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Clinical Cases

Drugs for the Shy?

Physicians should encourage patients who show signs of social phobias to continue the therapy process to understand the symptoms and causes and not only rely on medications that mask the symptoms.

Commentary by Jeremy A. Lazarus, MD

Learning Objective Understand the principal ethical arguments concerning prescription of psychoactive drugs.

Jonathan Parker was brought to Dr. Reiser, a psychiatrist, by his mother. Mrs. Parker said that Jonathan, aged 22, lived at home with her and his father and seldom left the house alone. He would socialize with his siblings and cousins, occasionally go to the movies with one of them or with his mother, and went to family gatherings and church. But, as Mrs. Parker told it, Jonathan never brought a friend to the house and, since completing his BS in computer science, had not been going out daily for school or work or anything else. He was pretty unhappy and had agreed to his mother's plea that he "get some help."

Jonathan had done well in school, had applied for a dozen or so jobs, and had been called in for several interviews. But he always returned home dejected, saying, "They're not going to call back." So far, he had been right.

Dr. Reiser accepted Jonathan as a patient and began seeing him once weekly. After 3 visits, he asked Jonathan whether he would agree to try one of a class of drugs known as SSRIs. Dr. Reiser wasn't certain it would help, but it had produced some good results in certain sociophobic patients. Jonathan agreed. Jonathan was bright, and, as he became more comfortable with Dr. Reiser, the psychiatrist could see Jonathan's mind at work, trying to understand the responses and feelings he had when he was alone with a stranger or in a social situation without his family members beside him.

After 3 months, Jonathan told Dr. Reiser that he felt ready to leave therapy. He had had a callback following an interview, and a job offer seemed likely. The drug was really working, Jonathan said. He and his family had talked about it and everyone was pleased. Jonathan said he wanted to continue on the prescription and stop therapy. Dr. Reiser opposed the idea, explaining that Jonathan's shyness had causes that would go undiscovered and unmanaged if he masked the symptoms with drugs. The psychiatrist preferred to continue the drug and "talk" therapies in tandem, so that they could get to the bottom of the shyness problem and eventually wean Jonathan from the drug. Jonathan said all he cared about was getting rid of the symptoms. Why did it matter what had caused the shyness if it had disappeared? Jonathan began to get angry. Once he had a job, he said, he wouldn't be able to take time off for the appointments. If Dr. Reiser wouldn't agree to prescribe the drug, Jonathan said, he'd find another doctor who would.

Commentary

This case raises several ethical questions, notably that of appropriate informed consent for treatment. Other questions to be considered are the conflicts between physician beneficence and patient autonomy and conflicts about the patient-physician treatment contract and alliance.

On initial evaluation, it appears that Jonathan had symptoms consistent with social anxiety, but without additional

information we would wonder whether he also had some underlying depressive disorder. We hope Dr. Reiser ruled out other more serious mental illness such as early schizophrenia or other psychotic disorders. Dr. Reiser would have wanted to be alert to the fact that the mother of a 22-year-old was making the initial contact and what that might mean for Jonathan's possible illness and symptoms (as well as its psychological meanings). For example, this could be related to Jonathan's "shyness" or could be symptomatic of more serious psychopathology.

In Dr. Reiser's assessment, he would need to determine whether Jonathan had some minimal symptoms of "shyness" or whether it caused him serious problems socially because of extensive inhibition of his activities with others. This might also help him to determine the timing of a therapeutic trial with medications versus an extended trial of more supportive or other psychotherapy. Jonathan's preferences in treatment would also be very important because many patients might be concerned about the meaning of taking medications of any sort. It would be important for Dr. Reiser and Jonathan to discuss those issues early on in the evaluation.

With the probable diagnosis of social anxiety or depression, a trial of antidepressants would be warranted. In addition, Dr. Reiser may have felt that, on the basis of his evaluation, exploration of underlying psychological issues, such as those arising from Jonathan's development or family dynamics, was appropriate. For informed consent, if Dr. Reiser considered the primary diagnosis social anxiety, then he would need to inform Jonathan of the research and benefits of using SSRIs to treat that condition, as well as the potential side effects. He should also explain the type of psychotherapy that he is also recommending and its utility in Jonathan's situation. If Dr. Reiser believed that both treatments were necessary and he had reasonable scientific or clinical experience to warrant that recommendation, he should inform Jonathan about that early in treatment. Of course, he should also inform Jonathan of the potential length of treatment for both the medication and psychotherapy.

This would all be tempered by Dr. Reiser's assessment of the patient-physician alliance and the degree to which he should explain in greater or lesser detail any of these informed consent necessities.

Jonathan's dependency on his family and his mother's role in bringing him to Dr. Reiser might raise issues about confidentiality, although there is no mention that his mother wanted information or intruded in any way. If she did, Dr. Reiser would need to be cautious about sharing any information with her without a full release from Jonathan.

In this case, it is unclear whether it was the medication alone, the psychotherapy alone, the patient-physician relationship, or the combination that led to the clinical improvement. A reasonable ethical and parallel therapeutic course would be for Dr. Reiser to sensitively explain his best psychiatric advice to Jonathan and find a way to leave the door open for further psychotherapeutic treatment if Jonathan chose the medication-only course.

Dr. Reiser's emphasis on stronger advocacy for continuing with therapy to "get to the bottom of the shyness problem" should be reserved for a time when there is a reasonably clear justification for that advice. If Dr. Reiser continued as Jonathan wished, he would still be in a position to monitor Jonathan's response to medication, assure that there were no worsening symptoms and retain a good patient-physician relationship.

Any patient-physician relationship is a combination of science and art— establishing and maintaining the relationship —and balancing physician beneficence with patient autonomy. This is often a challenge. Being able to adjust within this conflict and to choose continuity of patient care would seem the best course. That is, of course, unless there is grave danger in the patient's not taking medical advice for ongoing psychotherapy. Dr. Reiser should draw a line on appropriate duration and frequency of follow-up, even if it is for the prescribing function alone. This would be important for ethical purposes in terms of reasonable observation of the patient's condition and for medico-legal reasons as well. If Dr. Reiser and Jonathan could agree on openness for continued treatment, should that be necessary, the best outcome would be achievable in this case.

Dr. Reiser could feel professionally that he had done a good job with Jonathan, offered to continue with the prescribing of medication and left the door open for further therapy. He would then be respecting the patient's autonomy while not relinquishing his obligation to provide his best medical advice.

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