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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Conquering an Unmasked Social Phobia

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Social phobia is a fairly common presenting problem in our psychiatric outpatient clinic. We have found, in our experience, that anxiety in social situations is accommodated in a variety of ways. Some patients choose to avoid the particular situation or setting that brings on the anxiety. Others manage to take this a step further by molding their professional and personal lives in such a way that they entirely bypass any number of anxiety-provoking experiences. Over time, this may at least temporarily remove from their conscious experience the idea that they are socially anxious. However, if life circumstances change and the anxiety-provoking situations are again presented, awareness of and impairment by social phobia may return. This was the case for the gentleman described in the following example.

CASE PRESENTATION

The patient is a 35-year-old single white man who presented to our psychiatric outpatient clinic seeking individual psychotherapy. He noted that "I've performed a self-evaluation and I'm not happy with where I am right now." Over the preceding several months, he noticed that he had become increasingly isolated and "disconnected from the world."

The patient grew up the youngest of 3 children in Cleveland, Ohio. He described his childhood as generally pleasant. He excelled academically and went on to earn a master's degree in engineering. Upon graduation from college, he began a successful career as a process engineer for a large manufacturing firm. He noted that his work was very stressful, consuming a great deal of time and energy.

Three months prior to his presentation to the clinic, the patient inherited a substantial amount of money from a relative who had passed away. Realizing that he would not have to work to support himself, he decided to quit his job and "take time to enjoy my life." As the weeks passed, however, he noticed that he became less engaged in social activities and "pretty much stayed around the house." When he attempted to attend social functions, he felt awkward and "unable to make interesting conversation." Overwhelming feelings of anxiety often prompted him to leave and return to his house. He began to realize that his prior social outlets were almost exclusively linked with his work. He remarked that "maybe I always had trouble making friends, but I never used to have all this time to think about it." He went to see his internist to discuss this major functional change. A careful evaluation led to no positive physical findings, and he was referred to our clinic.

The patient's goal for therapy was to "learn a better way of interacting with people." He was uncertain how to go about this, but made clear that he was not interested in taking medication. He was diagnosed with social phobia and adjustment disorder. He agreed to meet with me (K.M.G.) for 8, weekly, 1-hour cognitive therapy sessions.

PSYCHOTHERAPY

During the first session, the cognitive model of psychotherapy was presented. This format made sense to the patient, and he agreed to initially discuss anxiety-provoking situations. He described several encounters at neighborhood functions and at his local tavern. When faced with a new acquaintance and time for conversation, he identified feelings of "conspicuousness and nervousness." He was then asked to explore the automatic thoughts associated with these feelings. He initially noted that the feelings existed "on their own" and that he could not determine what thoughts were behind them. I explained that people sometimes become unaware of pervasive automatic thoughts, though they are generally retrievable. I asked him to imagine viewing himself from others' perspectives in these recent social situations. With some effort, he was able to identify thoughts that he "looked or behaved foolishly" and that he was "not capable of capturing someone's interest." When it was explained that his responsibility would be to learn ways to challenge these thoughts, he compared it to a military operation in which the goal is to "identify, attack, and destroy."

As the sessions progressed, the patient continued to identify situations that prompted awkward or uncomfortable feelings. With practice during sessions and in between via homework, he became adept at determining automatic thoughts related to his feelings. When the time came to "attack and destroy," he described the automatic thoughts as seeming "perfectly reasonable" when in the situations, but conspicuously erroneous when reviewed during sessions. He noted that therapy was his first opportunity to "bounce my thinking off someone else."

A particular recurring thought that the patient experienced was "I'll be rejected." He mulled over the implications of any "incorrect" interaction or attempt at conversation. He worried that others were waiting to reject him as soon as he made a wrong move. We discussed the implications of using a term such as "rejection" to describe any interaction that does not go ideally. We also tested his automatic thinking against reality, and he admitted that it was not likely that people were relishing an opportunity to reject him. He began to realize that his method of thinking might be interfering with social success. He agreed to try entering social situations with a more optimistic approach and to be more accepting of those interactions that do not go well.

With newfound confidence, the patient began to apply his therapy to real life situations. He noticed a gradual reversal of his previous trend toward isolation. He accepted more invitations to social gatherings and even began volunteering at a local hospital. By his sixth session, he felt comfortable enough with his progress that he agreed to lengthen the time between sessions. He returned in 2 weeks for his seventh session and then returned 1 month later for his eighth session. At that point, he expressed enhanced confidence in his ability to make connections with people. He also remarked that he no longer considered himself "rejected" or a failure if he was unable to connect with an individual. As his improvement had continued with less frequent sessions, he agreed that his acute course of psychotherapy was complete. The clinic telephone number was given for him to call if he felt the need for any "brush-up" sessions in the future.

COMMENT

In summary, the patient went several years without being aware of his social anxiety. When life circumstances changed, this anxiety became severe enough to prompt him to get help. During therapy, he worked to uncover recurring thoughts that guided his uncomfortable feelings. Through "reality testing" and redefining of terms, he became comfortable approaching social situations with a new perspective. With practice, this new perspective yielded a decrease in overall social anxiety and allowed him to feel capable of functioning well.