Discussion

Pharmacotherapy of Social Anxiety Disorder

Dr. Westenberg: I want to comment on your data and the cognitive effects of SSRIs. We did a study with fluvoxamine in panic disorder where we challenged with CCK4 before and after treatment and found that cognitions about somatic symptoms diminished rather than the physical symptoms themselves.[1] The emphasis was on cognitions about people's situations, about somatic symptoms that disappeared or diminished on treatment, when these panic attacks were elicited by a pharmacologic compound, suggesting that SSRIs do have an effect on negative cognitions, which is also apparent in social phobia.

Dr. Davidson: That is right. The physiologic question was: How much have you been distressed by blushing? It was not: How much have you blushed? Many times there are still symptoms, but subjects are not bothered by them.

I understand that you have conducted a study with venlafaxine and placebo,[2] which was positive. This is another positive study of a serotonergic, although not a selective serotonergic, drug in social phobia.

Dr. Westenberg: We also did a study with buspirone in social phobia,[3] which was negative (7% response rate). As in panic disorder, buspirone has no effect in social phobia.

Professor Lecrubier: Do you have any information on the impact of intervention on comorbid conditions and/or their development, and if there are long-term data on the development of further comorbidity? Many of these people were suffering from alcoholism or depression, and I think it is crucial to see whether treatment improves prognosis at that level. It is as important as it is for social phobia itself.

Dr. Davidson: Nearly all studies excluded people with significant comorbidity, such as major depression or generalized anxiety disorder, but, in the phenelzine study by Liebowitz[4] and our clonazepam study,[5] avoidant personality disorder responded well to either drug. We are about to start a clinical trial of paroxetine in alcohol abusers with social phobia.

Professor Lecrubier: In disorders where comorbidity is the rule, it is strange that you never have information about comorbidity and that it is excluded from all trials. We have to give the message that we lack crucial data on the majority of patients because we artificially exclude them. We could use methodology to control for comorbidity in clinical trials.

Dr. Davidson: Our group should recommend that such studies are done.

Dr. Ballenger: A phase IV study in some 120 comorbid patients for a year would be very interesting, for example, to the see whether symptoms of depression went away and did not come back.

Professor Lecrubier: This would be representative of the actual patient population that will be treated.

Professor Nutt: Do we have any data on paroxetine discontinuation?

Dr. Davidson: Not yet.

Professor Nutt: What about the issue of combination and the related issue of getting worse to start with? Is there any evidence for initial worsening?

Dr. Westenberg: Not in my experience. That is one big difference from panic disorder patients; there is no exacerbation at the outset of the treatment.

Professor Nutt: So, we all agree on that. What about the combination of clonazepam and an SSRI?

Dr. Davidson: An SSRI with a benzodiazepine might work, but the question is, When would one want to do that? I would start with one treatment and add another agent if necessary. There is less pressure to start with a combination, like in panic disorder, because there is no initial agitation.

Dr. Westenberg: What would you choose? Clonazepam or an SSRI?

Dr. Davidson: As a first line, I think an SSRI for the most part.

Dr. Ballenger: What do we know about the recommendations for an initial and a target dose?

Dr. Davidson: From the fixed-dose studies, the recommendation is to aim for paroxetine, 20 mg, and increase if necessary. There was a tendency for some side effects to be more apparent at the higher dose. My experience is that when there is comorbidity or a more severe type of social phobia, higher doses of SSRIs may be necessary, much like when we treat OCD.

Dr. Westenberg: It also takes a longer time for the drug to become efficacious, as compared with panic disorder, for instance, where significant differences are seen at 4 to 6 weeks. In patients with social phobia, it takes longer periods of time to have clinically significant efficacy.

Professor Nutt: We usually warn our patients that it may take 3 months before they benefit from treatment, although it can be sooner.

Professor Lecrubier: How much stability would you ask for before decreasing or stopping treatment, since you showed that continuing treatment was effective?

Dr. Davidson: These are long-term disorders. My own feeling is that you must continue treatment for a minimum of 12 months before considering discontinuing medication.

Dr. Ballenger: Is that recommendation based on reasoning rather than data?

Dr. Davidson: There are no data outside of 12 months.

Professor Bobes: What is the profile of a good responder?

Dr. Davidson: Less severity and no personal or family history of alcoholism.

Professor Nutt: Were most of these studies in generalized social phobia?

Dr. Davidson: I think Liebowitz's first study had some performance anxiety, but in recent trials the diagnosis is almost exclusively generalized. Performance social anxiety is no longer being studied in controlled pharmacotherapy trials.

Professor Nutt: That leads me to the issue of β-blockers, which are a first-line treatment in the United Kingdom. If a diagnosis of social phobia is made, the general practitioner is most likely to use β-blockers.

Professor Lecrubier: Many people treat social phobics with β-blockers because of their effect on social performance, but that is not appropriate. They are ineffective in social phobia.

Dr. Westenberg: But does that hold for discrete social phobia?

Dr. Davidson: The 2 studies, yours[6] and Mike Liebowitz's,[4] did not show β-blockers in a favorable light, even in the performance subtype.

Professor Lecrubier: All studies of β-blockers are negative, and I think we should recommend that they not be prescribed for social phobics, certainly not with the generalized form.

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