Social anxiety disorder is a common, debilitating and life-affecting disorder that is under-recognised and undertreated. Although many of us have experienced anxiety in social settings, such as at a job interview or at a party where we are not familiar with the other guests, people with SAD experience more intense and persistent emotions, fearing they will appear unacceptably foolish or awkward in the eyes of others.

These negative expectations provoke intense self-consciousness, which itself may affect the individual’s ability to cope because their attention is directed inwardly. The typical symptoms of anxiety become even more problematic because physiological changes – such as tremor, blushing or sweating – are felt to be obvious to others.

People with SAD are also likely to experience excessive worry before anxiety-provoking events and negative self-judgment afterwards. Perhaps most damagingly, they may attempt to avoid social situations, which can have a negative impact on their personal, educational and professional development.

The disorder can co-occur with depression and other anxiety disorders, as well as with drug and alcohol use, which can cause it to often go unrecognised or be misdiagnosed.

In children, SAD may manifest itself differently than in adults. Affected children may be prone to tantrums, disruptive social behaviour or marked avoidance that may be mislabelled as “shyness” or a reluctance to “join in” group activities. In some children, refusing to go to school may be a sign of social anxiety disorder.

The guideline says that one US study found as many as 12% of the population experience SAD over their lifetime. Typical onset is in late childhood or adolescence, but those affected may take as long as 20 years to seek treatment.

Alternatively, short-form questionnaires such as the seven-item Generalised Anxiety Disorder assessment (GAD-7), or the three-item Mini-Social Phobia Inventory (Mini-SPIN) can be used. If either method suggests the presence of social anxiety, a more detailed assessment should be carried out or the patient should be referred to appropriate services.

Patients with alcohol and drug problems may be using these substances to try to cope with their social anxiety.

Treatment

For both children and adults, the primary treatment is cognitive behavioural therapy. In adults, individual therapy has been shown to be both more effective and more cost-effective than group therapy, while in children there is evidence that both approaches are effective.

Interventions must be designed for social anxiety (Clark, 2009) and treatment should only be offered by practitioners trained in the appropriate therapeutic approach. With young people, especially younger children, professionals should consider the involvement of parents in treatment.

Patients unwilling or unable to attend individual CBT may be offered appropriate self-help material or referred to an appropriate prescriber to discuss antidepressant options. Psychodynamic treatment may also be considered.

The guideline is available for download at www.nice.org.uk/CG159

Peter Armstrong is former director of training at Newcastle Cognitive and Behavioural Therapies Centre, Northumberland, Tyne and Wear Foundation Trust

Reference