PSYCHOPHARMACOLOGY OF ANXIETY DISORDERS

CODE-AD

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I.

CURRENT CLASSIFICATIONS OF ANIETY DISORDERS

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CURRENT CLASSIFICATION OF ANXIETY DISORDERS

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Introduction

The class of "anxiety disorders" is one of the most controversial chapters of the Third Edition of the Diagnostic and Statistical Manual (DSM-III) of the American Psychiatric Association (1980). It refers to two major groups of disorders i.e., phobic disorders and anxiety states which in the Ninth Edition of the International Classification of Diseases (ICD-9) of the World Health Organization (1977) are included within the neurotic disorders under the diagnoses of anxiety states, phobic states and obsessive-compulsive disorders. The scope of neurotic disorders in the ICD-9 is considerably broader than the scope of anxiety disorders in the DSM-III. It includes also hysteria, neurotic depression, neurasthenia, depersonalization syndrome and hypochondriasis. On the other hand by distinguishing within phobic disorders among simple phobia, social phobia and agoraphobia and by separating within anxiety states panic disorder from generalized anxiety disorder the DSM-III provides far greater specificity in syndromatologic differentiation with the hope that the greater specificity might result in increased biological homogeneity of diagnostic groups (Table I).

The immediate response of French psychiatrists to the DSM-III chapter on anxiety disorders was "complete bewilderment." In French psychiatry, anxiety is considered to be part of a number of disorders and not a disorder in itself, even if it dominates the clinical picture. Furthermore, according to Pull, Pull and Pichot (1983), the chapter introduces a number of new concepts which are not described in French psychiatric textbooks, of which some simply cannot be translated into correct French. The same apparently does not apply to German psychiatrists, who seem to be more open to the American approach. In

Table I

Neurotic Disorders (ICD-9)	Anxiety Disorders (DSM-III)
300.0 Anxiety States	300.01 Panic disorder
	300.02 Generalized anxiety disorder
300.1 Hysteria	Somatoform disorders
	300.11 Conversion disorder
300.2 Phobic state	300.21 Agoraphobia with panic attacks
	300.22 Agoraphobia without panic attacks
	300.23 Social phobia
	300.29 Simple phobia
300.3 Obsessive-compulsive disorders	300.30 Obsessive-compulsive disorder
300.4 Neurotic depression	Affective disorders
	300.40 Dysthymic disorder
300.5 Neurasthenia	Affective disorders
	300.40 Dysthymic disorder
300.6 Depersonalization syndrome	Dissociative disorders
	300.60 Depersonalization disorder
300.7 Hypochondriasis	Somatoform disorders
	300.70 Hypochondriasis
300.8 Other neurotic disorders	
300.9 Unspecified	
	308.30 Post-traumatic stress disorder, acute
	309.80 Post-traumatic stress disorder, chronic or delayed

Corresponding diagnostic categories and diagnoses between ICD-9 and DSM-III.

fact, a somewhat similar diagnostic scheme was proposed by Langen (1971) from the Federal Republic of Germany almost 10 years prior to the publication of the DSM-III (Table II).

Concept of Neurosis

The disorders included among anxiety disorders in the DSM-III are subsumed under neurotic disorders in the ICD-9.

Neurotic disorders in the ICD-9 are defined as "mental disorders without any demonstrable organic basis in which the patient has considerable insight and unimpaired reality testing." This implies, that patients with neurotic disorders do not confuse their morbid subjective experiences and fantasies with external reality and that the behavior of patients with neurotic disorders remains within the socially accepted limits since only part of the personality is involved in the illness. A corresponding definition of neurotic disorders was given by Fish in his Clinical Psychopathology (Hamilton, 1974).

Criteria of neurotic disorders are fulfilled by the diagnoses included in the class of anxiety disorders in the DSM-III. However to prevent confusion with Freud's (1895, 1926) etiological concept of "psychoneurosis" and Pavlov's (1927, 1941) etiological concept of "experimental neurosis," the term "neurotic disorders" is not used in the DSM-III. On the other hand Freud's original description of anxiety neurosis (Angstneurose), or generalized anxiety disorder, was adapted by the DSM-III.

The origin of the other diagnoses under anxiety disorders in the DSM-III are in the work of Morel (1860) who in his classification of psychiatric disorders described "phobias and neuroses" under the heading of "delire emotif"; Benedikt (1870) and Westphal (1872) who independently identified agoraphobia under the name of Platzschwindel (dizziness occurring in open

Table II

Diffuse Anxiety Syndrome

Acute Diffuse Anxiety Syndrome

Chronic Diffuse Anxiety Development

Attack-Like Anxiety Syndrome

Phobic Syndromes

Phobic Responses

Psychasthenic Phobic Syndrome

Phobic Syndromes Occurring during Biological Crises

Phobic Syndromes associated with Neurotic Development

Chronic Progredient Anxiety Syndromes

Langen's (1971) proposed classification of anxiety disorders. (Adapted from Jablensky A: Approaches to the definition and classification of anxiety and related disorders in European psychiatry. In Tuma HA and Maser JD (eds): Anxiety and the Anxiety Disorders. Laurence Erlbaum, Hillsdale, 1985).

spaces) and Platzangst (fear of open spaces) respectively; Oppenheim (1892) who described anxiety as a morbid response to severe stress; and Janet (1903) who defined the criteria of obsessive-compulsive neurosis (Jablensky, 1985; Solyom et al., 1985).

Neuroses and Personality Disorders

According to Schneider (1958,1959) neuroses and personality disorders are variations of human existence which differ from the social-statistical norm quantitatively rather than qualitatively. Therefore they are considered to be developmental anomalies and as such, different from sui generis psychiatric illnesses, e.g., functional psychoses in which qualitative changes are brought about by an intruding disease process.

In Schneider's frame of reference, neuroses are regarded as reactions of abnormal personalities to moderate or mild stress and the reactions of normal personalities to severe stresss. In the term "abnormal personalities," however, the word abnormal is not used by Schneider in the sense of "morbid," but merely in the sense that the individual has one or more personality traits which lie outside the range that is generally regarded as normal in the particular society in which he/she lives. Furthermore, since the word reaction is used to designate the result of the effect of the causative event (psychological trauma) on the patient's personality, Schneider regards neuroses as psychogenic reactions to stressful environmental events, the form of which is determined by patient's personality and socio-cultural factors.

In variance with Schneider's contention is the notion that neuroses which are referred to as anxiety disorders in the DSM-III are sui generis psychiatric illnesses. Anxiety disorders or neuroses, differ from functional psychoses in terms of insight, reality testing, behavior, and personality

involvement. Similar to functional psychoses, however, there is a disease process, which yields to distinct clinical syndromes in the course of its five developmental stages (Table III).

Similar to functional psychoses, anxiety disorders might be subdivided into two major categories of illnesses, i.e., reactive and productive. In "reactive" illness, it is assumed that a preexisting abnormal constitution reacts in an abnormal way, while in "productive" illness, a process takes its course leading to predetermined and predictable changes in psychopathology and behavior.

The prototype of "reactive" illness within anxiety disorders is post-traumatic stress disorder and prototypes of "productive illness" are anxiety states, phobic disorders and obsessive-compulsive disorders. Furthermore, within phobic disorders there are at least three (simple phobia, social phobia and agoraphobia) distinct illnesses and within anxiety states at least two (panic disorder and generalized anxiety disorder) (Table IV).

Different Approaches to Diagnostic Classifications

In the absence of well-identified etiology, there are three approaches employed in differentiating biologically meaningful homogenous psychiatric populations: the empiricistic, the experimental and the nosological.

The empiricistic approach is based on the development of an assessment instrument, e.g., rating scale, that is constructed in a manner to include all known manifestations of a psychiatric disease, e.g., anxiety-disorders. It is assumed that by administering such a scale to large, clinically homogenous populations within anxiety disorders and by employing different statistical procedures, e.g., factor analysis, cluster analysis, multiple discriminant function analysis in the treatment of collected data, meaningful subtypes or diagnoses within a group of disorders can be obtained.

Table III

Variables	Psychoses	Neuroses
Insight	-	+
Reality Testing	-	+
Confusion of subjective experiences with external reality	+	-
Behavior outside of social limits	+	-
Distortion of whole personality	+	-
Disease process of increasing differentiation	+	+

Differential and common features of psychoses and neuroses. Based on definition given by Ban and Petho (1985) and Fish (1974).

Table IV

ANXIETY DISORDERS

NEUROSES

Reactive		Productive					
Post-Traumatic Stress Disorder		Phobic Disorders			Anxiety States		Obsessive-Compulsive Disorder
Acute	Chronic	Agora-phobia	Social phobia	Simple phobia	Panic Disorder	Generalized Anxiety Disorder	

Schematic presentation of anxiety disorders. (Based on DSM-III).

An alternative to the empiricistic approach is the experimental approach. It is based on biologic measures, e.g., neurophysiologic, biochemical, neuroendocrine. While it is hoped that some of these measures (biologic markers) will bring about a more meaningful classification of clinical psychopathology, it is commonly held that the meaningfulness of biologic markers is limited by the extent that they can be linked to a clinically identifiable diagnostic group (Ban and Petho, 1985).

The prototype of the third, or nosological approach is Kraepelin's (1896) classification of functional psychoses. The origin of this classification is in Kahlbaum's (1874) formulation of a nosological entity (which postulates a close correspondence betwen etiology, brain pathology, symptom pattern and outcome picture) which in turn is based on Falret's (1864) contention that for a better understanding one has to learn about "the progression and the various stages of the natural forms of mental disorders." For Falret a "natural form" of a disease" implies a well defined natural predictable course," which in turn "presupposes the existence of a natural form of disease with a specific pattern of development."

There is no good reason to believe that the nosological approach cannot be employed in the classification of anxiety disorders.

The proposed (DSM-III based) classification of anxiety disorders is firmly rooted in cross-sectional psychopathology, extending its boundaries beyond experiential phenomenology into behavior, performance and general characteristics of the disease. It differs from syndromatological classification because the clinical syndromes are not studied in isolation but in the nosological context of the total longitudinal picture of the illnesss. Employment of a nosological approach should prevent the confounding of biological correlates of any particular stage (cross-sectional syndrome) of a

disease with the central biological mechanism of the illness, although the nosological entities described do not necessarily fulfill all the criteria of a "disease" (Jaspers 1959, 1963).

The diagnostic process of proposed classification employs a decision tree model in which alternative decisions are based not merely on a given set of knowledge (cross-sectional psychopathology) and a logical process moving within one set of data, but also follows the evolution of the subject (illness) under study in time. In the course of this process first the general characteristics of the illness are recognized; and on the basis of these general characteristics patients who fulfill criteria of "neuroses" (i.e., anxiety disorders) are identified. Subsequently patients with neuroses are separated into two major groups i.e., reactive (post-traumatic stress disorder) and productive (all other anxiety disorders), implying the presence or absence of precipitatory life event; and patients of the productive group are divided into three major categories of diagnoses on the basis of the psychopathological structures involved. The three categories are anxiety states, characterized by anxiety which is free floating, phobic disorders, characterized by fear which is related to a specific object, activity or situation and obsessive compulsive disorders, characterized by concern which is related to persistent thoughts, drives and actions. Finally on the basis of the formal characteristics of the course of illness, i.e., continuous or episodic, generalized anxiety disorder is distinguished from panic disorder within the anxiety states, and on the basis of end-state characteristics within the phobic disorders, agoraphobia, social phobia and simple phobia are separated (Table V).

Table V

Steps	General Characteristics	Etiology-Onset	Cross-Sectional Psychotherapy	Course	Outcome-End State
1	Neuroses				
2	Neuroses	Reactive vs Productive			
3	Neuroses	Reactive vs Productive	Phobic Disorders vs Anxiety States vs Obsessive Compulsive Disorder		
4	Neuroses	Reactive vs Productive	Phobic Disorders vs Anxiety States vs Obsessive Compulsive Disorders	Generalized Anxiety vs Panic Disorder	
5	Neuroses	Reactive vs Productive	Phobic Disorders vs Anxiety States vs Obsessive Compulsive Disorder	Generalized Anxiety vs Panic Disorder	Agoraphobia Social Phobia Simple Phobia

Schematic presentation of decision tree in the diagnoses of anxiety disorders. Five consecutive steps.

Nosological Classification

In the proposed classification of anxiety disorders, there are four groups of illnesses, and only in one of these groups, i.e., post-traumatic stress disorder is there an identifiable antecedent factor (recognizable stressor) which is relevant to the etiology of the disease. In none of the other groups of disorders are there verified predisposing factors, although it has been suggested that separation anxiety disorder in childhood and sudden object loss, predispose for the development of agoraphobia and panic disorder.

There are no verified data regarding form of onset (i.e., acute, subacute or insidious) of anxiety disorders. There are indications, however, that the onset of social phobia is in the late childhood and early adolescence, while of agoraphobia, panic disorder and obsessive compulsive disorder in the late adolescence and early adulthood.

Although cross-sectional clinical features of all four groups of anxiety disorders fulfill criteria of neurosis, the pivotal clinical features of the four groups and within the four groups of disorders of the major diagnoses are distinct. Among the phobic disorders the pivotal clinical feature of agoraphobia is a marked fear of being alone, or being in public places from which escape might be difficult; of social phobia a persistent irrational fear of, and compelling desire to avoid situations in which the individual may be exposed to scrutiny by others; and of simple phobia, a persistent, irrational fear of and compelling desire to avoid an object, or a situation other than being alone, or in public places, or in certain social situations. Similarly, among the anxiety states the pivotal clinical feature of panic disorder is the recurrence of panic attacks which are manifested by discrete periods of apprehension and fear associated with dyspnea, palpitations, chest pain, choking sensation, dizziness, feelings of unreality, parasthesias, hot flashes, sweating, faintness, trembling and/or shaking; and of generalized

anxiety disorder, a persistent anxiety manifested in motor tension, autonomic hyperactivity, apprehensive expectation, vigilance and/or scanning. The pivotal features of obsessive compulsive disorder are recurrent, persistent ideas, thoughts, images or impulses which are ego dystonic, and/or repetitive and seemingly purposeful behavior which are performed according to certain rules or in a stereotyped fashion. Finally, the pivotal features of post-traumatic stress disorder involve the reexperiencing of the traumatic event with numbing of responsiveness to the external world.

Similar to form of onset, there are no verified data regarding the formal characteristics of the course of anxiety disorders. There are indications, however, that panic disorder and post-traumatic stress disorder follow an episodic, while phobic disorders, generalized anxiety disorder and obsessive compulsive disorder follow a continuous course. Nevertheless, patients with agoraphobia, generalized anxiety disorder and obsessive compulsive disorder have characteristic fluctuations, waxing and waning in the intensity of their clinical syndromes.

Finally, insofar as outcome is concerned there are reasons to believe that phobic disorders (and within the phobic disorders simple phobia, social phobia and agoraphobia), anxiety states (and within the anxiety states panic disorder and generalized anxiety disorder), obsessive compulsive disorder and post-traumatic stress disorders are end-states and as such distinct from each other. On the other hand, information on outcome variables, e.g., recovery rate of the different anxiety disorders is not available.

Therapeutic Implications

In the absence of etiological knowledge there are three empirical treatment approaches employed in the therapy of patients with anxiety disorders: psychotherapy, behavior therapy and pharmacotherapy. Of them,

psychotherapy and behavior therapy are based on the etiological preconceptions of psychodynamic and learning theories respectively. While the content of the different clinical manifestations might be understood on the basis of learning and/or psychodynamics, the fact remains that neither psychodynamics nor learning can explain the different forms of anxiety disease.

There are a number of different empirical pharmacotherapeutic approaches in the treatment of anxiety disorders with proven therapeutic efficacy. Among them the most extensively employed are treatment with benzodiazepines, such as alprazolam and diazepam, substances which augment GABA-stimulated chloride conductance (Ballanger, 1985); β-adrenergic receptor blockers, such as propranolol (DiGiacomo, 1985); presynaptic α_2 agonists, such as clonidine (Uhde et al., 1985); MAOI's such as phenelzine (Robinson et al.. 1973); MAUI cyclic antidepressants, such as imipramine (Klein, Rabkin and Gorman, 1985); and specific serotoninergic substances, such as l'tryptophan or chlorimipramine (Yaryura-Tobias and Bhagavan, 1977). It is a common contention that diagnostically different populations within the anxiety disorders respond differentially to the different pharmacotherapeutic approaches, e.g., patients with generalized anxiety disorder respond most favorably to benzodiazepines, such as alprazolam, patients with panic disorders to cyclic antidepressants, such as imipramine, patients with agoraphobia to presynaptic α_2-agonists, such as clonidine and patients with obsessive compulsive disorders to serotoninergic substances such as chlorimipramine. In spite of the rather convincing clinical impressions (and possibly even consensus among experts) it remains to be seen whether the differential therapeutic effects of drugs with different action mechanisms in the different diagnostic groups could be supported by properly designed

clinical experiments. In the meantime, the fact remains that todate none of the pharmacological or other treatment modalities can cure any of the anxiety disease.

Probably even more important are clinical findings that there is a heterogeneity of therapeutic responsiveness to the same substance within one and the same diagnostic group; that there are no verified predictors of clinical responsiveness in any of the diagnostic groups; and that discontinuation of treatment even after extended periods (well beyond the periods given for benzodiazepines in textbooks and the physician's desk reference) may result in relapse in a considerable proportion of patients. In view of these one must be cautious and not to confound the action mechanism of any of the drugs with the pathomechanism of any of the anxiety disease. This caution is especially warranted in the light of findings that correspondence between the different pharmacologically-induced anxiety syndromes, regardless whether induced by caffeine, yohimbine, -carboline or sodium lactate is at best tenuous and in terms of the different disorders (with a characteristic form of onset, cross-sectional psychopathology, course and outcome), nonexistent.

Conclusions

Classifications of anxiety disorders were reviewed with special reference to the DSM-III. It was emphasized that diagnoses based on consideration to all developmental stages of the illness, are prerequisites of the optimal utilization of available treatments, development of new treatment modalities and conductance of meaningful research about the nature of these disorders.

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II.

ANXIETY DISORDERS

Composite Diagnostic Evaluation

ANXIETY DISORDERS
Composite Diagnostic Evaluation

Thomas A. Ban, M.D.

Introduction

Introduction of therapeutically effective psychotropic drugs (in the 1950's), and the subsequent recognition that the differential therapeutic effects of these compounds are intimately linked to their differential action on the synaptic cleft (in the 1960's), triggered fundamental changes in the conceptualization of mental illness (during the 1970's). The new neurobiologic paradigm, which rapidly emerged (during the 1980's), and virtually replaced the old psychodynamic paradigm (by the 1990's), was formulated with primary consideration to the action mechanism of psychotropic drugs.

Within the new frame of reference, psychopathologic symptoms are perceived as expressions of pathology in the processing of ideas (impulses) derived from experience; and mental illness is seen as the result of an integration of psychopathologic symptoms. Because of this intimate link between psychopathology and the neurochemistry of the synapse, it has increasingly been acknowledged that the provision of valid diagnostic end-points for research is the single, most important prerequisite of psychiatric progress.

Introduction of therapeutically effective benzodiazepines -- drugs which facilitate transmission of impulses at the synaptic cleft of gabaminergic neurons (Costa, 1985) -- focused attention on the biologic heterogeneity (in terms of pharmacologic responsiveness) of neurotic (anxiety) disorders. To overcome this heterogeneity by identifying the treatment responsive population, consideration was given to the employment of a psychometric-psychopharmacologic approach, i.e., linear regression equations to detect common characteristics in anxiolytic benzodiazepine responsive patients. It was the failure of this approach to arrive at meaningful diagnostic concepts, i.e., diagnostic categories with predictive validity -- in terms of therapeutic responsiveness to anxiolytic benzodiazepines and unresponsiveness to drugs other than anxiolytic benzodiazepines -- that prompted a re-examination of the diagnostic concept of neurotic (anxiety) disorders.

Prelude to Nosologic Development

Nosology is the scientific discipline which deals with the identification and classification of disease. Classifying implies the "ordering of objects on the basis of their relationships" (Sokal, 1974); and a proper system of diagnostic classification provides for "denomination", "qualification" and "prediction", i.e., common names, descriptive features and probablistic statements about the expected course and outcome of its diagnostic

groups (Feinstein, 1972).

Development of psychiatric nosology was triggered by the work of Boisier de Sauvages (1768) who, by adopting some of the basic rules employed by Linne (1736) in the classification of flowering plants, classified "diseases as if they were specimens of nature", dividing them into 2400 species and 295 genera. His assertion that naturally occurring categories of disease (including mental disease) exist, and can be identified in a manner which would "allow the attribution of each patient to one and only one class" by the grouping of symptoms at a particular point, or cross-section, in time, opened the path for the early syndromic classification of psychiatric disorders.

The first cross-sectional syndromic classification was that of Cullen (1769). He believed that "life is a function of nervous energy, muscle a continuation of nerve, and disease is mainly nervous disorder"; and contended that "all diseases with their seat in the nervous system are associated with and/or result in mental derangement". Introducing the term neurosis for this all-embracing (disease) category, Cullen (1772) classified medical illness into fever, cachexias, local diseases and neuroses. Recognition, however, that "not every defect of the nervous system is necessarily accompanied by a mental disorder" led to the introduction of the concept of "psychosis" by Feuchtersleben (1845)

with the separation of psychiatric from neurologic disorders; and recognition that identifiable neuropathology is not present in all mental syndromes -- coupled with the belief that in mental syndromes in which neuropathologic changes are absent, such changes will become detectable at a later stage of disease development -- led to the re-introduction of the concept of unitary psychosis by Griesinger (1845) with the separation of sui generis psychiatric disorders from neuropsychiatric disorders.

In the ultimate analysis, it was Griesinger's (1845) unitary concept of psychosis (mental illness) which focused attention on the lack of identifiable neuropathology in some of the mental syndromes; and it was "unitary psychosis" from which Morel (1852) separated demence precoce (the predecessor of the diagnostic category of schizophrenic disorders), Lasegue (1852) separated delire de persecution (the predecessor of the diagnostic category of delusional disorders), Falret (1854) separated folie circulaire (the predecessor of the diagnostic category of mood disorders), Briquet (1859) separated hysterie (the predecessor of the diagnostic category of somatization disorders), and Morel (1860) separated delire emotif (the predeccesor of the diagnostic category of anxiety disorders). It was Morel's (1860) delire emotif from which Beard (1869) separated neurasthenia (the predecessor of generalized anxiety disorder and panic disorder) and Westphal

(1871-72) separated obsessive-compulsive disorder and agoraphobia (the predecessors of obsessive-compulsive disorder and phobic disorders) (Table 1).

Development of the Nosologic Approach

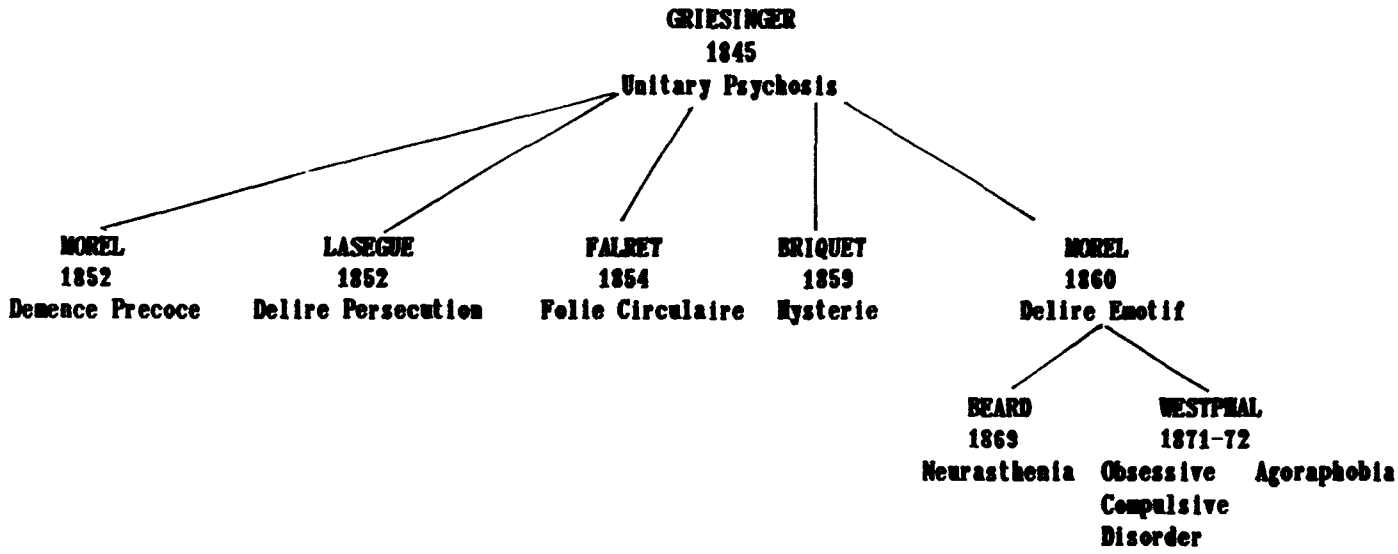
Since the introduction of the unitary concept of psychosis 150 years have passed. During this period detection and classification of mental disorders without identifiable neuropathologic changes was pursued on at least four different directions, i.e., symptom-oriented psychopathologic, neurobiologic, disease-oriented psychopathologic, and new nosologic.

From Psychopathology to Neurobiology

Within the traditional, symptom-oriented psychopathologic frame of reference, the elementary units which serve as the building blocks of mental illness (disorder) are psychopathologic symptoms. Each psychopathologic symptom is perceived as a concept, which is based on pathologic or abnormal subjective experiences (phenomena) with a content derived from past experience and a form which is characteristic of the illness (Jaspers, 1913). It was within this psychopathologic frame of reference that the nosologic concept of anxiety disorders has been formulated and separated into three distinct forms, i.e., generalized anxiety disorder, phobic disorders and obsessive-compulsive disorder.

Introduction of therapeutically effective psychotropic drugs

Table 1



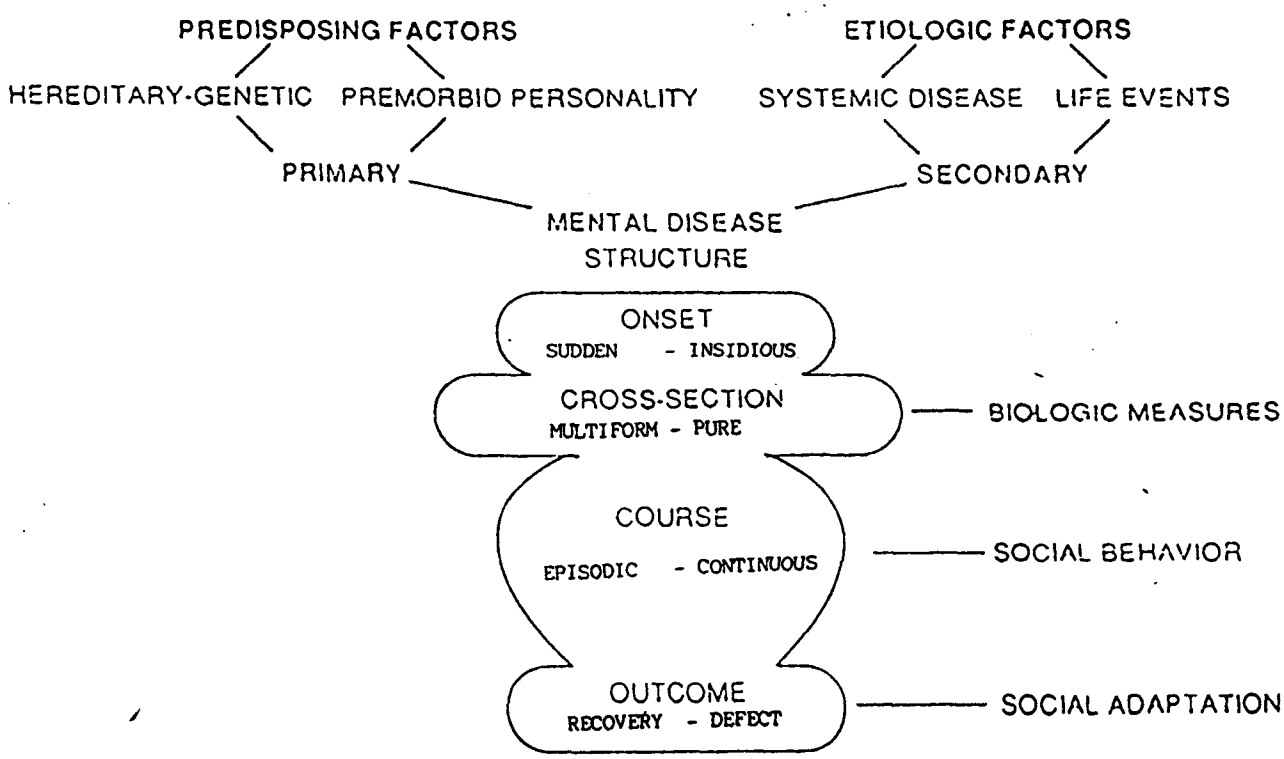
Origin of current diagnostic concepts: disorders separated from unitary psychosis between 1852-1860.

led to the replacement of the traditional symptom-oriented psychopathologic with a neurobiologic conceptualization of mental illness. Regardless of conceptualization, however, attempts to replace psychopathologic symptoms with neurobiologic measures as the building blocks of mental illness have remained so far without success.

From Neurobiology to Nosology

Recognition that neurobiologic measures cannot substitute for psychopathologic symptoms as building blocks of mental illness and that cross-sectional manifestations alone do not suffice for the identification of valid nosologic categories of disease, led to the gradual replacement of the traditional symptom-oriented cross-sectional psychopharmacologic approach with a disease-oriented psychopathologic approach in the detection and classification of mental illness. Within this disease-oriented psychopathologic approach, it is in terms of its dynamic totality, i.e., sudden vs insidious onset, episodic vs continuous course and recovery vs defect at the outcome, that each mental illness is defined, and it is in terms of its specific structure, created by the adding of each single pathologic and/or abnormal form of experience, that mental illness is perceived (Figure 1). It was within this disease-oriented approach that panic disorder, a disorder with acute onset and episodic course, was separated from

Figure 1: Schematic presentation of the structure of psychiatric disease.



generalized anxiety disorder, a disorder with insidious onset and chronic continuous course.

Nosology: Organizing Principles

Development of the nosologic approach was triggered by the recognition that a valid classification of mental illness cannot be attained on the basis of psychopathologic symptoms alone. One possible reason for this is that in both the organization of a psychiatric disorder and classification of psychiatric disorders there are other factors -- which might be referred to as nosologic or taxonomic organizing principles -- which play an important role. To-date at least four such "other factors" or organizing principles have been identified, i.e., temporality, polarity, spatiality and totality. Nevertheless, the fact remains that psychopathology, i.e., pathologic processing of experience, has remained the primary and first organizing principle (Table 2).

Psychopathology

The primary and first organizing principle, psychopathology, is based on Jaspers' (1910, 1913) recognition that development is displayed in behavior (normal or abnormal) that corresponds with events related to the content of subjective experience, whereas psychiatric disease process is displayed in productive-pathologic and/or non-productive abnormal forms of subjective experience and corresponding -- congruent or incongruent -

Table 2

ORGANIZING PRINCIPLES

1st	--	Psychopathology	:	Jaspers	1910
2nd	--	Temporal Organization Falret 1857	:	Kraepelin	1896
3rd	--	Polarity	:	Leonhard	1957
4th	--	Spatial Organization	:	Wernicke	1899
5th	--	Totality Lasegue 1852 Westphal 1872 Leonhard 1957	:	Ban	1987

The five organizing principles of psychiatric nosology.

patterns of behavior.

It was on the basis of the first organizing principle that Kurt Schneider (1959) succeded in separating developmental anomalies, such as mental retardation, personality disorders and character disorders, from the disorders perceived as "effects of illness", i.e., "psychoses". While Schneider (1959) perceived neurotic (anxiety) disorders as reactions of abnormal personalities to stress, introduction of anxiolytic-benzodiazepines focused attention on the fact that similar to the pathomechanism of "psychoses", in the pathomechanisms of anxiety disorders abnormal processing of experience plays a crucial role. The difference -- within the frame of reference of the first organizing principle -- between the disorders referred to as "psychoses" and the disorders referred to as "anxiety disorders" is that in anxiety disorders abnormal processing of experience does not yield productive psychopathology. Another difference between "anxiety disorders" and conditions referred to as "psychoses" is that in anxiety disorders the pattern of behavior is congruent with the content of the abnormal forms of experience.

Temporality

The second organizing principle of psychiatric nosology, temporality, or representation of psychopathology in time, is based on Falret's (1854) separation of folie circulaire from other mental

disorders. It was on the basis of the second organizing principle that panic disorder, characterized by episodic pathology in the processing of experience, was separated from generalized anxiety disorder, characterized by continuous pathology in the processing of experience. It was also on the basis of the second organizing principle that panic disorder, characterized by anxiety attacks lasting from minutes to hours, could be separated from phasic mood disorders, characterized by phases and periods of moods lasting from days to weeks or even months.

Polarity

The third organizing principle of psychiatric nosology, polarity, is based on Leonhard's (1957) conceptualization of the distinction between polymorphic (multiform) -- bipolar -- disorders and monomorphic (pure) -- unipolar -- disorders; and it was on the basis of polarity that Leonhard (1957) separated unipolar phasic psychoses from bipolar manic depressive psychoses. In terms of anxiety disorders, however, polarity does not play an important role.

Spatiality

The fourth organizing principle of psychiatric nosology, spatiality, or representation of psychopathology in space, is based on Wernicke's (1899) conceptualization of psychic reflex and his descriptions of different psychopathologic symptoms displayed in

terms of the different affected components of this reflex, i.e., afferent-perceptual, central affective and/or efferent psychomotor. It was on the basis of the fourth organizing principle that Leonhard (1957) separated the bipolar cycloid psychoses from unipolar manic depressive illness. It was also on the basis of the fourth organizing principle that phobic disorders, i.e., disorders in which fear (anxiety) is triggered by specific perceptual experience, was separated from obsessive-compulsive disorders, i.e., disorders in which fear (anxiety) is triggered by images, thoughts and impulses which against one's will, protrude into and persist in consciousness.

Totality

The fifth and final organizing principle of psychiatric nosology, totality, is based on Lasegue's (1852) concept of partial insanity, i.e., mental illness without personality deterioration, Westphals' (1871-72) concept of abortive insanity, i.e., mental illness with recognition of the pathologic nature of the psychopathologic symptoms, and Leonhard's (1957) concept of incomplete insanity (Petho and Ban, 1989) in which the pathologic process remains restricted to one or two components of the psychic reflex. In terms of anxiety disorders, introduction of the fifth organizing principle has not lead to any further diagnostic differentiation. On the other hand, since anxiety disorders as a

rule are partial, abortive and incomplete, it is on the basis of the fifth organizing principle that anxiety disorders are separated from the other psychiatric disorders (Table 3).

Development of CODE-AD

It was in the Third Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (1980) that the term anxiety disorder was first used in reference to a category of clinical syndromes (providing for an Axis I diagnosis) distinctive from the personality disorders (i.e., Axis II diagnoses). It included two groups of disorder, i.e., phobic disorders, consisting of agoraphobia, social phobia and simple phobia -- diagnoses based on the content of the experience which triggers the fear response -- and anxiety states, consisting of panic disorder, generalized anxiety disorder, obsessive compulsive disorder and post- traumatic stress disorder -- a diagnosis based on a stressful life experience (event) in the patient's past (Table 4).

In prior classifications, such as the Ninth Edition of the International Classification of the World Health Organization, the three prototypes of anxiety disorders, i.e., anxiety states, phobic states and obsessive compulsive disorder, were an integral part of the class of Neurotic Disorders, Personality Disorders and Other Nonpsychotic Mental Disorders. As such, they were conceptualized as conditions which develop in subjects under stress with

Table 3

ORGANIZING PRINCIPLES	DIFFERENTIATION	CHARACTERISTICS
First	Anxiety disorders are "effects of illness"	No productive psychopathologic symptoms; pattern of behavior is congruent with content of abnormal forms of experience
Second	Separation of Panic Disorder from Generalized Anxiety Disorders	Nil
Third	Nil	Nil
Fourth	Separation of phobic disorders from obsessive compulsive disorders	Nil
Fifth	Nil	Partial, abortive and incomplete

The five organizing principles in the differentiation of disorders within the category of anxiety disorders and in the identification of characteristics which differentiate the category of anxiety disorders from other categories of psychiatric disorders.

Table 4

ANXIETY DISORDERS

I. PHOBIC DISORDERS
- **Agoraphobia with Panic Attack**
- **Agoraphobic without Panic Attack**
- **Social Phobia**
- **Simple Phobia**

II. ANXIETY STATES
- **Panic Disorder**
- **Generalized Anxiety Disorder**
- **Obssessive Compulsive Disorder**
- **Post-traumatic Stress Disorder Acute**
- **Post-traumatic Stress Disorder Chronic or Delayed**

Anxiety Disorders in the DSM-II.

personality disorder (Table 5).

Similar to the DSM-III, in the DSM-III-R of the American Psychiatric Association, anxiety disorders remain Axis I diagnoses. In variance with the DSM-III, however, anxiety disorders are no longer divided into two groups, but separated into seven distinct syndromes (Table 6).

Unlike the ICD-9, DSM-III and DSM-III-R, in the ICD-10, anxiety disorders, i.e., phobic anxiety disorders and other anxiety disorders, together with obsessive-compulsive disorder, stress related and adjustment disorder, dissociative disorder and somatoform disorder, are an integral part of neurotic, stress-related and somatoform disorders (Table 7).

Considering that anxiety disorders and their forms and subforms are conceptualized differently and identified by different diagnostic criteria in the various classifications, it was decided to develop a Composite Diagnostic Evaluation of Anxiety Disorders (CODE-AD), suitable for the screening for and identification of anxiety disorders; for comparing diagnostic concepts in the DSM-III-R and ICD-10; and for determining whether the anxiety disorder identified qualifies for a nosologic category.

The diagnostic instrument for screening, the first component of CODE-AD consists of 20 variables (Table 8),

Table 5

NEUROTIC DISORDERS, PERSONALITY DISORDERS AND OTHER NONPSYCHOTIC MENTAL DISORDERS

Anxiety States
Hysteria
Phobic State
Obsessive-compulsive Disorder
Neurotic Depression
Neurasthenia
Depersonalization Syndrome
Hypochondriasis

Neurotic Disorders, Personality Disorders and Other Nonpsychotic Mental Disorders in the ICD-9.

Table 6

ANXIETY DISORDERS

Panic Disorder with Agoraphobia
Panic Disorder without Agoraphobia
Social Phobia
Simple Phobia
Generalized Anxiety Disorder
Obsessive Compulsive Disorder
Post-traumatic Stress Disorder

Anxiety disorders in the DSM-III-R.

Table 7

NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS

I. Phobic anxiety disorders
- **Agoraphobia without panic disorder**
- **Agoraphobia with panic disorder**
- **Social phobia**
- **Specific phobia**

II. Other anxiety disorders
- **Panic disorder**
- **Generalized anxiety disorder**
- **Mixed anxiety and depressive disorder**

III. Obsessive-compulsive disorder
- **Predominantly obsessive**
- **Predominantly compulsive**
- **Mixed**

IV. Reaction to severe stress, and adjustment disorders
- **Acute stress reaction**
- **Post-traumatic stress disorder**
- **Adjustment disorder**
- **Dissociative disorder**
- **Somatoform disorder**

Neurotic, stress-related and somatoform disorders in the ICD-10.

Table 8

CODE-AD VARIABLES

1. **Agoraphobia**
2. **Anxious Mood**
3. **Anxious Nervousness**
4. **Autonomic Hyperactivity**
5. **Avoidance Behavior**
6. **Compulsive Acts**
7. **Feared Endurance**
8. **Increased Arousal**
9. **Motor Tension**
10. **Numbing of General Responsiveness**
11. **Obsessive Thoughts**
12. **Panic Attacks**
13. **Persistent Avoidance**
14. **Persistent Reexperience**
15. **Phobic Fear**
16. **Psychic Trauma**
17. **Psychogenic Amnesia**
18. **Recurrent Panic Attacks**
19. **Social Phobia**
20. **Spontaneous Panic Attacks**

Variables employed in screening for anxiety disorders.

which are assessed in terms of "present" or "absent"; a glossary of definitions and a decision tree (Table 9). By employing this screening instrument, a decision can be reached whether or not the disorder in question displays characteristic features of one or more of seven anxiety diseases (Table 10).

The diagnostic instrument for the comparison of diagnostic concepts in the DSM-III-R and ICD-10, the second component of CODE-AD, consists of a semi-structured interview which can be administered with or without the use of a computer. Employment of the semi-structured interview (Table 11) generates the information necessary to decide whether the disorder identified by the screening instrument fits diagnostic criteria of one or more of the seven anxiety disorders of the DSM-III-R and the corresponding diagnoses in the ICD-10 (Table 12).

Finally, the diagnostic instrument for the determination of whether the disorder identified by the screening instrument qualifies for a nosologic entity, the third component of CODE-AD, consists of variables which are assessed in terms of "present" or "absent"; a glossary of definitions; and a decision tree which indicates whether the disorder fits any of the accepted diagnoses of anxiety disease (Table 13) and, if it does, whether it qualifies as a nosologic entity (Table 14).

Table 9

Decision Tree

	Variables	No.	Diagnosis
1.	Psychic trauma	16	
	Present proceed to 2.		
	Absent proceed to 7.		No PTSD
2.	Increased arousal	8	
3.	Numbing of general responsiveness	10	
4.	Persistent avoidance	13	
5.	Persistent re-experience	14	
6.	Psychogenic amnesia	17	
	At least 2 of 5 present, STOP, then proceed to 7.		PTSD
	Less than 2 of 5 present, proceed to 7.		No PTSD
7.	Compulsive acts	6	
8.	Obsessive thoughts	11	
	At least 1 of 2 present, STOP, then proceed to 9.		OCD
	Both absent, proceed to 9.		No OCD
9.	Anxious nervousness	3	
10.	Anxious mood	2	
	At least 1 of 2 present, proceed to 11.		
	Both absent, proceed to 14.		No GAD
11.	Autonomic hyperactivity	4	
12.	Increased arousal	8	
13.	Motor tension	9	
	At least 2 of 3 present, STOP, then proceed to 14.		GAD
	Less than 2 of 3 present, proceed to 14.		No GAD
14.	Panic attack	12	
	Present, proceed to 15.		
	Absent, proceed to 17.		No PD
15.	Recurrent panic attacks	18	
16.	Spontaneous panic attacks	20	
	Both present, STOP, then proceed to 17.		PD
	Less than 2 present, proceed to 17.		No PD

Table 9 (cont.)

Decision Tree

	Variables	No.	Diagnosis
17.	Agoraphobia		
	Present, proceed to 18.		
	Absent, proceed to 20.		No AP
18.	Avoidance behavior	5	
19.	Feared endurance	7	
	At least 1 of 2 present, STOP, then proceed to 20.		AP
	Both absent, proceed to 20.		No AP
20.	Social phobia	19	
	Present, proceed to 21.		
	Absent, proceed to 23.		No SP
21.	Avoidance behavior	5	
22.	Feared endurance	7	
	At least 1 of 2 present, STOP, then proceed to 23.		SP
	Both absent, proceed to 23.		No SP
23.	Phobic fear	15	
	Present, proceed to 24.		
	Absent, STOP.		No SSP
24.	Avoidance behavior	5	
25.	Feared endurance	7	
	At least 1 of 2 present, STOP.		SSP
	Both absent, STOP.		No SSP

Diagnostic decision tree used in the screening for anxiety disorders.

Table 10

Anxiety Disorders

Generalized Anxiety Disorder	GAD
Obsessive Compulsive Disorder	OCD
Panic Disorder	PD
Agoraphobia	AP
Social Phobia	SP
Simple Phobia	SSP
Post-Traumatic Stress Disorder	PTSD

The seven conditions included under anxiety disorders in the DSM-III-R.

Table 11

31. Dr.-Pt. A discrete, well-defined episode of intense fear or discomfort is commonly referred to as a panic attack. Have you ever experienced one?

If Yes, proceed to 32. DSM-III-R: No PD
If No, STOP, then proceed to C 69. ICD-10: No PD

32. Dr.-Pt. Did it occur only immediately before or after exposure to a dangerous or life-threatening situation or in a situation that has almost always caused you anxiety?

If Yes, STOP, then proceed to C 69. DSM-III-R: No PD
If No, proceed to 33. ICD-10: No PD

33. Dr.-Pt. Did it occur only in situations when you were the focus (center) of the attention of others?

If Yes, STOP, then proceed to C 69. DSM-III-R: No PD
If No, proceed to 34. ICD-10: No PD

34. Dr.-Pt. Did it occur only when you were under physical strain by markedly exerting yourself?

If Yes, STOP, then proceed to C 69. DSM-III-R: No PD
If No, proceed to 35. ICD-10: No PD

35. Dr.-Pt. Are you drinking coffee in excess?

If Yes, proceed to 36. DSM-III-R: No PD
If No, proceed to 37. ICD-10: No PD

Illustration of the semi-structured interview used to determine whether the anxiety disorder identified by the screening interview fits diagnostic criteria of any of the anxiety disorders in DSM-III-R and/or ICD-10.

Table 12

281. Computer Generated: (Check [✓] the one from DSM-III-R and from ICD-10 which apply.)

DSM-III-R	ICD-10
_____ No PD	_____ No PD
_____ PD Severe	_____ PD Severe Degree
_____ PD in Full Remission	_____ PD Moderate Degree
_____ PD Moderate	_____ PD
_____ PD Mild	
_____ PD in Partial Remission	
_____ No AP	_____ No AP
_____ AP Severe	_____ AP
_____ AP Moderate	
_____ AP Mild	
_____ AP in Partial Remission	
_____ AP in Full Remission	
_____ No SP	_____ No SP
_____ SP	_____ SP
_____ No SSP	_____ No SSP
_____ SSP	_____ SSP
_____ No OCD	_____ No OCD
_____ OCD	_____ OCD with Mixed Obsessional Thoughts and Acts
	_____ OCD with Predominantly Compulsive Acts
_____ No PTSD	_____ No PTSD
_____ PTSD Delayed Onset	_____ PTSD Delayed Onset
_____ PTSD	_____ PTSD
_____ No GAD	_____ No GAD
_____ GAD	_____ GAD

Proceed to 282.

Table 12 (cont.)

282. Computer Generated: (Check [✓] the one from DSM-III-R and from ICD-10 which apply.)

DSM-III-R	ICD-10
_____ PD-Severe with AP	_____ AP with PD Severe Degree
_____ PD-Moderate with AP	_____ AP with PD Moderate Degree
_____ PD-Mild with AP	_____ AP with PD
_____ PD in Partial Remission with AP	
_____ PD in Full Remission with AP	
_____ PD-Severe without AP	_____ PD-Severe Degree
_____ PD-Moderate without AP	_____ PD-Moderate Degree
_____ PD-Mild without AP	_____ PD
_____ PD in Partial Remission without AP	
_____ PD in Full Remission without AP	
_____ AP without History of PD	_____ AP without PD
_____ No PD and/or AP	_____ No AP and/or PD

Proceed to 283.

283. Computer Generated: (Write out combined -- mixed -- diagnosis, if present, in DSM-III-R or ICD-10, separately.)

Diagnoses from DSM-III-R and ICD-10 which can be identified by the employment of the semi-structured interview.

Table 13

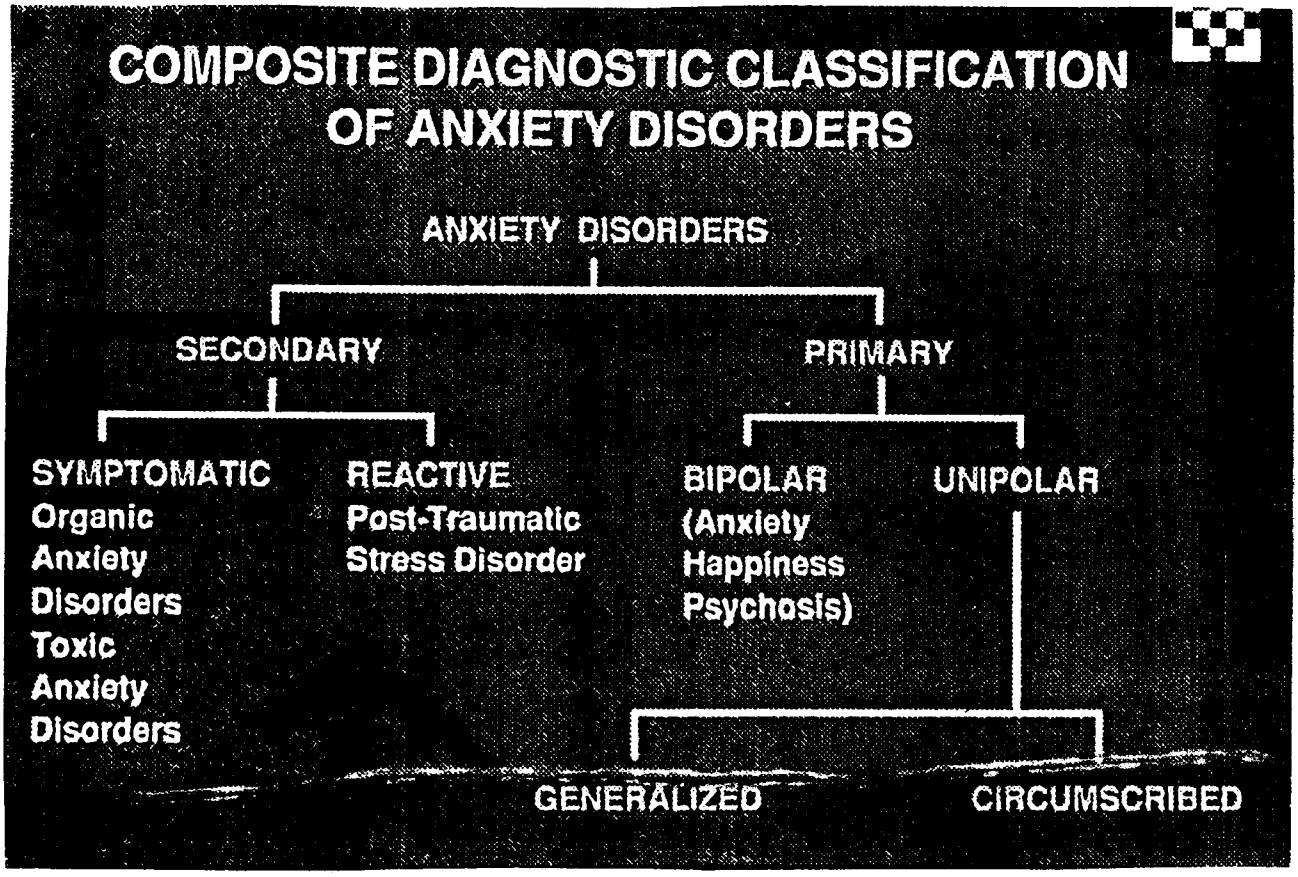

COMPOSITE DIAGNOSTIC CLASSIFICATION OF ANXIETY DISORDERS
ANXIETY DISORDERS
SECONDARY
PRIMARY
SYMPTOMATIC
Organic
Anxiety
Disorders
Toxic
Anxiety
Disorders
REACTIVE
Post-Traumatic
Stress Disorder
BIPOLAR
(Anxiety
Happiness
Psychosis)
UNIPOLAR
GENERALIZED
CIRCUMSCRIBED

Table 13 (cont.)

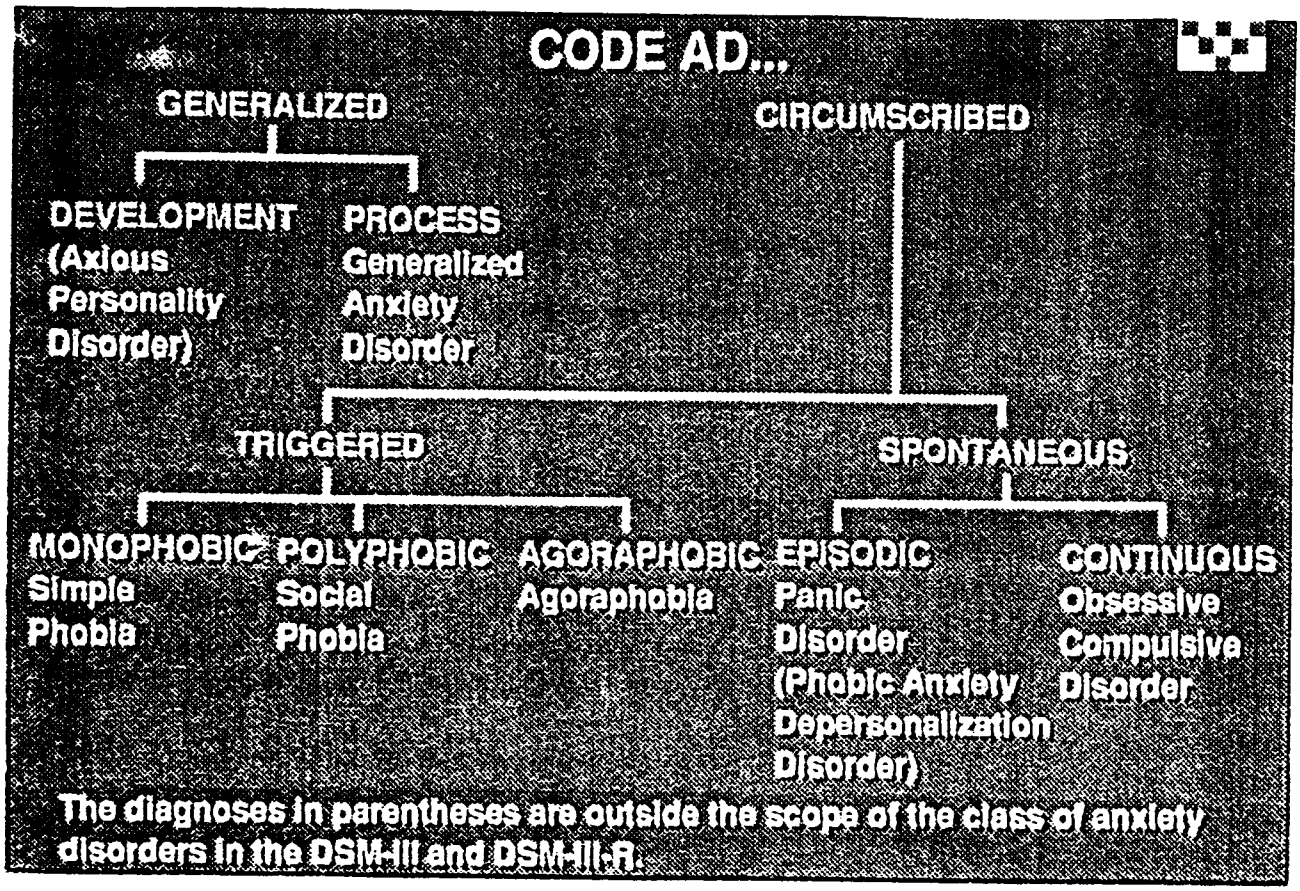


Table 14

ORGANIZING PRINCIPLES	RESPONSE
First	
Productive Psychopathologic Symptoms	Absent
Non-productive Psychopathologic Symptoms	Present
Pattern of Behavior Congruent with Content of Abnormal forms of experience	Present
Pattern of Behavior Incongruent with Content of Abnormal Forms of Experience	Absent
Second	
Episodic Pathology	Present/Absent
Continuous Pathology	Present/Absent
Third	
Bipolar-Polymorphic	Absent
Unipolar-Monomorphic	Present
Fourth	
Lower Afferent - Central	Present/Absent
Higher Afferent - Central	Present/Absent
Fifth	
Partial	Present
Abortive	Present
Incomplete	Present

Criteria to qualify as a nosologic entity within anxiety disorders.

Concluding Remarks

In this presentation the transformation of the diagnostic concept of neurotic disorders, based on a psychologic frame of reference, into the diagnostic concept of anxiety disorders, based on a psychopathologic frame of reference, was outlined; and recent developments in the conceptualziation of anxiety disorders, triggered by the introduction of anxiolytic-benzodiazepines, were discussed. It was emphasized that a valid classification of anxiety disorders cannot be attained on the basis of psychopathologic symptoms alone, because in the organization of anxiety disorders factors other than pathology in the processing of ideas (impulses) derived from experience, such as temporality, spatiality and totality, also play an important role.

The shift of emphasis from one conceptual framework to another has far reaching practical and heuristic implications in psychiatry. Thus, replacement of the psychopathologic with the biologic conceptualization of mental illness resulted in a shift of emphasis from phenomenologic explorations to biochemical and neurophysiologic measures; and replacement of the psychopathologic approach in diagnosis and classification with a holistic-nosologic approach may result in a shift of emphasis from the spatial to the temporal organization of mental illness and a shift in priorities of biologic research from the detection of

the biologic correlates of the disease to the recognition of its genetic pattern. Furthermore, in clinical investigations with psychotropic drugs replacement of the psychopathologic with a nosologic approach may result in a shift of emphasis from establishing clinical efficacy to the identification of the treatment responsive population; and in the methodology of clinical investigation the replacement of dimensional rating scale measures of improvement, i.e., decrease of scores, with categorical nosologic end-points, i.e., resolution of nosologic pattern(s).

To ascertain that the different disorders identified represent meaningful categories of disease validation studies employing statistical approaches and external correlates, are in progress. To facilitate this process a composite diagnostic evaluation of anxiety disorders -- CODE-AD -- was developed which can provide the clinician -- as well as the epidemiologist -- a simple screening procedure for anxiety disorders; the researcher with a suitable assessment instrument to ascertain that the disorder identified fits criteria of the same disorder in both major consensus based classifications, i.e., the ICD-10 and DSM-III-R and the educater with a means to provide an understanding how the different nosologic entities were derived in anxiety disease.

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III.

COMPOSITE DIAGNOSTIC EVALUATION OF ANXIETY DISORDERS

(CODE-AD)

May 6, 1991

COMPOSITE DIAGNOSTIC EVALUATION

of

ANXIETY DISORDERS

(CODE-AD)

A. Panic Disorder

1. A panic attack is a discrete, well-defined episode of intense fear or discomfort. Have you ever experienced one?

   Yes, proceed to 2

   No, proceed to B — ICD-10, DSM-III-R: No Panic Disorder

2. Have you ever experienced one which did not occur immediately before or after exposure to a dangerous or life-threatening situation or a situation that has almost always caused you anxiety?

   Yes, proceed to 3

   No, proceed to B — ICD-10, DSM-III-R: No Panic Disorder

3. Have you ever experienced one which did not occur in a situation when you were the focus (center) of the attention of others?

   Yes, proceed to 4

   No, proceed to B — ICD-10, DSM-III-R: No Panic Disorder

4. Have you ever experienced one which occurred at a time when you were not under physical strain by markedly exerting yourself?

   Yes, proceed to 5

   No, proceed to B — ICD-10, DSM-III-R: No Panic Disorder

5. Are you drinking coffee in excess?

   Yes, proceed to 6

   No, proceed to 7

6. Have you ever had a panic attack at a time when you were not drinking coffee in excess?

Yes, proceed to 7

No, proceed to B ICD-10, DSM-III-R: No Panic Disorder

7. Are you taking any drug for weight reduction and/or for other reasons which contains the stimulant, amphetamine?

Yes, proceed to 8

No, proceed to 9

8. Have you ever had a panic attack without taking a drug which contains the stimulant, amphetamine?

Yes, proceed to 9

No, proceed to B ICD-10, DSM-III-R: No Panic Disorder

9. Do you have any problems with your thyroid gland?

Yes, proceed to 10

No, proceed to 12

10. Was it diagnosed as hyperthyroidism?

Yes, proceed to 11

No, proceed to 12

11. Have you ever had a panic attack before your hyperthyroidism was diagnosed?

Yes, proceed to 12

No, proceed to B ICD-10, DSM-III-R: No Panic Disorder

12. Have you ever experienced any of the following symptoms? Please mark each of those which you experienced at least once during a panic attack:

a. shortness of breath (dyspnoea) or smothering sensation

b. dizziness, unsteady feelings, or faintness

c. palpitations or accelerated heart rate (tachycardia)

d. trembling or shaking

e. sweating

f. choking

g. nausea or abdominal distress

h. that the world appears to be unfamiliar, peculiar, ghostly, unreal, strange, or somehow changed, and/or that you, yourself are feeling unreal, detached, strange, changed, or unidentifiable

i. numbness or tingling sensations

j. flushes (hot flashes) or chills

k. chest pain or discomfort

l. fear of dying

m. fear of going crazy or of doing something uncontrolled

At least 4 of 13 present, proceed to 13

Less than 4 of 13 present, stop, then proceed to 14 — DSM-III-R: No Panic Disorder

13. Would it be correct to say that during some of the attacks at least four of these symptoms (See 12) _____

_____

developed suddenly and increased in intensity within the first 10 minutes?

Yes, proceed to 22

No, stop, then proceed to 14 — DSM-III-R: No Panic Disorder

14. Have you ever experienced at least one panic attack during which at least one of the following four symptoms were present? If you did, please mark the one(s) which you experienced:

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling or shaking limbs

d. dry mouth

e. none of the above

Yes, proceed to 15

No, stop, then proceed to B — ICD-10: No Panic Disorder

15. During the same panic attack, was at least one of the following five symptoms also present? If it was, please mark the one(s) which were present:

a. feeling of loss of emotional control, or the feeling of becoming mad, or the feeling of impending death

b. discomfort or pain in chest or epigastrium (e.g., butterflies or churning in the stomach)

c. difficulty in breathing or feeling of choking

d. feeling of dizziness, unsteadiness or light-headedness

e. feelings of unreality, being distant, "not really here"

f. none of the above

Yes, proceed to 16

No, stop, then proceed to B — ICD-10: No Panic Disorder

16. If one defines a panic attack as an episode of fear associated with some of the symptoms described above, which starts abruptly, soon reaches a crescendo and lasts at least a few minutes, am I correct then to say that you have experienced such attacks?

Yes, proceed to 17

No, stop, then proceed to B — ICD-10: No Panic Disorder

17. Have you ever experienced at least four panic attacks weekly over a four-week period which fulfilled the above definition?

Yes, proceed to 19

No, proceed to 18

18. Have you ever experienced at least three panic attacks within a three-week period which fulfilled the above definition?

Yes, proceed to 20

No, proceed to 21

19. Have you ever been diagnosed as suffering from schizophrenia, an affective-mood disorder and/or a somatoform disorder?

Yes, stop, then proceed to B — ICD-10: No Panic Disorder

No, stop, then proceed to B — ICD-10: Panic Disorder Severe Degree

20. Have you ever been diagnosed as suffering from schizophrenia, affective-mood disorder and/or somatoform disorder?

Yes, stop, then proceed to B — ICD-10: No Panic Disorder

No, stop, then proceed to B — ICD-10: Panic Disorder Moderate Degree

21. Have you ever been diagnosed as suffering from schizophrenia, an affective-mood disorder and/or a somatoform disorder?

Yes, stop, then proceed to B — ICD-10: No Panic Disorder

No, stop, then proceed to B — ICD-10: Panic Disorder

22. Have you ever experienced at least one panic attack during which at least one of the following four symptoms was present? If you did, please mark the one(s) which you experienced:

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling or shaking limbs

d. dry mouth

e. none of the above

Yes, proceed to 23

No, stop, then proceed to B — ICD-10: No Panic Disorder

23. During the same panic attack, was at least one of the following five symptoms also present? If it was, please mark the one(s) which were present:

a. feeling of loss of emotional control, or the feeling of becoming mad, or the feeling of impending death

b. discomfort or pain in chest or epigastrium (e.g., butterflies or churning in the stomach)

c. difficulty in breathing or feeling of choking

d. feeling of dizziness, unsteadiness or light-headedness

e. feelings of unreality, being distant, "not really here"

f. none of the above

Yes, proceed to 24

No, stop, then proceed to B — ICD-10: No Panic Disorder

24. If one defines a panic attack as an episode of fear associated with some of the symptoms described above, which starts abruptly, soon reaches a crescendo and lasts at least a few minutes, am I correct then to say that you have experienced such episodes?

Yes, proceed to 25

No, stop, then proceed to B — ICD-10: No Panic Disorder

25. Have you ever experienced at least four panic attacks weekly, over a four-week period which fulfilled the above definition?

Yes, proceed to 27

No, proceed to 26

26. Have you ever experienced at least three panic attacks within a three-week period which fulfilled the above definition?

Yes, proceed to 28

No, proceed to 29

27. Have you been diagnosed presently as suffering from schizophrenia, an affective-mood disorder and/or a somatoform disorder?

Yes, stop,
then proceed to 30 — ICD-10: No Panic Disorder

No, stop,
then proceed to 30 — ICD-10: Panic Disorder Severe Degree

28. Have you been diagnosed presently as suffering from schizophrenia, an affective-mood disorder and/or a somatoform disorder?

Yes, stop,
then proceed to 30 — ICD-10: No Panic Disorder

No, stop,
then proceed to 30 — ICD-10: Panic Disorder Moderate Degree

29. Have you been diagnosed recently as suffering from schizophrenia, an affective-mood disorder and/or a somatoform disorder?

Yes, stop,
then proceed to 30 — ICD-10: No Panic Disorder

No, stop,
then proceed to 30 — ICD-10: Panic Disorder

30. To ascertain that we have all the necessary information, let us review: Have you ever experienced four panic attacks within a four-week period?

Yes, proceed to 32

No, proceed to 31

31. Have you ever had one or more panic attacks which were followed for at least a month by a period of persistent fear of having another attack?

Yes, proceed to 32

No, stop, then proceed to B — DSM-III-R: No Panic Disorder

32. Have you had eight or more panic attacks during the past month?

Yes, stop, then proceed to B — DSM-III-R: Panic Disorder Severe

No, proceed to 33

33. In your case, the simultaneous presence of at least four of these symptoms (See12)_____ represents a panic attack, and the presence of one to three of these symptoms represents a limited symptom attack. Have you had a panic attack or limited symptom attack during the past six months?

Yes, proceed to 34

No, stop, then proceed to B — DSM-III-R: Panic Disorder in Full Remission

34. Have you had more than one panic attack during the past month?

Yes, stop, then proceed to B — DSM-III-R: Panic Disorder Moderate

No, proceed to 35

35. Have you had a panic attack during the past month?

Yes, stop, then proceed to B — DSM-III-R: Panic Disorder Mild

No, proceed to 36

36. Have you had one or more limited symptom attacks during the past month?

Yes, stop,
then proceed to B

DSM-III-R: Panic Disorder Mild

No, stop,
then proceed to B

DSM-III-R:
Panic Disorder in Partial Remission

B. Agoraphobia

1. Some people complain that they develop marked fear in certain situations. This fear is sometimes so severe that it makes them avoid the fear provoking situation. Is there any situation in which you have consistently developed a marked fear in the past and/or a situation which you have been avoiding because you have consistently developed a marked fear of it?

   Yes, proceed to 2,

   No, stop, then proceed to C — ICD-10, DSM-III-R: No Agoraphobia

2. Some people with such a problem say that they are afraid of being in places or situations from which escape might be difficult (or embarrassing), or in which help might not be available in the event of suddenly developing a symptom that could be incapacitating or extremely embarrassing. Is anything like that the case with you?

   Yes, proceed to 3

   No, stop, then proceed to 9 — DSM-III-R: No Agoraphobia

3. Different people develop marked fear in different situations. However, there are at least four situations in which marked fear is encountered more frequently than in others. Please mark those which apply to you:

a. crowds

b. public places

c. travelling alone

d. travelling away from home

e. none of the above

All absent, stop, then proceed to 4 — ICD-10: No Agoraphobia

1 of 4 present, stop, then proceed to 5 — ICD-10: No Agoraphobia

2 or more present, proceed to 10

4. What about the following situations? Please mark those which apply to you:

a. being outside of home alone

b. standing in a line

c. being on a bridge

d. travelling in a bus

e. travelling in a train

f. travelling in a car

g. none of the above.

At least 1 of 6 present, proceed to 5

All absent, stop, then proceed to C — DSM-III-R: No Agoraphobia

5. Is your fear in (See B3) _____

and/or (See B4) _____ to the extent that you are avoiding (See B3) _____

and/or (See B4)_____ and as a result you are nearly or completely homebound or unable to leave your home unaccompanied?

Yes, stop, then proceed to C — DSM-III-R: Agoraphobia, Severe

No, proceed to 6

6. Is your fear to the extent that even if you are not completely housebound, you are living a constricted life style?

Yes, stop, then proceed to C — DSM-III-R: Agoraphobia, Moderate

No, proceed to 7

7. Would it be correct to say that although at present you can live a relatively normal life style, you are still avoiding (See B3 and B4)

_____

_____to some extent and/or if you are exposing yourself to it you can endure it only with great distress?

Yes, stop, then proceed to C — DSM-III-R: Agoraphobia, Mild

No, proceed to 8

8. Would it be correct to say that presently you are not avoiding any of the fear provoking situations, but have still avoided some during the past six months?

Yes, stop, then proceed to C	DSM-III-R: Agoraphobia in Partial remission
No, stop, then proceed to C	DSM-III-R: Agoraphobia in Full Remission

9. Different people develop marked fear in different situations. However, there are at least four situations in which marked fear is encountered more frequently than others. Please mark those which apply to you:

a. crowds

b. public places

c. travelling alone

d. travelling away from home

e. none of the above

At least 2 or more present, proceed to 14

Less than 2 of 4 present, stop, then proceed to C — ICD-10: No Agoraphobia

10. Is your fear in (See B3) _____ and/or (See B4) _____ to the extent that you are avoiding (See B3) _____ and/or (See B4) _____, and as a result you are nearly or completely homebound, or unable to leave your home unaccompanied?

Yes, stop, then, proceed to 14 — DSM-III-R: Agoraphobia, Severe

No, proceed to 11

11. Is your fear to the extent that even if you are not completely housebound, you are living a constricted life style?

Yes, stop, then proceed to 14 — DSM-III-R: Agoraphobia, Moderate

No, proceed to 12

12. Would it be correct to say that although at present you can live a relatively normal life style, you are still avoiding (See B9)

_____

_____ to some extent and/or if you are exposing yourself to it you can only endure it with distress?

Yes, stop, then proceed to 14 — DSM-III-R: Agoraphobia, Mild

No, proceed to 13

13. Would it be correct to say that presently you are not avoiding any of the fear provoking situations, but have still avoided some during the past six months?

Yes, stop, then proceed to 14 — DSM-III-R: Agoraphobia in Partial Remission

No, stop, then proceed to 14 — DSM-III-R: Agoraphobia in Full Remission

14. To ascertain that we have all the necessary information, let us review: Have you experienced at least one of the following symptoms when exposed to (See B3, B4 and/or B9)_____

_____?

If you did, please mark the one(s) which you experienced:

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling with shaking of limbs

d. dry mouth

e. none of the above

Yes, proceed to 15

No, stop, then proceed to C — ICD-10: No Agoraphobia

15. During the same time, was at least one of the following symptoms also present? If it was, please mark the one(s) which were present:

a. feeling of loss of emotional control, or the feeling of becoming mad, or the feeling of impending death

b. discomfort or pain in chest or epigastrium, e.g., butterflies or churning in the stomach

c. difficulty in breathing or feeling of choking

d. feelings of dizziness, unsteadiness or light-headedness

e. feelings of unreality, being distant, "not really here"

f. none of the above

Yes, proceed to 16

No, stop, then proceed to C — ICD-10: No Agoraphobia

16. Would it be correct to say that you find it quite distressing that when exposed to (See B3, B4 or B9)_____

_____

you are developing (See B14 and B15)_____?

Yes, proceed to 18

No, proceed to 17

17. But you do recognize that developing (See B14 and B15)_____

_____

when exposed to (See B3, B4 or B9) _____

_____

excessive and/or unreasonable?

Yes, proceed to 18

No, stop, then proceed to C — ICD-10: No Agoraphobia

18. Have you been diagnosed recently as suffering from schizophrenia, an affective-mood disorder and/or an obsessive compulsive disorder?

Yes, stop, then proceed to C — ICD-10: No Agoraphobia

No, stop, then proceed to C — ICD-10: Agoraphobia

C. Agoraphobia and Panic Disorder
(Computer Generated from A and B)

Mark the one from ICD-10 and the one from DSM-III-R which applies:

ICD-10

- Agoraphobia without Panic Disorder
- Agoraphobia with Panic Disorder - Severe Degree
- Agoraphobia with Panic Disorder - Moderate Degree
- Agoraphobia with Panic Disorder
- Panic Disorder - Severe Degree
- Panic Disorder - Moderate Degree
- Panic Disorder
- No Agoraphobia and/or Panic Disorder

DSM-III-R

- Panic Disorder - Severe with Agoraphobia
- Panic Disorder - Moderate with Agoraphobia
- Panic Disorder - Mild with Agoraphobia
- Panic Disorder in Partial Remission with Agoraphobia
- Panic Disorder in Full Remission with Agoraphobia
- Panic Disorder - Severe without Agoraphobia
- Panic Disorder - Moderate without Agoraphobia
- Panic Disorder - Mild without Agoraphobia
- Panic Disorder in Partial Remission without Agoraphobia
- Panic Disorder in Full Remission without Agoraphobia
- Agoraphobia without History of Panic Disorder
- No Panic Disorder and/or Agoraphobia

D. Social Phobia

1. Some people complain that they develop a marked fear in social situations. They dread being the focus of attention and/or behaving in a way that will be embarrassing or humiliating. Is there any social situation in which you have consistently developed a marked fear in the past and/or a social situation which you have been avoiding because you have consistently had a marked fear when exposed to it?

   Yes, proceed to 2

   No, stop, then proceed to E — ICD-10, DSM-III-R: No Social Phobia

2. Different people develop a marked fear in different social situations. However, there are at least four social situations in which a marked fear is encountered more frequently than in others. Please mark those which apply to you:

   a. eating in public

   b. speaking in public

   c. encountering known people in public

   d. entering or enduring small group situations such as parties or meetings

   e. none of the above

   All absent, stop, then proceed to 3 — ICD-10: No Social Phobia

   At least 1 of 4 present, proceed to 13

3. What about urinating in a public lavatory?

   Yes, proceed to 5

   No, proceed to 4

4. What about writing in the presence of others?

Yes, proceed to 5

No, stop, then proceed to E — DSM-III-R: No Social Phobia

5. Would it be correct to say that there has been a period in your life when (See D3 and D4) _____ _____ almost invariably provoked an immediate anxiety response in you?

Yes, proceed to 6

No, stop, then proceed to E — DSM-III-R: No Social Phobia

6. Would it be correct to say that you are avoiding (See D3 or D4) _____ and/or that you can endure (See D3 or D4) _____ _____ only with great difficulties and with intense anxiety?

Yes, proceed to 7

No, stop, then proceed to E — DSM-III-R: No Social Phobia

7. Does your fear of (See D3 or D4) _____ interfere with your occupational functioning and/or usual social activities and/or relationships with people?

Yes, proceed to 9

No, proceed to 8

8. Am I correct to assume, however, that you are quite distressed in having this fear of (See D3 or D4)_____?

Yes, proceed to 9

No, stop, then proceed to E — DSM-III-R: No Social Phobia

9. But you do recognize, that your fear of (See D3 or D4) _____ _____ is excessive and/or unreasonable?

Yes, proceed to 10

No, stop, then proceed to E — DSM-III-R: No Social Phobia

10. Have you been diagnosed as having panic disorder?

Yes, stop, then proceed to E — DSM-III-R: No Social Phobia

No, proceed to 11

11. Have you been diagnosed as having Parkinson's disease?

Yes, proceed to 12

No, stop then proceed to E — DSM-III-R: Social Phobia

12. Do you think that your fear of (See D3 or D4) _____ _____ is due to your concern about exhibiting some of the features of your Parkinson's disease?

Yes, stop, then proceed to E — DSM-III-R: No Social Phobia

No, stop, then proceed to E — DSM-III-R: Social Phobia

13. Would it be correct to say that there has been a period in your life when (See D2)_____almost invariably provoked an immediate anxiety response?

Yes, proceed to 14

No, stop, then proceed to 25 — DSM-III-R: No Social Phobia

14. Would it be correct to say that you are avoiding (See D2) _____ _____and/or that you can endure (See D2) _____ _____only with great difficulties and with intense anxiety?

Yes, proceed to 15

No, stop, then proceed to 25 — DSM-III-R: No Social Phobia

15. Does your fear of (See D2) _____ interfere with your occupational functioning and/or usual social activities and/or relationships with people?

Yes, proceed to 17

No, proceed to 16

16. Am I correct to assume, however, that you are quite distressed in having this fear of (See D2)_____?

Yes, proceed to 18

No, stop, then proceed to 25 — DSM-III-R: No Social Phobia

17. But you do recognize, that your fear of (See D2) _____

_____ is excessive and/or unreasonable?

Yes, proceed to 18

No, stop, then proceed to 25 — DSM-III-R: No Social Phobia

18. Have you been diagnosed as having panic disorder?

Yes, stop then proceed to 25 — DSM-III-R: No Social Phobia

No, proceed to 19

19. Have you been diagnosed as having Parkinson's disease?

Yes, proceed to 20

No, proceed to 21

20. Do you think that your fear of (See D2) _____

_____ is due to your concern about exhibiting some of the features of your Parkinson's disease?

Yes, stop, then proceed to 25 — DSM-III-R: No Social Phobia

No, proceed to 21

21. Have you been diagnosed as having an eating disorder?

Yes, proceed to 22

No, proceed to 23

22. Do you think that your fear of (See D2)_____

_____is due to your concern in exhibiting some of the features of your eating disorder?

Yes, stop, then proceed to 25 — DSM-III-R: No Social Phobia

No, proceed to 23

23. Do you stutter?

Yes, proceed to 24

No, stop, then proceed to 25 — DSM-III-R: Social Phobia

24. Do you think that your fear of (See D2)_____

_____is due to your concern about exhibiting your stuttering?

Yes, stop, then proceed to 25 — DSM-III-R: No Social Phobia

No, stop, then proceed to 25 — DSM-III-R: Social Phobia

25. To ascertain that we have all the necessary information, let us review: Have you experienced at least one of the following symptoms when exposed to (See D2)_____? If you did, please mark the one(s) which you experienced:

a. blushing or shaking

b. nausea or fear of vomiting

c. urgency or fear of having an accident (micturition or defecation)

d. none of the above

Yes, proceed to 26

No, stop, then proceed to E — ICD-10: No Social Phobia

26. During the same time, was at least one of the following symptoms also present? If it was, please mark the one(s) which were present:

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling with shaking of limbs

d. dry mouth

e. none of the above

Yes, proceed to 27

No, stop
then proceed to E

ICD-10: No Social Phobia

27. What about the following symptoms. Was at least one also present during the same time? If it was, please mark the one(s) which were present:

a. feeling of loss of emotional control, or the feeling of becoming mad, or the feeling of impending death

b. discomfort or pain in chest or epigastrium, e.g., butterflies or churning in the stomach

c. difficulty in breathing or feeling of choking

d. feeling of dizziness, unsteadiness or light-headedness

e. feelings of unreality, being distant, not really here

f. none of the above

Yes, proceed to 28

No, stop
then proceed to E

ICD-10: No Social Phobia

28. Would it be correct to say that you find it quite distressing that when exposed to (See D2)_____you are developing (See D25, D26, D27) _____

_____?

Yes, proceed to 39

No, proceed to 29

29. But you do recognize that developing (See D25, D26, D27) _____

_____when exposed to (See D2)_____is excessive and/or unreasonable?

Yes, proceed to 30

No, stop, then proceed to E — ICD-10: No Social Phobia

30. Have you been diagnosed recently as suffering from schizophrenia, an affective-mood disorder and/or an obsessive-compulsive disorder?

Yes, stop, then proceed to E — ICD-10: No Social Phobia

No, stop, then proceed to E — ICD-10: Social Phobia

E. Simple (Specific) Phobia

1. Regardless of whether or not you are afraid of being in places from which escape might be difficult (or embarrassing), and regardless of whether or not you do develop a marked fear in certain social situations, is there any other situation and/or specific object which triggers consistently marked fear in you to the extent that you feel like avoiding it or may even avoid it?

   Yes, proceed to 2

   No, stop, then proceed to F — ICD-10, DSM-III-R: No Simple Phobia

2. In different people different situations and/or different specific objects trigger marked fear. There are, however, at least 11 different situations and/or objects in which marked fear is triggered more often than in others. Please mark those which apply to you:

   a. animals
   b. birds
   c. insects
   d. heights
   e. thunder
   f. flying
   g. small enclosed spaces
   h. sight of blood or injury
   i. injections
   j. dentists
   k. hospitals
   l. none of the above

   None, proceed to 3

   At least 1 of 11 present, proceed to 4

3. Since none of the above triggers marked fear in you, would you please identify the situation and/or special object which does by typing it in:

_____

Proceed to 4

4. Would it be correct to say then that you have a fear of (See E2 or E3)

_____and

at least some time you have developed one or more of the following symptoms when you were exposed to it?

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling with shaking limbs

d. dry mouth

e. none of the above

Yes, proceed to 5

No, stop
then proceed to 8

ICD-10: No Specific Phobia

5. During the same time, was at least one of the following symptoms also present? If is was, please mark the one(s) which were present:

   a. feeling of loss of emotional control or going mad or impending death

   b. discomfort or pains in chest or epigastrium

   c. difficulty in breathing or feeling of choking

   d. feelings of dizziness, unsteadiness or light-headedness

   e. feelings of unreality, being distant, "not really here"

   f. none of the above

Yes, proceed to 6

No, stop — ICD-10: No Specific Phobia
then proceed to 8

6. Would it be correct to say that you are finding it quite distressing that you have a fear of (See E2 and E3) _____ _____ and that you are developing (See E4 and E5) _____ when exposed to and/or even when you are thinking about it?

Yes, proceed to 7

No, stop — ICD-10: No Specific Phobia
then proceed to 8

7. But you do recognize that developing (See E4 and E5) _____ _____ when exposed to (See E2 and E3) _____ is excessive and/or unreasonable?

Yes, stop, — ICD-10: Specific Phobia
then proceed to 8

No, stop, — ICD-10: No Specific Phobia
then proceed to 8

8. To ascertain that we have all the necessary information, let us review: Would it be correct to say that there had been a period in your life when (See E2 or E3) _____ almost invariably provoked in you an immediate anxiety response?

Yes, proceed to 9

No, stop, then proceed to F — DSM-III-R: No Simple Phobia

9. Would it be correct to say that you are avoiding (see E2 or E3) _____ and/or that you can endure (See E2 or E3) _____ _____ only with great difficulties and with intense anxiety?

Yes, proceed to 10

No, stop, the proceed to F — DSM-III-R: No Simple Phobia

10. Does your fear of (See E2 or E3) _____ _____ interfere with your occupational functioning and/or social activities and/or relationships with people?

Yes, proceed to 12

No, proceed to 11

11. Am I correct to assume, however, that you are quite distressed about having this fear of (See E2 or E3) _____?

Yes, proceed to 12

No, stop then proceed to F — DSM-III-R: No Simple Phobia

12. But you do recognize that your fear of (See E2 or E3) _____

_____is excessive and/or

unreasonable?

Yes, proceed to 13

No, stop — DSM-III-R: No Simple Phobia
then proceed to F

13. Have you been diagnosed as having an obsessive compulsive disorder and/or a post-traumatic stress disorder?

Yes, stop, — DSM-III-R: No Simple Phobia
then proceed to F

No, stop, — DSM-III-R: Simple Phobia
then proceed to F

F. Social Phobia and Simple (Specific) Phobia

(Computer generated from C and D)

Mark the one from ICD-10 and the one from DSM-III-R which applies:

ICD-10	Social Phobia
	No Social Phobia
	Specific Phobia
	No Specific Phobia
DSM-III-R	Social Phobia
	No Social Phobia
	Simple Phobia
	No Simple Phobia

G. Generalized Anxiety Disorder

1. Are you a person who feels anxious, worried and apprehensive about matters in your everyday life? Someone who, for example, keeps on worrying about possible misfortune occurring to someone close to him/her who is in no real danger; someone who worries about finances for no real good reason?

   Yes, proceed to 2

   No, stop, then proceed to K — ICD-10, DSM-III-R: No Generalized Anxiety Disorder

2. Can you identify at least two of the things about which you feel excessively anxious, worried and apprehensive?

   Yes, proceed to 3

   No, stop, then proceed to K — ICD-10, DSM-III-R: No Generalized Anxiety Disorder

3. Would you please type them in?

   a. _____

   b. _____

   Proceed to 4

4. Would it be correct to say that you have been anxious, worried and apprehensive about everyday events and problems for a period of at least six months?

   Yes, proceed to 5

   No, stop, then proceed to K — ICD-10, DSM-III-R: No Generalized Anxiety Disorder

5. Different people experience different symptoms when they are worried. There are, however, 17 symptoms which are experienced more often than others. Please mark each of those which apply to you:

a. palpitations or pounding heart

b. hot or cold sweats or flushes

c. trembling with shaking limbs

d. dry mouth

e. feeling of loss of emotional control or going mad or impending death

f. discomfort or pains in chest or epigastrium

g. difficulty in breathing or feeling of choking

h. feelings of dizziness, unsteadiness or light-headedness

i. feelings of unreality, being distant, "not really here"

j. muscle tension or aches and pains

k. restlessness and inability to relax

l. feeling keyed up or on edge or of mental tension

m. a sensations of a lump in the throat or difficulty swallowing

n. exaggerated response to minor surprises or being startled

o. difficulty in concentrating or mind going blank because of worry or anxiety

p. persistent irritability

q. difficulty getting to sleep because of worry

At least 4 of 17 present, proceed to 6

Less than 4 of 17 present, stop then proceed to 7

ICD-10, DSM-III-R:
No Generalized Anxiety Disorder

6. To ascertain that we have all the necessary information, let us review. Please mark <u>each</u> of those symptoms which you frequently experience when you are anxious:

a. trembling, twitching or feeling shaky

b. muscle tension, aches or soreness

c. restlessness

d. easy fatigability

e. shortness of breath or smothering sensations

f. palpitations or accelerated heart rate

g. sweating or cold clammy hands

h. dry mouth

i. dizziness or light-headedness

j. nausea, diarrhea or other abdominal distress

k. flushes (hot flashes) or chills

l. frequent urination

m. trouble swallowing or "lump in throat"

n. feeling keyed up or on edge

o. exaggerated startle response

p. difficulty concentrating or "mind going blank" because of anxiety

q. trouble falling or staying asleep

r. irritability

At least 6 of 18 present, proceed to 8

Less than 6 of 18 present, stop then proceed to 9

<u>ICD-10, DSM-III-R:</u>
<u>No Generalized Anxiety Disorder</u>

7. To ascertain that we have all the necessary information, let us review. Please mark <u>each</u> of those symptoms which you frequently experience when you are anxious:

a. trembling, twitching or feeling shaky

b. muscle tension, aches or soreness

c. restlessness

d. easy fatigability

e. shortness of breath or smothering sensations

f. palpitations or accelerated heart rate

g. sweating or cold clammy hands

h. dry mouth

i. dizziness or light-headedness

j. nausea, diarrhea or other abdominal distress

k. flushes (hot flashes) or chills

l. frequent urination

m. trouble swallowing or "lump in throat"

n. feeling keyed up or on edge

o. exaggerated startle response

p. difficulty concentrating or "mind going blank" because of anxiety

q. trouble falling or staying asleep

r. irritability

At least 6 of 18 present, proceed to 10

Less than 6 of 18 present, stop then proceed to K

<u>ICD-10, DSM-III-R:</u>
<u>No Generalized Anxiety Disorder</u>