National Institute for Health and Clinical Excellence

Social Anxiety Disorder
Scope Consultation Table
22nd March to 19th April 2011

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No	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment	Change to Scope
1	SH	Association for Family Therapy and Systemic Practice	10.01	General	Given the links between social and relationship issues and anxiety, a systemic approach will be a useful way to address relationships, ethnic, cultural and contextual issues and their families – partners, parents, siblings and their children. There may not be evidence that fits with NICE criteria for systemic couple and family therapy treatments for social anxiety disorder, but there is good evidence for problems that may be associated with social anxiety – eg for Alcohol Dependence and Harmful alcohol use; couple therapies for Depression in adults, Family therapy for children and young people, Post Traumatic Stress Disorder.	Thank you for your comments; we will bear these issues in mind when developing the guideline.	n/a
2	SH	British Association for Performing Arts Medicine	14.01	General	Group Composition of GDG. Would be useful to include a Psychologist and/or Psychiatrist specialising in the Performing Arts area	Thank you for your suggestion. Individuals are selected for their expertise as set out in the scope and to ensure that the GDG can properly address the scope of the guideline.	n/a
3	SH	British Association for Psychopharmacology	5.01	General	A clinical psychopharmacologist is needed on group	Thank you; we agree and this will be taken into account during GDG recruitment.	n/a
4	SH	British Association for Psychopharmacology	5.02	General	The issues of comorbidity with other anxiety disorders, with depressive disorder and with alcohol abuse need to be brought to the fore.	Thank you for your comment; we agree and how the treatment of social anxiety disorder might need to be modified in the context of comorbid	n/a

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						conditions will be covered in the guideline [please see 4.3.1 h) of the scope].	
5	SH	British Association for Psychopharmacology	5.03	General	Communicating how SAD differs from 'shyness' is likely to be important for a general understanding of the condition Differentiation between Social Anxiety and Social anxiety Disorder is also important	Thank you for your suggestion; this will be covered in the introduction of the guideline and in the section on assessment.	n/a
6	SH	British Association for Psychopharmacology	5.04	General	Commenting on the likely drivers of the differences in prevalence between different studies will help to reconcile day to day experience with some of the epidemiological figures	Thank you for your comment. We agree and this will be covered in the guideline.	n/a
7	SH	British Association for Psychopharmacology	5.05	General	The use of simple diagnostic instruments such as SPIN must be included A GP representative and the possible use of a 'citizen's jury' could be important to ensure that the guidelines deal with the issues of under-recognition, prejudice and stigma	Thank you for your comments. Suitable diagnostic instruments such as the SPIN (currently used in IAPT services) will be considered. The issues of under-recognition, prejudice and stigma will all be looked at during guideline development and a GP representative will be recruited on the GDG. However, the use of a 'citizen's jury' is outside the guideline scope.	n/a
8	SH	British Association for Psychopharmacology	5.06	General	Recognition of how SAD may adversely affect access to primary care and general medical settings is likely to be an important topic.	Thank you for your comment; this issue will be raised in the guideline.	n/a
9	SH	British Association for Psychopharmacology	5.07	General	The fact that it is rare for people with SAD to be able to access secondary care in the UK needs to be recognised	Thank you for your comment; we will address the issue of access in the guideline.	n/a
10	SH	British Association for Psychopharmacology	5.08	General	The role of the voluntary sector in supporting people with SAD needs to be discussed	Thank you for your comment; this issue will be covered in the guideline.	n/a
11	SH	British Association for Psychopharmacology	5.09	General	The issues of personal distress, social educational and economic impairment and burden of disability need to be discussed in	Thank you for your comments; all the issues you have raised will be discussed in the guideline.	n/a

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					detail, especially in view of the fact that many people experience SAD from early adolescence		
12	SH	British Association for Psychopharmacology	5.10	General	The issue of understanding which medicines can be used in adolescence needs to be discussed as well as the implications of and evidence for long term use.	Thank you for your comment. The use of prescribed drugs for young people will be reviewed in the pharmacology chapter of the guideline.	n/a
13	SH	British Association for Psychopharmacology	5.11	General	The relationship with elctive mutism needs to be discussed	Thank you for your comment. Selective mutism as a presentation of social anxiety disorder will be covered in the guideline.	n/a
14	SH	British Association for Psychopharmacology	5.12	General	Review of pharmacological strategies should include large case series from other countries e.g. Brazil	Thank you. We will consider the best available evidence during guideline development.	n/a
15	SH	British Association for Psychopharmacology	5.13	General	The use of venlafaxine, mirtazapine, first generation MAOIs and antiepileptic medication needs to be reviewed	Thank you. All the appropriate drugs will be reviewed in the pharmacology chapter of the guideline [please see 4.3.1 e) of the scope].	n/a
16	SH	British Association for Psychopharmacology	5.14	General	The evidence for the use of tricyclic antidepressants needs to be assessed in detail as the evidence seems may indicate that they are less effective	Thank you. All the appropriate drugs will be reviewed in the pharmacology chapter of the guideline [please see 4.3.1 e) of the scope].	n/a
17	SH	British Association for Psychopharmacology	5.15	General	The use of cycloserine to augment psychotherapy needs to be included	Thank you. Cycloserine will be included in the review.	n/a
18	SH	British Association for Psychopharmacology	5.16	General	A comparison of group versus individual CBT would be useful The use of botulinum toxin injections to stop hyperhidrosis needs to be reviewed	Thank you for your comments. Individual and group CBT will be reviewed in the guideline [please see 4.3.1 d) of the scope] as will physical interventions [please see 4.3.1 i)].	n/a
19	SH	British Psychological Society	9.04	General	The Society has recently commented on the misuse of medication in children. We specifically mentioned the overuse of medication to address common problems which should, in our view, be seen as educational, social, and developmental problems deserving of pedagogic and	Thank you for your comments. This issue will be addressed by careful assessment of the evidence for long-term, as well as short term, treatment benefits and limitations.	n/a

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					psychosocial help rather than disorders requiring medical intervention. This echoes the point above, but reflects our principled concern over the use of medication in young people. We are even more concerned about "surgical interventions" (mentioned in point 4.3.1 h.) The Society fully respects evidence-based systematic reviews and recommendations. However, we also recognise that such reviews may, by restricting the scope and extent of their review, result in biased findings. The Society therefore recommends these issues and concerns must be part of the review scope.	Thank you for the comment. Side-effects and possible harmful effects of surgical interventions will be carefully considered. We will use the best available evidence to address the review questions that will include but will not be restricted to RCTs. It should be pointed out that RCTs are one of the most effective ways to reduce bias.	n/a n/a
20	SH	British Psychological Society	9.05	General	**Reference** Healy, D. (1997). *The Antidepressant Era*. Cambridge, MA: Harvard University Press.	Thank you for this reference which we will consider.	n/a
21	SH	Department of Health	7.01	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you.	n/a
22	SH	MHRA	12.01	General	We have no comment on the draft scope for social anxiety disorder guideline.	Thank you.	n/a
23	SH	Nottinghamshire Healthcare NHS Trust	4.01	General	The document excludes those with autistic spectrum, which is where I have mainly seen this in Learning Disabilities clinical work, so I have not commented on this.	Thank you.	n/a
24	SH	Nottinghamshire Healthcare NHS Trust	4.03	General	Document discussed with CBT colleagues. It appears sensible and comprehensive. We have no specific comments.	Thank you.	n/a
25	SH	Royal College of General Practitioners	13.01	General	Happy with the scope of the consultation and no new additions	Thank you.	n/a

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26	SH	Royal College of Nursing	11.01	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The draft scope is comprehensive	Thank you.	n/a
27	SH	Royal College of Nursing	11.02	General	A close look at social anxiety disorder is a positive step to getting a treatment pathway recognised.	Thank you for your comment.	n/a
28	SH	Royal College of Paediatrics and Child Health	6.02	General	The College thinks that NICE has made an extremely important omission in this scope: that of Selective Mutism (SM) (see (reference 1, listed in comment 10) for recent review and consensus study). This is a complex phenomenon (usually poorly understood and vastly under-recognised), and is conceptualised as an anxiety disorder lying on a spectrum between shyness and severe social phobia (reference 2).	Thank you for your comment. The current draft Social Anxiety Disorder criteria for DSM-V include Selective Mutism as a sub-category, so it will be covered in the guideline and has now been added to the scope. The DSM-V definition of SM in the context of social anxiety disorder is: "**Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations**".	4.1.1 d)
29	SH	Royal College of Paediatrics and Child Health	6.10	General	1. Keen D V, Fonseca S and Wintgens A. Selective mutism: a consensus based care pathway of good practice Arch. Dis. Child. 2008;93;838-844; 2. Standart S, Le Couteur A. The quiet child: a literature review of selective mutism. Child and Adolescent Mental Health 2003;8:154–160. 3. Kopp S, Gillberg C. Selective mutism: A population based study-research note. J Child Psychol Psychiatry 1997;38:257–62. 4. Kristensen H. Selective mutism and comorbidity with developmental disorder/delay, anxiety disorder and elimination disorder. J Am Acad Child Adolesc Psychiatry. 2000;39:249–	Thank you for these helpful references which we will consider.	n/a

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					56. 5. Schneier FR, Blanco C, Antia SX, et al. The social anxiety spectrum. Psychiatr Clin North Am 2002;25:757–74. 6. Cline T, Baldwin S. Selective mutism in children. 2nd edn. London: Whurr, 2004. 7. Toppelberg CO, Tabors P, Coggins A, et al. Differential diagnosis of selective mutism in bilingual children. J Am Acad Child Adolesc Psychiatry 2005;44:592–5. 8. Steinhausen H-C, Wachter M, Laimbock K, et al. A long-term outcome study of selective mutism in childhood. J Child Psychol Psychiatry 2006;47:751–6. 9. Cohan SL, Chavira DA, Stein MB. Practitioner review: psychosocial interventions for children with selective mutism: a critical evaluation of the literature from 1990–2005. J Child Psychol Psychiatry 2006;47:1085–97.		
30	SH	Royal College of Psychiatrists	15.01	General	This stakeholder responded with no comments to make.	Thank you.	n/a
31	SH	Whitstone Head Educational (Charitable) Trust Ltd.	2.01	General	The draft final scope accurately reflects the outcomes of the Stakeholder Workshop held on the 4th February 2011.	Thank you for your comment.	n/a
32	SH	Anxiety UK	1.01	1	Might be useful to include the term 'social phobia' as many individuals living with this condition still use this term	Thank you for your suggestion; we agree and the terminology used in the guideline will be fully defined (please also see 'The remit' on page 1 of the scope).	n/a
33	SH	Humber NHS Foundation Trust	3.01	2	Welcome the plan to produce clinical guidance on social anxiety disorder	Thank you for your comment.	n/a
34	SH	Anxiety UK	1.02	2f	Might be useful to say that social phobia often prevents individuals from progressing in their	Thank you; we agree and occupational performance/ functioning will be	n/a

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					careers with many accepting jobs of a lesser status	covered in the guideline [please see 4.4 d) of the scope].	
35	SH	Association for Family Therapy and Systemic Practice	10.02	3.1	Suggest that the impact of social anxiety on parenting is included. Although there may not be good evidence because of so many people take a long time to seek treatment, addressing concerns on parenting and other relationship issues can be part of a way to provide early interventions. It would be interesting to know whether better access to talking therapies for relationship problems would be more beneficial than having a diagnosis of social anxiety?	Thank you for your comments. Family based/ parenting interventions will be considered in the guideline [please see 4.3.1 g) of the scope].	n/a
36	SH	Royal College of Paediatrics and Child Health	6.04	3.1	In SM there is also a high level of 'comorbid' neuro-developmental impairment (in over 2/3 of children), with associated language/communication disorders and motor impairments frequently present (reference 4), and an excess of other disorders such as autistic spectrum disorder and eating disorders, intellectual disability (references 2, 5).	Thank you for this information and references on selective mutism which we will consider.	n/a
37	SH	British Psychological Society	9.01	3.1a	The diagnostic issues are crucial here. Quintessentially, social anxiety is a problem that confounds classical categorical diagnosis. Even more than depression, social anxiety MUST be seen as a component of normal human psychology which can, for all kinds of reasons, blur across the continuous spectrum of functioning and distress into serious problems for the individual. There are therefore dangers in discussing anxiety 'disorders' as if a categorical / diagnostic approach is an unchallenged reality.	Thank you for your comments. We agree that most researchers see social anxiety as a continuum with the clinical cut-off being based on interference with current functioning (disability) as well as symptom severity. Treatment trials almost always focus on populations that meet diagnostic criteria, even if the clinical/non-clinical cut-off is fairly arbitrary. For this reason, the data that is available for treatment recommendations predominantly come from clinical cases but it is recognised that it may	n/a

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					We note that social phobia only appeared in the Diagnostic and Statistical Manual for Mental Health (DSM) in 1980, and its prevalence appears to mirror the marketing of selective serotonin reuptake inhibitors (SSRI) interventions (see Healy, 1997).	have broader applicability. It is not really correct to say that social phobia was not recognised in the diagnostic system until 1980 when DSM-III was released. Social Phobia was first formally proposed in 1966 by Marks and Gelder. DSM-II, which was released in 1968, recognised three categories of anxiety problem: i) anxiety neurosis (also termed free-floating anxiety), ii) phobic neurosis, and iii) obsessive-compulsive neurosis. The definition of phobic neurosis made it clear that wide range of feared stimuli were covered by the term and clinicians certainly recognised social interactions and public speaking among these stimuli (as did various self-report scales that were available from the 1960s onwards). In 1980 DSM-III divided anxiety problems into a larger number of categories. Dividing phobic neurosis into three main types of phobia (agoraphobia, social phobia, specific phobias) was one of the changes but the most significant one was the introduction of a panic disorder, a completely new disorder that was partly justified by research findings with tricyclic anti-depressants (not SSRIs).	n/a
38	SH	Royal College of	6.03	3.1a	Reported prevalence rates of SM have ranged	Thank you for this information on	n/a

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		Paediatrics and Child Health			from 3 to 18/10 000 but more recent school-based studies report rates as high as 2% (reference 3) which suggests a significant level of unrecognised and ''hidden'' SM.	selective mutism which we will consider.	
39	SH	Royal College of Paediatrics and Child Health	6.05	3.1b 3.2a 3.2b 4.3.1a & g	Many young people (under-18s) with social anxiety disorder presenting to CAMHS may do so with other conditions that can mask the social anxiety, such as: • depression; • school refusal; • substance misuse; • PTSD. It is not only in primary care and educational settings that the condition is poorly recognised, but also in CAMHS settings. The College believes that the guideline should explicitly address this under diagnosis (the scope does so implicitly).	Thank you for this comment. Social anxiety disorder has an early age of onset (for an anxiety disorder) and is particularly persistent in the absence of treatment. However, there is often a long lag between onset and identification. This may be because for some people what is first identified is a consequence of the condition (depressive episode, substance misuse) and/or some unrelated mental health problem (PTSD for example). The guideline will attempt to address this issue by considering impediments to prompt diagnosis and treatment in children and adults (please note that this has now been added to the scope accordingly).	4.3.1 a)
40	SH	Royal College of Paediatrics and Child Health	6.06	3.1c	SM is slightly more common in females (F:M ratio 1.2–1.6:1), an excess is seen in ethnic minorities (reference 6) and it is considerably more frequent in bilingual immigrant children (references 2, 7).	Thank you for this information and references on selective mutism which we will consider.	n/a
41	SH	Royal College of Paediatrics and Child Health	6.07	3.1d	There have been very few large treatment studies and no randomised controlled trials, and little research on long-term outcome or the natural course (reference 2) although eventual psychosocial outcome is thought to be poor (reference 8) with a number having a chronic course and a majority remaining impaired	Thank you for this information and references on selective mutism which we will consider.	n/a

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					despite the resolution of the SM (reference 9).		
42	SH	Humber NHS Foundation Trust	3.02	3.1e & f	Highlight importance of better and earlier identification and the impact in later life; welcome the inclusion of school age children	Thank you for your comments which will be discussed in detail in the guideline.	n/a
43	SH	Royal College of Paediatrics and Child Health	6.08	3.2	Despite persistence and severity of mutism, the majority of SM children in primary schools do not receive appropriate diagnosis or treatment (reference 9). Only a minority are referred for intervention programmes and a large proportion present late to specialist services (reference 8). Children with SM can present in various guises. Unresponsiveness to teachers and/or unusual emotional and social responses may raise concerns about impairment of hearing or language comprehension or the presence of autism. Consistent with approaches to other anxiety disorders, behavioural and cognitive behavioural therapies seem effective (reference 2).	Thank you for this information and references on selective mutism which we will consider.	n/a
44	SH	Anxiety UK	1.03	3.2a	It would be helpful to say that by virtue of the nature of the condition, many living with social phobia find it hard to access talking therapies – finding social interaction even with a therapist difficult, therefore take up of traditional treatment is affected. The promotion of alternative modes of delivery of therapy should be addressed.	Thank you for your comments; the GDG will bear in mind the issues you have raised during guideline development.	n/a
45	SH	Anxiety UK	1.04	3.2c	May be worth referencing that there is sometimes an overlap with avoidant personality disorder and that an accurate diagnosis is required.	Thank you for your comment; we agree and how the treatment of social anxiety disorder might need to be modified in the context of comorbid conditions (which will include avoidant personality disorder / avoidant type) will be covered in the guideline [please	n/a

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						see 4.3.1 h) of the scope].	
46	SH	Nottinghamshire Healthcare NHS Trust	4.02	4.1.1 & 4.1.2	The scope document needs to be clear as to whether adults with Learning Disabilities are within the scope and, if they are, NICE needs to ensure the development group has access to the appropriate evidence	Thank you for your comment. How the treatment of social anxiety disorder might need to be modified in the context of comorbid conditions (which will include mild learning disabilities) will be covered in the guideline [please see 4.3.1 h) of the scope].	n/a
47	SH	Association for Family Therapy and Systemic Practice	10.03	4.1.1	Suggest that issues around attachment are included. De Zulueta, F. (2006): The treatment of psychological trauma from the perspective of attachment research. Journal of Family Therapy. 28.4.334-351.	Thank you for your suggestion. We will consider the reference you have provided.	n/a
48	SH	Association for Family Therapy and Systemic Practice	10.04	4.1.1	Suggest that parenting issues are included in the population covered, although there may not be research, it would fit with relationship and social issues that are being addressed.	Thank you for your comment. We will consider parenting issues both in the discussion of the development of the disorder, and also in the experience of care section. We will search for relevant evidence.	n/a
49	SH	British Association for Counselling and Psychotherapy	8.02	4.1.1	BACP is surprised to see the omission of agoraphobia. Social anxiety is often accompanied by agoraphobia and can develop into full blown agoraphobia.	Thank you for your comment. The guideline will cover "how the treatment of social anxiety disorder might need to be modified in the context of comorbid conditions "[4.3.1.h)] which will include agoraphobia.	n/a
50	SH	British Association for Counselling and Psychotherapy	8.03	4.1.1	It is unclear whether cultural factors will be fully considered by the Development Group in relation to the UK BME community. A thorough understanding of different models of health, deriving from differing cultural understandings that prevail in new and emerging communities, will be essential if anxiety and depression are not to be misunderstood in these groups.	Thank you for your comment. The guideline scope includes consideration of "the particular needs of Black and minority ethnic groups" [4.1.1.c)].	n/a
51	SH	Royal College of	6.09	4. 1.1	Although 'performance social anxiety' is	Thank you for your comment.	4.1.1 d)

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		Paediatrics and Child Health			recognised in the draft scope as a sub-classification, selective mutism has been omitted although it is clearly a closely related phenomenon.	Selective mutism as a symptom of social anxiety disorder will be covered in the guideline and has now been added to the scope. Please see the response to comment number 28.	
52	SH	British Association for Performing Arts Medicine	14.05	4.1.1a	Include professionals on the registers for BAPAM, Dance UK, Music Conservatories Counsellor Groups etc	Thank you for your suggestions. Individuals are selected for their expertise as set out in the scope and to ensure that the GDG can properly address the scope of the guideline.	n/a
53	SH	British Association for Performing Arts Medicine	14.02	4.1.1b	Specialist performing arts training organisations and teachers often see children younger than 8.	Thank you for your comment. The guideline will cover children from school age to 17 years [please see 4.1.1 b)].	n/a
54	SH	British Association for Performing Arts Medicine	14.03	4.1.1d	Would be helpful to define and give examples of performance situations to include the range of face to face and non face to face small and large scale circumstances and contexts in which a performance can take place. These have been shown to affect the occurrence, nature and severity of Performance Social Anxiety (PSA).	Thank you for your comment. A wider range of performance situations has been added to the scope (i.e. music, acting and dance performances). Within each of these categories (and many of the other categories of stimuli that trigger social anxiety) it is recognised that context can have a large effect on the anxiety experienced.	4.1.1 d)
55	SH	Humber NHS Foundation Trust	3.03	4.1.1d	Unclear whether performance social anxiety is appropriate to include is this appropriately seen as a disorder?	Thank you for your query. Public speaking anxiety (and several other types of performance anxiety) are very common in the general population and in many cases do not need to be treated (as people organise their lives so they do not need to lecture/give speeches etc). It is only diagnosed as a disorder when it severely interferes with functioning. At this level, it is	n/a

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						recognised by most diagnostic systems as a sub-category of social anxiety disorder.	
56	SH	Royal College of Paediatrics and Child Health	6.01	4.1.2	The exclusion of body dysmorphic disorder is understandable in view of the social anxiety in that condition being secondary to the person's distorted perception of her body. It is true in general that the social anxiety seen in autism spectrum disorders is rather different from that seen in individuals without an autistic condition. The problem however with excluding this group is that many individuals may have autistic traits without having a formal diagnosis: their social anxiety will not be covered in either of the two guidelines. There is a continuum between autism and non-autism; and between autistic-type social anxiety and non-autistic type social anxiety. Not only the non-autistic end of this continuum, but also the middle, should be covered by this guideline. This appears to be partially recognised as a general principle in 4.3.1 (g).	Thank you for your comments. Both BDD and autism have already been the subject of NICE guidance. We will consider these issues in the same way as we will deal with other comorbidities.	n/a
57	SH	British Association for Performing Arts Medicine	14.04	4.2c	Include specialist settings for performers e.g. BAPAM, Dance UK, Music Conservatories, Specialist Music Schools, Theatre Schools, performing arts courses, dance centres etc etc	Thank you for your suggestions – these will be covered in 'other settings' in 4.2 c) of the scope. Please also note that a wider range of performance situations that will be covered in the guideline have been added to the scope (i.e. music, acting and dance performances).	4.1.1 d)
58	SH	Royal College of Nursing	11.03	4.3.1	We would have concerns that normal anxiety related to stressful life events (or any life event)	Thank you for your comments. DSM-IV requires social anxiety to have been	n/a

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					is medicalised in anyway. Exposure to some anxiety and stressful social situations from an early age is the mechanism for the development of coping strategies in adulthood. Therefore the diagnostic criteria should be applied using DSMIV before treatment is considered. A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing - how is this going to be assessed in the context of the individual's mood, self esteem and personality and life events?	present for *at least* 6 months, partially to avoid giving a diagnosis to a transient reaction to a stressful life event. Exposure to a range of stressful social situations in childhood can indeed be an important part of social development. The problem is that people with severe social anxiety in childhood tend to miss out on this learning opportunity (through avoidance). Ensuring that contextual variables are taken into account when identifying diagnoses is very important.	
59	SH	Royal College of Nursing	11.04	4.3.1	In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults - how is this going to be assessed when the assessor will be an adult? If this is diagnosed in primary care, it will be dependent on self report and parental report and this may not be objective enough to make a diagnosis.	Thank you for your comments. It is generally agreed that accurate diagnosis in children depends on multiple informants and information from a range of contexts. The text of the guideline will aim to clarify this point.	n/a
60	SH	British Psychological Society	9.02	4.3.1a	This point addresses assessment and identification issues. So the diagnostic, conceptual and formulatory issues are part of the scope - and should be. It is essential, as NICE develops this guidance, that issues related to these matters are considered fully and	Thank you but the diagnostic criteria for social anxiety disorder is outside of the guideline scope; assessment and case identification are not.	n/a

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					critically. In particular, the use of multi-axial, multi-domain assessments and formulations are crucial to good care (and are ubiquitously recommended in peer-review publication).		
61	SH	Whitstone Head Educational (Charitable) Trust Ltd.	2.02	4.3.1a	Identification and recognition of social anxiety disorder, including age differences in presentation (i.e., between young children, young people and adults)	Thank you for your comment. Age differences in presentation will be looked at in detail during guideline development.	n/a
62	SH	Anxiety UK	1.05	4.3.1c	We feel it would be helpful to include examining the role of user-led social phobia support groups as we have (through our sister organisation, Self Help Services – www.selfhelpservices.org.uk) run a very successful support group for those with social phobia which has been in existence for 11 years and which has proved to be vital to many attendees over the years. The social outcomes of attending this group are numerous and often attending the group has been the key factor for individuals in recovering from this condition.	Thank you for your suggestion; we agree and support groups will be reviewed in the guideline [please see 4.2 b) and 4.3.1 d) of the scope for areas where support groups will be covered].	n/a
63	SH	Association for Family Therapy and Systemic Practice	10.05	4.3.1c	Suggest including family interventions because of the relationship issues covered.	Thank you for your suggestion; we agree which is why family based/ parenting interventions have been outlined in the scope as a clinical issue that will be covered in the guideline [please see 4.3.1 g)].	n/a
64	SH	British Association for Counselling and Psychotherapy	8.01	4.3.1 c	BACP acknowledges that under the key clinical issues to be covered, several psychological interventions are mentioned; however counselling is not. The IAPT commissioned analysis (Glover et al, 2010), shows that of patients suffering from generalised anxiety	Thank you for your comment. The psychological interventions listed in 4.3.1 d) are "examples" rather than an exhaustive list of the interventions that will be covered. The guideline development group will search for	n/a

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					disorder, 22.7% chose CBT and 19.2% chose counselling. In terms of outcomes for both interventions, the report shows from patients with complete data that 56.2% moved to recovery with CBT, 41.1% for counselling. Therefore BACP would strongly suggest that counselling is included as an intervention.	evidence related to counselling in social anxiety disorder, as well as the "examples" provided. Regarding the Glover report, generalized anxiety disorder will not be covered in the social anxiety disorder guideline as it has already been covered in a separate NICE guideline published in 2011 [please see Anxiety (partial update) guideline http://guidance.nice.org.uk/CG113]. Glover found that very few patients with social phobia received counselling in the first year of IAPT services (around 3%).	
65	SH	British Psychological Society	9.03	4.3.1d	Since we are unaware of clear evidence of a biological 'cause' of social anxiety, the Society considers medication to be unlikely to offer more than symptomatic relief. Furthermore, it may have disadvantages. We fully respect the need to be driven by evidence, but we do feel that a theoretically and scientifically informed version of the 'precautionary principle' should apply here. A 'psychosocial priority principle' perhaps - that, since these phenomena are essentially normal human responses (problems absolutely worthy of intervention, but no more 'abnormal' or 'pathological' than other human problems in fields such as education, employment or relationships) the most appropriate forms of help are likely to be psychosocial. Furthermore, if medication is helpful, it is highly	Thank you for your comments and support for: i) being guided by evidence about long-term effects, as well as short-term symptomatic relief and ii) clarification of the context within which a treatment needs to be delivered (such as maximizing opportunities for new learning).	n/a

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					likely to be maximally effective if it permits the person to learn new ways of responding to anxiety-provoking situations or stimuli - people essentially relearn their responses. It is therefore likely to be the case that medication should be accompanied by systematic psychosocial interventions. Again, we must be guided by the evidence, but theoretical considerations would strongly implicate such a presumption.		
66	SH	Association for Family Therapy and Systemic Practice	10.06	4.3.1f	Treatments for adults can also be included in the family based/parenting interventions - Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The Efficacy of Systemic Therapy With Adult Patients: A Meta-Content Analysis of 38 Randomized Controlled Trials. *Family process*, *49*(4), 457–485	Thank you for your reference which we will consider during guideline development.	n/a
67	SH	Royal College of Nursing	11.05	4.3.2	Although it is not the remit to look at co-morbid social anxiety, one would hope that this might be identified as leading to assessment in specialist mental health services due to the complexities and the severity of impact on functioning this may incur.	Thank you for your comment; we agree and how the treatment of social anxiety disorder might need to be modified in the context of comorbid conditions will be covered in the guideline [please see 4.3.1 h) of the scope].	n/a
68	SH	Humber NHS Foundation Trust	3.04	4.3.2b	Agree with not covering prevention in guidance within school settings.	Thank you for your comment.	n/a
69	SH	Humber NHS Foundation Trust	3.05	4.4a	Value improving recognition tools b which also highlight severity; how to avoid shyness/low confidence becoming seen as a clinical presentation	Thank you for your comment. Issues of identification ,including specific tools, will be addressed in the guideline [please see 4.3.1.b) of the scope].	n/a
70	SH	Anxiety UK	1.06	4.6.2	We would strongly urge that appropriate user feedback is sought and that the guideline development group be mindful that they may not get the full spectrum of experience required if the only source of feedback from service users	Thank you for your comment which we agree with. Several service users with close links to groups such as Anxiety UK are likely to be recruited to join the Guideline Development Group. In	n/a

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					is derived via attendance at formal meetings.	addition, these organisations are encouraged to register as stakeholders so they can comment on drafts of the guideline prior to publication.	

These organisations were approached but did not respond:
Alder Hey Children's NHS Foundation Trust
Association for Cognitive Analytic (ACAT) Therapy
Association for Rational Emotive Behaviour Therapy
Association for the advancement of meridian energy techniques (AAMET)
Association of Psychoanalytic Psychotherapy in the NHS
BMJ
Bolton Council
Bradford District Care Trust
British Association for Behavioural & Cognitive Psychotherapies (BABCP)
British Association of Psychodrama and Sociodrama (BPA)
British Medical Association (BMA)
British National Formulary (BNF)
British Psychodrama Association
Care Quality Commission (CQC)
CCBT Ltd
Cerebra
Citizens Commission on Human Rights
Cochrane Depression, Anxiety & Neurosis Group
College of Mental Health Pharmacy
College of Occupational Therapists
Commissioning Support for London
Connecting for Health
Critical Psychiatry Network
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)

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Faculty of Occupational Medicine
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Healthcare Improvement Scotland
Healthcare Quality Improvement Partnership
Hertfordshire Partnership NHS Trust
Institute of Psychiatry
Kent & Medway NHS and Social Care Partnership Trust
Lambeth Community Health
Lancashire Care NHS Foundation Trust
Liverpool Community Health
Lundbeck Ltd
Mental Heath and Vascular Wellbeing Service
MIND
Ministry of Defence (MoD)
National CAMHS Support Service
National Patient Safety Agency (NPSA)
National Treatment Agency for Substance Misuse
NEt (North East Together)
NETSCC, Health Technology Assessment
NHS Bath and North East Somerset
NHS Buckinghamshire
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Direct
NHS Milton Keynes
NHS Plus
NHS Sheffield
NHS Western Cheshire
Northumberland, Tyne & Wear NHS Foundation Trust
OCD - UK
PERIGON Healthcare Ltd
Pfizer Limited
Public Health Wales
Rotherham NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists

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Royal College of Pathologists
Royal College of Physicians London
Royal College of Surgeons of England
Royal Pharmaceutical Society of Great Britain
Royal Society of Medicine
Scarborough and North Yorkshire Healthcare NHS Trust
Scottish Intercollegiate Guidelines Network (SIGN)
Sensory Integration Network
Sheffield Health and Social Care Foundation Trust
Social Care Institute for Excellence (SCIE)
Social Exclusion Task Force
Solent Healthcare
South Essex Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust
United Kingdom Council for Psychotherapy
University of Edinburgh
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
West London Mental Health NHS Trust
Western Health and Social Care Trust
Worcestershire PCT
York Teaching Hospital NHS Foundation Trust

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