



## What are the Relative Merits of Benzodiazepines Taken as Needed vs Regular Dosing in Cases of Social Anxiety Disorder?

My patient is a woman, aged 55 years, with a long history of social phobia that partially responded to treatment with sertraline 150 mg daily. Her social anxiety worsened recently, after she was fired from her job. She has been staying at home, is very fearful of job interviews, is avoiding social occasions, and is now reluctant to go to the grocery store. Cognitive therapy has not helped a great deal, and she is too anxious to attempt its behavioural exposure component. Does it make sense to give her lorazepam to be taken as needed before attempting each exposure? Or should I use a longer-acting benzodiazepine on a regular basis? If so, what medication would you suggest, and how long should I continue it?

Unfortunately, there is little available evidence to guide the use of benzodiazepines in treating social phobia, either as a primary treatment or as an adjunct. There is no doubt that social fears and avoidance can be reduced by the administration of low-dosage benzodiazepines taken just before a predictable event. Placebo-controlled trials have shown that clonazepam effectively reduces social fears and avoidance. However, the average dosage was 2.5 mg daily, and at this level, clonazepam may cause sedation and motor impairment.

If social anxiety occurs infrequently, benzodiazepines taken as needed can be very helpful. In the case described, the social anxiety disorder appears to be generalized and accompanied by significant avoidance and disability. I would not advise benzodiazepines taken as needed in this situation, since the frequency of the anxiety episodes is probably high.

The approach to treatment should be two-pronged. In managing this patient's medication, the first step is to address the antidepressant dosage. She is already taking a selective serotonin reuptake inhibitor (SSRI) indicated for the treatment of social phobia (sertraline 150 mg daily). If she can tolerate an increase in the dosage, she may benefit over two to four weeks. Alternatively, she could be switched to another approved SSRI or a serotonin norepinephrin reuptake inhibitor.

It is important to address the avoidance quickly, so that this patient has a good chance of returning to the workforce. In her case, it is reasonable to offer a treatment regimen including a low-dosage benzodiazepine (usually clonazepam 0.5 mg twice daily) in the context of a behavioural program.

There is no information about this patient's previous experience with benzodiazepines, alcohol or other substances leading to potential dependence. Assuming that she is not at high risk for developing dependence, I would discuss the use of clonazepam with her and stress the need to take it regularly, avoiding as-needed dosing. It has to be clear from the outset that clonazepam is a temporary agent that will be faded as the antidepressant changes make a difference and as she increases her tolerance of feared situations.

I would have this patient keep a daily diary of her activities, so that avoidance can be clearly identified and quantified. At the next appointment, I would review both her response to the medication changes and her activity diary. Assuming that she is still experiencing avoidance, I would have her set activity (exposure) goals, both for the next week and for the long term. Her homework would consist of daily exposure to graded feared situations. It is essential to get this particular patient out of the house at least daily. Appointments should be spaced, ideally weekly and at the most biweekly, until she is fully mobile.

It has been shown that the people at greatest risk for continuation of benzodiazepines are elderly women with anxiety and depression. At each session, it is essential to review the reduction of clonazepam.

## Suggested Reading

1. Otto MW, Pollack MH, Gould RA, Worthington JJ 3rd, McArdle ET, Rosenbaum JF. A comparison of the efficacy of clonazepam and cognitive-behavioral group therapy for the treatment of social phobia. *J Anxiety Disord* 2000;14:345-58.
2. Antony MM, Swinson RP. Phobic disorders and panic in adults: a guide to assessment and treatment. Washington (DC): American Psychological Association; 2000. p 265-86.

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