Surveillance report – Social anxiety disorder (2013) NICE guideline CG159

September 2015

Surveillance decision

We will not update the guideline at this time.

Reason for the decision

We found 16 new studies relevant to the guideline through the surveillance process.

We found new evidence on interventions for adults with social anxiety disorder, interventions for children and young people with social anxiety disorder and interventions that are not recommended to treat social anxiety disorder. Topic expert feedback suggested that the new evidence was unlikely to impact on the guideline recommendations.

We did not find any new evidence on the general principles of care in mental health and general medical settings, the identification and assessment of adults, the identification and assessment of children and young people and specific phobias.

None of the new evidence considered in surveillance of this guideline was thought to have an effect on current recommendations.

See ‘how we made the decision’ for further information.

Commentary on selected new evidence

With advice from topic experts we selected 2 studies for further commentary.

Interventions for adults with social anxiety disorder

We selected the randomised controlled trial by Dagoo et al. (2014) for a full commentary because it involves an emerging intervention and may potentially impact on recommendations in the future.

What the guideline recommends

The guideline recommends offering adults with social anxiety disorder individual cognitive behavioural therapy (CBT) that has been specifically developed to treat social anxiety disorder. It recommends that group CBT should not routinely be offered in preference to individual CBT.

The guideline also recommends that CBT-based supported self-help should be offered to those who decline CBT but wish to consider another psychological intervention.

For those who decline cognitive behavioural interventions and express a preference for pharmacological interventions, the guideline recommends discussing the reasons why and addressing any concerns the person has about such interventions. If the person wishes to receive a pharmacological intervention instead, the guideline recommends offering either escitalopram or sertraline (both are selective serotonin reuptake inhibitors).

Methods

Dagoo et al. (2014) conducted a randomised controlled trial that compared mobile cognitive behavioural therapy (mCBT) with mobile interpersonal psychotherapy (mIPT). Both were delivered via a smartphone and computer.

During 2011 and 2012, 52 adults (18 and over) who had a diagnosis of social anxiety disorder were recruited in Sweden. The diagnosis was made using the Mini International Neuropsychiatric Interview and the social anxiety disorder section of the research version of the Structured Clinical Interview for DSM-IV (SCID-I-RV).

The mCBT manual used was based on a previous guided self-help Internet-based CBT programme developed for people with social anxiety disorder. The intervention consisted of weekly text-based modules for 9 weeks. Participants were also given homework exercises to do between each module.

The mIPT was the same length and format as the mCBT intervention and was modified for viewing on a smartphone. However, the manual was based on evidence from interpersonal psychotherapy for depression. Participants had to work through the 4 areas of an IPT treatment during the 9 modules: grief, interpersonal disputes, role transitions and interpersonal sensitivity. Participants were also asked to contact a therapist each week and in between sessions reflect on their own work and the module materials.

The primary outcome was the Liebowitz Social Anxiety Scale – self rated (LSAS-SR). This measures the degree of avoidance and fear in 24 social situations.

Results

Paired sample t-tests were conducted to assess improvement from pre to post treatment within-groups and to compare post treatment and follow-up for the primary outcome.

At pre-treatment the mCBT and mIPT groups did not differ significantly on LSAS-SR score (mCBT: M 60.19 (SD=18.95): mIPT: M 65.72 (SD=27.15): $t(50)=-0.86$, not significant).

Both the mCBT and mIPT groups showed significant improvements in LSAS-SR score at pre/post-test

- mCBT: $t(24)=6.18$, p=0.001
- mIPT: $t(21)=2.75$, p=0.01.

Furthermore, within-group Cohen's effect sizes (Cohen's d) were large for mCBT (Cohen's d=0.99, confidence interval [CI] 0.58 to 1.39) and small for mIPT (Cohen's d=0.43, CI 0.09 to 0.77). The between-group effect size was

found to be moderate (Cohen's d=0.64, CI 0.06 to 1.22), with mCBT performing better than mIPT.

Between post-test and 3-month follow-up the results for both groups remained stable:

- mCBT: post-test M 38.21 (SD=24.50); follow-up M 39.75 (SD=24.87), t(21)=−0.74, p= 0.47
- mIPT: post-test M 57.21 (SD =28.24); follow-up M 59.00 (SD=28.84), t(14)=1.27, p=0.23).

At post treatment 55.6% of people in the mCBT group could be classified as responders while only 8% in the mIPT group could be classified as responders. This difference was statistically significant ($\chi^2(1)= 9.07$, p=0.04).

For secondary outcome measures, small between group effect sizes were found for both general anxiety (Cohen's d=0.46, 95% CI −0.10 to 1.03) and quality of life (Cohen's d=0.37, 95% CI −0.25 to 0.99). For depression, there was a large between-group effect size (Cohen's d=0.88, 95% CI 0.28 to 1.47).

Strengths and limitations

Strengths

The strengths of this study are:

- Details of randomisation and allocation concealment methods are provided. This means the study is at a low risk of selection bias and adds to the study's internal validity.
- A flow diagram of participant flow is provided. This allows attrition bias to be assessed.

Limitations

Limitations of this study are:

- The authors stated that no placebo control group was included as the study evaluated 2 active interventions.

- The small sample size was also highlighted by the authors. This could have resulted in low statistical power. This means we should interpret the findings with caution.
- The authors reported technical problems related to the use of the smartphone platform and interface. This meant most participants used a computer to get the treatments.
- The authors stated that no conclusions can be made about treatment credibility since there was no measure of this included.
- People who were suicidal, had secondary depression or who abused, or were dependent on, alcohol were not included. This makes it difficult to judge how easy it is apply the findings to a general clinical population – and to the guideline.
- The mCBT manual was based on an established model for social anxiety disorder. But the mIPT manual was not based on established methods for social anxiety disorder, so the findings may not be applicable to this population or to the guideline.

Impact on guideline

This study found that both CBT via mobile phone and guided self-help treatment based on interpersonal psychotherapy were effective for treating social anxiety disorder.

The guideline does not make recommendations on the use of mobile-phone-based interventions. Feedback from topic experts suggests that mobile phone technology is a creative way of delivering parts of a treatment package and may affect the guideline in the future. However, they also say that the population and interventions included in this study may not be applicable to the guideline. This is because the mIPT intervention was based on evidence from people with depression.

In addition, this study has a number of limitations and further evidence is needed before mobile phone CBT and guided self-help interventions can be considered for inclusion in the guideline.

Research recommendation: individual versus group CBT for children and young people with social anxiety disorder

We selected a randomised controlled trial by Ingul et al. (2014) for full commentary because it partly addresses a research recommendation and reinforces a current guideline recommendation.

What the guideline recommends

The guideline recommends offering children and young people with social anxiety disorder individual or group-based CBT focused on social anxiety. It says to consider involving parents and carers to ensure effective delivery of these interventions.

Methods

Ingul et al. (2014) conducted a randomised controlled trial comparing the effectiveness of:

- individual cognitive therapy
- group cognitive behaviour therapy
- an attentional placebo.

The study included 128 adolescents aged between 13 and 16 (mean age 14.5) with a primary diagnosis of social phobia. Adolescents being treated elsewhere for mental health conditions were excluded.

The manual for individual cognitive therapy was based on a developed model used for treating adults with social phobia. However the language, tempo and type of interventions were adapted for adolescents. The intervention consisted of 12 50-minute sessions.

The group-based CBT manual was based on an established manual for adolescents, but some elements were extracted from the Social Effectiveness Therapy for Children and Adolescents Program. The intervention consisted of 10 90-minute sessions.

The attentional placebo exposed participants to adult, peer and social attention through social activity, social interaction and social support in 10 90-minute sessions.

Assessments were conducted before and after treatment and at 12-month follow-up. The primary outcomes were:

- Assessment of symptoms of DSM-IV social phobia using the Social Phobia and Anxiety Inventory for Children (SPAI-C).
- Assessment of cognition using the Social Thoughts and Beliefs Scale (STABS).

Results

Paired-sample t-tests assessed the effects of the different treatments. Analysis of covariance (ANCOVA) with planned contrasts was used for between–condition comparisons.

For group CBT, no significant changes on either the SPAI-C or STABS were found from pre to post treatment. However, for individual cognitive therapy significant reductions were found from pre to post treatment on both the SPAI-C ($t(20)=8.47$, $p<0.001$) and STABS ($t(20)=8.12$, $p<0.001$) scales.

For group CBT, significant changes on the SPAI-C scale ($t(14)=2.45$, $p<0.05$) were identified at follow-up compared to pre-treatment. For the individual cognitive therapy group significant reductions for both the SPAI-C ($t(11)=4.04$, $p<0.01$) and STABS ($t(11)=3.64$, $p<0.01$) were found from pre–treatment to follow-up.

The attentional placebo results were only analysed at the end of treatment, not at 12–month follow-up. At the end of treatment, participants showed a significant reduction in symptoms on the SPAI-C ($t(14)=2.37$, $p<0.05$) and STABS scales ($t(13)=3.61$, $p<0.01$).

Planned contrasts found significant differences between the individual cognitive therapy group and those who had group CBT (SPAI-C $t(35)=6.34$, $p<0.001$; STABS $t(35)=4.18$, $p<0.001$). There were also significant differences

between the individual cognitive therapy and the attentional placebo groups (SPAI-C $t(32)=4.25$, $p<0.001$; STABS $t(32)=2.07$, $p<0.01$).

At 12–month follow-up, significant differences were found between the individual cognitive therapy group and those who had group CBT on the SPAI-C ($t(25)=2.22$, $p<0.05$) and STABS ($t(25)=2.59$, $p<0.05$) scales.

Strengths and limitations

Strengths

The strengths of this study are:

- Study assessors were blinded. This lowers the risk of detection bias. However, because no methods are provided to explain how the outcome assessment was blinded, we should interpret the results with caution.
- A flow diagram of participant flow is provided so attrition bias can be assessed.

Limitations

The study has several limitations that mean we should interpret the results with caution:

- Small sample size. This could have resulted in low statistical power.
- The authors state that a third of those completing treatment did not participate in follow–up. This may have inflated the results because it is likely that participants for whom the treatment was successful would show up.
- The authors note that the outcomes measuring change were based on self-reporting and clinical interviews.
- Little detailed information is provided on the lead therapists. This limits the applicability of the study to the guideline.
- No confidence intervals have been reported, meaning that there is insufficient reporting of results.

Impact on guideline

The study found that individual cognitive therapy was more effective for adolescents with social phobia than both group CBT and the attentional placebo. Currently, the guideline recommends offering individual or group CBT to children and young people with social anxiety disorder.

Feedback from topic experts suggest that this study was well–designed, with effect sizes similar to those found in studies using the Clark and Wells model in adults. They suggest that it may be useful in helping people to think about generic compared with specific approaches to social anxiety disorder treatment for children and young people.

However, the topic experts also highlighted that the group CBT intervention was based on a different module to that included in NICE CG159. If the study's results were to be applied to the guideline, they said more information would be needed on the lead therapists involved.

The study also has other limitations that may affect how applicable it is to the guideline and how the findings are interpreted. Furthermore it did not address the question in the research recommendation about cost–effectiveness.

Further evidence is needed to examine the effectiveness and cost–effectiveness of individual compared with group CBT for children and young people before specific recommendations can be made.

How we made the decision

We check our guidelines regularly to ensure they remain up to date. We based the decision on surveillance 2 years after the publication of Social anxiety disorder (2013) NICE guideline CG159.

For details of the process and update decisions that are available, see ensuring that published guidelines are current and accurate in 'Developing NICE guidelines: the manual'.

New evidence

We found 12 new studies in a search for randomised controlled trials. The search period covered studies published between 1 August 2011 and 18 February 2015. We also considered 4 additional studies identified by members of the Guideline Committee who originally worked on this guideline. From all sources, 16 studies were considered to be relevant to the guideline.

We also checked for relevant ongoing research, which will be evaluated again at the next surveillance review.

See appendix A: decision matrix for summaries and references for all new evidence considered in surveillance of this guideline.

Views of topic experts

We considered the views of the topic experts, including those who helped to develop the guideline.

Views of stakeholders

Stakeholders are consulted only if we decide not to update the guideline following checks at 4 and 8 years after publication. Because this was a 2-year surveillance review, and the decision was not to update, we did not consult on the decision.

See ensuring that published guidelines are current and accurate in 'Developing NICE guidelines: the manual' for more details on our consultation processes.

Date of next surveillance

Our next surveillance to decide whether the guideline should be updated is scheduled for 2017.

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