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A case report of cognitive behavioural therapy for social anxiety in an ultra-high risk patient

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Abstract

Aim—Psychological treatments such as cognitive behavioural therapy (CBT) may have efficacy in young people at ultra-high risk (UHR) for psychosis. Case reports can illuminate the obstacles and challenges, and potential trajectory of symptom changes, observed with this treatment.

Methods—This is a detailed case report of a young adult at UHR for psychosis who received manualized CBT for accompanying social anxiety.

Results—Cognitive deficits and suspiciousness created initial challenges for successful implementation of CBT. Engagement in treatment occurred with slowing of pace and simplification of material, and modelling of social interaction. Treatment of social anxiety was accompanied by decreases in suspiciousness, conceptual disorganization, and social anhedonia, and increase in range of affect.

Conclusions—Adaptation of manualized CBT to accommodate cognitive deficits and suspiciousness in UHR patients may improve engagement. CBT focused on social anxiety can lead to improvement across symptom domains in UHR patients.

Keywords

case report; clinical high risk; cognitive behavioural therapy; psychosis; ultra-high risk

INTRODUCTION

Herein, we present a case report that was presented and discussed at the Department of Psychiatry Grand Rounds at Columbia University on 8 July 2011. With guidance from Dr Deborah Cabaniss (Clinical Professor of Psychiatry and Director of Psychotherapy Training at the Columbia University Department of Psychiatry), Dr Margaret Haglund organized the case presentation, and Drs Cheryl Corcoran and David Kimhy were the discussants, respectively, with areas of expertise in the phenomenology of the ultra-high risk (UHR) syndrome, and in cognitive behavioural therapy (CBT) across stages of psychotic disorders. In line with the format employed by other medical and psychiatric journals, we have opted

to employ herein the structure of initial case presentation, with subsequent commentary by the discussants.

DR MARGARET HAGLUND: CASE PRESENTATION

‘Mr. A’ presented as a 20-year-old Filipino man in his junior year of college, stating: ‘I want to be less afraid of speaking to people and I want to be able to concentrate in class.’ He was referred by his therapist to the Center of Prevention and Evaluation (COPE), a psychosis risk research program, because of his blunted affect, poor eye contact and paucity of speech. Mr A was eligible on the basis of attenuated psychotic symptoms of unusual thought content, suspiciousness and conceptual disorganization. He provided written informed consent for participation in the study, which was approved by the Institutional Review Board at New York Psychiatric Institute. Mr A was offered treatment, which he began with Dr Margaret Haglund 10 months after study entry.

Mr A had worsening anxiety and depression since age 12, when he had moved with his family to the United States from his country of origin. He reported a recent increase in suspiciousness, suspecting that his Internet usage was monitored, therefore no longer communicating via email. Mr A also reported increasing involvement in fantasy, spending 7 h daily daydreaming about being a popular young man who ‘partied’ with friends and broke rules. His daydreaming and anxiety interfered with class participation and academic functioning, and he had little peer interaction. His grades declined from As to Cs and Ds and he withdrew from an important seminar.

Mr A had prior psychotherapy but no previous exposure to psychotropic medications.

He denied any history of perceptual disturbances, obsessions or compulsions, manic symptoms, drug use or experimentation, or medical illness. His reality testing was intact. Though he lived with his brothers, he was not close with them. He was unaware if relatives had any psychiatric illnesses and refused any contact with his family.

Using standardized instruments, Mr A was diagnosed with social anxiety (score in severe range of Social Anxiety Scale for Adolescents) and attenuated psychotic symptom syndrome (symptoms in the prodromal range of Structured Interview for Prodromal Syndromes/Scale of Prodromal Symptoms (SIPS/SOPS)). The Social Anxiety Scale for Adolescents Revised,¹⁻³ a self-report scale that was read aloud to participants to ensure comprehension, captures three facets of social anxiety: fear of negative evaluation, social avoidance and distress generally experienced in the company of peers, and social avoidance and distress specific to new situations or unfamiliar peers. Mr A had scores on the ‘severe’ range on all three subtypes of social anxiety. His total score was 71, which exceeds the threshold of 50 suggested by LaGreca as a cut-off for social anxiety disorder. The SIPS/SOPS^{4,5} assesses positive symptoms (i.e. unusual thought content, suspiciousness, grandiosity, perceptual disturbances and cognitive disorganization) and negative symptoms (i.e. social anhedonia, avolition, deterioration in role function, and decreased experience and expression of emotion). The range of scores is from 0 to 6, with scores from 3 to 5 for positive items to be considered in the range of psychosis risk. Mr A had scores in the ‘prodromal’ range on

measures of unusual thought content, suspiciousness, disorganization, social anhedonia and decreased expression of emotion (Fig. 1).

Mr A declined to consider an anxiolytic or antidepressant for treatment of his symptoms as he feared being experimented on 'like a guinea pig'. Ten months after study entry, he began weekly psychotherapy with periodic discussion of the potential utility of medications. I suggested that we begin CBT using a manual specific to social anxiety.⁶

Initially, Mr A was enthusiastic about treatment and assiduously completed assignments. After 1 month, however, when examining and challenging cognitive distortions, he began coming to sessions unprepared and fell silent when I attempted to help with homework. When asked what was wrong, he said, 'forget it' or 'whatever.' I changed tack and suggested we focus on behavioural strategies, like increasing pleasurable social activities, but he was unable to generate lists of potential activities. He became increasingly dysphoric in sessions but could not explain why.

Despite this, Mr A did not miss his appointments and continued to track daily anxiety and depression symptoms as assigned. By month 3, we noticed that he consistently rated therapy as his most anxiety-provoking activity. Upon exploration, he explained that he thought about therapy daily, fantasized about being able to speak assertively in sessions, and felt hopeless when he perceived that he had failed. He felt we were moving too fast and that his mind 'went blank' during sessions. He was unable to elaborate further, and I could not determine whether this was caused by anxiety or paucity of thoughts. Mr A also revealed that he had difficulty trusting me and wondered whether I was using him as 'learning material'.

Our discussion of his difficulties marked a turning point in the therapy. Starting in our third month of treatment (13 months after study enrolment), I spoke more slowly and introduced fewer subjects in each session. I also worked on challenging his negative thoughts and feelings about therapy and on helping him change his behaviour in sessions. I asked that in each session, he tell me at least one thing he had been thinking about during the week. Finding this difficult, he suggested he write the material in advance and read it to me. I increased my verbal support, praising his improvement and smiling more frequently, overtly demonstrating encouragement and interest. He mirrored these, smiling more and engaging in small talk himself. I began to use humour, and though he did not always understand my jokes, and asked for explanations, he responded positively and kindly, even teasing me at times. After several weeks, he became able to talk about events without having to write them down first.

Six months into treatment (and 16 months into his participation in the study), Mr A began to demonstrate trust by asking for help with his personal life. For example, he sought advice on how to reply to text messages from another student who invited him out. Mr A began to report improvement in his social and academic functioning. He made some friends at school, and in our eighth month of treatment enrolled in a seminar and gave an oral presentation. Additionally, his daydreaming decreased significantly. By the end of our treatment (9 months after beginning therapy), he reported fantasizing about 15 min each day, down from the 7 h daily he had reported initially. His end of treatment SIPS/SOPS scores showed

improvements in emotional expression, organization of thought and speech, social function, motivation, and in enjoyment of life (Fig. 1). (Unfortunately, we failed to assess his social anxiety beyond baseline using the Social Anxiety Scale for Adolescents.)

DISCUSSION OF PHENOMENOLOGY OF THE UHR SYNDROME: DR CHERYL CORCORAN

This case illustrates the challenges inherent in the identification and treatment of young people at clinical risk for psychosis. These youths typically have not only unusual thought content and suspiciousness, but also symptoms attributable to other disorders, such as social anxiety, depressed mood and attentional deficits. This constellation of symptoms is conceptualized as UHR status for psychosis and is proposed for inclusion in the DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) Section III (appendix) as the ‘attenuated psychotic symptom syndrome’. As yet, no clear evidence base exists for its treatment.

This patient presented with social anxiety, which has a high prevalence in schizophrenia and related disorders,^{7,8} including in its early stages, such as during a first episode of psychosis,^{9,10} and in putatively prodromal periods marked by attenuated psychotic symptoms.^{11–13} Across stages of psychotic disorder, social anxiety coexists with social anhedonia,^{14,15} as is evident in Mr A. It may be that this social anxiety reflects stigma and shame about emerging symptoms, and fear of related rejection by peers.^{16,17} On the other hand, social anxiety may be related to emergent psychotic symptoms such as paranoia,¹⁰ and hence a component of the patho-physiology of emergent schizophrenia in a developmental context. Treatment is clearly of utility in treating current morbidity – social anxiety – in at-risk patients. However, the improvement of symptoms across the board in Mr A, including attenuated psychotic symptoms, raises the additional possibility of whether the treatment of his social anxiety may have prevented the onset of psychotic disorder.

COPE is a prospective cohort study of help-seeking individuals, ages 14–30, who present with sub-threshold psychotic symptoms (illusions, over-valued ideas and/or suspiciousness), which exist in the context of intact reality testing but nonetheless cause distress or functional impairment. Eligibility is determined on the basis of moderate or high scores for positive or disorganized symptoms using the SIPS/SOPS.⁴ Symptoms must have begun or worsened in the past year and cannot be better accounted for by another disorder. Individuals at COPE also have cognitive deficits, negative symptoms, and depression and anxiety.¹⁸ One-third develops threshold psychosis within 2 years.¹⁹

Mr A's cognitive deficits included attentional deficits²⁰ and marked verbal memory deficit in the context of intact visual memory.²¹ Verbal memory deficits are common in UHR cohorts, and may predict later onset of psychosis.^{22–25} Mr A's cognitive deficits created challenges for implementing CBT: he forgot assignments, felt the therapy went too fast, and reported feeling that his mind went blank in sessions. During the first 6 months of treatment, Mr A's positive, negative and mood symptoms remained largely refractory to treatment, reflecting his difficulty in therapy. When therapy was modified to accommodate his learning pace and incorporated social role modelling, Mr A showed a positive response.

DISCUSSION OF CBT IN UHR PATIENTS: DR DAVID KIMHY

CBT has proven efficacy for psychotic disorders as an adjunct to pharmacological treatment, as supported by more than 30 randomized clinical trials and meta-analysis. Adjunctive CBT leads to significant reduction in positive symptoms and improvement in negative symptoms, negative mood, social anxiety, social functioning and vocational performance.²⁶

As for young people at clinical risk for psychosis, evidence suggests that CBT may also have utility.^{27–32} However, the active ingredients key to efficacy are not clear: in the clinical trials conducted to date, good outcomes are also found for patients assigned to the comparison psychological treatment arms. Potential mechanisms for the therapeutic effects of CBT and psychological treatments in both schizophrenia and UHR patients include improved coping mechanisms, strengthened social skills, increased ability to manage daily stress, reduced self-stigma and reduction in externalization of negative affect.

More research is needed to understand the potential efficacy of CBT to treat the constellation of symptoms that comprise psychosis risk or ‘attenuated psychotic symptom syndrome’, especially that there is a limited evidence base for treatment. CBT has the benefit of causing no side effects, is less stigmatizing than the use of antipsychotic medication, and is acceptable to many patients.

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Change in "prodromal" symptoms over time

FIGURE 1.

Trajectory of symptoms over time (SOPS = Scale of Prodromal Symptoms). —■—, suspiciousness; —▲—, conceptual disorganization; —×—, social anhedonia; —*—, decreased emotional expression.