Social anxiety disorder: recognition, assessment and treatment of social anxiety disorder

NICE guideline

Draft for consultation, December 2012

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

This guidance updates and replaces the section of NICE technology appraisal guidance 97 (published February 2006) that deals with phobia.

Introduction

Social anxiety disorder (previously known as 'social phobia') is one of the most common of the anxiety disorders. Estimates of lifetime prevalence vary but according to a US study, 12% of adults in the US will have social anxiety disorder at some point in their lives, compared with estimates of around 6% for generalised anxiety disorder (GAD), 5% for panic disorder, 7% for post-traumatic stress disorder (PTSD) and 2% for obsessive–compulsive disorder. There is a significant degree of comorbidity between social anxiety disorder and other mental health problems, most notably depression (19%), substance-use disorder (17%), GAD (5%), panic disorder (6%), and PTSD (3%).

Social anxiety disorder is persistent fear of or anxiety about one or more social situations that involve interaction, observation and performance that is out of proportion to the actual threat posed by the social situation. Typical social situations that might be anxiety-provoking include meeting people, including strangers, talking in meetings or in groups, starting conversations, talking to authority figures, working, eating or drinking while being observed, going to school, going shopping, being seen in public, using public toilets and public performances such as public speaking. Although worries about some of these situations are common in the general population, people with social anxiety disorder can worry excessively about them and can do so for weeks in advance. They fear that they will do or say something that they think will be humiliating or embarrassing (such as blushing, sweating, appearing boring or stupid, shaking, appearing incompetent, looking anxious). Social anxiety disorder can have a great impact on a person’s functioning, disrupt normal life, interfere with their social relationships and quality of life and impair performance at work or school. People with the disorder may misuse alcohol or drugs to try to reduce their anxiety (and alleviate depression).

Children may show their anxiety in different ways than adults: as well as shrinking from interactions, they may be more likely to cry, freeze or have tantrums. They may also be less likely to acknowledge that their fears are irrational when they are away from a social situation. Particular situations that can cause difficulty for socially anxious children and young people include participating in classroom activities, asking for help in class, joining activities with peers (such as attending parties or clubs), and being involved in school performances.

Social anxiety disorder has an early median age of onset (13 years) and is the most persistent of the anxiety disorders. Despite the extent of distress and impairment, only about half of those with the disorder ever seek treatment, and those who do generally only seek treatment after 15–20 years of symptoms. A substantial number of people who develop social anxiety disorder in adolescence may recover before reaching adulthood. However, if the disorder has persisted into adulthood, the chance of recovery in the absence of treatment is modest when compared with other common mental health problems.

Effective psychological and pharmacological interventions for social anxiety disorder exist but may not be accessed due to poor recognition, inadequate assessment and limited awareness or availability of treatments. Social anxiety disorder is under-recognised in primary care or commonly misdiagnosed as depression, and the early age of onset means that recognition in educational settings is also challenging.

Some recommendations in this guideline have been adapted from recommendations in other NICE clinical guidance. In these cases the Guideline Development Group was careful to preserve the meaning and intent of the original recommendations. Changes to wording or structure were made to fit the recommendations into this guideline. The original sources of the adapted recommendations are shown in the recommendations.

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual service users.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The service user (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the Good practice in prescribing medicines – guidance for doctors for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Person-centred care

This guideline offers best practice advice on the care of children and young people (from school age to 17 years) and adults (aged 18 years and older) with social anxiety disorder.

People with social anxiety disorder and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. People should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If someone does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If the person is under 16, healthcare professionals should follow the guidelines in the Department of Health's Seeking consent: working with children. Parents and carers should also be given the information and support they need to help the child or young person in making decisions about their treatment.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in Patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All health and social care providers working with people using adult NHS mental health services should follow the recommendations in Service user experience in adult mental health.

If a young person is moving between child and adolescent mental health services (CAMHS) and adult mental health services, and adult services, care should be planned and managed according to the best practice guidance

described in the Department of Health's Transition: getting it right for young people.

CAMHS and adult mental health services should work jointly to provide assessment and services to young people with social anxiety disorder. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most people would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the person about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also 'Person-centred care').

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of people, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most people.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most people, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the person's values

and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the person.

Recommendation wording in adapted recommendations

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations that have been adapted from guidelines that started development before this. In particular, adapted recommendations using the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Principles for working with all people with social anxiety disorder

- 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
  - 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). [1.1.3]

Identification and referral of adults with possible social anxiety disorder

- Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix A).
  - If the person scores 3 or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see recommendations 1.2.5–1.2.13).
  - If the person scores less than 3 on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following 2 questions:
    - ◊ Do you find yourself avoiding social places or activities?
    - ◊ Are you fearful or embarrassed in social situations?

If the person answers 'yes' to either of these questions consider social anxiety disorder. [This recommendation is adapted from Common mental health disorders (NICE clinical guideline 123)]. [1.2.1]

Interventions for adults with social anxiety disorder

- 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 Social Phobia Inventory (SPIN), the Liebowitz Social Anxiety Scale (LSAS) or the Social Phobia Scale and the Social Interaction Anxiety Scale (SPS/SIAS) 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. [1.3.1]

- Offer adults with social anxiety disorder individual cognitive behavioural therapy (CBT) specifically developed for social anxiety disorder (based on the Clark and Wells model or the Heimberg model; see recommendations 1.3.12 and 1.3.13). [1.3.2]
- For adults who decline individual CBT and wish to consider another psychological intervention, offer supported self-help (see recommendation 1.3.16). [1.3.4]
- For adults who decline individual CBT and express a preference for a pharmacological intervention, discuss their reasons for declining CBT and address any concerns. If the person wishes to proceed with a pharmacological intervention, offer a selective serotonin reuptake inhibitor

(SSRI) (fluvoxamine[1] or escitalopram). Monitor the person carefully for adverse reactions (see recommendations 1.3.17–1.3.23). [1.3.5]

Interventions for children and young people with social anxiety disorder

- Offer group-based CBT (see recommendation 1.4.6) to children and young people with social anxiety disorder aged 7 years and older. [1.4.4]
- Consider parent-delivered individual CBT (see recommendation 1.4.7) for children with social anxiety disorder aged 4–12 years. [1.4.5]

[1] At the time of publication (May 2013) fluvoxamine did not have a UK marketing authorisation for use in adults with social anxiety disorder. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

1 Recommendations

The following guidance is based on the best available evidence. The full guideline [hyperlink to be added for final publication] gives details of the methods and the evidence used to develop the guidance.

The recommendations relate to children and young people (from school age to 17 years) and adults (aged 18 years and older).

1.1 General principles of care in mental health and general medical settings

Principles for working with all people with social anxiety disorder

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 When assessing or treating 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 phone call, text and email.

1.1.3 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
- 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).

1.1.4 When a person with social anxiety disorder is first offered an appointment, 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.

1.1.5 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.

1.1.6 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.

Principles for working with children and young people with social anxiety disorder

1.1.7 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.

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

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

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 mutism may be unable to speak at all; accept information from parents or carers, but ensure that the child or young person is given the opportunity to answer for themselves, through writing or drawing 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.

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 **and**
- managing issues related to information sharing and confidentiality as these apply to children and young people **and**
- referring children with possible social anxiety disorder to appropriate services.

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 parents or carers are involved in the care 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)].

1.1.16 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.

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

1.2 Identification and assessment

Identification and referral of adults with possible social anxiety disorder

1.2.1 Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix A).

- If the person scores 3 or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see recommendations 1.2.5–1.2.13).
- If the person scores less than 3 on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following 2 questions:
  - Do you find yourself avoiding social places or activities?
  - Are you fearful or embarrassed in social situations?

If the person answers 'yes' to either of these questions consider social anxiety disorder. [This recommendation is adapted from Common mental health disorders (NICE clinical guideline 123)].

1.2.2 If a person scores 3 or more on the GAD-2 or answers 'yes' to either of the 2 questions in recommendation 1.2.1, consider using the Mini-Social Phobia Inventory (Mini-SPIN). If the person scores 6 or more on the mini-SPIN, consider a full assessment for social anxiety disorder (see recommendations 1.2.5–1.2.13).

1.2.3 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. [This

recommendation is adapted from Common mental health disorders (NICE clinical guideline 123)].

1.2.4 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. [This recommendation is adapted from Common mental health disorders (NICE clinical guideline 123)].

Assessment of adults with possible social anxiety disorder

1.2.5 Offer adults with possible social anxiety disorder the choice of an initial assessment by phone or in person.

1.2.6 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.

1.2.7 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 1.2.1 in this guideline).

1.2.8 Consider using:

- a diagnostic or problem identification instrument or algorithm, for example, the Improving Access to Psychological Therapies screening prompts
- a validated measure relevant to the disorder or problem being assessed, for example, the Social Phobia Inventory (SPIN), the Social Phobia Scale and the Social Interaction Anxiety Scale

(SPS/SIAS) or the Liebowitz Social Anxiety Scale (LSAS) to inform the assessment and support the evaluation of any intervention.

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

- situational anxiety such as:
  - feared and avoided social situations
  - problematic social beliefs and negative automatic thoughts
  - anxiety symptoms
  - view of self
  - content of self-image
  - safety behaviours
  - focus of attention and anticipatory and post-event processing
- occupational, educational, financial and social circumstances
- medication, alcohol and recreational drug use.

1.2.10 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.

Planning treatment for adults diagnosed with social anxiety disorder

1.2.11 After diagnosis of social anxiety disorder in an adult, identify the goals for treatment and provide information about the disorder and its treatment including:

- the nature and course of the disorder and commonly occurring comorbidities
- the impact on social and personal functioning
- commonly held beliefs about the cause of the disorder
- beliefs about what can be changed or treated
- choice and nature of evidence-based treatments.

1.2.12 If the person also has symptoms of depression, assess the nature and extent of the depressive symptoms and determine their functional link with the person's social anxiety disorder.

- Discuss with the person which disorder they prefer to be treated first and ask: “If I could wave a magic wand and you were no longer anxious, would you still be depressed?”
- If the person does not identify a preference, consider treating the social anxiety disorder first unless the severity of the depressive symptoms prevents this or it is clear that the social anxiety disorder developed after the depression.
- If a depressive disorder prevents treatment of the social anxiety disorder, provide or refer the person for treatment of depression in line with Depression (NICE clinical guideline 90). Treat the social anxiety disorder when improvement in depressive symptoms allows.

1.2.13 For people[2] 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.

[2] Including young people with social anxiety disorder.

Identification of children and young people with possible social anxiety disorder

1.2.14 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 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 can't do these things or try to get out of them?"

Assessment of children and young people with possible social anxiety disorder

1.2.15 A comprehensive assessment of a child or young person with possible social anxiety disorder should be conducted by a healthcare professional who is competent to undertake the assessment and 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 1 professional to ensure a comprehensive assessment can be undertaken.

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

- situational anxiety, such as:
  - feared and avoided social situations
  - problematic social beliefs and negative automatic thoughts
  - anxiety symptoms
  - view of self
  - content of self-image
  - safety behaviours
  - focus of attention and 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.

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

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

1.2.18 To aid the assessment of social anxiety disorder and other commonly comorbid anxiety disorders consider using formal instruments 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), the Spence Children's Anxiety Scale (SCAS) or the Screen for Child Anxiety Related Emotional Disorders (SCARED) for children.

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

- the Wechsler Intelligence Scale for Children (WISC-IV) (short or long form) for a child or young person with a suspected learning disability
- the Strengths and Difficulties Questionnaire for all children and young people.

1.2.20 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.

1.2.21 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 behavioural problems (for example, selective mutism)
- any coexisting mental health problems
- 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.

1.3 Interventions for adults with social anxiety disorder

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, LSAS or SPS/SIAS) 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) specifically developed for social anxiety disorder (based on the Clark and Wells model or the Heimberg model; see recommendations 1.3.12 and 1.3.13).

1.3.3 Do not routinely offer group CBT. Although group CBT can be beneficial, it is less clinically and cost effective than individual CBT.

1.3.4 For adults who decline individual CBT and wish to consider another psychological intervention, offer supported self-help (see recommendation 1.3.16).

1.3.5 For adults who decline individual CBT and express a preference for a pharmacological intervention, discuss their reasons for declining CBT and address any concerns. If the person wishes to proceed with a pharmacological intervention, offer a selective serotonin reuptake inhibitor (SSRI) (fluvoxamine[3] or escitalopram). Monitor the person carefully for adverse reactions (see recommendations 1.3.17–1.3.23).

1.3.6 For adults who decline individual CBT, supported self-help and pharmacological interventions, consider interpersonal psychotherapy or short-term psychodynamic psychotherapy specifically developed for social anxiety disorder (see

[3] At the time of publication (May 2013) fluvoxamine did not have a UK marketing authorisation for use in adults with social anxiety disorder. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

recommendations 1.3.14 and 1.3.15). Be aware of the more limited response to these interventions compared with individual CBT.

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

1.3.7 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 1.3.5) in combination with individual CBT.

1.3.8 For adults whose symptoms have only partially responded to an SSRI (fluvoxamine[4] or escitalopram) after 10 to 12 weeks of treatment, offer individual CBT in addition to the SSRI.

1.3.9 For adults whose symptoms have not responded to an SSRI (fluvoxamine[5] or escitalopram) or who cannot tolerate the side effects, and who have declined individual CBT, offer an alternative SSRI (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.

Monitor the person carefully for adverse reactions (see recommendations 1.3.17–1.3.23).

[4] At the time of publication (May 2013) fluvoxamine did not have a UK marketing authorisation for use in adults with social anxiety disorder. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

[5] At the time of publication (May 2013) fluvoxamine did not have a UK marketing authorisation for use in adults with social anxiety disorder. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

1.3.10 For adults whose symptoms have not responded to an alternative SSRI or an SNRI, offer a monoamine oxidase inhibitor (phenelzine[6] or moclobemide). Monitor the person carefully for adverse reactions.

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

Delivering psychological interventions for adults

1.3.12 Individual CBT (Clark and Wells model) for social anxiety disorder should consist of 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 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.

[6] At the time of publication (May 2013) phenelzine did not have a UK marketing authorisation for use in adults with social anxiety disorder. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing medicines – guidance for doctors for further information.

1.3.13 Individual CBT (Heimberg model) for social anxiety disorder should consist of a first session of 90 minutes' duration followed by 15 sessions of 60 minutes' duration 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.

1.3.14 Interpersonal psychotherapy for social anxiety disorder should consist of 16 to 20 sessions of 50 minutes’ duration over 4−5 months, and include the following:

- education about social anxiety
- linking social anxiety to 1 or more of 4 key relationship problem areas (role dispute, role transition, grief and interpersonal deficits)
- addressing the problem area(s) by clarifying roles and their associated emotions, giving advice, using role-play if indicated, and encouraging the person to communicate and express feelings
- preparing for the end of the therapy and future stressors.

1.3.15 Short-term psychodynamic psychotherapy for social anxiety disorder should consist of 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.

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

- 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.

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 medication 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 aged under 30 years 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.

1.4 Interventions for children and young people with social anxiety disorder

Treatment principles

1.4.1 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, LSAS or SPS/SIA for young people
  - the MASC, RCAD, 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.

1.4.2 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.

1.4.3 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.

Treatment options for children and young people with social anxiety disorder

1.4.4 Offer group-based CBT (see recommendation 1.4.6) to children and young people with social anxiety disorder aged 7 years and older.

1.4.5 Consider parent-delivered CBT (see recommendation 1.4.7) for children with social anxiety disorder aged 4–12 years.

Delivering psychological interventions for children and young people

1.4.6 Group-based 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 newly acquired skills in social situations.

1.4.7 Parent-delivered CBT should consist of the following, taking into account the child or young person's cognitive and emotional maturity:

- the use of CBT-based materials specifically designed for parents for treatment of their child's anxiety problem and
  - group training for parents in using the materials, consisting of 5−8 sessions of 90 minutes' duration over 12 weeks or
  - individual training for parents in using the materials, consisting of 5−8 sessions of 45 minutes' duration over 12 weeks
- a problem-solving approach focused on helping the parent implement the treatment programme.

1.5 Interventions that are not recommended for social anxiety disorder

1.5.1 Do not routinely offer mindfulness-based CBT or supportive psychotherapy to people with social anxiety disorder.

1.5.2 Do not routinely offer anticonvulsants, tricyclic antidepressants, beta-blockers or antipsychotic medication to people with social anxiety disorder.

1.5.3 Do not routinely offer benzodiazepines to people with social anxiety disorder except as a short-term measure during crises. Follow the advice in the British national formulary on the use of a benzodiazepine in this context.

1.5.4 Do not offer St John's wort, or other over-the-counter medications and preparations for anxiety, to people with 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.

1.5.5 Do not offer botulinum toxin for the treatment of 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.

1.5.6 Do not offer endoscopic thoracic sympathectomy for the treatment of 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.

1.5.7 Do not routinely offer pharmacological interventions or other physical interventions (botulinum toxin and endoscopic thoracic sympathectomy) for the treatment of social anxiety disorder in children and young people.

1.6 Interventions for specific phobias

Interventions that are not recommended

1.6.1 Do not routinely offer computerised CBT for the treatment of specific phobias in adults.

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

2.1 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?

Why this is important

Effective interventions exist for social anxiety disorder but access to and uptake of services is limited and over 50% of people with social anxiety disorder never receive treatment; of those who do receive treatment many wait 10 years or more for it.

This question should be addressed by a programme of work that tests a number of strategies to improve uptake and engagement, including:

- Development and evaluation of improved pathways into care, in collaboration with low users of services, through a series of cohort studies with the outcomes including increased uptake of and retention in services.
- Adapting the delivery of existing interventions for social anxiety disorder in collaboration with service users. Adaptations could include changes to the settings for, methods of delivery of, or staff delivering the interventions. These interventions should be tested in a randomised controlled trial (RCT) design that reports short- and medium-term outcomes (including cost effectiveness) of at least 18 months' duration.

2.2 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?

Why this is important

Children and young people with social anxiety disorder have commonly been treated with psychological interventions that cover a broad range of anxiety disorders, rather than interventions specifically focused on social anxiety disorder. This approach may be considered to be easier and cheaper to deliver, but emerging evidence suggests that children and young people with social anxiety disorder may do less well with these generic treatments than those with other anxiety disorders. There have, however, been no direct comparisons of treatment outcomes using generic compared with social anxiety-specific treatment programmes.

This question should be answered using an RCT design, reporting short- and medium-term outcomes (including cost-effectiveness) with a follow-up of at least 12 months. The outcomes should be assessed by structured clinical interviews, parent- and self-reports using validated questionnaires and objective measures of behaviour. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators (in particular the child or young person's age) should be investigated.

2.3 Involving parents in the treatment of children and young people with social anxiety disorder

What is the clinical and cost effectiveness of involving parents in the treatment of children and young people with social anxiety disorder?

Why this is important

Parental mental health difficulties and parenting practices have been linked with the development and maintenance of social anxiety disorder in children and young people. This suggests that interventions targeting these parental factors may improve treatment outcomes. However, interventions for children and young people with social anxiety disorder have varied widely in the extent and manner in which parents are involved in treatment and the benefit of including parents in interventions has not been established.

This question should be addressed in two stages.

- An intervention to target parental factors should be developed based on a systematic review of the literature and in collaboration with service users.
- The clinical and cost effectiveness of the intervention should be tested using an RCT design, comparing standard care (for example, group CBT) with care enhanced by a targeted parental component. It should report short- and medium-term outcomes (including cost effectiveness) with a follow-up of at least 12 months. The outcomes should be assessed by structured clinical interviews, parent- and self-reports using on validated questionnaires and objective measures of behaviour. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators (in particular the child or young person's age) should be investigated.

2.4 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?

Why this is important

The majority of systematic evaluations of interventions for social anxiety disorder in children and young people have taken a group approach. Studies with adult populations, however, indicate that individually-delivered treatments are associated with better treatment outcomes and are more cost effective.

This question should be addressed using an RCT design comparing the clinical and cost effectiveness of individual and group-based treatments for children and young people with social anxiety disorder. It should report short- and medium-term outcomes (including cost effectiveness) with a follow-up of at least 12 months. The outcomes should be assessed by structured clinical interviews, parent- and self-reports using validated questionnaires and objective measures of behaviour. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators (in particular the child or young person’s age and familial and social context) should be investigated.

2.5 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?

Why this is important

There is evidence for the effectiveness of both CBT and medication, in particular SSRIs, in the treatment of social anxiety disorder. However, little is known about the effects of combined pharmacological and psychological interventions despite their widespread use. Understanding the costs and benefits of combined treatment could lead to more effective and targeted combinations if they prove to be more effective than single treatments. The study will also provide important information on the long-term benefits of medication.

This question should be addressed in a large-scale 3-arm RCT comparing the clinical and cost effectiveness of combined individual CBT and SSRI treatment with individual CBT or an SSRI alone. Trial participants receiving medication should be offered it for 1 year. The study should report short- and medium-term outcomes (including cost effectiveness) with a follow-up of at least 24 months. The primary outcome should be recovery, with important secondary outcomes being retention in treatment, experience and side effects of medication, and social and personal functioning. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators should be investigated.

2.6 Additional interventions for adults whose social anxiety disorder has not responded to individual CBT

What is the clinical and cost effectiveness of additional psychological and pharmacological interventions in the treatment of adults with social anxiety disorder who have not recovered when treated with individual CBT?

Why this is important

Individual CBT is probably the most cost-effective intervention for adults with social anxiety disorder but short-term psychodynamic psychotherapy and SSRIs are also effective treatments. However, even with individual CBT, 30–40% of people may not recover. In clinical practice such individuals may be offered or seek alternative treatments including other psychological interventions and medication. Currently there is no high-quality evidence available to inform service users or clinicians about which of the alternative treatments may be most helpful. Understanding the costs and benefits of the use of additional treatments could lead to more effective sequencing of interventions and more cost-effective use of NHS resources.

This question should be addressed in a large-scale, 2-arm RCT comparing the clinical and cost effectiveness of short-term psychodynamic psychotherapy and an SSRI in people whose social anxiety disorder has not responded to adequate course of individual CBT. It should report short- and medium-term outcomes (including cost-effectiveness) with a follow-up of at least 30 months. The primary outcome should be recovery, with important secondary outcomes being retention in treatment, experience and side effects of medication, and social and personal functioning. The study needs to be large enough to determine the presence of clinically important effects, and mediators and moderators should be investigated.

3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

3.2 Related NICE guidance

Details are correct at the time of consultation on the guideline (December 2012). Further information is available on the NICE website.

Published

General

- Patient experience in adult NHS services. NICE clinical guidance 138 (2012).
- Service user experience in adult mental health. NICE clinical guidance 136 (2011).
- Common mental health disorders. NICE clinical guideline 123 (2011).
- Medicines adherence. NICE clinical guideline 76 (2011).

Condition-specific

- Alcohol dependence and harmful alcohol use. NICE clinical guideline 115 (2011).
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).
- Looked-after children and young people. NICE public health guidance 28 (2010).
- Depression . NICE clinical guideline 90 (2009).

- Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009).
- Social and emotional wellbeing in primary education. NICE public health guidance 12 (2008).
- Obsessive–compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Depression in children and young people. NICE clinical guideline 28 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).

Under development

NICE is developing the following guidance (details available from the NICE website):

- Autism: management of autism in children and young people. NICE clinical guideline. Publication expected November 2013.

4 The Guideline Development Group, National Collaborating Centre and NICE project team

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Appendix A GAD-2 short screening tool

The GAD-2 short screening tool consists of the first 2 questions of the GAD-7 scale.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

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