
Behavioral Activation and CBT as an Intervention for Coexistent Major Depression and Social Phobia for a Biracial Client With Diabetes

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Abstract

Major depressive disorder (MDD) and social anxiety disorder (SAD) frequently co-occur in individuals seeking treatment for either problem individually. Strong empirical support exists for the use of behavioral activation approaches for MDD and for cognitive-behavioral approaches for SAD, but these strategies may also work well when used concurrently to treat comorbid MDD and SAD. This study presents a biracial client seeking treatment for chronic MDD maintained in part by his symptoms associated with SAD, which also impacted service utilization in relation to diabetes. Behavioral activation treatment for depression (BATD) and cognitive-behavioral therapy for SAD were used integratively to simultaneously address MDD and SAD symptoms. Following nine sessions of treatment, the patient experienced dramatic changes in both anxiety and depression symptoms across all measures and successfully sought out and received medical treatment for his health problems. Data from this case study suggest an integrative approach for addressing co-occurring MDD and SAD symptoms.

Keywords

depression, anxiety, behavioral activation, CBT, biracial

I Theoretical and Research Basis

Epidemiological studies indicate that both social anxiety disorder (SAD) and major depressive disorder (MDD) occur at a high frequency, representing two of the most common psychiatric disorders experienced in the United States. The lifetime prevalence for SAD in the United States is 8.4% and the lifetime prevalence for MDD is 18.4% (Kessler et al., 2005). Moreover, SAD and MDD frequently co-occur; several studies suggest that up to 37% of patients presenting primarily for MDD also meet criteria for SAD (Belzer & Schneier, 2004; Fava, Judge, Hoog, Nilsson, & Koke, 2000; Kessler, McGonagle, Zhao, & Nelson, 1994).

Taken individually, powerful treatments exist to address symptoms of both MDD and SAD. For example, behavioral activation treatment for depression (BATD; Dimidjian, Martell, Addis,



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Herman-Dunn, & Barlow, 2008; Lejuez, Hopko, & Hopko, 2001) is guided by the theory that depression stems from a paucity of reinforcement in the individual's environment (Lewinsohn, Friedman, & Katz, 1974) and involves systematically increasing an individual's contact with reinforcers in the environment, which both improves mood and facilitates the individual's ability to resolve problems that contribute to depression-related symptoms. A growing research literature supports the efficacy of (BATD) in both inpatient and outpatient MDD populations (Hopko, Lejuez, LePage, Hopko, & McNeil, 2003; Jacobson et al., 1996; Lejuez et al., 2001).

Cognitive-behavioral therapy (CBT) for SAD (Antony & Rowa, 2008; Turk, Heimberg, Magee, & Barlow, 2008) is guided by the view that SAD stems from an aversive learning history vis-à-vis social interactions and is maintained by avoidance of social situations due to irrational beliefs that others hold negative and critical views about the client. CBT for SAD addresses avoidance symptoms with therapeutic exposure and response prevention to feared situations and with cognitive restructuring to reduce the effect of irrational socially related thoughts. CBT is, by far, the most researched and supported psychological treatment for SAD (Rodebaugh, Holaway, & Heimberg, 2004).

Although large research literatures support BATD and CBT with regard to MDD and SAD, respectively, relatively few data exist concerning use of these treatments for comorbid MDD and SAD. Recent studies provide some guidance regarding whether comorbid problems influence treatment effects for the primary disorder. Smits, Minhajuddin, and Jarrett (2009) found that cognitive therapy for MDD is equally effective among patients with and without a comorbid SAD diagnosis and Joermann, Kosfelder, and Schulte (2005) found that comorbid MDD did not hamper treatment for SAD (Ledley et al., 2005). There is no gold standard for how to effectively treat conditions that are comorbid. Oftentimes, clinicians are urged to focus primarily on the diagnostic category that is posing the most impairment and address remaining symptoms after treatment for the primary problem is completed (Turk et al., 2008). However, a sequential treatment strategy for treating comorbid problems becomes less straightforward when symptoms of one disorder serve to maintain symptoms of the other. In such a case, it is reasonable to simultaneously target anxiety- and depression-related symptoms using an integrated treatment strategy.

Hopko, Lejuez, and Hopko (2004) reported a case study involving the simultaneous treatment of MDD and panic disorder with agoraphobia (PDA) in which exposure strategies typically used in CBT for PDA were integrated with behavioral activation strategies to target depressive symptoms. At the end of a 10-session treatment, the patient reported decreases in both anxiety and depression symptoms. Although preliminary, such treatment modifications provide a basis on which to build effective strategies for treating comorbid diagnostic conditions. The following case study illustrates the treatment of an individual's symptoms of social anxiety and depression that integrates two well-supported treatment protocols for MDD and SAD. 

2 Case Presentation

The patient was a 46-year-old single Japanese-American male. At the commencement of therapy, he was unemployed due to voluntary termination.

3 Presenting Complaint


The patient reported that he was experiencing coexistent depressive and anxiety related symptoms. Severity of depressive symptoms fluctuated significantly with long periods of normal functioning. The patient's depressed mood had been present for several years and increased when he quit his job prior to a work-related social event due to fears of criticism from others. He also reported that his unemployment cued significant anhedonia, psychomotor agitation, feelings


of worthlessness and inappropriate guilt, insomnia, fatigue, and diminished appetite. The patient reported recurrent thoughts of death and had a history of suicide attempts.

Anxiety symptoms centered on social interactions and situations and included increased heart rate, shortness of breath, sweating, trembling, chest pain, and fears of going crazy. In social situations, he reported that faces of individuals are illuminated, sounds dampen, and everyone stares at him. His cognitions centered on individuals judging him based on his biracial appearance, others fearing his presence, and the possibility of embarrassment. He avoided most public places including restaurants, shopping centers, grocery stores, and community areas. At times, he was unable to enter businesses to pay bills or refuel his vehicle at service stations when people were present. The patient reported extensive avoidance of physiological and cognitive responses associated with social interactions.


The patient also was diagnosed with diabetes, but failed to seek out appropriate medical care due to feelings of dread regarding crowded waiting rooms and entering pharmacies to fill prescriptions. His untreated medical condition led to diminished vision, loss of finger sensation, and lethargy. The patient presented at the clinic in the face of anxiety-related distress with a desire to avoid another pervasive depressive episode or possible suicide attempt.


4 History

The patient's depressive and anxiety symptoms had been present since adolescence. His family moved around frequently to accommodate his father's military placements, he had difficulty in forming friendships, friendships he did form ended abruptly with each move, and he persistently felt like "the new kid" in social situations. He related verbal and physical altercations with peers involving his biracial appearance. In addition, he did not develop close relationships with either parent or younger siblings. These early life experiences led him to feel like he was an "alien" and a "race of one." At age 15, he attempted to take his life by shooting himself and received electroconvulsive therapy for depression. 

In his adulthood, he described cycles of employment where he dreaded social interactions until they became too distressing resulting in voluntary termination. Following job loss, he would experience major depressive episodes lasting 2 to 3 years. During these periods, he was unable to get out of bed for 1 to 2 weeks at a time, maintain personal hygiene, or leave his residence. He also attempted suicide on multiple occasions by driving his vehicle into a tree and engaging in risky behaviors, such as wandering outdoors in dangerous locations. The patient indicated once depressive symptomology subsided, he would regain employment, though his social anxiety symptoms would remain and pose a barrier in maintaining his employment. 

5 Assessment

The patient presented during the evaluation sessions as attentive and motivated. His verbal expression was somewhat labored and he spoke in abbreviated statements. The patient was oriented on all spheres. He expressed adequate insight about his psychological symptoms. His affect reflected depressed mood and mild psychomotor agitation was evident. There was no evidence of perceptual distortions. He denied any alcohol or drug use. The patient endorsed current suicidal ideation but denied any plans to complete a suicide. During the initial evaluation sessions, he repeatedly stated the difficulty in coming to sessions due to anxiety and the fear of succumbing to another depressive episode. 

A semistructured interview using the *Anxiety Disorder Interview Schedule for DSM-IV* (Brown, Di Nardo, & Barlow, 1994) revealed two primary diagnoses of major depression and social phobia. His multiaxial diagnosis was as follows: 

Axis I	296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features, Chronic 300.23 Social Phobia, Generalized
Axis II	V71.09 None
Axis III	250.01 Diabetes mellitus, type I/insulin-dependent
Axis IV	Inadequate social support, unemployment
Axis V	GAF = 50

The patient completed a number of self report assessment instruments during the evaluation period.

The Beck Depression Inventory-Second Edition (Beck, Steer, Ball, & Ranieri, 1996) consists of 21 items, each rated on a 4-point Likert-type scale indicating severity of depressive symptoms.

The Outcome Questionnaire (Lambert & Finch, 1999) is a 45-item measure rated on a 5-point Likert-type scale assessing three overall areas: symptomatic distress, interpersonal relationship functioning, and social role functioning. Ratings of distress are made for each domain and an overall score. Total scores range from 0 to 180 with changes greater than 14 indicating significant improvement.

The Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998; Osman, Gutierrez, Barrios, Kopper, & Chiros, 1998) is a 20-item measure scored on a 5-point Likert-type scale assessing anxiety related to initiating and maintaining interactions with individuals in social situations.

The Social Avoidance and Distress Scale (SADS; Watson & Friend, 1969) consists of 28 true-false items designed to measure distress and avoidance of social situations.

The Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969) consists of 30 true-false items designed to measure distress over negative evaluations, avoidance of evaluative situations, and expectations of others negative evaluations.

The Social Phobia Scale (SPS; Mattick & Clarke, 1998; Osman et al., 1998) consists of 20 items each rated on a 5-point Likert-type scale assessing anxiety symptoms related to performing various tasks including writing, drinking, and eating in public.

The Albany Panic and Phobia Questionnaire (APPQ; Rapee, Craske, & Barlow, 1994-1995) is a 27-item measure is a designed to assess social fears that are relatively distinct from agoraphobic fears. The measure has three subscales: agoraphobia (A), social phobia (SP), and interoceptive (I). Norms for nonclinical, panic disorder, and SP individuals are provided.

The Anxiety Sensitivity Index (Reiss, Peterson, Gursky, & McNally, 1986) consists of 16 items, each rated on a 5-point Likert-type scale, that measure sensitivity to anxiety-related sensations. The instrument includes three subscales: physical, mental incapacitation, and social concerns.

The Personality Assessment Inventory (PAI; Morey, 1991) is 344-item instrument with 22 full scales (validity, clinical, treatment, interpersonal) which provides information relevant for clinical diagnoses and assessment of mental disorders.

Pretreatment evaluation sessions occurred within a 2 week period prior to beginning the behavioral activation and CBT protocols. The patient's scores on pretreatment measures were as follows: BDI-II = 46, 41, 44, and 28 (severe depression); Outcome Questionnaire (OQ) = 131 (severe distress); SIAS = 62; SADS = 27; FNE = 30; SPS = 67; APPQ: A = 21, SP = 64, I = 6; ASI = 35; PAI *T* scores: NIM = 77, ANX = 78, ARD 79, DEP 86, SCZ = 78, SUI = 111, and NON = 78 (significant elevation in anxiety, depression, social detachment, suicidal ideation, and nonresponse to treatment).

6 Case Conceptualization

The case formulation was based on a cognitive behavioral model of depression and anxiety (Antony & Rowa, 2008; Martell, Addis, & Jacobson, 2001). Research suggests that depression

is associated with decreases in response contingent reinforcement for healthy behavior leading to a depressive effect (Hopko et al., 2003; Martell et al., 2001). Subsequent decreases in once rewarded behavior combined with increases of depressive behavior exacerbate feelings of depression. Furthermore, anxiety provoking thoughts including fear of negative evaluation, worthlessness, and embarrassment contribute to being isolated, withdrawn, and having restricted interests. In the case of this patient, antecedents to depressive episodes involved voluntary termination of employment due to fears of negative evaluation and criticism. In spite of his social fears, he reported that work provided a sense of accomplishment, routine, and means to go on trips and pursue hobbies (i.e., work was an important reinforcer). Within weeks of ending employment, he began to experience depressive symptoms, which includes loss of interest in previously rewarded behavior, feelings of failure, and hopelessness.

In addition to prompting him to quit his job, the patient's persistent social phobia also prohibited him from seeking assistance from treatment providers or family members. He was unable to maintain interpersonal relationships with others resulting in further depressed mood. The patient described excessive feelings of unexplained guilt and anxiety which he attempted to control by distracting himself by watching television and oversleeping. As significant attempts to avoid anxiety related symptoms increased, behaviors resulting in depression also increased. Importantly, this patient experienced diminished appetite tied to his depressive mood resulting in irregular and unhealthy meals. This negatively affected his untreated diabetic condition intensifying loss of energy and motivation. Continual worry about medical complications contributed to heightened anxiety and sensitivity to physiological cues. The severity of the patient's presenting problems stemmed from the interaction between lifelong social anxiety and periodic major depressive episodes combined with an untreated medical condition. Furthermore, isolation and discomfort in social situations originated from restricted biracial identity development. The patient did not identify with either parent's culture and felt out of place and misunderstood by others.

7 Course of Treatment and Assessment of Progress

Based on this case conceptualization, the patient was treated using the BATD (Lejuez, Hopko, & Hopko, 2002) protocol concurrently with cognitive behavioral therapy (CBT) for social anxiety (Antony & Rowa, 2008). In addition to the above protocols, continuous suicidal assessment was implemented. Due to the severity of the depressive symptoms (e.g., suicidal ideation and history of suicide attempts) and untreated diabetic condition, the patient was referred to a physician for a physical examination and evaluation for medication management of his depression symptoms. After 2 sessions of psychoeducation regarding his depression and anxiety symptoms, the patient elected to see a physician in the face of his dread of crowded waiting rooms to make progress with treatment. He was prescribed 10 mg of Prozac during the evaluation period and began to take insulin injections during treatment.

The patient was informed about the dual treatment approach and collaborated with the clinician to devote half of each session to two protocols. The intervention was carried out over nine, 90 minute, biweekly sessions. Initial sessions were spent building rapport, psychoeducation about depression and social phobia, and working toward creating a healthier environment. Therapist-patient transference issues were addressed regarding the therapist's Caucasian ethnicity with respect to the patient's negative experiences with other Caucasians and his biracial identity concerns. Diagnostic criteria, prevalence rates, and associated symptoms of his diagnoses were discussed. The patient reported this information attenuated feelings of isolation, knowing he was not the only one experiencing these symptoms. Research regarding the efficacy of combined medication and treatment for severe depression as well as support for both treatment protocols was provided.

The patient and therapist discussed the case conceptualization and the hypothesis that the primary mechanism for improving depressive affect was to increase his contact with meaningful reinforcers in the environment, which included social interactions. Once more effort is dedicated to activities that were once enjoyable and elicited a sense of accomplishment, energy level, motivation, and positive affect would follow. The patient's anxiety related symptoms and intervention associated with each component were addressed. The patient was oriented to the standard social phobia treatment, which includes challenging anxiety provoking thoughts, exposure to feared situations, and understanding physiological responses. Additional discussion involved the use of diagnostic labels that explained clusters of symptoms that often have considerable overlap with other disorders. Eliminating artificial distinctions between the two presenting disorders was critical to successfully blend both treatment approaches.

The behavioral activation intervention for depression includes a self-monitoring assignment of daily activities. Initially, this provides a baseline assessment of activity, increases awareness of depressive and healthy behaviors for the patient, and guides subsequent target activities. The next session involved the patient identifying goals in various life areas including relationships, education, employment, and physical health. An activity hierarchy was developed from the goals the patient selected and rated from the easiest to the most difficult to accomplish. The activities included ones the patient was currently engaging in, some rewarding activities he used to engage in, as well as new activities he wanted to accomplish. Goals associated with the frequency and duration of each activity was set and daily monitoring was recorded. To facilitate the intervention and provide social support, a contract was signed with a family member who agreed to reward him for achieving his goals and to withhold the reward if he engaged in unhealthy behavior. The patient exhibited very good compliance and was able to achieve most of his daily and weekly goals. He reported increased feelings of accomplishment and improvements in mood as he progressed through his activity hierarchy and engaged in enjoyable behaviors. He was able to improve his diet, exercise, accomplish household tasks, go on trips, and reconnect with previous enjoyable activities.

The cognitive behavioral intervention for social anxiety includes self-monitoring of cognitions associated with social situations. To guide the cognitive restructuring intervention, the patient monitored his anxiety provoking thoughts in a variety of situations. The next sessions provided opportunities and skills to challenge anxiety provoking thoughts. A list of common cognitive distortions was provided and applied to the client's thoughts. Cognitions that were particularly difficult to challenge in session were submitted to behavioral experiments to test the validity of the thought. For example, the patient felt very anxious each time he went to the service station to fill up his vehicle. His anxiety provoking thought was he would give the clerk the wrong money resulting in ridicule and embarrassment. The patient was instructed to intentionally give incorrect money to the clerk and observe the outcome. He reported feeling no embarrassment and that the clerk hardly noticed the mistake. The patient subsequently challenged the same thought on two more occasions because the experience was so positive. A hierarchy of feared social situations was compiled and rated on the level of fear each situation evoked. The patient was instructed to implement the skills learned in-session to challenge anxiety provoking thoughts and to confront the social situations. Many of the activities for BATD and exposures for the anxiety treatment were integrated to address overlapping areas. For example, one of the healthy activities the patient selected was to read a preferred book. The patient's vision had declined and he was no longer able to read without considerable effort. However, in order to purchase reading glasses he was required to enter shopping centers and try the reading glasses on which caused a lot of distress. Five shopping centers were selected which ranged in density of patrons. He was instructed to try on glasses at each store successively and then purchase the reading glasses he liked the most. The patient reported that within an hour he visited all five stores and was able to try on glasses at the final crowded store with only minimal feelings of anxiety.



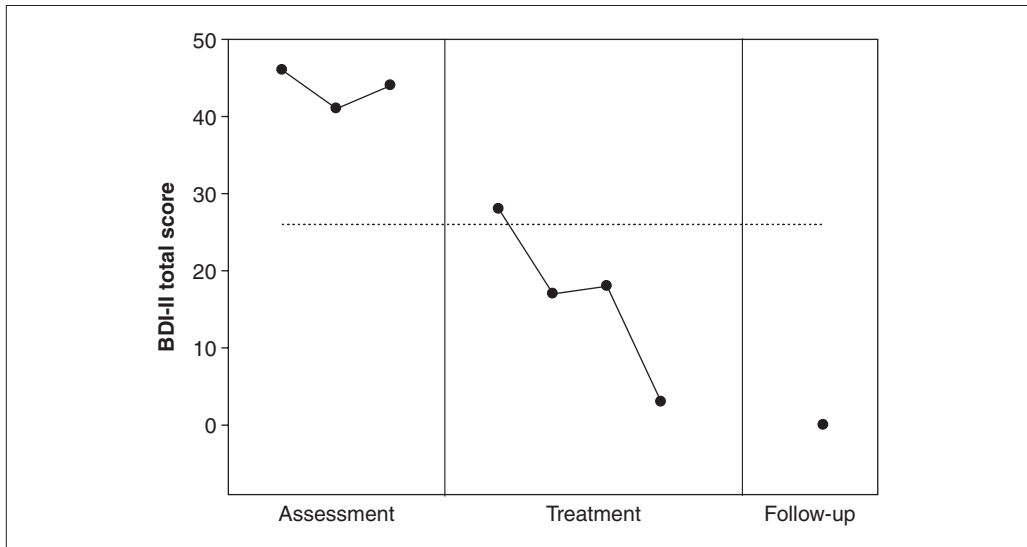


Figure 1. Beck Depression Inventory-II scores across assessment, treatment, and 3-week follow-up sessions

Through the course of treatment the patient was able to keep all of his medical appointments, eat in multiple restaurants, initiate conversations with strangers in shopping centers, and reconnect with past relationships.

The patient reported that a considerable amount of anxiety resulted from racial discord in social situations. Based on his learning experiences, he felt he did not fit in with any racial group and others feared him based on his biracial appearance. To improve identity development, he was instructed to talk to two of his siblings, who were also biracial, about their identity. He also searched for resources online that contained first person accounts of biracial individuals addressing their own identity formation. The client was encouraged to explore possible identity outcomes to ameliorate his comfort with racial identities. Root's (2003) identity model was presented in therapy which focuses on five positive biracial identity development outcomes: acceptance of ascribed identity, identification with both, single, or new racial groups, or adoption of a symbolic race or ethnicity. The options and availability of choice were emphasized. The therapist's racial identity was utilized to challenge thoughts regarding fear, prejudice, and judgment. Furthermore, other aspects of identity were discussed including gender, age, religion, social class, and so forth to highlight the complexity of identity. In addition, situations where individuals are a minority in regards to other aspects of their identity were presented to assist the patient in recognizing universal identity related issues. The patient reported that the identity development discussion improved his self-concept and further exploration would be beneficial following treatment.

Continuous assessment of depression (see Figure 1) and anxiety (see Figure 2) symptoms revealed a linear decline throughout the course of treatment. His post-treatment scores revealed significant decreases in depression and anxiety with significant improvement in life satisfaction. His post-treatment scores on measures were as follows: BDI-II = 3; SPS = 17; SIAS 29; and OQ = 32.

8 Complicating Factors

The primary complicating factor for this patient involved periodic health related concerns. Twice during treatment the patient became sick resulting in canceled sessions and diminished capacity

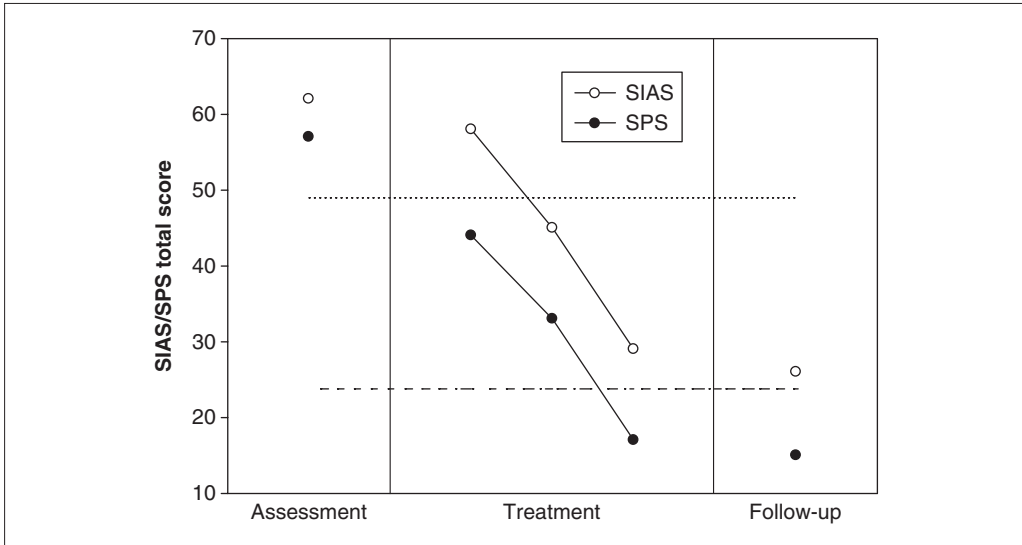


Figure 2. Social Phobia Scale (SPS; closed circles) and Social interaction anxiety (SIAS; open circles) total scores across assessment, treatment, and 3-week follow-up sessions

for exposure exercises. However, treatment was robust and positive outcomes remained, in spite of these setbacks. During his treatment, he was prescribed insulin to regulate his diabetic condition. He experienced grief knowing he would be required to take insulin the rest of his life. Sessions included discussions about administering medication and his feelings about his medical condition. Occasionally, the patient had some negative physiological reactions to the insulin resulting in illness. To maintain the therapeutic alliance, the patient was telephoned when he was unable to attend the clinic to check in on his health. Eventually, his response to the insulin stabilized and he reported having more energy and consistent appetite.

9 Managed Care Considerations

The dual nature of mental and physical related conditions was evident in this case. Due to severe social anxiety, the patient was unable to properly seek treatment for his medical condition. After brief psychoeducation about mental health disorders, the patient was able to visit a medical clinic, fill his prescription, and keep successive medical appointments. Treating mental health disorders in tandem with physical illness provides a holistic treatment approach (Hopko & Armento, 2009). Preventative care should focus on treating mental health concerns so patients will have the ability to seek medical assistance if necessary. Implementing behavioral and cognitive-behavioral treatment approaches are time-efficient and practical interventions within community mental health and primary care settings (Lejuez, Hopko, LePage, Hopko, & McNeil, 2001).

10 Follow-Up



Assessment at 3 week follow-up revealed maintenance and improvement of gains in terms of reduced depression, anxiety, and distress in life functioning. The patient's scores on follow-up measures were as follows: BDI-II = 0; SPS = 15; SIAS = 26; and OQ = 17 (see Figure 3).

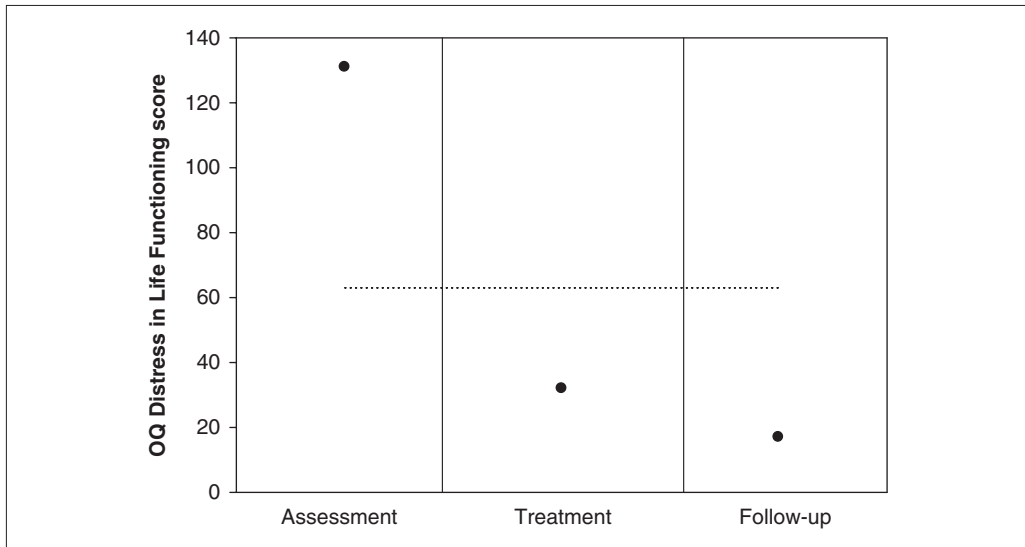


Figure 3. Total score of the Outcome Questionnaire (OQ) across assessment, treatment, and 3-week follow-up sessions

The interventions, maintenance, and relapse preventions strategies, as well as future treatment related goals were addressed. The patient planned on maintaining treatment gains by increasing activities that targeted depression- and anxiety-related symptoms. He planned on enrolling in a college course in a desired subject for enjoyment and to facilitate opportunities to confront anxiety provoking cognitions related to social interactions. At 2 months, the patient reported returning to his previous employment requiring interactions with coworkers and clientele. The patient reported that he had stayed in contact with friends and continued going to shopping centers two to three times a week. He has remained physically active, improved his diet, and was consistently taking insulin injections.

11 Treatment Implications of the Case

Perhaps the most important implication of this case study is the ability to integrate behavioral activation for depression and CBT for social anxiety concurrently. Given the high comorbidity between mood and anxiety disorders, the necessity of effectively treating multiple disorders simultaneously is evident. The protocols utilized in this case study were flexible to the idiographic presentation of the client. Additional resources including identity development was included in the treatment to enhance outcomes. In addition, the treatment approach was effectively implemented with coexisting medical problems and in collaboration with his physician. Finally, reduction in depressive and anxiety related symptoms by increasing behaviors, overcoming avoidance tendencies, and challenging cognitive distortions corresponds well with emerging therapy approaches aimed at addressing clinical presentations that involve comorbid disorders (Barlow, Allen, & Choate, 2004). Addressing underlying mechanisms that maintain various disorders is an efficient and effective way of treating interacting disorders.

12 Recommendations to Clinicians and Students

Many treatment protocols for anxiety and mood disorders have been empirically validated. However, interventions targeting comorbid anxiety and mood disorders are scarce (Hopko et al., 2004).

Furthermore, efficacy of these treatments with biracial clients is limited. Selecting treatment approaches that adequately address your client's needs is essential. Disorders which interact and maintain each other present a difficult predicament for clinicians to determine the primary diagnosis and which manualized treatment to select. Adopting a cognitive behavioral approach is a flexible way to adapt behavioral as well as cognitive interventions to treat a range of symptoms across many domains. In addition, multicultural competence should be a key component with all patients receiving treatment. A holistic approach addressing identity, mental, and physical health is often necessary to provide the best available care for patients with complex presentations.

Declaration of Conflicting Interests

The authors declared that they had no conflicts of interests with respect to their authorship or the publication of this article.

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Bios

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Steven R. Lawyer, PhD, received his PhD from Auburn University in 2002 and is currently an associate professor at Idaho State University. His research focuses on the laboratory study of decision-making, anxiety, and trauma. His clinical interests are in the assessment and treatment of anxiety and mood-related disorders.