2-year surveillance 2015 – Social anxiety disorder (2013) NICE guideline CG159

Appendix A: decision matrix

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
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? (1.1.1 – 1.1.18)		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
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. • **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)? (1.1.1 – 1.1.18)**		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
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? (1.2.1-1.2.3, 1.4.1-1.4.4)		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
159-04: For people with suspected social anxiety disorder, what are the key components of, and the most effective structure for a clinical assessment? (1.2.4-1.2.9, 1.4.5-1.4.12)		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
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? • **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. (1.3.1-1.3.25, 1.6.1-1.6.6)**		
Pharmacological interventions *Paroxetine* Paroxetine, an attention modification program (AMP) and a combination of both were compared in an RCT[1]. Thirty three patients with a DSM-IV-TR definition of social anxiety disorder were randomly assigned to the three interventions over 8 weeks. Results showed that paroxetine was more effective in reducing symptoms of social anxiety disorder, depressive symptoms and enhancing daily life functioning compared to AMP. However, no significant difference between paroxetine and the combined treatment was found. *Augmentation and switching for refractory social anxiety disorder* A 12 week RCT[2] examined three strategies for social anxiety disorder patients who remained symptomatic after 10-weeks of sertraline treatment. One hundred and eighty one patients were randomised to sertraline plus clonazepam, venlafaxine alone or to sertraline with placebo. More patients received remission in the combination strategy compared to the sertraline group and the venlafaxine group but this did not reach statistical significance. Furthermore, whilst the combination strategy was associated with a significantly greater decrease in LSAS score and disability compared to the sertraline group, no difference was found when the combination group and the sertraline group were compared with the venlafaxine group. For response rate, a significantly greater proportion of the combination strategy group responded to treatment when compared to the sertraline group. However, no significant difference was found between venlafaxine when compared to both the	The following was highlighted by topic experts: • New internet-based package for treating social anxiety disorder • Trials of pharmacological treatment refractory social anxiety disorder • Trials on the delivery of psychotherapies • Escitalopram is off patent	For paroxetine, the new evidence was inconclusive as whilst paroxetine was found to be beneficial compared to AMP, no significant differences were found between paroxetine and a combination of AMP plus paroxetine. In CG159 paroxetine is considered as a second-line pharmacological option. This was due to GDG concerns about side effects and discontinuation effects. The new evidence is unlikely to impact on this guideline since the study identified was small and the conclusion inconclusive. Further trials of paroxetine and the combination intervention are required. The new evidence on augmentation and switching for refractory social anxiety disorder was inconclusive since for the majority of outcomes no difference was found between venlafaxine, the combination strategy and the sertraline group. As such, there is currently insufficient conclusive new evidence to impact on CG159. The guideline recommendation states that anticonvulsants and benzodiazepines should not be routinely offered to treat social anxiety disorder in adults (1.6.2) whilst clonazepam is not currently licensed for use in social anxiety disorder. Venlafaxine, on the other hand, is recommended in CG159 (1.3.10)

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combination strategy and the sertraline group for this outcome. **Social anxiety disorder and at-risk drinking** An RCT[3] investigated a brief alcohol intervention (BI) plus paroxetine in adults with social anxiety disorder who endorsed drinking to cope with anxiety and who were at-risk drinkers. Eighty three patients were randomised to 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 decreasing drinking and drinking to cope. **Psychological interventions** *Trial-based thought record (TBTR)* An RCT[4] compared TBTR and a set of conventional cognitive therapy (CCT) techniques in 36 patients with social anxiety disorder. It was found that TBTR was as efficacious as CCT in reducing social anxiety disorder symptoms. *Social skills training* In an 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 wait list control. Both exposure therapy alone and the combination intervention were found to be effective. However, the combination intervention provided better outcomes than the exposure training on measures of social skill and general clinical status. *Cognitive bias modification* An RCT[6] of 134 Patients with a DSM-IV diagnosis of social phobia investigated the integration of cognitive bias modification (CBM) into a standard cognitive behavioural treatment package. Patients were randomised to either an additional computerised probe procedure designed to train attentional resource allocation away from threat or to a placebo variant of this procedure. Findings showed no significant difference between the groups in attentional bias towards threat or in treatment response. Furthermore, both groups showed similar and significant reductions in diagnostic severity, social		but only if patients have not responded to the selective serotonin reuptake inhibitor (SSRI) or cannot tolerate their side effects. The GDG thought that although this drug was possibly as effective as other SSRI's it would be best to consider this drug as a second line pharmacological option. This was because they had concerns about side effects and discontinuation effects. Limited new evidence from a small study shows that a brief-alcohol intervention plus paroxetine was as effective as paroxetine alone for social anxiety. CG159 does include studies investigating interventions for those with social anxiety and alcohol misuse and recommendation 1.2.12 suggests offering a brief intervention for hazardous alcohol or drug misuse. This recommendation then cross-refers to CG115: Alcohol use disorders and CG51: Drug misuse. To date, only a small study looking at a brief-alcohol intervention in addition to paroxetine has been identified and since this study also found no additional benefit to paroxetine alone it is unlikely to warrant an update in the guideline. New evidence on TBTR indicates that it is as beneficial as CCT for social anxiety disorder treatment. Currently, CG159 does not make any recommendations on TBTR. However, the study identified during this 2 year surveillance review was small and so unlikely to warrant an update for this intervention. More larger trials investigating TBTR are required. For social skills training, the new evidence

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
anxiety symptoms, depression symptoms and life interference. *Attention modification* An RCT[7] randomised 108 treatment-seeking adults with social anxiety disorder to either a standard or modified dot-probe protocol condition. Follow-up was at 8 months. Results showed that both standard and modified conditions produced significant sustained symptom reductions. No differences were found based on protocol type. *Internet - based cognitive behavioural therapy (ICBT) and attention bias modification* Attention bias modification (ABM) in addition to ICBT was evaluated in an RCT[8]. One hundred and thirty three patients diagnosed with social anxiety disorder were randomised to either ICBT with ABM or to ICBT with control training. Even though both groups improved substantially on social anxiety symptoms, no changes in attention processes were found. Moreover, no significant differences between the two groups were found. *ICBT alone* An RCT[9] investigated ICBT versus a wait list control in 76 patients for social anxiety disorder. Results showed that ICBT was effective for treating social anxiety disorder symptoms. Furthermore, recovery rates were found to be 36.8% for the intervention group but 2.6% for the control group. *Internet based therapy* An RCT[10] examined the efficacy of an attention training programme which trained attention towards positive cues and a programme which trained attention towards negative cues. Patients diagnosed with social anxiety disorder (n=129) were randomised to the positive cues programme, the negative cues programme or to a control training condition. Results showed that symptoms of social anxiety reduced significantly 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. However, no significant differences in social anxiety outcomes between the positive cue		suggests that a combination of exposure therapy and social skills training was beneficial for social anxiety disorder when compared to exposure therapy alone. Both social skills training and exposure therapy are included in CG159. However, in this guideline, the original GDG concluded that patients with social anxiety disorder should be offered an integrated programme of treatment rather than separate components, such as social skills training or exposure therapy, since the majority of separate components did not show clinical efficacy as stand-alone interventions. The new evidence identified is consistent with this conclusion since the combination intervention was found to be beneficial. As the new evidence is consistent it is unlikely to currently impact on CG159. For cognitive bias modification, the new evidence suggests 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 is unlikely to be sufficient new evidence to warrant an update of CG159. The new evidence on attention modification showed the modified protocol to provide no benefit compared to the standard protocol. Since the study showed no benefit it is unlikely to be sufficient to warrant an update of the guideline. The new evidence on ICBT plus ABM suggests that the addition of ABM to ICBT was ineffective. ICBT is included in CG159 but no recommendations on the use of this intervention

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
programme and the control condition were found. *Mobile Phone administration of cognitive behavioural therapy (mCBT)* An RCT[11] in 52 adults diagnosed with social anxiety disorder compared mCBT to a mobile guided self-help treatment based on interpersonal psychotherapy (mIPT). The two treatments could be accessed through smartphones, tablets and standard computers. Results showed that both interventions improved patients LSAS scores but mCBT performed significantly better than mIPT. *Pre-treatment interview* A randomised control trial (RCT)[12] investigated the impact of a pre-treatment diagnostic interview on the outcomes of an internet based treatment. Patients with social anxiety disorder (n=109) were randomised to either an interview group or to a non-interview group and then undertook a 10 week cognitive behavioural unguided self-help programme. Patients in both groups showed significant improvements on social anxiety measures. However, between-group effects in favour of the pre-treatment interview were found on the secondary outcomes of depression and general distress. **Nutritional supplement** *Yohimbine* An RCT[13] assessed yohimbine versus placebo in forty adults diagnosed with DSM-IV 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, between-group differences in the Liebowitz Social Anxiety Scale (LSAS) were found to be moderated by the level of fear reported at the end of the exposure exercise so that the advantage of the intervention drug over placebo was only seen in those who reported low end fear.		are made. However, the new evidence is limited since it comes from one study which showed the intervention to be ineffective. This is unlikely to be sufficient to warrant an update. Further research into the effectiveness of ICBT plus ABM and ICBT alone is required before consideration for inclusion in the guideline. For ICBT alone, the new evidence suggests that it is effective for the treatment of social anxiety disorder. ICBT is included in CG159 but no recommendations on the use of this intervention are made. However, the evidence is currently limited to a small study which is unlikely to be sufficient to warrant an update at this time. Furthermore, the study abstract provides no details as to the study participants and so it may be that the findings are not generalisable to the guideline population. More large trials investigating the effectiveness of ICBT are needed before this intervention can be considered for inclusion in CG159. Limited new evidence from a small study indicates that negative cue attention training programmes are beneficial in reducing social fears when compared to a control condition whilst positive cue programmes are not. CG159 does not currently include negative or positive cue programmes. However, only one small study was identified during this 2 year surveillance review. More larger trials investigating the effectiveness of negative and positive cue programmes are needed before considering these interventions for inclusion in the guideline.

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
		The new evidence for mCBT indicates that this intervention was as effective as mIPT. Currently, CG159 does not make any recommendations about the use of mCBT or mIPT. However, the evidence is currently limited to one small RCT and so further large studies investigating the effectiveness of mCBT and mIPT are required before this intervention can be considered for inclusion in CG159. The new evidence on pre-treatment diagnostic interviews suggests that receiving an interview before an internet based treatment is no more effective than no interview. However, this new evidence is limited to one small RCT which is unlikely to be sufficient to warrant an update of this area. Further research into pre-treatment diagnostic interviews before treatment is needed before considering them for inclusion in CG159. The new evidence on yohimbine was inconclusive since it was found to be beneficial when measured by self-report but not when it was clinician rated. As such, there is currently insufficient conclusive new evidence to impact on CG159. Furthermore, it is important to note that MHRA guidance on banned and restricted herbal ingredients states that yohimbe bark can only be sold in premises which are registered pharmacies and by or under the supervision of a pharmacist. With regards to GDG feedback, new studies on internet based packages, pharmacological therapies for treatment resistant social anxiety disorder and trials on the delivery of psychotherapies were all identified during this 2

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
		year surveillance review. These studies have been included in the summary of new evidence with their impact on the guideline noted. As stated in GDG feedback, the patent for escitalopram expired on 31/05/14 and this has enabled generic versions to be marketed in the UK. This may impact on drug acquisition costs. However, as escitalopram is already recommended as a first line pharmacological intervention and since little new efficacy evidence has been identified this evidence is unlikely, at present, to impact on CG159.
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? (1.5.1-1.5.6, 1.6.1-1.6.6)		
Internet delivered treatment An RCT[14] investigated an internet based cognitive bias modification(CBM) intervention in 240 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 a control group with no training. At 12 months follow-up the reduction in social anxiety symptoms was similar between the control, CBM and school based cognitive behavioural therapy groups. **Selective Mutism** A home and school based intervention for selective mutism was investigated in an RCT[15]. Twenty four children aged between 3 to 9 years were randomised to either the home and school based intervention or to the wait list control group. Treatment was for 3 months. The intervention was found to significantly improve speech.	An RCT was highlighted through the topic expert questionnaire which was also identified in the evidence search. This has been included in the evidence summary.	The new evidence about internet delivered treatment shows that internet based CBM and school based cognitive behavioural therapy are not beneficial for decreasing social anxiety symptoms when compared to no training. Currently, CG159 does not make any recommendations on the use of internet based CBM in children. Since the new evidence showed no benefit it is unlikely to currently impact on CG159. Limited new evidence from a small study indicates that a home and school based intervention is beneficial in children with selective mutism. CG159 does consider selective mutism since in some children social anxiety may be expressed as selective mutism. At present, only a

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
		small study looking at a home and school based interventions for this population was identified and this is unlikely to warrant an update regarding this intervention. More larger trials investigating this intervention in children with selective mutism are needed.
Specific Phobias		
159-07: For adults with specific phobias, what are the relative benefits and harms of computerised cognitive behavioural therapy? (1.7.1)		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
Research Recommendations		
RR-01: Adults' uptake of and engagement with interventions for social anxiety disorder:- What methods are effective in improving uptake of and engagement with interventions for adults with social anxiety disorder?		
See 159-05 above.	None identified relevant to this question.	See 159-05 above.
RR-02: Combined interventions for adults with social anxiety disorder:- 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?		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
RR-03: The role of parents in the treatment of children and young people with social anxiety disorder:- 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?		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.
RR-04: Specific versus generic CBT for children and young people with social anxiety disorder:- 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?		
No relevant evidence identified.	None identified relevant to this question.	No relevant evidence identified.

Summary of new evidence from 2-year surveillance	Summary of new intelligence from 2-year surveillance	Impact
RR-05: Individual versus group CBT for children and young people with social anxiety disorder:- What is the clinical and cost effectiveness of individual and group CBT for children and young people with social anxiety disorder?		
An RCT[16] of adolescents aged 13 to 16 years with a diagnosis of social phobia evaluated individual cognitive therapy compared with group CBT. Patients were randomised to individual cognitive therapy, group CBT or to an attentional placebo. Follow-up was 12 months and data was available for 57 participants. 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.	An RCT was highlighted through the topic expert questionnaire which was also identified in the evidence search. This study has been included in the evidence summary.	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. Furthermore, the study did not address the question about cost–effectiveness. Due to this, this study is unlikely to be sufficient to warrant an update of this guideline. Further research investigating the effectiveness and cost-effectiveness of individual versus group CBT is needed.

References

1. Khedmatgozar H, Birashk B, Ashayeri H et al. (2012) Comparing the effectiveness of paroxetine, attention modification program and combination of both on improving social anxiety symptoms. Basic and Clinical Neuroscience.3 (4) (pp 36-44), 2012.Date of Publication: 2012. 36-44.

2. Pollack MH, Van AM, Simon NM et al. (2014) A double-blind randomized controlled trial of augmentation and switch strategies for refractory social anxiety disorder. American Journal of Psychiatry 171:44-53.

3. Book SW, Thomas SE, Smith JP et al. (2013) Treating individuals with social anxiety disorder and at-risk drinking: phasing in a brief alcohol intervention following paroxetine. Journal of Anxiety Disorders 27:252-258.

4. de Oliveira IR, Powell VB, Wenzel A et al. (2012) Efficacy of the trial-based thought record, a new cognitive therapy strategy designed to change core beliefs, in social phobia. Journal of Clinical Pharmacy & Therapeutics 37:328-334.

5. Beidel DC, Alfano CA, Kofler MJ et al. (2014) The impact of social skills training for social anxiety disorder: A randomized controlled trial. Journal of Anxiety Disorders.28 (8) (pp 908-918), 2014.Date of Publication: December 01, 2014. 908-918.

6. Rapee RM, MacLeod C, Carpenter L et al. (2013) Integrating cognitive bias modification into a standard cognitive behavioural treatment package for social phobia: a randomized controlled trial. Behaviour Research & Therapy 51:207-215.

7. Carleton RN, Teale Sapach MJN, Oriet C et al. (2015) A randomized controlled trial of attention modification for social anxiety disorder. Journal of Anxiety Disorders 33:35-44.

8. Boettcher J, Hasselrot J, Sund E et al. (2014) Combining attention training with internet-based cognitive-behavioural self-help for social anxiety: a randomised controlled trial. Cognitive Behaviour Therapy 43:34-48.

9. Tulbure BT, Szentagotai A, David O et al. (4-5-2015) Internet-Delivered Cognitive-Behavioral Therapy for Social Anxiety Disorder in Romania: A Randomized Controlled Trial. PLoS ONE 10:e0123997.

10. Boettcher J, Leek L, Matson L et al. (2013) Internet-based attention bias modification for social anxiety: a randomised controlled comparison of training towards negative and training towards positive cues. PLoS ONE [Electronic Resource] 8:e71760.

11. Dagoo J, Asplund RP, Bsenko HA et al. (2014) Cognitive behavior therapy versus interpersonal psychotherapy for social anxiety disorder delivered via smartphone and computer: a randomized controlled trial. Journal of Anxiety Disorders 28:410-417.

12. Boettcher J, Berger T, and Renneberg B. (2012) Does a pre-treatment diagnostic interview affect the outcome of internet-based self-help for social anxiety disorder? a randomized controlled trial. Behavioural & Cognitive Psychotherapy 40:513-528.

13. Smits JA, Rosenfield D, Davis ML et al. (1-6-2014) Yohimbine enhancement of exposure therapy for social anxiety disorder: a randomized controlled trial. Biological Psychiatry 75:840-846.

14. Sportel BE, de HE, de Jong PJ et al. (2013) Cognitive bias modification versus CBT in reducing adolescent social anxiety: a randomized controlled trial. PLoS ONE [Electronic Resource] 8:e64355.

15. Oerbeck B, Stein MB, Wentzel-Larsen T et al. (2014) A randomized controlled trial of a home and school-based intervention for selective mutism - defocused communication and behavioural techniques. Child and Adolescent Mental Health.19 (3) (pp 192-198), 2014.Date of Publication: September 2014. 192-198.

16. Ingul JM, Aune T, and Nordahl HM. (2014) A randomized controlled trial of individual cognitive therapy, group cognitive behaviour therapy and attentional placebo for adolescent social phobia. Psychotherapy & Psychosomatics 83:54-61.