



Medicines Evidence Commentary

commentary on important new evidence from Medicines Awareness Weekly

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Treatment for adults with social anxiety disorder

A large UK systematic review and network meta-analysis in adults with social anxiety disorder found that individual cognitive behavioural therapy (CBT) was the only psychological intervention that showed a statistically significant benefit on outcomes compared with psychological placebo. Individual CBT also showed a statistically significant benefit compared with pill placebo, psychodynamic psychotherapy and other psychological therapies. For drug treatments, selective serotonin reuptake inhibitors (SSRIs) showed the most consistent evidence of benefit. SSRIs, serotonin noradrenaline reuptake inhibitors (SNRIs) and monoamine oxidase inhibitors were the only drug treatments that showed a statistically significant benefit compared with pill placebo. This study was commissioned by NICE in the development of its guideline on social anxiety disorder (see Study sponsorship below for details).

Overview and current advice

Social anxiety disorder is persistent fear of or anxiety about one or more social or performance situations that is out of proportion to the actual threat posed by the situation. Effective psychological and drug treatments for social anxiety disorder exist but may not be accessed due to poor recognition, inadequate assessment and limited awareness or availability of treatments.

The NICE guideline on [social anxiety disorder](#) recommends that for adults, initial treatment with individual cognitive behavioural therapy (CBT) that has been specifically developed to treat this condition should be offered. Group CBT should not be routinely offered in preference to individual CBT because it is not as clinically and cost-effective. CBT-based supported self-help should be offered to adults who decline CBT and wish to receive another psychological intervention.

NICE [recommends](#) that adults who decline cognitive behavioural interventions and express a preference for pharmacological intervention should be offered a selective serotonin reuptake inhibitor (SSRI, escitalopram or sertraline). Combining individual CBT with an SSRI may be considered for adults who have only a partial response to either treatment alone. Another SSRI (fluvoxamine or paroxetine) or a serotonin noradrenaline reuptake inhibitor (SNRI [venlafaxine]) may be considered for adults whose symptoms have not responded to escitalopram or sertraline, or who cannot tolerate the side effects. People should be monitored carefully for adverse reactions. The [NICE quality standard for anxiety disorders](#) recommends that people receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

See the [NICE Evidence topic page on social anxiety disorder](#) for a general overview of the condition. The NICE Pathway on [social anxiety disorder](#) brings together all related NICE guidance and associated products on the condition in a set of interactive topic-based diagrams.

New evidence

A UK [systematic review](#) and [network meta-analysis](#) considered which commonly-used drug and psychological interventions were most effective for the initial management of social anxiety disorder in adults¹. The authors of [this study](#) assessed 101 randomised controlled trials (duration 2–28 weeks) of 41 treatments (including control) in 13,164 adults (aged 18 years or older) with social anxiety disorder. Studies were identified from published or unpublished sources between 1988 and September 2013. At least 3 randomised controlled trials^{2–6} that were not included in the [NICE evidence review](#) for the NICE guideline on [social anxiety disorder](#) were included in this recent study; one of these³ was specifically [excluded](#) by the NICE evidence review because the main intervention was not considered to be eligible. Participants generally had severe and longstanding social anxiety in those studies that reported on this. Drug classes studied were SSRIs and SNRIs, monoamine oxidase inhibitors, benzodiazepines, anticonvulsants and the mirtazapine (noradrenaline and selective serotonin antagonist).

For the psychological interventions, individual CBT; group CBT; self-help with support, psychodynamic psychotherapy; and exposure and social skills had a statistically significant benefit on outcomes compared with patients on a waiting list (no treatment, not even placebo). However, no benefit was seen with exercise promotion or other psychological therapies (supportive therapy, mindfulness and interpersonal psychotherapy). Compared with patients on a waiting list, all drugs (including placebo pill) individually and by class, except for mirtazapine, had a [statistically significant](#) benefit on the various outcomes of social anxiety. However, data on mirtazapine were based on one small study in only 30 people.

Compared with placebo pill, the only drug classes that showed a statistically significant benefit on symptoms of social anxiety were SSRIs and SNRIs ([standardised mean difference](#) [SMD] –0.44, 95% [confidence interval](#) [CI] –0.67 to –0.22) and monoamine oxidase inhibitors (SMD –0.53, 95% CI –1.06 to –0.01). The most data were available for SSRIs and SNRIs. From the psychological interventions, only individual CBT showed a statistically significant benefit on outcomes compared with psychological placebo (SMD –0.56, 95% CI –1.00 to –0.11). Individual CBT also showed a statistically significant benefit on symptoms of social anxiety compared with pill placebo (SMD –0.72, 95% CI –1.13 to –0.30), psychodynamic psychotherapy (SMD –0.56, 95% CI –1.03 to –0.11) and other psychological therapies (SMD –0.82, 95% CI –1.41 to –0.24).

For the outcome of recovery from social anxiety, the results followed a similar pattern as symptoms. Again, the only drug classes that showed a statistically significant benefit compared with placebo pill were SSRIs and SNRIs (SMD 1.93, 95% CI 1.23 to 3.18) and monoamine oxidase inhibitors (SMD 2.08, 95% CI 1.01 to 5.26). As with symptoms of social anxiety, individual CBT showed a statistically significant benefit on recovery compared with psychological placebo (SMD 2.02, 95% CI 1.11 to 4.83). In addition, individual CBT also showed a statistically significant benefit on recovery compared with placebo pill (SMD 2.64, 95% CI 1.29 to 6.30), psychodynamic psychotherapy (SMD 2.04, 95% CI 1.10 to 5.09) and other psychological therapies (SMD 3.14, 95% CI 1.24 to 11.13).

Limitations include lack of long-term data and the poor quality of studies. Most were not registered, only a few were at low risk of bias, most outcomes were self-reported, and for several interventions there were only a few trials of moderate size. The authors concluded that individual CBT is associated with large effect sizes and should be regarded as the best intervention for the initial treatment of social

anxiety disorder. For individuals who decline psychological intervention, SSRIs show the most consistent evidence of benefit.

Commentary

Commentary provided by Louise Jackson, Chief Pharmacist, North Staffordshire Combined Healthcare NHS Trust; Member of [College of Mental Health Pharmacy](#)

This independent review evaluating both pharmacological and psychological interventions is welcome. Rarely are these two types of treatment intervention compared to support identification of the best treatment strategies for patients who may benefit from each type of intervention alone or in combination.

This network meta-analysis, reviewed published and unpublished data available over 25 years to September 2013 to identify the most effective acute treatment for social anxiety disorder. Most of the 101 studies were also included in [the analysis](#) carried out by the Guideline Development Group for the NICE guideline on social anxiety disorder that was published in 2013. As a result, the meta-analysis recommendation is consistent with the NICE guideline on social anxiety disorder, which recommends individual CBT for adults initially and SSRIs for adults who decline a psychological intervention or who have only partially responded to individual CBT.

A total of 17 classes of intervention for the treatment of social anxiety disorder were identified and studies were compared by class and individual interventions. Placebo or another medicine was usually the control in pharmacological studies and comparison to 'patients on the waiting list' was often the control for psychological interventions. Use of 'patients on a waiting list' as control group would not be the usual control for medicine studies.

To strengthen the evidence base, further studies are needed for this chronic condition over longer time periods and it would be useful to evaluate combined pharmacological and psychological interventions in addition to interventions alone.

Study sponsorship

The National Institute for Health and Care Excellence (NICE) commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop guidance for the identification and management of social anxiety disorder. NICE also approved funding for the Technical Support Unit to support NCCMH in undertaking a network meta-analysis of intervention studies. NICE had no further role in study design, data collection, data analysis, data interpretation or writing the report.

References

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