Discussion

How Is Recovery From Social Anxiety Disorder Defined?

Dr. Davidson: The Duke Brief Social Phobia Scale[1] is really an interview-based scale, although it has been converted by John Greist through an interactive voice response, so you could sit at a telephone and do your own rating. What we have developed in some 350 people from the Brief Social Phobia Scale is a self-rated version called the Social Phobia Inventory or the SPIN. Nothing is published yet. The SPIN screens those with and without social phobia to about a 90% level of accuracy. Marks has done something similar with his fear questionnaire, but these are the only 2 scales tested for their utility as screening instruments.

Professor Bobes: Yes, I agree with this procedure because we have to look for a way to find people with social phobia. Self-rated scales usually have a good sensitivity but lower specificity. I think we need to use complementary but different approaches.

Professor Lecrubier: I think you are addressing 2 very different questions. One is whether you can measure improvement induced by a drug. For that, you need a sensitive specific index. From what you describe, it is not that difficult.

The second is whether you can reach consensus on what you would consider an improved patient, an important question for this consensus meeting. As I understand it, you propose that there is no single instrument and we need to have improvement in 3 domains: symptoms, functionality, and a subjective assessment of well-being by the patient. I support the view that no single domain is sufficient for what we would like to call improvement. Recovery also involves stable improvement, which we have not discussed yet. I agree that these 3 domains are the major domains and patients should reach some level of absolute improvement in all of them. I would not call the last one quality of life because that is a different concept. I think it is self-assessment of the burden of the disorder or self-disability assessment. It is the subjective disappearance of disability and self-suffering due to the disease. Overall, I agree that these 3 domains should be taken into consideration.

Dr. Ballenger: We struggled with this question when we discussed panic disorder at the last consensus meeting[2] and reached a clear consensus on a preferred way and the instruments to measure response, which is what Professor Lecrubier is talking about.

We also defined what we might call remission or recovery, involving a longitudinal perspective and, for instance, we reached an "almost well" kind of criterion. We would call a very good response over a period of 3 months full remission.

Dr. Westenberg: Even a small improvement can mean a lot for a patient as, for instance, in obsessive-compulsive disorder, where a small change in rating can have a tremendous effect on the quality of life of patients. It also depends on severity at the outset of the trial.

Dr. Ballenger: We could call that a good response in obsessive-compulsive disorder, but we would not call it recovery or remission.

Dr. Westenberg: No, that is correct.

Dr. Beidel: Clinically significant improvement has been used in the panic literature and can also be used here. It requires having a scale on which there are normative data, either Dr. Davidson's scale[3] or the scale that I have been involved in developing,[4] a social phobia and anxiety inventory. Given a normative group and the mean for that group, you can look at the scores of social phobics and see if they fall within the distribution of normal functioning. You can see whether a patient's score has changed on an inventory, but you do not need to try to decide how much change is enough change. By comparing the score with where it fits in the normal distribution, you can have an idea whether the patient is now in the range of normal functioning. This kind of scale can show you where that person is in relationship to normal functioning, which is different from improvement. It is sort of an end-state assessment.

Professor Bobes: This goes a step beyond most clinical trials in which you need only to measure the differences from baseline.

Dr. Ballenger: At the panic disorder meeting, we suggested a global assessment to help in describing response. It is clear that we should measure symptoms in social phobia and the Liebowitz scale[5] is a good measure for that. Are we also saying that a CGI of 1 or 2 is good enough for us to suggest it as 1 of the 3 or 4 ways we should characterize response?

Dr. Westenberg: We recently conducted a study with venlafaxine[6] and the CGI was more sensitive in predicting response than was the Liebowitz scale. Patients were stratified into responders and nonresponders on the basis of 50% decrease on the Liebowitz scale. Patients had the option of a 6-month follow-up including nonresponders who felt that they had fewer problems and were able to

continue treatment. At the end, it appeared that the opinion of the patients was more sensitive in predicting a response than was the Liebowitz scale: a number of patients who had been defined as nonresponders became responders when treatment was continued and these were patients who had identified themselves as responders, after acute treatment. I think that rating scales are not always sensitive and predictive of response.

Professor Bobes: They are probably sensitive but not predictive.

Professor Lecrubier: As the CGI is a complex index across the 3 domains that we are referring to, this is not surprising. We have 2 issues: prediction of response and response to a drug, that is, improvement. Some improvement may be more important for the patient than it is considered to be by the doctor. We probably need to define what we consider full and partial responses, so that we can say, for example, when the patient has had a good response for more than 6 months, consider stopping treatment.

Dr. Ballenger: For panic disorder, we defined response as a stable, clinically significant improvement usually occurring after 4–8 weeks of treatment, such that the patient no longer has the full range of symptoms. So a clinically significant response meant that the treatment is beginning to work in a clinically significant way.

Dr. Westenberg: From the clinicians' perspective or from the patients' perspective?

Dr. Ballenger: We had previously agreed that response in panic disorder would be measured across 5 domains: anticipatory anxiety, panic attacks, panic-related phobias (including agoraphobia and body-sensation phobias), well-being/overall severity of illness, and disability in terms of work and social and family impairment. By analogy here, we could measure response in social phobia using the Liebowitz scale[5] to capture symptoms, the CGI for the global assessment, and the Sheehan Disability Scale[7] for impairment. Response would be defined as a clinically significant reduction, for example, a 50% reduction, in symptoms. The other step we took in panic disorder was to define full remission as almost complete resolution of symptoms across the 5 domains maintained for a period of at least 3 months. I think that these are helpful analogies.

Dr. Westenberg: I agree. In our study, those patients who were responders after 6 months had scores at the upper end of the normal range on the Liebowitz scale. That is where patients with social phobia will end if they are responders and in remission.

Professor Lecrubier: We still have problems. Whereas panic and agoraphobia are reasonably well defined, in social phobia, we have patients with a single fear or we have complex social phobia with many different comorbid conditions. Therapeutic intervention and expectations from treatment vary from one group to another. For some patients, the coping mechanism is the main problem and symptoms are not that important, but, in others, symptoms are the major problem.

Dr. Ballenger: In fact, the scale that we recommend using in panic disorder, the Panic Disorder Severity Scale (PDSS),[8] has a measure of the cognitive aspect of panic disorder. If we propose the Liebowitz scale,[5] does it adequately capture that?

Dr. Beidel: I think Dr. Davidson's scale[3] has better psychometric properties than the Liebowitz and is about the same length.

Dr. Davidson: We did develop it in more than 300 patients. What it contains, and the Liebowitz scale does not, is physiologic symptoms. It is often these symptoms, such as sweating and blushing, that drive people to consult their doctors. Our scale performs well in terms of psychometric properties and treatment sensitivity.

Dr. Ballenger: We have a practical problem in that the Liebowitz scale has been used in almost every trial and is likely to become the gold standard. There are the psychometric problems, and these must be resolved. We could suggest further research to decide on the best scale.

Dr. Davidson: That is a good suggestion because the scales could end up having somewhat different uses.

Dr. Beidel: Rather than saying that the Liebowitz scale has poor psychometric properties, we want to say that its psychometric properties are not known. The studies have not been done.

Professor Nutt: I was disturbed by the factor analysis. Do you think that it is a quirk of that particular study?

Professor Bobes: When Liebowitz proposed the scale, he identified 4 domains, but the factor analyses have not confirmed this.

Professor Nutt: How many factors are there?

Professor Bobes: Two, 3, or more. Different publications disagree about the 4 factors.

Professor Lecrubier: That is why I was insisting on the fact that you have very heterogenous patients and therefore it is difficult to extrapolate. We can say that we are referring to the kind of social phobics for whom we would like to have intervention. For those with a single unique fear, most of the time the outcome is reasonably good. For the complex and the comorbid, intervention is needed but the threshold for this is captured only by a combined index.

Dr. Ballenger: Is it not reasonably true that the Liebowitz and the CGI combined would capture response in most generalized social phobics, because, between them, they seem to capture most of the important issues?

Professor Lecrubier: I agree.

Dr. Ballenger: I do not know how specific response in social phobics could be best captured, but we are saying that this should probably be the principal way of measuring response.

Dr. Ono: Is there any difference between the anxiety personality disorders and the avoidance personality disorders, and is social phobia similar or different?

Dr. Ballenger: If you look at the people diagnosed with social phobia using DSM-IV criteria, 70% to 80% in large samples meet criteria for avoidant personality disorder.

Dr. Beidel: That is because they utilize many of the same criteria, and many experts think they are the same disorder.

Professor Bobes: We probably need to recommend the use of personality scales.

Professor Nutt: We need to say something about the issue of avoidant personality disorder. Does it exist or is it a misapprehension that was understandable at the time the DSM was put together but is no longer valid?

Dr. Davidson: If the group agrees, I think the statement should be made that avoidant personality is not a separate issue. It is more an extension: earlier onset, more pervasive, more disabling, and associated with some other features like poor self-esteem.

Professor Nutt: It would be helpful to make a clear statement because this question is asked continually.

Dr. Ballenger: Dr. Davidson, will you draft a statement and I will bring this up as a potential consensus because I am hearing broad agreement. Let me suggest that we have reached a consensus about using 3 domains: symptoms reflected in the Liebowitz Social Anxiety Scale, impairment utilizing disability scales, and overall improvement with the CGI. We have not reached consensus about well-being and some of the feeling about the syndrome that Dr. Lecrubier was trying to capture. Is that a domain that needs to be measured routinely? If so, what is it, and how do you measure it?

Dr. Davidson: It gets measured in the CGI, which may be partly why it often does so well.

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