates that self-referent thinking, attentional bias, and reasoning processes underlie both the anxiety and depression that Jim is experiencing (Antony & Swinson, 2000; J. Beck & Tompkins, 2007; Townend & Grant, 2008). Principal to this is the situation-emotion-thought-behaviour cycle as negatively interpreting events due to dysfunctional beliefs about the self and situation cause anxiety and depression (Bieling & Kuyken, 2003), tantamount to that seen in Jim. Therefore targeting these common core cognitions should treat Jim's anxiety and depression simultaneously and more effectively than cognitive-behavioural-therapy as cognitions are acknowledged to maintain emotional problems (Butler, Cullington, Munby, Amies, & Gelder, 1984; Clark & Wells, 1995; Field, 2006).

The cognitive model of social phobia (GMSP; Clark & Wells, 1995) from which CT is derived is utilised in this formulation as Jim's anxiety and depression appear to be ultimately caused by the fear of negative social evaluation; synonymous with the description of " a strong desire to convey a particular favourable impression of oneself to others and marked by insecurity about one's ability to do so" (Clark & Wells, 1995, p. 69).

The GMSP (Clark & Wells, 1995) however does not explicitly have a transdiagnostic approach to account for depression which Jim is also experiencing (Hirschfeld, 2001; Sartorius, Ustün, Lecrubier, & Wittchen, 1996). To overcome this, similarities across anxiety and depression such as core cognitions are drawn upon in the formulation (Bieling & Kuyken, 2003; Townend & Grant, 2008). For example, the negative assumptions regarding the self with respect to social situations found in social anxiety (Clark & Wells, 1995) mirror the schemas within negative cognitive triad (Beck, 1967).

To further address depression, the role of goal conflict described in perceptual control theory (Powers, 1973) is implicitly discussed as it can provide a possible explanation for a cyclical relationship between anxiety and depression (Bird, Mansell, & Tai, 2009; Powers, 1973; Mansell, 2005; Renner & Leibetseder, 2000). For example, the inability to engage in reorganisation and alter the reference values of social expectations within the control hierarchy, or schema, to match the perceptual input can initially result in social anxiety (Bird et al., 2009). Consequently depression can arise as conflicts between the approach and avoidance goals transpire preventing fulfilment of certain goals (Carey, 2008; Mansell, 2005; Powers, 2005).

(3) A written description of your formulation (this needs to clearly explain the hypothesis you have developed for the client's problem)

Stage 1: Assumptions

A developmental experience, perhaps social humiliation regarding his sweating or the separation from his daughter's mother, has led to Jim's dysfunctional assumptions regarding his self in relation to social interactions (Clark & Wells, 1995). He appears to have negative unconditional self-beliefs such as " I'm inadequate" and has created unattainable expectations for social-performance that he " must get everyone's approval" to be worthy (Clark & Wells, 1995). As these beliefs appear static, persisting in all social situations (Shafran & Mansell, 2001), the discrepancy between them remains large (Powers, 1973; Powers, 2005; Mansell, 2005; Spratt & Carey, 2009). Jim may consequently feel unable to achieve this expectation, believing he is negatively evaluated in all social situations, that " if others see that I'm inadequate, they will reject me", predisposing his anxiety (Clark & Wells, 1995). Such assumptions also mirror depressive schemas with respect to his self, world, and future (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979) and therefore it is possible that a history of depression underlies his social anxiety.

Stage 2: Perceived social danger and self as a social object

Before entering a social situation, Jim uses such pre-existing assumptions to predict social rejection and worries about this possibility (Clark & Wells, 1995; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). He consequently produces physiological symptoms of feared anxiety responses

such as sweating, trembling, and breathlessness to which he focuses attention (Gilbert, 2001; Trower & Gilbert, 1989). This attentional bias affects his interpretation of the social situation, forming a cyclical relationship between perceived social danger and perceived social-self (Clark & Wells, 1995).

Jim interprets internal cues of feeling sweaty to infer that he is sweaty, creating an image of " sweat pouring down" his face from an observer's perspective (Clark & Wells, 1995). He also interprets ambiguous social cues such as the presence of unfamiliar people negatively as " people are staring at me and think I'm weird". Attending to such cues provides evidence confirming Jim's pre-existing beliefs regarding self-worth and social threat (Clark, 2001); particularly as disconfirming cues are ignored. This strengthens his somatic and cognitive symptoms (Clark, 2001; Teasdale & Barnard, 1993), provoking social anxiety and the desire to withdraw from social situations " I want to leave now… go home where I feel safe".

Stage 3: Safety behaviours

As Jim attempts to minimise his physiological arousal caused by perceived social danger by not leaving the house, he misses reception of unambiguous social approval and misinterprets the purpose of this behaviour post-event in that " I was lucky this time, but next time I will be rejected", failing to learn that his predictions may be untrue (Clark, 2001; Clark, Ehlers, Hackmann, McManus, Gennell, Grey, Waddington, & Wild, 2006; Salkovskis, 1991). Alternatively, when social situations are unavoidable, his nail biting behaviour can provoke distant behaviours from others as he is attracting

attention to his anxiety (Clark, 2001; Clark & Wells, 1995). Consequently Jim’s pre-existing assumptions are confirmed, (Clark, 1999), believing that “ everyone is staring at me, thinking I’m weird”, further perpetuating social anxiety.

As anxiety has resulted from Jim’s inability to reorganise his reference value of social-performance, remaining discrepant from his self-perception (Carey, 2008; Powers, 1973; Powers, 2005), his avoidance goal entailing social withdrawal takes priority while his approach goals of returning to work and seeing his daughters and friends in public are neglected. This can consequently prevent him from attaining his higher goal of “ having a normal life” (Bird et al., 2009), sustaining dysfunctional cognitions of “ I’m inadequate”, “ no-one will like me”, and “ I will never be accepted”, resulting in depression (Beck, 1967; Beck et al., 1979). This can predispose him to social anxiety as his negative underlying core beliefs become salient (Clark, 2001; Young, Klosko, & Weishaar, 2003).

(4) Diagrammatic formulation (your formulation might be based on a published theory or model)

Social Situation

Somatic & Cognitive Symptoms

Immediate symptoms: sweaty, hot, under pressure, trembling, agitation

General symptoms: anxiety and depression – producing worry thoughts, self-harm ideation, insomnia

Behavioural symptoms

Safety behaviours are believed to reduce risks of negative evaluation.

“ I must avoid social situations as I will be rejected”

Unaware that safety behaviours e. g. nail biting can provoke distant behaviours of others

Stage 3

Assumption

Low self-worth, high social-expectations, and unattainable conditions for positive social evaluation underlie anxiety, perhaps caused by a depressive cognitive triad

“ I’m inadequate”; “ I must gain everyone’s approval”; “ If others see that I’m inadequate they won’t like me”

Self as a Social object

Attends and interprets physiological symptoms as how he appears objectively.

“ The sweat is pouring down my face”

Attention focused on ambiguous cues and interpreted negatively

“ People are staring at me, thinking I’m weird”

Perceived social danger

Uses physiological symptoms e. g. sweating as evidence of social danger

Jim cannot reorganise effectively, maintaining a discrepancy between his internal reference and self-perception

“ I cannot fulfil the expectations of my social-performance as I’m inadequate”

Feared anxiety responses are produced

Stage 2

Stage 1

(5) Implications for further assessment (according to your formulation, what other information might you need to obtain from the client to test if your hypothesis is correct?)

Jim initially needs to identify a recent social situation whereby he felt anxious (Veale, 2003). The primary hypothesis that Jim has negative core beliefs can be assessed by asking what it would mean to him if the worst assumption he made was true (Veale, 2003). This will illustrate what his beliefs are regarding his self, expectations of social-performance, and social evaluation (Clark & Wells, 1995); and if these aspects reflect negative cognitions regarding himself, the world, and the future (Beck, 1967). The following is an example of an assessment of his core beliefs (adapted from Veale, 2003, pp. 261):

Therapist:

How did you feel you appeared in this situation?

Jim:

I felt I had sweat pouring down my face (self-beliefs; the self).

Therapist:

Assuming this is true, what does that mean about you?

Jim:

I’m unacceptable and people think I’m weird (social-performance; the world).

Therapist:

Assuming this is true, what does that mean to you?

Jim:

No-one will like me (social evaluation; the future). His attentional focus on internal physiological and ambiguous external cues which he appears to interpret negatively, creating a distorted self-image (J. Beck & Tompkins, 2007; Bieling & Kuyken, 2003; Clark, 2001), can be assessed using questions such as: “ What did you notice when you were self-conscious?”, “ Did you have a mental image of how you looked?”, “ How do you think others saw you?” (Clark, 2001). If Jim’s description of a sweaty appearance is repeated the source of this self-image, perhaps an early distressing social event, needs to be addressed and modified (Clark, 2001).

The suggestion that Jim’s safety behaviours perpetuate anxiety as he fails to discover that not all social situations are threatening (Salkovskis, 1991) can be illustrated by using the situation-emotion-thought-behaviour cycle (Bieling & Kuyken, 2003) to demonstrate the effects his behaviours have on his cognitive and emotional problems. Questions can include: “ When you feared social rejection, did you do anything to stop it?”, “ Did you do

anything to ensure you looked respectable?”, “ How did this make you feel?”(Clark, 2001; Veale, 2003).

The hypothesis that Jim’s depression stems from his inability of achieving certain goals as his avoidance goals taking precedence because of immediate anxiety (Powers, 2005) can be examined using an adaptation of the Goals Task (Dickson & MacLeod, 2004). By asking Jim to describe his approach and avoidance goals and how achievable they are, areas of conflict can be identified and questions can be made to assess how this affects him and the relationship between depression and anxiety. Questions may include: “ Why do you feel you cannot achieve this goal?”, “ What does this mean to you?”, “ How does that make you feel?”.

(6) Implications for treatment (according to your formulation, what are your hypotheses about what might go well/ less well when providing treatment for the client? Are there factors that might make treatment difficult or less likely to succeed? Does your formulation indicate things that would need to be given special consideration during treatment?) – 556

As modifying behaviours through exposure therapy alone is ineffective (Field, 2006), dysfunctional cognitions are targeted in accordance to CT as they perpetuate Jim’s problems (Clark & Wells, 1995; Clark, 2001; Veale, 2003). This usually involves behavioural experiments; however Jim may have difficulty engaging in this and attempting homework tasks outside the therapist’s supervision due to his social phobia (Clark & Wells, 1995). Therefore it is essential that verbal reattribution is made first to help him understand these maintenance cycles and to address his negative cognitions

by using specific examples that he described during assessment (J. Beck & Tompkins, 2007; Wells, 2008). By the therapist taking caution to not engage in behaviours that can increase Jim's self-consciousness in initial sessions, he should become more comfortable with this social interaction, creating a trusting therapist-client relationship (Clark, 2001). Furthermore by orienting treatment towards Jim's goals of having a ' normal life', he may become more willing to engage in behavioural experiments particularly as the therapeutic plans are set collaboratively (J. Beck & Tompkins, 2007; Veale, 2003).

Jim's dysfunctional cognitions can be modified by testing his core beliefs through social situation exposure such as a shopping centre while being video recorded (Hackmann, 1999; Wells, 2008). Jim can make predictions regarding how sweaty he thinks he will appear in this situation pre-exposure, and compare this with his video feedback post-exposure which would demonstrate that his self-image is inaccurate, and that although he may feel that " sweat is pouring down his face" it is not objective reality (Clark, 2001; Veale, 2003). Even if Jim engages in anxiety displaying activities such as nail biting, the video feedback should demonstrate that his actual fear of excessively sweating is unreal but that his safety behaviours are counterproductive and result in enhanced anxiety (Clark, 2001; Clark & Wells, 1995). Attentional biases can also be modified as Jim can predict how many people he feels would monitor him while intentionally increasing the feeling that he is the centre of attention (Clark & Wells, 1995). Comparing this to the extent that people actually look at him should demonstrate that it is rare that anyone is watching him to the extent that he believes, illustrating

his attentional bias and interpretational styles perpetuate his social anxiety while the reality of these cues are benign (Clark, 2001).

To modify Jim’s negative assumptions regarding his perceived-self with respect to social situations, his armpits may be dampened to confirm his fears of social rejection while comparing the predicted with the actual reactions of others (Veale, 2003). This would be beneficial as his self-perception of being sweaty is disconfirmed due to the nature of having to initially dampen his armpits, and that predicted social ridicule is unrealistic even when he appears sweaty. This should help him engage in reorganisation to reduce the discrepancy between these values (Powers, 1973; Spratt & Carey, 2009), consequently improving his negative core beliefs that cause anxiety and depression (Powers, 2005; Tai, 2009).

Such behavioural experiments would be beneficial as the other symptoms that Jim is experiencing are implicitly treated. By addressing and providing alternative schemas regarding his self and social situations should prevent activation of his suicide-ideation mode during distress (Beck & Clark, 1997; Berk, Henriques, Warman, Brown, & Beck, 2004). By illustrating Jim’s negative interpretations of himself and social situations may be untrue and that the situation is not uncontrollable, his worry thoughts should decline (Freeston, Dugas, & Ladouceur, 1996; Wells & Carter, 2001). With respect to his insomnia, dysfunctional beliefs regarding sleep that Jim may have can be addressed by demonstrating that staying at home to preserve energy due to lack of sleep can be maladaptive as this behaviour could increase his anxiety and prevent him from expending energy to make him tired enough to sleep

(Harvey, Sharpley, Ree, Stinson, & Clark, 2007; Morin, Bootzin, Buyssen, Edinger, Espie, & Lichstein, 1998-2004).