

**(including phobias)**

1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:
  - 1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.
  - 1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA. However UK psychiatrists were consulted in its formulation.
2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.
3. This appendix relies on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD-10 codes (numbers usually prefixed with F) are also provided.
4. This appendix summarises the generally recognised clinical features and aetiology of the phobic anxiety disorders, generalised anxiety disorder and panic disorder. These neurotic disorders have been grouped together as they share many clinical and aetiological features.

**Normal anxiety**

5. Most people experience periods of anxiety at some stage in their lives and this is recognised as a normal part of the human condition. Only when anxiety causes clinically significant distress or impairment in social, occupational or personal functioning can it be considered to be a disorder. In addition the anxiety must not merely be an understandable response to a particular event but must be a manifestation of a behavioural or psychological dysfunction in the person.

**Agoraphobia, social phobias, isolated specific phobias.**

6. In this group of disorders excessive anxiety is provoked by well defined situations or objects which are not currently dangerous. As a result these situations are either avoided or endured with dread.

## DEFINITIONS AND CLINICAL MANIFESTATIONS

### Agoraphobia

F40.0

7. The original meaning of the term was "fear of the market place". However this has broadened to include the related aspects of anxiety when in situations the sufferer cannot leave easily, when in the presence of crowds in general and difficulty in leaving the safe environment of the home.
8. Two main groups of symptoms occur, that is, panic attacks (see below) and anxious fears about collapsing or losing control, imagining themselves to be left helpless and unable to get back to their home. Many patients then become terrified at the thought of leaving the house alone and some may become housebound. The symptoms usually begin in early adult life and the condition often becomes chronic although fluctuating in intensity. Symptoms of agoraphobia may be a prominent feature of a depressive episode in older people.
9. Some agoraphobes manage to avoid their phobic situations and consequently do not suffer significant anxiety. Other symptoms may be present, such as depression, depersonalisation and social phobias and their presence does not invalidate the diagnosis if they are not prominent.
10. In order for the diagnosis to be made there must be significant distress caused by the symptoms or there is avoidance of the provoking situation and the individual recognises that the fears are excessive or unreasonable. The symptoms are restricted to the feared situation and the distress is manifest by the presence of at least two symptoms from the following symptoms of anxiety:
  - 10.1. Palpitations (or pounding heart), sweating, trembling, dry mouth which occurs when not on any medication causing this symptom. (One of the symptoms **must** be from this category).
  - 10.2. Difficulty breathing, feeling of choking, nausea, "churning stomach", chest pain or discomfort.
  - 10.3. Feeling dizzy, unsteady, faint, light-headed, feeling "not really here" (depersonalisation) or that surroundings seem unreal (derealisation), fear of losing control, passing out, going mad or dying.
  - 10.4. Flushes or chills, numbness or tingling sensations.
11. Panic attacks (see below) may occur in conjunction with agoraphobia and may be recorded as such in the label.

### Social Phobia

F40.1

12. This is the fear of scrutiny by other people leading to avoidance of social situations. It often begins in adolescence and is equally common in both sexes usually being associated with low self esteem and fear of criticism. The fears may be restricted to specific situations such as eating in public, encounters with the opposite sex or public speaking or they may be more global and involve almost all situations outside the family.

13. The presenting symptoms may be complaints of tremor, blushing, nausea or urgently needing to void urine, the patient sometimes believing that these symptoms (which are in fact secondary to anxiety) are the actual cause of the problem. In addition to at least one of these symptoms there must be at least two symptoms of anxiety, which are listed in paragraph 10 above.
14. Again significant distress is caused by the symptoms or there is avoidance of the provoking situations and the individual recognises that the fears are excessive or unreasonable.

### **Specific (isolated) phobias**

**F40.2**

15. These are highly specific fears of individual situations such as animals, thunder, heights (this being "acrophobia" and not the commonly misused term "vertigo"), darkness, flying, closed spaces (claustrophobia), injury, the sight of blood, needles, the fear of exposure to specific diseases etc. The themes occurring in disease phobias often reflect the times, the prevailing ones being radiation sickness, venereal disease and AIDS.
16. Specific phobias usually arise in childhood or early adulthood and can persist for years if untreated. The degree of disablement they cause however depends on how easy it is for the person to avoid the object or situation.

### **Phobic anxiety disorder, unspecified**

**F40.9**

17. This diagnosis may be used when the criteria for any of the above disorders are not met. The specific criteria in each individual case should be defined.

### **Panic Attacks and Panic Disorder**

**F41.0**

18. The essential feature is recurrent attacks of severe anxiety with sudden onset of various physical symptoms accompanied by the fear of losing control, going mad or dying. The physical symptoms include palpitations or pounding heart, chest pain, difficulty breathing or feelings of suffocation, dizziness, shaking and choking.
19. The individual attack may last a few minutes or a little longer and result in the individual feeling compelled to escape from wherever they may be at the time.
20. For a diagnosis of panic disorder (as opposed to panic attacks occurring as an isolated incident or as part of a phobic disorder) there must have been several severe panic attacks in a month occurring in circumstances where there is no objective danger, not confined to a predictable situation and with comparative freedom of symptoms between attacks.

## Generalised anxiety disorder

F41.1

21. The essential feature is anxiety which is not restricted to any particular environment or stressful event. The anxiety symptoms are often said to be "free-floating" in this situation. There is pervasive worry with ideas such as fear of illness in the sufferer or in members of their family. In addition there are feelings of nervousness and apprehension with physical symptoms such as light-headedness, muscular tension, inability to relax, palpitations, dizziness and sweating.
22. The diagnostic criteria in ICD-10 in brief are:
  - 22.1. That there must be a period of at least 6 months in which there has been prominent tension, worry and apprehension about everyday problems.
  - 22.2. In addition there are at least four of the symptoms of anxiety listed in paragraph 10.1-10.4 above.
  - 22.3. In addition there is muscle tension, restlessness and inability to relax, feeling "on edge" or tense, a sensation of a lump in the throat or difficulty swallowing. There may also be an exaggerated response to being startled, difficulty concentrating, persisting irritability and difficulty getting to sleep because of worrying.
  - 22.4. Similar symptoms can be caused by physical disorders such as hyperthyroidism, the consumption of amphetamines or withdrawal from benzodiazepines. To be diagnosed as generalised anxiety disorder none of these physical disorders must be present.
  - 22.5. The sufferer must have the symptoms on most days, for at least several weeks at a time (and usually for several months).
23. The disorder also appears in DSM-IV. However at least six symptoms must be present (as opposed to four in ICD-10). It has also been noted that the condition is very difficult to diagnose, different diagnosticians varying greatly in their opinions as the symptoms are very common in many other psychiatric disorders.

## Mixed Anxiety and Depressive Disorder

F41.2

24. In those conditions where both anxiety and depression are **equally** present this diagnosis may be made. It is characterised by the presence of physical symptoms of anxiety such as palpitations, tremor, dry mouth etc. with a considerable element of feeling "depressed" or low in mood. Many individuals with this mixture of comparatively mild symptoms may never present to medical or psychiatric services.
25. If any aspect of the syndrome is stronger than the others, the more specific appropriate diagnosis should be used. Furthermore if there is a clear and close association with a stressful life event and the condition has not lasted for more than two years, the diagnosis should be of an **adjustment disorder**, in particular the brief or prolonged depressive reactions.

## **Depersonalisation and derealisation disorder**

**P48.1**

26. This condition results in a sensation in which the person feels unreal, remote or like an automaton. There is a sense of detachment from the body and a sense of "not me" when they see parts of themselves. "Derealisation" refers to the same quality of sensation but it is the surroundings which appear unreal. The phenomenon may transiently occur in normal people when under stress, when fatigued, in states of sensory deprivation or when falling asleep or waking up. As a disorder in its isolated form it is rare and is much more commonly seen in association with depressive illnesses, phobic disorder or the other anxiety disorders.

## **Anxiety disorder unspecified**

**F41.9**

27. This diagnosis may be used when the symptoms of anxiety do not meet the full criteria for any of the above diagnoses. The specific features in each individual case should be defined.

## **AETIOLOGY**

### **Genetics**

28. The anxiety neuroses fall on a continuum with the normal personality and some of the symptoms may be a feature of various personality disorders. Anxiety Disorders are more frequent among relatives of patients with Generalised Anxiety Disorder (approximately 15%) compared with the general population (3%).
29. Upbringing may make a contribution in these cases. However twin studies have tended to suggest not only a genetic neurotic predisposition but also some genetic specificity for anxiety, which seems to have a significantly stronger genetic component than any other neurotic disorder. There is an increased risk for the development of agoraphobia in the first degree relatives of known agoraphobes compared with the general population. This risk is greater in females. The prevalence of anxiety disorders is about 3% among women and 1.5% among men.
30. Early studies of frank anxiety disorders found a family history of nervousness in 45% of World War I soldiers with panic attacks. Studies of World War II soldiers showed a family history of "probable cardiac neurosis" in 25% of sufferers from the syndrome. Later studies confirmed the increase of anxiety disorders in the family history with the type of anxiety disorder breeding true.

### **Psychological factors**

31. It is generally agreed that insecurity in childhood can predispose to most forms of anxiety disorder and children with school phobia are more prone to develop anxiety and depressive disorders in later life.
32. It has been proposed that parental over protection and lack of parental affection during childhood are influential in the aetiology of phobic disorders in later life. Some studies have shown that the majority of patients however come from stable families but have passive, anxious and rather dependent premorbid personalities.

33. Studies have also shown that panic attacks are often triggered through the misattribution of a physical sensation to a catastrophic cause, such as worrying that a momentary pain in the chest wall is a heart attack or that a simple faint on standing is a sign that the person is about to have a stroke or even to die. These ideas are the basis of the mounting anxiety and the subsequent development of panic. The breathing pattern may then become rapid leading to further symptoms which in turn serve to compound the sufferer's fears. Another important factor in the onset of a panic attack is the increased expectation that an attack will occur. A sense of being unable to control either the symptom or its consequences also augments the panic.
34. In certain phobias, classical learning theory proposes that the feared object or situation (which is inherently innocuous) is often initially experienced at the same time as an unpleasant sensation, for example pain or fear. When the object is then re-encountered the previous feelings are automatically recalled and the anxiety is inextricably associated with it.
35. It is, however, clear that many phobias are not associated with obvious psychological trauma or easily remembered noxious stimuli and they appear to originate spontaneously at times of mood change or emotional turmoil. Learning theory does not provide an adequate explanation of the onset in these cases.
36. In psychoanalytical terms Freud initially conceptualised anxiety as being the result of an unpleasant or upsetting event "traumatic anxiety" which he felt was a normal reaction. However he later concluded that as many cases appeared to have no precipitating cause he postulated that it was in many cases the result of repressed inner drives "the neurotic anxiety".
37. Panic disorder is considered to be a psychobiological disorder due to a strong biological vulnerability and the effects of early experience. Prevailing cognitive behavioural models describe a fundamental conditioned misperception of internally perceived bodily cues.

### **Life events**

38. Research in this area has focused on panic disorder and agoraphobia, studies suggesting that an increase in life events is found in the three month period prior to onset of symptoms. However it appears to be the amount of adversity which the events cause, and the impact they have on a person's life, rather than their mere presence or the number of events experienced. This in turn is a reflection of the personality and the individual's coping mechanisms. Studies have also shown that in those with long standing agoraphobia and panic disorder, reported stress in the year preceding the onset of the disorder is associated with personality dysfunction. Other findings have been that what is viewed by one person as an overwhelmingly "positive" event (such as a holiday or a move to a better house) may be viewed by others as a "negative" event.
39. The onset of symptoms often seems to coincide with life changes which require the assumption of adult responsibilities such as leaving home, getting married, the birth of a child or loss of a close maternal relationship. It also appears likely that the most frequent stressful life event associated with a first panic attack is separation from a person who holds significance for the patient.

## CONCLUSION

40. The **anxiety disorders** fall on a continuum with normality and most people experience periods of anxiety at some stage in their lives. Pathological anxiety may be classified into different clinical subtypes but the various subtypes share a substantial psychological aetiology.
41. The disorders may manifest in response to stressful life events that have occurred within three months of the appearance of symptoms or they may arise without any clear external cause. Genetic predisposition and factors relating to personality structure and early life experiences are considered to be of prime importance in the aetiology of these disorders.

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