

## Social Anxiety Disorder

Stakeholder Workshop Notes – 4<sup>th</sup> February 2011

1. Suggested guideline development group composition – Are all the suggested members (and the numbers of each type of member) appropriate and important? Should we be including any other types of members for this guideline? Could there be a role for expert advisers in this guideline?

### Group A

Suggested GDG composition:

- School nurse
- Health visitor
- Teacher or Special Education Needs Coordinator (SENCO)
- Educational psychologist (preferably one that runs an EdPsych course – so we can cover the training issue)
- Social care/ social worker
- Psychopharmacologist
- Child and Adolescent Mental Health (CAMHS) worker
- GP
- IAPT worker

### Group B

Suggested GDG composition:

- Healthcare professionals (psychiatrists and psychologists) from children and young people mental health settings e.g. CAMHS, tier 3, representative from The Association for Child and Adolescent Mental Health (ACAMH)
- Psychopharmacologist or psychiatrist with an interest in pharmacology
- GP
- IAPT representative(s) [children and adults]
- Carer
- Service users e.g. an adult and a young person (older teenager perhaps)
- CBT Psychotherapist
- Educational psychologist (could be a Special Advisor)
- A Special Advisor from a BME group

2. **Scope - Are we on the right track? Have we struck an appropriate balance between the need to keep the scope manageable and covering the most important clinical issues?**

**Group A**

The group was concerned about the age limit of the population that the guideline will cover (4.1.1 b in the scope) and perhaps there is a need to look at interventions earlier than from 8 years old. It was suggested that children aged 6 and over could be looked at to address any school phobia issues and lessen the burden of disability and subsequent learning disabilities etc.

The group felt that BME groups (especially women) should be added as a subgroup to the population being looked at in the guideline.

It was also suggested that the following evidence could be looked at:

- Public's perception/ stigma of social anxiety disorder (SAD) [particularly children's literature/ educational settings]
- International literature

**Group B**

The group felt that the remit should be changed to include recognition i.e. 'To produce a clinical guideline on the **recognition**, diagnosis and treatment of social anxiety disorder.'

The group looked at the 'Epidemiology' section of the scope (3.1) and thought the following points need to be added:

- Negative effects of social networking e.g. bullying on Facebook
- Potential of the internet for treatment e.g. positive effects of support groups and self help (but awareness that this can also lead to avoidance of seeking necessary help)
- Computer therapy – effective for those that do not like being part of a group
- Comorbidities – SAD can occur alongside schizophrenia and other psychotic illnesses
- Adults and adolescents with SAD are drawn to drugs and alcohol as a form of self medication. Psychological treatments can be effective for those involved in substance misuse. It was suggested that the alcohol dependence guideline could be looked at to see if there are treatment recommendations for service users with SAD
- Genetic factors e.g. the likelihood of identical twins both having SAD.

With regards to the 'Current practice' section in the scope (3.2), the group stated that the following points should also be addressed:

- Early diagnosis (possibly at school)
- Renowned pessimism regarding treatment outcomes (drug company pressures to raise awareness)
- Stigma of the disorder in health professions/ under-recognition.

The group was also concerned about the age limit of the population that the guideline will cover (4.1.1 b in the scope) and suggested that there should be a lower cut-off than 8 years old. It was agreed that the cut-off age should be

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determined by a literature search. Treatment will differ dependent on the age of a child e.g. more parenting interventions with younger children, and medication restrictions also come into play. There are also developmental factors that need to be considered with children, not just chronological factors. It was suggested that a separate guideline could be produced for children under 8 years e.g. CMHD in children.

The group also discussed whether there is a need to add BME groups as a subgroup to the population being looked at in the guideline. Are people with SAD less likely to present from BME groups? Do they have unmet needs? Is there different treatment for BME groups? It was suggested that a literature search needs to be done in this area e.g. break down the data from the household survey. Perhaps a Special Advisor could be recruited in this area for the GDG?

When discussing the subgroups of the guideline's groups that will be covered (4.1.1 c + d), the following points were raised:

- Comorbidity is a rule rather than an exception [it was suggested that the recognition of schizophrenia could be looked at in this guideline as the schizophrenia (update) guideline does not specifically cover SAD]
- Psychotic illnesses can have a large effect on social functioning
- There are many anxiety conditions
- Should the holistic approach be looked at?
- Primary conditions can be referred to in published guidelines e.g. PTSD
- A service user can become stable after a diagnosis of psychosis but can then go onto suffer with SAD. There may not be a lot of literature on this but good practice points could be looked at.

The group discussed the 'Groups that will not be covered' (4.1.2) and agreed that:

- The cut-off age of 8 years old needs to be looked at and possibly revised
- Asperger's needs to be referred to as Autism Spectrum Conditions (ASC). It was queried as to whether the ASC guideline will cover SAD. It was agreed that ASC should not be covered in this guideline but difficulties will arise with borderline diagnoses; therefore, perhaps there could be a flow-chart offering advice to cover comorbidities and raise awareness.

The 'Healthcare setting'(s) [4.2] were agreed upon by the group and it was also queried as to whether physical issues in general hospitals can be looked at e.g. obesity. It was agreed that this was more to do with BDD so outside of the scope. There was also a discussion about targeting mental health issues in schools and places of work but this again is outside of the scope and the health service needs to be the main focus of the guideline. It was queried as to whether occupational health could be looked at.

3. Do the topics listed in the scope (section 4.3.1) cover the most important areas? Are there any omissions or any topics on the list that should be deleted?

**Group A**

**Suggested additional clinical issues (in bold):**

- **Identification and recognition of SAD in adults, young people and children** [currently poor recognition in primary/ secondary care and school settings (by teachers and educational psychologists)]; misdiagnosis occurring – depression, Asperger's, autism; self-referral is a common feature of this disorder.
- **Routes of access to treatment.** SAD is not picked up because of reluctance to attend medical appointments in the first place; when SAD is diagnosed there may be issues with the nature of the assessment and where it takes place (venue needs to be a place comfortable for the individual – e.g. at home); access to ongoing support. Does the care pathway need to be different for SAD? (not necessarily IAPT – secondary care – tertiary care).
- **Diagnostic categories** (e.g. elective mutism).
- **Comorbidities** (e.g. how to deal with psychosis and SAD).
- **Disability (extent of functioning/ impairment with social anxiety disorder).**

**Suggested amendments to clinical issues (in bold):**

- Assessment in children [**educational psychologists need a better understanding/ training of how to do an assessment**].
- Psychological interventions [e.g. individual or group cognitive behaviour therapy, **computerised CT**, social skills training (especially in children), exposure therapy, anxiety management, interpersonal psychotherapy, psychodynamic psychotherapy, **social care (befriending/email/forum)**, **intervention for learning difficulties etc.**].
- **Generalised/ specific interventions for settings (social/health/school).**
- Surgical interventions (e.g. surgery for facial blushing and **underarm botox for sweating**).

**Group B**

**Suggested additional clinical issues (in bold):**

- **Recognition of social anxiety disorder in adults and children.** The review of this area may be short if a cross reference to the CMHD guideline is possible. The need for training in e.g. primary care and schools should be focused on here.

**Suggested amendments to clinical issues (in bold):**

- **Content and structure of an assessment in children (including who performs the assessment)**
- Psychological interventions [e.g. individual or group cognitive behaviour therapy, **guided and non-guided self help, computerised cognitive therapy, Eye Movement Desensitisation Therapy (EMDR), social skills training (especially in children), exposure therapy, anxiety management, interpersonal psychotherapy, psychodynamic psychotherapy, etc.**]
- **Family and parenting interventions.**

**Suggested amendment to clinical issue not being covered (in bold):**

- Treatment of co-morbid conditions (**although guidance will be provided on how the treatment of social anxiety disorder might need to be modified in the context of other co-morbid disorders**).

**4. Suggested clinical questions – ask the group the following general questions in order to agree/prioritise their selection.**

- a) **There is a particular emphasis on diagnosis and treatment. Is this the right place to start?**

**Group A and Group B**

Both groups agreed that emphasis should be placed on diagnosis and treatment but recognition also needs to be included.

- b) **What are the key outcomes to be considered (see also section 4.4 of the draft scope)?**

**Group A**

**Suggested adding (in bold):**

- **Work and social functioning (e.g. relationships)**

**Group B**

No comments

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5. **Equalities – how do inequalities impact on the provision of care for those with social anxiety disorder? Should any particular subgroups of the population be considered within the guideline?**

### **Group A**

The group felt that BME groups (particularly women) definitely need addressing.

### **Group B**

This group also agreed that BME groups should be addressed.