National Institute for Health and Care Excellence

4-year surveillance (2017) – Social anxiety disorder: recognition, assessment and treatment (2013) NICE guideline CG159

Appendix A: Summary of new evidence from surveillance

General principles of care in mental health and general medical settings

159–01 What methods increase the proportion and diversity of people with social anxiety disorder initiating and continuing treatment?

Recommendations derived from this review question

Improving access to services

1.1.1 Be aware that people with social anxiety disorder may:

- not know that social anxiety disorder is a recognised condition and can be effectively treated
- perceive their social anxiety as a personal flaw or failing
- be vulnerable to stigma and embarrassment
- avoid contact with and find it difficult or distressing to interact with healthcare professionals, staff and other service users
- avoid disclosing information, asking and answering questions and making complaints
- have difficulty concentrating when information is explained to them.

1.1.2 Primary and secondary care clinicians, managers and commissioners should consider arranging services flexibly to promote access and avoid exacerbating social anxiety disorder symptoms by offering:

- appointments at times when the service is least crowded or busy
- appointments before or after normal hours, or at home initially
- self-check-in and other ways to reduce distress on arrival
- opportunities to complete forms or paperwork before or after an appointment in a private space
- support with concerns related to social anxiety (for example, using public transport)
- a choice of professional if possible.

1.1.3 When a person with social anxiety disorder is first offered an appointment, in particular in specialist services, provide clear information in a letter about:

- where to go on arrival and where they can wait (offer the use of a private waiting area or the option to wait elsewhere, for example outside the service's premises)
- location of facilities available at the service (for example, the car park and toilets)
- what will happen and what will not happen during assessment and treatment.

When the person arrives for the appointment, offer to meet or alert them (for example, by text message) when their appointment is about to begin.

1.1.4 Be aware that changing healthcare professionals or services may be particularly stressful for people with social anxiety disorder. Minimise such disruptions, discuss concerns beforehand

and provide detailed information about any changes, especially those that were not requested by the service user.

1.1.5 For people with social anxiety disorder using inpatient mental health or medical services, arrange meals, activities and accommodation by:

- regularly discussing how such provisions fit into their treatment plan and their preferences
- providing the opportunity for them to eat on their own if they find eating with others too distressing
- providing a choice of activities they can do on their own or with others.

1.1.6 Offer to provide treatment in settings where children and young people with social anxiety disorder and their parents or carers feel most comfortable, for example, at home or in schools or community centres.

1.1.7 Consider providing childcare (for example, for siblings) to support parent and carer involvement.

1.1.8 If possible, organise appointments in a way that does not interfere with school or other peer and social activities.

Communication

1.1.9 When assessing a person with social anxiety disorder:

- suggest that they communicate with you in the manner they find most comfortable, including writing (for example, in a letter or questionnaire)
- offer to communicate with them by phone call, text and email
- make sure they have opportunities to ask any questions and encourage them to do so
- provide opportunities for them to make and change appointments by various means, including text, email or phone.

1.1.10 When communicating with children and young people and their parents or carers:

- take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems and delays in language development
- be aware that children who are socially anxious may be reluctant to speak to an unfamiliar person, and that children with a potential diagnosis of selective mutism may be unable to speak at all during assessment or treatment; accept information from parents or carers, but ensure that the child or young person is given the opportunity to answer for themselves, through writing, drawing or speaking through a parent or carer if necessary
- use plain language if possible and clearly explain any clinical terms
- check that the child or young person and their parents or carers understand what is being said
- use communication aids (such as pictures, symbols, large print, braille, different languages or sign language) if needed.

Competence

1.1.11 Healthcare, social care and educational professionals working with children and young people should be trained and skilled in:

- negotiating and working with parents and carers, including helping parents with relationship difficulties find support
- managing issues related to information sharing and confidentiality as these apply to children and young people
- referring children with possible social anxiety disorder to appropriate services.

Consent and confidentiality

1.1.12 If the young person is 'Gillick competent' seek their consent before speaking to their parents or carers.

1.1.13 When working with children and young people and their parents or carers:

- make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected
- be clear with the child or young person and their parents or carers about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others). [This recommendation is adapted from Service user experience in adult mental health (NICE clinical guidance 136)].

1.1.14 Ensure that children and young people and their parents or carers understand the purpose of any meetings and the reasons for sharing information. Respect their rights to confidentiality throughout the process and adapt the content and duration of meetings to take into account the impact of the social anxiety disorder on the child or young person's participation.

Working with parents and carers

1.1.15 If a parent or carer cannot attend meetings for assessment or treatment, ensure that written information is provided and shared with them.

1.1.16 If parents or carers are involved in the assessment or treatment of a young person with social anxiety disorder, discuss with the young person (taking into account their developmental level, emotional maturity and cognitive capacity) what form they would like this involvement to take. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once. As the involvement of parents and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with parents and carers, and also in managing issues relating to information sharing and confidentiality.[This recommendation is adapted from Service user experience in adult mental health (NICE clinical guidance 136)].

1.1.17 Offer parents and carers an assessment of their own needs including:

- personal, social and emotional support
- support in their caring role, including emergency plans
- advice on and help with obtaining practical support.

1.1.18 Maintain links with adult mental health services so that referrals for any mental health needs of parents or carers can be made quickly and smoothly.

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

159–02 What dimensions of the experience of care for people with social anxiety disorder require adjustments to the procedures for access to and delivery of interventions for social anxiety disorder over and above those already developed for common mental health conditions?

Subquestion

Do obstacles to access or the effectiveness of interventions differ across the following subgroups:

- white people versus black and minority ethnic groups
- men versus women
- children (5 to 12 years), young people (13 to 18 years), adults (18 to 65 years), older adults (65+ years)?

Recommendations derived from this review question

Improving access to services

1.1.1 Be aware that people with social anxiety disorder may:

- not know that social anxiety disorder is a recognised condition and can be effectively treated
- perceive their social anxiety as a personal flaw or failing
- be vulnerable to stigma and embarrassment
- avoid contact with and find it difficult or distressing to interact with healthcare professionals, staff and other service users
- avoid disclosing information, asking and answering questions and making complaints
- have difficulty concentrating when information is explained to them.

1.1.2 Primary and secondary care clinicians, managers and commissioners should consider arranging services flexibly to promote access and avoid exacerbating social anxiety disorder symptoms by offering:

- appointments at times when the service is least crowded or busy
- appointments before or after normal hours, or at home initially
- self-check-in and other ways to reduce distress on arrival
- opportunities to complete forms or paperwork before or after an appointment in a private space
- support with concerns related to social anxiety (for example, using public transport)
- a choice of professional if possible.

1.1.3 When a person with social anxiety disorder is first offered an appointment, in particular in specialist services, provide clear information in a letter about:

- where to go on arrival and where they can wait (offer the use of a private waiting area or the option to wait elsewhere, for example outside the service's premises)
- location of facilities available at the service (for example, the car park and toilets)
- what will happen and what will not happen during assessment and treatment.

When the person arrives for the appointment, offer to meet or alert them (for example, by text message) when their appointment is about to begin.

1.1.4 Be aware that changing healthcare professionals or services may be particularly stressful for people with social anxiety disorder. Minimise such disruptions, discuss concerns beforehand and provide detailed information about any changes, especially those that were not requested by the service user.

1.1.5 For people with social anxiety disorder using inpatient mental health or medical services, arrange meals, activities and accommodation by:

- regularly discussing how such provisions fit into their treatment plan and their preferences
- providing the opportunity for them to eat on their own if they find eating with others too distressing
- providing a choice of activities they can do on their own or with others.

1.1.6 Offer to provide treatment in settings where children and young people with social anxiety disorder and their parents or carers feel most comfortable, for example, at home or in schools or community centres.

1.1.7 Consider providing childcare (for example, for siblings) to support parent and carer involvement.

1.1.8 If possible, organise appointments in a way that does not interfere with school or other peer and social activities.

Communication

1.1.9 When assessing a person with social anxiety disorder:

- suggest that they communicate with you in the manner they find most comfortable, including writing (for example, in a letter or questionnaire)
- offer to communicate with them by phone call, text and email
- make sure they have opportunities to ask any questions and encourage them to do so
- provide opportunities for them to make and change appointments by various means, including text, email or phone.

1.1.10 When communicating with children and young people and their parents or carers:

- take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems and delays in language development
- be aware that children who are socially anxious may be reluctant to speak to an unfamiliar person, and that children with a potential diagnosis of selective mutism may be unable to speak at all during assessment or treatment; accept information from parents or carers, but ensure that the child or young person is given the opportunity to answer for themselves, through writing, drawing or speaking through a parent or carer if necessary
- use plain language if possible and clearly explain any clinical terms
- check that the child or young person and their parents or carers understand what is being said
- use communication aids (such as pictures, symbols, large print, braille, different languages or sign language) if needed.

Competence

1.1.11 Healthcare, social care and educational professionals working with children and young people should be trained and skilled in:

- negotiating and working with parents and carers, including helping parents with relationship difficulties find support
- managing issues related to information sharing and confidentiality as these apply to children and young people
- referring children with possible social anxiety disorder to appropriate services.

Consent and confidentiality

1.1.12 If the young person is 'Gillick competent' seek their consent before speaking to their parents or carers.

1.1.13 When working with children and young people and their parents or carers:

- make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected
- be clear with the child or young person and their parents or carers about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others). [This recommendation is adapted from Service user experience in adult mental health (NICE clinical guidance 136)].

1.1.14 Ensure that children and young people and their parents or carers understand the purpose of any meetings and the reasons for sharing information. Respect their rights to confidentiality throughout the process and adapt the content and duration of meetings to take into account the impact of the social anxiety disorder on the child or young person's participation.

Working with parents and carers

1.1.15 If a parent or carer cannot attend meetings for assessment or treatment, ensure that written information is provided and shared with them.

1.1.16 If parents or carers are involved in the assessment or treatment of a young person with social anxiety disorder, discuss with the young person (taking into account their developmental level, emotional maturity and cognitive capacity) what form they would like this involvement to take. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once. As the involvement of parents and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with parents and carers, and also in managing issues relating to information sharing and confidentiality.[This recommendation is adapted from Service user experience in adult mental health (NICE clinical guidance 136)].

1.1.17 Offer parents and carers an assessment of their own needs including:

- personal, social and emotional support
- support in their caring role, including emergency plans
- advice on and help with obtaining practical support.

1.1.18 Maintain links with adult mental health services so that referrals for any mental health needs of parents or carers can be made quickly and smoothly.

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

Identification and assessment of adults; Identification and assessment of children and young people

159–03 For suspected social anxiety disorder, what identification instruments when compared to a gold standard diagnosis (based on DSM or ICD criteria) have adequate clinical utility (i.e. clinically useful with good sensitivity and specificity) and reliability?

Recommendations derived from this review question

Identification of adults with possible social anxiety disorder

1.2.1 Ask the identification questions for anxiety disorders in line with recommendation 1.3.1.2 in Common mental health disorders (NICE clinical guideline 123), and if social anxiety disorder is suspected:

- use the 3-item Mini-Social Phobia Inventory (Mini-SPIN) **or**
- consider asking the following 2 questions:
    - Do you find yourself avoiding social situations or activities?
    - Are you fearful or embarrassed in social situations?

  If the person scores 6 or more on the Mini-SPIN, or answers yes to either of the 2 questions above, refer for or conduct a comprehensive assessment for social anxiety disorder (see recommendations 1.2.5–1.2.9).

1.2.2 If the identification questions (see recommendation 1.2.1) indicate possible social anxiety disorder, but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral.

1.2.3 If the identification questions (see recommendation 1.2.1) indicate possible social anxiety disorder, a practitioner who is competent to perform a mental health assessment should

review the person's mental state and associated functional, interpersonal and social difficulties.

Identification of children and young people with possible social anxiety disorder

1.4.1 Health and social care professionals in primary care and education and community settings should be alert to possible anxiety disorders in children and young people, particularly those who avoid school, social or group activities or talking in social situations, or are irritable, excessively shy or overly reliant on parents or carers. Consider asking the child or young person about their feelings of anxiety, fear, avoidance, distress and associated behaviours (or a parent or carer) to help establish if social anxiety disorder is present, using these questions:

- "Sometimes people get very scared when they have to do things with other people, especially people they don't know. They might worry about doing things with other people watching. They might get scared that they will do something silly or that people will make fun of them. They might not want to do these things or, if they have to do them, they might get very upset or cross."
    - "Do you/does your child get scared about doing things with other people, like talking, eating, going to parties, or other things at school or with friends?"
    - "Do you/does your child find it difficult to do things when other people are watching, like playing sport, being in plays or concerts, asking or answering questions, reading aloud, or giving talks in class?"
    - "Do you/does your child ever feel that you/your child can't do these things or try to get out of them?"

1.4.2 If the child or young person (or a parent or carer) answers 'yes' to one or more of the questions in recommendation 1.4.1 consider a comprehensive assessment for social anxiety disorder (see recommendations 1.4.5–1.4.11).

1.4.3 If the identification questions (see recommendation 1.4.1) indicate possible social anxiety disorder, but the practitioner is not competent to perform a mental health assessment, refer the child or young person to an appropriate healthcare professional. If this professional is not the child or young person's GP, inform the GP of the referral.

1.4.4 If the identification questions (see recommendation 1.4.1) indicate possible social anxiety disorder, a practitioner who is competent to perform a mental health assessment should review the child or young person's mental state and associated functional, interpersonal and social difficulties.

Surveillance decision

This review question should not be updated.

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

2-year feedback

No topic expert feedback was relevant to this evidence.

4-year feedback

Topic experts highlighted a couple of articles (not specified) discussing the conceptualisation of social anxiety disorder within the Diagnostic and Statistical Manual of Mental Disorder (DSM-5). Experts stated that studies discuss implications of changes to the manual but felt that there was no substantial evidence to support changes.

Impact statement

No new evidence was identified at any surveillance review. Furthermore, topic experts did not feel that there was substantial evidence indicating that this question should be updated.

New evidence is unlikely to change guideline recommendations.

159–04 For people with suspected social anxiety disorder, what are the key components of, and the most effective structure for a clinical assessment?

Recommendations derived from this review question

Assessment of adults with possible social anxiety disorder

1.2.4 If an adult with possible social anxiety disorder finds it difficult or distressing to attend an initial appointment in person, consider making the first contact by phone or internet, but aim to see the person face to face for subsequent assessments and treatment.

1.2.5 When assessing an adult with possible social anxiety disorder:

- conduct an assessment that considers fear, avoidance, distress and functional impairment
- be aware of comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis and autism.

1.2.6 Follow the recommendations in Common mental health disorders (NICE clinical guideline 123) for the structure and content of the assessment and adjust them to take into account the need to obtain a more detailed description of the social anxiety disorder (see recommendation 1.2.8 in this guideline).

1.2.7 Consider using the following to inform the assessment and support the evaluation of any intervention:

- a diagnostic or problem identification tool as recommended in recommendation 1.3.2.3 in Common mental health disorders (NICE clinical guideline 123)
- a validated measure for social anxiety, for example, the Social Phobia Inventory (SPIN) or the Liebowitz Social Anxiety Scale (LSAS).

1.2.8 Obtain a detailed description of the person's current social anxiety and associated problems and circumstances including:

- feared and avoided social situations
- what they are afraid might happen in social situations (for example, looking anxious, blushing, sweating, trembling or appearing boring)
- anxiety symptoms
- view of self
- content of self-image
- safety-seeking behaviours
- focus of attention in social situations
- anticipatory and post-event processing
- occupational, educational, financial and social circumstances
- medication, alcohol and recreational drug use.

1.2.9 If a person with possible social anxiety disorder does not return after an initial assessment, contact them (using their preferred method of communication) to discuss the reason for not returning. Remove any obstacles to further assessment or treatment that the person identifies.

Assessment of children and young people with possible social anxiety disorder

1.4.5 A comprehensive assessment of a child or young person with possible social anxiety disorder should:

- provide an opportunity for the child or young person to be interviewed alone at some point during the assessment
- if possible involve a parent, carer or other adult known to the child or young person who can provide information about current and past behaviour

- if necessary involve more than one professional to ensure a comprehensive assessment can be undertaken.

1.4.6 When assessing a child or young person obtain a detailed description of their current social anxiety and associated problems including:

- feared and avoided social situations
- what they are afraid might happen in social situations (for example, looking anxious, blushing, sweating, trembling or appearing boring)
- anxiety symptoms
- view of self
- content of self-image
- safety-seeking behaviours
- focus of attention in social situations
- anticipatory and post-event processing, particularly for older children
- family circumstances and support
- friendships and peer groups, educational and social circumstances
- medication, alcohol and recreational drug use.

1.4.7 As part of a comprehensive assessment, assess for causal and maintaining factors for social anxiety disorder in the child or young person's home, school and social environment, in particular:

- parenting behaviours that promote and support anxious behaviours or do not support positive behaviours
- peer victimisation in school or other settings.

1.4.8 As part of a comprehensive assessment, assess for possible coexisting conditions such as:

- other mental health problems (for example, other anxiety disorders and depression)
- neurodevelopmental conditions such as attention deficit hyperactivity disorder, autism and learning disabilities
- drug and alcohol misuse (see recommendation 1.2.12)
- speech and language problems.

1.4.9 To aid the assessment of social anxiety disorder and other common mental health problems consider using formal instruments (both the child and parent versions if available and indicated), such as:

- the LSAS – child version or the Social Phobia and Anxiety Inventory for Children (SPAI-C) for children, or the SPIN or the LSAS for young people
- the Multidimensional Anxiety Scale for Children (MASC), the Revised Child Anxiety and Depression Scale (RCADS) for children and young people who may have comorbid depression or other anxiety disorders, the Spence Children's Anxiety Scale (SCAS) or the Screen for Child Anxiety Related Emotional Disorders (SCARED) for children.

1.4.10 Use formal assessment instruments to aid the diagnosis of other problems, such as:

- a validated measure of cognitive ability for a child or young person with a suspected learning disability
- the Strengths and Difficulties Questionnaire for all children and young people.

1.4.11 Assess the risks and harm faced by the child or young person and if needed develop a risk management plan for risk of self-neglect, familial abuse or neglect, exploitation by others, self-harm or harm to others.

1.4.12 Develop a profile of the child or young person to identify their needs and any further assessments that may be needed, including the extent and nature of:

- the social anxiety disorder and any associated difficulties (for example, selective mutism)

- any coexisting mental health problems
- neurodevelopmental conditions such as attention deficit hyperactivity disorder, autism and learning disabilities
- experience of bullying or social ostracism
- friendships with peers
- speech, language and communication skills
- physical health problems
- personal and social functioning to indicate any needs (personal, social, housing, educational and occupational)
- educational and occupational goals
- parent or carer needs, including mental health needs.

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

Interventions for adults with Social Anxiety Disorder; Interventions that are not recommended to treat social anxiety disorder

159–05 For adults with social anxiety disorder, what are the relative benefits and harms of psychological and pharmacological interventions alone or in combination?

Subquestion

Does the effectiveness of treatment differ across populations:

- generalised social anxiety versus performance social anxiety
- people with comorbid problems (for example, substance misuse, other anxiety disorders or depression) versus those with only social anxiety disorder.

Recommendations derived from this review question

Treatment principles

1.3.1 All interventions for adults with social anxiety disorder should be delivered by competent practitioners. Psychological interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:

- receive regular, high-quality outcome-informed supervision
- use routine sessional outcome measures (for example, the SPIN or LSAS) and ensure that the person with social anxiety is involved in reviewing the efficacy of the treatment
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny if appropriate.

Initial treatment options for adults with social anxiety disorder

1.3.2 Offer adults with social anxiety disorder individual cognitive behavioural therapy (CBT) that has been specifically developed to treat social anxiety disorder (based on the Clark and Wells model or the Heimberg model; see recommendations 1.3.13 and 1.3.14).

1.3.3 Do not routinely offer group CBT in preference to individual CBT. Although there is evidence that group CBT is more effective than most other interventions, it is less clinically and cost effective than individual CBT.

1.3.4 For adults who decline CBT and wish to consider another psychological intervention, offer CBT-based supported self-help (see recommendation 1.3.15).

1.3.5 For adults who decline cognitive behavioural interventions and express a preference for a pharmacological intervention, discuss their reasons for declining cognitive behavioural interventions and address any concerns.

1.3.6 If the person wishes to proceed with a pharmacological intervention, offer a selective serotonin reuptake inhibitor (SSRI) (escitalopram or sertraline). Monitor the person carefully for adverse reactions (see recommendations 1.3.17–1.3.23).

1.3.7 For adults who decline cognitive behavioural and pharmacological interventions, consider short-term psychodynamic psychotherapy that has been specifically developed to treat social anxiety disorder (see recommendation 1.3.16). Be aware of the more limited clinical effectiveness and lower cost effectiveness of this intervention compared with CBT, self-help and pharmacological interventions.

Options for adults with no or a partial response to initial treatment

1.3.8 For adults whose symptoms of social anxiety disorder have only partially responded to individual CBT after an adequate course of treatment, consider a pharmacological intervention (see recommendation 1.3.6) in combination with individual CBT.

1.3.9 For adults whose symptoms have only partially responded to an SSRI (escitalopram or sertraline) after 10 to 12 weeks of treatment, offer individual CBT in addition to the SSRI.

1.3.10 For adults whose symptoms have not responded to an SSRI (escitalopram or sertraline) or who cannot tolerate the side effects, offer an alternative SSRI (fluvoxamine or paroxetine) or a serotonin noradrenaline reuptake inhibitor (SNRI) (venlafaxine), taking into account:

- the tendency of paroxetine and venlafaxine to produce a discontinuation syndrome (which may be reduced by extended-release preparations)
- the risk of suicide and likelihood of toxicity in overdose.

1.3.11 For adults whose symptoms have not responded to an alternative SSRI or an SNRI, offer a monoamine oxidase inhibitor (phenelzine or moclobemide).

1.3.12 Discuss the option of individual CBT with adults whose symptoms have not responded to pharmacological interventions.

Delivering psychological interventions for adults

1.3.13 Individual CBT (the Clark and Wells model) for social anxiety disorder should consist of up to 14 sessions of 90 minutes' duration over approximately 4 months and include the following:

- education about social anxiety
- experiential exercises to demonstrate the adverse effects of self-focused attention and safety-seeking behaviours
- video feedback to correct distorted negative self-imagery
- systematic training in externally focused attention
- within-session behavioural experiments to test negative beliefs with linked homework assignments
- discrimination training or rescripting to deal with problematic memories of social trauma
- examination and modification of core beliefs
- modification of problematic pre- and post-event processing
- relapse prevention.

1.3.14 Individual CBT (the Heimberg model) for social anxiety disorder should consist of 15 sessions of 60 minutes' duration, and 1 session of 90 minutes for exposure, over approximately 4 months, and include the following:

- education about social anxiety
- cognitive restructuring
- graduated exposure to feared social situations, both within treatment sessions and as homework
- examination and modification of core beliefs
- relapse prevention.

1.3.15 Supported self-help for social anxiety disorder should consist of:

- typically up to 9 sessions of supported use of a CBT-based self-help book over 3−4 months
- support to use the materials, either face to face or by telephone, for a total of 3 hours over the course of the treatment.

1.3.16 Short-term psychodynamic psychotherapy for social anxiety disorder should consist of typically up to 25−30 sessions of 50 minutes' duration over 6−8 months and include the following:

- education about social anxiety disorder
- establishing a secure positive therapeutic alliance to modify insecure attachments
- a focus on a core conflictual relationship theme associated with social anxiety symptoms
- a focus on shame
- encouraging exposure to feared social situations outside therapy sessions
- support to establish a self-affirming inner dialogue
- help to improve social skills.

Prescribing and monitoring pharmacological interventions in adults

1.3.17 Before prescribing a pharmacological intervention for social anxiety disorder, discuss the treatment options and any concerns the person has about taking medication. Explain fully the reasons for prescribing and provide written and verbal information on:

- the likely benefits of different drugs
- the different propensities of each drug for side effects, discontinuation syndromes and drug interactions
- the risk of early activation symptoms with SSRIs and SNRIs, such as increased anxiety, agitation, jitteriness and problems sleeping
- the gradual development, over 2 weeks or more, of the full anxiolytic effect
- the importance of taking medication as prescribed, reporting side effects and discussing any concerns about stopping medication with the prescriber, and the need to continue treatment after remission to avoid relapse.

1.3.18 Arrange to see people aged 30 years and older who are not assessed to be at risk of suicide within 1 to 2 weeks of first prescribing SSRIs or SNRIs to:

- discuss any possible side effects and potential interaction with symptoms of social anxiety disorder (for example, increased restlessness or agitation)
- advise and support them to engage in graduated exposure to feared or avoided social situations.

1.3.19 After the initial meeting (see recommendation 1.3.18), arrange to see the person every 2–4 weeks during the first 3 months of treatment and every month thereafter. Continue to support them to engage in graduated exposure to feared or avoided social situations.

1.3.20 For people aged under 30 years who are offered an SSRI or SNRI:

- warn them that these drugs are associated with an increased risk of suicidal thinking and self-harm in a minority of people under 30 and
- see them within 1 week of first prescribing and
- monitor the risk of suicidal thinking and self-harm weekly for the first month. [This recommendation is from Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (NICE clinical guideline 113)].

1.3.21 Arrange to see people who are assessed to be at risk of suicide weekly until there is no indication of increased suicide risk, then every 2–4 weeks during the first 3 months of treatment and every month thereafter. Continue to support them to engage in graduated exposure to feared or avoided social situations.

1.3.22 Advise people taking a monoamine oxidase inhibitor of the dietary and pharmacological restrictions concerning the use of these drugs as set out in the British national formulary.

1.3.23 For people who develop side effects soon after starting a pharmacological intervention, provide information and consider 1 of the following strategies:

- monitoring the person's symptoms closely (if the side effects are mild and acceptable to the person)
- reducing the dose of the drug
- stopping the drug and offering either an alternative drug or individual CBT, according to the person's preference.

[This recommendation is adapted from Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (NICE clinical guideline 113)].

1.3.24 If the person's symptoms of social anxiety disorder have responded well to a pharmacological intervention in the first 3 months, continue it for at least a further 6 months.

1.3.25 When stopping a pharmacological intervention, reduce the dose of the drug gradually. If symptoms reappear after the dose is lowered or the drug is stopped, consider increasing the dose, reintroducing the drug or offering individual CBT.

Interventions that are not recommended to treat social anxiety disorder

1.6.1 Do not routinely offer pharmacological interventions to treat social anxiety disorder in children and young people.

1.6.2 Do not routinely offer anticonvulsants, tricyclic antidepressants, benzodiazepines or antipsychotic medication to treat social anxiety disorder in adults.

1.6.3 Do not routinely offer mindfulness-based interventions or supportive therapy to treat social anxiety disorder.

1.6.4 Do not offer St John's wort or other over-the-counter medications and preparations for anxiety to treat social anxiety disorder. Explain the potential interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

1.6.5 Do not offer botulinum toxin to treat hyperhidrosis (excessive sweating) in people with social anxiety disorder. This is because there is no good-quality evidence showing benefit from botulinum toxin in the treatment of social anxiety disorder and it may be harmful.

1.6.6 Do not offer endoscopic thoracic sympathectomy to treat hyperhidrosis or facial blushing in people with social anxiety disorder. This is because there is no good-quality evidence showing benefit from endoscopic thoracic sympathectomy in the treatment of social anxiety disorder and it may be harmful.

Surveillance decision

This review question should not be updated.

2-year surveillance summary

Pharmacological interventions

In 1 RCT[1] the efficacies of paroxetine, an attention modification program (AMP) and a combination of both were assessed in 33 people with social anxiety disorder. Results indicated that paroxetine was more effective at reducing symptoms of social anxiety disorder, depressive symptoms and enhancing daily life functioning compared to AMP at 8 week follow-up. No significant differences in improvements in symptoms of social anxiety disorder, depressive symptoms and daily life functioning were observed between paroxetine and combined treatment at 8 week follow-up.

A 12 week RCT[2] examined 3 strategies for treating people with social anxiety who remained symptomatic after 10-weeks of sertraline treatment. One hundred and eighty one people were randomised to sertraline plus clonazepam, venlafaxine alone or sertraline monotherapy. Remission was observed in more people in the combination therapy group compared to the sertraline monotherapy group and the venlafaxine group; however, differences were not statistically significant. Furthermore, while combination therapy was associated with a significantly greater reduction in Liebowitz Social Anxiety Scale (LSAS) scores and disability compared to the sertraline group, no significant differences were observed when the combination therapy group and the sertraline monotherapy group were compared with the venlafaxine group. A significantly higher response rate was observed in the combination therapy group compared to the sertraline monotherapy group. No significant differences in response rates were observed between venlafaxine and combination therapy, as well as venlafaxine and sertraline monotherapy.

One RCT[3] assessed the efficacy of a brief alcohol intervention (BI) plus paroxetine in 83 adults with social anxiety disorder who endorsed drinking to cope with anxiety and who were at-risk drinkers. Participants were randomised to receive paroxetine plus BI or to paroxetine alone. Both groups were found to have significant improvements in social anxiety severity; however, BI was found to be ineffective at reducing drinking and drinking to cope.

Psychological interventions

One RCT[4] compared trial-based thought record (TBTR; targets the restructuring of participants' core beliefs) and conventional cognitive therapy (CCT) in 36 people with social anxiety disorder. Results indicated that TBTR was as efficacious as CCT in reducing social anxiety disorder symptoms.

In 1 RCT[5], 106 adults with social anxiety disorder were randomised to exposure therapy alone, a combination of social skills training and exposure training known as Social Effectiveness Therapy (SET) or to a waiting list (control group). Both exposure therapy alone and the combination therapy were found to be effective. Combination therapy was found to provide significantly better improvements in measures of social skill and general clinical status compared to exposure training.

One RCT[6] of 134 people with a DSM-IV diagnosis of social phobia investigated the integration of cognitive bias modification (CBM) into a standard cognitive behavioural treatment package. Participants were randomised to receive CBM as an adjunct to a computerised probe procedure, or a placebo variant of the computerised procedure. Results revealed no significant difference in attentional bias towards threat between groups. Furthermore, no significant difference in treatment response rates were observed between groups. Both treatment approaches showed similar significant reductions in diagnostic severity, social anxiety symptoms, depression symptoms and life interference.

In another RCT[7] 108 adults with social anxiety disorder, who were seeking treatment, were randomly allocated a standard or modified dot-probe protocol condition. Results showed that both standard and modified conditions produced significant sustained improvements in symptoms at 8 month follow-up. No significant differences were observed between groups.

Psychological interventions: Internet-based therapy

One RCT[8] evaluated attention bias modification (ABM) in addition to Internet-based cognitive behavioural therapy (ICBT) in 133 people with social anxiety disorder. Participants were randomised to receive either ICBT with ABM or to ICBT alone. Even though people in both groups had substantial improvements in social anxiety symptoms (unclear if statistically significant), no changes in attention processes

were observed. No significant differences in improvements in social anxiety symptoms were observed between the 2 groups.

An RCT[9] investigated ICBT versus a waiting list (control group) in 76 people for social anxiety disorder. Results indicated that ICBT was effective for treating social anxiety disorder symptoms. The recovery rate was 36.8% in the ICBT group and 2.6% in the control group.

One RCT[10] examined the efficacy of an internet-based attention training programme which trained attention towards positive cues and a programme which trained attention towards negative cues. Individuals with social anxiety disorder (n=129) were randomly allocated to the positive cues programme, the negative cues programme or to a control training condition. Results showed that symptoms of social anxiety significantly improved in all three conditions. The programme of negative cues was found to lead to a significantly greater reduction of social fears when compared to the control. No significant differences in social anxiety outcomes were observed between the positive cue programme and the control group.

One RCT[11] investigated the impact of a pre-treatment diagnostic interview on the outcomes of an internet based treatment in 109 people with social anxiety disorder. Participants were randomised to either an interview group or a non-interview group and both groups undertook a 10 week unguided cognitive behavioural self-help programme. Participants in both groups showed significant improvements in social anxiety measures (not specified). The pre-treatment interview group had significantly better improvements in depression and general distress compared with the non-interview group.

An RCT[12] compared mobile phone administration of cognitive behavioural therapy (mCBT) with mobile guided self-help treatment based on interpersonal psychotherapy (mIPT) in 52 adults diagnosed with social anxiety disorder. The 2 treatments were accessible from smartphones, tablets and standard computers. Results indicated that both interventions improved LSAS scores but mCBT yielded significantly better improvements than mIPT.

Nutritional supplement

One RCT[13] assessed yohimbine versus placebo in 40 adults with social anxiety disorder. Yohimbine was found to be beneficial for self-reported but not for clinician-rated outcomes of social anxiety severity and improvement. Furthermore, authors reported that between-group differences in the LSAS scores were found to be moderated by the level of fear reported at the end of the exposure exercise. The advantage of the intervention drug over placebo was only seen in those who reported low end fear.

4-year surveillance summary

Pharmacological interventions

One meta-analysis[14] pooled data from 3 RCTs comparing 1,598 people with social anxiety disorder treated by escitalopram or placebo. Results indicated that escitalopram 5mg/day, escitalopram 10mg/day and escitalopram 20mg/day were significantly superior at improving LSAS scores compared to placebo, at 12 week follow-up. Individuals treated with escitalopram 10mg/day and escitalopram 20mg/day had significantly better improvements in clinical global impression-severity scores compared with those who received placebo at 12 week follow-up. Overall, escitalopram resulted in significantly higher rates of withdrawal due to adverse events compared with placebo.

In 1 RCT[15] people with social anxiety disorder were randomised to receive escitalopram 10mg, escitalopram 20mg, or placebo (sample size not provided in abstract). No significant differences in changes in LSAS scores were observed between participants who received escitalopram 10 mg and those who received placebo at 12 week follow-up. Escitalopram 20mg was found to be significantly better than placebo at improving LSAS scores. Authors noted that common adverse events included somnolence, nausea and ejaculation disorder.

One RCT[16] randomly assigned 29 university students with social anxiety disorder to treatment with sertraline, short-term dynamic psychotherapy or to a waiting list. Significant improvements in mean social phobia inventory scores were reported in the 2 active intervention groups but not the waiting list group at 12 week follow-up. Compared to the waiting list group, significantly greater improvements in social phobia inventory scores were reported in in the sertraline and dynamic psychotherapy groups. No significant

differences in scores were observed between the sertraline group and the dynamic psychotherapy group. Authors reported that similar results were observed for clinical global impression scale and global assessment of functioning measurements.

Two RCTs[17,18] were identified which assessed the efficacy of oxytocin in people with social anxiety disorder. Additionally, 1 RCT[19] was identified which assessed the efficacy of vilazodone and another RCT[20] assessed the efficacy of aloradine. None of the aforementioned medications are currently licensed for treating social anxiety disorder or any other type of anxiety disorder. As a result, these studies were not considered in this 4-year surveillance review.

Psychological interventions: Cognitive behavioural therapy

One RCT[21] assessed the efficacy of CBT in people with social anxiety that failed to respond to antidepressants. People with social anxiety disorder (n=42) were randomly assigned to usual care plus CBT or usual care alone (no definition of usual care was provided). At 16 week follow-up, people who received adjunctive CBT had significantly greater improvements in LSAS scores compared to those who received usual care alone. Significantly higher response and remission rates were reported in the adjunctive CBT group at 16 week follow-up. Furthermore, people who received adjunctive CBT had significantly better improvements in social anxiety symptoms, depressive symptoms and functional impairment than those who received usual care alone.

In 1 RCT[22] 40 people with social anxiety disorder were randomly assigned to a cognitive therapy group (a type of CBT) or a waiting list group. Depersonalisation significantly decreased in the cognitive therapy group at final follow-up. Pre-treatment depersonalisation did not predict or mediate social anxiety severity.

One RCT[23] compared cognitive therapy alone (a variant of CBT), paroxetine alone, cognitive therapy plus paroxetine combination therapy, or placebo in 102 people with social anxiety disorder with or without avoidant personality disorder. Cognitive therapy was significantly better at improving outcomes (not specified) than paroxetine monotherapy and placebo after 26 weeks of treatment. No significant differences in changes in outcomes were observed between cognitive therapy alone and cognitive therapy plus paroxetine combination therapy after 26 weeks of treatment. Cognitive therapy was significantly better than paroxetine monotherapy and placebo at 12 month follow up. No significant differences were observed between combination therapy, paroxetine monotherapy, and placebo at 12 month follow-up. Recovery rates were 68% in the cognitive therapy group, 24% in the paroxetine monotherapy group, 40% in the combination therapy group, and 4% in the placebo group at 12 month follow-up.

One RCT[24] compared the efficacies of traditional cognitive-behaviour treatment (tCBT) and an acceptance-based behaviour treatment (ABBT) in 21 people with public speaking anxiety. ABBT resulted in greater improvements in observer-rated performance relative compared to tCBT (not stated if significant). Conversely, tCBT resulted in greater improvements in subjective anxiety levels compared to ABBT.

One RCT[25] assessed the efficacy of individual cognitive therapy in 29 people with social anxiety disorder: comparator group was not specified in the abstract. Therapy involved changing people's focus from themselves to external factors. Results indicated that changes from self-focused to externally focused attention resulted in improvements in social anxiety at 1 week follow-up. Change in frequency of, or belief in, negative automatic thoughts did not predict social anxiety at 1 week follow-up.

In 1 RCT[26], 12 women with social anxiety were randomised to receive therapy combining equine-assisted activities with cognitive behavioural strategies or no treatment. Significantly greater improvements in LSAS scores were observed in the treatment group compared to the control group at 6 week follow-up.

In 1 RCT[27] 60 people with social anxiety disorder were randomly allocated imagery re-scripting (a type of CBT), cognitive restructuring or control conditions (not specified) in between 2 speeches. Compared to control conditions imagery re-scripting and cognitive restructuring produced similar reductions in social anxiety.

In another RCT[28] 25 people with social anxiety disorder were randomly assigned 1 session of

imagery re-scripting or no treatment. Compared to individuals who had no treatment, people who received imagery re-scripting had improvements in social anxiety symptoms. Furthermore, the imagery re-scripting group had more positive and less negative appraisals of their autobiographical memories. Individuals in the imagery re-scripting group had greater changes in content, validity and the accuracy of their negative beliefs about themselves and others, but not about the world.

In 1 RCT[29], 72 people with social anxiety were randomised to 1 session of computerised interpretation training, cognitive restructuring or an active placebo control condition in between 2 speech tasks. Higher quality speech ratings were given to people in the cognitive restructuring group compared to the individuals in the interpretation training group after the post-training speech task. Furthermore, individuals in the cognitive restructuring group exhibited fewer signs of anxiety compared to those in the interpretation training group. Compared to the cognitive restructuring and control groups, participants in the interpretation training group reported significantly more positive perceptions of ambiguous situations after training.

One RCT[30] assessed outcomes of 60 people with social anxiety assigned to individual virtual reality exposure therapy (VRET), individual in-vivo exposure therapy (iVET), or a waiting list. Compared to the waiting list, VRET and iVET improved social anxiety symptoms, speech duration, perceived stress, and avoidant personality disorder related beliefs (unclear whether statistically significant). Participants in the iVET reported improvements in fear of negative evaluation, speech performance, general anxiety, depression and quality of life compared to those on the waiting list; however, people in the VRET group did not. Comparisons between active interventions indicated that iVET was superior to VRET at improving social anxiety symptoms after therapy and at follow-up. Furthermore, iVET was superior to VRET at improving avoidant personality disorder related beliefs at follow-up. Authors noted that all improvements in the iVET group were significant but only improvements in perceived stress in the VRET group were significant.

In 1 RCT[31] 96 adults with elevated social anxiety were randomised to 1 of 3 exposure therapy interventions (fear reduction/cognitive reappraisal, acceptance, or personal values) or to a control group. At follow-up, individuals in the active treatment arms reported significantly higher treatment credibility, exposure engagement and improvements in social anxiety symptoms. Authors stated few differences were observed between the 3 study arms: no further details were provided.

One RCT[32] assessed the efficacy of exposure therapy by randomly allocating people with public speaking anxiety to exposure therapy with or without affect labelling. Individuals in the affect labelling group had larger reductions in psychological activation than those in the group who didn't use affect labelling. Furthermore, people who used more affect labels during exposure had even greater reductions in psychological activation. No significant differences in self-reported measures were observed between groups. Authors noted that larger deficits in emotional regulation, at baseline, resulted in greater psychological arousal in the affect labelling group compared the control group.

One RCT[33] explored the effects of virtual reality exposure training on students with music performance anxiety. Participants (n=17) were randomised to receive virtual training or no training delivered between 2 separate recitals. Compared with no training, virtual training significantly decreased social anxiety (measured by the State-Trait Anxiety Inventory and the Personal Report of Confidence scale) in participants with high levels of state or trait anxiety, those with high immersive tendencies and women. Virtual training was also found to significantly improve performance quality.

One RCT[34] compared group CBT (G-CBT), mindfulness-based stress reduction (MBSR) and a waiting list in 108 people with generalised social anxiety disorder. Results at 1 year follow-up indicated that both G-CBT and MBSR were better than the waiting list at improving social anxiety symptoms, cognitive reappraisal frequency and self-efficacy, cognitive distortions, mindfulness skills, attention focusing and rumination. Comparisons between G-CBT and MBSR revealed that G-CBT produced greater improvements in subtle avoidance behaviour. Authors reported improvements in reappraisal frequency, mindfulness skills, attention focusing, and attention shifting, subtle avoidance behaviours and cognitive distortions, mediated the impact of both G-CBT and MBSR

on social anxiety symptoms. Mediation analysis also revealed that improvements in reappraisal self-efficacy and avoidance behaviours mediated the superiority of G-CBT over MBSR.

Another study[35] compared outcomes of people with social anxiety disorder who received G-CBT (n=32) or mindfulness and acceptance-based group therapy (MAGT) (n=37). Assessment of latent difference scores indicated that that cognitive reappraisal had a greater impact on social anxiety in people who received G-CBT than those who received MAGT. Authors reported that the bidirectional mindfulness model (in which mindfulness predicts subsequent change in social anxiety and social anxiety predicts subsequent change in mindfulness) was supported in both treatments.

One RCT[36] compared outcomes of 45 university students with social anxiety who received G-CBT or group psychotherapy for 8 weeks. In both treatment arms, participant engagement increased during sessions, avoidance behaviour decreased and there was minimal conflict between participants.

Psychological interventions: Internet-based CBT

One systematic review[37] pooled data from 37 RCTs, including 2,991 people, which assessed technology-assisted interventions for treating social anxiety disorder. Significantly less social anxiety symptoms in people undergoing internet-based CBT (ICBT) and virtual reality exposure therapy (VRET) compared to people who received passive control conditions. ICBT was superior at reducing social anxiety disorder symptoms than active control conditions whereas no significant differences were observed between the VRET group and active controls. Analysis of people who received cognitive bias modification (CBM) indicated that CBM was only significantly superior to passive control conditions when delivered in a laboratory.

In 1 RCT[38] 233 people with social anxiety disorder were randomised to receive internet-delivered disorder-specific or transdiagnostic CBT using clinician-guided or self-guided formats. All forms of ICBT resulted in large reductions in social anxiety disorder symptoms (Cohen's d>1.01; avg. reduction>30%) after therapy. The reductions in symptoms were maintained at 2 year follow-up. Authors stated that no differences were observed between treatment strategies.

One study[39] compared outcomes of 149 people with social anxiety disorder who were randomly assigned individual ICBT, group ICBT or to a waiting list. Compared to the waiting list group, both ICBT groups had significant improvements in social anxiety disorder symptoms after 12 weeks of treatment, and at 6 month follow-up. No significant differences in improvements in symptoms were observed between ICBT groups. The average therapist time per patient was 17 minutes in the individual ICBT group and 5 minutes in the group ICBT group.

One RCT[40] evaluated outcomes of 48 people treated by ICBT plus escitalopram or ICBT plus placebo. Compared to ICBT plus placebo, ICBT plus escitalopram yielded significantly higher clinical response rates at 15 month follow-up. Furthermore ICBT plus escitalopram resulted in significant reductions in anticipatory speech anxiety post-treatment and significant reductions in social anxiety symptom severity at 15 month follow-up.

One RCT[41] compared the efficacies of ICBT monotherapy and ICBT with prior face-to-face psychoeducation in 37 people with social anxiety disorder. After therapy, significant improvements in social anxiety symptoms were observed in both treatment arms but no significant differences were observed between groups. Significant improvements in self-rated social anxiety symptoms were reported in both groups post-treatment and at 6 month follow-up.

Psychological interventions: Mindfulness-based interventions

One systematic review[42] reported that mindfulness and acceptance-based treatments significantly improved social anxiety disorder symptoms. Authors stated that the benefits of mindfulness and acceptance based treatments were “equivalent or less than yielded by CBT”.

In an RCT[43] of 39 people with social anxiety treated by a mindfulness-based intervention or placed on a waiting list, significantly greater improvements in symptom severity, depression and social adjustment were reported in the mindfulness-based intervention group. Furthermore, significantly better self-compassion and facets of mindfulness were reported in the mindfulness-based intervention group compared to the waiting list group.

One RCT[44] compared reappraisal, acceptance and distraction strategies for management of social anxiety disorder. People with social anxiety disorder (n=67) and healthy controls (n=72) were randomly assigned to 1 of the 3 strategies. Compared to healthy controls, people with social anxiety disorder had more difficulties implementing assigned strategies. People with social anxiety disorder and healthy controls reported greater difficulties adopting acceptance strategies than reappraisal and distraction. People with social anxiety disorder and healthy controls reported that anticipatory anxiety, experienced within 10 minutes of delivering a speech, decreased. Decreases in anxiety were observed with all strategies; however, all participants experienced increased anxiety immediately before delivering the speech. Authors reported that neither social anxiety status (present or absent) nor strategy were associated with changes in psychophysiological parameters.

Another RCT[45] explored the effect of rumination and reappraisal on social anxiety symptoms during CBT for social anxiety. Note: 75 participants were included but the study abstract did not give details of group/treatment allocations. Authors reported that baseline rumination scores were predictive of social anxiety, rumination and reappraisal. Moreover, greater rumination was associated with greater weekly social anxiety. No predictive value of baseline reappraisal scores were reported.

Psychological interventions: Cognitive bias modification / Attention bias modification

A systematic review[46] of 15 RCTs, including 1,043 people, assessed the efficacy of attention bias modification for treating social anxiety disorder. Pooled analysis indicated that attention bias modification yielded a significant reduction in social anxiety disorder symptoms, as well as significant improvements in reactivity to speech challenges and attentional bias (timing of follow-up not reported). No significant improvements in secondary symptoms and social anxiety disorder symptoms at 4 month follow-up.

In 1 RCT[47] 113 adults with social anxiety disorder were assigned to a standard or modified online dot-probe protocol, delivered over 4 weeks. Significant reductions in symptoms of anxiety, fear of negative evaluation, trait anxiety, and depression were reported in both groups at 4 month follow-up, and were maintained at 8 month follow-up. Authors stated that reductions in symptoms did not vary between groups. Furthermore, attentional biases observed during dot-probe tasks were not related to changes in symptoms. No significant reductions in fear of positive evaluation were observed in both groups at 4 and 8 month follow-up assessments.

In 1 RCT[48] 62 people with social anxiety disorder were randomly assigned single-sessions of attention bias modification using non-emotional contingency, non-emotional no-contingency, or control conditions. All approaches of attention bias modification yielded significant improvements in self-reported and behavioural measures of speech anxiety. Furthermore, inter-group comparisons highlighted no significant differences between groups.

One RCT[49] randomly assigned people with social anxiety disorder to receive attention bias modification training toward non-threat, training toward threat, or no-contingency condition (sample size not provided in abstract). After 2 treatment sessions, participants in each group reported significant reductions in self-reported and behavioural measures of anxiety after performing a speech task. Authors reported that similar significant improvements in alerting and executive aspects of attention were observed in each treatment arm.

One RCT[50] assessed attention bias modification in people with social anxiety disorder who were alcohol dependent (n=86). Participants were randomised to receive either 2 or 1 target of attention bias modification. Investigators assessed attention bias using trial-level bias scores. Furthermore, symptoms of social anxiety and alcohol dependence (unspecified) were assessed. Attention bias modification resulted in significant improvements in all attention trial-level bias score parameters at follow-up. No further information was provided about intergroup comparisons. Authors reported that improvements in traditional attention bias scores were not observed over time. Attention bias modification was also found to improve symptoms of social anxiety and alcohol dependence.

One RCT[51] evaluated the efficacy of attention bias modification in 62 people with social anxiety disorder. Participants were randomly allocated attention bias modification conditions with either 100- or 500- millisecond stimulus

durations (ABM-100 and ABM-500), or attention placebo conditions with either 100- or 500- millisecond stimulus durations. After completion of 8 attentional training sessions, the ABM-100 group had significantly quicker responses to 100- and 500-millisecond 'invalid social threat trials', as well as 500-millisecond invalid neutral trials. Significant reduced latencies to 500-millisecond invalid social threat trials. Compared to attention placebo groups, both ABM-100 and ABM-500 groups significantly reduced fear of negative evaluations and interactional anxiousness. No significant differences were observed between ABM-100 and ABM-500 groups.

Another RCT[52] assessed outcomes of 27 people receiving group CBT who were randomly assigned to undergo attention bias modification using a dot-probe protocol or sham attention bias modification. Participants were also randomised to receive random or high reward after receiving neutral stimuli (No further details were provided in the abstract). Assessment of attention bias indicated that attention bias modification, using a dot-probe protocol, yielded no additional benefit when given to individuals undergoing group CBT. Active attention bias modification did not result in improvements in social anxiety disorder symptoms. Authors stated that reward had a strong influence on attention bias; however, no additional information was provided in the abstract. Authors also stated that reward yielded no added benefit in people undergoing group CBT.

In 1 RCT[53], 40 students with social anxiety were randomised to receive cognitive bias modification for interpretation (CBM-I) plus computerised-CBT (C-CBT) or neutral cognitive bias modification (N-CBM) plus C-CBT (Control group). At 2 week follow-up, CBM-I plus C-CBT yielded less interpretations of ambiguous situations than N-CBM plus C-CBT (unclear whether significant). Results indicated that both treatment strategies improved social anxiety, cognitive distortions, work adjustment and social adjustment. Greater effect sizes were observed in the CBM-I group compared to the control group.

Psychological interventions: Other

One systematic review[54] pooled data from 23 RCTs including 2,171 adults with social anxiety disorder treated by group psychotherapy or placed on a waiting list. Authors reported that positive effects were observed for studies of specific symptoms (g=0.84; 95% Confidence interval [CI], 0.72 to 0.97) and general psychopathology (g=0.62; 95% CI, 0.36 to 0.89). Group therapy was superior at alleviating symptoms of social anxiety disorder compared to control conditions but was not superior at improving general psychopathology. No significant differences were observed for comparisons between group psychotherapy and individual psychotherapy or pharmacotherapy.

One systematic review[55] pooled data from 2 studies comparing Morita therapy with pharmacological agents for treating social phobia. Morita therapy is described as an alternative treatment based on eastern philosophy. Meta-analysis indicated that Morita therapy was significantly better at improving individuals' global state compared to pharmacological treatment at 12 week follow-up. Furthermore, the number needed to treat for an additional beneficial outcome was 3.

One RCT[56] assessed outcomes of 41 socially anxious people assigned to an audio feedback intervention group (based on reduced self-focus) or a control group. Participants were asked to give a speech then asked to listen to a taped recording of their speech. After which, they were asked to give a second speech. In the reduced self-focus group, participants were asked to reduce their self -focus prior to receiving audio feedback whereas the control group received audio feedback without reducing their self-focus. Compared with audio feedback alone, audio feedback with reduced self-focus resulted in better voice evaluations of the first speech. Effects remained when participants evaluated the second speech. Authors reported that the positive speech evaluations were associated with reductions in social anxiety.

Health economic evaluations

One UK health economics evaluation[57] used a decision analytic model to assess the cost effectiveness of 28 interventions for social anxiety disorder. Analysis revealed that individual cognitive therapy was the most cost effective strategy, followed by generic CBT. Phenelzine was the third most cost-effective intervention, followed by book-based self-help without support. Authors reported that group-based psychological interventions, other self-administered psychological interventions, and

drugs other than phenelzine were less cost effective. No additional information was provided.

Topic expert feedback

2-year feedback

Topic experts highlighted that internet-based packages for treating social anxiety disorder were being developed. They indicated that this approach could be an important intervention in the current economic climate. They stated that there were some trials which evaluated delivery of psychotherapies as well as pharmacological treatment of refractory social anxiety disorder. No further details were provided. Finally, experts noted that escitalopram was off patent.

4-year feedback

Topic experts highlighted some studies which were already identified in literature searches; however, they felt that there haven't been any major developments in pharmacological treatments and psychological therapies for social anxiety disorder. Experts stated that they were not aware of any significant changes in terms of cost of delivering psychological therapies.

In relation to the costs of pharmacological treatments:

- Escitalopram's patent expired in 2014, after CG159 was published, so there are now generic versions available.
- Paroxetine's patent expired in 1999, so was already generic at time when CG159 was produced.
- Sertraline's patent expired in 1999, so was already generic at time when CG159 was produced.

Impact statement

Pharmacological interventions

During the 2-year surveillance review, the new evidence on paroxetine was inconclusive. While paroxetine was found to be beneficial compared to AMP, no significant differences were found between paroxetine and the combination of paroxetine plus AMP. In CG159, paroxetine is considered as a second-line pharmacological option. The new evidence is unlikely to impact on this guideline since the study identified was small and results were inconclusive.

In the 2-year surveillance review the new evidence on augmentation and switching for refractory social anxiety disorder was also inconclusive. No significant difference was found between venlafaxine, sertraline alone and sertraline plus clonazepam.

During the 4-year surveillance review, 3 studies were identified which assessed the efficacy of SSRIs. Two studies which assessed the efficacy of escitalopram (one systematic review and 1 RCT). The systematic review indicated that escitalopram was superior to placebo whereas the RCT did not. The third study, identified in the 4-year surveillance review, reported significant improvements in social anxiety symptoms associated with sertraline (compared with placebo). Currently, SSRIs are recommended as second-line treatments for social anxiety disorder. Since the identified studies did not use CBT (first line therapy) as a comparator, it was unclear whether the evidence would have an impact on guideline recommendations.

Two RCTs were identified which assessed the efficacy of oxytocin in people with social anxiety disorder. Additionally, 1 RCT[1] was identified which assessed the efficacy of vilazodone and another RCT assessed the efficacy of aloradine. None of the aforementioned medications are currently licensed for treating social anxiety disorder or any other type of anxiety disorder. As a result, these studies were not considered in this 4-year surveillance review.

Overall, it was considered that none of the identified new evidence would have an impact on guideline recommendations.

Psychological interventions

The guideline recommends that clinicians should offer adults with social anxiety disorder individual CBT that has been specifically developed to treat social anxiety disorder. The identified new studies evaluating various types of CBT (including cognitive therapy, exposure therapy and re-scripting) were largely in line with guideline recommendations. The majority of studies reported that people who received CBT had improvements in a variety of outcome measures compared those placed on a waiting list (no treatment). Furthermore, a UK-based cost-effectiveness analysis indicated that individual cognitive therapy was the most cost effective strategy, followed by generic CBT. This was consistent with guideline

recommendations which recommend CBT as first-line treatment for social anxiety disorder.

NICE CG159, recommends that group CBT should not be routinely offered in preference to individual CBT to people with social anxiety disorder. Two studies reported that group CBT was superior to mindfulness-based stress reduction and mindfulness and acceptance-based group therapy. One study reported improved participation, decreased avoidance and minimal conflicts in people who received group CBT and group psychotherapy; however, information about changes in social anxiety symptoms was not available from the study abstract. One study which compared internet-based group CBT with individual CBT reported no differences in outcomes between groups. Overall, the evidence on group therapy was not considered sufficient to change guideline recommendations.

In relation to ICBT, 1 study reported that ICBT was superior to virtual reality exposure training, another study reported that social anxiety-specific ICBT was superior to generic ICBT, and 2 studies highlighted potential benefits of adding adjunctive escitalopram or psychoeducation to ICBT therapy. None of the identified studies explored whether ICBT was superior to conventional face-to-face CBT. Furthermore, the interventions which were compared against ICBT did not have established efficacy profiles. As a result it was not possible to determine whether ICBT could be used as an alternative to conventional CBT.

Three studies which evaluated mindfulness-based interventions were identified. A systematic review, and 2 RCTs (both with less than 100 participants) reported that mindfulness-based interventions improved social anxiety symptoms. It was not clear from the study abstracts whether mindfulness-based treatment conferred any long term benefit in people with social anxiety disorder. Moreover, the identified studies made no comparisons with current first-line treatment (CBT). Thus, more research is needed to ascertain the role of mindfulness-based interventions for social anxiety disorder.

For cognitive bias modification, the evidence identified during the 2-year surveillance suggested that an additional computerised probe procedure was not beneficial for the treatment of social anxiety disorder. As the study showed no benefit and had a small sample size it was considered unlikely to be sufficient enough to warrant an update of CG159. During the 4-year surveillance review, some additional new evidence on cognitive/attention bias modification highlighted that a dot-probe protocol improved social anxiety symptoms when compared with other attention bias modification techniques, or placebo. Other studies reported no significant differences in outcomes of people who received attention bias modification using a dot-probe protocol and those who received attention bias modification that didn't adopt a dot-probe protocol. One RCT indicated that attention bias modification yielded no additional benefit when given to individuals undergoing group CBT. The inconsistent study results indicated that more research (especially research comparing attention bias modification with CBT) is needed to establish whether this treatment approach is suitable for treating social anxiety disorder.

Individual studies which assessed group psychotherapy, Morita therapy and audio feedback therapy were identified. The systematic review which assessed group psychotherapy did not specify what type of psychotherapy was offered to participants. Thus, it was not possible to determine the potential impact of guideline recommendations. The other 2 studies made comparisons between active interventions and control conditions: no comparisons were made with CBT. The systematic review on Morita therapy only reported short-term follow-up (12 weeks) data while the study on audio feedback had a small sample size (n=41). Considering the 2 treatment approaches, larger studies with longer follow-up periods are needed to trigger an update of this clinical question.

Topic expert feedback indicated that, since the last surveillance review there have been no new developments in psychological and pharmacological interventions for treating social anxiety disorder. This was largely consistent with what was identified in this 4-year surveillance review. As a result, there is insufficient new evidence to prompt an update of this clinical question.

New evidence is unlikely to change guideline recommendations.

Interventions for children and young people with Social Anxiety Disorder; Interventions that are not recommended to treat social anxiety disorder

159–06 For children and young people with social anxiety disorder, what are the relative benefits and harms of psychological and pharmacological interventions?

Recommendations derived from this review question

Treatment principles

1.5.1 All interventions for children and young people with social anxiety disorder should be delivered by competent practitioners. Psychological interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:

- receive regular high-quality supervision
- use routine sessional outcome measures, for example:
  - the LSAS – child version or the SPAI-C, and the SPIN or LSAS for young people
  - the MASC, RCADS, SCAS or SCARED for children
- engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny if appropriate.

1.5.2 Be aware of the impact of the home, school and wider social environments on the maintenance and treatment of social anxiety disorder. Maintain a focus on the child or young person's emotional, educational and social needs and work with parents, teachers, other adults and the child or young person's peers to create an environment that supports the achievement of the agreed goals of treatment.

Planning treatment for adults diagnosed with social anxiety disorder

1.2.12 For people (including young people) with social anxiety disorder who misuse substances, be aware that alcohol or drug misuse is often an attempt to reduce anxiety in social situations and should not preclude treatment for social anxiety disorder. Assess the nature of the substance misuse to determine if it is primarily a consequence of social anxiety disorder and:

- offer a brief intervention for hazardous alcohol or drug misuse (see Alcohol use disorders [NICE clinical guideline 115] or Drug misuse [NICE clinical guideline 51])
- for harmful or dependent alcohol or drug misuse consider referral to a specialist alcohol or drug misuse service.

Treatment for children and young people with social anxiety disorder

1.5.3 Offer individual or group CBT focused on social anxiety (see recommendations 1.5.4 and 1.5.5) to children and young people with social anxiety disorder. Consider involving parents or carers to ensure the effective delivery of the intervention, particularly in young children.

Delivering psychological interventions for children and young people

1.5.4 Individual CBT should consist of the following, taking into account the child or young person's cognitive and emotional maturity:

- 8−12 sessions of 45 minutes' duration
- psychoeducation, exposure to feared or avoided social situations, training in social skills and opportunities to rehearse skills in social situations
- psychoeducation and skills training for parents, particularly of young children, to promote and reinforce the child's exposure to feared or avoided social situations and development of skills.

1.5.5 Group CBT should consist of the following, taking into account the child or young person's cognitive and emotional maturity:

- 8−12 sessions of 90 minutes' duration with groups of children or young people of the same age range
- psychoeducation, exposure to feared or avoided social situations, training in social skills and opportunities to rehearse skills in social situations
- psychoeducation and skills training for parents, particularly of young children, to promote and reinforce the child's exposure to feared or avoided social situations and development of skills.

1.5.6 Consider psychological interventions that were developed for adults (see section 1.3) for young people (typically aged 15 years and older) who have the cognitive and emotional capacity to undertake a treatment developed for adults.

Interventions that are not recommended to treat social anxiety disorder

1.6.1 Do not routinely offer pharmacological interventions to treat social anxiety disorder in children and young people.

Surveillance decision

This review question should not be updated.

2-year surveillance summary

An RCT[58] (n=240) investigated an internet based cognitive bias modification (CBM) intervention in 13 to 15 year olds who had high social and/or test anxiety. Participants were randomised to CBM, school based cognitive behavioural therapy or to no training (control group). No significant differences in reductions in social anxiety symptoms were observed between groups at 12 month follow-up.

In 1 RCT[59] 24 children with selective mutism were randomised to receive a home-based intervention, a school-based intervention or were placed on a waiting list (control group). Treatment was for 3 months. Authors reported that both active interventions significantly improved speech.

4-year surveillance summary

Pharmacological interventions

One systematic review[60] of 10 studies assessed the efficacy of selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors for treating selective mutism. Pooled analysis revealed that improvements in selective mutism symptoms were reported in 83.5% (66/78) of children treated by SSRIs and 100% (4/4) of children treated by monoamine oxidase inhibitors (phenelzine).

Psychological therapy

In 1 RCT[61] children with selective mutism were randomly assigned to receive standard psychomotor treatment (n=67) or behavioural and educational counselling. Children who received psychomotor treatment had significant reductions in scores of social relations, anxious/depressed, social problems and total problems domains of the child behaviour checklist questionnaire. Furthermore, significant reductions in withdrawn, and internalising problem domains of the child behaviour checklist questionnaire were observed in children who received psychomotor treatment. The study abstract did not report outcomes of participants in the counselling group and no intergroup comparisons were reported. Authors reported that children who received psychomotor treatment had significant reductions in selective mutism symptoms in school, family and social situations, assessed by selective mutism questionnaire scores. Psychomotor treatment was also found to produce significant reductions in total selective mutism questionnaire scores.

One study[62] compared outcomes of 124 adolescents who received attention bias modification or placebo for social anxiety. Attention bias modification did not result in improvements in social anxiety symptoms or attention bias to threat.

One RCT[63] compared attention bias modification and attention control training in 67 children with social anxiety disorder. Significant reductions in clinician and self-rated social anxiety measures were reported post-treatment. Authors stated that further significant reductions in clinician-rated social anxiety measures were observed in both groups at 3 moth follow-up. An association between age and self-reported anxiety was identified. Compared to the attention control training group, older children in the attention bias modification group had significant reductions in self-reported social anxiety compared to younger children (age groups were not defined). In the attention bias modification group, children who were rated by their parents as having low attention control had greater improvements in self-reported outcome measures than those who were rated by their parents as having higher attention control.

One systematic review[64] assessed the efficacies of different types of CBT in children and adolescents with social anxiety disorder. The effect size (Hedges g) of CBT was 0.99 in studies which examined pre- and post-treatment and 0.71 in studies which made between-group comparisons. The effect size was 1.18 in studies which made comparisons between pre-test and follow-up assessment, and 0.25 in studies which made comparisons between post-test and follow-up assessment comparisons. Investigators noted that the number of treatment sessions had a moderating effect on effect sizes. Furthermore larger effect sizes were observed in studies which included social skills training in the CBT approach. No sample size or number of included studies are reported in the abstract.

One RCT[65] compared outcomes of 138 high-school students assigned to CBT delivered by school counsellors (CBT-C), CBT delivered by psychologists (CBT-P) or non-specific counselling (control group). At the end of therapy significantly greater reductions in social anxiety were reported in the CBT-C and CBT-P groups compared to the control group. These improvements were maintained at 5 month follow-up. No significant differences were observed between CBT-C and CBT-P groups.

Topic expert feedback

2-year feedback

No topic expert feedback was relevant to this evidence.

4-year feedback

Topic experts highlighted 1 RCT[66] which compared the efficacies of generic versus social anxiety CBT for children with social anxiety disorder. Children (n=125) were randomly assigned to generic CBT, social anxiety specific CBT or to a waiting list group. Therapy was delivered via a therapist-supported online programme. Compared to the waiting list group, children in both CBT groups had significant improvements in social anxiety, post-event processing and global functioning at 12 week, and 6 month follow-up assessments. Improvements in social anxiety symptoms were associated with improvements in post-event processing. Although, participants in both CBT exhibited improvements in social anxiety, they continued to meet diagnostic criteria for social anxiety disorder at 6 month follow-up. No significant differences in improvements in social anxiety, post-event processing and global functioning were observed between CBT groups at either follow-up assessment.

Topic experts highlighted an RCT[67] (n=56) which compared Cognitive Bias Modification of Interpretation (CBM-I) training against no training in children aged 7 to 12 years with social anxiety disorder. No significant differences were found between groups for changes in interpretation bias of social scenarios. No significant changes in social anxiety symptoms were found between groups as reported by the child, parent or clinician.

Topic experts highlighted additional studies which were already identified in literature searches; however, they felt that there haven't been any major developments in pharmacological treatments and psychological therapies for social anxiety disorder. Experts stated that they were not aware of any significant changes in terms of cost of delivering psychological therapies.

In relation to the costs of pharmacological treatments:

- Escitalopram's patent expired in 2014, after CG159 was published, so there are now generic versions available.
- Paroxetine's patent expired in 1999, so was already generic at time when CG159 was produced.
- Sertraline's patent expired in 1999, so was already generic at time when CG159 was produced.

Impact statement

CG159 recommends that pharmacological interventions should not be routinely offered to treat social anxiety disorder in children and young people. The systematic review, identified from literature searches, suggested potential benefits of using SSRIs and monoamine oxidase inhibitors for treating selective mutism. The results of the study are unlikely to affect guideline recommendations as the total number of children that were included was relatively small. Furthermore, the study only focussed on one class of medication and one consequence of social anxiety (as opposed to social anxiety in general).

One study, identified during the 2-year surveillance review, reported that internet-based CBM and school based cognitive behavioural therapy are not beneficial for decreasing social anxiety symptoms when compared to no training. Another small study highlighted some improvements in attention bias associated with CBM; however, children did not report improvements in social anxiety symptoms. Since the identified new evidence generally showed no benefit compared to no treatment, it is unlikely to currently impact on CG159.

Results of studies which assessed cognitive bias modification were inconsistent. One study reported that attention bias modification improved social anxiety symptoms whereas another study indicated that attention bias modification provided no benefit over placebo. A further study found no benefit on symptoms of social anxiety disorder for cognitive bias modification. As a result, more research about the potential benefits of attention bias modification is needed to ascertain its role for treating social anxiety disorder.

RCTs which assessed the efficacy of CBT highlighted significant improvements in social anxiety symptoms. This is in line with guideline recommendations which state that CBT-focussed on social anxiety should be offered to children and young people with social anxiety disorder.

Topic expert feedback was largely consistent with the identified new evidence. Experts felt that there haven't been any major developments in pharmacological treatments and psychological therapies for social anxiety disorder.

New evidence is unlikely to change guideline recommendations.

Specific Phobias

159–07 For adults with specific phobias, what are the relative benefits and harms of computerised cognitive behavioural therapy?

Recommendations derived from this review question

Interventions that are not recommended

1.7.1 Do not routinely offer computerised CBT to treat specific phobias in adults.

Surveillance decision

No new information was identified at any surveillance review.

This review question should not be updated.

Research recommendations

Prioritised research recommendations

At 4-year and 8-year surveillance reviews of guidelines published after 2011, we assess progress made against prioritised research recommendations. We may then propose to remove research recommendations from the NICE version of the guideline and the NICE database for research recommendations. The research recommendations will remain in the full versions of the guideline. See NICE's research recommendations process and methods guide 2015 for more information.

These research recommendations were deemed priority areas for research by the Guideline Committee; therefore, at this 4-year surveillance review time point a decision **will** be taken on whether to retain the research recommendations or stand them down.

We applied the following approach:

- New evidence relevant to the research recommendation was found and an update of the related review question is planned.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database. If needed, a new research recommendation may be made as part of the update process.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because the new evidence is insufficient to trigger an update.
  - The research recommendation will be retained because there is evidence of research activity in this area.
- New evidence relevant to the research recommendation was found but an update of the related review question is not planned because evidence supports current recommendations.
  - The research recommendation will be removed from the NICE version of the guideline and the NICE research recommendations database because further research is unlikely to impact on the guideline.
- Ongoing research relevant to the research recommendation was found.
  - The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.
- No new evidence relevant to the research recommendation was found and no ongoing studies were identified.
  - The research recommendation will be removed from the NICE version of guideline and the NICE research recommendations database because there is no evidence of research activity in this area.
- The research recommendation would be answered by a study design that was not included in the search (usually systematic reviews or randomised controlled trials).
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.
- The new research recommendation was made during a recent update of the guideline.
  - The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 01 What methods are effective in improving uptake of and engagement with interventions for adults with social anxiety disorder?

The research recommendation would be answered by a study design that was not included in the search (usually systematic reviews or randomised controlled trials).

Surveillance decision

The research recommendation will be retained in the NICE version of the guideline and the NICE research recommendations database.

RR – 02 What is the clinical and cost effectiveness of combined psychological and pharmacological interventions compared with either intervention alone in the treatment of adults with social anxiety disorder?

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

One RCT[23] compared cognitive therapy alone (a variant of CBT), paroxetine alone, cognitive therapy plus paroxetine combination therapy, or placebo in 102 people with social anxiety disorder with or without avoidant personality disorder. Cognitive therapy was significantly better at improving outcomes (not specified) than paroxetine monotherapy and placebo after 26 weeks of treatment. No significant differences in changes in outcomes were observed between cognitive therapy alone and cognitive therapy plus paroxetine combination therapy after 26 weeks of treatment. Cognitive therapy was significantly better than paroxetine monotherapy and placebo at 12 month follow up. No significant differences were observed between combination therapy, paroxetine monotherapy, and placebo at 12 month follow-up. Recovery rates were 68% in the cognitive therapy group, 24% in the paroxetine monotherapy group, 40% in the combination therapy group, and 4% in the placebo group at 12 month follow-up.

Topic expert feedback

Topic experts highlighted additional studies which were already identified in literature searches; however, they felt that there haven't been any major developments in pharmacological treatments and psychological therapies for social anxiety disorder. Experts stated that they were not aware of any significant changes in terms of cost of delivering psychological therapies.

Impact

The study identified in the 4-year surveillance review suggested that there was no added benefit of adding pharmacological treatments to psychological therapies for treating social anxiety disorder. Since the only study assessed combination of cognitive therapy and paroxetine, more research is needed to ascertain whether other combinations of pharmacological and psychological interventions could potentially be used to treat social anxiety disorder.

Surveillance decision

The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.

RR – 03 What is the best way of involving parents in the treatment of children and young people (at different stages of development) with social anxiety disorder?

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

One RCT[68] assessed whether a parent education course would improve social anxiety in adolescents. Treatment involved individual exposure and group skills training. Fifty five children were randomly assigned to treatment with their parents attending the course, treatment without their parents attending the course, or a waiting list. Compared to the waiting list group, children in the 2 active treatment groups had significantly greater improvements in self-reported and independent assessor-rated outcomes post-treatment, and at 1 year follow-up. No significant differences were observed between the 2 training approaches post-treatment and at 1 year follow-up.

Topic expert feedback

No relevant evidence was identified.

Impact

The study identified during the 4-year surveillance review highlighted that parents attending their children's' training courses resulted in improvements anxiety symptoms. However, the improvements in symptoms were no different in children whose parents didn't attend their training course. The study was relatively small (n=55). As a result, more research is needed to ascertain the best way of involving parents in the treatment of children and young people with social anxiety disorder.

Surveillance decision

The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.

RR – 04 What is the clinical and cost effectiveness of specific CBT for children and young people with social anxiety disorder compared with generic anxiety-focused CBT?

2-year surveillance summary

No relevant evidence was identified.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

Topic experts highlighted an ongoing trial evaluating specific versus generic psychological therapy for children and young people with social anxiety disorder.

Impact

Ongoing research which was relevant to the research recommendation was found.

Surveillance decision

The research recommendation will be retained and evidence from the ongoing research will be considered when results are published.

RR – 05 What is the clinical and cost effectiveness of individual and group CBT for children and young people with social anxiety disorder?

2-year surveillance summary

An RCT[69] of 57 adolescents with social anxiety evaluated the efficacy of individual cognitive therapy compared with group CBT. Participants were randomised to individual cognitive therapy, group CBT or to an attentional placebo. At 12 month follow-up, significant reductions in symptoms, impairment and diagnostic criteria were found with individual cognitive therapy. Furthermore, individual cognitive therapy showed significantly greater effects on symptoms and impairment compared to both group CBT and placebo. No significant differences were found between group CBT and placebo; however, it should be noted that the attentional placebo group was not assessed at follow-up.

4-year surveillance summary

No relevant evidence was identified.

Topic expert feedback

No relevant evidence was identified.

Impact

The new evidence indicates that for young people individual cognitive therapy is beneficial compared to both group CBT and placebo. Currently the guideline recommends offering individual or group CBT to children and young people with social anxiety disorder. However, the new evidence is limited since the study was small and the attentional placebo group was not assessed at follow-up.

Surveillance decision

The research recommendation will be retained because there is evidence of research activity in this area.

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