

Effectiveness of Brief Cognitive Behavioral Therapy in Reducing Psychological Distress in a Client With Social Anxiety Disorder: A Single-Case Study

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ABSTRACT

Social anxiety disorder (SAD) is one of the most common psychological disorders that can happen at some point in one's life. It is characterized by intense distress that occurs before, during, and after engaging in social situations. SAD can negatively affect an individual's functioning in many aspects of life. Therefore, SAD is often associated with severe psychological distress. This research aimed to evaluate the effectiveness of brief cognitive behavioral therapy (CBT) combined with counseling techniques in reducing psychological distress in a client with SAD. CBT targeted the maladaptive thoughts, which were considered as the leading cause of SAD. The changes brought by the psychological distress symptoms were quantified using a pre-post design with a single-case study (n = 1). The participant was a 19-year-old first-year female student who had been avoiding many social situations for the last 8 months. She came to the counseling center with complaints of distress and intense anxiety when facing social situations. HSCL-25 measurements reduced from 2.56 to 1.72, indicating that her psychological distress, which included anxiety and depression symptoms, was significantly decreased. The GHQ-12 measures also decreased, showing that psychological distress and adjustment disorder symptoms had diminished. In the last session, the participant also managed to develop a more adaptive way of thinking. Therefore, CBT combined with counseling techniques can effectively reduce psychological distress symptoms on a client with SAD.

Keywords: anxiety, depression, psychological distress, social anxiety disorder, social phobia.

1. INTRODUCTION

Social anxiety disorder (SAD) is one of the most common psychological disorders, with a lifetime prevalence of up to 12% (Kessler et al., 2005). It is characterized by intense distress that occurs before, during, and after engaging social situations where an individual is subject to scrutiny (American Psychiatric Association, 2013). SAD has a negative effect on the individual's functioning in various aspects of life, such as in the fields of education, employment, family

relationships, marriage or romantic relationships, social networks of friendships, and other interests (Schneier, et al., 1994). This condition can also be comorbid with depression (Dalrymple & Zimmerman, 2007; Stein et al., 2001; Katzelnick et al., 2001; Mannuzza et al., 1995; Van Ameringen et al., 1991) and other anxiety disorders (Fehm & Wittchen, 2003). Therefore, SAD may also be linked to severe psychological distress consisting of anxiety and depression symptoms.

When a person with a SAD has comorbidity with other mental disorder's symptoms, it can cause nosology and diagnosis difficulties and create treatment challenges (Koyuncu, Ince, Ertekin, & Tukel, 2019).

Cognitive behavioral therapy (CBT) is proven to be effective for SAD treatment (Goldin, et al., 2012; Ledley, et al., 2009; Gil, Carrillo, & Mecca, 2001) and can be conducted in various techniques. The most researched CBT techniques are social skills training, exposure techniques, cognitive restructuring techniques, and the combined exposure and cognitive restructuring techniques. Furthermore, social skills training, exposure techniques, and cognitive restructuring techniques in a global way are relatively effective in treating SAD (Gil, Carrillo, & Mecca, 2001). CBT can reduce not only the severity of SAD symptoms but also the psychological distress symptoms experienced by the client (Hunger, 2018).

CBT sessions mainly address clients' negative patterns and distortions on how they perceive the world and themselves; such negative outlook is believed to be the main cause of social anxiety and psychological distress symptoms. After identifying the maladaptive thoughts, the therapist assists the clients in becoming more adaptive. This intervention mainly targets clients' maladaptive thinking, considering that such thinking is assumed to be the leading cause of the problem. Typical CBT consists of 14–16 sessions (Wells, 1997). However, considering the increasing demand for psychological interventions for SAD, the time and cost-effective methods of this anxiety disorder must be determined.

In primary care, the time and the number of professionals available are usually limited; therefore, brief formats of CBT are needed. Brief CBT can consist of 4 to 8 sessions (Wells & Papageorgiou, 2001). A preliminary investigation suggests that brief CBT can be effective in managing clients with SAD and in the longer term, can also be cost-effective. To shorten the CBT sessions or to conduct a brief CBT, the meetings should focus on changing the distorted cognitive processes and eliminating negative beliefs that maintain the SAD symptoms (Pinjarkar, Sudhir, & Math, 2015). This study aimed to examine the effectiveness of a four-session CBT combined with counseling techniques in reducing psychological distress in a client with SAD who participated in this study.

2. METHODS

2.1. Participants

Our participant was a 19-year-old first-year female student. She voluntarily visited a university counseling service center and requested an intervention from a researcher to treat her problem. Based on the assessment, the participant met the criteria of SAD and manifested psychological distress symptoms. Her life story and the details of her problems were determined using a semistructured interview. Some psychological distress measurements were also employed.

2.1.1. Case introduction

To protect the participant's confidentiality, we used the pseudonym "Bunga." As mentioned, Bunga was a 19-year-old first-year female student who voluntarily registered to the university counseling service center. It was her first

experience coming to a counseling session. Before entering the counseling room, Bunga was waiting in the waiting room sitting with a slightly bent position and her hands in front of the body; thus, she looked a little curled up. At the beginning of the session, Bunga cried while trying to cover her tears with an awkward laughter, and her voice was soft. Bunga is the second child in a family of three children with one older brother and one younger sister. Currently, she lives with her parents and sister in Jakarta City.

2.1.2. *Complaints*

Bunga claimed that she suspected herself of having SAD, especially after reading a friend's post on social media about the symptoms of SAD. The symptoms that she felt she experienced were the feeling of fear when she was in a social situation, feeling of nervousness when she was going to respond to others, feeling of anxiousness and even crying when thinking about the upcoming social situations, and fear of embarrassing herself in front of other people. Bunga often thought about what people would think about her, and she was afraid of being talked behind by others; hence, she frequently tried to avoid social situations for the last 8 months. Apart from her suspicion of having SAD, Bunga claimed to have some psychological distress symptoms, such as anxiety symptoms (fast heartbeat and nervousness) and depression symptoms (feeling worthless, self-blame, sleep disturbance, loss of interest in doing activities, indecisiveness, and loss of energy).

2.1.3. *Background information*

Bunga was born and raised in Jakarta. Bunga's father is a technician, while her

mother is a housewife. Bunga described her family as not warm, lack of praise, and lack of healthy communication. Her parents rarely asked her about how she was doing and inadequately guided her in taking the path of life. Her parents tended to let her decide everything, including choosing a university major without any suggestions. Bunga also did not have a close relationship with her siblings. Since she was born until she was 15 years old, she lived in a household with two other families from his father's side. According to her, these two other families have a difficult temperament; they easily get upset and offended. Thus, their house condition was not conducive to her.

As a kid, Bunga was cranky. However, she was quite talkative, liked to play, and was active as other kids. At 8 years old, she was once scolded by her mother for not wanting to take a shower, and then she cried loudly. Her uncle who was disturbed by her crying scolded her mother harshly. Bunga then felt shocked and scared. Since that day, Bunga has questioned herself why she has to be born into this world, and it was the first time when she felt unworthy. Since then, Bunga limited her interaction with the families living in their house and became less talkative at home.

Another unforgettable experience was that Bunga caught her father and mother having an affair with other partners when she was still in elementary school. When she was in the sixth grade, Bunga was scolded by all of her classmates because she admired a male friend who was not approved by her classmates. Since then, she became more cautious in interacting with others and felt like she had to fulfill her friends' expectation about her. When she entered junior high school, her mother

left them for 3 years because she fought with her father after her mother was presumed to be cheating. Bunga stated that she only cried over her mom once and then continued her life. Since she was in the third grade of junior high school, she has become quieter. She tended to be quiet during gathering with friends or managed to not initiate a conversation with people who were not close to her. She also often thought that she was ugly and stupid and had terrible social skills. She questioned why she had to be born that way, and often pitied her condition.

During her teenage years, Bunga often felt disappointed with her shortcomings. This negative feeling continued until she was entering early adulthood. Her psychological state had got worse since she enrolled to a university and peaked since the last 8 months before the counseling started. Since then, she has always gone home immediately after class to avoid social interaction in the campus. She felt tired of the thought of her inability to communicate and feared that she would be the subject of other people's conversation. Consequently, she often got tired of being alone and unfocused when the thought emerged, causing a drop in her grades in the second semester. She was also worried that she would not be able to have a discussion partner for research activities on their final class project.

During the counseling session, we found that the most debilitating psychological symptoms that Bunga had were her feelings of self-worthlessness and extreme dissatisfaction because she thought that she did not have any good qualities and had many shortcomings in many life aspects such as social skills, personality, and academics. Regarding

social skills, Bunga claimed that she did not have the talent to make the conversation funny, cool, fun, and last long; thus, Bunga excluded herself from any peer group in the campus. In terms of personality, she believed she had some bad traits, such as impatience when interacting with family members, laziness in reading, inability to control emotions properly, no focus on long-term goals, and a "deadliner." Bunga perceived that being lazy to read made her looked less knowledgeable compared with her colleagues on campus. In the academic field, Bunga felt that she was stupid because her GPA did not reach 3.5. She also believed that obtaining a GPA of 3.5 is easy in her department, but she was not able to achieve it. Bunga was worried that she was not equal to others; hence, she presumed that she did not deserve to be accepted by others. Bunga considered that other people were smarter and friendlier than her. She was also unaware of the strengths she possesses. Overall, she felt hopeless with her condition. She thought of committing suicide but was not brave enough to do so. This kind of thinking led to her debilitating psychological distress symptoms, such as SAD symptoms (fast heartbeat and nervousness) and depression symptoms (feeling of worthless, self-blame, sleep disturbance, loss of interest in doing activities, indecisiveness, concentration difficulty, and loss of energy).

2.1.4. Case conceptualization

Bunga's case conceptualization was established according to the techniques adopted from Westbrook, Kennerley, and Kirk (2011) to outline the current problem overview, describe the causes and how the problems developed, and analyze the

maintenance process that caused the problems to persist. In Bunga's case, her negative thoughts were caused by her maladaptive core belief "I am not good enough," which then became the root cause of her psychological symptoms. In addition, the maladaptive cycle was maintained by her maintenance process. Figures 1 and 2 present the details of Bunga's case conceptualization and maintenance process.

2.2. Design

This study has a pre-post design with a single-case study ($n = 1$). The pre-test was conducted during the first session, whereas the post-test was conducted on the last session. The intervention was performed in

four sessions, lasting for 2–2.5 hours each. All four sessions were conducted once a week for a total span of approximately 4 weeks.

2.3. Approval

The participant agreed on the recording and publishing of data obtained from the intervention process, in an educational setting. The counselor (the first author) also ensured participant anonymity in all published data. The participant had signed the informed consent. The counselor was under the supervision of a psychologist (the second author) during the intervention process. The second author also served as the counselor's supervising lecturer.

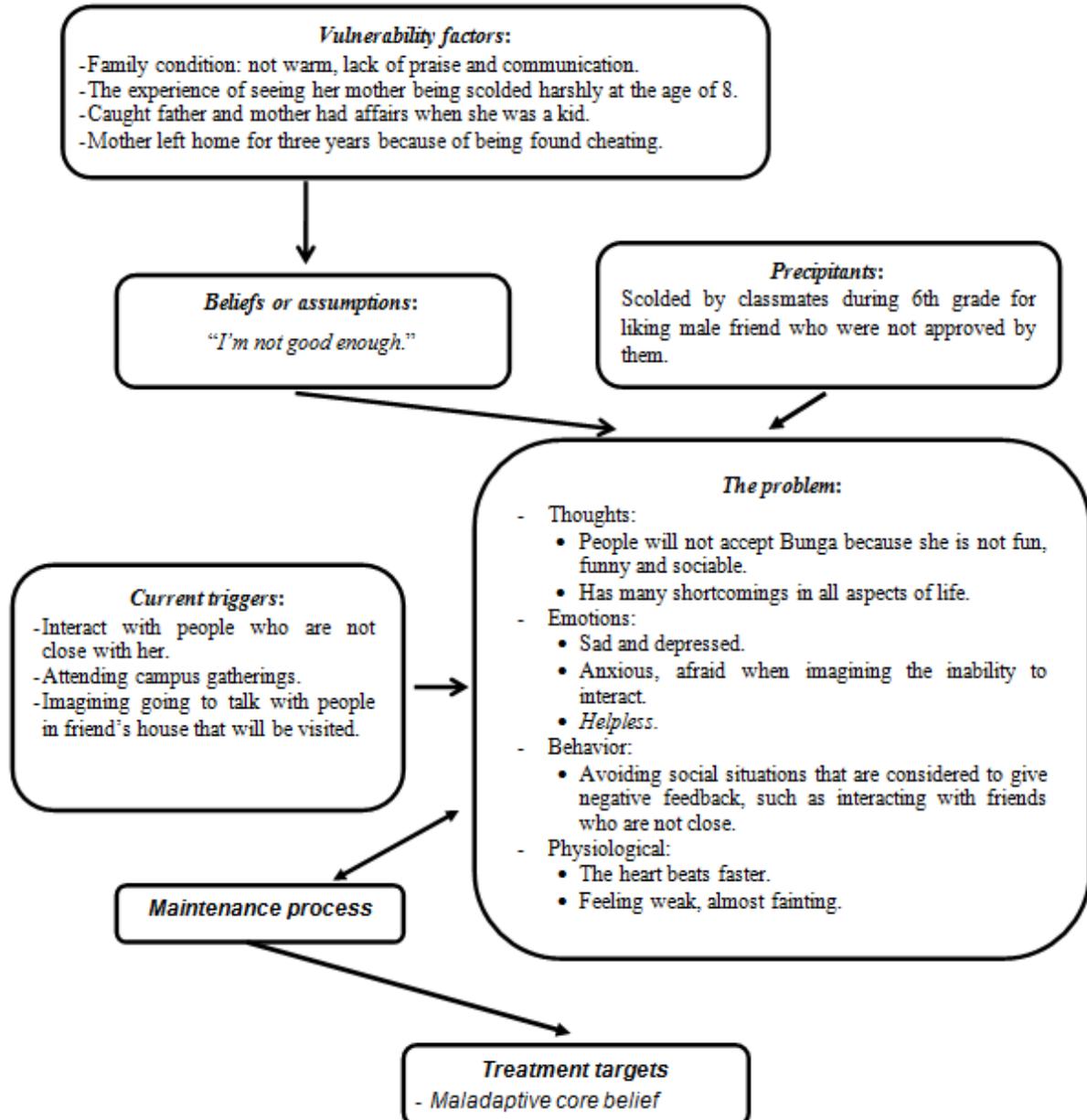


Figure 1. Bunga's problems and several factors related to the problems according to CBT assessment and formulation methods. Adapted from An Introduction to Cognitive Behavioral Therapy: Skills and application (2nd ed.) (p. 13), by D. Westbrook, H. Kennerley, and J. Kirk, 2011, London: SAGE Publications.

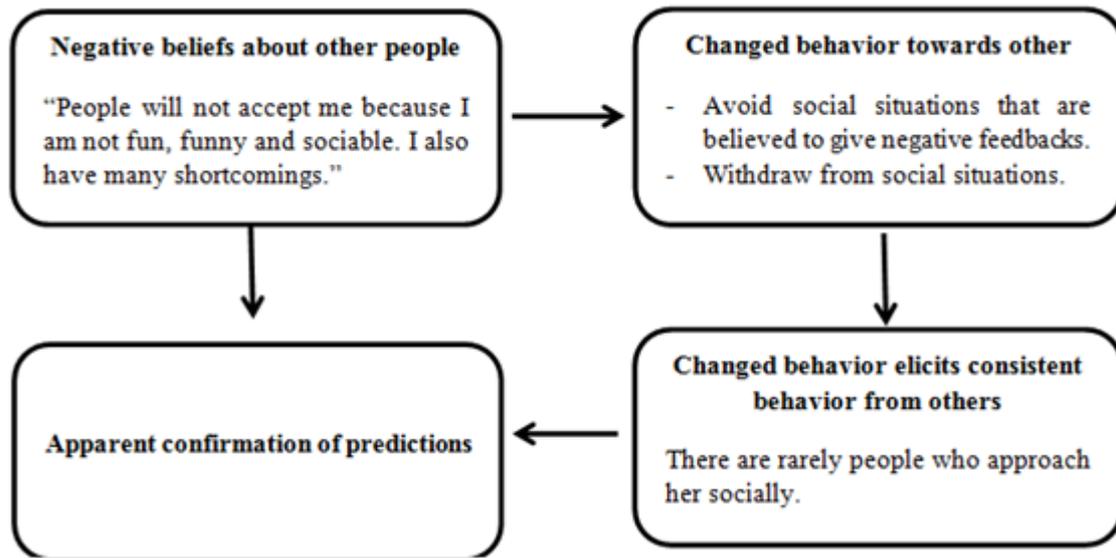


Figure 2. Bunga’s maintenance process. Adapted from *An Introduction to Cognitive Behavioral Therapy: Skills and application* (2nd ed.), by D. Westbrook, H. Kennerley, and J. Kirk, 2011, London: SAGE Publications.

2.4. Measurements

2.4.1. Social anxiety symptoms

The SAD symptoms were assessed using the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders IV (SCID-IV). SCID is a widely used semistructured interview designed to determine if an individual meets any DSM disorder criteria (Glasofer, Brown & Riegel, 2015).

2.4.2. Psychological distress symptoms

Hopkins Symptom Checklist (HSCL), which is a commonly used self-reported questionnaire that measures psychological symptoms and psychological distress, has been used in clinical screening and research outcomes (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The current study used the HSCL-25, which consists of 25 items in which the first part has 10 items measuring anxiety symptoms and the second part has 15 items measuring depression symptoms. General Health Questionnaire 12 (GHQ-12), which is a psychological distress self-report

measure (Goldberg, 1972), was also used to measure psychological distress. In fact, it is one of the popular measures for such condition.

2.5. Intervention

The intervention was held at Universitas Indonesia’s counseling service center in Depok City. The intervention was conducted in a counseling room with an individual setting, with four sessions lasting for 2–2.5 hours each. The sessions were conducted once a week with a total span of approximately 4 weeks.

The main technique used in this intervention was CBT. The CBT process was also supported by counseling techniques, which aimed to help client understand herself and explore her problems deeper. A personalized brief CBT that consisted of four sessions was designed to obtain the maximum effect of the intervention. In this study, CBT focused on the cognitive restructuring technique, targeting the negative thought patterns and distortions and the

maladaptive belief that Bunga had in the way she perceived the world and herself. After identifying the maladaptive belief, the counselor helped her change to be more adaptive by finding a new healthier belief. Thus, this intervention mainly

targeted the maladaptive thinking that Bunga had because it was assumed to be the main cause of the problem. The description below is the explanation of how each of the intervention session was conducted.

Table 1. Summarizes the four sessions of the intervention processes.

| Session | Brief Description |
|-----------|--|
| Session 1 | <ul style="list-style-type: none"> - Introduction - Initial interview followed by counseling techniques to explore the problem deeper and assess the possible contributing factors to the problem - Psychoeducation about SAD - Introducing ABC model and practice it - Teaching the breathing relaxation technique to reduce the physiological symptoms - Pre-test (SCID, HSCL-25, and GHQ-12) |
| Session 2 | <ul style="list-style-type: none"> - Allowing the client to describe how she was during the days between sessions and responding by counseling skills - Discussing NATs related to SAD. Identifying client’s NATs - Discussing how to find the alternative thought to dispute the NATs - Introducing the Thought Record sheet, giving a homework to fill up the Thought Record sheet to identify which negative thought caused the negative feelings, and using it to find the alternative thought to dispute the negative thought |
| Session 3 | <ul style="list-style-type: none"> - Allowing the client to express how she was during the days between sessions and responding by counseling skills - Reviewing the homework - Using the Vertical Arrow technique to determine the maladaptive core belief - Giving a homework to identify client’s good qualities |
| Session 4 | <ul style="list-style-type: none"> - Allowing the client to describe how she was during the days between sessions and responding by counseling skills - Reviewing homework - Disputing client’s maladaptive core belief through Socratic Questioning and creating a mantra - Post-test (SCID, HSCL-25, and GHQ-12) - Termination |

2.5.1. First session

At the first session, Bunga described how worried she was of having SAD. She also mentioned how hopeless and unhappy she was about herself regarding her inability to socialize well like other people.

She also stated how the condition had led her to have symptoms such as feeling worthless and how she felt trapped in a body full of shortcomings. She reportedly often cried and frustrated over her condition. Hence, a counseling technique

was employed to explore her problem deeper and assess the possible contributing factors to her problem. After 1 hour, the counselor introduced Bunga with the ABC model to identify the thoughts and emotions caused by a certain event that she was anxious about. She then tried the ABC model and was able to comprehend the model. In this session, the counselor also conducted SCID for SAD and asked her to answer the HSCL-25 and GHQ-12. Bunga was also given a brief psychoeducation about SAD. This session, which lasted for approximately 2 hours, ended by teaching Bunga the breathing relaxation technique to minimize the physiological symptoms.

2.5.2. *Second session*

The second session aimed to identify client's negative automatic thoughts (NATs). This session started by allowing Bunga to describe how she was doing during the days between sessions, and she was responded by counseling skills such as active listening, being empathetic and genuine, and giving her unconditional positive regard to create a comfortable and trusted environment. On this second session, Bunga cried when she talked about her parents and how unsatisfied she was by their lack of communication and their tendency to let Bunga decide everything alone in her life, making her feel neglected. After an hour of sharing her stories and problems, the session focused on identifying Bunga's NATs. Bunga was asked to tell what usually came to her mind when she felt like she could not socialize with others. Her NAT was "I'm not a funny and sociable person." Then, the counselor introduced Bunga with the Thought Record sheet and gave her a homework to answer the Thought Record sheet whenever she had a negative feeling,

so that she could identify which negative thought caused it. Subsequently, they tried to identify an alternative thought to dispute the negative thought. The second session lasted for 2 hours.

2.5.3. *Session 3—Mindfulness*

The third session aimed to identify client's maladaptive core belief. This session also began by letting Bunga express how she was doing during the days between sessions and reviewing the homework she had last meeting. In this session, Bunga discussed her shortcomings. She elaborated that she had many shortcomings in many aspects of life. When she was asked about her good qualities, Bunga could not answer. She said that she probably did not have any good qualities and strengths and that everyone is better than her. Therefore, in this session, Bunga was given a homework to identify the good qualities that she possessed. After sharing her stories and being responded by a counseling technique for approximately an hour, Bunga was assisted in identifying her core maladaptive belief. She was asked to choose one event where she felt extremely uncomfortable, regarded as the Activating Event (A). From that Activating Event (A), Bunga was asked to identify the Consequences that she felt on that event (C) and the Belief or thought that emerged on that event (B). Thereafter, she was asked by the counselor with Socratic questioning to explore her thought until they reached a core belief and summarized it by using the Vertical Arrow technique. Figure 3 illustrates the summary of the Vertical Arrow technique process. The third session lasted for approximately 2 hours.

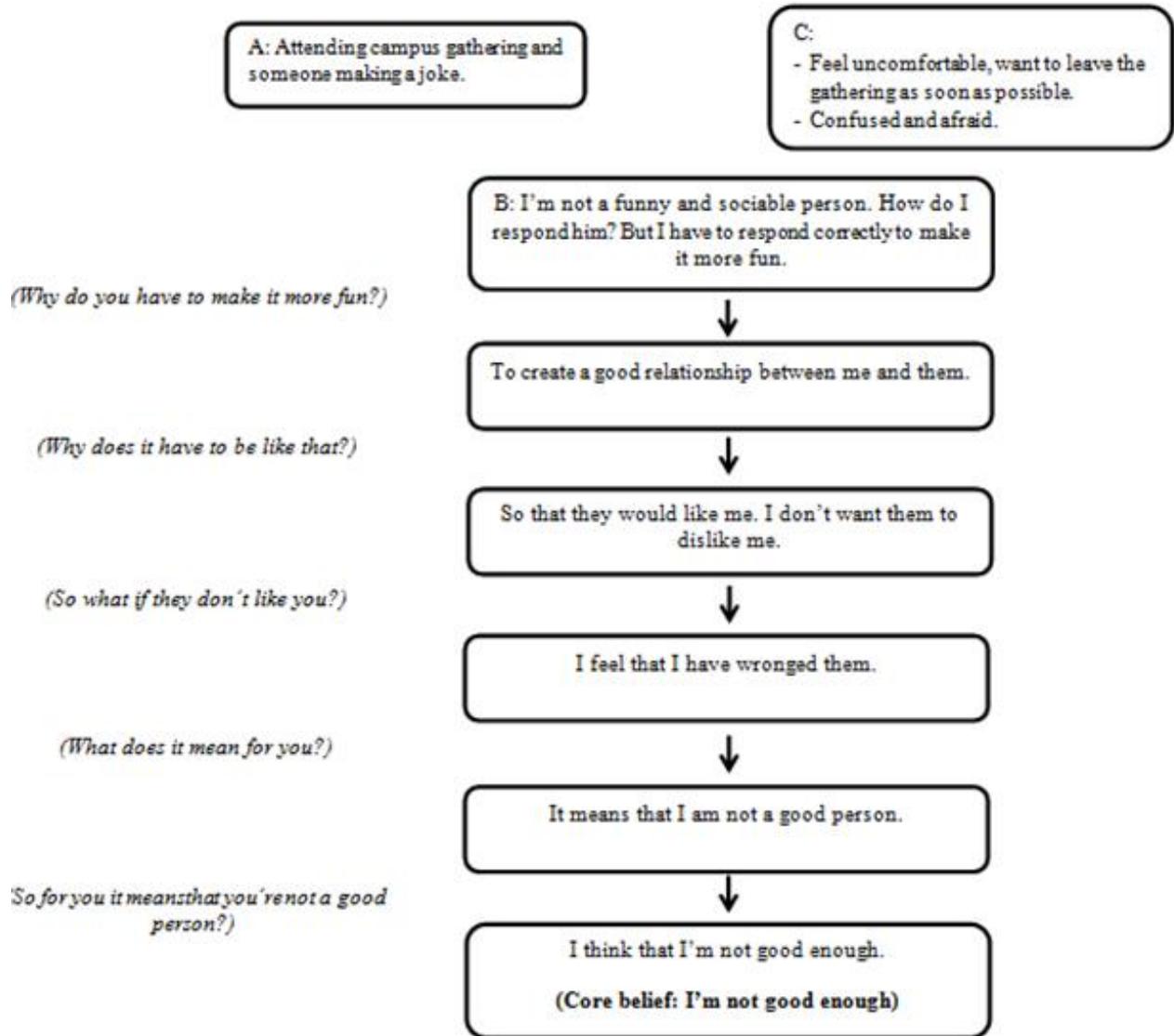


Figure 3. The Process of Finding Core Belief by Using Vertical Arrow Technique in CBT

2.5.4. Fourth session

The third session aimed to dispute client's maladaptive core belief. This session was also started by allowing Bunga to express how she was during the days between sessions, and she was responded using counseling techniques. Next, the counselor reviewed her completed homework. Her good qualities were as follows: caring, loyal to her close friends, and could be a fun person when

she was with friends whom she felt comfortable with. Bunga managed to identify her good qualities by contemplating and asking it to some friends. After approximately 45 minutes, the session focused on disputing Bunga's maladaptive core belief, which was "I'm not good enough," by using Socratic questioning technique in CBT. The fourth session lasted for 2.5 hours.

3. RESULTS

3.1. First session

The pre-test data showed that Bunga had an overall average HSCL-25 score of 2,4, specifically 1,9 for anxiety subscale and 2,73 for depression subscale. These scores were beyond the cutoff point, which is 1,75, indicating that Bunga experienced psychological distress symptoms. Such scores were also supported by the GHQ-12 results, further suggesting psychological distress. The result of the SCID diagnostics met the criteria for SAD and some depression symptoms. After the first session ended, Bunga reported that she was slightly relieved after sharing her problems to the counselor and realized that the ABC technique was useful in identifying her negative thoughts and feelings. She also understood that the cause of her negative emotions is her own thoughts.

3.2. Second session

Bunga reported that she felt comfortable enough to open up in the counseling session. She also realized that many of her thoughts were not necessarily true and had caused her uncomfortable feeling, thereby needed to be modified. Bunga also managed to identify her NAT, that is, "I'm not a funny and sociable person." After being introduced with the Thought Record technique, Bunga knew how to stop the negative feelings that arose by changing her negative thought or her automatic thoughts. She believed that the technique would be helpful when implemented and that she would like to try it.

3.3. Third session

From the completed homework, Bunga

could identify the negative thoughts and emotions and the situation that triggered them. She could also determine the alternative thoughts, so that she could feel better. On the third session, Bunga realized that her maladaptive core belief was "I'm not good enough." When she was asked to describe her good qualities, she could not. Thus, she realized that she was unable to see herself objectively, given that no person has no good qualities or strength. She thought that she needed to see herself more objectively by assessing her qualities and strength.

3.4. Fourth session

The post-test data showed that Bunga had an overall average HSCL-25 score of 1,72, which consisted of 1,7 for anxiety subscale and 1,73 for depression subscale. These scores fell below the cutoff point (1,75), indicating that Bunga had no psychological distress symptoms. Such scores were also supported by most of the GHQ-12 scores, further implying that she had no psychological distress. The SCID diagnostics demonstrated some remission of the SAD symptoms. Bunga reported that she was already less distracted with her anxiety when facing with social situations (9 to 7).

At the end of the session, Bunga felt very relieved because she knew that the root of her problems was her maladaptive core belief, that is, "I'm not good enough." After going through the process of disputing the maladaptive core belief, Bunga managed to develop a more adaptive way of thinking. Her past belief, which was "I'm not good enough" (e.g., feeling socially incompetent, no high GPA, impatient, and lazy to read), was changed into a new belief and mantra,

which was “I still have time to improve myself; I may improve myself and don’t have to be perfect.” The created mantra would remind her whenever a negative thought appears. Bunga felt relieved knowing the core problem, knowing how to tackle NATs, and feeling less pressure when performing social interactions. Bunga also reported less anxiety

symptoms such as fast heartbeat and nervousness. She also reported improvements on depression symptoms such as better decision-making, increased ability to enjoy daily activities, better sleep quality, less worry about everything, increased interest in doing activities, and feeling of increased self-worth.

Table 2. Pre-post HSCL-25

| | Average Score | Cut-off | Interpretation |
|------------------------------------|---|---------|---|
| Pre-test (First session) HSCL-25 | Anxiety subscale: 1,9 Depression subscale: 2,73 Overall: 2,4 | 1,75 | Indication of psychological distress (PD) |
| Post-test (Fourth session) HSCL-25 | Anxiety subscale: 1,7 Depression subscale: 1,73 Overall: 1,72 | | No indication of PD |

Table 3. Pre-post GHQ-12

| | Bimodal | Likert | CGHQ | Cut-off | Interpretation |
|------------------|---------|--------|------|--|--|
| Pre-test GHQ-12 | 8 | 25 | 11 | Bimodal → 2 Likert → 11 CGHQ → 4 | Indication of PD or adjustment disorder |
| Post-test GHQ-12 | 1 | 10 | 6 | | No indication of PD or adjustment disorder, except in CGHQ score |

Table 4. Condition Before and After the Treatment

| Before Treatment | After Treatment |
|--|--|
| Experienced some anxiety symptoms such as fast heartbeat and nervousness when thinking about social interactions. | Experienced less anxiety symptoms such as fast heartbeat and nervousness when thinking about social interactions. |
| Experienced some depression symptoms such as decision-making difficulty, inability to enjoy daily activities, sleep disturbance, excessive worry about things, loss of interest in doing activities, and feeling of worthlessness. | Experienced less depression symptoms. Had better decision-making skill, increased ability to enjoy daily activities, better sleep quality, less worry about things, increased interest in doing activities, and feeling of increased self-worth. |

Felt tense and confused about her condition.

Felt relieved after knowing the core problem, knew how to tackle NATs, and developed a more adaptive way of thinking. Therefore, she felt less pressure when performing social interactions.

4. DISCUSSION and CONCLUSION

This study found that brief CBT could be an effective treatment in reducing PD, which included anxiety and depression symptoms, on a client with SAD who participated in this study. It could also reduce the severity of SAD symptoms. The evidence was based on Bunga's pre-post-test results on HSCL-25 and GQH-12 measurements on PD; SCID results; and her confirmation that she felt relieved because she had known the cause of her problem, known how to tackle NATs, and felt less pressure to perform social interactions. Furthermore, Bunga reported reductions in anxiety symptoms such as rapid heartbeat and nervousness. She also claimed improvements on her depression symptoms such as better decision-making, increased ability to enjoy daily activities, better quality of sleep, less worry about everything, increased interest in doing things, and greater sense of self-worth. The decrease in Bunga's psychological symptoms possibly also occurred because of her high motivation to change and active involvement in the treatment process. Bunga always complied with all of her homework assignments and was able to learn from the sessions and assignments given.

The study results suggested that the intervention had positive effects on the participant. However, this research also had limitations. First, this study did not include follow-up sessions; thus, the intervention could not be determined

whether it was applicable for a long-term or short-term period only. Second, this study lacked quantitative measures to assess the SAD symptoms experienced by the participant because it was only assessed by SCID. Third, the symptoms of SAD were not completely reduced. Hence, further research is required to conduct a follow-up session and use quantitative measures to assess SAD. To eliminate SAD symptoms fully, researchers need more comprehensive and longer CBT sessions. For example, exposure techniques could be combined to produce better results (Feske & Chambless, 1995).

In conclusion, brief CBT is effective in reducing PD on a client with SAD who participated in this study, but it cannot be generalized to other people who experience SAD. Nevertheless, the study results can still be useful for future research that addresses related topics, such as cognitive behavioral approaches, to overcome PD on clients with SAD and reduce the severity of the symptoms. Brief CBT that focused on cognitive restructuring might also be beneficial as a reference to be conducted in a setting that needs short-term treatments.

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