

Initial Treatment Success Followed By Failure

How Do We Deal With Toxic Core Beliefs in the Context of Comorbid Major Depression With Psychotic Features, Social Phobia, and Axis II Pathology?

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This article presents a diagnostically complicated case involving comorbid major depressive disorder with psychotic features, social phobia and personality pathology (including avoidant, paranoid, and obsessive compulsive traits). "Mr. X" was a 45-year-old single White male who was unemployed and living with his parents at the time of treatment. He presented with severe anxiety (Beck Anxiety Inventory = 43) and depression (Beck Depression Inventory = 41) as well as active psychotic symptoms (e.g., self-depreciating auditory hallucinations). Although a cognitive case formulation and treatment plan led to initial success in terms of improvements in symptomatology and functional impairment, we speculate that failure to adequately address core toxic beliefs (e.g., "I am inadequate") ultimately contributed to a precipitous return of symptomatology, followed by a suicide attempt and premature treatment termination. We discuss the challenges of working within a cognitive framework with this client and suggest alternative approaches that might have proven more successful.

Keywords: *comorbidity; depression; social phobia; personality pathology; treatment failure; case formulation; CBT*

1 Theoretical and Research Basis

Although it is well established that cognitive behavioral therapy (CBT) is an efficacious treatment for a variety of mood and anxiety disorders, including major depressive disorder and social phobia (Butler, Chapman, Forman, & Beck, 2006), it is less clear whether CBT is effective for clients with comorbid disorders (see Westen, Novotny, & Thompson-Brenner, 2004 for a review). Indeed, several studies have found that comorbidity between anxiety and depressive disorders can be associated with a relatively poor treatment response (e.g., Albus & Scheibe, 1993; Erwin, Heimberg, Juster, & Mindlin, 2002; Frank et al.,

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2000), perhaps in part because these patients tend to have relatively more severe cognitive vulnerability. For example, Voncken, Bogels, and Peeters (2007) found that the combination of social phobia and depressive symptoms was associated with relatively high levels of interpretation and judgmental biases across both social and nonsocial situations. Likewise mood and anxiety disorders complicated by comorbid personality pathology are often associated with a more poor treatment response (e.g., Bajaj & Tyrer, 2005; Fournier et al., 2008; Massion et al., 2002), possibly as the result of more severe negative cognition (Candrian, Farabaugh, Pizzagalli, Baer, & Fava, 2007). For example, previously depressed individuals with personality disorders have been found to have trait elevations in depressogenic thinking (Ilardi & Craighead, 1999), and individuals with various Axis II disorders have elevated rates of rumination (Smith, Grandin, Alloy, & Abramson, 2006). In addition to contributing to treatment failure, these cognitive dysfunctions appear to place comorbid individuals at increased risk for relapse (Ilardi, Craighead, & Evans, 1997).

Practitioners wishing to apply CBT to diagnostically complicated cases must adapt existing treatment protocols created for single psychiatric problems to cases with several diagnoses. In such situations, Persons and colleagues have suggested that individualized case conceptualization can be helpful (Persons & Davidson, 2001). Persons' approach to idiographic case conceptualization consists of creating a list of the client's problems (including the symptoms associated with the client's psychiatric diagnoses) and developing a working hypothesis that explains the relationships between these problems. The working hypothesis is a "minitheory" of the case that can be used to generate an individualized treatment plan that addresses the relationships between the client's various psychiatric and social problems. Once a working hypothesis is created, a nomothetic theory is adapted and applied to the particular case (Persons & Davidson, 2001).

Beck's cognitive theory represents a viable nomothetic theory that can be adopted in developing a working hypothesis, as it has survived a large amount of empirical scrutiny and has been applied to a variety of psychological problems (e.g., depression, anxiety, personality disorders; Leahy, 2004). Cognitive theory suggests that individuals who are vulnerable to psychopathology have latent dysfunctional schemas developed in childhood. Schemas are defined as cognitive structures for screening, coding, and evaluating stimuli relevant to the individual. They are made up of core beliefs that represent fundamental views of the self or the world (e.g., "I am inadequate"). Core beliefs influence the development of intermediate beliefs, which consist of inflexible attitudes, rules, and assumptions. Dysfunctional attitudes are conceptualized as conditional rules for happiness, such as "If I am not perfect then I am a failure," which remain outside of awareness until activated by negative life events (Beck, 1995; Young, Weinberger, & Beck, 2001).

According to cognitive theory, psychiatric difficulties occur when dysfunctional schemas become activated by negative life events. Once these schemas are activated, the individual encodes, selects, and categorizes information in a way that maintains the schemas (e.g., by fixating on negative stimuli while ignoring positive stimuli). This distorted cognitive processing gives rise to negative automatic thoughts, which are defined as quick, evaluative negative thoughts. In the cognitive model, situational factors (e.g., getting a "B" on a test) elicit distorted cognitive processing (in this case "all or nothing thinking"), which results

in an automatic negative thought (e.g., "I failed"). This automatic thought subsequently results in negative emotions (Young et al., 2001).

The case presentation that follows applies Persons' approach, using Beck's cognitive theory, to a diagnostically complicated individual presenting with psychotic depression, severe social anxiety, and severe personality pathology.

2 Case Introduction

Mr. X was a 45-year-old single, heterosexual, White male living with his parents who was referred for psychological treatment by his psychiatrist.¹ Mr. X was raised Catholic, but did not practice any religion at the time of treatment. Although Mr. X had a bachelors degree, he was unemployed at intake. Given his lack of employment, Mr. X primarily relied on his parents' financial assistance.

3 Presenting Complaints

Mr. X stated that he was entering treatment for depression and anxiety. The client reported that he was unable to handle new and stressful situations and that he was fearful about being negatively evaluated and betrayed by others. He noted that he had been experiencing what he called racing negative thoughts, hopelessness, suicidal thoughts, panic attacks, anger, and severe insomnia. He reported that these problems had made him unable to work, maintain friendships, or maintain a romantic relationship and that his problems had gradually worsened over the previous year.

4 History

Mr. X reported a good relationship with his parents, but noted that they had always held him to very high standards and that they were critical of him unless his performance was perfect (e.g., only an "A" was acceptable in school). A year prior to the initial evaluation his long-term girlfriend left him after he began having psychological problems. He subsequently dated a few other women, but stated these women mistreated him by not being emotionally available. Mr. X reported that after he began having psychological problems, all of his friends had abandoned him. Furthermore, the client was unemployed at the time of the initial evaluation having quit a sales position after customers were reportedly overly aggressive and threatening. He subsequently took a less demanding job, but soon quit after having panic attacks at work.

Mr. X's first contact with psychiatric care was 26 years ago when he was taken to the psychiatric emergency room following an impulsive suicide attempt. He noted that his experience in the emergency room was so negative that it had since deterred him from making subsequent suicide attempts. He also complained that more recent counseling and psychiatric treatment had not been helpful and that taking antidepressant medications had made him agitated and angry.

5 Assessment

Based on the structured clinical interview for *DSM-IV Axis I Conditions* (SCID-I) Interview, the client met criteria for major depressive disorder with psychotic features. Specifically, Mr. X reported clinically significant levels of all nine diagnostic symptoms of depression, as well as mood congruent illusions and auditory hallucinations. In addition, Mr. X reported experiencing symptomatology consistent with social phobia. Specifically, he was reportedly afraid of being negatively evaluated by other people in a variety of social situations, including being in crowds and meeting new people. He avoided most social situations, but endured limited situations with intense distress and panic. Mr. X was also fearful of many other stimuli, including doctors, needles, dentists, loud noises (e.g., fireworks), and driving. However, these concerns seemed to reflect his fear of being negatively evaluated. For example, the client suggested that the reason he was afraid of driving was because he feared he would be late to appointments and would be negatively evaluated for being tardy. Overall, the client's various fears interacted to greatly impair his ability to complete routine activities. For example, Mr. X noted that over an hour before he had an obligation, and he became terrified that he may get into traffic, may get lost, may be late to an appointment, may not say the right thing, and may not wear the right clothes.

Consistent with his Axis I diagnoses of major depressive disorder with psychotic features and social phobia, Mr. X's average scores across intake evaluation sessions on the Beck Depression Inventory-II (BDI; $M = 41$) and Beck Anxiety Inventory (BAI; $M = 43$) were reflective of severe depression and anxiety.

Based on the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) Questionnaire, Mr. X reported traits consistent with avoidant personality disorder, including worrying about being criticized or rejected in social situations; being afraid to try new things; and believing that he was not as good, as smart, or as attractive as most other people.² In addition, he reported traits consistent with paranoid personality disorder (e.g., suspiciousness and mistrust of others) and obsessive compulsive personality disorder (e.g., perfectionism and rigidity). Mr. X's Minnesota Multiphasic Personality Inventory (rev. ed.) profile could not be unambiguously interpreted. Although the scores on the validity scales indicated that the client responded in a consistent manner (VRIN: $T = 34$; TRIN: $T = 50$), he was either experiencing severe psychopathology or was overreporting his symptoms ($F: T = 120$, $Fb: T > 120$, $Fp: T = 42$, $K: T < 30$, $S: T = 30$). With these interpretational cautions in mind, the client's profile was a 6-8-7 code type (Scale 6: $t = 118$, Scale 8: $t = 108$, Scale 7: $t = 98$). Individuals who score similarly are described as having severe depression and anxiety, chronic feelings of inadequacy, poor problem solving, and severe alienation. They tend to be paranoid and psychosis prone and are not seen as good candidates for psychotherapy.

6 Case Conceptualization

Problem List

Mr. X's individualized case conceptualization began with his problem list, which was limited to 8 items to maintain its manageability. His problem list included (a) Insomnia:

Despite lying in bed for 12 hr each night and taking naps during the day, Mr. X slept 4 hr each day. He had difficulty falling asleep, woke up several times during the night, and was unable to fall back asleep. As a result the client experienced constant fatigue; (b) Social anxiety, isolation, and unassertiveness: Mr. X was terrified of meeting new people, being in large crowds of people, and giving presentations. The client feared others would dislike him and negatively evaluate him. The client was terrified of confrontation and never asserted himself to others. In social situations, the client often experienced panic attacks. As a result, he had socially isolated himself, avoided going in public, and only had contact with his immediate family. Thoughts included, "If I assert myself, no one will love me and people will leave me," "No one likes me"; (c) Perfectionism and rigidity: Mr. X had high standards of right and wrong, was stubborn, had a hard time letting others help him unless they did things the way he wanted, and often felt sure he was right about many issues. Mr. X believed that if he did not do something completely or perfectly, he had failed. Thoughts included, "I'm a failure," "I'm stupid," "I shouldn't have these thoughts"; (d) Mistrust of others: Mr. X believed it was just a matter of time before close others betrayed him and that other people were universally inconsiderate of him because they had no conscience. He reported being suspicious of everyone, detecting hidden threats or insults in things people say or do, lashing out when others insulted him, holding grudges, and suspecting that past partners had been unfaithful. Thoughts included, "The world is out to get me," "No one ever stands up for me," "Everyone I have ever known has wronged me"; (e) Dissatisfaction and hopelessness regarding impairment: Mr. X was unable to work, was experiencing family strain, had lost all of his friends, and could not complete basic routine tasks due to psychopathology. Mr. X did not believe that he would be able to improve his life circumstances. Thoughts included, "I'll never be able to get another job," "I'm a failure because I don't have a wife or a job"; (f) Distress: The client was highly emotionally reactive to negative stimuli and as a result experienced steadily high levels of distress and anxiety. Aside from social anxiety, Mr. X experienced near-constant worry and fear regarding various topics including the health of close others, bad weather, doctors, and driving. Mr. X's negative emotional reactions to negative stimuli included physical symptoms of anxiety including panic attacks, anger (e.g., yelling, punching inanimate objects), dysphoria, and crying; (g) Perceptual aberrations: Mr. X experienced auditory hallucinations involving criticisms and threats from key figures in his life. He also experienced visual illusions (i.e., transiently seeing the faces of individuals who had previously criticized or threatened him on the bodies of strangers) and described frequently misinterpreting noises in the house as people breaking into his home. In addition to sensory aberrations, the client also had a number of atypical beliefs, for example, that he could foresee the future and that spirits could influence people; (h) Depression: In addition to emotional distress/dysphoria, insomnia, and fatigue, Mr. X also experienced anhedonia, concentration difficulties, indecision, worthlessness, guilt, suicidal ideation, psychomotor retardation, and weight loss (25 pounds in past year) as well as pervasive negative thoughts reflecting mistrust of others and perfectionism.

Working Hypothesis

Our working hypothesis emphasized the development of core negative beliefs early in life that undergirded his depression, social anxiety, and maladaptive personality traits.

Throughout his childhood, the client's parents held him to rigid perfectionistic standards for success. Because the standards for success were set so high, the client frequently fell short and was subsequently criticized. It is hypothesized that partially as a result of his parents' perfectionistic standards and criticism, the client developed the dysfunctional core beliefs, "Other people are out to depreciate me," and "I am inadequate." According to Beck's cognitive theory of personality disorders, these core beliefs are common in individuals with paranoid and obsessive compulsive personality disorders (Beck, Freeman, Davis, & Associates, 2004). As an adaptation to his core beliefs, it is hypothesized that Mr. X developed the intermediate beliefs, "If I do not perform perfectly, I am a failure," "I must do everything right," and "Others should try harder and do more." In support of these hypotheses, Mr. X reported that he attempted suicide 26 years ago after learning that he was going to fail a class in college. Based on our conceptualization, learning he would fail violated his conditional rule for happiness and activated his core belief that he was inadequate and inept. The activation of this core belief led to a surge of negative emotions and an impulsive suicide attempt.

Although Mr. X stated that he could not identify events that triggered his recent symptomatology, at about the time of onset he was experiencing interpersonal conflict at work involving coworkers questioning his decisions and a customer threatening to assault him. He further noted that his superior publicly sided with the customer. This event likely activated Mr. X's core beliefs that "Other people are out to get me," and "I am inadequate and inept." This experience appeared to have a large impact on the client's emerging symptomatology as he noted he would have panic attacks when thinking about the event. The client also reported having auditory hallucinations consisting of the customer threatening him and visual illusions consisting of seeing this individual's face on strangers' bodies. Mr. X reported that as his symptoms worsened, his friends started to abandon him. For example, he noted that a close friend refused to talk with him following a public panic attack and that his long-time girlfriend broke up with him due to his symptomatology. These events reinforced the client's beliefs that other people did not care about him and that he was inadequate. He stated that he was always emotionally available to his friends and was bitter that his friends did not support him when he needed them. He reported that most people do not have a conscience and everyone he has ever gotten close to has betrayed him. Due to the client's preoccupation with appearing competent and being acceptable to others, when the client began having conspicuous symptomatology (especially situationally bound panic attacks), his fear that others would negatively evaluate him increased dramatically. Over the year following his symptom onset, the client quit two jobs due to his symptomatology and moved in with his parents due to financial troubles. Mr. X's inability to work and live on his own violated his conditional rule, "If I don't perform perfectly, I am a failure," and further activated and reinforced his core belief, "I am inadequate." The client's social isolation became so severe that, at the onset of treatment, the client had no contact with anyone outside of his family. The client's avoidance of social situations was negatively reinforced because the client did not experience panic attacks and did not fear negative evaluation from others when at home alone. However, his avoidance reduced his confidence that he could successfully endure social situations and over time the thought of going out in public became more foreboding.

At the time of intake, the activation and reinforcement of the client's schemas had resulted in pervasive negative automatic thoughts that in turn generated severe depression

with psychotic features and anxiety. Furthermore, the client frequently engaged in ruminative thinking regarding the perceived negative consequences of his symptoms and associated impairment (e.g., "I'll never be able to get another job," "I'll never be able to have a romantic relationship again"), which further increased the client's symptomatology.

Treatment Plan

To increase the client's ability to function and engage in therapy, Mr. X's initial treatment plan consisted of interventions aimed at reducing his anxious arousal (i.e., progressive muscle relaxation [PMR]) and improving his sleep (i.e., sleep hygiene; Morin, 1993). Given the client's severe psychopathology, Mr. X's initial treatment plan also consisted of assisting him in obtaining psychiatric services in the community.

Following an improvement in the client's overall anxiety and sleep disturbance, the therapist and Mr. X were to begin treatment for social phobia and depression guided by Heimberg's *Cognitive Behavioral Treatment for Social Phobia* manual (Heimberg & Becker, 2002) and Beck's cognitive therapy manual for depression (Beck, 1995). Heimberg's treatment involves exposing the client to threatening social situations in a graded fashion and restructuring his automatic thoughts. By facilitating the client's experience of competence and habituation to anxiety symptoms in social situations, exposure helps the client learn that social situations are not dangerous. Cognitive restructuring helps to question some of the client's strongly held beliefs that others are going to betray him and negatively evaluate him. Given the client's comorbid diagnosis of major depressive disorder, an extended period of time was to be initially spent on working with the client's automatic negative thoughts prior to engaging in exposures. Subsequent exposures to social situations were intended not only to allow the client to experience habituation and confidence in social settings but also to challenge the client's dysfunctional beliefs that others were negatively evaluating him and watching for him to make a mistake. The initial treatment plan provisioned that the client would begin exposure for social anxiety once he had experienced a marked decrease in his depressive symptoms and was relatively proficient in identifying and disputing automatic thoughts.

7 Complicating Factors

Personality Pathology

Given the client's paranoid traits and his reported dislike for his current and past health care providers, it was anticipated that he would likely be mistrustful of the therapist. Three strategies were to be used to establish and maintain trust: (1) The therapist would make efforts to be appropriately empathic with the client to prevent appearing uncaring or disingenuous, (2) The therapist would normalize the client's distress to prevent alienation from the therapist, and (3) The therapist would be honest about the limitations or potential side effects of therapeutic interventions. For example, the therapist would explain to the client that it was likely he would experience a period of increased daytime fatigue when beginning to implement behavioral interventions for insomnia.

Given Mr. X's obsessive compulsive traits and his rigid manner of thinking, it was anticipated that he would likely be overly critical of failed attempts to implement therapeutic techniques and become frustrated by minor setbacks. To address these concerns, the therapist would provide normalization and psychoeducation regarding failed attempts to implement therapeutic techniques and transient returns of symptoms.

Psychosis

Given the client's psychotic symptoms and his emotional reactivity, asking the client to evaluate dysfunctional beliefs and engage in anxiety-provoking situations could trigger further psychosis. To address this concern, the client's psychotic symptoms would be monitored on a weekly basis. The triggers of identified psychotic symptoms would be explored using functional analyses, and any interventions suspected to be contributing to psychosis would be modified.

Suicidality

As noted earlier, the client reported attempting suicide 26 years previously. Nevertheless, Mr. X was not considered to be at acute suicide risk at the time of the evaluation because his current ideation was passive and did not include a specific plan regarding how he would harm himself. The client's deterrents to committing suicide included his family, his belief that suicide is wrong, and his previous negative experience with the psychiatric emergency room. The therapist made a verbal contract with the client on each assessment occasion that the client would refrain from harming himself until his next session, that he would call a crisis services hotline if his suicidal ideation worsened, and that he would place a picture of his mother in the physical location of his sleeping pills (which he was not currently taking). The therapist subsequently renewed the client's no-harm contract each week throughout the course of therapy.

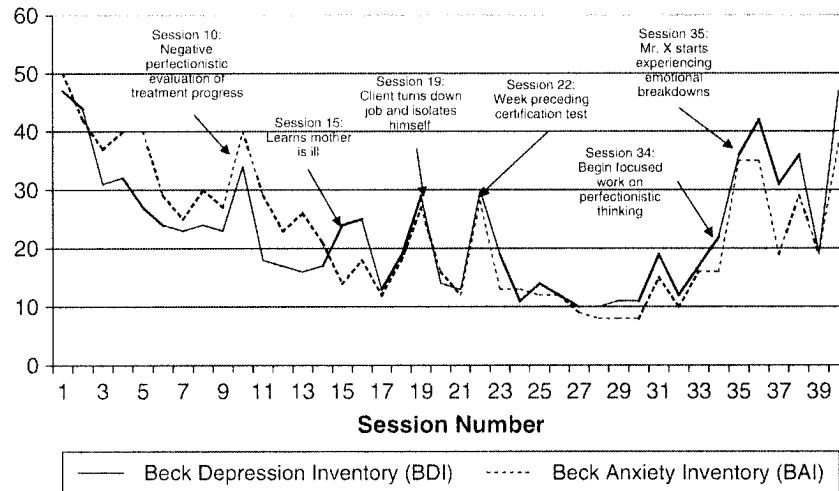
8 Course of Treatment and Assessment of Progress

Figure 1 graphs Mr. X's session-by-session BDI and BAI scores, whereas Figure 2 demonstrates that there was a statistically significant curvilinear effect involving initial improvement followed by a precipitous return of symptomatology later in treatment.

Early Sessions (Sessions 1 to 10)

The first goal of early sessions was to reduce the client's distress and to improve his sleep to increase his level of general functioning and his ability to engage in therapy. To reduce the client's overall anxiety, Mr. X was taught PMR and was assigned to practice PMR each night. He was also encouraged to use "on-the-spot" brief forms of PMR and deep breathing to alleviate acute anxiety throughout the day. To improve the client's sleep, Mr. X was taught a number of behavioral techniques for reducing insomnia (e.g., having a regular nightly sleep interval, restricting his time in bed, leaving bed if there is >20 min lag to sleep onset, avoiding large meals and caffeine prior to bed).

Figure 1
Weekly BDI and BAI Scores Over the Course of Treatment

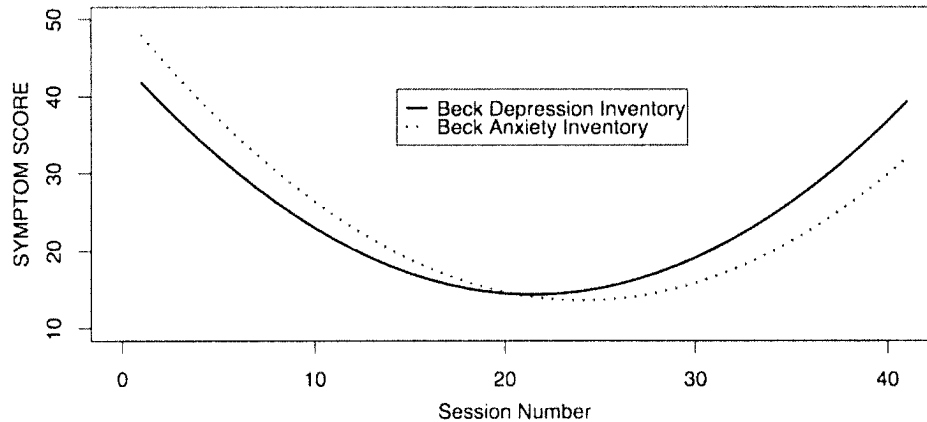


NOTES: BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory.

In contrast to our predictions based on his past relationships with mental health care professionals, personality pathology, and core beliefs involving distrust, the client was consistently on time to sessions, was cooperative and friendly with the therapist, and was compliant with all assigned between-session homework. Despite his compliance, Mr. X was unable to secure psychiatric services from the community for a variety of reasons. For example, he lacked health insurance, had few financial resources, and was unable to successfully apply for financial assistance. In addition, he was told he could not return to a number of psychiatry practices he had frequented in the past due to previous nonattendance. Nonetheless, Mr. X experienced a marked decrease in symptomatology from early interventions. Specifically, Mr. X reported a substantial (30%) decrease in his anxiety following in-session PMR, and reported a 13-point decrease in his BDI scores and a 5-point drop in his BAI scores following 1 week of practicing PMR and on-the-spot relaxation techniques. After assigning behavioral strategies for reducing insomnia, the client reported experiencing more continuous hours of sleep. The client's sleep subsequently normalized with continued practice of sleep hygiene over the next several sessions.

The second goal of early sessions was to introduce the client to the CBT model and to teach the client to identify and dispute negative automatic thoughts in the context of exposure. The clinician and Mr. X developed a detailed hierarchy of anxiety-provoking social situations, developed a subjective units of distress (SUDS) scale for measuring the client's anxiety in social situations, and discussed the rationale for working on negative automatic thinking using the ABC (antecedents, beliefs, consequences) model. Mr. X was asked to monitor his negative automatic thoughts and was taught to classify his cognitive distortions. Finally, the client was taught to systematically dispute his negative automatic thoughts.

Figure 2
Symptom Scores Across Treatment Sessions Modeled
With Generalized Least Squares and Maximum Likelihood
Estimation Using R 2.61 (R Development Core Team, 2007)



NOTES: Serial dependencies were addressed by including an autoregressive structure with a lag of 1 [AR(1)]. The quadratic effect of session number was statistically significant for both the BDI, $B = .066$, $t = 5.74$, $p < .001$, and the BAI, $B = .064$, $t = 6.66$, $p < .001$. Cubic effects were not statistically significant and were, therefore, not included in final models.

After learning about the CBT treatment model and how to identify and classify automatic thoughts, Mr. X reported a sharp decrease in his symptomatology (Session 7: BDI = 23, BAI = 25) and an absence of suicidal ideation and psychotic symptoms. Following this improvement in symptomatology, the client took a delivery job because he believed the job would provide him with exposure to his driving fears and social anxiety. Although challenging, he noted that he was typically able to control his anxiety using on-the-spot relaxation. However, around this time the client reported a return of hallucinations and suicidal ideation, which he interpreted in a self-critical manner (e.g., "I am a failure, treatment should be working more quickly"). Although he was able to dispute these thoughts successfully in session, he continued to respond to these symptoms in a self-critical manner between sessions (Session 10: BDI = 34, BAI = 40).

Middle Sessions (Sessions 11-19)

It was hypothesized that Mr. X's worsening of symptoms and his inability to manage these symptoms violated the client's conditional rule for happiness, "If I am not perfect, I am a failure." Thus, the first goal of middle sessions was to teach the client to identify and modify his dysfunctional perfectionistic beliefs. Because perfectionistic beliefs undergirded much of Mr. X's negative thinking, efforts at disputing these beliefs resulted in a substantial reduction in the number and severity of his automatic thoughts. Accordingly, following success in disputing his perfectionistic beliefs, Mr. X experienced a substantial reduction in symptoms (Session 12: BDI = 17, BAI = 23).

Due to the client's relative mastery of identifying and disputing negative thoughts, the clinician and Mr. X progressed to the second goal of middle sessions: exposure to social situations. Initially, the clinician accompanied Mr. X to social situations that were moderately anxiety provoking (e.g., sitting in a crowd of people) and taught him to apply thought and relaxation techniques to reduce his anxiety. Subsequently, Mr. X and the clinician completed exposures in increasingly anxiety-provoking situations (e.g., interacting with store clerks), and the client was asked to complete several exposures on his own between sessions. The client participated in all exposures without resistance and had perfect homework compliance. During each of his exposures he experienced a large decrease in anxious symptoms over a relatively brief period of time and was quickly completing exposures that were very high on his anxiety hierarchy. Due to overall improvements in his symptomatology and functioning, the client was able to take a more demanding and satisfying job in his field.

Following his mother being diagnosed with diabetes, Mr. X experienced a substantial increase in his depressive symptoms and reported experiencing a marked loss of interest and pleasure in activities. He had catastrophic automatic thoughts about these symptoms; for example, he interpreted them as a sign that he had permanently lost interest in everything, which necessitated him reevaluating his life and career. Mr. X reported difficulty using cognitive techniques to reduce his symptoms and noted that after disputing a negative thought, several more would take its place. It was hypothesized that cognitive techniques were at times increasing the client's negative thinking because these techniques forced the client to actively engage with his thoughts. Although the goal of therapy at this time was to complete exposures to social situations, the clinician and Mr. X decided to temporarily focus on increasing the client's experience of pleasure and disengaging from ruminative thinking. To reduce his anhedonia, Mr. X was asked to schedule activities that he previously found to be pleasant, to engage in these activities (e.g., by paying attention to sensory information), and to monitor and dispute negative thoughts occurring during and after these activities. To decrease rumination, Mr. X was asked to carry an index card reminding him to dispute his negative thoughts at the first sign of sad mood and to engage in an activity if he was unable to improve his mood, using thought disputes after 15 min. He reported an increased ability to enjoy activities and decreased depressive symptoms (e.g., Session 17: BDI = 13), subsequent to increasing pleasant activities and actively engaging in these activities. However, the client continued to struggle with rumination. Although he could often reduce his negative thoughts by engaging in an activity, he noted that his ruminative thoughts immediately returned once the activity had ended. The client continued to strictly adhere to the therapeutic protocol, but his enthusiasm and faith in treatment seemed to be diminished. He was discouraged that he was not always able to reduce his symptoms by therapeutic techniques, and he felt that his life was a constant struggle against depressive thoughts and moods.

Late Sessions (Sessions 20-31)

The goals of late sessions were to continue to work with the client's dysfunctional beliefs and to conduct exposures to social situations whenever the client's mood seemed to be relatively stable. The first several of these sessions were spent helping the client to cope

with an upcoming work-related certification test (rated as the most difficult social situation on the client's social anxiety hierarchy) through positive coping statements, relaxation, and disputing negative automatic thoughts. Also at this time he reported turning down a date due to his belief that if he gets close to someone, they will hurt him. To challenge this belief, Mr. X and the clinician developed a list of all the people who the client had known and whether they had hurt him or not. The client acknowledged that the list strongly suggested that most people did not hurt him.

After successfully completing his certification test, the client expressed a desire to work on developing assertiveness because he felt like his coworkers were taking advantage of him. For example, he noted that he had not had a lunch break for several weeks because he was asked each day to cover for a coworker during his break time. The clinician and Mr. X developed an exposure hierarchy of assertiveness situations and the therapist taught the difference between passive, assertive, and aggressive interactions through discussion and role play and worked with the client to dispute negative thoughts regarding being assertive (e.g., "If I am assertive, people will leave me"). Over the following several weeks (Sessions 24 to 28), the client practiced assertiveness on several occasions with coworkers, strangers, and his family. Mr. X reported success with assertiveness and experienced consistently low symptomatology (BDI = 10-14, BAI = 8-12). The client noted that by being assertive he learned that there is no one correct way to do things and that he can be assertive with someone close to him without he or she leaving him.

At Session 29 the client continued to report success with assertiveness but noted that he had been experiencing periods of hopelessness regarding what he should do with his life. The client was instructed to weigh the pros and cons of various options for homework, and he subsequently reported that this exercise worsened his negative thinking and depressive symptoms because he believed that no matter what life changes he made they would inevitably result in pain. For example, he believed that if he found a romantic partner, she would hurt him. At this time, it was hypothesized that the client's paranoid beliefs were activated by various environmental triggers. For example, the client reported experiencing paranoid thinking after going on a date with a woman who disclosed she was an active drug user. In subsequent sessions, the client reported additional beliefs that reflected his mistrust of other people (e.g., "Most people I have become close to have been jerks to me and have been unwilling to change to please me"). As had occurred in the middle sessions of treatment, the focus of therapy returned to managing the client's dysfunctional thinking due to its associated distress and impairment.

End of Treatment (Session 32-40)

The goals of therapy around the time that treatment ended were to reduce the client's negative thinking and to modify the client's dysfunctional beliefs. At the end of treatment, the client's negative thinking was dominated by themes of perfectionism and mistrust of others. For example, following a confrontation with people at his workplace, the client reported dreading going back to work because he felt like he was no longer perfect at resolving interpersonal disputes. The therapist worked with Mr. X to understand and modify his dysfunctional beliefs. Mr. X agreed that his dysfunctional beliefs stemmed from a core belief that he was inadequate. However, he argued that he did not

want to modify these perfectionistic beliefs because he believed that his perfectionism helped him maintain relationships and prevented him from becoming a bad person like most others. Although the client agreed that people had not abandoned him in the past when his behavior was less than perfect and that most people who were good did not have perfectionistic attitudes, Mr. X's dysfunctional belief was not significantly weakened by these interventions. As time passed, the client's faith in treatment and in his future declined.

In the final 2 months of treatment, the goals of therapy shifted from working on the client's dysfunctional beliefs to ensuring the client's safety and exploring alternative treatment options (e.g., pharmacotherapy). Unfortunately, Mr. X continued having problems obtaining psychiatric services due to his financial difficulties and negative past experiences with psychiatrists. During this time, Mr. X reported experiencing numerous emotional breakdowns associated with negative thoughts such as, "I will always be like this," "People will leave me," and "I have no control over my emotions." His symptoms of depression and anxiety approached their pretreatment levels (e.g., Session 36: BDI = 42, BAI = 35), and he reported extreme anger, psychomotor agitation, frequent and intense automatic thoughts (whose content involved self and other devaluation), and strong desires to hurt himself and others. Although the client reported having frequent fantasies of assaulting people who angered him, he only expressed his agitation in safe contexts (e.g., by screaming and punching pillows in his room).

On the final session (Session 40), the client's depression and anxiety had severely worsened (BDI = 47, BAI = 38), and the client stated that he struggled from hour to hour to not harm himself. This session focused on the option of hospital-based psychiatric care. Although the client was reporting substantial suicidal ideation, he had not made significant preparations to commit suicide, and he was able to sign a written contract that he would not harm himself. For these reasons, Mr. X was not thought to be imminent danger for suicide and was allowed to leave the session. A few days later the clinician received a phone call from the client's mother stating that he had been taken to the emergency room following a suicide attempt. The clinician learned from calling the hospital on a later date that Mr. X had been discharged several days following admission. Mr. X did not return the clinician's subsequent phone calls or letters.

9 Managed Care Considerations

Mr. X's treatment was provided in an outpatient mental health clinic that does not accept health insurance. Instead, clients pay a sliding-scale fee for services. Therefore, Mr. X's CBT was not limited by managed health care. However, Mr. X was unable to obtain psychiatric services, partly due to his lack of health insurance.

10 Follow-Up

Due to Mr. X's abrupt termination of treatment and our inability to contact him following his hospital discharge, follow-up was not possible.

11 Treatment Implications of the Case

Although the client made rapid initial improvements in response to the behavioral interventions employed early in treatment, as well as interventions aimed at modifying automatic thoughts, the client deteriorated later in the course of therapy apparently following activation of his core dysfunctional beliefs. Though the client appeared competent in using techniques to dispute negative automatic thinking, he often struggled with intervening in his negative thinking between sessions and found that engaging his negative thoughts resulted in a worsening of his symptoms. This appeared to occur in part because he would experience self-devaluative thoughts ("This should be going better, I've failed") following his initial inability to dispute his negative thinking. In addition to these difficulties, the client was never able to consistently reduce the strength of his core beliefs. Although he explicitly acknowledged the relative validity of healthy core beliefs (e.g., "People are generally trustworthy"), he quickly reverted to firm belief in unhealthy core beliefs (e.g., "Other people cannot be trusted") whenever environmental stressors appeared to affirm these unhealthy beliefs. Furthermore, it is possible that the client was not ready to work on his core beliefs (possibly because he saw certain beliefs such as his perfectionism as adaptive) and that the therapists' effort to do so generated resistance and perhaps ultimately confirmed his belief that mental health professionals cannot be trusted. In accordance with Mr. X's difficulties managing his negative thinking with cognitive techniques, research has shown that individuals with greater severity of depression (Elkin et al., 1989), more negative cognitive styles (Slotsky et al., 1991), and more comorbid disorders (Reich, 2003) are less likely to respond to CBT. This case raises a paradox: Toxic dysfunctional beliefs appear to be at the core of the client's pathology and yet the cognitive interventions employed in his treatment seemed to result in a worsening of his symptoms. Also, paradoxically, though the client's perfectionistic beliefs likely facilitated his initial progress with more behavioral approaches, they ultimately contributed to the downward spiral that culminated in a suicide attempt and treatment termination.

12 Recommendations to Clinicians and Students

CBT case formulation suggests that core dysfunctional beliefs likely play a strong role in the onset and maintenance of the various symptoms, impairments, and interpersonal difficulties seen in comorbid clients, such as Mr. X. What is at question is how to effectively deal with these core beliefs. On one hand, the important role of core beliefs in generating pain and suffering suggests that therapy needs to focus on either modifying these beliefs or creating and reinforcing more adaptive positive beliefs. Much of the cognitive therapy literature suggests this kind of approach (e.g., Beck, 1995). Furthermore, a recent offshoot of cognitive therapy, schema therapy (Young, Klosko, & Weishaar, 2003), focuses primarily on modifying core dysfunctional beliefs. In addition to the traditional cognitive therapy techniques for working with core beliefs (using evidence to challenge dysfunctional beliefs and to create and reinforce healthy beliefs), schema therapy incorporates experiential techniques (e.g., imagery, emotional processing, venting negative feelings), techniques to break interpersonal patterns that maintain unhealthy beliefs and a corrective therapeutic relationship.

Although the clinician worked extensively with Mr. X to identify and challenge automatic thoughts and intermediate beliefs (e.g., "If I am not perfect, I am a failure"), relatively little work was done to modify the client's core beliefs (e.g., "I am inadequate"). In fact, only two sessions toward the end of treatment were devoted to disputing the client's core belief ("I am inadequate"), creating a healthy alternative belief and finding evidence to support the healthy belief. The turn of events toward the end of therapy suggests that failure to adequately address dysfunctional core beliefs may have turned an initially successful course of therapy into a failure. Specifically, relatively mundane life events (e.g., not being able to settle a dispute at work) activated the client's core dysfunctional beliefs and resulted in large increases in depressive and anxious symptomatology.

Although dysfunctional thinking tends to become dormant during periods of remission from depression (Abramson et al., 2002), depression-prone individuals with comorbid personality pathology frequently exhibit negative thinking in the absence of depressive symptoms, which in turn places these individuals at risk for relapse (Ilardi et al., 1997). Indeed, in the absence of substantial depressive and anxious symptoms, Mr. X remained strongly convicted and vocal about his dysfunctional core beliefs. This persistent activation of Mr. X's core beliefs likely made him unusually vulnerable to environmental triggers and led to his symptom relapse at the end of treatment. Although further attention to Mr. X's core beliefs was arguably important, this had been hard to accomplish because the client often presented to sessions with severe psychiatric symptoms that appeared to require immediate attention through either behavioral or more superficial cognitive interventions (e.g., working with automatic thoughts). Given the client's severe symptomatology, psychotropic medications may have been a useful adjunct to psychotherapy for this case. Unfortunately, Mr. X was unable to obtain psychiatric services throughout the course of therapy. Regardless of his symptom severity, though, it is unclear whether the client was ready to work on changing his core beliefs. If this indeed had been the case, it might have been helpful to use a Motivational Interviewing (Miller & Rollnick, 2002) approach toward increasing his readiness before implanting interventions aimed at schema change.

In contrast to working directly with core beliefs, some have argued that it may be most effective to navigate around these cognitions, for example, by employing behavioral activation techniques such as engaging in goal-directed behaviors and using mindfulness meditation (Bottonari, Roberts, Thomas, & Read, 2008; Dimidjian et al., 2006). It may be the case that severe and complicated cases with comorbidity, particularly Axis II pathology, and significant dysfunctional core beliefs are precisely those clients for whom cognitive therapy is going to be the most challenging and the most prone to failure. As suggested by Bottonari et al., efforts at cognitive modification with these clients have the potential to trigger further rumination and a spiraling of negative thinking, particularly when using between-session assignments where the therapist is not available to help disengage these processes. This pattern of efforts at cognitive modification triggering rumination frequently occurred for Mr. X, and behavioral activation techniques (e.g., engaging in goal-directed activities) were successful in temporarily relieving his depressive rumination. Related to a behavioral activation approach, cognitive defusion techniques from acceptance and commitment therapy (Hayes, Strosahl, & Wilson 2003) might have helped disarm Mr. X's core beliefs with less risk of entanglement with them than direct efforts at changing their content. For example, Mr. X could have been asked to repeatedly state that he was experiencing given negative

thoughts ("I am having the thought that I am a failure") until the emotional impact of the thoughts were lessened through habituation.

What is clear in this case is that persistently touching on these core cognitions without fully addressing them resulted in an unfortunate treatment failure. It is possible that therapy would have been more successful by either (a) spending more time directly challenging core toxic beliefs and developing more positive alternative beliefs, perhaps after initially working on insuring that he was committed to working on modifying his core beliefs; (b) taking a strictly behavioral approach toward treatment, including persistently redirecting away from negative thinking in terms of the content of therapy (e.g., focusing on activity scheduling, exposure) as well as the process of therapy (e.g., commenting on and then redirecting when client verbalizes negative thinking during session); or (c) defusing negative thinking and beliefs through ACT techniques and abandoning the control agenda through the development of creative hopelessness.

Notes

1. To protect the privacy of the client described in this report, demographic and descriptive details have been modified.

2. He also reported avoiding getting involved with people unless he was certain they would like him, avoiding jobs or tasks that involved having to deal with a lot of people, finding it hard to be *open* even with people he was close to, usually being quiet when he meets new people, and being fearful of others' negative evaluations.

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