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BMHP6029-Psychopathological Classifications and Provisions

Component 2: Written Assignment (Report)

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Introduction

Social Anxiety Disorder (SAD) is a prevalent and often debilitating mental health disorder characterised by a persistent fear of social situations in which others may scrutinise an individual. Individuals with SAD commonly fear negative evaluation, embarrassment, or rejection, leading to avoidance behaviours and significant impairment across social, educational, and occupational domains. This report critically examines Social Anxiety Disorder in accordance with the International Classification of Diseases, 11th Revision (ICD-11), following the BMHP6029 Component 2. The discussion addresses classification and diagnosis, treatment and rehabilitation, current debates and emerging issues, and concludes with evidence-based recommendations for practice, policy, and further research.

Classification and Diagnosis: Social anxiety disorder

In ICD-11, Social Anxiety Disorder is classified under *Anxiety or Fear-Related Disorders* (code 6B04) (World Health Organisation [WHO], 2019). It is defined as a mental disorder characterised by marked and excessive fear or anxiety in social situations involving potential scrutiny, such as social interactions, being observed, or performing in front of others. The anxiety is persistent, disproportionate to the actual threat posed, and results in clinically significant distress or functional impairment.

Diagnostic criteria include fear of negative evaluation, avoidance of feared social situations or endurance with intense anxiety, persistence of symptoms for several months or more, and impairment across key life domains. Diagnosis relies on a comprehensive clinical assessment, including detailed clinical interviews, symptom severity measures, and differential diagnosis to exclude conditions such as depressive disorders, autism spectrum disorder, or panic disorder. ICD-11 emphasises cultural sensitivity, recognising that social norms and expectations vary across cultures.

The terminology “disorder” reflects a categorical medical model that supports diagnostic clarity and access to treatment. However, this language has been

criticised for potentially pathologising normative variations in social behaviour (Stein & Stein, 2008).

Treatment and Rehabilitation:

Cognitive Behavioural Therapy (CBT) is widely recognised as the first-line psychological treatment for Social Anxiety Disorder. CBT interventions aim to challenge maladaptive beliefs, reduce avoidance behaviours, and promote gradual exposure to feared social situations (Clark & Wells, 1995; Heimberg, 2002). Strong empirical evidence supports CBT as an effective intervention with sustained treatment gains.

Pharmacological treatment is recommended for moderate to severe cases or when psychological interventions alone are insufficient. Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) are the most commonly prescribed medications (American Psychiatric Association [APA], 2022). While effective, pharmacological treatments may be associated with side effects and relapse following discontinuation.

Although ICD-11 does not specify treatment protocols, it endorses evidence-based practice. Rehabilitation extends beyond symptom reduction and includes psychoeducation, social skills training, vocational support, and relapse prevention. Limitations of current approaches include variable treatment response, medication side effects, stigma, and restricted access to specialist psychological therapies (National Institute for Health and Care Excellence [NICE], 2013).

Current Debates and Emerging Issues:

One ongoing debate concerns the medicalisation of social anxiety and whether Social Anxiety Disorder represents a pathological condition or an extreme variant of normal social fear. Critics argue that categorical diagnostic systems may inadequately capture the dimensional nature of anxiety severity (Rapee & Spence, 2004).

Another significant issue involves the overlap between Social Anxiety Disorder and neurodivergence, particularly autism spectrum conditions. Research suggests that autistic traits may influence the presentation and severity of social anxiety, increasing

the risk of misdiagnosis and inappropriate intervention (Bejerot & Mörtberg, 2009). These debates have important implications for diagnostic accuracy, service provision, and inclusive mental health policy.

Recommendations:

Improvements in practice should include the integration of dimensional assessment tools alongside categorical diagnosis, enhanced clinician training in neurodiversity-informed practice, and improved access to evidence-based psychological therapies. Policy initiatives should prioritise early intervention, culturally responsive services, and the integration of mental health support within educational and occupational settings. Further research is required to examine personalised treatment approaches and long-term functional outcomes.

Conclusion

Social Anxiety Disorder is a well-established diagnosis within ICD-11, supported by robust diagnostic criteria and effective treatment approaches. However, ongoing debates surrounding classification, medicalisation, and neurodivergence highlight the need for continued refinement. Implementing the recommendations outlined in this report may enhance diagnostic accuracy, treatment effectiveness, and ethical mental health practice.

References

American Psychiatric Association. (2022). *DSM-5-TR: Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). APA Publishing.

Bejerot, S., & Mörtberg, E. (2009). Do autistic traits play a role in the severity of social anxiety disorder? *Nordic Journal of Psychiatry*, 63(5), 341–346.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. Heimberg et al. (Eds.), *Social phobia: Diagnosis, assessment, and treatment*. Guilford Press.

Heimberg, R. G. (2002). Cognitive-behavioural therapy for social anxiety disorder: Current status and future directions. *Biological Psychiatry*, 51(1), 101–108.

Kessler, R. C., et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders. *Archives of General Psychiatry*, 62(6), 593–602.

McManus, F., Clark, D. M., & Hackmann, A. (2000). Specificity of cognitive biases in social phobia. *Journal of Abnormal Psychology*, 109(2), 321–331.

National Institute for Health and Care Excellence. (2013). *Social anxiety disorder: Recognition, assessment and treatment (CG159)*. NICE.

Rapee, R. M., & Spence, S. H. (2004). The aetiology of social phobia. *Behaviour Research and Therapy*, 42(6), 737–767.

Stein, M. B., & Stein, D. J. (2008). Social anxiety disorder. *The Lancet*, 371(9618), 1115–1125.

World Health Organisation. (2019). *International classification of diseases for mortality and morbidity statistics (11th ed.)*. WHO.