

## CHAPTER 15. ANXIETY DISORDERS

### 15.6 ANXIETY DISORDERS: CLINICAL FEATURES

DANIEL S. PINE, M.D.

[Panic Disorder and Agoraphobia](#)

[Specific and Social Phobias](#)

[Obsessive-Compulsive Disorder](#)

[Posttraumatic Stress and Acute Stress Disorders](#)

[Generalized Anxiety Disorder](#)

[Substance-Induced Anxiety and Anxiety Due to a General Medical Condition](#)

[Anxiety Disorder not otherwise Specified](#)

The last 30 years have seen a dramatic increase in clinical research on a group of mental conditions labeled “anxiety disorders” in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) nomenclature. While the term “anxiety” has been applied to diverse phenomena in the psychoanalytic, learning-based, and neurobiological literature, the term “anxiety” in the clinical psychopathological literature refers to the presence of fear or apprehension that is out of proportion to the context of the life situation. Hence, extreme fear or apprehension can be considered “clinical anxiety” if it is developmentally inappropriate (e.g., fear of separation in a 10-year-old child) or if it is inappropriate to an individual's life circumstances (e.g., worries about unemployment in a successful business executive). The last 30 years of clinical research has led to progressive refinement of the nosology for clinical anxiety disorders. While these disorders were broadly conceptualized in the early twentieth century, narrower definitions have arisen, partially stimulated by Donald Klein's observations on pharmacological distinctions between panic and nonpanic anxiety.

Consensus has emerged on the view of anxiety disorders as a family of related but distinct mental disorders. This consensus is reflected in the relatively minor changes to the broad categorization of anxiety disorders over the last 15 years, between the third edition of DSM (DSM-III) and the fourth edition (DSM-IV). Both DSM-IV and the 10th revision of *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) recognize similar groups of syndromes as discrete diagnostic entities. There is some disagreement, however, on whether all of these syndromes are most properly considered anxiety disorders. While DSM-IV considers a group of nine disorders to be the primary anxiety disorders, ICD-10 adopts a broader category of neurotic, stress-related, and somatoform disorders that includes each of the conditions in DSM-IV, as well as a number of disorders not

considered anxiety disorders in DSM-IV. Prior to DSM-III, which brought a relatively major revision to the nosology of mental disorders in the United States, anxiety disorders were classified in a group of conditions that included many of the disorders currently listed in DSM-IV along with a set of disorders that have been reclassified. These reclassified disorders included affective disorders (formerly classified as “depressive neurosis”), somatoform and dissociative disorders (formerly classified as “hysterical neurosis”), and neurasthenia, a disorder that was eliminated with the writing of DSM-III.

DSM-III, with its emphasis on empiricism and the validity of nosological categories, reclassified anxiety disorders into categories that were quite similar to the disorders included in the current anxiety section of DSM-IV, which include panic disorder with and without agoraphobia, agoraphobia with and without panic disorder, specific phobia, social phobia, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), acute stress disorder, and generalized anxiety disorder. This chapter reviews the clinical features of these nine conditions, as conceptualized in DSM-IV. This includes the primary symptomatology, history, epidemiology, differential diagnosis, and course of each disorder, along with a clinical vignette designed to capture the essential features of each disorder as it typically presents in the clinic.

## PANIC DISORDER AND AGORAPHOBIA

The panic attack is the key feature of panic disorder, which is characterized by a pattern of recurrent panic attacks. The *panic attack* is defined as an episode of abrupt intense fear that is accompanied by at least four autonomic or cognitive symptoms listed in [Table 15.6-1](#). Such episodes of abrupt fear occur in many situations. For example, a healthy person might experience a panic attack when confronted with sudden extreme danger, and an individual with a phobia of heights might experience a panic attack when confronted with the feared situation.

**Note:** A panic attack is not a codable disorder. Code the specific diagnosis in which the panic attack occurs (e.g., panic disorder with agoraphobia).

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy
- (11) fear of dying
- (12) paresthesias (numbness or tingling sensations)
- (13) chills or hot flashes

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

**Table 15.6-1** DSM-IV Criteria for Panic Attack

DSM-IV recognizes three types of panic attacks. The unexpected or spontaneous panic attack occurs without cue or warning; the situationally bound panic attack occurs upon exposure to, or in anticipation of, exposure to a feared stimulus; and the situationally predisposed panic attack is more likely to occur, but does not necessarily have to occur, on exposure to a situational trigger. In panic disorder, panic attacks occur spontaneously, arising without any trigger or environmental cue. As shown in [Table 15.6-](#)

2, panic disorder requires at least two spontaneous panic attacks, at least one of which is associated with either concern with additional attacks, worry about attacks, or changes in behavior.

**Table 15.6-2 DSM-IV Criteria for Agoraphobia**

---

**Note:** Agoraphobia is not a circumscribed disorder. Code the specific disorder in which the agoraphobia occurs (e.g., panic disorder with agoraphobia or agoraphobia without history of panic disorder).

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally precipitated panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

**Note:** Consider the diagnosis of specific phobia if the avoidance is limited to one or only a few specific situations, or social phobia if the avoidance is limited to social situations.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as social phobia (e.g., avoidance limited to social situations because of fear of embarrassment), specific phobia (e.g., avoidance limited to a single situation like elevators), obsessive-compulsive disorder (e.g., avoidance of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), or separation anxiety disorder (e.g., avoidance of leaving home or relatives).

---

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Patients with panic disorder present with a number of comorbid conditions, but there has been considerable interest in the relationship between panic disorder and agoraphobia, which refers to fear or anxiety of places from where escape might be difficult (Table 15.6-2). There has in fact been some debate about whether agoraphobia is best conceptualized as a complication of panic disorder or as a separate condition. This controversy centers on the frequency with which patients develop agoraphobia in the absence of panic disorder or panic attacks (Table 15.6-3) DSM-IV suggests that such patients do exist, noting the existence of panic disorder with agoraphobia (Table 15.6-4) and without agoraphobia (Table 15.6-5). However, even in agoraphobia without history of panic disorder, agoraphobia is considered related to the fear of developing paniclike symptoms.

**Table 15.6-3 DSM-IV Diagnostic Criteria for Agoraphobia Without History of Panic Disorder**

- 
- A. The presence of agoraphobia related to fear of developing panic-like symptoms (e.g., dizziness or diarrhea).
  - B. Criteria have never been met for panic disorder.
  - C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
  - D. If an associated general medical condition is present, the fear described in criterion A is clearly in excess of that usually associated with the condition.
- 

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

**Table 15.6-4 DSM-IV Diagnostic Criteria for Panic Disorder With Agoraphobia**

- 
- A. Both (1) and (2):
- (1) recurrent unexpected panic attacks
  - (2) at least one of the attacks has been followed by 1 month (or more) of the following:
    - (a) persistent concern about having additional attacks
    - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
    - (c) a significant change in behavior related to the attacks
- B. The presence of agoraphobia.
- C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).
- 

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

**Table 15.6-5** DSM-IV Diagnostic Criteria for Panic Disorder Without Agoraphobia

- 
- A. Both (1) and (2):
- (1) recurrent unexpected panic attacks
  - (2) at least one of the attacks has been followed by at least 1 month (or more) of the following:
    - (a) persistent concern about having additional attacks
    - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
    - (c) a significant change in behavior related to the attacks
- B. Absence of agoraphobia.
- C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).
- 

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington DC, 1994.

As with most anxiety disorders, panic disorder often co-occurs with a number of mental conditions beyond agoraphobia, particularly anxiety and depressive disorders. These include specific and social phobia, generalized anxiety disorder, and major depressive disorder. Some data also suggest associations with substance use disorders, bipolar disorder, and suicidal behavior. While the high comorbidity seen in the clinic partially reflects referral bias, considerable comorbidity with these anxiety and depressive disorders is also found in epidemiological studies, which suggests that panic disorder in the community is frequently compounded by comorbid mental conditions.

**History and Comparative Nosology** While the term “panic disorder” was first coined in DSM-III, a syndrome characterized by recurrent episodes of spontaneous fear has been recognized for more than 100 years. This syndrome has been given various labels throughout history, including DaCosta's syndrome in the late nineteenth century, and effort syndrome or neurocirculatory asthenia in the earlier part of the twentieth century. Even Freud's descriptions of “anxiety neurosis” invoked many of the key features of panic disorder.

A major change to the DSM conceptualization of anxiety occurred in 1980, with DSM-III, where panic disorder was first recognized as a distinct entity. Between 1980 and 1994 one significant change to the conceptualization of the disorder involved refining the view of panic disorder and agoraphobia as tightly linked constructs. As conceptualized in DSM-IV, agoraphobia invariably involves at least some form of spontaneous crescendo anxiety, even if such episodes do not meet formal criteria for panic attacks ([Table 15.6-3](#) and [Table 15.6-4](#)). In the earlier versions of the DSM and in ICD-10, agoraphobia is considered less closely linked to panic disorder. Indeed, ICD-10 classifies agoraphobia as one of many

phobic disorders and does not emphasize the relationship with panic disorder to the same degree as DSM-IV. [Table 15.6-6](#) presents the ICD-10 diagnostic criteria for phobic anxiety disorders, including agoraphobia. [Table 15.6-7](#) presents the ICD-10 criteria for other anxiety disorders, including panic disorder.

**Table 15.6-6** ICD-10 Diagnostic Criteria for Phobic Anxiety Disorders

**Table 15.6-7** ICD-10 Diagnostic Criteria for Other Anxiety Disorders

**Differential Diagnosis** Panic disorder with or without agoraphobia must be differentiated from a number of medical conditions that produce similar symptomatology. Panic attacks are associated with a variety of endocrinological disorders, including both hypo- and hyperthyroid states, hyperparathyroidism, and pheochromocytomas. Episodic hypoglycemia associated with insulinomas can also produce paniclike states, as can primary neuropathological processes. These include seizure disorders, vestibular dysfunction, neoplasms, or the effects of both prescribed and illicit substances on the central nervous system. Finally, disorders of the cardiac and pulmonary systems, including arrhythmias, chronic obstructive pulmonary disease, and asthma, can produce autonomic symptoms and accompanying crescendo anxiety that can be difficult to distinguish from panic disorder. Clues of an underlying medical cause for paniclike symptoms include atypical features during panic attacks, such as ataxia, alterations in consciousness, or bladder dyscontrol; onset of panic disorder relatively late in life; or physical signs or symptoms indicating a medical disorder.

Panic disorder also must be differentiated from a number of psychiatric disorders, particularly other anxiety disorders. Since panic attacks occur in many anxiety disorders, including social and specific phobia, posttraumatic stress disorders, or even obsessive-compulsive disorder, the key to correctly

diagnosing panic disorder involves documenting recurrent spontaneous panic attacks at some point in the illness. Differentiation with generalized anxiety disorder can also be difficult. Classically, panic attacks are characterized by their rapid onset, within minutes, and short duration, usually less than 10 to 15 minutes, in contrast to the anxiety associated with generalized anxiety disorder, which emerges and dissipates more slowly. This distinction can be difficult, however, as the anxiety surrounding panic attacks can be more diffuse and dissipate more slowly. Since anxiety is a frequent concomitant of many other psychiatric disorders, including the psychoses and affective disorders, distinctions between panic disorder and a multitude of disorders can also be difficult.

**Course** Panic disorder typically has its onset in late adolescence or early adulthood, although cases of childhood-onset and late adulthood–onset disorder have been described. Only tentative data exist on the natural course of panic disorder. The best evidence on the course of any disorder, including panic disorder, derives from prospective epidemiological research, since both retrospective and clinically based studies are vulnerable to biases that preclude firm conclusions on course. Unfortunately, few such studies exist. Retrospective or clinical studies suggest that panic disorder tends to exhibit a fluctuating course, with varying levels of persistence over the life span. Approximately one third to one half of patients are psychiatrically healthy at follow-up, with most living relatively normal lives, despite either fluctuating or recurrent symptoms. Typically, patients with chronic disorders exhibit a pattern of exacerbation and remissions rather than chronic disability.

Ms. S. was a 25-year-old student who was referred for a psychiatric evaluation from the medical emergency room at a larger university-based medical center. Ms. S. had been evaluated three times over the preceding 3 weeks in this emergency room. Her first visit was prompted by a paroxysm of extreme dyspnea and terror that occurred while she was working on a term paper. The dyspnea was accompanied by palpitations, choking sensations, sweating, shakiness, and a strong urge to flee. Ms. S. thought that she was having a heart attack, and she immediately went to the emergency room. She received a full medical evaluation, including an electrocardiogram (ECG) and routine blood work, which revealed no sign of cardiovascular, pulmonary, or other illness. Although Ms. S. was given the number of a local psychiatrist, she did not make a follow-up appointment, since she did not think that her episode would recur. She developed two other similar episodes, one while she was on her way to visit a friend and a second that woke her up from sleep. She immediately went to the emergency room after experiencing both paroxysms, receiving full medical workups that showed no sign of illness.

## **SPECIFIC AND SOCIAL PHOBIAS**

The term “phobia” refers to an excessive fear of a specific object, circumstance, or situation. Phobias are classified on the basis of the feared object or situation, and DSM-IV recognizes three distinct classes of phobia: agoraphobia (discussed above as it is considered closely related to panic disorder), specific phobia, and social phobia. Criteria for specific and social phobia are shown in [Table 15.6-8](#) and [Table 15.6-9](#). Both specific and social phobia require the development of intense anxiety, to the point of even situationally bound panic, upon exposure to the feared object or situation. Both conditions also require

that fear either interferes with functioning or causes marked distress. Finally, both conditions require that an individual recognizes the fear as excessive or irrational and that the feared object or situation is either avoided or endured with great difficulty.

**Table 15.6-8 DSM-IV Diagnostic Criteria for Specific Phobia**

- A. A recurrent and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, blood).
  - B. Exposure to the phobic situation almost invariably provokes an immediate anxiety response, which may take the form of a panic attack if the phobic situation is unambiguously perceptually present (e.g., being in a lift when the elevator stops for unexpected fire, earthquake, flooding, or a trapping).
  - C. The person recognizes that the fear is excessive or unreasonable. *Noted in children, this feature may be absent.*
  - D. The phobic situation is avoided, or else endured with intense anxiety or distress.
  - E. The avoidance, anxious anticipation, or distress in the feared situation seriously interferes with the person's normal activities, occupational (or academic) functioning, or social activities or relationships with others, or there is marked distress about having the phobia.
  - F. In individuals under age 18 years, the situation is limited to animals.
  - G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder (e.g., agoraphobia, panic disorder, or social phobia) or by a medical condition (e.g., hyperthyroidism, phobic disorder, or agoraphobia without history of panic disorder).
- Specify type:*  
*Animal type:* (e.g., heights, animals, and water)  
*Natural environment type:* (e.g., storms, and waves)  
*Situational type:* (e.g., elevators, airplanes, and blood phobias)  
*Other type:* (e.g., claustrophobia, tunnels, and lifts)  
*Specify:* (e.g., flying, receiving an injection, or blood phobia, claustrophobia, or agoraphobia without history of panic disorder)
- Reprinted with permission from American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*, Washington, DC, 1994.

**Table 15.6-9 DSM-IV Diagnostic Criteria for Social Phobia**

- A. A recurrent and persistent fear of one or more social or performance situations in which the person is exposed to another person (or persons) to whom the person is subject to scrutiny. The individual fears that he or she will act in a way that shows anxiety symptoms that will be humiliating or embarrassing. *Noted in children, this feature may be absent or cued by the age-appropriate social interactions with family members and the anxiety may occur in some settings, not just in interpersonal social settings.*
  - B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a panic attack if the situation is unambiguously perceptually present (e.g., being in a lift when the elevator stops for unexpected fire, earthquake, flooding, or a trapping).
  - C. The person recognizes that the fear is excessive or unreasonable. *Noted in children, this feature may be absent.*
  - D. The feared social or performance situations are avoided, or else endured with intense anxiety or distress.
  - E. The avoidance, anxious anticipation, or distress in the feared social or performance situations seriously interferes with the person's normal activities, occupational (or academic) functioning, or social activities or relationships with others, or there is marked distress about having the phobia.
  - F. In individuals under age 18 years, the situation is limited to situations of a social nature (e.g., a class of activities, a number of situations of a general social nature (e.g., public speaking, receiving an injection, or social activities or relationships with others), family relationships (e.g., phobic disorder, agoraphobia, or agoraphobia without history of panic disorder), or a general anxiety disorder).
  - G. In a general anxiety disorder, the phobic situation is persistent, the fear is excessive or unreasonable (e.g., the fear to meet and interacting, interacting in the person's situation, or performing a social task meeting behavior in a social setting or public setting).
- Specify if:*  
*Generalized if the fear includes most social situations (also note whether the additional diagnosis of agoraphobia is necessary).*
- Reprinted with permission from American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*, Washington, DC, 1994.

Specific phobia is divided into four subtypes (animal type, natural environment type, blood-injection-injury type, situational type, and other type), with a residual category for phobias that do not clearly fall into any of these four categories. The key feature in each type of phobia is that the fear is circumscribed to a specific object, both temporally and with respect to other objects. Hence, an individual with specific phobia becomes immediately frightened when presented with a feared object. This fear may relate to concern about harm from a feared object, concern about embarrassment, or fear of consequences related to exposure to the feared object. For example, individuals with blood-injury phobia may be afraid of fainting on exposure to blood, and individuals with fear of heights may be afraid of becoming dizzy.

Specific phobia often involves fears of more than one object, particularly within a specific subcategory of phobia. For example, it is common for an individual with a phobia of thunderstorms to also have a phobia of water, both phobias being classified as natural environment type phobias. Further, in the clinical setting, specific phobia often occurs with other anxiety or mood disorders. Since it is rare for patients to seek treatment for an isolated phobia, some of the comorbidity seen in the clinic reflects referral bias. Community-based studies also suggest that specific phobia is associated with other anxiety disorders, although at lower rates than seen in the clinic. Quantifying the impairment associated with a specific phobia is sometimes difficult, since the comorbid disorders typically tend to cause more

impairment than specific phobia and since individuals with isolated specific phobia are rarely seen in the clinic. Impairment associated with specific phobia typically restricts the social or professional activities of the individual.

Social phobia involves fear of social situations, including situations that involve scrutiny or contact with strangers. Individuals with social phobia typically fear embarrassing themselves in social situations (e.g., social gatherings, oral presentations, or meeting new people). This can involve specific fears about performing certain activities, such as writing, eating, or speaking in front of others. It can also involve a vague, nonspecific fear of embarrassing oneself. DSM-IV provides a specifier for the diagnosis of social phobia. Individuals with social phobia who fear most situations are considered to suffer from generalized social phobia. Such individuals are fearful of initiating conversations in many situations, about dating or participating in most group activities or social gatherings, and about speaking with authority figures.

The clinician should recognize that many patients exhibit at least some social anxiety or self-consciousness. In fact, community studies suggest that roughly a third of all people consider themselves to be far more anxious than other people in social situations. Such anxiety only becomes social phobia when the anxiety either prevents an individual from participating in desired activities or causes marked distress in such activities. Individuals with the more specific form of social phobia possess fear of specific, circumscribed social situations. For example, extreme anxiety about public speaking that interferes with an individual's job performance is a common type of specific social phobia; it would not be considered generalized social phobia unless it was associated with fears related to many other social situations besides public speaking.

As with other anxiety disorders, social phobia frequently co-occurs with other mood and anxiety disorders. The association of social phobia with both panic disorder and major depression has received considerable attention in recent literature. Associations with substance use disorders and childhood conduct problems have also been documented.

**History and Comparative Nosology** Phobias have been recognized as incapacitating mental disorders for more than 100 years. The prominent place of phobia in the history of modern mental health science is indicated by the major role case histories of phobic patients played in the development of both psychoanalytic and cognitive therapies. The category of phobia has undergone progressive refinement over the past 20 years, as research has focused on each of the specific classes of phobia described above. Much of this refinement crystallized in DSM-III, which was based on emerging evidence that phobias represent a group of related but distinct conditions, rather than one heterogeneous disorder. Such evidence included Isaac Mark's work on differentiating social and specific phobias. The refinement in DSM-III categorized agoraphobia as a condition closely related to panic disorder and distinguished social and simple phobia, which was relabeled specific phobia in DSM-IV.

The view of phobias has changed since the writing of DSM-III. While discussion of agoraphobia has emphasized the role of panic since DSM-III, DSM-IV also contains descriptions of paniclike phenomena



in both the specific and social phobia sections, as well as in the discussion of agoraphobia. Beyond this change, the most significant other change for specific phobia between DSM-III and DSM-IV involved inclusion of the above subcategories of phobia, based on research noting distinct physiology and demographics of the subtypes. For social phobia, the most significant other change occurred with the revised third edition (DSM-III-R), which distinguished between generalized and more specific forms of social phobia. This change was based on descriptive phenomenology, epidemiology, and pharmacology studies that validated the two variants of the condition.

The approach to categorization of phobias in the ICD system is quite similar to that in DSM-IV. ICD-10 recognizes specific phobia as a distinct category, including the subtypes in DSM-IV. Social phobia is also classified in ICD-10, although without the qualifier in DSM-IV. Perhaps the major difference between DSM-IV and ICD-10 in the consideration of phobia relates to agoraphobia. While DSM-IV emphasizes the relation between panic disorder and agoraphobia, in ICD-10 the term “panic disorder” is restricted to cases without phobia, and the term “agoraphobia” is applied to all cases that meet criteria, regardless of the presence or absence of panic attacks ([Table 15.6-6](#) and [Table 15.6-7](#)).

**Differential Diagnosis** Specific phobia is usually quite easily distinguished from anxiety stemming from primary medical problems by the focused nature of the anxiety, which is not typical of anxiety disorders related to medical problems. The most difficult diagnostic issues involve differentiating specific phobia from other anxiety disorder. As DSM-IV emphasizes the presence of paniclike symptoms with specific phobia, including situationally bound panic attacks, specific phobia must be differentiated from panic disorder, in which panic attacks occur without a cue. Specific phobia can occasionally be confused with PTSD, as both conditions can involve focused fears of specific objects or situations. The two disorders are most easily differentiated by the marked other features of PTSD, such as reexperiencing the trauma, avoidance, and enhanced startle, which are absent in specific phobia. Similarly, specific phobia can occasionally be confused with generalized anxiety disorder, as both conditions may involve worry about exposure to specific situations. The two disorders are differentiated on the basis of the focused nature of the fear, both over time and with respect to objects, in specific phobia.

Like specific phobia, social phobia is rarely confused with anxiety that is the primary result of medical disorders. However, the number of psychiatric disorders that are associated with social withdrawal make it difficult to diagnose social phobia correctly. Perhaps the most difficult distinction involves differentiating social phobia and agoraphobia, since both conditions involve fears of situations where people typically gather. The key distinction between the disorders centers on the nature of the feared object. Patients with social phobia are specifically afraid of encountering people; individuals with agoraphobia are afraid of situations from which escape would be difficult but do not specifically fear people. Hence, an individual with agoraphobia might be reassured in the presence of other people, provided the physical properties of the location are suitable, while an individual with social phobia flees other people. The clinician might also encounter difficulty in distinguishing social phobia from the social isolation that accompanies a number of psychiatric disorders, including major depression and the early stages of psychosis. Two factors are essential in making this distinction. First, the individual with social phobia must experience anxiety or fear in social situations; individuals who are isolated due to

depression or indolent psychosis often isolate themselves for other reasons. Second, with social phobia, symptomatology is restricted to the fears of social situations; with other disorders social isolation is accompanied by a broad array of symptoms that are not found in social phobia.

**Course** Specific phobia exhibits a bimodal age of onset, with a childhood peak for animal phobia, natural environment phobia, and blood-injury phobia and an early adulthood peak for other phobias, such as situational phobia. As with other anxiety disorders, limited prospective epidemiological data exist on the natural course of specific phobia. Because patients with isolated specific phobias rarely present for treatment, research on the course of the disorder in the clinic is limited. The information that is available suggests that most specific phobias that begin in childhood and persist into adulthood continue to persist for many years. The severity of the condition is thought to remain relatively constant, without the waxing and waning course seen with other anxiety disorders.

Mr. A. was a successful businessman who presented for treatment following a change in his business schedule. While he had formerly worked largely from an office near his home, a promotion led to a schedule of frequent out-of-town meetings, requiring weekly flights. Mr. A. reported being “deathly afraid” of flying. Even the thought of getting on an airplane led to thoughts of impending doom as he envisioned his airplane crashing to the ground. These thoughts were associated with intense fear, palpitations, sweating, clammy feelings, and stomach upset. While the thought of flying was terrifying enough, Mr. A. became nearly incapacitated when he went to the airport. Immediately before boarding, Mr. A. often had to turn back from the plane and run to the bathroom to vomit.

Social phobia tends to have its onset in late childhood or early adolescence. Social phobia tends to be a chronic disorder, although as with the other anxiety disorders, prospective epidemiological data are limited. Both retrospective epidemiological studies and prospective clinical studies suggest that the disorder can profoundly disrupt the life of an individual over many years. This can include disruption in school or academic achievement, interference with job performance, and social development.

Ms. M. was a successful secretary working in a law firm. While she reported a long history of feeling uncomfortable in social situations, Ms. M. came for treatment when she began to feel that her uneasiness was interfering with her social life and job performance. Ms. M. reported that she noticed herself feeling increasingly nervous whenever she met a new person. For example, upon meeting a new member of the law firm, she described feeling suddenly tense and sweaty, noticing that her heart was beating very fast. She had the sudden thought that she would say something foolish in these situations or commit a terrible social gaffe that would make people laugh at her. At social gatherings she described similar feelings that led her to either leave the gathering early or decline invitations to attend.

## **OBSESSIVE-COMPULSIVE DISORDER**

Obsessions and compulsions are the essential features of OCD. As shown in [Table 15.6-10](#), an individual must exhibit either obsessions or compulsions to meet DSM-IV criteria. DSM-IV recognizes *obsessions* as “persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate,” causing distress. Obsessions are anxiety provoking, accounting for the categorization of OCD as an anxiety disorder; they must be differentiated from excessive worries about real life problems; and they must be associated with either efforts to ignore or suppress the obsessions. Typical obsessions associated with OCD include thoughts about contamination (“my hands are dirty”) or doubts (“I forgot to turn off the stove”).

**Table 15.6-10** DSM-IV Diagnostic Criteria for Obsessive-Compulsive Disorder

*Compulsions* are defined as repetitive acts, behaviors, or thoughts that are designed to counteract the anxiety associated with an obsession. A compulsion reduces the anxiety associated with the obsession. While many compulsions are acts associated with specific obsessions, such as hand-washing or checking, other compulsions can be thoughts. For example, patients may have the obsession that they have committed a sin and might relieve the resultant anxiety by repetitively saying a silent prayer to themselves.

Obsessions and compulsions must cause marked distress, consume at least 1 hour a day, or interfere with functioning to be considered above the diagnostic threshold. At least during some point in the illness, symptoms of OCD must be recognized as unreasonable for adults, though this varies greatly both across individuals and in a given individual over time. For example, early in the course of the disorder patients may recognize their hand washing is excessive or irrational but, over a number of years, lose this recognition. DSM-IV recognizes a poor insight subtype of OCD when an individual fails to recognize the irrational or unreasonable nature of the obsessions. This subtype of OCD has been labeled the psychotic subtype in some of the clinical literature, prompting trials of antipsychotic pharmacotherapy. The criterion related to insight does not apply to children, who may either not possess the insight to recognize the unreasonableness of their condition or may be too embarrassed to discuss the condition as unreasonable.

OCD frequently co-occurs with other disorders. The association with major depression is particularly prominent, although comorbidity with panic disorder, phobias, and eating disorders is also not uncommon. Finally, OCD exhibits a particularly interesting association with Tourette's disorder. Approximately half of all patients with Tourette's disorder meet criteria for OCD, although less than 10

percent of patients with OCD meet criteria for Tourette's disorder. There is also evidence of cotransmission of Tourette's disorder, OCD, and chronic motor tics within families.

**History and Comparative Nosology** Descriptions of patients with a syndrome of recurrent obsessions and compulsions are found in the nineteenth century, when these conditions were viewed as a form of “depressive state.” Descriptions of OCD also played a prominent role in Freud's writings, as captured in the case history of the Rat Man, and in early learning-based theories that attempted to apply treatments developed among patients with phobias to patients with OCD. Research on OCD changed with the ECA study in the early 1980s. Prior to this study, OCD was recognized as a discrete but rare entity, stimulating a modest degree of research. The Epidemiologic Catchment Area (ECA) Study noted that OCD had a prevalence in excess of 1 percent in the population and was associated with marked impairment. This stimulated extensive research on all aspects of OCD, including its phenomenology.

The major change in OCD from DSM-III to DSM-IV involved the conceptualization of compulsions. While DSM-III-R viewed compulsions as behaviors, DSM-IV recognized compulsions as either behaviors or mental acts designed to reduce the anxiety-provoking nature of the obsession. The conceptualization of OCD in the ICD and DSM systems is generally similar with a few exceptions in the emphasis on specific features of the condition. For example, ICD-10 emphasizes that a compulsive act must not be pleasurable. ICD-10 also stipulates that obsessions or compulsions must be present most days for 2 weeks, a requirement not included in DSM-IV, and ICD-10 does not stipulate the amount of time a patient must spend on compulsions. Perhaps the major difference between the DSM-IV and ICD-10 view of the disorder relates to the categorization of the disorder with respect to other anxiety disorders. DSM-IV recognizes OCD as one of the nine anxiety disorders discussed in the current chapter. There has been some debate in the United States and Europe about whether OCD is more properly classified in a distinct category. ICD-10 has adopted such a scheme, using OCD to designate a group of syndromes considered distinct from anxiety disorders ([Table 15.6-11](#)).

**Table 15.6-11** ICD-10 Diagnostic Criteria for Obsessive-Compulsive Disorder

<p>A. Either obsessions or compulsions (or both) are present on most days for a period of at least 2 weeks.</p> <p>B. Obsessions (thoughts, ideas, or images) and compulsions (acts) share the following features, all of which must be present:</p> <ol style="list-style-type: none"> <li>(1) They are acknowledged as originating in the mind of the patient and are not imposed by outside persons or influences.</li> <li>(2) They are repetitive and unpleasant, and at least one obsession or compulsion that is acknowledged as excessive or unreasonable must be present.</li> <li>(3) The patient tries to resist them (but resistance to very long-standing obsessions or compulsions may be minimal). At least one obsession or compulsion that is unsuccessfully resisted must be present.</li> <li>(4) Experiencing the obsessive thought or carrying out the compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety.)</li> </ol> <p>C. The obsessions or compulsions cause distress or interfere with the patient's social or individual functioning, usually by wasting time.</p> <p>D. <i>After commonly used exclusion clause.</i> The obsessions or compulsions are not the result of other mental disorders, such as schizophrenia and related disorders or mood (affective) disorders.</p> <p>The diagnosis may be further specified by the following four-character codes:</p> <p>Predominantly obsessional thoughts and ruminations          Predominantly compulsive acts (obsessional rituals)          Mixed obsessional thoughts and acts          Other obsessive-compulsive disorders          Obsessive-compulsive disorder, unspecified</p> <p><small>Reprinted with permission from World Health Organization: The ICD-10 Classification of Mental and Behavioral Disorders. Diagnostic Criteria for Research. © World Health Organization, Geneva, 1993.</small></p>
---

**Differential Diagnosis** A number of primary medical disorders can produce syndromes bearing a striking resemblance to OCD. In fact, the current conceptualization of OCD as a disorder of the basal ganglia derives from the phenomenological similarity between idiopathic OCD and OCD-like disorders that are associated with basal ganglia diseases, such as Sydenham's chorea and Huntington's disease. Hence, neurological signs of such basal ganglia pathology must be assessed when considering the

diagnosis of OCD in a patient presenting for psychiatric treatment. OCD frequently develops before age 30, and new-onset OCD in an older individual should raise questions about potential neurological contributions to the disorder. Finally, some evidence suggests an association between an immune reaction to streptococcal infections and either initial manifestations or dramatic exacerbation of OCD in children. This syndrome appears to emerge relatively acutely, in contrast to the more indolent onset of other cases of childhood OCD. Hence, in children with such presentations, the role of such an infectious process should be considered.

Obsessive-compulsive behavior is also found in a host of other psychiatric disorders, and the clinician must also rule out these conditions when diagnosing OCD. OCD exhibits a superficial resemblance to obsessive-compulsive personality disorder, which is associated with an obsessive concern for details, perfectionism, and similar personality traits. The conditions are easily distinguished by the fact that only OCD is associated with a true syndrome of obsessions and compulsions, as described above.

Psychotic symptoms often lead to obsessive thoughts and compulsive behavior that can be difficult to distinguish from OCD with poor insight, in which obsessions border on psychosis. The key to distinguishing OCD from psychosis involves the fact that patients with OCD can almost always acknowledge the unreasonable nature of their symptoms and the fact that psychotic illnesses are typically associated with a host of other features that are not characteristic of OCD. Similarly, OCD can be difficult to differentiate from depression since it is often associated with comorbid major depression and since major depression is often associated with obsessive thoughts that can at times border on true obsessions, as conceived in OCD. The two conditions are best differentiated by their course. Obsessive symptoms associated with depression are only found in a depressive episode; true OCD persists despite remission of depression.

Finally, OCD is closely related to Tourette's disorder; the two conditions frequently co-occur, both in an individual over time and within families. In its classic form, Tourette's disorder is associated with a pattern of recurrent vocal and motor tics that bears only a slight resemblance to OCD. However, the premonitory urges that precede tics often bear a striking resemblance to obsessions, and many of the more complicated motor tics can bear a close resemblance to compulsions.

**Course** OCD typically begins in late adolescence, though onset in childhood is not uncommon. The disorder tends to exhibit a waxing and waning course over the life span, with periods of relative good functioning and limited symptoms punctuated by periods of symptomatic exacerbation. A small minority of subjects exhibit either complete remission of their disorder or a progressive, deteriorating course.

Ms. B. presented for psychiatric admission after being transferred from a medical floor where she had been treated for malnutrition. Ms. B. had been found unconscious in her apartment by a neighbor. When brought to the emergency room by ambulance, she was found to be hypotensive and hypokalemic. At psychiatric admission, Ms. B. described a long history of recurrent obsessions about cleanliness, particularly related to food items. She reported that it was difficult for her to eat any food unless it had been washed by her three to four times, since she often thought that a food item was dirty. She reported that washing her food decreased the anxiety she felt about the dirtiness of food. While Ms. B. reported that she occasionally tried to eat food that she did not wash (e.g., in a restaurant), she became so worried about contracting an illness from eating such food that she could no longer dine in restaurants. Ms. B. reported that her obsessions about the cleanliness of food had become so extreme over the past 3 months that she could eat very few foods, even if she washed them excessively. She recognized the irrational nature of these obsessive concerns, but either could not bring herself to eat or became extremely nervous and nauseous after eating.

## POSTTRAUMATIC STRESS AND ACUTE STRESS DISORDERS

**Symptomatology** Both PTSD and acute stress disorder are characterized by the onset of psychiatric symptoms immediately following exposure to a traumatic event. As noted in [Table 15.6-12](#), DSM-IV specifies that the traumatic event involves either witnessing or experiencing threatened death or injury or witnessing or experiencing threat to physical integrity. Further, the response to the traumatic event must involve intense fear or horror. Such traumatic experiences might include being involved in or witnessing a violent accident or crime, military combat, assault, being kidnapped, being involved in natural disasters, being diagnosed with a life-threatening illness, or experiencing systematic physical or sexual abuse. Both PTSD and acute stress disorder also require characteristic symptoms following such trauma. There is evidence of a relation between the degree of trauma and the likelihood of symptoms. The proximity to, and intensity of, the trauma relate to the probability of developing symptomatology.

**Table 15.6-12** DSM-IV Diagnostic Criteria for Posttraumatic Stress Disorder

In PTSD, the individual develops symptoms in three domains: reexperiencing the trauma, avoiding stimuli associated with the trauma, and experiencing symptoms of increased autonomic arousal, such as an enhanced startle. Flashbacks represent the classic form of reexperiencing: the individual may act and

feel as if the trauma were recurring. Other forms of reexperiencing include distressing recollections or dreams and either physiological or psychological stress reactions upon exposure to stimuli linked to the trauma. An individual must exhibit at least one symptom of reexperiencing to meet criteria for PTSD. Symptoms of avoidance associated with PTSD include efforts to avoid thoughts or activities related to the trauma, anhedonia, reduced capacity to remember events related to the trauma, blunted affect, feelings of detachment or derealization, and a sense of a foreshortened future. An individual must exhibit at least three such symptoms. Symptoms of increased arousal include insomnia, irritability, hypervigilance, and exaggerated startle. An individual must exhibit at least two such symptoms. Finally, the diagnosis of PTSD is only made when these symptoms persist for at least 1 month; the diagnosis of acute stress disorder is made in the interim. DSM-IV acknowledges three subtypes of PTSD that differentiate syndromes with varying time courses. *Acute PTSD* refers to an episode that lasts less than 3 months. *Chronic PTSD* refers to an episode lasting 3 months or longer. *PTSD with delayed onset* refers to an episode that develops 6 months or more after exposure to the traumatic event

The diagnosis of acute stress disorder is applied to syndromes that resemble PTSD but last less than 1 month after a trauma. Acute stress disorder is characterized by reexperiencing, avoidance, and increased arousal, much like PTSD. Acute stress disorder is also associated with at least three of the dissociative symptoms listed in [Table 15.6-13](#).

*(The following table content is extremely faint and largely illegible in the provided image. It appears to be a list of criteria for Acute Stress Disorder.)*

**Table 15.6-13 DSM-IV Diagnostic Criteria for Acute Stress Disorder**

Because individuals often exhibit complex biological and behavioral responses to extreme trauma, the clinician must recognize other medical and psychiatric conditions in the traumatized patient. Particularly after traumatic events that involve physical injury, the clinician must always consider neurological causes of symptoms that develop after trauma. Traumatized patients also can develop mood disorders, including dysthymia and major depression, as well as other anxiety disorders, such as generalized anxiety disorder or panic disorder, and substance use disorders. Finally, recent research suggests that some psychiatric features of posttraumatic syndromes can relate to the state of a patient before the trauma. For example, patients with premorbid anxiety or affective syndromes may be more likely to develop posttraumatic symptoms than individuals who are free of mental illness before the trauma. Thus, the clinician should consider the premorbid mental state of the traumatized patient to enhance understanding of symptoms that develop following a traumatic event.

**History and Comparative Nosology** Astute clinicians have recognized the juxtaposition of acute

mental syndromes to traumatic events for more than 200 years. Observations of trauma-related syndromes were documented following the Civil War, and early psychoanalytic writers, including Freud, noted the relation between neurosis and trauma. Considerable interest in posttraumatic mental disorders was stimulated by observations of “battle fatigue,” “shell shock,” and “soldier's heart” in World War I and World War II. Moreover, increasing documentation of mental reactions to the Holocaust, to a series of natural disasters, and to assault contributed to the growing recognition of a close relationship between trauma and psychopathology.

The syndrome of PTSD was first recognized in the DSM nosology in DSM-III in 1980; acute stress disorder was first recognized in DSM-IV in 1994. The recognition of acute stress disorder followed observations suggesting that many individuals exhibit mental syndromes immediately following trauma; such individuals might face an elevated risk for PTSD. The original DSM-III definition of PTSD required only one symptom of reexperiencing, two symptoms of “psychic numbing,” and one symptom from a list of miscellaneous items, with no duration criteria. DSM-III-R added a number of symptoms to the DSM-III definition and removed the DSM-III symptom of guilt. DSM-III-R also adopted the symptom groupings found in DSM-IV, where symptoms are classified as manifestations of either reexperiencing, avoidance, or hyperarousal. The major change to the definition in DSM-IV involved the definition of trauma. While DSM-III-R emphasized trauma as an event that was “outside of normal experience,” a number of field studies suggested that the typical traumatic precipitants of PTSD were relatively common events. As a result, DSM-IV emphasizes the threat and fear-provoking nature of a trauma, without reference to “normal experience.”

Some variation exists in the definitions of PTSD and acute stress disorder in DSM-IV and ICD-10. While ICD-10 acknowledges the same core group of symptoms as DSM-IV for PTSD, including exposure to a trauma, reexperiencing, avoidance, and increased arousal, ICD-10 provides considerably less detail than DSM-IV for each of the criteria. For example, unlike DSM-IV, ICD-10 provides only brief examples of reexperiencing or avoidance symptoms. The broader view of PTSD and acute stress disorder also differs in the DSM and ICD systems. As with OCD, ICD-10 groups PTSD and acute stress reaction in a distinct category rather than including them with other anxiety disorders ([Table 15.6-14](#)).

Acute stress reaction	Posttraumatic stress disorder
A. The patient must have been exposed to an exceptional mental or physical stressor.	A. The patient must have been exposed to a traumatic event or situation of either death or long-term or exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.
B. Exposure to the stressor is followed by an immediate onset of symptoms within 1 hour.	B. There must be persistent re-experiencing or "reliving" of the stressor in situations that bear no resemblance to the original stressor, or recurring dreams or nightmares, or persistent avoidance of circumstances resembling or associated with the stressor.
C. Two groups of symptoms are given: the acute stress reaction is graded as mild or severe.	C. The patient must exhibit at least three of the following symptoms with clinical significance, and must also have the reaction, which was not premeditated, during or shortly after the stressor.
Only criterion B is listed as fulfilled.	D. Either of the following must be present:
1. Criterion B is met, and there are any four symptoms from criterion C.	(1) persistent symptoms of increased psychological sensitivity and arousal that persist before exposure to the stressor, those to any one of the following:
2. Criterion B, C, and D for generalized anxiety disorder are met.	(a) irritability or being easily annoyed
3. Criterion B, C, and D for panic disorder are met.	(b) difficulty in concentrating
4. Criterion B, C, and D for agoraphobia are met.	(c) hypervigilance
5. Criterion B, C, and D for obsessive-compulsive disorder are met.	(d) exaggerated startle response.
6. Criterion B, C, and D for post-traumatic stress disorder are met.	E. Criterion C, and D must all be met within 6 months of the stressful event or of the end of a period of stress. (For acute reactions, onset should occur within 4 weeks, but this should be clearly specified.)
7. Criterion B, C, and D for adjustment disorder are met.	
8. Criterion B, C, and D for acute stress reaction are met.	
9. Criterion B, C, and D for acute stress reaction are met.	
10. Criterion B, C, and D for acute stress reaction are met.	
11. Criterion B, C, and D for acute stress reaction are met.	
12. Criterion B, C, and D for acute stress reaction are met.	
13. Criterion B, C, and D for acute stress reaction are met.	
14. Criterion B, C, and D for acute stress reaction are met.	
15. Criterion B, C, and D for acute stress reaction are met.	
16. Criterion B, C, and D for acute stress reaction are met.	
17. Criterion B, C, and D for acute stress reaction are met.	
18. Criterion B, C, and D for acute stress reaction are met.	
19. Criterion B, C, and D for acute stress reaction are met.	
20. Criterion B, C, and D for acute stress reaction are met.	

**Table 15.6-14 ICD-10 Diagnostic Criteria for Reactions to Severe Stress**

**Differential Diagnosis** Because patients often exhibit complex reactions to trauma, the clinician must be careful to exclude syndromes other than PTSD and acute stress disorder when evaluating patients



presenting in the wake of trauma. Recognizing potentially treatable medical contributors to posttraumatic symptomatology is particularly important. For example, neurological injury following head trauma can contribute to the clinical picture, as can psychoactive substance use disorders or withdrawal syndromes, either in the period immediately surrounding the trauma or many weeks after the trauma. Medical contributors can usually be detected through a careful history and physical examination, if the clinician remembers to consider such factors.

Symptoms of PTSD can be difficult to distinguish from those of either panic disorder or generalized anxiety disorder, as all three syndromes are associated with prominent anxiety and autonomic arousal. Keys to correctly diagnosing PTSD involve a careful review of the time course relating the symptoms to a traumatic event. Further, PTSD is associated with reexperiencing and avoidance of a trauma, features typically not present in panic or generalized anxiety disorder. Major depression is a frequent concomitant of PTSD. While the two syndromes are generally readily distinguishable phenomenologically, comorbid depression should be noted because it may affect treatment of PTSD. Finally, PTSD must be differentiated from a series of related disorders that can exhibit phenomenological similarities, including borderline personality disorder, dissociative disorders, and factitious disorders.

**Course** Much recent research on the course of psychological reactions to trauma focused on the time course of symptoms immediately following a trauma. The likelihood of developing symptoms, the severity of such symptoms, and the duration of the symptoms are each proportional to the proximity, duration, and intensity of the trauma. Many individuals develop acute stress reactions when faced with close, persistent, intense trauma. Moreover, many individuals who develop PTSD exhibit features of the acute stress syndrome prior to developing PTSD, although many individuals with acute stress syndromes do not develop PTSD. Finally, the full syndrome of PTSD also exhibits a variable course, with some evidence that this also relates to the nature of the trauma. A large minority of patients experience complete remissions, while another large group exhibits only mild symptoms. Approximately 10 percent of patients with PTSD exhibit a persistent or chronic course to their disorder.

Mr. F. sought treatment for symptoms that he developed in the wake of an automobile accident that had occurred about 6 weeks prior to his psychiatric evaluation. While driving to work on a mid-January morning, Mr. F. lost control of his car on an icy road. His car swerved out of control into oncoming traffic in another lane, collided with another car, and then hit a nearby pedestrian. Mr. F. was trapped in his car for 3 hours while rescue workers cut the door of his car. Upon referral, Mr. F. reported frequent intrusive thoughts about the accident, including nightmares of the event and recurrent intrusive visions of his car slamming into the pedestrian. He reported that he had altered his driving route to work to avoid the scene of the accident, and he found himself switching the television channel whenever a commercial for snow tires appeared. Mr. F. described frequent difficulty falling asleep, poor concentration, and an increased focus on his environment, particularly when he was driving.

## GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder is characterized by a pattern of frequent, persistent worry and anxiety that is out of proportion to the impact of the event or circumstance that is the focus of the worry (Table 15.6-15). For example, while college students often worry about examinations, a student who persistently worries about failure despite consistently outstanding grades displays the pattern of worry typical of generalized anxiety disorder. Patients with generalized anxiety disorder may not acknowledge the excessive nature of their worry, but they must be bothered by their degree of worry. This pattern must occur “more days than not” for at least 6 months. The patients must find it difficult to control this worry and must report at least three of six somatic or cognitive symptoms, including feelings of restlessness, fatigue, muscle tension, or insomnia. Worry is a ubiquitous feature of many anxiety disorders: patients with panic disorder often worry about panic attacks, patients with social phobia worry about social encounters, and patients with OCD worry about their obsessions. The worries in generalized anxiety disorder must be beyond the those that characterize these other anxiety disorders. Children exhibiting characteristic symptoms are also considered to meet criteria for generalized anxiety disorder, but they need only meet one of the six somatic or cognitive symptom criteria rather than three.

A.	Excessive anxiety and worry (apprehensive expectations, restlessness, feeling tense, shaky, irritability, or fear) about a number of events or activities (such as work or school performance).
B.	The person finds it difficult to control the worry.
C.	The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more than half the days for the past 6 months). <b>Note:</b> Only one item is required in children. <ul style="list-style-type: none"> <li>(1) restlessness or feeling keyed up or on edge</li> <li>(2) being easily fatigued</li> <li>(3) difficulty concentrating or mind going blank</li> <li>(4) irritability</li> <li>(5) muscle tension</li> <li>(6) sleep disturbance (difficulty falling or staying asleep, or restless/satisfying sleep)</li> </ul>
D.	The focus of the anxiety and worry is not restricted to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), getting weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.
E.	The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F.	The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), and does not occur exclusively during a major depressive, manic-depressive, or a personality disorder.

**Table 15.6-15** DSM-IV Diagnostic Criteria for Generalized Anxiety Disorder

**History and Comparative Nosology** Like those of other anxiety disorders symptoms of generalized anxiety disorder have been noted for more than 100 years. Many syndromes considered to be related to panic disorder (e.g., DaCosta's syndrome or neurocirculatory asthenia) also closely resemble generalized anxiety disorder. In fact, prior to DSM-III, panic disorder and generalized anxiety disorder were both subsumed under the broader category of anxiety neurosis.

The conceptualization of generalized anxiety disorder has changed gradually from DSM-III to DSM-IV. The disorder was originally considered a residual category in DSM-III for anxiety disorders that did not fulfill criteria for another disorder. DSM-III required only 1-month duration of symptoms, and concerns arose about the low reliability of the diagnosis. DSM-III-R increased the duration criterion to 6 months, placed more emphasis on the symptom of worry, and added a list of 18 symptoms, from which patients had to exhibit at least 6. DSM-III-R also removed some of the hierarchical rules that had limited the diagnosis to individuals who were free of specific disorders in DSM-III. Finally, DSM-IV further revised the diagnosis. The list of associated symptoms was narrowed from 18 to 6, from which patients had to exhibit at least 3, and more emphasis was placed on the pervasiveness of the worry. DSM-IV attempted to integrate the approach to worry across development. While DSM-III-R possessed the

diagnosis of overanxious disorder for use among children, DSM-IV integrated this DSM-III-R diagnosis into generalized anxiety disorder, with some minor threshold differences in making the diagnosis in children.

ICD-10 includes the diagnosis of generalized anxiety disorder and emphasizes the distinction between generalized anxiety and panic disorders ([Table 15.6-7](#)). While ICD-10 places an emphasis on worry that is similar to the emphasis in DSM-IV, ICD-10 adopts an approach to the other symptoms of generalized anxiety disorder that is closer to the approach in DSM-III-R than that in DSM-IV. For example, in ICD-10 the diagnosis requires 4 associated symptoms from a list of 22.

**Differential Diagnosis** Like other anxiety disorders, particularly panic disorder, generalized anxiety disorder must be differentiated from both medical and psychiatric disorders. Neurological, endocrinological, metabolic, and medication-related disorders similar to those considered in the differential diagnosis of panic disorder must be considered in the differential diagnosis of generalized anxiety disorder. Common co-occurring anxiety disorders must also be considered, including panic disorder, phobias, OCD, and PTSD. A patient must exhibit the full syndrome of generalized anxiety disorder that cannot be explained by the presence of such a comorbid anxiety disorder. Diagnosing generalized anxiety disorder in the presence of such other anxiety disorders requires documenting anxiety or worry related to circumstances or topics that are either unrelated or only minimally related to other disorders. Hence, proper diagnosis involves both definitively establishing the diagnosis and properly diagnosing other anxiety disorders. Patients with generalized anxiety disorder also frequently develop major depressive disorder; thus this condition must also be recognized and distinguished. Again, the key feature to making a correct diagnosis is documenting anxiety or worry that is unrelated to the depressive disorder.

**Course** The lack of prospective epidemiological studies precludes firm conclusions about the course of generalized anxiety disorder. Prospective research, even among clinical samples, is also insufficient. The most complete data on the course of the disorder derive from retrospective epidemiologically based studies. These studies suggest that generalized anxiety disorder is a chronic disorder, as most patients report symptoms for many years prior to assessment. Given the possible biases in such studies, no definitive statement on the course of the disorder can be made.

Ms. X. was a successful, married, 30-year-old attorney who presented for a psychiatric evaluation to treat growing symptoms of worry and anxiety. For the preceding 8 months, Ms. X. had noted increased worry about her job performance. For example, while she had always been a superb litigator, she increasingly found herself worrying about her ability to win each new case she was presented. Similarly, while she had always been in outstanding physical condition, she increasingly worried that her health had begun to deteriorate. Ms. X. noted frequent somatic symptoms that accompanied her worries. For example, she often felt restless while she worked and while she commuted to her office, thinking about the upcoming challenges of the day. She reported feeling increasingly fatigued, irritable, and tense. She noted that she had increasing difficulty falling asleep at night as she worried about her job performance and impending trials.

# SUBSTANCE-INDUCED ANXIETY AND ANXIETY DUE TO A GENERAL MEDICAL CONDITION

These conditions are characterized by prominent anxiety that arises as the direct result of some underlying physiological perturbation. Hence, for patients with substance-induced anxiety disorder (Table 15.6-16), clinically significant symptoms of panic, worry, phobia, or obsessions emerge in the context of prescribed or illicit substance use. For example, both prescribed and illicit sympathomimetic substances can often produce relatively marked degrees of anxiety. Similarly, for anxiety due to a general medical condition (Table 15.6-17), symptoms develop in the context of an identifiable medical syndrome. For example, panic attacks have been tied to various medical conditions, including endocrinologic, cardiac, and respiratory illnesses.

This table contains the DSM-IV diagnostic criteria for Substance-Induced Anxiety Disorder. The criteria are as follows:

- A.** Prominent anxiety, panic attacks, or obsessions or compulsions predominate in the clinical picture.
- B.** There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C.** The disturbance is not better accounted for by another mental disorder (e.g., adjustment disorder with anxiety, in which the stressor is a serious general medical condition).
- D.** The disturbance does not occur exclusively during the course of a delirium.
- E.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- With generalized anxiety:** if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation
- With panic attacks:** if panic attacks predominate in the clinical presentation
- With obsessive compulsive symptoms:** if obsessions or compulsions predominate in the clinical presentation

**Table 15.6-16** DSM-IV Diagnostic Criteria for Substance-Induced Anxiety Disorder

This table contains the DSM-IV diagnostic criteria for Anxiety Disorder Due to a General Medical Condition. The criteria are as follows:

- A.** Prominent anxiety, panic attacks, or obsessions or compulsions predominate in the clinical picture.
- B.** There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C.** The disturbance is not better accounted for by another mental disorder (e.g., adjustment disorder with anxiety, in which the stressor is a serious general medical condition).
- D.** The disturbance does not occur exclusively during the course of a delirium.
- E.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

- With generalized anxiety:** if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation
- With panic attacks:** if panic attacks predominate in the clinical presentation
- With obsessive compulsive symptoms:** if obsessions or compulsions predominate in the clinical presentation

**Table 15.6-17** DSM-IV Diagnostic Criteria for Anxiety Disorder Due to a General Medical Condition

The first step in identifying anxiety disorder due to a general medical condition or substance-induced anxiety disorder is to confirm the presence of one or the other complicating factor. Clearly, practitioners should routinely document the medical and substance use status of all patients. However, the clinician should be particularly wary when encountering a patient with an unusual symptomatic presentation. For example, changes in consciousness or neurological function almost never occur in acute anxiety states unless there is also an underlying medical component to the syndrome. In patients where there is a suspicion of such complicating factors, the presence of substance use or medical problems first must be definitively confirmed by obtaining the necessary medical history or evaluative procedures. Next, the

clinician must determine that this underlying problem is the cause of the ongoing anxiety symptoms. While there is no definitive test to establish such a causal relationship, several factors can help confirm the diagnosis. These include the timing of the symptoms, the existing literature pertaining to the strength of the association between anxiety and the potential complicating factor, and signs or symptoms (e.g., changes in consciousness) that are atypical for an anxiety disorder. Finally, even more suggestive evidence can be provided if alleviation of the complicating medical factor produces an amelioration of the anxiety symptoms.

## ANXIETY DISORDER NOT OTHERWISE SPECIFIED

Anxiety represents one of the most common psychiatric symptoms encountered in various settings, including primary care settings, and it is relatively common to encounter patients who exhibit impairment from anxiety but who do not meet criteria for one of the specific anxiety disorders. These patients are appropriately classified as suffering from anxiety disorder not otherwise specified ([Table 15.6-18](#)).

---

This category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific anxiety, disorder, adjustment disorder with anxiety, or adjustment disorder with mixed anxiety and depressed mood. Examples include

1. Mixed anxiety-depressive disorder: clinically significant symptoms of anxiety and depression, but the criteria are not met for either a specific mood disorder or a specific anxiety disorder.
2. Clinically significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder (e.g., Parkinson's disease, dermatological conditions, stuttering, anorexia nervosa, body dysmorphic disorder).
3. Situations in which the clinician has concluded that an anxiety disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

### Table 15.6-18 DSM-IV Diagnostic Criteria for Anxiety Disorder Not Otherwise Specified

---

Reprinted with permission from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Two clinical features of this disorder must be recognized to properly identify the condition. First, the anxiety described by the patients must be distressing and interfere with some aspect of functioning. Second, the anxiety must not be attributable to another psychiatric condition. For example, patients with generalized anxiety disorder may not initially report sufficient associated symptoms to meet criteria for this condition. However, on further probing such symptoms may be identified. Particularly in patients with long standing anxiety, it is important to establish that another anxiety disorder does not account for the complaints. Anxiety concerning an embarrassing medical problem or scenario is another frequently encountered form of anxiety disorder not otherwise specified. For example, patients who exhibit excessive concern regarding a dermatological condition might exhibit symptoms of this syndrome.

Perhaps the most consistent research on this condition examines patients with mixed anxiety-depressive disorder, a condition described in an Appendix of DSM-IV ([Table 15.6-19](#)). Patients with mixed anxiety-depressive disorder exhibit symptoms both of depression and anxiety that do not meet criteria for another mood or anxiety disorder. Such patients must show signs of consistent low mood for at least a month, accompanied by additional symptoms that include prominent worries. Longitudinal studies find a

relatively high risk for later mood or anxiety disorders with this condition, particularly major depressive disorder. Due to the paucity of data on treatment for the condition, clinicians often use approaches that are effective in other mood or anxiety disorders.

**Table 15.6-19 DSM-IV Research Criteria for Mixed Anxiety-Depressive Disorder**

- 
- A. Persistent or recurrent dysphoric mood lasting at least 1 month.
  - B. The dysphoric mood is accompanied by at least 1 month of four (or more) of the following symptoms:
    - (1) difficulty concentrating or mind going blank
    - (2) sleep disturbance (difficulty falling or staying asleep, or excessive oversleeping)
    - (3) fatigue or low energy
    - (4) irritability
    - (5) worry
    - (6) being easily moved to tears
    - (7) hypervigilance
    - (8) anticipating the worst
    - (9) hopelessness (pervasive pessimism about the future)
    - (10) low self-esteem or feelings of worthlessness
  - C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
  - E. All of the following:
    - (1) criteria have never been met for major depressive disorder, dysthymic disorder, panic disorder or generalized anxiety disorder
    - (2) criteria are not currently met for any other anxiety or mood disorder (including an anxiety or mood disorder, in partial remission)
    - (3) the symptoms are not better accounted for by any other mental disorder
- 

Reprinted with permission from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ed 4. © American Psychiatric Association, Washington, DC, 1994.

## SECTION REFERENCES

Angst J, Vollrath M: The natural history of anxiety disorders. *Acta Psychiatr Scand* 84:446, 1991.

Ballenger JC, Fyer AJ: DSM-IV in progress: Examining criteria for panic disorder. *Hosp Community Psychiatry* 44:226, 1993.

\*Barsky AJ, Delamater BA, Orav JE: Panic disorder patients and their medical care. *Psychosomatics* 40:50, 1999.

Barlow DH: *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic*. Guilford, New York, 1988.

Breslau N, Davis GC, Andreski P, Peterson E: Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Arch Gen Psychiatry* 48:216, 1991.

\*Calamari JE, Wiegarts PS, Janeck AS: Obsessive-compulsive disorder subgroups: A symptom-based clustering approach. *Behav Res Ther* 37:113, 1999.

Carden E, Spiegel D: Dissociative reaction to the San Francisco Bay Area earthquake of 1989. *Am J Psychiatry* 150:474, 1993.

Davidson JRT, Foa EB: Diagnostic issues in posttraumatic stress disorder: Considerations for the DSM-IV. *J Abnorm Psychol* 100:346, 1991.

Davidson JRT, Hughes DL, George LK, Blazer DG: The epidemiology of social phobia: Findings from the Epidemiologic Catchment Area study. *Psychol Med* 23:709, 1993.

- Freud S: Inhibitions, symptoms and anxiety. In standard edition of *The Complete Psychological Works of Sigmund Freud*, vol 20. Hogarth Press, London, 1966, p 77.
- Freud S: Obsessions and phobias. In standard edition of *The Complete Psychological Works of Sigmund Freud*, vol 3. Hogarth Press, London 1966.
- Fyer AJ, Mannuzza S, Chapman T, Liebowitz MR, Klein DF: A direct interview family study of social phobia. *Arch Gen Psychiatry* 50:286, 1994.
- Gater R, Tansella M, Korten A, Tiemens BG, Maurbas VG, Olatawura MO: Sex differences in the prevalence and detection of depressive and anxiety disorders in general care settings: Report from the WHO collaborative study on psychological problems in general health care. *Arch Gen Psychiatry* 55:405, 1998.
- Gorman JM, Papp LA: Chronic anxiety: Deciding the length of treatment. *J Clin Psychiatry* 5:11, 1990.
- Gorman JM, Papp LA, editors: Anxiety disorders. In *Annual Review of Psychiatry*, vol 11, A Tasman, editor. American Psychiatric Association Press, Washington, DC, 1992.
- Horwath E, Wolk SI, Goldstein RB, Wickramaratne P, Sobin C, Adams P, Lish JD, Weissman MM: Is the comorbidity between social phobia and panic disorder due to familial contranmission or other factors? *Arch Gen Psychiatry* 52:574, 1995.
- Jarrell MP, Ballenger JC: Psychiatric comorbidity in patients with generalized anxiety disorder. *Am J Psychiatry* 150:1216, 1993.
- Jenike MA, Baer L, Minichiello WE: *Obsessive-Compulsive Disorders: Theory and Management*, ed 2. Year Book Publishing, Chicago, 1990.
- Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB: Posttraumatic stress disorder in the national comorbidity survey. *Arch Gen Psychiatry* 52:1048, 1995.
- Klein DF: Delineation of two drug-responsive anxiety syndromes. *Psychopharmacology* 5:397, 1964.
- Klein DF: False suffocation alarms, spontaneous panics, and related conditions: An integrative hypothesis. *Arch Gen Psychiatry* 50:306, 1993.
- Klein DF, Rabkin JG, editors: *Anxiety: New Research and Changing Concepts*. Raven, New York, 1981.
- Klerman GL, Weissman MM, Ouellette R, Johnson J, Greenwald S: Panic attacks in the community: Social morbidity and health care utilization. *JAMA* 265:742, 1991.
- Liebowitz MR, Gorman JM, Fyer AF, Klein DF: Social phobia: Review of a neglected anxiety disorder. *Arch Gen Psychiatry* 42:729, 1985.

Magee WJ, Eaton WW, Wittchen HU, McGonagle KA, Kessler RC: Agoraphobia, simple phobia, and social phobia in the National Comorbidity Survey. *Arch Gen Psychiatry* 53:159, 1996.

Marks IM: *Fears, Phobias, and Rituals: Panic, Anxiety, and Their Disorders*. Oxford University Press, New York, 1988.

McFarlane AC: The phenomenology of post-traumatic stress disorders following a natural disaster. *J Nerv Ment Dis* 176:22, 1988.

Pine DS, Cohen P, Gurley D, Brook J, Ma Y: The risk for early-adult anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Arch Gen Psychiatry* 56:775, 1998.

\*Rapee RM, Barlow DH, editors: *Chronic Anxiety*. Guilford, New York, 1991.

Rapoport JL: *The Boy Who Couldn't Stop Washing*. Dutton, New York, 1989.

Shalev AY, Sakar T, Freedman S, Peri T, Glick N, Brandes D, Orr SP, Pitman RK: A prospective study of heart rate response following trauma and the subsequent development of PTSD. *Arch Gen Psychiatry* 56:553, 1998.

Stein MB, Walker JR, Forde DR: Public-speaking fears in a community sample: Prevalence, impact on functioning, and diagnostic classification. *Arch Gen Psychiatry* 53:169, 1995.

Smoller JW, Tsuang MT: Panic and phobic anxiety: Defining phenotypes for genetic studies. *Am J Psychiatry* 155:1152, 1998.

Weissman MM: Panic and generalized anxiety: Are they separate disorders? *J Psychiatr Res* 24(Suppl):157, 1990.

Wittchen HV, Reed V, Kessler RC: The relationship of agoraphobia and panic in a community sample of adolescents and young adults. *Arch Gen Psychiatry* 56:1017, 1998.

Books@Ovid

[Copyright](#) © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry



**Table 15.6-1** DSM-IV Criteria for Panic Attack

---

**Note:** A panic attack is not a codable disorder. Code the specific diagnosis in which the panic attack occurs (e.g., panic disorder with agoraphobia).

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy
- (11) fear of dying
- (12) paresthesias (numbness or tingling sensations)
- (13) chills or hot flushes

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-2** DSM-IV Criteria for Agoraphobia

---

**Note:** Agoraphobia is not a codable disorder. Code the specific disorder in which the agoraphobia occurs (eg, panic disorder with agoraphobia or agoraphobia without history of panic disorder).

- A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

**Note:** Consider the diagnosis of specific phobia if the avoidance is limited to one or only a few specific situations, or social phobia if the avoidance is limited to social situations.

- B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
- C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as social phobia (e.g., avoidance limited to social situations because of fear of embarrassment), specific phobia (e.g., avoidance limited to a single situation like elevators), obsessive-compulsive disorder (e.g., avoidance of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), or separation anxiety disorder (e.g., avoidance of leaving home or relatives).
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-3** DSM-IV Diagnostic Criteria for Agoraphobia Without History of Panic Disorder

- 
- A. The presence of agoraphobia related to fear of developing panic-like symptoms (e.g., dizziness or diarrhea).
  - B. Criteria have never been met for panic disorder.
  - C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
  - D. If an associated general medical condition is present, the fear described in criterion A is clearly in excess of that usually associated with the condition.
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-4** DSM-IV Diagnostic Criteria for Panic Disorder With Agoraphobia

- 
- A. Both (1) and (2):
    - (1) recurrent unexpected panic attacks
    - (2) at least one of the attacks has been followed by 1 month (or more) of the following:
      - (a) persistent concern about having additional attacks
      - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
      - (c) a significant change in behavior related to the attacks
  - B. The presence of agoraphobia.
  - C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or a general medical condition (e.g., hyperthyroidism).
  - D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-5** DSM-IV Diagnostic Criteria for Panic Disorder Without Agoraphobia

- 
- A. Both (1) and (2):
    - (1) recurrent unexpected panic attacks
    - (2) at least one of the attacks has been followed by at least 1 month (or more) of the following:
      - (a) persistent concern about having additional attacks
      - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
      - (c) a significant change in behavior related to the attacks
  - B. Absence of agoraphobia.
  - C. The panic attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
  - D. The panic attacks are not better accounted for by another mental disorder, such as social phobia (e.g., occurring on exposure to feared social situations), specific phobia (e.g., on exposure to a specific phobic situation), obsessive-compulsive disorder (e.g., on exposure to dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., in response to stimuli associated with a severe stressor), or separation anxiety disorder (e.g., in response to being away from home or close relatives).
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

Table 15.6-6 ICD-10 Diagnostic Criteria for Phobic Anxiety Disorders

**Agoraphobia**

- A. There is marked and consistently manifest fear in, or avoidance of, at least two of the following situations:
- (1) crowds;
  - (2) public places;
  - (3) traveling alone;
  - (4) traveling away from home.
- B. At least two symptoms of anxiety in the feared situation must have been present together, on at least one occasion since the onset of the disorder, and one of the symptoms must have been from items (1) to (4) listed below:

**Autonomic arousal symptoms**

- (1) palpitations or pounding heart, or accelerated heart rate;
- (2) sweating;
- (3) trembling or shaking;
- (4) dry mouth (not due to medication or dehydration);

**Symptoms involving chest and abdomen**

- (5) difficulty in breathing;
- (6) feeling of choking;
- (7) chest pain or discomfort;
- (8) nausea or abdominal distress (e.g., churning in stomach);

**Symptoms involving mental state**

- (9) feeling dizzy, unsteady, faint, or light-headed;
- (10) feelings that objects are unreal (derealization), or that the self is distant or "not really here" (depersonalization);
- (11) fear of losing control, "going crazy," or passing out;
- (12) fear of dying;

**General symptoms**

- (13) hot flushes or cold chills;
- (14) numbness or tingling sensations.

- C. Significant emotional distress is caused by the avoidance or by the anxiety symptoms, and the individual recognizes that these are excessive or unreasonable.
- D. Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations.
- E. *Most commonly used exclusion clause.* Fear or avoidance of situations (criterion A) is not the result of delusions, hallucinations, or other disorders such as organic mental disorders, schizophrenia and related disorders, mood [affective] disorders, or obsessive-compulsive disorder, and is not secondary to cultural beliefs.

The presence or absence of panic disorder in a majority of agoraphobic situations may be specified by using a fifth character:

**Without panic disorder**

**With panic disorder**

**Options for rating severity**

Severity in agoraphobia may be rated by indicating the degree of avoidance, taking into account the specific cultural setting. Severity in social phobias may be rated by counting the number of panic attacks.

**Social phobias**

- A. Either of the following must be present:
- (1) marked fear of being the focus of attention, or fear of behaving in a way that will be embarrassing or humiliating;
  - (2) marked avoidance of being the focus of attention, or of situations in which there is fear of behaving in an embarrassing or humiliating way.

These fears are manifested in social situations, such as eating or speaking in public, encountering known individuals in public, or entering or enduring small group situations (e.g., parties, meetings, classrooms).

- B. At least two symptoms of anxiety in the feared situation as defined in agoraphobia, criterion B, must have been manifest at some time since the onset of the disorder, together with at least one of the following symptoms:
- (1) blushing or shaking;
  - (2) fear of vomiting;
  - (3) urgency or fear of micturition or defecation.
- C. Significant emotional distress is caused by the symptoms or by the avoidance, and the individual recognizes that these are excessive or unreasonable.
- D. Symptoms are restricted to, or predominate in, the feared situations or contemplation of the feared situations.
- E. *Most commonly used exclusion clause.* The symptoms listed in criteria A and B are not the result of delusions, hallucinations, or other disorders such as organic mental disorders, schizophrenia and related disorders, mood [affective] disorders, or obsessive-compulsive disorder, and are not secondary to cultural beliefs.

**Specific (isolated) phobias**

- A. Either of the following must be present:
- (1) marked fear of a specific object or situation not included in agoraphobia or social phobia;
  - (2) marked avoidance of a specific object or situation not included in agoraphobia or social phobia.
- Among the most common objects and situations are animals, birds, insects, heights, thunder, flying, small enclosed spaces, the sight of blood or injury, injections, dentists, and hospitals.

- B. Symptoms of anxiety in the feared situation as defined in agoraphobia, criterion B, must have been manifest at some time since the onset of the disorder.
- C. Significant emotional distress is caused by the symptoms or by the avoidance, and the individual recognizes that these are excessive or unreasonable.
- D. Symptoms are restricted to the feared situation or contemplation of the feared situation.

If desired the specific phobias may be subdivided as follows:

- animal type (e.g., insects, dogs)
- nature-forces type (e.g., storms, water)
- blood, injection, and injury type
- situational type (e.g., elevators, tunnels)
- other type

**Other phobic anxiety disorders**

**Phobic anxiety disorder, unspecified**

Copyright © 2000 Lippincott Williams & Wilkins  
Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

Table 15.6-7 ICD-10 Diagnostic Criteria for Other Anxiety Disorders

**Panic disorder [episodic paroxysmal anxiety]**

A. The individual experiences recurrent panic attacks that are not consistently associated with a specific situation or object and that often occur spontaneously (ie, the episodes are unpredictable). The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations.

- B. A panic attack is characterized by all of the following:
- (1) it is a discrete episode of intense fear or discomfort;
  - (2) it starts abruptly;
  - (3) it reaches a maximum within a few minutes and lasts at least some minutes;
  - (4) at least four of the symptoms listed below must be present, one of which must be from items (a) to (d):

**Autonomic arousal symptoms**

- (a) palpitations or pounding heart, or accelerated heart rate;
- (b) sweating;
- (c) trembling or shaking;
- (d) dry mouth (not due to medication or dehydration);

**Symptoms involving chest and abdomen**

- (e) difficulty in breathing;
- (f) feeling of choking;
- (g) chest pain or discomfort;
- (h) nausea or abdominal distress (e.g., churning in stomach);

**Symptoms involving mental state**

- (i) feeling dizzy, unsteady, faint, or light-headed;
- (j) feelings that objects are unreal (derealization), or that the self is distant or "not really here" (depersonalization);
- (k) fear of losing control, "going crazy," or passing out;
- (l) fear of dying;

**General symptoms**

- (m) hot flushes or cold chills;
- (n) numbness or tingling sensations.

C. *Most commonly used exclusion clause.* Panic attacks are not due to a physical disorder, organic mental disorder, or other mental disorders, such as schizophrenia and related disorders, mood [affective] disorders, or somatoform disorders.

The range of individual variation in both content and severity is so great that two grades, moderate and severe, may be specified, if desired, with a fifth character.

**Panic disorder, moderate**

At least four panic attacks in a 4-week period.

**Panic disorder, severe**

At least four panic attacks per week over a 4-week period.

**Generalized anxiety disorder**

*Note:* In children and adolescents the range of complaints by which the general anxiety is manifest is often more limited than in adults, and the specific symptoms of autonomic arousal are often less prominent. For these individuals, an alternative set of criteria is provided for use in (generalized anxiety disorder of childhood) if preferred.

A. There must have been a period of at least 6 months with prominent tension, worry, and feelings of apprehension about everyday events and problems.

B. At least four of the symptoms listed below must be present, at least one of which must be from items (1) to (4):

**Autonomic arousal symptoms**

- (1) palpitations or pounding heart, or accelerated heart rate;
- (2) sweating;
- (3) trembling or shaking;
- (4) dry mouth (not due to medication or dehydration);

**Symptoms involving chest and abdomen**

- (5) difficulty in breathing;
- (6) feeling of choking;
- (7) chest pain or discomfort;
- (8) nausea or abdominal distress (e.g., churning in stomach);

**Symptoms involving mental state**

- (9) feeling dizzy, unsteady, faint, or light-headed
- (10) feelings that objects are unreal (derealization), or that the self is distant or "not really here" (depersonalization);
- (11) fear of losing control, "going crazy," or passing out;
- (12) fear of dying;

**General symptoms**

- (13) hot flushes or cold chills;
- (14) numbness or tingling sensations;

**Symptoms of tension**

- (15) muscle tension or aches and pains;
- (16) restlessness and inability to relax;
- (17) feeling keyed up, on edge, or mentally tense;
- (18) a sensation of a lump in the throat, or difficulty in swallowing;

**Other nonspecific symptoms**

- (19) exaggerated response to minor surprise or being startled;
- (20) difficulty in concentrating, or mind "going blank," because of worrying or anxiety;
- (21) persistent irritability;
- (22) difficulty in getting to sleep because of worrying.

C. The disorder does not meet the criteria for panic disorder, phobic anxiety disorders, obsessive-compulsive disorder, or hypochondriacal disorder.

D. *Most commonly used exclusion clause.* The anxiety disorder is not due to a physical disorder, such as hyperthyroidism, an organic mental disorder, or a psychoactive substance-related disorder, such as excess consumption of amphetamine-like substances or withdrawal from benzodiazepines.

**Mixed anxiety and depressive disorder**

There are so many possible combinations of comparatively mild symptoms for these disorders that specific criteria are not given, other than those already in *Clinical descriptions and diagnostic guidelines*. It is suggested that researchers wishing to study patients with these disorders should arrive at their own criteria within the guidelines, depending upon the setting and purpose of their studies.

**Other mixed anxiety disorders**

**Other specified anxiety disorders**

**Anxiety disorder, unspecified**



Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-8 DSM-IV Diagnostic Criteria for Specific Phobia**

- 
- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
  - B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** in children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
  - C. The person recognizes that the fear is excessive or unreasonable. **Note:** in children, this feature may be absent.
  - D. The phobic situation(s) is avoided, or else endured with intense anxiety or distress.
  - E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships with others, or there is marked distress about having the phobia.
  - F. In individuals under age 18 years, the duration is at least 6 months.
  - G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder (e.g., fear of dirt in someone with an obsession about contamination), posttraumatic stress disorder (e.g., avoidance of stimuli associated with a severe stressor), separation anxiety disorder (e.g., avoidance of school), social phobia (e.g., avoidance of social situations because of fear of embarrassment), panic disorder with agoraphobia, or agoraphobia without history of panic disorder.

*Specify type:*

**Animal type**

**Natural environment type** (e.g., heights, storms, and water)

**Blood-injection-injury type**

**Situational type** (e.g., planes, elevators, enclosed places)

**Other type** (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American  
Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-9** DSM-IV Diagnostic Criteria for Social Phobia

- 
- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** in children, there must be evidence of capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
  - B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
  - C. The person recognizes that the fear is excessive or unreasonable. **Note:** in children, this feature may be absent.
  - D. The feared social or performance situations are avoided, or else endured with intense anxiety or distress.
  - E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships with others, or there is marked distress about having the phobia.
  - F. In individuals under age 18 years, the duration is at least 6 months.
  - G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, a pervasive developmental disorder, or schizoid personality disorder).
  - H. If a general medical condition or other mental disorder is present, the fear in criterion A is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa.

*Specify if:*

**Generalized:** if the fears include most social situations (also consider the additional diagnosis of avoidant personality disorder).

---

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

Table 15.6-10 DSM-IV Diagnostic Criteria for Obsessive-Compulsive Disorder

- 
- A. Either obsessions or compulsions:
- Obsessions as defined by (1), (2), (3), and (4):*
- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
  - (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
  - (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
  - (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)
- Compulsions as defined by (1) and (2):*
- (1) repetitive behaviors (e.g., handwashing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
  - (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** this does not apply to children.
- C. The obsessions or compulsions cause marked distress; are time-consuming (take more than an hour a day); or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an eating disorder; hair pulling in the presence of trichotillomania; concern with appearance in the presence of body dysmorphic disorder; preoccupation with drugs in the presence of a substance use disorder; preoccupation with having a serious illness in the presence of hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a paraphilia; or guilty ruminations in the presence of major depressive disorder).
- E. The disturbance is not due to the direct effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

philia; or guilty ruminations in the presence of major depressive disorder).

- E. The disturbance is not due to the direct effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*Specify if:*

- **With poor insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-11 ICD-10 Diagnostic Criteria for Obsessive-Compulsive Disorder**

- 
- A. Either obsessions or compulsions (or both) are present on most days for a period of at least 2 weeks.
  - B. Obsessions (thoughts, ideas, or images) and compulsions (acts) share the following features, all of which must be present:
    - (1) They are acknowledged as originating in the mind of the patient and are not imposed by outside persons or influences.
    - (2) They are repetitive and unpleasant, and at least one obsession or compulsion that is acknowledged as excessive or unreasonable must be present.
    - (3) The patient tries to resist them (but resistance to very long-standing obsessions or compulsions may be minimal). At least one obsession or compulsion that is unsuccessfully resisted must be present.
    - (4) Experiencing the obsessive thought or carrying out the compulsive act is not in itself pleasurable. (This should be distinguished from the temporary relief of tension or anxiety.)
  - C. The obsessions or compulsions cause distress or interfere with the patient's social or individual functioning, usually by wasting time.
  - D. *Most commonly used exclusion clause.* The obsessions or compulsions are not the result of other mental disorders, such as schizophrenia and related disorders or mood [affective] disorders.

The diagnosis may be further specified by the following four-character codes:

- Predominantly obsessional thoughts and ruminations**
- Predominantly compulsive acts [obsessional rituals]**
- Mixed obsessional thoughts and acts**
- Other obsessive-compulsive disorders**
- Obsessive-compulsive disorder, unspecified**

---

Reprinted with permission from World Health Organization: *The ICD-10 Classification of Mental and Behavioral Disorders: Diagnostic Criteria for Research*. © World Health Organization, Geneva, 1993.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry



**Table 15.6-12** DSM-IV Diagnostic Criteria for Posttraumatic Stress Disorder

- 
- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
  - (2) the person's response involved intense fear, helplessness, or horror. **Note:** in children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** in young children, repetitive play may occur in which themes or aspects of the trauma are expressed
  - (2) recurrent distressing dreams of the event. **Note:** in children, there may be frightening dreams without recognizable content
  - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** in young children, trauma-specific reenactment may occur.
  - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - (5) physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
  - (3) inability to recall an important aspect of the trauma
  - (4) markedly diminished interest or participation in significant activities
  - (5) feeling of detachment or estrangement from others
  - (6) restricted range of affect (e.g., unable to have loving feelings)
  - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
  - (2) irritability or outbursts of anger
  - (3) difficulty concentrating
  - (4) hypervigilance
  - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**Acute:** if duration of symptoms is less than 3 months

**Chronic:** if duration of symptoms is 3 months or more

*Specify if:*

**With delayed onset:** onset of symptoms at least 6 months after the stressor

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-13** DSM-IV Diagnostic Criteria for Acute Stress Disorder

- 
- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
  - (2) The person's response involved intense fear, helplessness, or horror
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
- (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
  - (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
  - (3) derealization
  - (4) depersonalization
  - (5) dissociative amnesia (e.g., inability to recall an important aspect of the trauma)
- C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, impairs the individual's ability to pursue some necessary tasks, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H. Not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
-

drug or abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

Table 15.6-14 ICD-10 Diagnostic Criteria for Reactions to Severe Stress

**Acute stress reaction**

- A. The patient must have been exposed to an exceptional mental or physical stressor.
- B. Exposure to the stressor is followed by an immediate onset of symptoms (within 1 hour).
- C. Two groups of symptoms are given: the acute stress reaction is graded as:
  - Mild  
Only criterion (1) below is fulfilled.
  - Moderate  
Criterion (1) is met, and there are any two symptoms from criterion (2).
  - Severe  
Either criterion (1) is met, and there are any four symptoms from criterion (2); or there is dissociative stupor.
    - (1) Criteria B, C, and D for generalized anxiety disorder are met.
    - (2) (a) Withdrawal from expected social interaction.
    - (b) Narrowing of attention.
    - (c) Apparent disorientation.
    - (d) Anger or verbal aggression.
    - (e) Despair or hopelessness.
    - (f) Inappropriate or purposeless overactivity.
    - (g) Uncontrollable and excessive grief (judged by local cultural standards).
- D. If the stressor is transient or can be relieved, the symptoms must begin to diminish after not more than 8 hours. If exposure to the stressor continues, the symptoms must begin to diminish after not more than 48 hours.
- E. *Most commonly used exclusion clause.* The reaction must occur in the absence of any other concurrent mental or behavioral disorder in ICD-10 (except generalized anxiety disorder and personality disorders) and not within 3 months of the end of an episode of any other mental or behavioral disorder.

**Posttraumatic stress disorder**

- A. The patient must have been exposed to a stressful event or situation (either short- or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.
- B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams or in experiencing distress when exposed to circumstances resembling or associated with the stressor.
- C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.
- D. Either of the following must be present:
  - (1) inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor;
  - (2) persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
    - (a) difficulty in falling or staying asleep;
    - (b) irritability or outbursts of anger;
    - (c) difficulty in concentrating;
    - (d) hypervigilance;
    - (e) exaggerated startle response.
- E. Criteria B, C, and D must all be met within 6 months of the stressful event or of the end of a period of stress. (For some purposes, onset delayed more than 6 months may be included, but this should be clearly specified.)

Reprinted with permission from World Health Organization: *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. © World Health Organization, Geneva, 1993.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-15** DSM-IV Diagnostic Criteria for Generalized Anxiety Disorder

- 
- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
  - B. The person finds it difficult to control the worry.
  - C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.
    - (1) restlessness or feeling keyed up or on edge
    - (2) being easily fatigued
    - (3) difficulty concentrating or mind going blank
    - (4) irritability
    - (5) muscle tension
    - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
  - D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during post-traumatic stress disorder.
  - E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), and does not occur exclusively during a mood disorder, psychotic disorder, or a pervasive developmental disorder.
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-16** DSM-IV Diagnostic Criteria for Substance-Induced Anxiety Disorder

- 
- A. Prominent anxiety, panic attacks, obsessions or compulsions predominate in the clinical picture.
  - B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):
    - (1) the symptoms in criterion A developed during, or within 1 month of, substance intoxication or withdrawal
    - (2) medication use is etiologically related to the disturbance
  - C. The disturbance is not better accounted for by an anxiety disorder that is not substance induced. Evidence that the symptoms are better accounted for by an anxiety disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence suggesting the existence of an independent non-substance-induced anxiety disorder (e.g., a history of recurrent non-substance-related episodes).
  - D. The disturbance does not occur exclusively during the course of a delirium.
  - E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Note:** This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the anxiety symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the anxiety symptoms are sufficiently severe to warrant independent clinical attention.

Code [Specific substance]-induced anxiety disorder (alcohol; amphetamine (or amphetamine-like substance); caffeine; cannabis; cocaine; hallucinogen; inhalant; phencyclidine (or phencyclidine-like substance); sedative, hypnotic, or anxiolytic; other [or unknown] substance)

*Specify if:*

**With generalized anxiety:** if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation

**With panic attacks:** if panic attacks predominate in the clinical presentation

**With obsessive-compulsive symptoms:** if obsessions or compulsions predominate in the clinical presentation



**With panic attacks:** if panic attacks predominate in the clinical presentation

**With obsessive-compulsive symptoms:** if obsessions or compulsions predominate in the clinical presentation

**With phobic symptoms:** if phobic symptoms predominate in the clinical presentation

*Specify if:*

**With onset during intoxication:** if the criteria are met for intoxication with the substance and the symptoms develop during the intoxication syndrome

**With onset during withdrawal:** if criteria are met for withdrawal from the substance and the symptoms develop during or shortly after, a withdrawal syndrome

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-17** DSM-IV Diagnostic Criteria for Anxiety Disorder Due to a General Medical Condition

- 
- A. Prominent anxiety, panic attacks, or obsessions or compulsions predominate in the clinical picture.
  - B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
  - C. The disturbance is not better accounted for by another mental disorder (e.g., adjustment disorder with anxiety, in which the stressor is a serious general medical condition).
  - D. The disturbance does not occur exclusively during the course of a delirium.
  - E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**With generalized anxiety:** if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation

**With panic attacks:** if panic attacks predominate in the clinical presentation

**With obsessive compulsive symptoms:** if obsessions or compulsions predominate in the clinical presentation

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry



**Table 15.6-18** DSM-IV Diagnostic Criteria for Anxiety Disorder Not Otherwise Specified

---

This category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific anxiety, disorder, adjustment disorder with anxiety, or adjustment disorder with mixed anxiety and depressed mood. Examples include

1. Mixed anxiety-depressive disorder: clinically significant symptoms of anxiety and depression, but the criteria are not met for either a specific mood disorder or a specific anxiety disorder.
2. Clinically significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder (e.g., Parkinson's disease, dermatological conditions, stuttering, anorexia nervosa, body dysmorphic disorder).
3. Situations in which the clinician has concluded that an anxiety disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

---

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.  
Kaplan & Sadock's Comprehensive Textbook of Psychiatry

**Table 15.6-19** DSM-IV Research Criteria for Mixed Anxiety-Depressive Disorder

- 
- A. Persistent or recurrent dysphoric mood lasting at least 1 month.
  - B. The dysphoric mood is accompanied by at least 1 month of four (or more) of the following symptoms:
    - (1) difficulty concentrating or mind going blank
    - (2) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
    - (3) fatigue or low energy
    - (4) irritability
    - (5) worry
    - (6) being easily moved to tears
    - (7) hypervigilance
    - (8) anticipating the worst
    - (9) hopelessness (pervasive pessimism about the future)
    - (10) low self-esteem or feelings of worthlessness
  - C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
  - E. All of the following:
    - (1) criteria have never been met for major depressive disorder, dysthymic disorder, panic disorder or generalized anxiety disorder
    - (2) criteria are not currently met for any other anxiety or mood disorder (including an anxiety or mood disorder, in partial remission)
    - (3) the symptoms are not better accounted for by any other mental disorder
- 

Reprinted with permission from American Psychiatric Association:  
*Diagnostic and Statistical Manual of Mental Disorders*, ed 4. © American Psychiatric Association, Washington, DC, 1994.

Books@Ovid

Copyright © 2000 Lippincott Williams & Wilkins

Harold I. Kaplan, M.D, Benjamin J. Sadock, M.D and Virginia A. Sadock, M.D.

Kaplan & Sadock's Comprehensive Textbook of Psychiatry