

Supplementary Appendix 1. Study Management

Data on the primary and secondary outcomes and adverse events were collected at weeks 0 (baseline), 8 (mid-intervention), and 16 (post-intervention). All data were collected by the independent data management center at Data Centre, Chiba University Hospital Clinical Research Centre. Investigators provided case report forms to the data center for input into the study database. Trained data managers inputted the data by double data entry. The clinical data entry, data management, and reporting were performed by the UHCT ACRess data management system (UHCT Alliance Clinical Research Supporting System) (FUJITSU ADVANCED ENGINEERING Ltd, Tokyo, Japan).

Supplementary Appendix 2. Details of Cognitive Behavioral Therapy used in the Trial

Individual cognitive behavioral therapy (CBT) was based on the Clark and Wells model (1995) of the maintenance of social anxiety disorder and its brief procedures (Clark and Wells, 1997, Chapter 7). Therapists adhered to the treatment manual (unpublished) developed by two of us (NY and ES) who attended a workshop run by Clark DM (however, he did not supervise our therapy sessions). The main steps of CBT employed in this study were as follows:

- (a) Developing an individualized version of the cognitive model of social anxiety disorder
- (b) Conducting role play-based behavioral experiments, with and without safety behaviors
- (c) Restructuring distorted self-imagery using videotape feedback
- (d) Practicing external focus and shifting attention
- (e) Performing a behavioral experiment to test the patient's negative beliefs
- (f) Modifying problematic pre-event and post-event processing
- (g) Surveying the differences between the beliefs of self and those of others
- (h) Dealing with the remaining assumptions
- (i) Re-scripting early memories linked to negative images in social situations
- (j) Preventing relapse

All sessions were audiotaped, and patients were encouraged to listen to the recordings as part of their homework. Therapy was conducted both inside and outside the treatment room, and between-session homework was designed in collaboration with the patient. To reduce patient self-consciousness and summarize discussions, notes were made on a whiteboard or notebook during the sessions.

Supplementary Appendix 3. Therapist Training in Cognitive Behavioral Therapy before the Trial

All therapists had completed a cognitive behavioral therapy (CBT) training course (Chiba Improving Access to Psychological Therapies project: Chiba-IAPT) and additional two-day special workshop about CBT for social anxiety disorder (SAD).

Chiba-IAPT was inspired and influenced by the IAPT Project in the UK, and was set up in 2010. It was the first post-qualification course for CBT in Japan. Trainees who enroll in the course are required to attend a series of workshops held over two years. The training day typically consists of a three-hour workshop in the morning, a 90-minute clinical case conference, and a 60-minute peer supervised group discussion in the afternoon. In addition, trainees receive 30-minute individual supervision. The full course of training takes more than 400 hours. Similar to the accreditation for 'high-intensity' practitioners in UK-IAPT, our trainees are required to complete 200 hours of clinical practice, receive 70 hours of supervision, and complete written reports for a minimum of eight cases.

An additional two-day (14 hours) special workshop was conducted by two study investigators (NY and ES) who attended a workshop run by original developer (Clark DM). Study therapists learned about the maintenance model of SAD and therapeutic techniques based on the treatment manual (unpublished) through both lectures and role-plays.

Supplementary Table 1. Raw Data of Antidepressant and Anxiolytic Dose

Medication and time	CBT + UC (n = 21)			UC (n = 21)			p value
	Mean	(SD)	95% CI	Mean	(SD)	95% CI	
Antidepressant (mg/day)[†]							
Week 0	70.5	(62.2)	43.9–97.1	84.5	(98.9)	42.2–126.8	0.97
Week 8	78.0	(68.0)	48.9–107.1	71.9	(88.7)	34.0–109.8	0.54
Week 16	77.1	(72.6)	46.0–108.2	70.6	(96.4)	29.4–111.9	0.47
Anxiolytic (mg/day)[‡]							
Week 0	3.5	(4.3)	1.7–5.3	6.7	(10.7)	2.1–11.2	0.48
Week 8	3.5	(4.2)	1.7–5.3	7.0	(20.9)	2.3–11.6	0.47
Week 16	3.4	(3.9)	1.7–5.1	6.4	(10.3)	2.0–10.8	0.45

[†] Imipramine-equivalent dose. [‡] Diazepam-equivalent dose. Abbreviations: CBT, cognitive behavioral therapy; CI, confidence interval; SD, standard deviation; UC, usual care

Supplementary Table 2. Details of Change in antidepressants during the trial

Type of change	Group	n/total	Details
Started	CBT + UC	1/21	One patient re-started escitalopram (10mg) (Before the trial the patient had been treated with Escitalopram.)
	UC	1/21	One patient started trazodone (25mg)
Increased	CBT + UC	2/21	One patient increased the dose of duloxetine (40mg to 60mg), and the other patient increased the dose of fluvoxamine (100mg to 150mg) and amoxapine (50mg to 75mg)
	UC	1/21	One patient increased the dose of fluvoxamine (250mg to 300mg)
Decreased	CBT + UC	1/21	One patient decreased the dose of sertraline (50mg to 25mg)
	UC	1/21	One patient decreased the dose of sertraline (50mg to 25mg)
Stopped	CBT + UC	1/21	One patient stopped taking paroxetine
	UC	2/21	One patient stopped taking fluvoxamine, and the other patient stopped taking sertraline
Other	CBT + UC	1/21	One patient stopped taking fluvoxamine, and increased the dose of nortriptyline (10mg to 25mg)
	UC	0/21	N/A

Abbreviations: CBT, cognitive behavioral therapy; UC, usual care

Supplementary Table 3. Raw Primary Outcome Data (Liebowitz Social Anxiety Scale)

Time	CBT + UC (n = 21)			UC (n = 21)			p value
	Mean	(SD)	95% CI	Mean	(SD)	95% CI	
Week 0	82.2	(20.4)	73.5–91.0	82.4	(17.5)	74.9–89.9	0.97
Week 8	62.6	(7.4)	55.1–70.0	81.1	(22.8)	71.1–91.1	0.0056
Week 16	39.2	(21.8)	29.9–48.6	80.9	(20.1)	72.1–89.7	<0.0001

Abbreviations: CBT, cognitive behavioral therapy; CI, confidence interval; SD, standard deviation; UC, usual care

Supplementary Table 4. Raw Blinding Status Data of the Respondents

Main data (Week 8)					
Actual intervention	Assessor rating, n				
	a	b	c	d	e
CBT + UC	0	2	1	3	15
UC	0	2	2	1	15

Ancillary data for “do not know” responses (Week 8)		
Actual intervention	Assessor guess, n	
	CBT + UC	UC
CBT + UC	11	4
UC	6	9

Main data (Week 16)					
Actual intervention	Assessor rating, n				
	a	b	c	d	e
CBT + UC	3	6	4	0	8
UC	1	4	4	1	10

Ancillary data for “do not know” responses (Week 16)		
Actual intervention	Assessor guess, n	
	CBT + UC	UC
CBT + UC	4	4
UC	6	4

Notes: a = strongly believe that the treatment is CBT + UC; b = somewhat believe that the treatment is CBT + UC; c = somewhat believe that the treatment is UC alone; d = strongly believe that the treatment is UC alone; e = do not know. Abbreviations: CBT, cognitive behavioral therapy; SD, standard deviation; UC, usual care

Supplementary Table 5. Blinding Indexes by Bang's and James' Methods

Time	Methods	Index	95% CI	p value	Conclusion
Week 8	James	0.87	0.79–0.96	1	Blinded
	Bang–CBT + UC 2 × 3	–0.12	–0.22–0.19	0.54	Blinded
	Bang–UC 2 × 3	0.09	–0.22–0.19	0.23	Blinded
	Bang–CBT + UC 2 × 5	0.01	–0.11–0.29	0.44	Blinded
	Bang–UC 2 × 5	0.11	–0.40–0.26	0.11	Blinded
Week 16	James	0.66	0.54–0.79	0.99	Blinded
	Bang–CBT + UC 2 × 3	0.23	–0.04–0.51	0.08	Blinded
	Bang–UC 2 × 3	–0.25	–0.29–0.24	0.56	Blinded
	Bang–CBT + UC 2 × 5	0.19	0.01–0.37	0.04	Unblinded
	Bang–UC 2 × 5	–0.25	–0.20–0.15	0.59	Blinded

Notes: Calculation was conducted in Stata/IC 11.2 (StataCorp, College Station, TX, USA) using the ‘blinding’ module written by Jiefeng Chan of Texas A&M University. Please see ‘James et al. Stat Med 1996; 15:1421-34’ for details of James’ methods. Abbreviations: CBT, cognitive behavioral therapy; CI, confidence interval; UC, usual care