In this issue of the *Journal*, Rapee et al (1) report a rigorous randomised controlled trial (RCT) comparing transdiagnostic treatment and specialized social anxiety treatment for children and young people with social anxiety disorder (SAD). The study is a welcome addition to the literature that highlights the need to renew our efforts to improve understanding and treatment of SAD in childhood.

We now have highly effective treatments for adult SAD. Individual Cognitive Behaviour Therapies (CBT) designed specifically to target the disorder, such as Cognitive Therapy following the Clark & Wells model and the Hope, Heimberg & Turk treatment (2), are associated with large effect sizes compared to waitlist, placebo and active comparators and have a lower risk of side-effects than pharmacotherapy. In contrast, treatment outcomes for children and young people with SAD are typically disappointing.

At the moment, children and young people with SAD are usually treated with a standard 'generic' form of CBT designed to treat all the common anxiety problems. Standard CBT comprises psychoeducation about anxiety, coping strategies (e.g., relaxation; problem solving; thought challenging) and graded exposure to feared situations. Many large RCTs have evaluated the various versions of standard CBT for the treatment of anxiety problems in children and young people and found them to be associated with substantial controlled effect sizes. However, as always, the devil is in the detail. The key outcomes in most of these trials were loss of primary diagnosis and change on continuous measures of broad anxiety symptoms. As studies began to look at outcomes for *specific* anxiety disorders, SAD was found to be a predictor of poor response in numerous studies. A recent meta-analysis confirmed this: young people with SAD are almost 50% less likely to recover from generic CBT than those with other anxiety disorders (3). The importance of improving treatment outcomes for this population is clear when one bears in mind that SAD is the most common anxiety disorder, with lifetime prevalence rates of around 7%, and has its onset before adulthood in over 90% of cases.

Here, Rapee et al (1) compare a standard version of CBT ('Cool Kids') with a version of the treatment that was adapted with additional elements for the treatment of SAD. 200 children and young people with SAD (aged 7-16 years, mean: 9.52 [SD=2.19]) were

randomly allocated to standard CBT or SAD-specific CBT. Both treatments were face-to-face and consisted of 10 sessions delivered over 12 weeks. The standard version of 'Cool Kids' provides generic skills for all anxiety types, such as anxiety management techniques, cognitive restructuring, and exposure tasks. For the SAD-specific treatment, 'Cool Kids' was augmented with elements aimed at targeting proposed mechanisms of SAD such as attention training, social skills training, cognitive restructuring, reduction of safety behaviours and video feedback. At baseline, post-treatment and six-months follow-up, measures of social anxiety, anxiety, depression and impact were taken, as well as measures of theorised mechanisms: focus of attention, perceived performance, negative beliefs, avoidant behaviours and therapeutic alliance. The study found diagnostic remission rates of 41% after generic CBT and 44% after SAD-specific CBT post-treatment, that increased to 51% and 69% respectively at follow-up. Remission rates did not significantly differ between groups at either time point. Similarly, although there were improvements over time for the secondary outcome measures and in measures of proposed mechanisms of change at post-treatment, the only measure that significantly differed between conditions after treatment was a measure of attentional focus; participants who received SAD-specific CBT showed greater improvement in attentional focus during a social task relative to those who received standard CBT.

The authors have undertaken a high-quality RCT. Strengths include the large sample size and inclusion of a good breadth of key outcome measures with both parent, child, and clinician ratings, including measures of proposed mechanisms. There are also a few limitations worth mentioning. First, this is a predominantly White, medium to high socioeconomic status sample recruited to a university research clinic. As a result, the sample is unlikely to be representative to the general population and caution is needed when considering applying the findings. Second, the measures of potential mechanisms (i.e., therapeutic alliance, attentional focus, subtle avoidance, perceived performance, and social threat beliefs) were assessed at baseline, post-treatment, and follow-up. The failure to collect these measures at an additional time point before the end of treatment precludes the opportunity to test temporal precedence in relation to change during the therapy process. Third, the age range for inclusion was wide (7-16 years) but few adolescents were included and no young people

over 16 years. This potentially raises questions about the generalisability of the findings to adolescents.

The failure to demonstrate significant differences between standard and SAD-specific CBT in the present study echo findings from a RCT by Spence et al (4). Spence et al compared a standard treatment ('BRAVE') to a version of 'BRAVE' modified for SAD. The SAD-specific version included social skills training, attention training, reduction of safety behaviours, cognitive challenging and coping skills. In a RCT of 125 8–17-year-olds, the standard and SAD-specific versions of the treatment (both internet-delivered) were compared to a waitlist control. Diagnostic remission rates were surprisingly low for all conditions (3-15%), but like the findings of Rapee et al the two treatment arms did not significantly differ at either post-treatment or follow-up assessment points. This approach of augmenting standard treatments has also been tested in adult SAD. In a RCT with 195 adults with SAD (5), although SAD-specific CBT outperformed standard CBT on some measures, diagnostic remission rates were comparable between the two treatment types.

Rapee et al (1) have reported a high-quality trial with an important aim. But taken together with the findings of Spence et al (4) and Rapee et al (5), it seems that augmenting standard CBT with certain SAD-specific techniques may not be the optimal approach to treating SAD. As suggested by Rapee et al (1), this may be because augmented CBT does not maximise opportunities to modify maintenance processes. Indeed, the adult treatments for SAD that have the highest efficacy, such as Cognitive Therapy based on the Clark & Wells model (2) tend to be integrated treatments that were specifically developed in response to theoretically derived models and they do not include many key elements of standard CBT, such as psychoeducation and social skills training. Each treatment element is optimised to target particular aspects of the model. For example, in Cognitive Therapy key maintenance processes such as self-focused attention and safety behaviours are targeted from very early on to ensure patients can rapidly begin to discover that they are more acceptable than they thought. In contrast, in the 'Cool Kids' SAD-specific treatment in the RCT of Rapee et al these processes are addressed mid-way through treatment following the introduction of various standard CBT strategies (1, 6).

What direction should we now take to develop effective treatments for SAD in young people? Rapee and his fellow authors convincingly argue that we should adopt an integrated theory-driven approach, as has been implemented so effectively in adults. Already this is bearing fruit in relation to adolescent SAD. Numerous recent studies have found support for the Clark & Wells model in adolescents (e.g., (7-10)) and two RCT's indicate that Cognitive Therapy for adolescent SAD is associated with large controlled effect sizes (11, 12). However, findings are more mixed for pre-adolescents (13) and it remains unclear when and how the psychological processes that we have found to be relevant to the maintenance of SAD in adolescents and adults come into play. As Rapee and his co-authors (1) suggest, we should now focus on delineating SAD maintenance mechanisms in middle and late childhood to optimise early interventions and so reduce the chronic burden of SAD.

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