

Comorbid Major Depression and Social Phobia

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To call attention to the high prevalence of depression in the community, National Depression Screening Day has been established. Materials are distributed to clinics and private doctors' offices to encourage the recognition of this disorder, commonly found in the primary care setting. The subject of this article, a 20-year-old, single white male college student, went to his primary care physician for a routine physical examination on this particular day and filled out a screening form. His score in the range of "clinical depression" led to a referral for evaluation and treatment at our university clinic. He had no prior history of depression or any other emotional disorder. His family history includes a great-aunt with diagnosed depression. He has no current medical problems and is in good physical health.

PRESENTATION OF THE PROBLEM

The patient is in his third year of college and is maintaining a good grade point average while he works 2 part-time jobs. He has a good relationship with his parents and his younger brother, all of whom live 2 hours away. He recalls feeling "down" during the summer, approximately 3 months prior to his presentation in my office. His sleep at that time was disrupted, his mood was sad, and he experienced no pleasure. These symptoms were relieved when school began. Since that time, however, his symptoms have returned. They now include depressed mood most of the time for the past 8 weeks, difficulty falling asleep and middle of the night awakenings, excessive guilt, poor concentration, and poor appetite, as well as hopelessness. At the time of presentation, he denied suicidal thoughts and symptoms of psychosis. There was no evidence of mania, obsessive-compulsive disorder, or panic anxiety. He did note, however, that he often felt "too embarrassed to ask questions in class." He thought he would "look or sound stupid and that people might laugh at him." He acknowledged dropping 2 classes due to the requirement to make a presentation in front of the class. With public speaking, he has become anxious, flushed, tachycardic, and short of breath, and he has experienced near syncope. These symp-

toms of social anxiety are dysphoric for him, and he has tried to avoid such situations. He denies using illicit drugs and drinks alcohol "only occasionally with friends" to relax. His average intake is 2 to 3 beers, 2 nights a week.

PSYCHOTHERAPY

During our initial office visit, the patient made poor eye contact and admitted to being nervous. He was unsure of what to expect in his first visit to a psychiatrist. He kept his baseball cap on during the interview and periodically gazed downward. His speech was normal in rate, volume, and tone. He described his mood as "down" and thought that nothing would get better for him. He knew he was depressed, but expressed surprise that his screening score was high enough to lead to a referral for treatment. He believed that he should be able to "snap out of this" himself.

Although he denied active suicidal thoughts, he expressed little hope for his future, and even though his symptoms of social phobia were bothersome to him, he had never spoken about them with anyone. He stated that he "did not know these feelings were a real diagnosis."

My diagnostic impression was (1) major depressive disorder, moderate severity (meeting criteria of depressed mood, poor sleep, decreased appetite, hopelessness, excessive guilt, and poor concentration) and (2) social phobia (meeting criteria of intense fear of public ridicule, fear of embarrassment, and avoidance of situations that may cause embarrassment). The options of medication treatment and cognitive therapy were presented to him, and he was open to both. A handout explaining the cognitive model was given to him, and we agreed to meet once every 2 to 3 weeks for treatment. Trazodone, 50 mg, was prescribed at bedtime to target insomnia.

During our second session, we reviewed the cognitive model, explaining the focus on how one's negative thoughts can affect feelings. He stated that he felt bad when he looked in the mirror each morning. When asked what he was thinking at that time, he replied: "I'm stupid, and I'll never get through college. I should have already graduated. I'm a loser." These thoughts represent cogni-

tive errors of overgeneralizing, “should” statements, and catastrophizing. The depressed brain can take any situation and turn it into a negative one. When this was described to the patient, he was able to recognize this faulty, self-deprecating thought pattern. By beginning his day with negative thoughts followed by bad feelings, he was setting himself up for failure and continued depression. Possible rebuttals to his thoughts were discussed. His suggested rebuttals included “Well, I guess I’m not really stupid, because I do make good grades. I probably will graduate, but maybe a little later than I had hoped.” It is important to stress that cognitive therapy is not simply a program of positive self-affirmation, but rather identifying and disputing the patient’s negative thoughts, which maintain and perpetuate depression. A starting dose of a selective serotonin reuptake inhibitor antidepressant (citalopram, 20 mg/day) was started to enhance his recovery from depression.

During our third session, it was apparent that the patient had started to recognize more of his cognitive distortions and their impact on his mood. He described his tendency to think in “all or nothing” terms (polarization). We discussed examples in which a person can be good but also have some undesirable qualities, leading to some “gray areas.” The patient also noticed a tendency to have negative thoughts about himself during class, preventing him from participating and asking questions. He had begun disputing these thoughts when they occurred, replacing them with more realistic alternatives, such as “Nobody is really staring at me. People are probably thinking about themselves, not necessarily me.” These thoughts led to his feeling more relaxed and allowed him to gain the courage to speak up in class.

Our fourth through seventh sessions focused on his steady progress utilizing the cognitive strategies he had

learned. He noticed that he was less frequently jumping to conclusions. When invited to eat with friends, he no longer thought “They’re just asking me because they feel sorry for me.” Another thought made more sense: “It’s nice to have friends who want to be with me.” He noted significant mood elevation. His appetite had returned. He felt confident enough to quit one of his part-time jobs, which he realized he did not enjoy. His sleep improved. He had excelled in his psychology course, and he felt that he had a greater understanding of it due to his real-life experience with depression and its treatment. He was now participating in class discussion. He reported entering a classroom 15 minutes late without dread. (In the past, he said, he would have skipped the class out of fear of embarrassment.)

During our eighth session, we reviewed his treatment and discussed options for continued contact. He thought the psychotherapy was very useful and “would be helpful throughout life.” He had mastered the skills necessary to utilize cognitive therapy, but asked if we could continue to meet every 2 to 3 months for follow-up. I agreed. Citalopram was continued, but the hypnotic trazodone was no longer needed.

This case outcome offers a good example of the usefulness of brief, focused cognitive therapy with a motivated patient for the treatment of both major depression and social phobia. This patient obtained optimal improvement in an approach that combined medication and psychotherapy. Either strategy alone may have worked; however, in my opinion, the combination afforded him the best chance of recovery. Simply rereading the cognitive handout served to “refill the prescription” for him of a model that had proved useful and provided a sense of autonomy (rather than dependency), with booster sessions available as a reminder of the cognitive method, if necessary.

Editor’s note: Dr. Douglas is in her fourth (and final) year of psychiatry residency training at the Medical University of South Carolina in Charleston.