Social phobia in spasmodic torticollis

H Gündel, A Wolf, V Xidara, R Busch, A O Ceballos-Baumann

Abstract

Objectives—To study the prevalence of psychiatric comorbidity assessed by the use of a structured clinical interview in a large, representative sample of patients with spasmodic torticollis (ST) and to test the hypothesis that social phobia would be highly prevalent.

Methods—In a consecutive cohort of 116 patients with ST treated with botulinum toxin overall psychiatric comorbidity was studied prospectively with the structured clinical interview (SCID) for DSM-IV axis I disorders. Physical disability and psychosocial variables were also assessed with standardised self rating questionnaires.

Results—41.3% of the subjects met DSM-IV clinical criteria A-G for current social phobia as the primary psychiatric diagnosis. This figure rose to 56% including secondary and tertiary psychiatric diagnosis. There was no correlation between severity of disease (Tsui score, severity of pain, body image dissatisfaction score) and psychiatric comorbidity. The only significant predictor of psychiatric comorbidity was depressive coping behaviour (logistic regression analysis, p<0.01; OR=10.8). Compared with a representative sample of the general adult population, in the patients with ST the prevalence of clinically relevant social phobia is 10-fold, of mood disorders 2.4-fold, and of lifetime psychiatric comorbidity 2.6-fold increased.

Conclusions—A particularly high prevalence of social phobia was found in the cohort of patients with ST. The finding of a high prevalence of social phobia and depressive coping behaviour as the main predictor of psychiatric comorbidity may make a subgroup of patients with ST particularly amenable to specific psychotherapeutic interventions.

Keywords: cervical dystonia; psychiatric comorbidity; social phobia

Chronic disease is commonly complicated by psychiatric comorbidity. Social phobia as significant psychiatric comorbidity coexists with chronic organic conditions such as stuttering and essential tremor which, like ST, compromise social interaction and are exacerbated by stress. However, little is actually known about the nature of the psychiatric comorbidity in ST.

Instead, a fruitless debate as to whether ST is an organic or psychogenic condition has dominated the scientific approach to psychiatric issues in ST. The disease was once considered “neurotic” and psychosocially stressful life events before onset of the illness have been found repeatedly in 30%–50% of the patients studied.

On the other hand, early reports already described motor abnormalities in one third of the examined group of patients with ST, including 4% with parkinsonism. Likewise, Paterson et al suggested that the corpus striatum might be “congenitally weak” and predisposed to torticollis, but at the same time, reported that 16 out of 21 patients with ST in their series had a “shy anxious immature disposition”.

In other reports, psychosocial stress in ST has been studied empirically with the aid of standardised questionnaires. Meares reported that patients with ST who remitted had a significant higher score of neuroticism (Eysenck personality inventory) and anxiety (Taylor manifest anxiety scale) than the remainder. This author concluded that this group is amenable to psychiatric treatment. Matthews et al showed no deviation from the normal in premorbid personality in a group of 30 patients with ST and already drew attention to the severe psychological adverse effects of ST in that “fear of ridicule and reluctance to leave the home were almost universal”.

Nearly 54% of all patients with ST felt themselves observed and critically looked on by the public and had withdrawn from social activities. A model of depression in ST was developed according to which the social embarrassment associated with the sense of disfigurement and self depreciation resulting from the abnormal head position leads to social avoidance and depression. Indeed, a third of patients were moderately or severely depressed according to Beck depression inventory scores, twice as many as in a control group of patients with cervical spondylosis. Self depreciation was the most salient predictor for depression in torticollis.

In summary, the picture emerges that increased levels of psychosocial stress in patients with ST are primarily reactive and social withdrawal plays an important part.
However, psychiatric (DSM-IV) diagnoses were not assigned in previous reports because the subjects were examined primarily with self rating questionnaires. Therefore, the present study addresses the following question: What is the prevalence of psychiatric comorbidity assessed by the use of a structured clinical interview in a large, representative sample of patients with ST? With special regard to the above cited empirical findings and theoretical models of depression in ST, we hypothesised that social phobia and phobic avoidance would be highly prevalent based on findings in similar conditions such as essential tremor and stuttering.

Method

PATIENTS

We studied 116 consecutive patients with ST who were referred for botulinum toxin treatment. The interview started shortly after they received their botulinum toxin injections during the same visit. Inclusion criteria for patients with ST were a diagnosis compatible with primary cervical dystonia amenable to botulinum toxin treatment (no other known cause for the dystonia, no tardive dystonia). Additional inclusion criteria were age over 18 years, no history or present use of neuroleptic medication, and ability and willingness to participate in the study. Patients with secondary forms of dystonia, including a positive history of exposure to neuroleptic drugs, and those with other additional focal dystonias more prominent than the ST were excluded. Table 1 gives general sociodemographic information about the patients.

Of the 116 patients, nine (7.6%) refused to participate fully in the study and did not fill out the self rating scales. This group of patients did not differ significantly from the group of patients who participated fully in age, sex, duration, or severity (Tsui index) of ST, localised pain, or frequency or effectiveness of treatment with botulinum toxin. All patients gave their informed consent. The study was approved by the local ethics committee.

MEASURES

Neurological history taking including a standardised questionnaire and physical examinations (including Tsui score) were performed by a neurologist who was blind to the results of the clinical psychiatric interview.

Additionally, a version of the structured clinical interview for DSM-IV (SCID-I) was administered. The SCID interview covers most psychiatric diagnoses by specific questions concerning the diagnostic criteria. The reliability and validity of the SCID have been well documented. According to guidelines concerning interviewer qualifications and training, the clinically experienced interviewers attended a training course for the SCID-I interview technique run by a certified SCID trainer (HU Wittchen, Munich), or performed 10 supervised SCID interviews, or both. Patients were assessed blind to the results of the neurological examination. According to DSM-IV guidelines a distinction was made between current (disease manifest in the past 4 weeks) and lifetime (disease not manifest in the past 4 weeks) diagnoses. To qualify for the diagnosis of social phobia in DSM-IV, subjects have to meet criteria A to H. DSM-IV criterion H specifies that social anxiety may not be in association with a “medical illness factor”. The resulting formal assignment of patients with ST meeting DSM-IV criteria A-G, but not H, to the category of anxiety disorder not otherwise specified (300.00), still describes a psychiatric disorder, but it completely blurs the specific clinical situation. As proposed by other authors, we therefore modified DSM-IV criteria to permit a diagnosis of social phobia if only the “clinical” criteria A to G were met. As an indicator of the construct validity of this modified definition of social phobia, we compared social anxiety self ratings among patients with and without the modified social phobia diagnosis.

We compared the prevalence of psychiatric comorbidity in our study group with the current and lifetime prevalence of psychiatric disorders in a representative subsample of the older general population. This representative sample of the general adult population is described in detail elsewhere. Briefly, out of a sample (n=2524) which was randomly drawn from the general population and interviewed by a health research survey company, a smaller simple random, stratified subsample (n=483) was extracted and subjects were interviewed by psychiatically experienced clinicians (psychiatrists and clinical psychologists) according to DSM criteria. This sample was split according to age as one subsample aged 25–44 years (n=250) and another subsample aged 45–64 years (n=233).

An additional structured interview was developed for the purpose of taking the necessary history. The 41 items covered demographic variables, medical history, the course of the disease, previous treatments, and current neurological symptoms. Items were rated on binary scales, four point rating scales, or VAS scales. Patients assessed their body image dissatisfaction on a self rating VAS scale. Ratings were from 0 to 10, and higher values indicated greater body image dissatisfaction.

RATING SCALES

The following instruments were administered:

Table 1: General sociodemographic characteristics of a group of patients with spasmodic torticollis (n=116)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD) or %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at onset (y)</td>
<td>39.6 (14.8)</td>
</tr>
<tr>
<td>Age at initial visit (y)</td>
<td>51.5 (12.6)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>% Female</td>
<td>53.0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Basic level</td>
<td>56.0</td>
</tr>
<tr>
<td>College-preparatory (abitur)</td>
<td>20.7</td>
</tr>
<tr>
<td>Duration of illness (y)</td>
<td>23.3</td>
</tr>
<tr>
<td>Mean event in year before onset (%)</td>
<td>11.9 (11.3)</td>
</tr>
<tr>
<td>Life event in year before onset (%)</td>
<td>50.0</td>
</tr>
</tbody>
</table>
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and its German version.29

mented the reliability and validity of this scale

psychiatric symptoms. Research has docu-

provide a continuous measure of general

index (GSI). The GSI was used in our study to

do of psychiatric distress, the general symptomatic

item questionnaire assessing general psychiat-

The literature provides su

Higher scores are associated with greater
 pathology.

The Freiburger Fragebogen zur Krankheitsver-

Krankheitsverarbeitung (FKV-LIS)32 takes into account a

pathology. The optimal cut o

in their

Social phobia scale and social interaction anxiety scale

The social phobia scale (SPS) and social inter-

scale

Social phobia scale and social interaction anxiety

scale

The social phobia scale (SPS) and social inter-

The symptom checklist (SCL-90R)28 29 is a 90

item questionnaire assessing general psychiat-

ery that prohibits the diagnosis when applied to a patient with a

physical disability, we diagnosed 48 (41.3%; 95% CI 32.8–51.0) of this 58 (50%) patients of

the treatment seeking sample as having social phobia as primary psychiatric comorbidity. Conside-

ring secondary and tertiary psychiatric diagnosis, 56 (48%; 95% CI 39.2–57.6) patients acquired the diagnosis of social

phobia. Forty five of the 56 patients (80% of this diagnostic sample) with the current
diagnosis of social phobia reported that social

anxiety had first occurred after the onset of ST—that is, they were reactive.

This assessment/view is supported by the following data: (1) The self rating scale SPS and SIAS showed a higher score (t test for

independent samples: SPS p<0.001; SIAS p=0.07) in our study group than in a sample of

normal controls.39 (2) Self report measures for

the patients meeting modified DSM-IV criteria for social phobia were compared with those for

the patients who did not fulfill this diagnostic
criterion. The patients with an SCID diagnosis of social phobia scored significantly higher (for

both scales p<0.001) on the two specific measures of social phobia as those without that diagnosis.

The second most frequent current and

lifetime diagnoses were mood disorders, usu-

ally major depressive disorders (table 2). Of the

116 patients, 19 (16.4%; 95% CI 10.5–24.6) had a current diagnosis and—additionally to the current diagnosis—62 (53.4%; 95% CI 44.0–62.4) a lifetime diagnosis of mood disor-
der.

Aside from the mentioned anxiety and mood disorders, there were two (1.7%) subjects with a current alcohol dependence and nine (7.6%) patients with current adjustment disorders. Concerning lifetime diagnosis, nine (7.8%) patients had a history of substance depend-
ence, 27 (23.3%) patients had a temporary adjustment disorder, and one (0.9%) patient had had an eating disorder.

Table 2  Frequency of psychiatric disorders (DSM-IV) in a group of patients with spasmodic torticollis (ST; n=116)

<table>
<thead>
<tr>
<th>DSM-IV diagnosis</th>
<th>Lifetime n</th>
<th>Lifetime %</th>
<th>Current n</th>
<th>Current %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders (total)</td>
<td>62</td>
<td>53.4</td>
<td>19</td>
<td>16.4</td>
</tr>
<tr>
<td>Major depressive disorder (with or without melancholic features) (296.2x)</td>
<td>53</td>
<td>45.7</td>
<td>15</td>
<td>12.9</td>
</tr>
<tr>
<td>Dysthmic disorder (300.4)</td>
<td>3</td>
<td>2.6</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Major depressive disorder (bipolar or recurrent) (296.3x)</td>
<td>9</td>
<td>7.8</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Anxiety disorders (total)</td>
<td>97</td>
<td>83.6</td>
<td>58</td>
<td>50.0</td>
</tr>
<tr>
<td>Panic disorder with or without agoraphobia (300.21 / 300.01)</td>
<td>8</td>
<td>6.9</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Agoraphobia without history of panic disorder (300.22)</td>
<td>9</td>
<td>7.8</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Social phobia (300.23)</td>
<td>82</td>
<td>70.7</td>
<td>48</td>
<td>41.3</td>
</tr>
<tr>
<td>Posttraumatic stress disorder (309.81)</td>
<td>6</td>
<td>5.2</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Specific phobia (300.29)</td>
<td>13</td>
<td>11.2</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Alcohol and other substance dependence (303.90; 305.00; ...)</td>
<td>9</td>
<td>7.8</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Eating disorders (307.1)</td>
<td>1</td>
<td>0.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment disorders (309.xx)</td>
<td>27</td>
<td>23.3</td>
<td>9</td>
<td>7.8</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>10</td>
<td>8.6</td>
<td>28</td>
<td>24.1</td>
</tr>
</tbody>
</table>
Table 3  Prevalence(%) of the most frequent psychiatric diagnoses in patients with spasmodic torticollis (ST; n=116) compared with the corresponding prevalence in a representative sample of the general population (n=483) (χ² test, df=1)

<table>
<thead>
<tr>
<th></th>
<th>Current ST patients</th>
<th>Current represent. sample</th>
<th>p Value</th>
<th>Lifetime ST patients</th>
<th>Lifetime represent. sample</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No diagnosis</td>
<td>24.1</td>
<td>85.4</td>
<td>0.000</td>
<td>8.6</td>
<td>65.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>16.4</td>
<td>6.9</td>
<td>0.001</td>
<td>53.4</td>
<td>13.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Major depressive disorder (296.2/3)</td>
<td>15.5</td>
<td>3.0</td>
<td>0.000</td>
<td>52.6</td>
<td>9.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>50.0</td>
<td>8.1</td>
<td>0.000</td>
<td>53.6</td>
<td>14.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Social phobia (300.23)</td>
<td>41.4</td>
<td>4.1</td>
<td>0.000</td>
<td>70.7</td>
<td>6.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Panic disorder with or without agoraphobia (300.21 / 300.01)</td>
<td>2.6</td>
<td>1.1</td>
<td>NS</td>
<td>6.9</td>
<td>2.8</td>
<td>&lt;0.03</td>
</tr>
<tr>
<td>Other</td>
<td>6.0</td>
<td>0.0</td>
<td>0.000</td>
<td>45.7</td>
<td>2.4</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

There were 43 patients (37%) with more than one psychiatric diagnosis. Thirteen patients (11.2%) had social phobia and affective disorder.

Comparison with epidemiological findings on psychiatric morbidity in the general population

Relative to the representative sample of the older German general population (range 45–65 years), there were significant differences (table 3). The prevalence of current social phobic syndrome in the ST group was 10-fold that in the general adult population. For current mood disorders the figure was 2.4-fold, and for the lifetime psychiatric comorbidity 2.6-fold. There were no significant differences in age and sex distribution (χ²; age p=0.19, sex p=0.91) compared with the representative subsample of the older general population.

Predictors of current psychiatric comorbidity and current social phobia

There was no significant relation between the objective measures of ST, in particular clinical severity (Tsui score) as rated by the neurologist, duration of illness, local pain, frequency of botulinum toxin administration, results of the botulinum toxin treatment, and psychiatric comorbidity (two tailed χ² or Student’s t tests, as appropriate; α=0.05). To investigate the predictors of current psychiatric comorbidity and current social phobia, a stepwise multiple regression analysis was calculated. Continuous variables were dichotomised by ROC analyses. Objective variables were education, marital status, severity (Tsui score), and extent (isolated pure rotational torticollis versus complex torticollis with adjacent dystonic involvement) of ST, frequency of botulinum toxin administration, duration of the illness (<5; ≥5 years). Subjective variables were pain (VAS 0–10); extent of psychopathology (SCL-90R mean general symptom index <0.5; ≥0.5); incriminating live event within the year before onset of disease yes/no; depressive coping (FKV subscore <22; ≥22); and extent of body image dissatisfaction (visual analogue score <5; ≥5).

The best predictors of current psychiatric comorbidity and social phobia were mostly subjective variables (personal views of the patients, chiefly depressive coping).

Depressive coping was the main predictor of current psychiatric comorbidity (p<0.01; odds ratio=10.8, 95% CI 3.0–40.1) and current social phobia (p<0.01; odds ratio=5.6, 95%CI 2.2–14.2). Other independent explanatory variables were for the prevalence of current psychiatric comorbidity, an incriminating life event in the 1 year period before the initial manifestation of ST (p<0.05; odds ratio=6.1, 95% CI 1.3–30.0), and for the diagnosis of social phobia the extent of body image dissatisfaction (p=0.05; odds ratio = 2.4, 95% CI 1.0–6.3).

Discussion

Our study on the prevalence of psychiatric comorbidity yielded two new findings. Firstly, over 75% of patients with ST had a psychiatric diagnosis when the study was conducted. Secondly, as predicted we found that more than 50% of the patients with ST fulfilled modified DSM-IV criteria for social phobia. Furthermore, there was a significant correlation between psychiatric comorbidity in accordance with the DSM-IV criteria and a depressive, maladaptive strategy for coping with ST, but not with an objective somatic variable indicating the severity of the disorder (Tsui score).

As a limitation of this study, only some potentially important psychosocial factors were measured in our sample. Thus, a more exhaustive list of psychosocial factors, including social support, personality, locus of control, and other personal outlook variables, may have disclosed an even more substantial association with psychiatric comorbidity.

The level (75.9%) of current psychiatric comorbidity in our patients with ST is considerably higher than the values that have been reported world wide in epidemiological studies on psychiatric morbidity in the general population.31 Here, the overall prevalence of psychiatric morbidity is between 29% and 34%.32 Even compared with the known high levels of psychiatric comorbidity seen in patients with chronic neurological disorders—for example, epilepsy and pseudoepilepsy (psychiatric comorbidity 65%) or migraine (psychiatric comorbidity 65%)—the level in the patients with ST seems high.33 34 Our most important finding is the high prevalence of social phobia in ST when this DSM-IV diagnosis was modified to permit a diagnosis of social phobia in patients with disfiguring or disabling physical conditions.35 36 In a recent short report37 on 44 consecutive patients with ST the authors reported current anxiety disorders in 18% (n=8), but did not comment on social phobia. The difference between our finding and that of this short report is unclear. Unfortunately, no information was provided on clinical details (for example, severity, treatment, duration of illness), definitions, and
Americans and non-hispanic whites in Los Angeles. *Arch Gen Psychiatry* 1987;44:687–94.


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