IJBS
International Journal of Behavioral Sciences

Original Paper 68

Emotion Regulation Therapy for Social Anxiety Disorder Comorbid with Major Depressive Disorder: A Case Study

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Submitted: 13 June 20019
Accepted: 21 July 2019

Int J Behav Sci. 2019; 13(2): 68-72

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Abstract

Introduction: Emotion Regulation Therapy (ERT) was firstly developed for treating Generalized Anxiety Disorder (GAD) and comorbid Major Depression Disorder (MDD). Social Anxiety Disorder (SAD) was also addressed regarding its high comorbidity with GAD and MDD. Despite the preliminary evidence for the utility of this treatment, its efficacy for SAD, particularly when it is accompanied by co-occurring depression, it has not yet been examined.
Method: The purpose of this study was to investigate the effect of ERT in an individual suffering from SAD and comorbid MDD. Due to the complexity of clinical presentation in patients suffering comorbid disorders, and also the novelty of ERT, the case study method was applied. The subject was a 29 year old woman who had been diagnosed with MDD and SAD by using Social Interaction Anxiety Scale and Beck Depression Inventory and also clinical interview based on DSM-V. The ERT was implemented in 16 sessions during 4 months. The process of changes was examined by re-completing the questionnaires and clinical interview during and at the end of the treatment.
Results: Results showed reductions in social anxiety and depression symptoms and increased use of emotion regulation strategies (attending, allowance, decentering, reframing). The score of psychological wellbeing had also increased.
Conclusion: Emotion Regulation Therapy (ERT) can be effective on reducing symptoms of SAD and comorbid MDD through increasing the motivational awareness, developing regulatory capacities and new contextual learning repertoires. Meanwhile, further research is needed to confirm the findings of the present study.

Keywords: Emotion Regulation Therapy, Comorbidity, Social Anxiety, Depression

Introduction

Social Anxiety Disorder (SAD) is the third most common life-time anxiety-mood disorders [1]. Lifetime prevalence of SAD in the European community sample is 6.65% [2]. In Iran, the prevalence of SAD in community sample has been estimated to be 0.82% [3]. It is associated with educational problems, difficulties in interpersonal relationship and also higher risks of suicide and comorbid disorders.

Based on Epidemiology data, SAD is mostly comorbid with other disorders [4]. As a result, further research is required to identify common and unique casual factors to design effective treatments.

Social anxiety is characterized by excessive emotional reactivity and this is responsible for its comorbidity with anxiety and mood disorders [5]. Recently, emotion regulation as a underlying factor in the psychopathology and treatment of social anxiety disorder, has been paid attention by many researchers [6, 7].

One of the most recent models and treatment approaches, considering many aspects of emotion regulation to explain and treat emotional disorders and comorbid conditions, is

the emotion dysregulation model proposed by Mennin and Fresco [8].

This model focuses on three main facets of emotional functioning: a) motivational mechanisms b) regulatory mechanisms c) contextual learning mechanisms [9, 10]. Motivational mechanisms refers to the safety and reward system. People with anxiety and mood disorders aren't able to establish a balance between safety and reward systems and they are mostly affected by the pull of the safety system [8]. The increased activity of the safety system is associated with negative affectivity often discussed as emotionality or emotional intensity [8, 11]. The second part of the model focuses on deficits in emotion regulation strategies caused by motivational dysfunction. The strategies emphasized in this model, include attending, acceptance (or allowance), decentering, and reappraisal (reframing) [8]. Individuals with this impaired emotion-regulation profile often exhibit inflexible repertoires of behavior (discussed as disordered contextual learning in the third part of the model) in response to the situations that typically function to promote escape, avoidance, or inactively as a means of managing emotional/motivational signals [11].

Based on all the aforementioned impairments, the aim of ERT is to promote detecting and attending to motivational and emotional cues and increase using adaptive emotion regulation skills [12].

Method

An individual who had satisfied the following research criteria was selected for the present case study.

The inclusion criteria of this research included: a) Getting the scores higher than the cut-off point in Social Interaction Anxiety Scale (SIAS) and Beck Depression Inventory (BDI-II). b) Principal diagnosis of SAD and MDD based on structured clinical interview for DSM-V [13] conducted by a postgraduate student of clinical psychology.

Furthermore, assessments were done to rule out the exclusion criteria including: a) Substance abuse or dependence, or psychotic disorders, dementia, organic mental disorder or other neurocognitive conditions; b) Being under any concurrent psychological treatment; c) Receiving medication in the last three months.

During a brief meeting, the process of the research was elucidated to the case of Zahra and her informed consent was obtained. It should be noted that the study was carried out with consideration of ethical issues and conforms to all the relevant laws and institutional guidelines.

The ERT was implemented in 16 weekly sessions, divided into two phases (four phases in previous version [12]. The prominent themes of Phase I of ERT (sessions 1-8) are to introduce clients to ERT model and train skills designed to promote early cue detection and mindful awareness (sessions 1-2). Additional goals of this phase is to develop regulation skills consisting of allowing, distancing, and reframing (sessions 3-8). Phase II plans on discerning values, exploring the internal obstacles that may impede moving towards these values, proactively approaching to actions congruent with value-related goals. The final sessions in phase II [14-16] are devoted to concluding treatment as well as relapse prevention [12].

In the case study method, all data collection methods can be applied and it is possible to use both qualitative and quantitative methods [14]. In this study, in addition to observation and clinical interview, the questionnaires, described below, were also used to control and validate the qualitative data.

Social Interaction Anxiety Scale (SIAS)

The SIAS is a 20-item self-report questionnaire. Internal consistency of SIAS in social phobia sample, community sample, and undergraduate sample has been reported to be $\alpha = 0.86$, α .95, and $\alpha = 0.85$ [15].

Beck Depression Inventory-Second Edition (BDI-II)

This questionnaire is composed of 21 clauses of which the subject selects one of the four options that indicate the severity of the symptoms of depression in them. The BDI has been used in more than 7,000 studies so far. The BDI has undergone two major revisions: in 1978 as the BDI-IA7 and in 1996 as the Beck Depression Inventory-II (BDI-II). In a research carried out on 354 subjects with major depression in Iran, the Cronbach's alpha was reported to be 0.91 for 21 items [16].

Client

Zahra was a married 29 year old woman. She was a master student. As she had got a high score (her score was 50) in social interaction anxiety scale and Beck depression inventory, she was invited to the clinic to be assessed more precisely. Based on the clinical interview, she met the criteria for SAD and MDD with no other comorbid disorders.

She had been experiencing symptoms of SAD since her early adolescence. These symptoms had intensified as she went to university manifested in social situations such as facing the opposite gender, presentation and stablishing friendship. Currently, she has limited social relationships (only with her first degree relatives). Symptoms of depression (including diminished interest or pleasure, insomnia, loss of energy, diminished ability to concentrate, and feeling of worthlessness) begun since 5 years ago and intensified after her childbirth. She had taken citalopram 4 years ago but she stopped usage due to its side effects.

In social situations such as presentation, Zahra reported severe anxiety that pushed her to a "nervous breakdown". In such situations, her concentration seemed to be restricted on actual or perceived danger finally leading other aspects of experiences or relationships to be ignored. Furthermore, simultaneous pulls for high threat and high reward caused her to be unable of making a decision. These evidences reflects motivational dysfunction.

Using strategies like avoidance, worry and rumination and lack of adaptive regulation skills such as acceptance, indicate regulatory dysfunction.

In addition to responding reactively to negative emotions, she also had difficulties responding to positive emotions, which causes reward motivation to be neglected or rarely acted upon. She also engaged in more

elaborative reactive responses such as self-criticism.

Within the ERT framework, deficits in emotion generation (intense emotional and motivational pulls) and emotion regulation strategies led to signs of behavior restriction and avoidance function as seen in Zahra (showing tendency to procrastination or avoidance of activities requiring spontaneity).

Results

In session 1 an emotion dysregulation conceptualization of disorders was introduced to Zahra and she was encouraged to tell her life story from an ERT lens. She was asked to begin self-monitoring through recording emotional situations and evoked emotions.

In later sessions, Zahra had to monitor and record more complex and detailed information as she became acquainted with other aspects of the model. Zahra was taught the first mindfulness skill called Mindful Belly Breathing (MBB) practice intended to providing immediate relief and also improving the ability of cue-detection. She was encouraged to practice mindfulness skills six times a week by the end of the treatment.

Session 2 addresses the role that motivations (reward and safety) play in experiencing intense emotions. Also, Zahra was taught the second mindfulness skill, Body and Muscle Awareness (BAMA), helping her to notice a variety of body states (from tense to relax).

In session 3, discussion shifted to normative and disordered function of motivations and how the tendency to act upon a security motivation can constrict actions. The exercise entitled "Mindfulness of Emotions" was taught in order for the flexible attention and noticing-without-judgment practiced in MBB and BAMA were utilized for the emotional experiences.

Then, Zahra became acquainted with the concept of allowance as the skill of being fully present with thoughts, feelings, emotions and bodily sensations without judgment or avoidance. In this regard, a mindfulness exercise naming Mindfulness of Emotions exercise was conducted to reinforce her ability to contact with her emotions.

In the fourth session, the therapist introduced the Counter Action technique suggesting being engaged in actions against the prevailing motivations in order to induce an opposite motivational stance and generate more flexible responses. The allowance skill called the *Open Presence Meditation* was trained to help Zahra remain in contact with her emotions.

At the end of this session, Zahra reported reductions in SAD and MDD symptoms (especially insomnia), rumination and self-critical thoughts. She believed that the mindfulness skills (especially BAMA) had been effective on sleep difficulties and diminished concentration. However, according to her feedbacks, the Open Presence Mediation exercise was complicated for her. Learning more concentrated and flexible attention to both interceptive and exteroceptive stimuli without judgment and elaboration resulted in promoted cue detection and immediate relaxation.

The online version of allowance skill called the Three Minute Breathing Space was taught in session 5. This session continued with introducing the concept of distancing through the Mountain Mediation skill which aims at seeing the more extensive picture of emotional state in time. It is worth mentioning that off-line skills refer to exercises which are not conducted in an emotional situation but only in approximately non emotional situations. Building upon these exercises, their online counterparts are utilized at the moment of facing emotionally evocative situations.

At the end of session 5, Zahra reported the process of improvement had been slowed down.

First introduced in session 6 was the abbreviated version of Mountain Mediation skill called Invoking the Mountain. This was used when she was confronted by emotional situations. Afterwards, Zahra was introduced to a new skill called *Finding an Observer's Distance*, with the purpose of getting a perspective in space through devoting physical attributes to intense emotions. This skill provides the basis of an online skill, bringing it with you to be introduced in the next session. Zahra reported that this skill had been helpful in making decisions, since it allowed her to see and examine the various thoughts and feelings that arise in her mind without any judgment instead of favoring the ones related to security.

Session 7 continued with the discussion about the obstacles to successful resolution of motivational conflicts: catastrophic elaboration and self-critical elaboration. Then, to successfully overcome these obstacles, the fourth emotion regulation strategy, reframing was introduced. In this regard, Zahra was taught to apply courageous and self-compassionate statements to overcome catastrophic and self-critical obstacles, respectively.

In session 8, the four ERT skill sets, orienting, allowing, distancing, and reframing were reviewed and packaged together to be utilized as an appropriate counteractive response.

At the end of this session, Zahra reported her gaining facility and confidence with all these skills. However, the distancing technique had been the most effective skill for her.

The combination of off-line and on-the spot skills helped Zahra to respond to difficult emotional situations counteractively, with necessary levels of adaptive cognitive elaboration.

The format of sessions 10 to 13 was similar, as follows: (1) working on skills in the beginning of session; (2) identifying important values and related goals and possible actions (3) engaging potential valued actions 4) exploring internal conflicts that hinder engaging in valued actions during the in-session experiential tasks and (5) undertaking both planned and spontaneous valued actions between sessions.

However, case 3 and 4 mentioned above were not addressed in session 9 but began in session 10. Values delineation, recording associated goals, possible actions, and potential obstacles were the main focus of session 9.

For example, a therapist helped Zahra to identify her values relating to her daughter and explore the security

(e.g. making sure nothing bad happens to her) and reward motivations (tendency to have new developing experiences with her) to be able to make more genuine and balanced choices.

As she reported at the end of session 9, the process of improvement sped up, presence in public was facilitated for her and she began to develop broader social relationships.

Sessions 14 to 16 were devoted to relapse prevention and preparing clients for therapy termination.

Discussion

The aim of the present study was to examine the effectiveness of ERT for treating SAD comorbid with MDD.

The ERT is mainly developed for the treatment of GAD through targeting emotion dysregulation difficulties underlying this disorder. However, research have demonstrated that these emotion regulation difficulties are common across anxiety and mood disorders [12]. So, ERT may help people suffering from SAD.

As ERT addresses transdiagnostic mechanisms, it can be effective for comorbid conditions (e.g. SAD and MDD) making ERT a treatment of practical option for clinical setting. Noteworthy is that the cases with a single diagnosis are rare in clinical settings, and it complicates the choice, sequence and process of the treatment.

As expected, this case provides a preliminary evidence for efficacy of ERT for SAD (particularly when it is along with depression). The results indicated reductions in the symptoms of anxiety and depression at post-treatment. In addition, the client's use of adaptive emotion regulation strategies (including attending, allowance, decentering and reframing) and psychological wellbeing (based on her scores of Ryff scale psychological wellbeing) were enhanced. As Zahra stated, her social psychological function improved and she was satisfied with the treatment results. Zahra's husband pointed out to the fact that she has become more relax, less angry and anxious. According to her class mate`s feedbacks, she has become more assertive and also happier. The achievements of the treatment were maintained at a 1 and 3 month follow-up period.

As individuals suffering from SAD have difficulties in emotion intensity and emotion regulation and fixedly utilize cognitive control strategies to avoid their intense emotional experiences, they benefit from interventions that increase their knowledge, acceptance, utilization and management of emotions. ERT integrates components of emotion focused treatment into a cognitive behavioral framework. Moreover, skill training interventions in other treatments are included in ERT. The results of the present study conform to the findings obtained from other treatments focusing on emotion regulation strategies in pathology and treatment of emotional disorders [17-19]. Also, the results of this intervention are in line with other research that have investigated the efficacy of ERT [10, 20, 21].

The evidence for applying this protocol in Iran is limited to 2 cases investigating the emotion regulation model and treatment: 1) in people suffering from GAD comorbid with MDD [21] and 2) in SAD patients [10]. The result of these studies confirm the effectiveness of this therapy. This study, as a case description one, proves ERT is effective for people suffering from SAD comorbid with MDD. The results could not be generalized to a wider population, due to the entity of the case study method and the effect of personal and cultural factors. The efficacy of this approach should be investigated in large samples and also compared with existing interventions. In addition, the process of change in ERT should be investigated in future.

Conclusion

The client treated with ERT, showed significant clinical improvement. As a result, this emotion-focused approach can be effective for understanding the psychopathology and treatment of social anxiety disorder and comorbid depression. Further research is needed to confirm this novel finding.

Acknowledgement

The authors would like to thank all the participants of the present study. Also, many thanks to Douglas Mennin for his valuable advices and guidance.

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