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Original article

A pilot study of clonazepam versus psychodynamic group therapy plus clonazepam in the treatment of generalized social anxiety disorder

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Abstract

Background. — Both psychodynamic group therapy (PGT) and clonazepam are used as treatment strategies in reducing symptoms of generalized social anxiety disorder (GSAD). However, many individuals remain symptomatic after treatment with PGT or clonazepam.

Method. — Fifty-eight adult outpatients with a diagnosis of GSAD according to DSM-IV were randomized to 12 weeks PGT plus clonazepam or clonazepam. The Clinical Global Impression-Improvement (CGI-I) Scale was the primary efficacy measure. Secondary efficacy measures included the Liebowitz Social Anxiety Scale (LSAS) total score, the World Health Organization Instrument to Assess Quality of Life—Brief (WHOQOL-Bref) Scale and the Beck Depression Inventory (BDI).

Results. — CGI-I data from 57 patients (intent-to-treat population) showed that patients who received PGT plus clonazepam presented significantly greater improvement than those who received clonazepam ($P = 0.033$). There were no significant differences between the two groups in the secondary efficacy measures.

Conclusions. — Our study suggests that the combination of PGT with clonazepam may be a promising strategy for the treatment of GSAD, regarding gains in the global functioning. However the present study failed to detect more specific changes in social anxiety symptomatology between the two groups.

Keywords: Anxiety disorders; Social anxiety disorder; Social phobia; Psychodynamic therapy; Treatment; Anxiolytics

1. Introduction

Treatment strategies for social anxiety disorder (SAD) have focused on psychotherapy and pharmacotherapy [49,51]. Controlled trials and meta-analyses suggest similar benefits from both psychological, mainly cognitive-behavioral therapy (CBT), and pharmacological [25,27,60] in the short-term treatment of SAD. Monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, noradrenergic agents and the high-potency benzodiazepines, clonazepam and bromazepam have demonstrated efficacy for SAD [7,48].

To date, most clinical trials of psychotherapy have used CBT [16,17,28,50] and interpersonal therapy (IPT) [40,41] as the experimental intervention. Very little empirical work has been conducted using other psychotherapy approaches [1,20,36,37,41]. More systematic research using therapy modalities other than CBT is needed in generalized SAD

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(GSAD) because many patients achieve only partial decrease in symptoms or experience recurrence of symptoms in long-term follow-up [16,41].

Most of what is known about psychoanalytic treatment for GSAD comes from case reports or uncontrolled studies [21,31,35,55]. Although psychodynamic psychotherapy has been shown in other disorders [8,34,43,45,59], there is only one published study suggesting its efficacy in GSAD [33]. In a recent study 30 patients were randomized to psychodynamic group therapy (PGT) or to a control group for 12 weeks in order to evaluate the efficacy of PGT. The control group consisted of an educational supportive psychotherapy group previously used by Heimberg et al. [27] to examine the efficacy of group CBT. At the end of the study, patients randomized to PGT were rated as more improved than controls in one of the efficacy measures, with an effect size for the interaction term in the ANOVA of 0.1 (Partial Eta Squared; $P = 0.036$), considered a medium effect size, suggesting that PGT may be a possible alternative to CBT or IPT for patients with GSAD [33].

Despite the efficacy of both psychotherapy and medication, only two thirds of patients who receive these treatments are considered responders, only half of those are considered remitters and most patients remain symptomatic after the initial treatment [28,38,46]. However, in contrast with the vast literature in the treatment of major depressive disorder (MDD), to date only a few studies have focused on how to augment treatment response on GSAD. The present study was designed to compare the efficacy of PGT plus clonazepam versus clonazepam in the treatment of GSAD. We chose clonazepam based on the promising results of prior studies [14,29,46,52,57], as well as relapse prevention effects with long-term clonazepam treatment in SAD [9].

2. Method

2.1. Study design

This was a randomized, 12-week study of PGT plus clonazepam versus clonazepam in 58 adult outpatients of the Anxiety Program of Hospital de Clínicas de Porto Alegre (HCPA), Brazil, who met the DSM-IV [2] criteria for GSAD as determined by the Mini International Neuropsychiatric Interview (MINI)—Portuguese Version 5.0 [3]. The study was approved by the Institutional Review Board (IRB) of HCPA. All subjects provided written informed consent prior to their enrollment in the study.

2.2. Prestudy procedures

The trial was conducted between March 2005 and November 2005. Participants were recruited from clinical referrals and media advertisements. Patients referred to the study were assessed by two psychiatrists with expertise in SAD to determine eligibility and willingness to participate. The assessment included a psychiatric history and the MINI [3]. Eligible subjects were randomly assigned to receive PGT plus clonazepam or clonazepam alone using a list of random numbers provided by a statistician not otherwise involved in the clinical trial. Randomization was stratified by symptoms severity using a cut off score of 82 in the Liebowitz Social Anxiety Scale (LSAS) total score [39], as suggested by prior studies [44]. After randomization, patients were scheduled for the pretreatment (i.e., baseline) assessment.

2.3. Patient sample

2.3.1. Inclusion criteria

Outpatients, 18–65 years old, who met DSM-IV criteria for primary diagnosis of GSAD for at least 2 years, and had a baseline LSAS of at least 55, with fear and/or avoidance in $\geq$4 social situations (at least 2 involving interpersonal interactions).

2.3.2. Exclusion criteria

A history of failure to respond to 2 mg of clonazepam taken for at least 12 weeks, hypersensitivity to benzodiazepines, prior or current psychotherapy for SAD (regardless of response); current comorbid anxiety disorders whose symptoms were more severe than those of SAD, a depressive episode (Beck Depression Inventory (BDI) $\geq$30), or suicide risk, in the previous 6 months, bipolar disorder or substance use disorder (except nicotine dependence); mental retardation or any neurological disease, use of psychotropic medications (including hypnotics) in the 4 weeks prior to the study, and women breastfeeding, pregnant or unwilling or unable to take adequate contraceptive precautions.

2.4. Treatments

2.4.1. Clonazepam treatment

Pharmacologic treatment consisted of individual 20-min visits in weeks 1, 2, 4, 6, 8 and 10. Patient adherence to the medication regimen was measured by pill count.

No systematic psychotherapeutic interventions (cognitive, behavioral or interpersonal) were delivered during the visits. Clonazepam regimen was started at an initial dose of 0.5 mg taken twice a day in the first week. The dose could be increased to up 1.0 mg taken twice a day in weeks 2–12 to maximize response. Dose reduction was allowed if necessary to improve tolerability (0.5 mg/day and 1 mg/day were considered minimum doses in week 1 and in weeks 2–12 respectively). At the end of the treatment period clonazepam was gradually discontinued using a fixed-dose taper of 0.25 mg/day every 2 weeks. Therefore, 16 weeks were required to taper off patients receiving the maximum dose of 2.0 mg/day. Safety assessments were based on reports of adverse events (possible adverse effects were monitored).

2.4.2. PGT and clonazepam treatment

The PGT intervention consisted of 12 weekly 90-min group sessions using a treatment manual (available from Dr. Knijnik upon request) developed for a previous randomized trial of PGT versus educational supportive psychotherapy group