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An Roinn Coimirce Sóisialai
Department of Social Protection
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Anxiety

Contents

1. Overview and Definition of Generalised Anxiety and Panic Disorders

1.1 Overview

This guideline covers Generalised Anxiety Disorder (GAD) and Panic disorders, which are recognised to be subtypes of a group of anxiety disorders which also include stress disorders (acute and post-traumatic), social and specific phobias and obsessive compulsive disorders (McIntosh, Cohen, Turnbull et al, 2004). These latter conditions are not covered specifically within this protocol, however information can be found within the appendices of this guideline, and where appropriate, within accompanying guidelines (e.g. Post Traumatic Stress Disorder, Stress) which are specific to these conditions.

Generalised Anxiety Disorder (GAD) and Panic Disorders are disabling chronic conditions that result in considerable economic and social costs in terms of disability. In the United States, the economic cost of such disorders has been estimated to be around US$44 billion per year – equalling the economic cost of depression (Greenberg et al, 1990). However Generalised Anxiety Disorder remains one of the least researched areas of mental health disorders (Papp and Kleber, 2002) as well as one of the most poorly recognised, diagnosed or treated (Bitran et al, 2009).

It should be noted that differentiation of these conditions is often difficult, as they often exist alongside other anxiety or mood disorders, or depressive conditions with 92% of individuals meeting criteria for other disorders, and 64% meeting criteria for Major Depressive Disorder (Brown et al, 2001).

Approximately 3-27% of individuals with GAD also have Panic Disorder (Wittchen et al, 1996).

1.2 Definition of Generalised Anxiety Disorder (GAD)

The Diagnostic and Statistical Manual of Mental Disorders (DSM) Fourth Edition text revision (American Psychiatric Association, 2000) (usually referred to as DSM-IV TR) states that GAD is generalised, excessive anxiety, persistent for more than 6 months, accompanied by 3 of the following symptoms:

- Restlessness
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension

- disturbed sleep

Anxiety typically causes a combination of physical and psychological symptoms:

Physical Symptoms	Psychological Symptoms
Tension headaches, dizziness.	Feeling of threat, distractible, difficulty concentrating.
Flushing, dry mouth, dysphagia, globus hystericus.	Tense, irritable, labile mood, noise intolerant.
Breathlessness, tachycardia.	Early insomnia, nightmares.
Nausea, diarrhoea, urinary frequency.	Panic attacks.
Trembling, cold clammy hands, sweating.	Perceptual distortion (such as distortion of walls).
Muscle tension, restlessness, fatigue.	Depersonalisation (dream-like sensation of unreality).

GAD also has the following features:

- Individuals may worry about any area of routine family life, relationships, natural disasters, etc
- Individuals' concerns and strength, length, and frequency of anxiety are considerably out of proportion to actual situations or threats
- Focus not confined to other disorders e.g. having panic attacks (panic disorder) or a excessive fear of spiders (specific phobia)
- Does not occur in response to psychological effects of a substance, or a general medical condition
- Whilst GAD may occur during mood, psychotic or pervasive developmental disorders, it also occurs in individuals who do not have these conditions
- Individuals may not identify their worries as excessive, but feel they are constantly worrying which may result in occupational or social situations, or result in a functional impairment

Other factors which may contribute to GAD (McIntosh, Cohen, Turnbull et al, 2004; Medical Disability Guidelines, 2009):

- Genetic factors
- Sleep Disorders

- Excessive amounts of Caffeine

- Medication (prescription, over the counter and herbal) including Adrenergic drugs, cyclic antidepressants, antihistamines, thyroid hormones, and antispasmodic drugs, can also play a role (O'Brien, Kifugi and Summergrad, 2006).

- Nutritional deficiencies, particularly deficiencies in certain B vitamins (e.g., niacin, thiamin and vitamin B12), (O'Brien, Kifugi and Summergrad, 2006)

- Underlying medical illness and anxiety disorders. In the presence of comorbid illness, anxiety symptoms and functional impairment increase, medical illness symptoms increase, outcomes are effected and quality of life is impaired (O'Brien, Kifugi and Summergrad, 2006).

- Substance and Alcohol abuse (including amphetamines and cocaine for example)

Most anxiety disorders including GAD usually develop in childhood or adolescence: in older individuals the occurrence of anxiety disorders can be related to an underlying medical disease, but can also occur without underlying disease or illness. (Medical Disability Guidelines, 2009).

Males, individuals from lower social classes, and members of some cultures are more likely to complain of somatic rather than psychiatric symptoms. It is important to understand these are real symptoms and not "all in the mind." It is understandable that a patient, unaware of the normal features of anxiety, can get into a vicious cycle of anxiety and worry about their somatic symptoms. They may forget the original stressor and become preoccupied with, for example, whether they are going to have a heart attack.

A detailed history, including past medical history and medication helps to eliminate organic causes. It is best to limit investigations to those tests needed to exclude an organic diagnostic possibility, based on positive findings from the history and examination.

1.3 Definition of Panic Disorder

DSM-IV TR defines Panic disorder is recurrent, acute, **unprovoked**, periods of intense fear (panic attacks) accompanied by at least one month of concern about such attacks.

The cardinal feature of panic disorder is fear of dying, going mad or losing control.

Features of Panic Disorder also include:

- Does not occur in response to psychological effects of a substance, and

does not usually occur in response to a general medical condition

- Attacks not better accounted for by another disorder
- Individuals display characteristic concerns about the implications or consequences of attacks
- Can be diagnosed with or without agoraphobia (anxiety about being in places or situations where escape may be perceived to be difficult - leading to an avoidance of such situations). Please see Appendix A for information regarding agoraphobia
- A diagnosis of panic disorder may be made if least two unexpected attacks have occurred.

Other symptoms include:

Shortness of Breath	Choking or Smothering	Paraesthesia
Palpitations	Chest Pain	Derealisation
Nausea	Abdominal Discomfort	Depersonalisation
Tremor	Dizziness	Muscle aches and pains

During a panic attack, the patient experiences such severe fear that they have to 'flee', regardless of the consequences. The episode usually resolves after a few minutes.

After a panic attack, the patient may develop a fear or phobia of the situation where the attack happened (Pollack and Marzol, 2000). Anxious anticipation of the next attack is common, and this may in turn precipitate a panic attack. A vicious circle of anxiety, fear and panic can rapidly develop.

The onset of panic disorder is commonest in adolescents and people in their mid 30s, and it is rare for it to begin after the age of 45(Angst and Vollrath, 1991; Davis and Crag, 2009).

2. Epidemiology

Prevalence and incidence figures are difficult to obtain for anxiety disorders (McIntosh, Cohen, Turnbull et al, 2004). This is due to lack of research and the complexity of the various anxiety disorders.

2.1 Epidemiology of Generalised Anxiety Disorder

The prevalence of GAD varies greatly from study to study according to which criteria are used to confirm the diagnosis (Bitran et al, 2009). Anxiety has been noted to be the most common mental health disorder (Medical Disability Guidelines, 2009), with middle aged people being at the highest risk.

With regard to a more general definition of anxiety, 16% of the general population suffer from some form of pathological anxiety, with a lifetime prevalence of 28% (Medical Disability Guidelines, 2009).

For GAD specifically, a 12 month prevalence of 3% and lifetime prevalence of 5.5% have been noted in the US, with the highest rates being in the 45-59 year age group (Kessleret al, 2005)

Epidemiological features of GAD include:

- Occurs twice as much in females as males
- Often begins in childhood or adolescence
- Onset in older adults often related to a medical condition
- Occurs more often in single people, ethnic minorities and individuals from poorer socio-economic backgrounds (Grant et al, 2006)
- Has a familial association
- Risk greater in those with certain chronic conditions including thyroid disease, gastrointestinal disease, allergies and migraine (Shearer, 2007)
- More common in the 35 to 54 year age group (ONS, 2000)
- Less common in the 16 to 24 year age group (ONS, 2000)
- More common in those living alone than those married or co-habiting (ONS, 2000).

2.2 Epidemiology of Panic Disorder

Figures from the US suggest that the epidemiological features of Panic Disorder include:

- 12 month and lifetime prevalence of Panic disorder with and without agoraphobia occurs in approximately 2 and 5% respectively of the general population (Grant et al, 2006). This breaks down as a lifetime prevalence of Panic Disorder with agoraphobia as being approximately 1%, and without agoraphobia as 4%.

- Psychiatric co-morbidity is common (Wilkinson, Moore and Moore, 2000; Pollack and Marzol, 2000)
  - Panic attacks + history of depression – 50%
  - Panic attacks + history of social anxiety disorder – 25%
  - Panic attacks + history of obsessional compulsive disorder – 25%
  - Panic attacks + history of anxiety problems – 20%

- Individuals with a close relative who has panic disorder are up to 8 times more likely to develop this disorder themselves (DSM-IV TR)

- Some disagreement in prevalence of panic disorder with relevance to Gender. Some sources state women 2-3 times more likely to suffer with Panic Disorders (Medical Disability Guidelines, 2009, Grant et al, 2006), although the ONS Psychiatric Morbidity survey (ONS, 2000) found no significant gender link.

3. Aetiology

3.1 Generalised Anxiety Disorder

Generalised Anxiety Disorder can be attributed to a number of factors (Bitran et al, 2009):

- **Genetic Predisposition**: There is evidence that there is a genetic factor which plays a part in the development of generalised anxiety disorders, however this does not appear to have high significance as in other psychological disorders such as depression
- **Childhood Trauma**: Evidence strongly supports the influence of early environmental factors and the impact of parenting on the development of anxiety disorders
- **Stressful life events**: Half of all individuals with GAD report at least one traumatic event such as early parental death, marital and family issues.
- **Specific Psychological Vulnerability**
- **Social and Environmental Issues:** Chronic anxiety tends to occur against a background of marital difficulties, unemployment, and lack of social support (Weich and Lewis, 1998).

3.2 Panic Disorder

Factors influencing the development of Panic Disorder include:

- **Genetic Predisposition**: Individuals with a close relative who has panic disorder are up to 8 times more likely to develop this disorder themselves (DSM-IV TR)
- **Precipitating Events**: Precipitating events have been reported in 60-96% of cases – these often centre on separation or loss such as death of a parent in childhood or separation from the mother (Ballenger, 2009).
- **Social Problems:** History of family conflict, and drug and alcohol abuse in the family.

4. Diagnosis

The presentation of Generalised Anxiety Disorder and Panic Disorder can vary considerably from individual to individual, and a diagnosis in some situations may only be considered once other medical conditions have been excluded (McIntosh, Cohen, Turnbull et al, 2004).

Diagnostic features have also been discussed in Section 1 'Overview and Definition of Condition' as both conditions feature diagnostic criteria within their definition.

4.1 Clinical Features

The clinical features of each condition are as below (McIntosh, Cohen, Turnbull et al, 2004; Medical Disability Guidelines, 2009, DSM- IV- TR, 2000):

GAD:

- Symptoms of anxiety, fear, avoidance, arousal
- Excessive worry and anxiety more days than not for a period of more than 6 months, with anxiety symptoms
- Difficulty in controlling worry
- At least 3 of the following symptoms: restlessness, becoming easily fatigued, difficulty with concentration, irritability, muscle tension, and disturbed sleep
- Not caused by other general medical or mental health conditions (e.g. alcohol or substance abuse) or if symptoms only occur during mood disorders or psychotic episodes.

Panic Disorder

- Symptoms of anxiety, fear, avoidance, arousal
- Recurrent and unexpected attacks, ***and*** a period of more than 1 month of concern about panic attacks (one or more of the following:
  - Worrying about implications of attack
  - Concern about future attacks
  - Change of behaviour with regard to attacks)
- At least 4 of the following symptoms: pounding heart or rapid heart rate, sweating, trembling or shaking, shortness of

breath or sensations of suffocating, feeling of choking, chest pain, nausea or abdominal distress, dizziness or faintness, feelings of unreality (derealisation) or being detached from oneself (depersonalisation), fear of losing control or going crazy, fear of dying, numbness or tingling sensations (paraesthesia), and chills or hot flashes.

- Not be caused by psychological effects of medication, other medical conditions, or better explained by other mental health conditions such as specific phobias or depression (DSM-IV-TR).
- Can be diagnosed with or without Agoraphobia (See Appendix A)

4.2 Physical Examination

A physical examination is appropriate should a diagnosis of GAD be suspected, in order to assess changes in behaviour and mood as well as neurological symptoms such as headaches, dizziness, disorientation, confusion, and syncope. Physical symptoms of anxiety disorders can include trembling, cold and sweaty hands, pale or flushed skin, an elevated heart rate, rapid breathing, and/or high blood pressure.

Any underlying medical conditions which may have precipitated generalised anxiety disorder should be detected.

However, a physical examination may be less necessary should a diagnosis of Panic Disorder be suspected, as panic disorders are unlikely to show physical symptoms except during an attack when a raised pulse rate and elevated blood pressure may be noted (Medical Disability Guidelines, 2009).

4.3 Investigations

The confirmation of Generalised Anxiety Disorder as a diagnosis does not normally require any routine investigations; however some individuals may require investigations to exclude underlying medical conditions.

Screening tools may be of use in the diagnosis of Generalised Anxiety Disorder (McIntosh, Cohen, Turnbull et al, 2004). Recent evidence indicates that the Generalised Anxiety Disorder Assessment (GAD -7) self-administered patient questionnaire was very effective at screening for Generalised Anxiety Disorder, and moderately effective in other anxiety disorders including Panic Disorder, Social Anxiety Disorder and Post Traumatic Stress Disorder (Spitzer, Kroenke and Williams, 2006; Kroenke et al, 2007).

5. Differential Diagnosis

Anxiety Disorder and Panic Disorder broadly share the same differential diagnoses (McIntosh, Cohen, Turnbull et al, 2004; Medical Disability Guidelines, 2009):

1. Cardiac conditions
    - Arrhythmias
    - Supraventricular tachycardia
2. Endocrine disorders
    - Hyperthyroidism / Thyrotoxicosis (most common cause of anxiety (Lader, 1994)
    - Hyperparathyroidism
    - Phaeochromocytoma
3. Vestibular dysfunctions
4. Seizure disorders
5. Other psychiatric conditions
    - Affective disorders
    - Adjustment disorders
    - Other anxiety disorders
        - Acute stress disorder
        - Obsessive compulsive disorder
        - Post-traumatic stress disorder
        - Social anxiety disorder
        - Specific phobia
    - Depressive disorders
    - Psychotic disorders
    - Substance abuse and dependence
        - Withdrawal from central nervous system depressants (e.g. Alcohol abuse (Present in 40% of panic disorder patients) or Barbiturates)
        - Stimulants: Cocaine, Amphetamines, Caffeine (Lader, 1994)
        - Cannabis
        - Hallucinogens
6. Other Medical Conditions
    - Asthma, Adult Respiratory Distress Syndrome
    - AIDS

6. Treatment

6.1 Treatment Options for Generalised Anxiety and Panic Disorders

For both Generalised Anxiety Disorders and Panic Disorders, there is evidence that psychological therapy, medication and self help are all effective interventions, with psychological therapy providing the longest duration of effect McIntosh, Cohen, Turnbull et al, 2004)

The choice of which intervention is appropriate for an individual may be determined by the availability of an intervention (for example cognitive behavioural therapy [CBT]), and the wishes and commitment of the individual concerned.

For Panic Disorder there is no evidence that either psychological therapies or medication interventions are more effective (McIntosh, Cohen, Turnbull et al, 2004).

For Generalised Anxiety Disorder there is no evidence to state which intervention is more effective with regard to duration of illness, severity of illness, age, sex, gender, or ethnicity (McIntosh, Cohen, Turnbull et al, 2004).

6.2 Psychological Therapies - Cognitive Behavioural Therapy

Psychological treatments aim to teach the skills needed to cope with the physical and cognitive aspects of anxiety. Evidence indicates that for both GAD and Panic Disorders, psychological therapies is more effective and longer lasting in terms of duration than medication interventions or self help (McIntosh, Cohen, Turnbull et al, 2004). However, such therapies depend on the motivation and commitment of the patient. National Institute of Clinical Excellence (2004) guidelines state that Cognitive Behavioural Therapy is the preferred psychological therapy for anxiety disorders. This type of therapy has the strongest empirical base (Medical Disability Guidelines, 2009), and for maximum effect, should be delivered by appropriately trained practitioners for an optimal period of 7-14 hours for Panic Disorders, and 16-20 hours for GAD delivered in weekly 1 to 2 hour sessions over a four month period (McIntosh, Cohen, Turnbull et al, 2004). Briefer sessions of CBT accompanied by self-help materials may also be appropriate.

Overall, with psychological treatments, about half of patients regain normal functioning (Lader, 1994).

6.3 Medication

When combined, drug and psychological treatments have a synergistic effect on the long-term outcome of anxiety disorders. Psychological treatments seem to be particularly effective at preventing relapse when drug treatment is eventually withdrawn. Randomised controlled trials found no significant difference in effect between antidepressants and benzodiazepines or buspirone.

6.3.1 Benzodiazepines

Benzodiazepines are highly effective in the "short-term relief of severe anxiety", but the potential benefits must be weighed up against the significant risk of developing adverse effects and dependence (Mitte et al, 2005).

Diazepam is the most widely used drug. Benzodiazepines should be prescribed in short (2 - 4 week), tapering courses, or used intermittently "as required." They are useful as a short-term adjunct to antidepressant therapy at the start of treatment for anxiety disorders. However, they are associated with several potential problems that may cause difficulties in their use:

- Tolerance and dependence are potential problems if benzodiazepines are prescribed for more than a few weeks.
- Abrupt withdrawal of a benzodiazepine causes withdrawal symptoms similar to the original condition including insomnia, anxiety, tremor, sweating, and tinnitus in up to 30% of cases. Withdrawal symptoms may start from a few hours to a few weeks after withdrawal, and in 10% can persist for months (Tyrer et al, 1990).
- Occasionally, patients experience "paradoxical effects" after taking benzodiazepines. These may range from talkativeness, excitement and increased anxiety, to hallucinations, hostility and aggression.
- Benzodiazepines cause drowsiness, impair judgement and decrease reaction times, so they may affect the performance of tasks such as driving or operating machinery, even after a dose on the day or night before. These effects are potentiated by alcohol.

6.3.2 Buspirone

Buspirone belongs to a new group of drugs called azapirones. It acts at serotonin (5-HT) receptors and is an effective treatment licensed for the short-term relief of anxiety. One drawback is that, unlike benzodiazepines, it can take up to 2 weeks for a response to begin. Buspirone can cause nausea and dizziness, but it has the advantage that there is a low risk of abuse and dependency and it does not potentiate the effects of alcohol (Chessick et al, 2007).

6.3.3 Beta-Blockers

Propranolol is an effective treatment for the physical symptoms of anxiety such as tremor and palpitations, and in turn, this may prevent the onset of psychological symptoms. Beta-blockers are not associated with dependency or abuse and so can be used for long-term treatment. Beta-blockers do not cause drowsiness, however fatigue is a side effect that may limit their use.

6.3.4 Antidepressants

Antidepressants can be effective in the treatment of anxiety, and some are specifically licensed for the treatment of panic disorder and phobias. Examples include the tricyclic clomipramine and the SSRI paroxetine. There is often a two-week delay before clinical improvement begins, and it often takes six weeks to

achieve optimum effect. The length of treatment depends on the patient's individual characteristics, but would typically last at least 6 months, followed by a gradual withdrawal over 3 months. Antidepressants are not addictive, but the tricyclics are associated with troublesome anticholinergic side effects and the SSRIs can initially worsen anxiety. These drugs all have the potential to impair the performance of skilled tasks, including driving (Rocca, 1997, Gorman, 1999).

6.3.5 Alternative Remedies

Patients frequently choose to self-medicate. Alcohol is often used, particularly as "Dutch Courage" in social anxiety disorder. Herbal and non-prescription remedies available over the counter are popular, although firm evidence of their safety and efficacy is often lacking. It is worth specifically asking patients about alcohol and non-prescription drugs when assessing their condition, motivation and treatment. Kava extract has been shown to be an effective treatment for anxiety symptoms, and adverse events are mild, transient and infrequent (Pittler, 2002).

6.4 Self Help

The following suggestions as to self help can be useful in the treatment of Generalised Anxiety Disorder and Panic Disorder (McIntosh, Cohen, Turnbull et al, 2004; NHS Institute for Innovation and Improvement, 2009)

- Offer bibliotherapy (for example self help books) based on CBT principles
- Offer information regarding support groups, including face-to-face meetings and telephone conference support groups
- Consider Large group CBT
- Discuss benefits of appropriate exercise regime
- There is evidence that CBT delivered via computer based technologies may be of benefit, however an NHS technology survey found that there was an insufficient evidence basis to generally recommend this technology for the treatment of Generalised Anxiety Disorder or Panic Disorder (National Institute of Clinical Excellence, 2006)

6.5 Address Social Problems

Social problems such as poverty, unemployment, poor housing and family break-up often contribute to anxiety. Patients find it helpful to talk about their problems, and referral to a social worker may help to resolve some of their difficulties (Goldberg, 1987).

7. Prognosis (Main Prognostic Factors)

7.1 Generalised Anxiety Disorder Prognosis (Main Prognostic Factors)

There is some debate as to the prognosis of GAD. Some studies note that recovery rates from GAD are poor – indicating that GAD is a chronic, disabling disease, whilst others show that around 50% of individuals experience periods of absence of symptoms (Bitran, et al, 2009) with 25% achieving a significant improvement in symptoms.

Co-morbidity with other mental health problems is common, and is associated with increased disability (Angst and Vollrath, 1991; Stein, 2001). 10% of patients with GAD become dependant on drugs or alcohol (Wilkinson 2000).

Anxiety can have significant effects on physical health. Patients with somatic symptoms tend to visit their GP frequently, and they may be referred to numerous hospital specialists. Anxiety is associated with higher rates of accidents and suicide, and there is increased mortality from natural causes, such as hypertension, peripheral vascular disease and coronary heart disease (Wilkinson, 2000). In one study, having GAD doubled the risk of developing cerebrovascular disease (Stein, 2001).

Other unfavourable prognostic features include:

- Coexisting Personality Disorder (Yonkers, 2000).
- Derealisation and Depersonalisation Katona (2000).
- Poor quality of relationships (Yonkers, 2000) or limited social interaction.
- Long duration of disabling anxiety (Wilkinson, 2000)
- Previous unsuccessful treatment.

GAD is a chronic condition. Spontaneous remissions are rare, and relapses are common.

About 40% of patients will experience full remission after 5 years (Yonkers, 2000).

Having achieved improvement, about 33% of patients will suffer a relapse in the next 3 years (Yonkers, 2000)**.**

7.2 Panic Disorder

Limited evidence is available with regard to the course of panic disorder; available evidence suggesting that Panic Disorder is a stable but chronic condition (Ballenger, 2009).

Whilst if left untreated, the majority of individuals symptoms do not improve with around 50% of individual's continuing to experience mild symptoms most of the time, if treated functional recovery will be achieved by the majority of people (Katschnig, 1996)

With treatment, up to half of patients with panic disorder may be symptom-free after 3 years.

Without treatment, affected individuals suffer significant impairment in their social functioning, are high users of medical resources, suffer premature mortality, and have a reduced quality of life (Pollack, 2000); Yonkers, 1998).

57% of sufferers are employed full-time, while 25% remain unemployed (Yonkers, 1998).

8. Information Gathering at the In Person Assessment

8.1 Assessing the Claimant

The assessment should be made using all the information available. This includes information from the claimant's file, informal observations, medical history, typical day, and examination. When it is available, information from family or carers accompanying the claimant may also be valuable.

To take account of the variability of anxiety symptoms, it is important to ask about the claimant's condition over time. Considering events in the last 2 years will give a representative impression, and avoid a misleading snapshot assessment.

Some claimants are distressed when they attend their assessment. It is vital to give them time to express their feelings, and to develop rapport by showing understanding and empathy. Although the claimant is upset when facing an assessment, they may actually function well on a typical day and this should be reflected in the report.

8.2 Mental Health Assessment

It is important to complete an appropriate mental health assessment. Claimants with anxiety related disabilities are sometimes difficult to assess. It is especially important to attempt to develop rapport in order to maximise the information that can be obtained at interview.

A detailed mental health history should be taken to include diagnosis, treatment, periods of hospitalisation etc. The loss of friends, social isolation, the avoidance of people and poor interpersonal skills are a cluster of features found in some claimants with anxiety related disability. These claimants function very poorly, and are highly disabled. Questions about social activities such as seeing their family, or activities that require interaction such as queuing in the supermarket or answering the door or the telephone may provide useful clues.

Informal observations can contribute to the overall assessment. For example, when calling a claimant from the waiting room, you may notice that they have been sitting away from other people or next to an open window. An anxious claimant may be sweating and have shaking hands. They may be hyper-alert, looking around the room, and constantly shifting in their chair. They may avoid eye contact, be tearful, and may have difficulty with their concentration and speech. Although these clues are helpful, they only represent a snapshot of the claimant's condition, and they should always be used in conjunction with the other available sources of information.

8.3 Questions for Assessing the Disabling Effects of Anxiety

- Does the claimant have another mental illness or a personality disorder? **The combined disabling effects of multiple illnesses are likely to be severe.** The assessment should focus on the most significant condition.

- Is the claimant abusing alcohol or drugs, and are they dependent on them? This is a relatively common scenario in our work as disability analysts, and is likely to increase their level of disability. (See the protocols about ***Alcohol Related Disability*** and ***Substance Use Disorders.***)

- What treatment have they received in the past, and is the claimant currently receiving treatment for their anxiety? Psychological and antidepressant treatments are effective in the majority of cases.

- Where is the claimant living? Do they have a home of their own, or are they living in a hostel, at home with their parents, or of no fixed abode? The lack of a safe home may indicate the claimant's life has disintegrated because of their anxiety.

- The claimant's employment history is often useful. It is significant if they have left a job because of anxiety.

- Does the claimant have a social life? If not, it suggests significant disability.

- How did the claimant travel to the examination centre? Routine unaccompanied travel on public transport suggests that they are functioning well.

- Who is accompanying the claimant? Those with severe anxiety often attend with their CPN, social worker or support worker. Those with mild or moderate problems often attend alone.

8.4 Assessment of Ability/Disability

***The key areas to address in ability/disability assessment medicine relate mainly to functional ability in relation to day to day and workplace activities*.**

The recommended approach to assessing an individual's functional ability is to ask them to describe their average day. Taking a history of a claimant's average day, from the moment they awake to how they sleep, will allow an evaluation of the nature and severity of their disability in relation to simple tasks in terms of comprehension, learning, concentration, memory and motivation. It will also provide an indication of any need for guidance, prompting or supervision. This information along with the other evidence obtained or provided will facilitate an overall assessment of disability in relation to the criteria for various scheme benefits. This analysis stage is covered further in chapter 9 of the protocol.

A number of areas are suggested under the four key headings below that should be explored during the assessment, where relevant, through open questioning and observation.

Completion of tasks

- Answering the phone
- Setting an alarm clock
- Operating domestic appliances
- Reading a magazine or watching TV
- Driving a car
- Hobbies and Interests
- Accidents in the home – hazard awareness.

Daily living

- Rising, washing, dressing
- Care over appearance/Self-Neglect
- Frequent mood fluctuation causing distress or panic
- Need for alcohol early in the day
- Sleep pattern.

Coping with Pressure and Change

- History of Work related stress
- Concerns that work may aggravate illness
- Symptoms of fear and panic
- Avoidance of stressful activities – going out, driving a car
- Effect of changes in routine

- Fatigue/Apathy or Disinterest – effect on activities.

Interaction with People

- Capability for self care
- Irritability/Disruption/Aggression
- Communicating with people
- Fear of going out alone
- Avoidance of the company of other people.

The period of review should range from 18 months in a younger person, to “in the longer term” for a claimant over 50 years old with significant disability:

9. Analysis of Effect on Functional Ability

Eligibility to DSP's various Illness-related schemes and the Activation Programme, is determined primarily by the degree of Ability/Disability and its expected duration.

The degree of Ability/Disability assessed, using the following Indicators, can be depicted on the Ability/Disability Profile illustrated below.

9.1 Indicators of Ability/Disability

Normal

- Claimant living independently
- Claimant enjoys contact with family and friends
- No loss of interests or hobbies
- Can travel unfamiliar routes unaccompanied on public transport

Mild

- Mild or intermittent anxiety symptoms
- May be receiving care from their GP or a counsellor
- Little or no restriction in Activities of Daily Living
- Specific phobias and trait anxiety
- Short-term "stress reactions"

Moderate

- Receiving drug treatment from GP
- Taking benzodiazepines most days for relief of anxiety symptoms
- Taking propranolol specifically for anxiety symptoms
- Taking antidepressant treatment or buspirone
- Referred to a Consultant Psychiatrist or the Community Mental Health Team
- May have another MH problem, such as depression or substance abuse

Severe

- Socially isolated with significant lifestyle restrictions
- Developing strategies for avoiding people or situations that cause anxiety
- Relying on family and friends to accompany them whilst shopping
- Only going out at times when there are unlikely to be many people about
- The claimant is likely to have requested a domiciliary assessment in preference to attending an unfamiliar examination centre
- N.B. CPNs routinely visit their patients at home, so this is not a reliable marker for severe disability

Profound

- Extremely limited social functioning
- GP or Psychiatrist may be visiting them at home
- Avoid almost all contact and never leave their homes

9.2 Ability/Disability Profile

Indicate the degree to which the claimant's condition has affected their ability in ALL of the following areas.					
	Normal	Mild	Moderate	Severe	Profound
Mental health/Behaviour	☐	☐	☐	☐	☐
Learning/Intelligence	☐	☐	☐	☐	☐
Consciousness/Seizures	☐	☐	☐	☐	☐
Balance/Co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs/Ladders	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

10. Summary of Scheme Criteria

Appendix A - Agoraphobia

A1: Definition of Agoraphobia

The term agoraphobia originates from the Greek 'agora' meaning market: - fear of the market place.

It now has a wider meaning and includes:

- Fear of open or public spaces.
- Fear of being far from home, family and friends.
- Fear of going to unfamiliar places alone.
- Fear of being in places or situations where escape may be difficult should a panic attack occur.

Symptoms of agoraphobia tend to emerge between the ages of late teens and mid 30s (Medical Disability Guidelines, 2009)

The most common diagnostic classification used for Anxiety Disorders is the American DSM-IV-TR (2000), however this does not classify Agoraphobia as a specific diagnosis, but one that only occurs in conjunction with Panic Disorder (Ballenger, 2009). Some authors suggest that should the agoraphobia occur in a limited context, such as only one specific situation then a diagnosis of Specific Phobia may be more appropriate (Kinrys and Pollack, 2004).

Patients suffer severe anxiety as a reaction to their fear, e.g. in anticipation of going out, particularly if they are unaccompanied. This may result in a restriction of activities such as going to the shops, being in crowded places, using public transport or travelling in lifts (claustrophobia).

Agoraphobics often feel worse the further they are away from home. Symptoms tend to escalate gradually over time. In the extreme the patient may become housebound, being unable even to open the front door or only able to go into the back (not front) garden.

In an effort to overcome agoraphobia, the patient may develop alcohol or drug dependency. Depression may result from the restriction in lifestyle and social isolation.

A2: Epidemiology of Agoraphobia

Agoraphobia occurs most commonly linked with Panic Disorders (see Section 2 – Epidemiology for incidence and prevalence linked with Panic Disorders). It is rare to occur as an isolated disease – with prevalence rates cited as being 0.05 – 1.5% (Grant et al, 2006).

A3: Aetiology

Agoraphobia can develop out of simple phobias, or can be the result of extreme trauma. It is most commonly linked with Panic Disorders.

Relatives of patients with agoraphobia have an increased risk of not only agoraphobia, but also other phobias. Other causes have been suggested as:

- Temperament
- Physiological reaction to illness – e.g. asthma in early childhood
- Social factors related to gender

A4: Treatment

The behavioural technique of exposure therapy is the most widely used long-term treatment however studies have also shown Cognitive Behaviour Therapy to be equally effective (Ost, Thulin and Ramnero,2004).

The SSRI and tricyclic antidepressants are also useful, because they can help to reduce anxiety symptoms so that the patient can begin behavioural therapy.

A5: Prognosis

Untreated, agoraphobia typically runs a chronic course.

Appendix B - Social Anxiety Disorder

Diagnostic classification systems now view social anxiety disorder (social phobia) as a distinct disorder from other specific phobias. Most people admit to social discomfort while under public scrutiny, but social anxiety disorder is an excessive fear that a performance or social interaction will be inadequate, embarrassing or humiliating.

B1: Definition of Social Anxiety Disorder

Anxiety is provoked by situations in which the person is 'on display.' Examples include: speaking to an audience, eating or writing in public (signing documents or cheques), going to the cinema or the pub, or using a public toilet. The problem may be discrete and limited to specific social situations, or more generalised, such as small social groups or speaking to strangers. Social anxiety disorder may also result from a fear of being criticised, or being asked questions.

Sufferers of social anxiety disorder may develop strategies to avoid their difficulties and so prevent social withdrawal; for example, someone may claim not to drink tea or coffee when at meetings or 'forget' reading glasses in order to avoid signing documents under the scrutiny of others.

The patient has insight that their fear is excessive and unreasonable.

The onset of social anxiety disorder may follow a specific stressful or humiliating experience such as a poor social or academic performance, or it may be insidious.

Alcohol abuse is common, as 'Dutch Courage' is often taken in an effort to control the anxiety.

Symptoms of social anxiety disorder commonly start during the teenage years, although individuals may state that they have had this condition for many years. Many individuals do not seek treatment, or delay seeking treatment for many years (Blackmore et al, 2009)

During an assessment**,** individuals who have social anxiety disorder may appear relaxed. Physical symptoms (blushing, inability to speak, shaking or vomiting) may only become apparent when they are placed in the stressful social situation.

The impact of the phobia depends on the job and the lifestyle of the individual.

B2: Epidemiology

As stated above, many individuals who suffer from social anxiety disorder do not seek treatment, and as such the condition is probably underreported. Kessler et al, (2005) found in studies in the US that Social Anxiety Disorder had the following incidence rates:

- 12 month prevalence rate for social anxiety disorder 6.8%

- Lifetime prevalence rate for social anxiety disorder 12.1%

Social Anxiety Disorder is the fourth most common psychiatric disorder behind major depression, according to the National Comorbidity Survey Replication in the US (Blackmore et al, 2009).

In the UK, NHS Direct cites the prevalence rates as being 1-2% of individuals, and as common in women as men (NHS Institute for Innovation and Improvement, 2009)

Clinical studies indicate that individuals with anxiety disorder have a 10% to 20% chance of developing social phobia (DSM-IV-TR)

Individuals are likely to be single or divorced, have few friends and miss work due to the condition (Blackmore et al, 2009)

B3: Aetiology

Several factors may contribute to the emergence of social anxiety disorder:

- Genetic Predisposition: Family and twin studies show a genetic component to the development of social phobia
- Neurobiological factors (for example, studies have shown increased activity in the regions of the brain associated with fear and anxiety when an individual performs tasks associated with anxiety (Stein et al, 2002), impairment of serotonin or dopamine systems (Blackmore et al, 2009).)
- Parental influences and significant life events (e.g. death of a parent)
- Stressful social situations in early life (e.g. being bullied

B4: Treatment

There are a number of treatment approaches:

- Cognitive Behaviour interventions
- Exposure therapy (possibly with cognitive restructuring)
- Cognitive behavioural group therapy
- Individual cognitive behavioural therapy
- Pharmacotherapy (possibly with cognitive behavioural interventions): The SSRIs and moclobemide are the drugs of choice. Beta-blockers can be helpful when the physical symptoms of anxiety are prominent. Exposure therapy and cognitive behaviour therapy complement the drug treatments (Liebowitz, 1999).

B5: Prognosis (Main Prognostic Factors)

With treatment there is a substantial improvement rate with respect to social anxiety disorder, with some studies reporting an 80% improvement rate after CBT (Blackmore, 2009).

Appendix C - Specific (Isolated) Phobias

A specific phobia is the excessive or unreasonable persistent inappropriate fear of a specific object or situation. Common examples include spiders, blood etc. In some individuals this can cause significant effects to daily living as the individual attempts to avoid the source of the fear, other individuals cope effectively by simply avoiding exposure to the source of their fear (Blackmore, 2009)

The degree of avoidance is a useful measure of severity.

C1: Definition of Specific (Isolated) Phobias

DSM-IV-TR is the most commonly accepted diagnostic classification of mental disorders, and this states that specific phobias arise from the presence or the anticipation of a specific object or situation which results in both acute autonomic and psychological symptoms of anxiety.

The ICD-10 diagnostic classification is similar; however this omits the anticipation of the cause of fear.

Some causes of phobia include:

Animals	Dogs, Mice, Spiders and Snakes. (Animals are the commonest cause.)
Natural Environment	Heights, Water and Storms.
Medical	Blood, Injections and Injury. (May provoke a vasovagal response.)
Situational	Driving, Flying, Using Tunnels, Lifts and Bridges.
Other	Dental, choking, inanimate objects

Most phobias start in childhood, but situational phobias have a second peak of onset in the mid 20s.

The degree of disability depends on the ease with which the phobic object can be avoided.

A claimant with a specific phobia undergoing behaviour therapy is likely to make a good recovery over 6 to 12 months

In general, specific phobias are less handicapping than other types of phobias.

C2: Epidemiology

Kessler et al, (2005) reported the following prevalence statistics for the US:

- 12 month prevalence ate 8.7% for specific phobias
- Lifetime prevalence rate of 12.5% for specific phobias.

Specific phobias are more common in women than men, and more common in individuals who have family members with a specific phobia (Medical Disability Guidelines, 2009)

C3: Aetiology

There is strong evidential support for a familial link in the development of specific phobias (Blackmore, 2009).

C4: Treatment

Medication therapy has been shown in trials to be less effective than behavioural treatments, with exposure therapy and CBT thought to be of far greater effect (Blackmore, 2009)

Other treatments which have been suggested include relaxation techniques and cognitive restructuring.

C5: Prognosis

If a phobia persists into adult life, then it usually follows a chronic course – only one fifth of childhood phobias resolve in later life (Medical Disability Guidelines, 2009).

Exposure treatment can achieve long-term cure in about half of patients with specific phobias (Park et al, 2001).

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