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Current PSYCHIATRY

CASES THAT TEST YOUR SKILLS

Fears of interacting with other people were taking an ever-increasing toll on Mr. I. Drawing from a small but growing body of evidence, these doctors try to help this patient regain control of his life.

A showdown with severe social phobia

History **Living in fear**

Mr. I, 41, presents for an initial psychiatric evaluation. He saw a psychologist 8 years ago for a "mild depression," which he described as a lack of motivation and difficulty concentrating. His mood has been chronically "flat" for the last 10 years. He complains of poor energy and decreased sleep because of irregular work hours, and admits to using over-the-counter caffeine pills to help him function.

The patient denies suicidal ideations, symptoms of guilt, psychotic symptoms, or crying spells, but has a history of alcoholism and cocaine abuse. (He has been sober for 5 years.) Significant recent stressors include a recent breakup with his girlfriend, which he adds "really hasn't bothered me at all."

Mr. I has been increasingly avoiding social situations. Though he denies having panic attacks, interaction with other people triggers shortness of breath and chest tightness, especially when speaking in public to strangers.

The fear of what others might think of him is dominating Mr. I's life. For example, he would like to console a housemate whose mother died, but because he is afraid of how the friend will react, Mr. I has not approached him. He adds that he goes out of his way to avoid contact with his co-workers, working irregular hours and eating his lunch in his car rather than the office lounge—even in inclement weather.

Mr. I does attend Alcoholic Anonymous meetings, but often sits toward the back. He had led some meetings, but refused to even look up from the podium while doing so. His anxiety worsened, his heart rate increased, and his palms sweated while leading the group. He began attending different AA meetings so that others would not recognize him and volunteer him to lead.

He adds that he feels comfortable meeting and dating women, since these exchanges are "scripted." As he gets to know his partner better, however, Mr. I becomes more self-conscious.

Which of Mr. I's symptoms would you address first: the depressive or the phobic?

Drs. Yu's, Gordon's, and Maguire's observations

Based on Mr. I's presentation, one might at first diagnose major depressive disorder, but chronic avoidance patterns differentiate his illness from an endogenous depression. Mr. I was diagnosed as having social phobia, a disorder that has been gaining attention among researchers.

A phobia is defined as an irrational fear that produces conscious avoidance of the feared subject, activity, or situation. The presence or anticipation of the phobic entity elicits severe distress, though the affected person usually recognizes that the reaction is excessive. DSM-IV defines social phobia as a strong, persisting fear of potentially embarrassing situations (*Box*).[1]

Two peaks of onset have been described: one occurring before age 5, and the other between ages 11 and 17.[2] The mean age of onset has been reported to be 15.[2]

DSM-IV describes two types of social phobia: generalized social phobia and performance phobia. Normal fear and shyness should be differentiated from social phobia. Medical conditions—including CNS tumors and cerebrovascular diseases—and drugs typically bring about neurologic and mental status symptoms that can confound the diagnosis.

Symptoms of other anxiety disorders, including panic disorder and agoraphobia, may mimic social phobia. Fear in social phobia is not present outside of, or in anticipation of, the feared situation. Social phobia also can be misdiagnosed as an avoidant personality, schizoid personality, or major depressive disorder.[1]

At this point, one should consider diagnosing Mr. I with social phobia, as evinced by his excessive avoidance of social situations. Mr. I also recognizes that his avoidance is excessive and causes difficulty in his daily functioning.

Behavioral inhibition in childhood is suggested to be more common in children with parents who had panic dis-

Box

SOCIAL PHOBIA: DSM-IV DIAGNOSTIC CRITERIA

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

Note: Children must exhibit a capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situational or predisposed panic attack.

Note: Children may express the anxiety by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable.

Note: In children, this feature may be absent.

D. The feared social or performance situations are avoided, or else endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational or academic functioning, or social activities or relationships with others, or there is marked distress about having the phobia.

F. In individuals younger than 18, the duration is at least 6 months.

G. The fear or avoidance is not caused directly by a substance (e.g., a drug of abuse or medication) or general medical condition, and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).

H. If a general medical condition or other mental disorder is present, the fear in criterion A is unrelated to it (e.g., the patient does not fear stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder).

SOURCE: *DSM-IV-TR*. Washington, DC: American Psychiatric Association, 2000.

order. Generalized fear may manifest later as excessive shyness. Several studies have linked childhood behavior inhibition to social phobia.[5-7]

First treatment Pharmacotherapy and psychotherapy

Mr. I is interested in trying an antidepressant, but noted that about 6 years ago a brief course of a selective serotonin reuptake inhibitor led to difficulty sleeping and decreased libido and orgasm. He agrees to take bupropion SR, 100 mg/d, titrated after 2 weeks to 100 mg bid.

He also begins cognitive-behavioral and supportive therapy, during which he reveals that his pattern of avoidance took root in grade school, where he was often a quiet sidekick to the popular kids. During therapy, he describes visitations with his daughters, both of whom live with his ex-wife, as extremely difficult.

"I really don't know what to say," Mr. I says. "We often stare at each other during dessert, and I want to get it over with and go home."

After 1 month, his bupropion SR is increased to 150 mg bid. One month later, his feelings of depression are under control. He sleeps well, no longer feels fatigued, and can concentrate. Still he isolates himself, fearing others' disapproval. He has become more resistant to psychotherapy. "I know my patterns. I know what I do, but I can't change it," he says.

How would you treat Mr. I's persistent social phobia? Would you switch his medications or augment existing ones? Does psychotherapy still have a role in treatment?

Drs. Yu's, Gordon's, and Maguire's observations

Pharmacologic treatment of social phobia has spawned several neurochemical hypotheses. As beta-adrenergic antagonists have been proven efficacious in treating performance phobia, an adrenergic hypothesis suggests patients with performance phobia release more norepinephrine and epinephrine or are more sensitive to normal levels of these neurotransmitters.[8]

The success of monoamine oxidase inhibitors in generalized social phobia suggests that dopamine plays a role in treating this form of the disorder. Central dopamine activity has been associated with positive emotions or extraversion.[9]

SSRIs have also demonstrated efficacy against generalized social phobia.[10] Researchers have associated higher serotonin levels with increased social dominance[11] and suggest that abnormal dopamine and serotonin levels contribute to the disorder's pathogenesis.

Current treatments include psychotherapy and pharmacotherapy, and studies suggest that a combination of the two may be more efficacious than either alone.[8] Venlafaxine, phenelzine, buspirone, benzodiazepines, and SSRIs have all demonstrated effectiveness and tolerability in generalized social phobia. Beta-adrenergic receptor antagonists (e.g., atenolol, propranolol) are commonly administered to treat performance phobia shortly before exposure to the phobic stimulus.

An adequate time frame for psychopharmacologic treatment of social phobia has not been defined. In depression therapy, medications should be maintained for at least 4 to 5 weeks before considering the regimen unsuccessful.[1]

While Mr. I's depression responded well to bupropion SR, a medication whose mechanism involves dopamine and norepinephrine reuptake, use of a medication that augments his serotonin may further improve his condition.

Cognitive and behavioral therapies also are indicated for both generalized social phobia and performance phobia. These should be considered along with medication therapy for Mr. I to treat his social phobia and prevent a relapse.

Despite the available evidence, however, the course and prognosis of social phobia are not clear. Data are still forthcoming on this recently recognized disorder.

Further treatment

Another neurotransmitter

Again cautious of potential adverse sexual effects, Mr. I agrees to try mirtazapine, 30 mg at bedtime, in addition to bupropion SR. He initially complains of sedation and lowered energy, but is willing to continue the mirtazapine, hoping that it will help his social phobia.

Two months after starting mirtazapine, Mr. I is still fearful at work and home, and his relationship with his

daughters has not improved. After another month, he reports that his sedation has resolved, but complains of increased fatigue and difficulty concentrating. He suspects that the bupropion SR has stopped working.

After another month, Mr. I self-discontinues the mirtazapine. Though he tries to participate in social situations, his anxiety has worsened. He goes to a country music club once a week but is afraid to ask anyone to dance.

Should you focus on Mr. I's depression rather than his social phobia? If so, how do you change his treatment?

Drs. Yu's, Gordon's, and Maguire's observations

The severity of Mr. I's social phobia may be causing his depression. Both trials of bupropion SR and mirtazapine have been adequate for his depression but have not alleviated his social phobia.

Medications that affect gamma-aminobutyric acid (GABA) levels, specifically benzodiazepines, have not been tried. Benzodiazepines provide rapid relief with little risk in short-term treatment, but dependence/withdrawal risks increase greatly when given more than 4 to 6 months.[8] Because of Mr. I's chronic anxiety in social phobia and his history of alcoholism, benzodiazepines are not recommended.

The novel compound tiagabine has been shown to increase GABA in the synaptic cleft.[12] GABA increases chloride conduction through its ligand-gated channels, creating a potential antianxiety effect similar to that produced by benzodiazepines.[8,13,14] GAT-1, the predominant transporter, removes excess GABA.

Bottom Line

Social phobia remains a relatively misunderstood disorder. Benzodiazepines, SSRIs, and other agents have been found to improve phobic symptoms, but patient tolerance should be considered. Cognitive and behavioral therapies also are indicated.

Just as SSRIs inhibit serotonin reuptake and allow the neurotransmitter to act on its receptors to alleviate depression and anxiety, so does tiagabine inhibit GAT-1. Theoretically, tiagabine may relieve anxiety by increasing synaptic concentrations of GABA.

Tiagabine also has been shown to be well-tolerated without a known abuse or dependence potential.[12] Possible adverse effects include impaired concentration, somnolence, fatigue, nausea, and dizziness. To avoid adverse effects, slow titration (about 4 mg per week) is recommended.

Changing treatment Looking up

Tiagabine, 4 mg at bedtime, is added to help with Mr. I's anxiety; he is instructed to increase the dosage by 4 mg every 5 days in divided doses. He began to sense improvement during the second week, at 4 mg bid, and 2 weeks later his anxiety has been greatly reduced. He can now sit quietly with his co-workers during coffee breaks and has begun training a co-worker, which he never dared to attempt before. At this point, he was tolerating tiagabine at 8 mg bid.

Related resources

- Anxiety Disorders Association of America www.adaa.org
- National Institute of Mental Health: Phobias from NLM's MEDLINEplus http://www.nlm.nih.gov/medlineplus/phobias.html

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DRUG BRAND NAMES

Bupropion • Wellbutrin
Buspirone • BuSpar
Mirtazapine • Remeron
Phenelzine • Nardil
Tiagabine • Gabitril
Venlafaxine • Effexor

DISCLOSURE
Dr. Yu reports that he serves on the speaker's bureau of Cephalon Inc., Novartis Pharmaceuticals Corp., and Pfizer Inc., and receives research/grant support from and serves as a consultant to Eli Lilly and Co.

Dr. Gordon reports no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.

Dr. Maguire reports that he receives research/grant support from, serves as a consultant to, and is on the speaker's bureau of Eli Lilly and Co., is on the speaker's bureau of Pfizer Inc., and receives research/grant support from Forest Laboratories and GlaxoSmithKline.

One month later, tiagabine is increased to 16 mg bid. Mr. I has noticed mild dizziness with each dosage increase, but each time it subsided within a day. He has been maintained on 16 mg bid.

Saying that his anxiety is now well-controlled, Mr. I enjoys at least one dance each week at the country music club he frequents. One week later, he led an Alcoholics Anonymous meeting—while looking up to his audience for the first time. He continues these activities and his therapy sessions, which are geared toward developing stronger skills to minimize his anxiety. He is considering lowering his medication dosages (though he is wary of a possible relapse) and furthering his therapy.

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