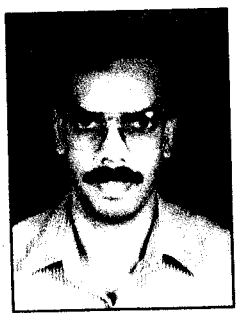

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NAGEMENT OF SOCIAL PHOBIA

ppreciation of the high prevalence and morbid ilse of social phobia underscores the need for ve management. Early intervention may help to impairment, development of harmful coping gies, and onset of co-morbid conditions. Aim of ment is to enable participation in desired social ities and improve occupational and interpersonal ioning. Both pharmacological and psychological apies have proven effective.

rmacotherapy

e specific goals of pharmacotherapy are to :

- Relieve painful affect and cognitions.
- Reduce anticipatory anxiety.
- Reduce avoidance behaviour.
- Reduce autonomic and physiologic symptoms of arousal and anxiety.
- And produce a concomitant improvement in the disability and quality of life.

MAOI

The irreversible MAOI phenelzine in a dose of 60-90mg per day has been studied in double-blind cross over study in the treatment of social phobia by at least 3 groups in 200 subjects. Positive response was reported in 65-75[1]% of cases. The main limiting factor is interaction with tyramine containing food and sympathomimetics as well as the presence of side-effects including insomnia, weight gain and sexual dysfunction. Moclobemide is a reversible MAOI. A recent trial by Schneider et al.[2] reported efficacy (17.5%) equal to placebo (13.5%). Brofaromine is another reversible MAOI whose efficacy was 50% compared with 19% in placebo group[3] (Lott et al, 1997). It is more promising than moclobemide.

Specific Serotonin Re-uptake Inhibitors

Three large multicentre, placebo controlled, clinical trials involving more than 800 patients with paroxetine in a dose ranging from 20-50 mg/day over 12 weeks reported significant improvement[4]. It is used as a first-line treatment with promising results. Sertraline in a flexible dose (50-200/day) cross over design study comprising 100 patients[5] reported 50% response compared with placebo rate of 9%. In a 12 weeks placebo controlled trial of fluvoxamine (150mg/day) 46% response is reported compared with 7% receiving

Sertraline shows 50% efficacy in social phobia while placebo shows 9%.

placebo[6]. Fluoxetine[7], Citalopram and venlafaxine[6] which posses both serotonergic and non-adrenergic properties are also effective but well controlled studies are lacking.

Benzodiazepines

High potency benzodiazepines have also demonstrated good treatment efficacy. Alprazolam was compared with phenelzine and CBGT in a placebo controlled study of 65 subjects. The response rate was 38% compared with 28% for placebo[9]. A more robust response rate is reported with clonazepam in a placebo controlled trial in 75 subjects with SP which was 78% compared with placebo rate of 20%[10]. Over all clonazepam is better than alprazolam in the treatment of SP.

Beta-blockers

It is effective only for controlling the autonomic symptoms associated with arousal and anxiety. This is supported by the findings of a placebo controlled comparison of atenolol and phenelzine in 74 patients with SP in which efficacy was equal to placebo.

Maintenance treatment and relapse

A full response to pharmacotherapy may take 2-3 months or more although benzodiazepines may decrease anxiety within the first 1-2 weeks of treatment. If there is response, continue treatment for minimum 12 months before discontinuing medication[11]. Most patients seem to benefit even for years of continued treatment but relapse rates are high after drug discontinuation; 74% for clonazepam responders[10] and up to 90% of initial moclobemide responders[12] experienced relapse.

Augmentation and Switching

There is lack of systematic data in this area. Augmentation of first-line treatment or combination treatment may be attempted prior to switching treatment. Addition of benzodiazepine to an antidepressant or vice versa, may benefit some patients[7] Van Ameringe reported efficacy with bupropion augmentation in patient with partial or inadequate response with SSRI alone SSRI and MAOI should not be combined and a wash out period is required before a switch between thes two class of drugs. If patient does not benefit from on class of drug he may respond to another. If there is n response with established agents, less well studie alternatives such as buspirone, bupropion and clonidin may be considered.

Physiological treatments

Cognitive behaviour therapy

It targets all the different components of anxiety suc as physiological activation, negative predictions expectations about social consequences and escap or avoidance behaviour. It is short term, sympton focussed and reduces the sense of uncontrollability t the feared situation. The key factor is exposure Exposure can be graded, intensive such as flooding in-vivo or imaginal. In in-vivo exposure, the phobi situation is difficult to reproduce in real life, whereas i imaginal exposure any situation can be crafte depending on the subjects imagination. Before doin the procedure the therapist has to educate the patien about the nature of illness, nature of treatment, and th patient has to do homework assignments.

In CBT the mechanism of improvement is by tw principles.

1. Habituation-repeated confrontation with a phobi stimulus without negative consequences leads t reduction in the reactivity to the stimulus.

2. Change in the individuals interpretation about a situation with disconfirming information[13].

Anxiety management techniques such as relaxation breathing training and attention focussing will help th individual to feel more comfortable in stressful situatio

and facilitates exposure. Cognitive restructuring will help to identify, challenge and change negative beliefs. It is effective for correcting the fear of negative evaluation by others and negative evaluation of the performance by the subject.

Cognitive behaviour group therapy

It is group therapy with the basic principles of CBT for a group of 6 patients balanced for age, sex, type of feared stimuli and degrees of impairment. It is led by one male and one female therapist consisting of 12-15 sessions, each lasting for $2^{1/2}$ hrs. Simulated exposure, cognitive restructuring and homework assignments are important components[13].

Social effectiveness therapy

SET will correct deficient social skills as a result of long history of social isolation. Key component in social skill training which is particularly useful generalised type of phobia. SET is done in group setting along with individual sessions of exposure. SET teaches social environment awareness by helping to contexualise social interaction. In homework sessions individual has to practice social skills and flexibility exercises, which will help the patient to think in a more dimensional way. Group might discuss, when, why and how to initiate and terminate conversations. Interpersonal skills, verbal and non-verbal skills are also taught[13].

Efficacy of psychological treatments

Efficacy of psychological treatments for patients with SP has been clearly documented although quantity of studies are somewhat smaller than other anxiety disorders. In several studies, exposure treatment alone has been demonstrated to be more effective than a psychological placebo[14,15]. A recently completed 2 site study compared CBGT with phenelzine, pill placebo and psychological placebo (expressive/support) in 133 patients for 12 weeks. Both CBGT and phenelzine (75%) was better than placebo (35%). In the same study phenelzine showed rapid effect but effect became equal to CBGT after 12 weeks. In the same study relapse rate with CBGT was lower than with phenelzine. A meta analysis comparing CBT with pharmacological treatment in 24 different studies by Gould & colleagues[16] could not find any significant difference between these two therapies. A 5-7 year follow up study of patients who received CBGT is the longest reported to date, showed good improvement with CBGT[7]. The efficacy of combing pharmacotherapy with psychological therapy has been found to be clinically very useful but studies focussing on this issue are lacking.

Conclusions

Both pharmacological and cognitive behavioural treatments have been found to be effective over the short term. Long-term follow-up data are lacking. Although symptoms seem to occur frequently after discontinuation of pharmacotherapy, CBT may produce more enduring improvements. A combination of pharmacotherapy and CBT may provide optimal effectiveness. Psychosocial treatments although free from attendant side-effects are not widely applied in the existing health care systems of many countries. Well designed, controlled, comparison studies are needed to establish the efficacy, indication, duration and cost effectiveness of different modalities - alone or in combination for the treatment of social phobia.

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ERRATUM

"April 2000"was misprinted in place of "July 2000" on the page "From the editors' desk"