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CBT FOR SOCIAL ANXIETY DISORDER: CHILDHOOD EXPERIENCES AND BELIEF FORMATION: A CLINICAL CASE STUDY

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ABSTRACT

Research on social anxiety disorder and its treatment especially cognitive behavioral approach focuses more on symptomatic nature and reduction. The present case study intends to highlight the significant childhood experiences resulting in belief formation that further activate during social interactions. Assessment of the client was done on both formal and informal levels. Clinical Interview was used as an informal way of assessment while Liebowitz Social Anxiety Scale, Social Interaction Anxiety Scale (SIAS) and Symptom Checklist-Revised were used as formal assessment tools. Analysis of scores and clinical interview lead to the diagnosis of 300.23 (F40.10) Social Anxiety Disorder with Mild Depressive Episode. Total number of 12 sessions were conducted with an average duration of 50 minutes for each session. It was found that childhood experiences play a significant role in developing certain beliefs later activated in social interactions and play a role in maintaining social anxiety disorder. Treatment focused more on these beliefs. Results indicated that CBT is an effective treatment approach for social anxiety disorder and treating maladaptive beliefs results in improved emotional and behavioral components of social anxiety disorder.

Keywords: Social Anxiety Disorder, Childhood Experiences, Maladaptive Beliefs, CBT

INTRODUCTION

Social Anxiety Disorder known as social phobia is a condition characterized by fear of social situations and avoiding them due to fear of negative evaluation. SAD condition interferes with and causes distress in various areas of functioning (Schneier & Goldmark, 2015).

Cognitive models of mood and anxiety disorders posit that maladaptive beliefs that are central to one's identity and are negatively biased, inaccurate, and rigid (e.g., "core beliefs") play a causal role in generating the emotional disturbance that characterizes these disorders (Beck & Dozios, 2011). Empirical research has provided evidence that these types of maladaptive beliefs are associated with psychopathology and are generally stable. (Riso, du Toit, Stein, & Young, 2007). Contemporary cognitive models of SAD (e.g., Heimberg, Brozovich, & Rapee, 2010; Rapee & Heimberg, 1997) posit that individuals with SAD have maladaptive beliefs regarding themselves (as socially incompetent) and others (as critical judges). When activated in a social situation, these maladaptive cognitions transform innocuous social cues (e.g., another person looking away during a conversation) into significant social threats. Whereas many studies have documented the role of less stable, surface-level maladaptive cognitions, such as appraisals, attributions, and thoughts in SAD (e.g., Schulz, Alpers, & Hofmann, 2008; Stopa & Clark, 1993).

Most of the studies focused on role of maladaptive beliefs in the context of CBT for depressive and other anxiety disorders. A few of them focused on social anxiety disorder with less emphasis on childhood

experiences that play a significant role in the development of maladaptive beliefs. Present study aims to investigate whether treatment focus on maladaptive beliefs results in improvement of other social and behavioral components of social anxiety disorder and to identify the role of childhood experiences and the process of development of these maladaptive beliefs.

Objectives of the Study

Objectives of the study were to investigate role of childhood experiences in the development of maladaptive beliefs and social anxiety disorder and to know the efficacy of CBT for social anxiety disorder.

Hypotheses of the Study

Childhood experiences play a role in the development of social anxiety disorder and CBT focusing more on maladaptive beliefs will significantly reduce the symptoms of social anxiety disorder.

METHOD

Research Design

A single-subject ABA research design was used in the study to know the efficacy of CBT for social anxiety disorder.

Participant's Illness Recount

The 20 years old student came to Centre with presenting complaints of avoiding situations such as eating lunch in canteen, avoiding answering to teacher during class including severe anxiety when teacher comes near or passes by her during lecture, avoiding a chat within group because of fear of stuttering and shaking. All these situations when confronted caused her excessive anxiety with a fear of negative evaluation by others and excessive post-event rumination. This avoidance and anxiety resulted in lack of interest and concentration during studies and in other daily activities, lethargy during most of the day and especially on weekends. She started experiencing all of these symptoms after entering to college 7 months back. In March 2020, during therapeutic sessions, Government of Pakistan announced to impose lockdown as a strategy to control COVID-19 pandemic. The client had no significant social interactions during this time period. During next therapeutic sessions the client started reporting anger issues especially self-directed anger with an internal sense of dissatisfaction i.e. frustration over lacking control and calling oneself names.

There was no history of any significant medical condition and seeking any psychotherapy or pharmacotherapy. One of her siblings was physically disable but there was no history of any significant psychological condition within the family.

Background Information & Childhood Experiences

The patient is 2nd born in six members family (Stepfather: a businessman, mother: a housewife, older brother: 24 years with Cerebral Palsy, younger brother: in his teen age youngest brother: school going). Her parents separated 3 years ago. Her real father married with another girl and after divorce her mother got married with his father's business partner. A surge of tension in her home environment started when her father had a significant loss in his business. As she reported her father dependent on his siblings, sort of careless, having a little capacity to bear tension, when experienced loss in his business, he could not bear and started having an affair with another girl being dependent on her. She reported poor emotional attachment by all her siblings with their father since childhood. She reported that she could not recall even a single incident of her father's loving attitude towards her. Her verbatim for her father "He has been an irresponsible person without any hard work in his life and I can just remember his coldness". The mother was described as caring and loving person. She started talking to her husband's business partner with an intension to help her husband but as the patient reported "She was so much fed up with her husband that when she found a little attention from uncle, she got relieved". Soon her father had a 2nd marriage and he moved to another city. The patient with her siblings and mother started living with her maternal uncle.

All of these circumstances affected the patient's studies, having poor grades in matric. They had to face humiliation from her maternal aunt. Her mother was blamed as talking to another guy on phone was interpreted as having a loose character, it also affected the patient as her mother was a role model for her, teaching her moral and cultural values.

"She used to tell me how should I behave with others, a well-mannered girl always don't make an eye-contact with opposite gender, and now she is blamed to have an affair".

In academics she reported a few incidents of humiliation by her school teacher. As reported "I was a shy girl having little conversation within the class but I used to help other students in their homework. One of my teachers used to announce in the class that I want to earn popularity in the class and that I am faking to be an innocent girl".

Currently, she is living with her mother who has married to her husband's business partner. They have moved to his stepfather's house. He has his own family in the same city. She could not establish secure and close ties with her stepfather yet as he has his own priorities. She is not participating in any extra-curricular activity, denies attending any friends' get to gather, later ruminating for not having a social life.

Analysis of Life Conditions

The patient is brought up in a family having less secure ties with her father and lack of bonding between parents. She is a single daughter raised by her mother on strict moral grounds as per a collectivistic culture i.e. a good girl never makes an eye-contact with a guy, a good girl should never talk to a stranger. She was being humiliated for her mother's contact with another person. Hence the patient developed dysfunctional beliefs and maladaptive assumptions (e.g. If I talk to an opposite gender, people will call me character less). She could not develop trustful father-daughter relationship since childhood and later rejected by father, thus during social interactions her strong desire for acceptance lead to greater difficulty (e.g. I must sound fluent and intelligent, otherwise I will not be accepted; this is the maladaptive assumption probed for situations i.e. not telling the doctor symptoms properly because of anxiety during an appointment and while talking with Class Representative). Her childhood experiences resulted in her inability to form secure and satisfying attachments with others. The observation of her father's irresponsibility and incompetency to resolve his problems lead her to develop dysfunctional belief (e.g. One must be competent and responsible to survive in life). In a collectivistic culture where father is considered as specialized for external protection who confronts the external social world, abandonment by her father resulted in strong negative signals about the social world, hence she adjusted her beliefs accordingly. Moreover, she reported about her father's indifferent and cold attitude towards her, her father's non-verbal controlling behavior during an interaction with her later resulted in social anxiety during interactions.

Similarly since childhood she was labeled as boring by her peer group for not participating in gatherings because of her shy nature. She has developed maladaptive assumption i.e. if I get my words wrong people will think that I am foolish and boring. When the client entered in her college she started avoiding most of social situations because of her anxiety that later resulted in depressive rumination, lethargy, lack of interest and concentration in her studies.

Assessment

Disorder Specific Diagnostics:

Tool	Cutoff	Obtained Score	Severity Level
Liebowitz Social Anxiety Scale	30	114	Severe
Social Interaction Anxiety Scale (SIAS)	35	58	Severe
Symptom Checklist-Revised	37	23	Mild

Liebowitz Social Anxiety Scale

Liebowitz Social Anxiety Scale was administered to assess social anxiety disorder. The score 114 was above the cut off score that is 30. The score indicates severe level of social anxiety disorder as the participant's score on various performance situations presented in Liebowitz Social Anxiety Scale was high.

Social Interaction Anxiety Scale (SIAS)

Social Interaction Anxiety Scale (SIAS) was administered to validate scores on first measure. Social Interaction Anxiety Scale (SIAS) presents various social interactions to participants. Participant's obtained score on SIAS was also above the cut off 35 assuring the diagnosis of social anxiety disorder.

Symptom Checklist-Revised

Scale II of Symptom Checklist Revised (Rahman, Dawood, Jagir, Mansoor, &Rehman, 1997) was

used, that has adequate psychometric properties. A score of 23 indicated mild level of depression.

INTERVENTION

When the client came for seeking therapy she was much reluctant to share her immense experiences. The only motivation to get her problem resolved came from listening to some inspirational stories on social media. Initially she was unable to correct any validating statement and summary of her statements by the therapist side and she was much concerned about negative evaluation by the therapist. Initially the focus was to build a warm and strong therapeutic alliance with the client by sharing common interests, encouraging her initiative to come and seek therapy, and encouraging her to talk about her experiences in a non-threatening way through verifying her thoughts about negative evaluation from the therapist. It took more time than any of the other client with other disorders because of her fear of negative evaluation.

After assessment via standardized testing including Liebowitz Social Anxiety Scale, Social Interaction Anxiety Scale (SIAS), and Beck Depression Inventory a longitudinal case conceptualization (Figure 1.1) was used to help her identify basic origin and maintaining cycle of her problems. Further a connection was built to help her understand how her childhood experiences lead her to develop specific beliefs that are later resulting in current problems. This connection also proved beneficial in understanding how her social anxiety symptoms were connected with loss of interest and "doing nothingism" rumination. For preventing daily blues a lethargy cycle was explained to the client and but re-but technique was used to help her understand how her negative thoughts were maintaining her problems. Activity scheduling helped her set a routine while mastery and pleasure technique helped her accept the fact that her predicted mastery and pleasure on any task on weekends was against the reality. In the 5th session the client was provided rationale to move towards interventions for social anxiety disorder. In the session an idiosyncratic model of social anxiety disorder was drawn in collaboration with the client and then was asked to draw it as a homework assignment (Figure 1.2 & 1.3). Sessions 5-8 included video feedback and safety behavior experiment. Session 9-12 focused on changing identified maladaptive beliefs i.e. "I am rejected", "One must be accepted by everyone", "One must perform according to other's standards", "One must be perfect in social situations". It consisted of a) informal assessment of these beliefs b) then spotting them in daily life experiences c) actively replacing these beliefs and adopting healthy cognitive and behavioral options. Follow up sessions were planned on daily activities of exposures to social situations that cause her anxiety.

RESULTS & CONCLUSION

Post-assessment revealed that The Liebowitz Social Anxiety Scale (LSAS-SR) total score was at 54 (cutoff, 30), the Social Interaction Anxiety Scale (SIAS) at 30 (cutoff, 35, and the Symptom Checklist-Revised Scale I was 10 (cutoff 37) (Table 1.2; Fig 1.2). Successfully dealing with preceding depressive symptoms followed by social anxiety disorder through CBT with more focus on childhood experiences and maladaptive beliefs, provides confidence that advancements in the treatment of SAD will continue to bring hope and relief to the people, and families, affected by anxiety disorders. No doubt, generalizability issues of a case study will remain obvious. However, the case study will provide a pathway for understanding the process of forming SAD related beliefs and the result of avoidance due to lack of social interactions.

Table 1.1

Representing Therapy Goal and Treatment Plan

	Therapy Goal	Treatment Plan
1	Development of a warm, strong therapeutic relationship	In sum, effective listening, validating, reflecting, and complimentary behavior by the therapist.
2	Developing an idiosyncratic model of the Client's problems	To help the client understand predisposing, precipitating, and perpetuating factors of her problem
3	Preventing daily "blues" promotion of activities.	Helping her understand lethargy cycle, Daily activity scheduling Help her grasp concept of mastery and pleasure.
4	Cognitive Restructuring	Cognitive restructuring of her dysfunctional beliefs identified by the client during depressive episode.
5	Providing rationale of the treatment of social anxiety disorder	Moving the focus of treatment from depression to social anxiety. Helping her understand the fact that her social anxiety preceded her depression.

6	Developing idiosyncratic model of SAD for patient	To help the client understand the importance of self-focus in maintaining her anxiety in social situations
7	Cognitive Restructuring	Cognitive restructuring of her beliefs about negative evaluation by others.
7	Video feedback and safety behavior experiment	To help the client understand the difference of social experience with and without focusing on internal symptoms and minor details.
8	Introduction to and practicing Exposure Exercises	Successive exposure to anxiety provoking situations to help her reduce avoidance.

Table1.2

Representing pre and post assessment of participant

Pre-Assessment			Post-Assessment		
Test	Obtained Score	Cut Off	Test	Obtained Score	Cut Off
1.Liebowitz Social Anxiety Scale	114	30	Liebowitz Social Anxiety Scale	54	30
2.Social Interaction Anxiety Scale (SIAS)	58	35	Social Interaction Anxiety Scale (SIAS)	30	35
3.Symptom Checklist-Revised	23	37	Symptom Checklist-Revised	10	37

1.1 Longitudinal Case Conceptualization

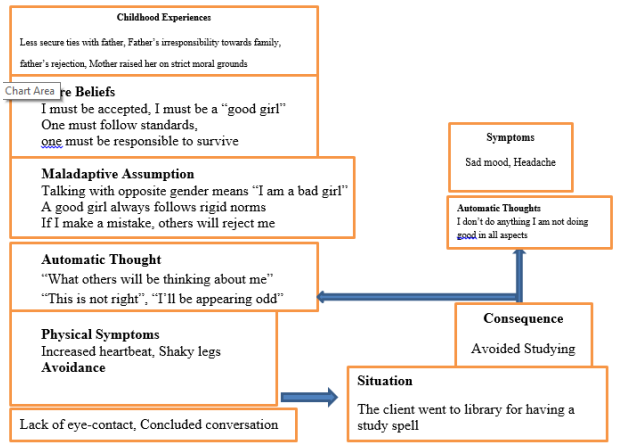


Figure 1.3

Idiosyncratic Model of Social Anxiety Disorder (Clark & Wells, 1995)

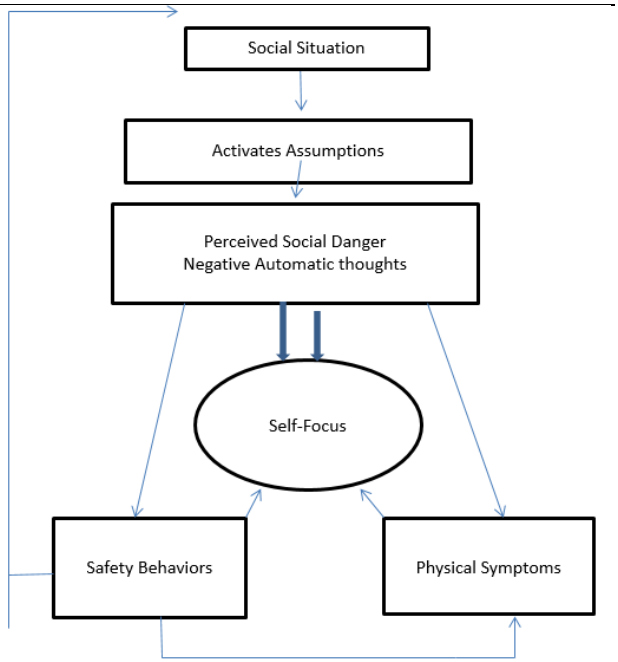
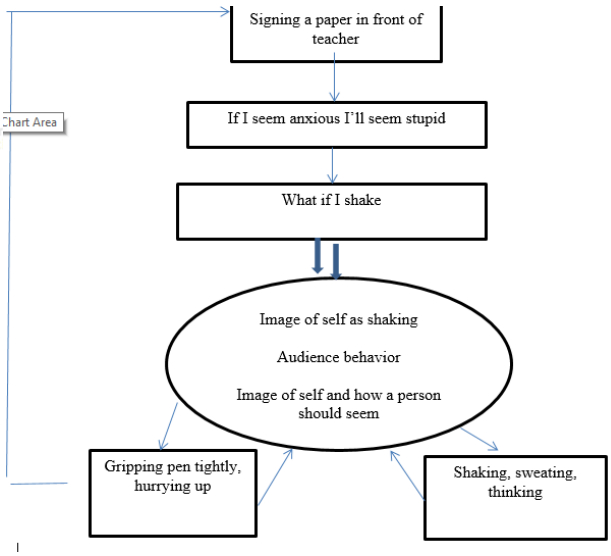


Figure 1.4

Client's Situation



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