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Cognitive-behavioral treatment of adolescent with social anxiety

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Summary

Adolescence is characterized by many developmental challenges and is a period of vulnerability to anxiety yet, paradoxically, is also period of increased risk-taking behavior and striving for autonomy. One of the most common problems that adolescents face is social anxiety. Social anxiety in many cases leads to impaired mental health in adolescence and adulthood, when left untreated. One of the most effective and evidence-based first-choice approaches in treating social anxiety of adolescents is Cognitive-Behavior Therapy (CBT).

The aim of this case study is to illustrate CBT treatment of social anxiety with adolescent client, to prove CBT's efficacy but also to stress out the importance of resilience building in adolescents as the way in improving their mental health.

The client (17 years old girl) is complaining to anxiety symptoms and claims that "she does not want to live in this suffering but she wants to make something out of her life" during the initial session. Basic complaints are social isolation that she wants to change and to spend more quality time with her peers, intense anxiety symptoms and irregular school attendance.

The treatment goals were set in collaboration with the client. In achieving these goals, we used behavioral techniques (role-plays, in-vivo exposure), cognitive techniques (psychoeducation, cognitive restructuration, behavioral experiment), techniques of mindfulness and Compassion Focused Therapy techniques. The treatment lasted 16 sessions. The client was highly motivated and worked hard in reaching the treatment goals. During the treatment, therapist-client relationship was cooperative and filled with compassion, trust, unconditional acceptance, but also with the presence of humor.

The treatment was successful, as confirmed through the results of the Social Anxiety Questionnaire and Beck's Anxiety Inventory, through the achievement of the goals set and the client's and her family's self-reports. Further prognoses are positive but also depending on social support factors that client will have in future.

In conclusion, we can state that CBT proved efficacy as described in this case study and confirmed its status of evidence-based first-choice approach in treating social anxiety of adolescents. Building resilience in adolescents has been confirmed as an effective way to improve their mental health.

***Key words**: social anxiety, Cognitive-Behavior Therapy, adolescence, resilient, mental health*

Sažetak

Period adolescencije je prožet mnogim razvojnim izazovima i predstavlja period povećane osjetljivosti na anksioznost, a paradoksalno predstavlja i period povećanja rizičnog ponašanja, te potrage za autonomijom. Jedan od najčešćih problema sa kojima se adolescenti suočavaju jeste socijalna anksioznost. Kada se ne tretira, socijalna anksioznost u velikom broju slučajeva dovodi do narušenog mentalnog zdravlja u samom periodu adolescencije, ali i odraslom dobu. Jedan od tretmana koji je dokazano prvi i najefikasniji izbor u tretmanima socijalne anksioznosti kod adolescenata jeste kognitivno-bihejvioralna terapija (KBT).

Cilj ove studije slučaja jeste prikazati primjenu KBT-a u tretmanu adolescentkinje sa problemom socijalne anksioznosti, dokazati efikasnost KBT-a, ali i ukazati na značaj jačanja otpornosti kod adolescenata i unaprijeđenja njihovog mentalnog zdravlja.

Klijentica dobi 17 godina, po dolasku na psihoterapiju se žali na simptome anksioznosti. Osnovne pritužbe su socijalna izolacija jer se ne druži sa vršnjacima iako bi željela, intenzivni simptomi anksioznosti, te neredovni odlasci u školu što želi da promjeni.

Zajedno sa klijenticom, postavljeni su ciljevi tretmana. U postizanju ovih ciljeva korištene su bihejvioralne tehnike (igranje uloga, bihejvioralni eksperiment, izlaganje uživo), kognitivne tehnike (psihoedukacija, kognitivna restrukturacija), tehnike pune svjesnosti (eng. mindfulness) i tehnike Terapije usmjerene na saosjećanje (eng. Compassion Focused Therapy). Tretman je trajao ukupno 16 seansi. Klijentica je bila motivisana za tretman i naporno radila na ispunjavanju dogovorenih ciljeva. Tokom tretmana je razvijen saradnički i saosjećajan odnos ispunjen povjerenjem i bezuslovnim prihvatanjem, ali i sa prisutnosti humora. Tretman je bio uspješan, što je potvrđeno kroz rezultate na Upitniku socijalne anksioznosti i Bekovoj skali anksioznosti, ostvarenosti postavljenih ciljeva i izvještajima klijentice, te njene porodice. Dalja prognoza je povoljna, uz napomenu da u određenoj mjeri zavisi i od faktora socijalne podrške u budućnosti.

Na kraju, možemo zaključiti da KBT jeste preporučeni prvi izbor u tretmanu socijalne anksioznosti adolescenata, upravo radi dokaza o svojoj efikasnosti, što potvrđuje i slučaj koji je opisan. Jačanje otpornosti kod adolescenata je efikasan put ka unaprijeđenju njihovog mentalnog zdravlja i boljih prognoza za budućnost.

***Ključne riječi**: socijalna anksioznost, kognitivno-bihejvioralna terapija, adolescencija, otpornost, mentalno zdravlje*

Introduction

The anxiety issues are among the most frequently seen psychological problems of children and adolescents (James at al 2015; Kendall 2000; Creswell et al 2014). The previous two decades saw a significant increase in scientific interest and number of studies striving to better understand the problem of anxiety / the anxiety disorder among children and adolescents (Kendall, 2000). Deeper and better understanding of childhood anxiety is of extreme importance as many problems and the anxiety disorders in childhood tend to reflect on the adulthood unless treated in counseling or psychotherapy (Kendall, 2000; Pine et al 1998).

The Social Anxiety Disorder - SAD (the old name of ***social phobia*** can still be found in the literature) is the excessive fear experienced in one or more social situations (Leahy et al, 2012). It is characterized by intense feeling of shyness, withdrawal from social situations and avoidance of new situations or persons (Kendall, 2000). Persons who experience social anxiety expect that others would assess them negatively, especially in situations that involve public speaking and public appearances, attending social events, meeting new people, eating in public, disagreeing with others' opinions (Leahy, 2012). Social Anxiety Disorder or intensive problems of social anxiety tend to appear for the first time between the age of 11 and 16, when they are most frequently recognized (Leahy, 2012). This age corresponds with adolescence, which is characterized by numerous developmental challenges and is a period of increased sensitivity to anxiety, and paradoxically, it is also the period of increase tendency towards risk-taking behaviors and seeking autonomy (Kendall et al, 2015; Justin et al, 2014). Social Anxiety Disorder and problems related to social anxiety are in many cases combined with other psychological problems and disorders, such as depression and other anxiety disorders, and abuse of psychoactive substances (Leahy, 2012). For adolescents, who are going through a sensitive and challenging developmental phase of life anyway, the problem of social anxiety may seriously harm their mental health and resilience that would otherwise allow them to overcome on their own all the challenges that are awaiting them. In this period, compassionate support of adults is the key. Speaking about models of professional assistance to adolescents by psychotherapists, research and clinical experiences have shown that in the treatment of social anxiety in children and adolescents the Cognitive-Behavioral Therapy (CBT) has proven to be the most effective and one of the first treatments of choice (Kendall, 2000; Scainiab et al 2016).

When we talk about the CBT, there are more than twenty different therapies that are called "cognitive" or "cognitive-behavioral" (Dattilio and Padesky, 1990, Mahoney and Lyddon, 1988, according to Corey, 2001). All cognitive-behavioral approaches are based on active roles of both psychotherapist and the client, and emphasize the importance of homework, structured psycho-educational model and use of various cognitive and

behavioral techniques for the purpose of achieving the change (Corey, 2001). Presently, the CBT is used in work with adults, couples, families and children (Kendall, 2000).

The case study that follows will provide an insight in manifestation of the problem of social anxiety among adolescents, but more importantly, it will provide a clear picture and guidelines on how to effectively support adolescents in learning new models of behaviors by using the CBT. This case study will be specifically focused on use of the CBT and presentation of the treatment outcomes.

General information and personal / social history

The client is an older adolescent girl at the age of 17. She attends secondary school regularly, and at the time when she came to psychotherapy she had enrolled the final grade of secondary school. She lives with her mother and grandmother in their own home. Father is absent, he works and lives outside of Bosnia and Herzegovina in a Western European country, but he is in regular contact with the family and financially supports them. The client has a close relationship with her parents, and parents are supportive of her. Mother of the client used to have psychological problems and she had been going to psychotherapy for her problem of agoraphobia, and her fear of leaving home is still present. The client has a limited social circle, problems with chronicle asthma, for which she had been hospitalized several times in her childhood, and she has problem of obesity (throughout her childhood and at present).

She developed avoidance style of coping and behaving, and this has contributed to the client becoming more and more socially isolated and afraid of how the others would perceive her, and she developed low self esteem.

Reasons for coming for psychotherapy and initial status

The client comes to psychotherapy complaining of anxiety and states that she feels it is difficult for her and that she "***does not want to live her life suffering like this, and she wants to make something of her life".*** The trigger that made her come to psychotherapy was that her school had notified her that she would have to take the extraordinary exams to pass the grade. The social isolation and feeling of exclusion have contributed to development of intense social anxiety and low self esteem. The client has recognized and had insight in her problem, but it was the mother who initiated her coming to psychotherapy, what is characteristic of problems of social anxiety and confirms the presumption of avoidance coping style.

To illustrate the overall psychological status of the client, the text bellow describes emotional, cognitive, behavioral and physiological symptoms that were present.

Emotional symptoms

Of emotional symptoms, the most obvious is anxiety, as well as the fear of assessment and rejection. Under these manifest symptoms there is also anger with oneself (self-criticism). There is also low mood, confirming numerous research results that suggest that clients having problem with social anxiety that is not treated in psychotherapy in many cases develop depression (Kendall, 2000; Stein et al, 2001; Leahy et al, 2012).

Cognitive symptoms

Among cognitive symptoms, most expressed are anxious automatic negative thoughts (ANT) like "*Someone will say that I am fat", "Someone will certainly look at me and cat-call when I pass by",* or irrational beliefs*: "I must please everyone, or they will reject me, and that feels awful", "I must know how to defend myself, otherwise I am unfit*". There are also self-critical thoughts: *"You are stupid, you will fail!", "Look at you, you should better stay home and never leave.", "It is no wonder everything scares you, you are such a coward".*

Behavioral symptoms

Out of behavioral symptoms, the most obvious one is social avoidance, such as: staying by oneself in her room, avoiding social contacts and avoiding going to school, avoiding going to any public places, with insomnia present as well.

Physiological symptoms

Characteristic physiological symptoms of anxiety, such as: breathing fast, sweating palms, heart beating faster, a "knot" in the stomach, weak limbs, chest pressure, trembling hands.

Case conceptualization

The client exhibits typical problem of social anxiety and low self esteem. Because of her looks (obesity), over-protective upbringing by her mother, insufficient socialization with her peers while growing up, health problems (asthma), the client developed avoidance as a style of coping and her typical behavior manifested in anxious reaction and core belief that she is a failure and not worthy as a person (***core belief from the domain of personal inadequacy***). In social situations that can become triggers, the core beliefs and anxious assumptions lead to avoidance. The avoidance of the situation / experiences brings short-term and immediate relief, but intensive self-criticism and anger at oneself come back very quickly, leading to even more social isolation and driving the client into depression.

Compensatory strategies (negative behavioral strategies developed in order to cope with symptoms): the most expressed compensation strategies are psychosomatic responses (stomach pain, headache, fatigue) and avoidance of school / public places.

The strengths that help with the therapy process: among the strengths, there is a powerful insight and desire to help herself through psychotherapy. A positive factor is also the relationship with the father, who is a stabile figure and someone with whom the client has an open and supportive relationship.

Treatment Goals

According to the CBT model and practice, the goals are set in collaboration with the client in the first three meetings, and are regularly revised throughout psychotherapeutic treatment. The following treatment goals have been identified:

1. Get educated on anxiety and cognitive-behavioral model for the purpose of normalization of the condition;
2. Learn to recognize symptoms of anxiety – through bodily reactions and appearance of ANT for the purpose of reducing anxiety;
3. Initiate conversation with a stranger for ***in-vivo*** exposure and facing the social situations;
4. Call a stranger by phone to test catastrophic predictions;
5. Invite a friend for a coffee and go with her for a coffee for the purpose of exposure;
6. Go by herself to a shopping mall and enter two shops to ask for the price of the items for the purpose of exposure;
7. Sit in the shopping mall alone for 20 minutes for the purpose of exposure and reducing the level of anxiety;
8. Successfully pass the school exams to finish the grade – the goal set by the client;
9. Focus on studying for at least two hours a day while preparing for the exams;
10. Learn to relax when on her own – to lie still and do the relaxation exercise (***mindfulness – body scanning***) 10-15 minutes three times a week;
11. Learn to send to herself compassionate messages when self-criticism emerges using the "***criticizer***" exercise for the purpose of building compassion for oneself.

Treatment plan

Based on all introductory information and after setting the treatment goals, the therapist, together with the client, has developed the initial and provisional treatment plan. The starting part was about psycho-education and normalization of the condition the client complained about, by learning the basic relaxation techniques, recognizing the initial anxiety symptoms and learning the CBT models for coping with anxiety. Continued treatment included the work on cognitive restructuring and testing and challenging the main irrational beliefs of the client about herself, other people and the world around her. ***In-vivo*** exposure was planned after the initial treatment steps, because the client first needed support and empowerment in order to expose herself to situations that were the most powerful triggers for the anxiety. In a number of final sessions, the plan was for the client to learn to build a more compassionate attitude towards herself, and to become empowered to independently use the skills and techniques learned at the therapy. The sessions were planned to be held once a week, gradually prolonging the time between sessions towards the end of the treatment.

Therefore, the treatment plan included implementation of various cognitive and behavioral techniques, as well as the ***mindfulness*** techniques and Compassion Focused Therapy (CFT). Here we offer a more detailed presentation of the techniques used.

Cognitive techniques:

- *Psycho-education:* learning about functional and dysfunctional emotions, about cognitive model, understanding the impact of negative thoughts and irrational beliefs on emotions and behavior, as well as about the importance of internal dialogue.
- *Cognitive restructuring:* monitoring automatic negative thoughts (ANT), recognizing cognitive distortion, responding to the ANT, identification of irrational beliefs, rules and assumptions, modification of irrational beliefs, identification of core belief, creating a more balanced core belief.
- *Behavioral experiment:* using the given form, a behavioral experiment has been agreed with the client for the purpose of testing catastrophic predictions.

Behavioral techniques:

- *Role playing:* for the purpose of practicing assertive dialogue and behavior, in preparation for exposure therapy;
- *In-vivo exposure:* using the exposure hierarchy, developed by the client with the psychotherapist's help, identified a hierarchy of social situations that the client used to avoid. By doing homework between sessions, the client exposed herself to every situation from the hierarchy, from the lowest ranked situation to the top of the hierarchy.

Mindfulness techniques

- *Mindfulness* technique of body-scan for relaxation.

Compassion Focused Therapy (CFT) techniques

- The "*criticizer*" exercise to learn to accept and respond to self-criticizing thoughts.

Treatment course and outcome

The treatment went on in accordance with the identified plan and goals, which were, according to the CBT model and the CBT approach to conceptualization of psychological problems, followed and modified in line with needs and progress made by the client. According to the CBT model, at the very beginning of the therapy, the therapist made a conceptualization of the client's problems, which was revised during the course of the treatment together with the client. Other segments of the course and outcome of the treatment are given bellow.

Relationship in the therapy

From the beginning of the treatment, a relationship filled with trust, acceptance and warmth was established. In certain phases of the therapy, particularly during the behavioral experiments, the psychotherapist used a more directive style, which the client accepted and responded positively to, in order to prevent avoidant behaviors and to motivate her to do the behavioral experiment. During the work, the relationship grew better and better, without difficulties in the relationship between the therapist and the client.

Problems/difficulties during the treatment

The client's behavioral avoidance had occasionally caused postponement of sessions and irregular work on the homework.

Treatment outcome and prognosis

The treatment was successful, as confirmed by the results at the ***Social Anxiety Questionnaire*** and the ***Beck's Anxiety Inventory,*** by achieving the set goals and by reports of the clients and her family. Further prognosis is good, with a note that to a certain extent it will also depend on the factors of social support in the future.

Three follow-up sessions were held to prevent relapse of symptoms, after 1 month, after 3 months and after 6 months. After the last follow-up session, there was no relapse and the client's condition has become stabile.

The treatment goals that were achieved:

1. The client learned what is the cognitive-behavioral model by learning the skills to recognize and respond to the ANT, recognize and respond to the Irrational Beliefs,
2. She learned to recognize symptoms of anxiety – bodily reactions and ANT (recognizes emergence of anxiety and applies the CBT model);
3. She has started conversation with a stranger (a girl) at a tram station while waiting for a tram;
4. At the session, succeeded in calling a stranger by phone and then saying she had called a wrong number;
5. Invited a friend for a coffee and went with her (initiated the hangout 10 times);
6. Went alone to the shopping mall and entered 2 stores and asked for the price of items;
7. Sat alone at the shopping mall for 20 minutes, observing people around her and her own reactions;
8. At the extraordinary school exams, successfully passed the grade and enrolled to the next grade;
9. Managed to focus on studying every day for at least 2 hours in preparation for the extraordinary exams;
10. Learned to relax when alone – she is able to lie still and do the relaxation exercise (***mindfulness – body scan***) for 10-15 minutes three times a week;
11. Learned to send to herself compassionate messages when the self-criticism occurs using the exercise with the "***criticizer***" (CFT).

Assessment of level of social anxiety at SAQ – Social Anxiety Questionnaire) (Leahy, 2012):

Date:	SAQ (total score)
08/04/2017	21 (high level)
22/07/2017	17 (medium level)
22/08/2017	7 (low level)

Conclusion

The case study, and particularly the achieved goals and results of the treatment re-confirm the already proven efficacy of the CBT in treating Social Anxiety Disorder and social anxiety problems in adolescents. As already stated, adolescence is a specific developmental period that brings along many risks, but also developmental opportunities for the adolescents (Kendall, 2000). Failure to recognize or to treat the recognized psychological problems in adolescents increases the risks for development of psychological disorders in adulthood (Coles et al, 2016). Speaking of the CBT model of development of psychological disorders, it is important to underline that in the root of psychological problems of adolescents and adults are the deep, unconscious and negative beliefs about oneself, other people and the world, which we call the ***core beliefs*** (Beck, 2007). The client whose case is described here had developed the core belief from the so-called domain of personal inadequacy ("***I am inadequate and I am not worthy as a person***"), and this belief was in the root of all described symptoms she had manifested. In order to make the psychotherapy successful, and to reduce the chances of the symptoms coming back, identification and alteration of this core belief is an unavoidable path one must take. As can be seen, the complete set of cognitive and behavioral techniques was used for this very purpose – to identify this negative core belief and create a new, functional core belief ("***I am sufficiently capable and I am as worthy as other people***"). The homework that makes an integral part of the CBT helped affirm this functional belief and contribute to experiencing functional emotions and more stabile emotional regulation. Therefore, we may conclude that effective combination of cognitive and behavioral techniques, along with ***mindfulness*** techniques and Compassion-Focused Therapy (CFT) whose effectiveness is proven, have lead to positive behavioral changes and achieving the goals of the treatment. It is important to say that the techniques are necessary part of the treatment, but they are not always enough for a successful treatment. One other equally important ingredient in therapy is development and maintenance of a therapeutic relationship between the therapist and the client. A relationship filled with trust, warmth, unconditional acceptance and encouragement provides a context in which the use of CBT techniques as such makes full sense. As psychotherapy, the CBT has in its repertoire a huge number of techniques whose efficiency has been evidence-based; however, the context in which the techniques are used has an equally important role.

In accordance with the above, we have yet another confirmation and response to the question as to why the CBT is one of the first recommended treatments for this kind of issues (Kendall, 2000). Taking into consideration how common is the problem of social anxiety among adolescents, and how serious its consequences may be if left unrecognized, we believe that this case study contributes to raising awareness among professionals about the importance of developing community-based support programs for

adolescents. We hope that this case study has succeeded in showing the importance of strengthening resilience among the adolescents, and that the recognition and support to adolescents who are facing psychological problems is an effective way to improve their mental health and give better prognosis for future.

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