Palliative and Supportive Care (2011), **9**, 103–105.

doi:10.1017/S1478951510000581

CASE REPORT

Social anxiety disorder as a hidden psychiatric comorbidity among cancer patients

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(RECEIVED April 18, 2010; ACCEPTED June 13, 2010)

ABSTRACT

Objective: Social anxiety disorder is one of the most popular psychiatric disorders in the general population and is also well known as a very common comorbid psychiatric disorder among patients with major depression. On the other hand, social anxiety disorder has been termed "the neglected anxiety disorder" because its diagnosis is often missed. Furthermore, the potential impact of social anxiety disorder on the psychological distress of cancer patients has not been reported.

Method: We encountered two cancer patients with refractory depression after cancer diagnosis, in whom comorbid social anxiety disorder was unexpectedly detected during a subsequent follow-up.

Results: To the best of our knowledge, this is the first report to discuss the potential impact of social anxiety disorder on cancer patients' distress. These two cases may help to improve our understanding of the complicated mental health problems of cancer patients and the potential influence of social anxiety disorder on patients' follow-up medical treatment.

Significance of results: Comorbid social anxiety disorder should be considered when a cancer patient's depression is resistant to treatment and the existence of communication problems between the patient and the medical staff is suspected.

KEYWORDS: Oncology, Depression, Social anxiety disorder, Comorbidity

INTRODUCTION

Social anxiety disorder is one of the most popular psychiatric disorders in the general population, and previous epidemiological studies have indicated that the lifetime prevalence of this disorder is >10% (Stein & Stein, 2008). Social anxiety disorder is also well-known as the most common comorbid psychiatric disorder among patients with major depression (Zimmerman & Chelminski, 2003). On the other hand, social anxiety disorder has been termed "the neglected anxiety disorder" because its diagnosis is often missed (Liebowitz, 1999).

We experienced two cancer patients who became depressed after being diagnosed with cancer and who did not respond to antidepressive treatment; comorbid social anxiety disorder was unexpectedly detected during a subsequent follow-up examination in both of these patients. To the best of our knowledge, the potential impact of social anxiety disorder on the distress of cancer patients has not been previously reported. Here, we report the two abovementioned cases in the hope of advancing our understanding of cancer patients' complicated mental health problems and the potential influence of

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social anxiety disorder on their follow-up medical treatment.

CASE REPORTS

Several items of personal information have been modified in the following case reports to preserve the anonymity of the patients.

Case 1

Ms. A was a 48-year-old single woman. She was diagnosed as having early-stage uterine cervical cancer (stage Ib) and received a surgical resection (extensive total resection of the uterus) and subsequent chemotherapy and radiotherapy over a 10-month period beginning in April X. She developed clinical depression in April X, mainly because of communication problems with her physician (She said, "I did not confide in my doctor and his words traumatized me"). She subsequently consulted a psychiatric clinic. Her depression fluctuated and finally led to a consultation with the psychiatry department of a general hospital 2.5 years after her cancer diagnosis, at which time her depression had worsened to major depression. Her depression gradually improved with antidepressive treatment and almost remitted after about 1.5 years. However, her depression relapsed despite continued treatment, when she experienced a bloody discharge 3 years after her initial consultation with our psychiatry department. Since then, her mental status has continued to fluctuate. Three years and nine months after her initial psychiatric consultation, she confided that she had always felt strong anxiety when she met her friends, and the presence of social anxiety disorder since her teens was unexpectedly detected through an additional diagnostic interview. The patient's total score on the Liebowitz Social Anxiety Scale (Heimberg et al., 1999) was 66, indicating moderately severe social anxiety disorder. Although she was supposed to participate in a group cognitive-behavioral therapy program for social anxiety disorder offered in our department, her depression (with atypical features such as an increase in appetite and leaden paralysis) worsened and she was admitted to an inpatient unit for the treatment of depression 4 years and 4 months after her initial psychiatric consultation. Although her depression improved after 10 weeks of inpatient treatment, it relapsed soon after discharge. Since her first admission, her depression has been refractory and fluctuating despite her participation in several pharmacological trials over the 7-year period since initial psychiatric consultation. She often claims that she feels depressed and fears several social situations, including medical follow-up visits to her oncologist.

Case 2

Ms. B was a 52-year-old housewife who lived with her husband and a son. She was diagnosed as having early-stage right breast cancer (stage IIb) and received a surgical resection (partial mastectomy and axillary lymph node resection), radiotherapy, and adjuvant chemotherapy over a 10-month period starting in March Y. Because she had refused hormonal therapy because of adverse effects, including hot flashes, and had continuous insomnia and appetite loss, she was referred to our psychiatry department approximately 1 year after her cancer diagnosis. She was diagnosed as having major depression, and pharmacotherapy with antidepressants was initiated. Her depression improved slightly but remained moderately severe. Five months after her initial psychiatric consultation, she reported that she felt extremely anxious when she thought about her son's forthcoming wedding ceremony. An additional diagnostic interview clarified that she had been experiencing strong performance fear and fear of social interaction since her childhood. She was subsequently diagnosed as having comorbid social anxiety disorder. Her total scores on the Social Interaction Anxiety Scale and Social Phobia scale (Mattick & Clarke, 1998) were 74 and 55 respectively, indicating severe social anxiety disorder. Although we recommended group psychotherapy for her social anxiety disorder, she declined to participate because the group situation was too burdensome for her in her current condition. Although she said that her social anxiety disorder did not influence her breast cancer care, she also said that she had difficulty talking with a medical staff member whom she felt was coercive. Her depression has also been refractory to several pharmacotherapy trials and has been ongoing for at least 20 months, despite psychiatric treatment. Her most recent Beck Depression Inventory-II [BDI-II] (Kojima et al., 2002) score was 44, indicating severe depression.

DISCUSSION

Both of the reported cases were cancer patients whose depression occurred after cancer diagnosis, and whose preexisting social anxiety disorder was detected serendipitously during clinical follow-up interviews conducted as a part of psycho-oncology care.

Although many studies have investigated depression among cancer patients, very few studies have focused on anxiety disorders among cancer patients (Stark & House, 2000; Stark et al., 2002). The cases reported here suggest that cancer patients with social anxiety disorder can develop refractory depression and may experience communication difficulties with medical staff, including their physicians.

Therefore, comorbid social anxiety disorder should be considered when a cancer patient's depression is resistant to treatment and communication problems exist between the patient and the medical staff.

Social anxiety disorder has an early onset in most patients and tends to manifest during adolescence (Stein & Stein, 2008). However, many patients do not receive therapy until a comorbid disorder is diagnosed later in life. Both pharmacologic therapies, especially selective serotonin reuptake inhibitors, and psychotherapeutic treatments such as cognitive-behavioral therapy, are effective. However, comorbid social anxiety disorder is a well-known risk factor for refractory depression (Souery et al., 2007; Rush et al., 2008).

Although patients with cancer are bound to have greater communication opportunities and needs, not only with the medical staff but also with their families, colleagues, neighbors, and others, and although pre-existing social anxiety disorder would undoubtedly render such communication difficult, the potential impact of social anxiety disorder on cancer patients has not been previously reported. Given the high prevalence of social anxiety disorder among cancer patients, as well as in the general population, more studies regarding social anxiety disorder, especially regarding the prevalence, early detection, and potential impact on medical communication, are urgently needed to enhance cancer patients' psychological well-being.

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