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Social Anxiety Disorder: Classification, Diagnosis, Treatment and Rehabilitation

Student name	Uzma Mehtab
Student number	2330366
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Introduction

Social anxiety disorder (SAD), previously known as social phobia, is a long-term fear of social situations in which a person fears they may be criticised, embarrassed, rejected, or humiliated. It is more than shyness since the anxiety results in avoidance, distress and poor schooling, work, relationships and everyday functioning (World Health Organization, 2024; Stein and Stein, 2008). SAD is important in the treatment of mental health in the UK since it usually begins before adulthood, may become a long term problem and can go undetected as the disease itself causes phone calls, visits and disclosure to be scary (Kessler et al., 2005; NHS, 2025). The study critically examines SAD via an exploration of categorisation, diagnosis, treatment, rehabilitation, current disputes and UK policy.

Classification and diagnosis

In ICD-11, SAD is included in Chapter 6 (anxiety or fear-related disorders) under code 6B04. The ICD-11 categorisation describes excessive fear or anxiety in social contexts, concern about negative appraisal, avoidance or persistence with great pain and substantial disability (World Health Organization, 2024). This is medically beneficial in that it separates a recognised sickness from normal nervousness. However the phrase 'disorder' may often seem stigmatising and thus practitioners should use person-centred language and avoid limiting the individual to a diagnostic (Bögels et al., 2010; NICE, 2013). The DSM-5-TR is similar, but has a "performance-only" specifier where anxiety is restricted to public speaking or acting. This allows for more accurate evaluation, but also brings up questions of whether SAD is categorical or dimensional (American Psychiatric Association, 2022; Aune et al., 2023).

Diagnosis should be structured but not mechanical. NICE recommends asking whether the person avoids social situations and whether they experience fear or embarrassment in social situations and then carrying out a full assessment of symptoms, triggers, safety behaviours, functional impairment, comorbidity, risk and personal goals (NICE, 2013). Screening measures such as the Mini-SPIN may be beneficial in identifying probable SAD but should not replace clinical judgement. Differential diagnosis is important since autism, body dysmorphic disorder, panic disorder, trauma, selective mutism, avoidant personality features and culture-influenced communication styles may apparently be similar (American Psychiatric Association, 2022;

Montaser et al., 2023). For example, an autistic person may avoid eye contact due to sensory or communication challenges yet an individual with SAD may avoid eye contact since they fear judgement. Mix them together and you may have a horrible treatment strategy.

Research from the UK and elsewhere shows SAD is common and debilitating. The World Mental Health Survey Initiative estimated the lifetime prevalence of SAD at 4.0% across nations, with higher rates in high income countries (Stein et al., 2017). Figures in England show a larger load on services: The APMS 2014 found approximately one in six met the criteria for a common mental illness; however, the APMS 2023/24 found an increase in the prevalence of common mental health conditions, particularly in younger adults (McManus et al., 2016; NHS Digital, 2025a). These percentages are larger than SAD, but important since social anxiety seldom occurs in a vacuum; it is usually associated with depression, other anxiety problems, loneliness or educational and occupational stress. Additional data indicates that greater social concerns are related to a worse quality of life and more comorbidity (Acarturk et al., 2008). So assessment needs to ask 'does the individual fit criteria?' but also 'what has anxiety prevented this person doing?'

Do not criticise the individual for avoidance in ethical judgement. Avoidance is neither laziness or rudeness; it is the person's short-term survival strategy. Social anxiety may be the tip of an iceberg of a broader risk picture and the practitioner should address safeguarding, thoughts of suicide, managing with alcohol or drugs, bullying and family pressure. Comorbidity is no small matter: social anxiety often co-exists with mood, substance and other anxiety problems, and SAD may precede later depression (Acarturk et al., 2008; Stein and Stein, 2008). Thus a formulation that is person-centred is more effective than a checklist, since it connects diagnosis to the person's history, culture, talents and objectives.

Treatment approaches

The strongest evidence-based treatment for adults is individual disorder-specific cognitive behavioural therapy. NICE recommends individual CBT based on the Clark and Wells or Heimberg models as first-line treatment, rather than generic anxiety management or simple confidence advice (NICE, 2013; Clark and Wells, 1995; Heimberg et al., 2014). These models explain SAD as being maintained by fear of negative evaluation, self-focused attention, safety behaviours, negative imagery, anticipatory worry and post-event rumination. CBT therefore uses behavioural experiments, attention training, video feedback, cognitive restructuring and graded

exposure to test feared predictions rather than merely telling the person to “calm down” (Rapee and Heimberg, 1997; Clark et al., 2006).

Evidence supports this recommendation. A network meta-analysis found that individual CBT produced strong effects and should be considered a first-line intervention for adults with SAD (Mayo-Wilson et al., 2014). Randomised trials found cognitive therapy superior to fluoxetine plus self-exposure in generalised social phobia and superior to exposure plus applied relaxation on social phobia outcomes (Clark et al., 2003; Clark et al., 2006). This does not mean medication has no place. SSRIs such as sertraline or escitalopram can help when CBT is declined, unavailable or insufficient, but they require monitoring for side effects, adherence and relapse after stopping (NICE, 2013; Leichsenring and Leweke, 2017). Short-term psychodynamic therapy is another option when CBT is declined, although trial evidence found stronger outcomes for CBT on several measures (Leichsenring et al., 2013).

Children and young people need adaptation rather than a copied adult model. NICE advises CBT focused on social anxiety, with parental involvement where useful, and states that medication should not routinely be offered to children and young people with SAD (NICE, 2013). Leigh and Clark (2018) argue that adolescent social anxiety can involve the same maintenance processes as adult SAD, but school context, peer judgement, family accommodation and social media comparison can make it harder to break avoidance. Treatment should therefore include school-related goals, such as asking for help in class, eating around peers, attending group activities or speaking in small stages, while ensuring that support does not accidentally protect avoidance forever.

Access is an awkward bit in the UK. NHS Talking Therapies services offer NICE-recommended psychological therapies for individuals with anxiety disorders and depression and may be referred by a GP or self-refer if accessible (NHS England, 2026). But targeting service availability isn't the same as providing the correct treatment. NHS Digital found that the majority of persons accessing NHS Talking Therapies began their course within six weeks. However, regional diversity, strong demand and the need for high intensity SAD-specific CBT may still pose barriers (NHS Digital, 2025b). Digital treatment may relieve pressure: a randomised experiment revealed online cognitive therapy for SAD to be equivalent to face-to-face cognitive therapy, while requiring less therapist time (Clark et al., 2023). The limitation is that digital routes may exclude people with low confidence, poor privacy, limited digital access or severe avoidance.

Treatment should also be critically assessed by outcomes that matter to the service user. A person might show lower questionnaire scores but still avoid work meetings, dating, study groups or GP appointments. NICE guidance is useful because it links symptom improvement with social, educational and occupational functioning, but services need enough time and skill to deliver the full model rather than a watered-down version (NICE, 2013). Therapists should also avoid overusing relaxation as the main intervention, because relaxation alone may not challenge the core fear of negative evaluation.

Rehabilitation and long-term management

The goal of rehabilitation should be participation, not only symptom ratings. Avoidance may narrow a person's environment such that education, job, friendships, attendance at healthcare appointments and independence become challenging. SAD has been associated with decreased quality of life and work impairment, particularly in the presence of comorbid depression (Wong et al., 2012; Moitra et al., 2011). A realistic recovery strategy should include relapse prevention, graduated return to dreaded activities, communication practice, help with education or job and preparedness for setbacks. Meaningful and collaborative exposure: one person's aim may be to order meals, another to attend university, answer a phone call, attend placement meetings or do job interviews.

Relapse prevention should be seen as part of the long-term treatment of social anxiety since life events such as changing course, beginning job, bereavement, relationship breakup or sickness may trigger relapse. The client should leave treatment with a strategy for identifying early warning signals, lowering safety habits, maintaining exposure and seeking assistance before avoidance gets established again. Charities, peer groups and university or workplace wellness programs may promote recovery, but should not be a substitute for evidence-based therapy when symptoms are severe.

Legal structures in the UK also impact rehabilitation. If SAD has a big and long term harmful impact on regular day to day activities the Equality Act 2010 may demand reasonable changes in education, employment and services (Equality Act 2010). Examples may include consistent presenting arrangements, incremental introduction to group duties, quiet waiting rooms, written communication alternatives or flexibility around appointments. These changes should help to break down unjust obstacles but yet assist rehabilitation rather than locking in permanent avoidance. The Care Act 2014 is applicable in cases of acute anxiety resulting in isolation or loss of freedom. Local authorities have a duty to promote wellness when persons have care and

support requirements (Care Act 2014). The Mental Health Act 1983 is less often fundamental to SAD, but becomes significant if severe comorbidity or risk leads to obligatory examination or treatment (Mental Health Act 1983).

Current debates, recommendations and conclusion

One significant dispute is whether SAD is a distinct condition or just the extreme end of a spectrum of social anxiety. Categorical diagnosis facilitates access to resources, research consistency and treatment planning, but a dimensional perspective better identifies patients with subthreshold yet debilitating symptoms (Bögels et al., 2010; Aune et al., 2023). Another conversation is on neuro-divergence. Social anxiety is frequent among autistic persons, but clinicians should not assume that autistic social communication abnormalities are inevitably problematic or overlook treatable anxiety because autism “explains everything” (Montaser et al., 2023). Good practice entails questioning whether the fear is triggered by negative appraisal, sensory overload, past bullying, pressure to mask, minority stress or a mixture of these.

Treatment format is likewise controversial. NICE recommends individual CBT, however group work normalises experiences and provides actual social practice, and digital CBT increases capacity (NICE, 2013; Clark et al, 2023). A balanced service provides options but should be disorder specific and result orientated in its therapy. These include better early identification in schools and primary care, training assessors in autism-aware differential diagnosis, protecting funding for high-intensity CBT, offering digital CT-SAD where appropriate, involving families without promoting overprotection and collecting outcomes by age, deprivation and ethnicity to reduce inequality (NHS England, 2026; NHS Digital, 2025b).

The problem is about funding since NICE guidelines are of little practical relevance if patients cannot get to see professional therapists fast. Commissioners need to ensure that persons with SAD are getting disorder-specific high intensity CBT and not being put into low intensity treatment which is unlikely to be adequate for severe avoidance. Services should also provide appointment means that lower initial contact barriers, such as online referral, SMS reminders and clear information on what an assessment would entail, since ambiguity itself may work to prevent attendance (NHS, 2025; NHS England, 2026).

To summarise, SAD is a condition connected to worry and dread in the ICD-11, which may significantly affect education, job, relationships and access to healthcare. Individual disorder-specific CBT is the best-supported adult treatment, with SSRIs, psychodynamic therapy, group methods and internet therapy employed as appropriate, depending to need,

preference and availability. "Success in rehabilitation should be measured by participation and quality of life, not just lower anxiety scores. UK practice should thus include early detection, person-centred diagnosis, evidence-based therapy, appropriate adaptations and autism-aware evaluation in an effort to bring individuals back into life, rather than merely teach them to avoid anxiety more politely.

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