

Discussion

Psychotherapy in the Overall Management Strategy for Social Anxiety Disorder

Professor Nutt: The educational system in the United States encourages children to talk at an early age: the “show and tell” approach. Is there evidence that this kind of education may be helping overall? The rates of social phobia seem somewhat lower here.

Dr. Beidel: The approach may help those who are in the middle, the “slow to warm-up” child or the “just a little shy” child. Short exposures like a 2–3 minute “show and tell” that must be done a number of times might be especially helpful. For those who have an extreme fear, however, short bursts of exposure could do more harm than good. The one fact that we know is that, when fear increases, social phobics escape from the situation. Marks has shown clearly that escaping before habituation makes the fear worse. We suggest leadership courses or groups called Toast Masters, as a maintenance strategy for adults with normal public speaking anxiety. These are not people who are quitting their jobs because of their public speaking fear.

Professor Nutt: I have trouble getting any social phobics to go to groups. Many of my patients say they will do anything but group therapy. How do you deal with that?

Dr. Beidel: First, we explain to them that we understand that being in front of the group is one of the things they fear, but that they are going to meet with other people who feel just as miserable as they do in that situation. Second, our groups are aimed at giving them skills that they can learn rather than sitting around, talking, and revealing their deepest, darkest fears. The groups are very structured with specific goals. Some 20% of our people refuse to have anything to do with the group, but their concern is more an issue of confidentiality.

Social phobics spend so much time hiding. Marks had the most useful distinction I ever heard—agoraphobia is fear of a crowd and social phobia is fear of the people who make up the crowd. They are afraid of the other people. If we tell them that it is a small group, that they are not going to be asked to get up and give a speech, and that it is different from any group that they have seen on television or in the news as far as psychotherapy goes, they seem willing to try. Once they get there the first day, they seem hooked into it, and a lot of our groups have stayed together afterward.

Dr. Davidson: I suspect you do something that you are not mentioning that has been shown to affect compliance, that is, give a rationale for the value of the activity. I am

sure you explain, “Well, it’s only a group, and we can practice this,” and they think, “I guess I have to go to group because it’s the only way I can actually have these situations.” We do that.

Dr. Beidel: Yes, so do we, although we do not say that it is only a group because we also have individual sessions. We say the group is a very important part.

Dr. Ono: In Japan, maureta therapy is available for people who have sensitivity interpersonal interaction. These people get together all over the country in a large number of small self-help groups, led by the patients themselves, not the physicians.

Dr. Ballenger: In the modern day, what happens in a maureta group?

Dr. Ono: They talk; they exchange their experiences about how to overcome the intrapersonal situations and manage these situations.

Dr. Ballenger: What we in the United States would call a support group?

Professor Lecrubier: Yes, but there is a connotation of getting more resources. There is a sort of moral restoration that may lead to hierarchy. To what extent the doctor is the hierarchical person, just allowing these people to reintroduce into society in a place acceptable for others is uncertain. That is very intuitive, but something around this that I do not understand very well is probably very important.

Professor Nutt: It raises the interesting point that many of these patients are phobic of doctors and that psychologists may be seen as less male or threatening or traditional. I wonder if the entry ought to be even lower, possibly patients themselves? If the first approach was to a patient group, would that encourage more people to enter treatment?

Dr. Beidel: The one time in Pittsburgh that we were able to get the newspaper to do a feature on social phobia and interview patients about the condition—what they felt like and what treatment had been like—the phone did not stop ringing for about a week. For many, it was hearing other people talking about real problems that made them pick up the phone and call. It was more effective than placing advertisements in the paper.

Professor Lecrubier: What comes to my mind is that, in terms of animal models, another property of antidepressants is to restore hierarchy.

Dr. Davidson: Social phobia is a confusion about one’s place in the social hierarchy.

Dr. Westenberg: The relationship between social phobia and separation is evident in an animal model. Because animals that are high in hierarchy have better access to sources of food and water, they leave their offspring alone for a short period of time, the separation anxiety is less in animals who are high in hierarchy than in those who are low in hierarchy. Data show that this relates to 5-HT functioning in these animals and that it can be restored with SSRIs.

Dr. Nutt: No one has talked about rational emotive therapy.

Dr. Beidel: It is now considered more under general cognitive-behavioral group therapy. In rational emotive therapy, you had what was called the ABCs: the antecedent of the behavior, the behavior itself, and then the consequence. Ellis called it “musturbation”: “I must be perfect.” It involved disputing that “must” behavior he talked about, so I think it is a kinder, gentler form of cognitive behavior.

Professor Nutt: Is it available as a private therapy?

Dr. Beidel: Ellis still runs an institute here in New York but now he calls it rational cognitive emotional therapy. The title has changed.