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Comorbid social anxiety disorder in clients with depressive disorders: Predicting changes in depressive symptoms, therapeutic relationships, and focus of attention in group treatment

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ABSTRACT

The current study examined whether depressed outpatients with comorbid SAD respond differently to a cognitive-behavioral group intervention and if so, how and why. Using growth curve modeling, we found evidence that depressed clients with comorbid SAD had rapid improvement in depressive symptoms over the course of treatment and generally did not differ from those without comorbidity in developing close therapeutic relationships and modifying the direction of attentional focus away from the self. Non-linear effects demonstrated that rates of change in depressive symptoms, relationship variables, and focus of attention, were most rapid early in treatment. In contrast to hypotheses, trajectories of change in therapeutic relationships and attentional focus did not mediate the effect of SAD on treatment improvement in depressive symptoms. These findings suggest that comorbid SAD does not have a detrimental effect on the course of depression treatment and group-based treatments can be as beneficial for depressed individuals with comorbid SAD. It may be that group-based treatments for depression provide explicit opportunity for emotional processing in social situations (i.e., exposure) and hence mimic efficacious therapies for SAD.

Although cognitive-behavioral therapy (CBT) is an efficacious intervention for depression, data suggest that between 20 and 64% of clients treated for depression fail to recover (e.g., Brown & Lewinsohn, 1984; Peterson & Halstead, 1998). Given these findings, it seems important to explore individual difference factors and change process variables that enable or thwart treatment impact. Some of the most replicated predictors of client changes in CBT for depression include comorbid anxiety disorders (e.g., Brown, Schulberg, Madonia, Shear, & Houck, 1996; Sherbourne & Wells, 1997), therapist–client interpersonal processes (e.g., Feeley, DeRubeis, & Gelfand, 1999; Persons & Burns, 1985), client perceptions of group cohesion (Hoberman, Lewinsohn, & Tilson, 1988), and interpersonal impairment (Sotsky et al., 1991). The foregoing constructs possess theoretical and empirical ties to social anxiety disorder (SAD). We explored how SAD is relevant to depressive symptom change across the course of group cognitive-behavioral therapy for depression.

Comparing social anxiety and depression

For people meeting criteria for SAD during their lifetime, rates of comorbid major depressive disorder range from 20 to 37% (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Merikangas & Angst, 1995). In an examination of over 1000 clients seeking treatment in anxiety disorder clinics (Brown, Campbell, Lehman, Grisham, & Mancill, 2001), 48% with principal diagnoses of SAD met criteria for comorbid major depressive disorder; 56% with a principal diagnosis of major depressive disorder met criteria for comorbid SAD. While these two disorders often co-occur, their convergence is often neglected and undertreated.

Both depression and SAD are characterized by chronic, excessive self-focused attention to negative stimuli (Clark & Wells, 1995; Ingram, 1990), an affective profile of intensified negative emotions and attenuated positive emotions (Kashdan, 2007; Kashdan, Weeks, & Savostyanova, 2011), and inhibited behaviors such as avoidance and unassertiveness (e.g., Eng, Heimberg, Hart, Schneier, & Liebowitz, 2001; Gotlib & Meltzer, 1987). Despite similarities, there are clinical features specific to SAD. According to cognitive models (Rapee & Heimberg, 1997), people with SAD disproportionately allocate attentional resources to negative self-

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appraisals and somatic symptoms as well as environmental social threat cues. Biased attention to negative stimuli such as memories of prior social failures, and negative attributions following ambiguous situations (such as when a conversation partner yawns), perpetuate initial fears and somatic symptoms.

People with SAD are also plagued by impression management concerns. Besides doubting their ability to form a good impression, people with SAD assume other people share these unflattering assessments. Subsequently, people with SAD tend to avoid social situations or be minimally engaged. The social impairments and hedonic deficits interfere with the ability of individuals with SAD to form and sustain healthy relationships.

Comorbidity implications

People with comorbid depression and SAD have been shown to exhibit greater distress, and occupational and social impairment than people meeting diagnostic criteria for only one of these conditions (Darlymple, & Zimmerman, 2007). In a one-year prospective study of adult outpatients, the presence of comorbid SAD increased the severity, chronicity, and disability associated with major depressive disorder (Gaynes et al., 1999). In a four-year prospective study of adolescents, the presence of comorbid SAD increased the likelihood that adolescents with major depressive disorder met criteria for substance abuse disorders, attempted suicide, and experienced chronic depression at the follow-up (Stein et al., 2001). Available evidence suggests that the presence of comorbid SAD amplifies the presenting problems of people suffering from major depressive disorder.

There is a surprising paucity of research on how anxiety symptoms influence the efficacy of treatments for depression on depressive symptoms. Published findings are mixed on the effects of comorbid anxiety symptoms on the treatment of depression. In two separate trials of CBT, clients with greater anxiety symptoms fared no worse than clients with "pure" depression (Fournier et al., 2009; Gibbons & DeRubeis, 2008). Two other studies found that clients treated for depression fared worse when diagnosed with comorbid SAD. Mulder et al. (2006) found that when diagnosed with comorbid SAD, clients treated for depression with fluoxetine or nortriptyline were 2.5 times more likely to achieve no remission or recovery (poor response) compared with full recovery up to six months. Brent et al. (1998) found that adolescents diagnosed with depression and comorbid SAD had a lower rate of depression remission compared with adolescents diagnosed with only depression. In a comparison of treatments for depression, people suffering from extreme, pervasive, chronic social anxiety difficulties (i.e., comorbid avoidant personality disorder) experienced poorer responses to interpersonal therapy, however, these symptoms did not influence responses to cognitive-behavioral therapy (Joyce et al., 2007). In sum, few published studies exist on the impact of SAD on depressive symptom outcomes following treatment for depression. Each of these studies used individual treatment approaches. Different results might emerge for comorbid SAD when examining cognitive-behavioral group treatment approaches to depression.

To our knowledge, only three studies of the efficacy of CBT for depression with comorbid SAD used intermittent assessments of depressive symptom s to study rate of improvement. Smits, Minhajuddin, and Jarrett (2009) found that clients with and without comorbid SAD did not differ in the amount or speed of improvement in depressive symptoms. Surprisingly, in two studies (each including 57 separate outpatients, respectively) researchers found that greater anxiety symptoms at baseline predicted a faster rate of depressive symptom improvement, which happened to occur in early sessions (i.e., rapid gains) (Forand, Gunthert, Cohen, Butler, & Beck, 2011). Following prior theory and research, two competing hypotheses emerged. First, depressed clients with comorbid SAD might exhibit poorer outcomes following group treatment for depression. This is because the excessive self-directed attention of people with SAD might interfere with learning information in social-evaluative situations, such as the skills being taught in a group treatment focusing on depression. Social anxiety difficulties in depressed clients might also lead to perceptions of poor relationships with therapists and other group members that in turn exacerbate social fears, inhibit motivation, and interfere with the benefits of healthy therapeutic alliances. Second, clients with comorbid SAD might fare better than clients with "pure" depression in treatment. After all, group-based interventions provide exposure to "safe" situations where clients can experiment with assertiveness, relaxation, and cognitive retraining skills being taught by clinicians (Heimberg & Becker, 2002). Cognitive-behavioral treatments have been shown to effectively treat the maladaptive emotions, thoughts, and behaviors that are common to anxiety and depressive conditions (Hollon, Stewart, & Strunk, 2006).

Potential mechanisms of action

The current study is the first to examine the impact of comorbid SAD on the processes and outcomes of group psychotherapy—depressive symptom change, the direction of attention (self vs. other) during treatment sessions, and closeness and attachment orientation to the therapy group. In terms of direction of attention, individuals with SAD have elevated levels of self-focused attention (e.g., Hofmann, 2000), which may interfere with their ability to fully focus and attend to the material covered during treatment sessions. Rather than attending to the particular skills being taught, these individuals might perceive themselves as social objects, and become inundated with negative self-focused thoughts including beliefs of social incompetence and concerns that symptoms are noticeable by others (Clark & Wells, 1995; Rapee & Heimberg, 1997). As a result, clients with comorbid SAD may derive less benefit from group treatment for depression. In addition, excessively anxious clients are more likely to have difficulty forming positive attachments with their therapists (Mallinckrodt, Coble, & Gantt, 1995), and rate themselves as less trusting and more fearful of being rejected by therapists (Mallinckrodt, King, & Coble, 1998). More generally, clients with SAD are prone to feeling abandoned and rejected by significant others (anxious dimension), and maintain beliefs that others cannot be trusted to provide support or be privy to personal vulnerabilities (avoidance dimension) (e.g., Eng et al., 2001). Given that attachment styles between clients and therapists are strong predictors of self-disclosure, social competence, emotion regulation, willingness to use intervention techniques, and treatment outcome (e.g., Lopez & Brennan, 2000; Satterfield & Lyddon, 1998) and that the quality of relationships between therapists and clients facilitates treatment engagement and symptom amelioration (e.g., Horvath & Symonds, 1991), individuals with SAD may be less likely to benefit from group treatment for depression; they would be predisposed to experiencing poor relationships with therapists and other group members.

On the other hand, it is plausible that each of the above mechanisms might accelerate recovery from depressive symptoms among depressed clients with comorbid SAD (cf. Forand et al., 2011). For instance, depressed individuals with SAD might have greater room for improvement in attentional focus than those with pure depression, and the group intervention might be particularly well suited for facilitating shifts in attentional focus from the self to positive attributes of the external environment. Consequently, the presence of SAD might lead to more rapid declines in depressive