Pacific Journal of Medical and Health Sciences
ISSN: 2456-7450 | Vol.4, No.2, 2022, pp-48-52

PJMHS
PACIFIC JOURNAL OF MEDICAL AND HEALTH SCIENCES

Case Report

Cognitive Behaviour Therapy for Social Anxiety Disorder – A Case Report

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ABSTRACT

The purpose of the present case study was to assess, diagnose, and demonstrate the use of Cognitive Behaviour Therapy (CBT) approach in dealing with a case of social anxiety disorder. This case report discusses the case of 24 years old young man referred to us due to long term issues of social anxiety and associated low mood about himself. Scores were obtained on Social Interaction Anxiety Scale (SIAS) and The Beck Depression Inventory-II at base line and at the termination of therapy. The framework of CBT was used to facilitate the client's understanding about his own thought process, to enable him to recognize faulty cognitions and reframe them in the present context. The client attended all the CBT sessions regularly and followed all the techniques to challenge himself to confront anxiety related to social context. The post intervention scores on SIAS dropped below the cut off score which distinguishes individuals with social anxiety from those without social anxiety disorder. The scores on BDI-II also came down to a considerable level at the time of post intervention.

KEYWORDS: Social Anxiety Disorder, Cognitive Behaviour Therapy, Anxiety, Fear

INTRODUCTION

The central symptomatology of social anxiety disorder (SAD) is characterized as the extreme fear or anxiety around social circumstances in which the person may fear being scrutinized or rejected as a result. People with SAD fear others will know they are on edge and will be adversely assessed, causing these circumstances to incite fear nearly continuously. The social circumstances are maintained as a strategic distance from or persevered with strong anxiety. In order to determine the definite diagnosis of SAD, the client must experience disproportionate intense anxiety or fear of the neutral social situation lasting for 6 months characterized by experiencing clinically significant fear or anxiety symptoms that is not due to other mental or medical condition. SAD influences several facets of a person's life such as social connections, interactions, academic and occupational functioning[1,2,3].

Several epidemiological studies reveal varying lifetime prevalence rate ranging between 5 to 15%[4-10]. With respect to the non-pharmacological treatment Cognitive and Exposure related therapies are found to be the most commonly utilized and broadly investigated interventions

for social anxiety disorder[5]. Existing models of SAD have overwhelmingly centered on the part of cognitions and behaviours within the support of the disorder, and have recommended that a few feelings such as uneasiness, disgrace, and shame may be related to social anxiety disorder[11-14].

CASE HISTORY

Mr. V was a 24-year-old, male, unmarried, graduate, currently working in corporate sector, belonging to Hindu nuclear family from a urban middle social-economic status. He was presented with 5 years history of feeling of nervousness while talking to people, palpitations and increased heart rate, disturbed sleep and diminished appetite, with Insidious onset and continuous course was reported with no significant family psychiatric history. He contacted at district mental health clinic, where he was suggested to take medication. However, over a period of time due to very minimal improvement, he was suggested for psychotherapy as well. The following details were collected during the initial intake for psychotherapy. Mr. was apparently well 5 years before. The problems began after he entered college. Change from school to college invited a new routine. He started feeling nervous as he was unable to do his work on time, it was getting difficult to understand concepts or grasp it quickly. He started experiencing decrease in confidence levels as his scholastic performance declined. He felt intimidated by his fellow classmates. Gradually he started experiencing worrisome thoughts. He would often feel worried in the class regarding being noticed and pin pointed by his professors. His friends would often ask him questions like *"mayus kyu rehte ho","hans lia kar kabhi"*. This further led to decrease in self-confidence and would make it difficult for him to strike conversations with others. What will the other person think about me, thoughts like these would bother him repeatedly. He further observed, when in social situations his hands would often tremble while taking food. He was able to pass his exams and got a job in event Management Company. However due to repeated interactions with people, he was not able to perform adequately, hence left the job. As per Mr. V he faces difficulties in initiating and sustaining conversations with people at work place also. As a result, he started avoiding social interactions and placed. His problems were less pronounced at his home.

Mr. V completed his schooling from a reputed school in Delhi in 2011. He completed his graduation also from Delhi in 2014. He was working with an event management company from 2014- 2015. However due to his illness he left the job. He was then working from Home for few months. In 2016 he started working with a corporate firm. He achieved puberty at 12-13 years of age. He identifies himself as male and is of heterosexual orientation. He is unmarried and reported having no history of any sexual exposure. Pre-morbidly he had good relationship with family members and friends. He was a sociable person, enjoyed going out for family gatherings and functions. Mr. V reported no usage of any substance.

Following the initial assessment, presenting problems we explored as Physiological: The patient had palpitations and increased heart rate and *ghabrahat*. He also reported feeling breathlessness and heaviness in the chest when around a group of people. At times, his hands would start trembling and shaking in social situations. Cognitive: He also tends to have several negative thoughts about himself and others. Thoughts such as "what would the other person think", "everybody is noticing me", *"koi tok na de"*, *"kisiko mera tremble kartahua face na dikhe"* would constantly surface in thinking. Affective: He reported feeling anxious and nervous when around people. There was a constant inner battle to fight those feelings and maintain social interactions effectively with people. He further reported he felt less anxious around his family members and relatives as compared to friends/colleagues. Behavioural: His current symptoms leave him feeling tired at times; he often tends to avoid meeting people and has limited her interaction due to this.

ASSESSMENTS

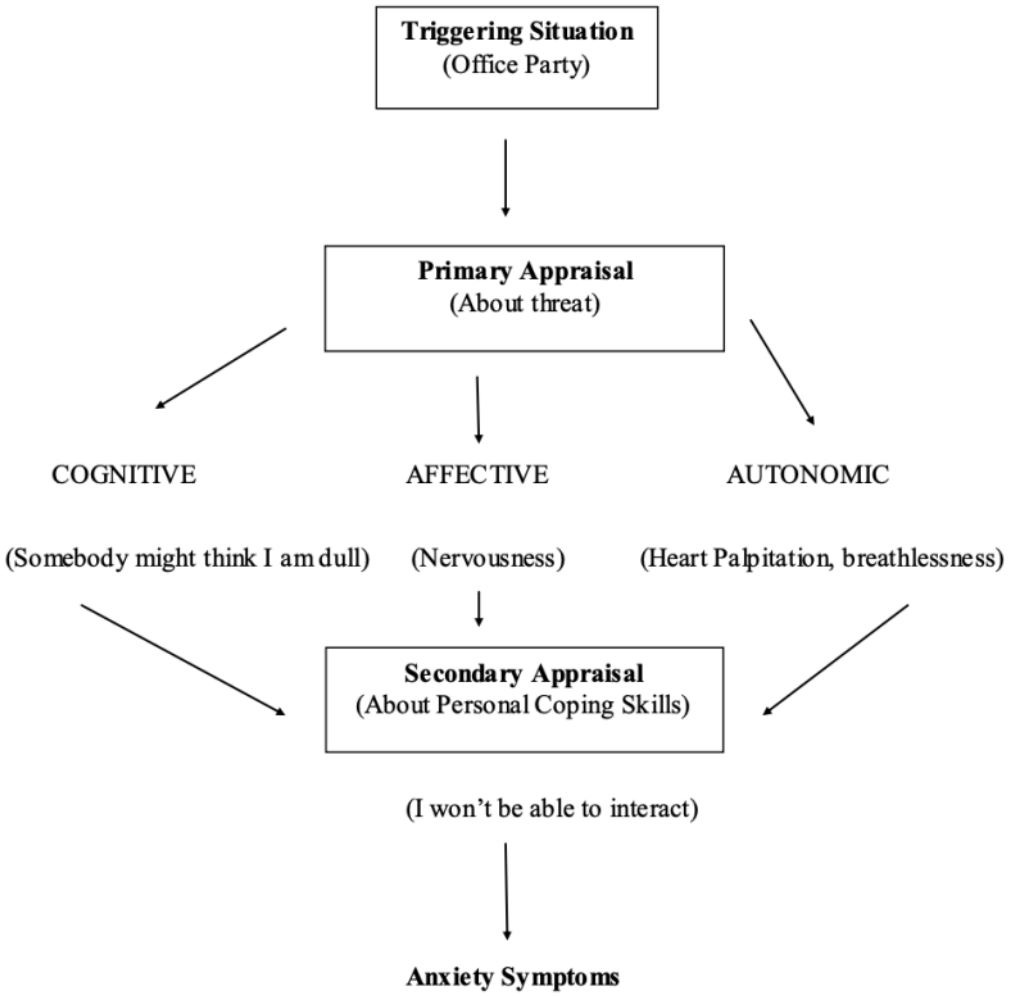
After obtaining informed consent from the client, pre-assessment was completed. At the completion of psychotherapy, post assessment was carried out. Beck Depression Inventory-II[15] and Social Interaction Anxiety Scale (SIAS)[16,17] tools were used.

Table 1: Pre, post, and follow-up assessment scores.

Sino.	Tools	Score at Pre-Assessment	Score at Post-Assessment
1	Beck Depression Inventory (BDI-II)	24	15
2	Social Interaction Anxiety Scale (SIAS)	60	28

PSYCHOLOGICAL FORMULATION

The following formulation regarding his illness was made.



Following the initial assessment, and after ruling out the contraindications, relaxation exercises were planned for the initial sessions. In addition, cognitive and behavioural intervention was planned which involved identifying and challenging dysfunctional thoughts both within and between sessions. After the psychoeducation, symptom reductions along with increasing social interactions were targeted as a main therapy goals followed by relapse prevention strategies.

Initial Phase

Initial few sessions with the client went spent in collecting information, establishing therapeutic relationship and orienting the client towards the cognitive-behavioural framework of understanding social anxiety. Distress of the patient was normalised. The sessions focused educating the patient regarding the problem that he was facing. Nature, symptoms and functions of anxiety were discussed. How autonomic symptoms of anxiety are not life threatening was spoken about. Furthermore, it was explained in situations which are perceived as threatening, client selectively tends to attend to aspects of the situation which to them appear to denote danger. Additionally, the management plan and the rationale of the treatment were discussed. Since autonomic symptoms were most disturbing to client, it was decided to focus on the physiological symptoms. Client was taught – Jacobson's Progressive Muscle Relaxation (JPMR) to deal with his arousal. Rationale was explained to the client. Three sessions were kept consecutively to teach this exercise, following which he carried out JPMR regularly at his home.

Middle Phase

In this a variety of distraction techniques were taught to the client, as they helped in immediate symptom management. Training in distraction helped him get control over his

symptoms. Techniques taught were focusing on object, sensory awareness, and mental exercises; a cognitive model of anxiety was discussed with the client. It was explained that it was not the events per se, but his expectations / thoughts / interpretations about the event which were responsible for negative emotional states. Relationship between thinking, feeling and behaviour was clearly demonstrated.

Concept of negative automatic thoughts was also spoken about using, examples from the client's life. Using the above rationale, client was asked to maintain diary, wherein he was supposed to record the negative automatic thoughts which could be later challenged. Initially client was not able to maintain a diary. One more session was then taken to emphasize the importance and how it was a skill which is difficult at first to learn. Subsequently client was able to record the dysfunctional thoughts. Once cognitive errors and patterns of thinking were recognized which were counterproductive to him they were systematically challenged using verbal challenge. The validity, functionality, benefits of alternative thinking was questioned. Subsequently the client was taught how to question oneself and substitute dysfunctional thinking patterns.

Termination Phase

As there were therapeutic gains, client was prepared for the termination phase. During the termination phase, the gains obtained during therapy were discussed, difficulties were identified and addressed and doubts. The role of dysfunctional thoughts was also discussed. Mr. V reported that there was significant improvement in his autonomic symptoms. Furthermore, this approach helped him have a greater understanding of his condition. He also reported an overall improvement in his mood and energy; with this discussion, therapy was terminated.

DISCUSSION

Social anxiety disorder is effectively treated with cognitive behavioural therapy. It is a systematic intervention that adheres to a conceptual approach that is tailored to each individual. Cognitive behaviour therapy must be detailed and definitive in order to be effective in treating SAD. CBT is unquestionably effective for a wide range of mental health issues[18]. This case report provides additional evidence to the efficacy of this intervention in minimizing social anxiety symptoms and remitting the disorder, for example in our case study we used cognitive based techniques in which it is critical for the clinician to explain the purpose behind each CBT sessions and help the patient in understanding each session's agenda until he/she feels comfortable setting their own objectives during the session. The client was well motivated for the sessions and CBT showed significant improvement in his symptomology.

Table 2: : An example of dysfunctional thinking pattern

Triggering Event	Automatic Thought	Emotions (1-10)	Adaptive Response	Outcome (1-10)
Talking to colleagues over lunch	They think I am dull	Nervousness (9)	1.I don't know if they really think that as there is no evidence to support it. 2.They are friendly towards me. 3.Benefit of thinking opposite would be that, I will interact with greater ease 4. This thinking is not helping me in anyway.	Feeling less nervous (6)

CONFLICT OF INTEREST: None

FINANCIAL SUPPORT: None

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