

EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Alone and Away From Home

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Social phobia typically has its onset in adolescence. The expectation for a social or performance situation is one of embarrassment. Panic attacks may occur in anticipation of an event or during exposure to it. Avoidance is common, and when the fears generalize to multiple situations, withdrawal and isolation may result.

Given the usual age at onset, college rosters are likely to include a number of students with social anxiety disorder. Since the clinical description of the problem emphasizes the young patient's thinking, cognitive therapy would seem to be a logical approach to treatment.

With the teenage years often featuring intense social learning and frequent social comparison, it's not hard to imagine negative consequences of social anxiety for self-worth. Whether you prefer genetic, biological, or psychological explanations, a high comorbidity for social phobia and major depressive disorder seems like a good bet.

CASE PRESENTATION

Ms. A was a 19-year-old college sophomore when she first consulted me in October. She was the youngest of 3 children in her family, having 2 older brothers. Her father was an attorney, and her mother taught nursery school in a major Ohio city. Ms. A first noticed signs of social anxiety in her freshman year of high school. Seen by her family, as well as her classmates, as an outstanding student, she never revealed her thoughts and fears to anyone while she compiled a successful academic record.

Ms. A applied and was accepted to a midsize South Carolina college. She was permitted to live off campus, and she performed well in school her freshman year, while staying mostly to herself. The onset of panic attacks led to frequent telephone calls to her family doctor back home. He agreed to talk with her and, after several months, prescribed a selective serotonin reuptake inhibitor (SSRI). When Ms. A told him that she had dropped several second-year classes she had been routinely not attending, and that she and her cat lived mostly apart from other students, he strongly suggested that she be treated by a psychiatrist in the local area.

My intake evaluation revealed a young woman experiencing periodic panic attacks, routinely skipping the few classes that she remained registered for, and manifesting the anergia, fatigue, and withdrawal typical of major depressive disorder. She was taking a moderate dosage of an SSRI drug, which seemed to be of little benefit. "I have all these unfounded beliefs," she told me. "I've dropped 3 classes, and I can't keep up with the 3 I've retained." She did not "go out" with friends, choosing to stay alone in her apartment with her cat.

She recalled a time (before high school) when she had many friends, was socially active and interested, and did not feel depressed. My DSM-IV diagnoses for Ms. A were social anxiety disorder (300.23) and major depressive disorder (296.30). My prescription was for a course of cognitive therapy and an increase in the sertraline she was taking from 150 mg to 200 mg.

PSYCHOTHERAPY

After I explained the cognitive therapy model to Ms. A and illustrated it with statements she had made in our intake session, she described a significant number

of situations that evoked anxiety. We considered class attendance to start, because it was a “life imperative” for her. Finding no acceptable basis for her anxiety about going to class, she promised to utilize the cognitive method when anxiety about class attendance arose.

We spoke in detail about anticipatory anxiety. I stressed that, by definition, there was no activity (other than thinking) that elicited this form of distress. The more we spoke, the more animated Ms. A became, and the more she stressed feeling a surge of relief. She spoke about recurring bouts of anxiety surrounding life issues: marrying, parenting, working, and studying abroad. She expressed a continuing fear of being “embarrassed or humiliated” in situations involving classmates or peers. In each case, I asked Ms. A to outline the consequences she anticipated. When she considered them openly, she found the anxiety hard to sustain.

I continually stressed “perspective.” We identified cognitive errors, and she became quite adept at labeling them as they occurred: polarization, personalization, and overgeneralization. In session 4, Ms. A told me how she had handled 2 minor car accidents competently and how she had dealt well with bringing her ill cat to a veterinarian, and then to a second veterinarian when she wanted another opinion.

Often she would dwell on how “others would see her” in a social situation. Typically, I would ask her how she would react to a friend in the same circumstance. Ms. A was now attending classes regularly and had spoken with each of her instructors. She was up to date on classwork. She began agreeing to go out with girlfriends whom she had previously avoided. As she confronted situations and gained self-confidence, her depressive symptoms disappeared.

At times Ms. A would report having anticipatory anxiety, but decided to “take part” anyway. Things seemed to always work out better than she expected. She went home to Ohio for a school break and initiated contact with a number of (surprised) old high school classmates. She found she was no longer avoiding social situations. “I’ve gotten the tools now,” she said. We discussed dating as a sorting process rather than one of acceptance or rejection.

“I’ve come a long way,” Ms. A said in our fifteenth (and final) session. “I’m no longer creating obstacles for myself. I no longer think in the same way.” She could now differentiate social anxiety and “normal” anxiety. When she described nervousness that she noted in others in a variety of situations, Ms. A suggested that “there are significant social advantages for me in what I’ve learned.” Cognitive therapy had contributed a new skill set, and this young woman was now putting it to good use. ♦