Medical Services

ANXIETY

1. Introduction

Anxiety is a normal phenomenon that occurs in response to stress, and at optimal levels, it can be beneficial:

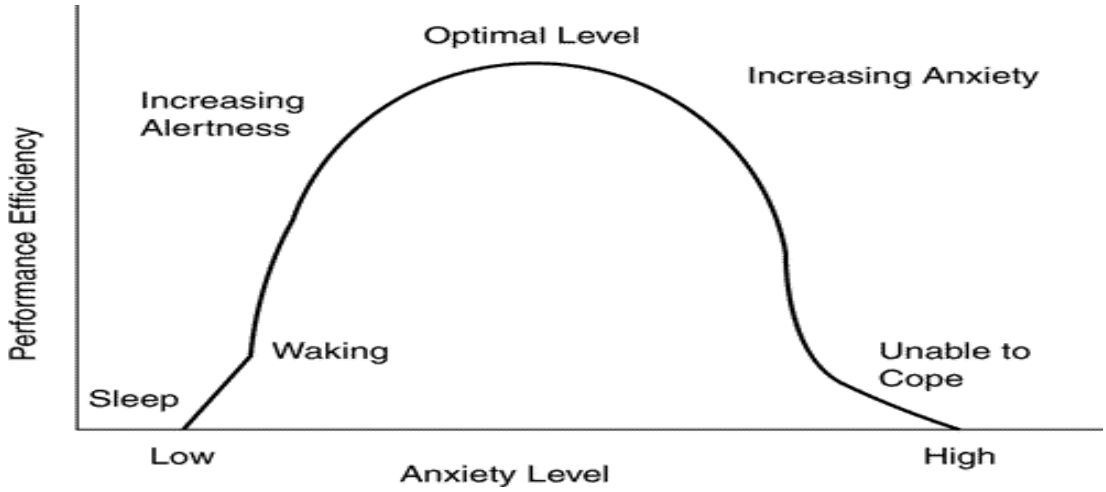

Figure 1 Yerkes Dodson Curve

Pathological anxiety is an unpleasant emotional state characterised by fearfulness and distressing physical symptoms. It is disproportionate to the severity of the stress, continues after the stressor has gone, or occurs in the absence of any external stressor.

Anxiety occurs when an individual believes that the demands of the situation are greater than their ability to cope with it. The bodily (somatic) effects seen in anxiety are caused by activation of the autonomic nervous system, resulting in release of adrenaline: “the fight or flight reaction.”

Pathological anxiety can present in a variety of forms:

- Discrete attacks with no external stimulus (panic disorder)
- Discrete attacks with a specific stimulus (phobias)
- A generalised persistent state (generalised anxiety disorder)

Anxiety can also occur as part of other disorders and medical conditions, such as depression or alcohol dependency. These, together with obsessive-compulsive disorder, post-traumatic disorder and adjustment disorder, are addressed in separate protocols.

2. Generalised Anxiety Disorder (GAD)

2.1 Clinical Features of Anxiety

GAD is generalised, excessive anxiety, persistent for more than 6 months.

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 usually develops in early adult life between the ages of 15 and 25. When anxiety begins after the age of 35, it is usually a consequence of another psychiatric disorder, for example, depression.[1]

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 a real diagnostic possibility, based on positive findings from the history and examination.

2.2 Epidemiology

16% of the general population suffer from some form of pathological anxiety.[2]

3-5% of the adult population suffers from generalised anxiety disorder at any time.[1 2]

The lifetime prevalence is 7%.[3]

Women are affected twice as often as men.[1]

Generalised anxiety disorder accounts for 30% of psychiatric consultations in General Practice.[2]

26% of patients consulting their GP with a new illness present with somatic (physical) symptoms of emotional disorder.[4]

2.3 Aetiology

Genetic Predisposition	Twin studies have shown 41% and 4% prevalence in monozygotic twins and dizygotic twins respectively, and a gene has recently been identified that appears to have a major role in the development of anxiety disorders.[5 6]
Childhood Traumas	Separation and demands for high achievement.[2]
Stress	Anxiety can be triggered and maintained by stressful life events, especially if associated with the fear of loss.[7]
Premorbid Personality	An anxious (avoidant) personality increases the risk of developing generalised anxiety disorder.[7]
Social Problems	Chronic anxiety tends to occur against a background of marital difficulties, unemployment, and lack of social support.[8]

2.4 Differential Diagnosis

- Anxiety secondary to another psychiatric disorder, such as depression or dementia.[9]
- Drug and alcohol withdrawal syndromes.[9]
- Excessive caffeine intake.[9]
- Ictal anxiety due to temporal lobe epilepsy.
- Endocrine disorders. Thyrotoxicosis is the commonest physical cause of anxiety.
  Hypoglycaemia, parathyroid disease, phaeochromocytoma and carcinoid disease are rarities.[9]
- Asthma, cardiac arrhythmias and angina.

2.5 Treatment

Explanation, reassurance and supportive counselling are sufficient for most patients, particularly if the cause of their anxiety is clear-cut. Antidepressants, relaxation and cognitive therapies offer long-term benefits for more severe, complex or chronic cases.[9]

2.6 Prognosis

Co-morbidity with other mental health problems is common, and is associated with increased disability.[7] [10] 10% of patients with GAD become dependant on drugs or alcohol.[5]

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.[5] 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.[5] In one study, having GAD doubled the risk of developing cerebrovascular disease.[11]

Other unfavourable prognostic features include:

- Personality Disorder.[12]
- Derealisation and Depersonalisation.[13]
- Poor quality of relationships.[12]
- Long duration of illness.[5]

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

About 40% of patients will experience full remission after 5 years.[12]

Having achieved improvement, about 33% of patients will suffer a relapse in the next 3 years.[12]

3. Panic Disorder (episodic, paroxysmal anxiety)

The term 'panic' derives from 'Pan', the dwarf-like god of Ancient Greek mythology; who would hide in his cave, only to jump out screaming at unsuspecting travellers. Their reaction to being "scared to death" was called "Pan-ic."

3.1 Clinical Features of Panic Disorder

Panic disorder is recurrent, acute, **unprovoked**, periods of intense fear (panic attacks).

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

Other symptoms include:

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

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

After a panic attack, the patient may develop a fear or phobia of the situation where the attack happened.[14] 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.[2 7]

3.2 Epidemiology

Panic disorder occurs in 1 or 2% of the general population.[1 2]

The lifetime prevalence is about 3%.[2 5]

Panic attacks are three times more common amongst women.[1 3]

Psychiatric co-morbidity is common:[5 14]

- Panic attacks + history of depression – 50%
- Panic attacks + history of social phobia – 25%
- Panic attacks + history of obsessional compulsive disorder – 25%
- Panic attacks + history of anxiety problems – 20%

3.3 Aetiology

Genetic Predisposition	First-degree relatives have a 4-7 times greater risk of developing panic disorder than the general population.[2]
Emotional Factors	Death of a parent in childhood or separation from the mother.[1]
Social Problems	History of family conflict, and drug and alcohol abuse in the family.[5]

3.4 Differential Diagnosis

Panic disorder shares the same differential diagnoses as generalised anxiety disorder.

3.5 Treatment

SSRI antidepressants are now the first-line treatment for panic disorder. Benzodiazepines have a complementary role in the first few weeks of treatment.[14] The drug treatments can provide a window of opportunity for effective treatment with relaxation, exposure or cognitive behaviour treatments.[2 15]

3.6 Prognosis

The early onset of panic disorder and the development of phobic avoidance predict a poor prognosis. The course is usually chronic, with remissions and relapses.[16]

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

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.[14 17] 57% of sufferers are employed full-time, while 25% remain unemployed.[17]

4. Agoraphobia

Excessive fear of a situation, which leads to avoidance of that situation, is called "phobia."

The degree of avoidance is a useful measure of severity.

4.1 Clinical Features

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 15 and 35.[2 3]

Agoraphobia is commonly associated with panic attacks.[5]

Patients suffer severe anxiety 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.[5]

4.2 Epidemiology

Agoraphobia occurs in about 1.5% of the general population.[5]

Agoraphobia accounts for 60% of the phobic patients who see a psychiatrist.[1 5]

Two thirds of sufferers are women.[1 2]

4.3 Aetiology

Genetic Predisposition	Relatives of patients with agoraphobia have an increased risk of not only agoraphobia, but also other phobias.[5]

4.4 Treatment

The behavioural technique of exposure therapy is the most effective long-term treatment.[2 5]

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

4.5 Prognosis

Untreated, agoraphobia typically runs a chronic course.

20% of patients with agoraphobia eventually achieve spontaneous remission.[5]

90% of patients with agoraphobia will experience significant improvement with treatment.[18]

5. Social Phobia

Most people admit to social discomfort while under public scrutiny, but social phobia is an excessive fear that a performance or social interaction will be inadequate, embarrassing or humiliating.

5.1 Clinical Features

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 phobia may also result from a fear of being criticised, or being asked questions.

Sufferers of social phobias 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 phobia 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 phobia may start in adolescence or even in childhood, though usually it begins between the ages of 20 and 35.[2]

During an assessment**,** social phobics 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.

5.2 Epidemiology

Social phobia occurs in at least 3-4% of the general population, and it is probably under-reported.[1]

The lifetime prevalence is about 5%.[2]

8% of phobic patients seen by a psychiatrist have a social phobia.[13]

Co-morbidity is common: 80% of people with social phobia have another psychiatric diagnosis:[19]

- Social phobia + anxiety disorder – 50%.
- Social phobia + depression – 20%.
- Social phobia + alcohol abuse – 15%.

5.3 Aetiology

Genetic Predisposition	Family and twin studies show a genetic component to the development of social phobia.[1 19]
Emotional Factors	Death of a parent in childhood or separation from the mother.[1]

5.4 Treatment

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.[2 20]

5.5 Prognosis

The condition is life-long and unremitting if untreated, and there is a substantial rate of relapse even after prolonged treatment.[20]

About a third of patients will enjoy a complete remission during long-term follow-up.[21]

6. Specific (isolated) Phobias

A specific phobia is the persistent inappropriate fear of a specific object or situation.

The degree of avoidance is a useful measure of severity.

6.1 Clinical Features

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.)
Travel	Driving, Flying, Using Tunnels, Lifts and Bridges.

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.

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

6.2 Epidemiology

10% of the population have a specific phobia.[1]

17% of phobic patients seeing a psychiatrist have a specific phobia.[13]

Women outnumber men for animal phobias, otherwise the incidence for men and women is equal.[5]

6.3 Aetiology

There is a biological predisposition. Specific phobias tend to 'run in families'.[2]

6.4 Treatment

Behaviour therapy is the most effective treatment. Drugs are of little use.[2]

6.5 Prognosis

If a phobia persists into adult life, then it usually follows a chronic course.[2]

Exposure treatment can achieve long-term cure in about half of patients with specific phobias.[15]

7. Treatment Options for Anxiety Disorders

The different anxiety disorders have different optimal treatments, so a precise diagnosis is important.

7.1 Psychological Treatments

Psychological treatments aim to teach the skills needed to cope with the physical and cognitive aspects of anxiety. They are at least as effective as drug treatments, and have fewer drawbacks, but they are not as readily available because they rely on the provision of specially trained therapists, and are time consuming.[2] They also depend on the motivation and commitment of the patient. Moderate or severe anxiety problems typically require 16 treatment sessions for symptomatic relief, and even more for lasting change.[22] Exceptions include simple phobias and panic disorder, which may respond to brief therapy.[22] **Overall, with psychological treatments, about half of patients regain normal functioning.[9]**

7.1.1 Reassurance and Advice

The process of clinical assessment itself can be therapeutic, especially if techniques such as empathy and active listening are used so that the patient is able to air their worries and receive reassurance about any irrational fears. It is helpful to explain that the symptoms of anxiety are part of a familiar syndrome, and in particular that the physical symptoms do not indicate serious disease.

7.1.2 Anxiety Management Training

Anxiety management training aims to help patients to cope more effectively with anxiety symptoms. A key part of the course is training in relaxation techniques: sit down, breathe slowly and try to relax while the symptoms gradually fade away. This skill should be practised so that it can be used even in situations that cause anxiety.[23] Other topics might include: how to identify anxiety-provoking thoughts and situations, how to generate self-reassuring thoughts, how to distract oneself from anxiety-provoking thoughts, and how to replace anxiety-provoking thoughts with coping strategies.[5]

7.1.3 Behaviour Therapy

In graded exposure therapy, a hierarchy of anxiety-provoking stimuli is agreed, and then these are presented to the patient in turn, (in their imagination or reality), starting with the most innocuous. The patient is encouraged to persist until their anxiety symptoms subside. The process usually takes months to complete.[15] In flooding, the patient is confronted by their worst fear. This is very challenging, but it can give good results very rapidly.[24]

7.1.4 Cognitive Behaviour Therapy

Cognitive behaviour therapy aims to teach the necessary skills for identifying anxiety-provoking thoughts. The thoughts can then be analysed to check whether they are realistic, and if not, they can be corrected before they cause distress. Cognitive therapy also aims to identify and modify the dysfunctional beliefs that often underlie anxious thinking.[23 25] This treatment is useful for all the forms of anxiety related disorder covered in this protocol.[22]

7.1.5 Self Help Support Groups

Self-help support groups exist to provide support from others who have suffered similar experiences. They are valuable in maintaining long-term improvements in anxiety symptoms.[24]

7.1.6 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.[24]

7.2 Drugs[26]

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.[5]

7.2.1 Benzodiazepines[9 27]

Benzodiazepines are highly effective in the “short-term relief of severe anxiety.” 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 30% of cases.[2] Withdrawal symptoms may start from a few hours to a few weeks after withdrawal, and in 10% can persist for months.[2 28]
- 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 increase 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.

7.2.2 Buspirone

Buspirone acts at serotonin (5-HT) receptors, and is an effective treatment licensed for the short-term relief of anxiety. A drawback is that buspirone takes up to 2 weeks for a response to begin. It can impair the performance of skilled tasks, but it has the advantage that there is a low risk of abuse and dependency.[9 26 29]

7.2.3 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.

7.2.4 Antidepressants[27]

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.[26 30 31]

7.2.5 Alternative Remedies

Patients frequently choose to self-medicate. Alcohol is often used, particularly as "Dutch Courage" in social phobia. 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.[32]

8. Main Disabling Effects

It is important to distinguish common anxiety conditions that have no long-term disabling effects from those that cause persistent disability. "Trait anxiety" (a lifelong personality characteristic) and "stress reactions" (a self-limiting effect of life events) do not cause significant long-term disability.

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.

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 be used in conjunction with the other available sources of information.

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.

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.

8.2 Helpful 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.

8.2.1 Mild Anxiety Related Disability

Claimants who are suffering from mild anxiety disorder will have some mild or intermittent symptoms, and may be receiving care from their GP or a counsellor. Their typical day history will reveal little or no restriction in their Activities of Daily Living. They should be able to live independently, enjoy some contact with friends or family, and continue with their usual interests and hobbies.

8.2.2 Moderate Anxiety Related Disability

Claimants who have chronic moderate anxiety or frequent episodes of severe anxiety are likely to be receiving drug treatment from their GP, and may have been referred to a Consultant Psychiatrist or the Community Mental Health Team. They may have another mental health problem, such as depression or substance abuse. Their typical day history will reveal some significant restrictions in their lifestyle. They may have become socially isolated, and developed strategies for avoiding people or situations that cause them anxiety. For example, they may rely on family and friends to accompany them while they do their shopping or take their children to school, or they may only go out at times when there are unlikely to be many people about.

8.2.3 Severe Anxiety Related Disability

Claimants with severe and chronic anxiety symptoms are extremely limited in their social function. They avoid almost all contact and never leave their homes. Their GP or Psychiatrist may be visiting them at home. (**NB** CPNs routinely visit their patients at home, so this is not a reliable marker for severe disability.) The claimant is likely to have requested a domiciliary assessment in preference to attending an unfamiliar examination centre.

8.3 How to Assess Prognosis

- A claimant with a specific phobia undergoing behaviour therapy is likely to make a good recovery over 6 to 12 months.
- Cognitive behaviour therapy is an effective treatment for most anxiety disorders. Typically, 50% of patients achieve a full recovery, and 25% achieve significant improvement. Claimants beginning treatment should be reviewed after 12 months, or sooner if they have already started their therapy.
- Several factors predict a chronic prognosis. 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:

  a) Co-morbidity with another mental illness.

  b) Co-existing personality disorder.

  c) Previous unsuccessful treatment.

  d) Long history of disabling anxiety.

  e) Very limited social interaction.

8.4 IB-PCA Considerations

Occasionally claimants request an assessment in their home because they feel too anxious to attend the examination centre. During a domiciliary assessment, the claimant may feel "safe," and may not exhibit signs of anxiety. Despite this, the claimant's lifestyle may reveal major functional limitations.

8.4.1 Exemption from the IB-PCA:

- If marked mental symptoms and signs relating to anxiety are found, consider exemption under the category severe mental illness*: "the presence of mental disease which severely and adversely affects a person's mood or behaviour and which severely restricts his social functioning or his awareness of his immediate environment."*
- In general, the review period of a claimant's exemption will depend on their history and whether they are receiving treatment. Claimants with several years of intractable anxiety should be reviewed after no less than 18 months, but those with acute problems should be reviewed after 6 months. Claimants beginning a course of psychological treatment should be reviewed after 12 months.

If sufficient medical evidence is available, claimants with severely disabling anxiety may be exempted or accepted at the scrutiny stage.

Those claimants who remain in great distress during an examination should be considered for a brief period of exemption.

9. References

1. Puri B. *Textbook of Psychiatry*: Churchill Livingstone, 1996.
2. *ABC of Mental Health*: BMJ Books, 1998.
3. Bloye S. *Crash Course Psychiatry*: Mosby, 1999.
4. Bass C, Murphy M. Somatisation, somatoform disorders and factitious illness. In: Guthrie E, Creed F, editors. *Seminars in Liason Psychiatry*. London: Royal College of Psychiatrists, 1996:103-156.
5. Wilkinson G, Moore B, Moore P. *Treating People with Anxiety and Stress: a practical guide for primary care.* : Radcliffe, 2000.
6. Gratacos M, Nadal M, Martin-Santos R, Pujana M, Gago J, Peral B. A polymorphic genomic duplication on human chromosome 15 is a susceptibility factor for panic and phobic disorders. *Cell* 2001;106:367-79.
7. Angst J, Vollrath M. The natural history of anxiety disorders. *Acta Psychiatrica Scandinavica* 1991;84:446-52.
8. Weich S, Lewis G. Poverty, unemployment, and common mental disorders: population based cohort study. *British Medical Journal* 1998;317:115-9.
9. Lader M. Treatment of anxiety. *British Medical Journal* 1994;309:321-4.
10. Stein D. Comorbidity in generalized anxiety disorder: impact and implications. *Journal of Clinical Psychiatry* 2001;62(Suppl 11):29-34.
11. Bowen R, Senthilselvan A, Barale A. Physical illness as an outcome of chronic anxiety disorders. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie* 2000;45:459-64.
12. Yonkers K, Dyck I, Warshaw M, Keller M. Factors predicting the clinical course of generalised anxiety disorder. *British Journal of Psychiatry* 2000;176:544-9.
13. Katona C, Robertson M. *Psychiatry at a Glance*, 2000.
14. Pollack M, Marzol P. Panic: course, complications and treatment of panic disorder. *Journal of Psychopharmacology* 2000;14:S25-S30.
15. Park J, Mataix-Cols D, Marks I, Ngamthipwatthana T, Marks M, Araya R. Two-year follow-up after a randomised controlled trial of self- and clinician-accompanied exposure for phobia/panic disorders. *British Journal of Psychiatry* 2001;178:543-8.
16. Yonkers K, Zlotnick C, Allsworth J, Warshaw M, Shea T, Keller M. Is the course of panic disorder the same in women and men? . *American Journal of Psychiatry* 1998;155:596-602.
17. Ettigi P, Meyerhoff A, Chirban J, Jacobs R, Wilson R. The quality of life and employment in panic disorder. *Journal of Nervous & Mental Disease* 1997;185:368-72
18. Agoraphobia: www.ehendrick.org/healthy/00036490.htm 1999.
19. den Boer J. Social phobia: epidemiology, recognition, and treatment. *British Medical Journal* 1997;315:796-800.

20. Liebowitz M. Update on the diagnosis and treatment of social anxiety disorder. *Journal of Clinical Psychiatry* 1999;60 (Suppl 18):22-6.

21. Yonkers K, Dyck I, Keller M. An eight-year longitudinal comparison of clinical course and characteristics of social phobia among men and women. *Psychiatric Services* 2001;52:637-43.

22. Anonymous. Treatment Choice in Psychological Therapies and Counselling 2001.

23. Wells A. *Cognitive therapy of anxiety disorders: a practice manual and conceptual guide.*: Wiley, 1997.

24. Goldberg D, Benjamin S, Creed F. *Psychiatry in Medical Practice*: Routledge, 1987.

25. Borkovec T, Costello E. Efficacy of applied relaxation and cognitive-behavioral therapy in the treatment of generalized anxiety disorder. *Journal of Consulting & Clinical Psychology* 1993;61:611-9.

26. Anonymous. *British National Formulary*: British Medical Association and Royal Pharmaceutical Society of Great Britain, 2001.

27. Gale C, Oakley-Browne M. Anxiety disorder. *British Medical Journal* 2000;321:1204-7.

28. Busto U, Sellers E, Naranjo C, Cappell H, Sanchez-Craig M, Sykora K. Withdrawal reaction after long-term therapeutic use of benzodiazepines. *New England Journal of Medicine* 1986;315:854-9.

29. Sramek J, Tansman M, Suri A, Hornig-Rohan M, Amsterdam J, Stahl S. Efficacy of buspirone in generalized anxiety disorder with coexisting mild depressive symptoms. *Journal of Clinical Psychiatry* 1996;57:287-91.

30. Rocca P, Fonzo V, Scotta M, Zanalda E, Ravizza L. Paroxetine efficacy in the treatment of generalized anxiety disorder. *Acta Psychiatrica Scandinavica* 1997;95:444-50.

31. Gorman J, Kent J. SSRIs and SMRIs: broad spectrum of efficacy beyond major depression. *Journal of Clinical Psychiatry* 1999;60(Suppl 4):3-8.

32. Pittler M, Ernst E. Kava extract for treating anxiety: Cochrane Database of Systematic Reviews, 2002