Importance of Establishing the Diagnosis of Persistent Anxiety

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Anxiety disorders, which include generalized anxiety disorder, panic disorder, posttraumatic stress disorder, obsessive-compulsive disorder, and phobic disorders, are the psychiatric disorders most commonly found in the community, according to the results of recent epidemiologic studies. However, failure to diagnose these disorders occurs in up to 50% of patients with an anxiety disorder. This failure to correctly diagnose and appropriately treat anxiety disorders can result in overutilization of health care services and increased morbidity and mortality rates from either the anxiety disorder or comorbid medical conditions. Reliable diagnostic tools to improve the early recognition of anxiety disorders can subsequently result in more effective treatment.

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Recent epidemiologic studies show that anxiety disorders are the most common psychiatric disorders in the community.[1,2] The results from the National Comorbidity Study indicate 24.9% lifetime and 17.2% 12-month prevalence rates for any anxiety disorder.[2] The anxiety disorders include generalized anxiety disorder, panic disorder, posttraumatic stress disorder, obsessive-compulsive disorder, and phobic disorders. Despite the fact that 27% to 48% of patients in a primary care setting have a diagnosable psychiatric disorder, studies suggest that failure to diagnose these disorders occurs in up to 50% of these patients.[3–9] Failure to appropriately diagnose and treat anxiety disorders can result in significant negative outcomes such as overutilization of health care services and increased morbidity and mortality rates for either the anxiety disorder or other comorbid medical conditions. Early recognition of anxiety disorders by utilizing reliable diagnostic approaches can subsequently lead toward using effective treatments that correlate positively with outcome to treat these disorders.

Several studies have systematically studied the prevalence of anxiety disorders in primary care populations. Fifer et al.[10] found that 33% of patients met screen criteria for an anxiety disorder in a group of 6307 outpatients who were systematically screened for psychiatric disorders. Fifty-six percent of these screen-positive patients had reported no previous recognition and treatment of their disorder. An analysis of a group of 647 screen-positive patients found that 52% met criteria for one or more anxiety disorder, and 28% met criteria for multiple diagnoses, including high rates of comorbid anxiety and depression. Patients with anxiety symptoms had significant impairment in psychosocial functioning, even if they did not meet full DSM-III criteria for a specific disorder. Shear and Schulberg[11] systematically assessed 330 patients at four primary care sites by utilizing the Primary Care Evaluation of Mental Disorders (PRIME-MD) and found prevalence rates of 11% for panic disorder and 10% for generalized anxiety disorder. Similar to the patients in the Fifer et al. study,[10] these patients had high rates of other comorbid anxiety disorders and depression, as well as significant psychosocial impairment.

Despite the fact that anxiety disorders are prevalent in primary care settings, these disorders are often erroneously approached as "diagnoses of exclusion," which can result in unnecessary medical workups and delay of symptom improvement, even when anxiety disorders exist concomitantly with another medical disorder. Clancy and Noyes[12] reported on 71 patients with "anxiety neurosis" who were referred for psychiatric consultation after medical workup showed no "physical reason" for their symptoms. Prior to their referral and appropriate diagnosis, 20 categories of tests were performed, 358 tests and procedures were performed (an average of five per patient), and 135 specialty referrals made (an average of two per patient) often to neurology, cardiology, and gastroenterology.

Several patient- and/or clinician-related obstacles contribute to the inadequate diagnosis of anxiety disorders in primary care. Patient-related obstacles to accurate diagnosis include frequent unwillingness of patients to disclose anxiety symptoms and/or to accept having a psychiatric

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illness. Patients often feel they may be stigmatized if they report such symptoms and often erroneously attribute anxiety and depression to being a "weakness of character" or a "normal reaction" to life events, including coping with other medical conditions. Additionally, patients may fear that their primary care physician will perceive them as not having a "real medical problem" and that the physician will subsequently refer the patient for psychiatric treatment, leaving the patient feeling abandoned or misunderstood. The primary care physician needs to be alert for such resistance and appropriately convey the message to the patient that anxiety and depression are common, treatable medical conditions.

Several clinician-related obstacles may also contribute to inadequate diagnosis and subsequent treatment of anxiety disorders. Clinicians may erroneously perceive patients with anxiety as "time-consuming," minimize the potential negative impact of these symptoms, or not know what to do once the diagnosis is made. The diagnosis of anxiety disorders—similar to the diagnosis of other medical disorders—can be approached in a systematic way and results in appropriate interventions that actually save time for the clinician and simplify the diagnosis and management of patients who otherwise appear to be more complicated.

Even when the clinician is well informed of the diagnostic criteria for the various anxiety disorders, the diagnosis can be complicated when the patient presents with "subsyndromal" symptoms, with comorbid disorders including substance abuse, or with somatic symptoms with or without other comorbid medical illness. Major depression is among the most common comorbid disorders associated with all of the anxiety disorders. The comorbidity of anxiety and depression can clinically present in a variety of ways, including subsyndromal features of either or both disorders. Subsyndromal anxiety and/or depression is extremely common in the primary care setting and is often associated with as much, and sometimes more, psychosocial impairment and distress than an anxiety disorder meeting full syndromal criteria.[10] In the appendix of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV),[13] and the text of the tenth edition of the *International Classification of Disease* (ICD-10),[14] a newly defined syndrome called mixed anxiety-depression is characterized by subsyndromal depressive and anxiety symptoms that are present for at least 1 month. The prevalence of mixed anxiety-depression in primary care settings has been reported to be 6.6%.[15] In the Fifer et al. study,[10] 26% of the screen-positive group had anxiety and depressive symptoms that failed to meet full syndromal criteria, yet reported levels of distress and impairment greater than anxiety disorders.

One of the greatest challenges of making an accurate diagnosis of anxiety disorders in primary care is separating the somatic symptoms from other potential medical conditions. Thirty percent to 60% of patients in primary care have somatic symptoms lacking an underlying nonpsychiatric medical illness.[16] Van Hemert et al.[17] assessed 191 newly referred patients in a general medical practice, who presented with somatic complaints unexplained by another medical illness, and reported that 38% had a psychiatric disorder (mostly anxiety [12%] and depression [19%]), and 15% had a psychiatric disorder even when the somatic symptoms could be explained by another medical illness. Common somatic symptoms of anxiety include fatigue, headaches, musculoskeletal pain, gastrointestinal symptoms, dizziness, chest pain, palpitations, breathlessness, and weight loss. Furthermore, anxiety disorders have high comorbidity rates with other medical disorders, including depression, irritable bowel syndrome, arthritis, cardiovascular disease, chronic medical illness, and acute medical illness.

The relationship between anxiety and comorbid medical illness was evaluated in the Harvard/Brown Anxiety Disorders Research Program (HARP), a long-term naturalistic follow-up project, which evaluated 711 patients with anxiety disorders.[18] The results of this study further confirm that anxiety may present with somatic symptoms in the absence of another diagnosable medical condition, anxiety states may be associated with an increased prevalence of other physical illness, and if left untreated, comorbidity can prolong or worsen the outcome of either illness. The clinician should avoid two potential pitfalls in approaching the patient who has anxiety symptoms accompanied by another medical disorder. First, do not falsely attribute the somatic symptoms of anxiety to the other medical condition, and, second, while it may be appropriate for the patient to be anxious about having a particular medical illness, it is not "normal" for the patient to have persistent symptoms of anxiety or depression associated with any acute, chronic, and even terminal illnesses. While it may be common to think that the medical illness can cause anxiety symptoms, studies suggest that anxiety may also provoke or maintain other medical disorders. Katon[19] found a 13.6% prevalence of hypertension in primary care patients diagnosed with panic attacks compared with 4.4% of controls without panic attacks. Appropriate diagnosis of and intervention into both anxiety and other comorbid medical disorders may prevent worsening the course of either disorder.

Improving the recognition of anxiety in primary care can be enhanced through utilizing specific diagnostic or interviewing skills and by routinely using diagnostic/screening instruments for anxiety and depression. Stuart and Lieberman, in their book, *The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician*,[20] propose an interviewing technique that can be used when assessing primary care patients for anxiety and depression. This system of inquiry is known as the BATHE technique; it asks about psychosocial issues in a sequential, logical, and brief approach, which enables the clinician to gather and record information in a typical medical model format.

An increasing number of psychiatric screening instruments are available for primary care physicians to aid in the screening and accurate diagnosis of anxiety disorders and depression. Systematized screening instruments can significantly improve the diagnoses of anxiety and depression. The routine screening and follow-up of anxiety disorders and depression should be a part of every patient visit in primary care, and the use of systematized screening and follow-up instruments can help establish such a practice. Advantages associated with the use of screening and follow-up instruments include assuring that anxiety and depressive symptoms are routinely assessed in a consistent and systematized manner. Additionally, they can be a time-saving method for the physician and ancillary staff to address issues that patients may not spontaneously report or the clinician fails to ask about (such as information about substance abuse) and can help decrease the misperceived dichotomy between anxiety/depression and other medical disorders.

Some of the commonly used instruments for the primary care physician to use to screen for anxiety and/or depression include the Zung Self-Rating Anxiety and Depression Scales, the Hamilton Rating Scales for Anxiety and Depression, the Beck Anxiety and Depression Inventories, the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC), and the Primary Care Evaluation of Mental Disorders (PRIME-MD). Despite the potential advantages associated with the use of these instruments, drawbacks to most of the currently available screening tools include lack of being user-friendly, lack of follow-up instruments for some screening tools, separation of psychiatric symptoms from a general review of systems, and minimal assessment of quality of life and psychosocial issues.

The Well-Being Life Chart (WBLC) is a recently developed screening instrument for psychiatric disorders in primary care settings to aid in the screening, diagnosis, and follow-up of anxiety, depression, and other medical disorders. The WBLC is a one-page (two-sided) patient-rated form that provides a succinct and comprehensive past and current history of medical illness, psychiatric disorders, substance use, and psychosocial and functional capacity, as well as a quality of life assessment. The retrospective version (Appendix 1) is designed to be used at baseline, and the identical prospective version is for follow-up. It includes a complete review of systems via a symptom checklist (122 items for men, 126 items for women), with psychiatric symptoms incorporated into the general review of systems. The clinician and/or ancillary staff can place a number of different templates over the symptom checklist that "shade over" a cluster of symptoms common for a particular anxiety disorder or depression. Patients do not feel they are being asked only psychiatric screening questions and, therefore, may not minimize acknowledgment of such symptoms. The WBLC also helps the clinician isolate somatic anxiety and depressive symptoms that may otherwise be erroneously attributed solely to other medical conditions.

Anxiety disorders, either full syndromal or subsyndromal, are common and treatable medical disorders in a primary care setting. Optimal evaluation of patients in primary care settings should involve a routine assessment of anxiety and depressive symptoms and should not be approached as diagnoses of exclusion. Overcoming patient- and clinician-related obstacles to adequate diagnosis, as well as training new clinicians and retraining experienced clinicians on diagnostic and screening techniques, can enhance the accuracy of diagnosing anxiety and depression in primary care. Early recognition and treatment of anxiety and other comorbid medical disorders are important for optimal outcome.

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PATIENT WELL-BEING LIFE CHART

Retrospective Screening Device

Name: _____ **Sex:** ❑ **Male** ❑ **Female** **Age:** _____ **Today's Date:** _____

Instructions: This Well-Being Life Chart is a confidential document between you and your doctor. It is intended to help you and your doctor discuss your well-being openly and candidly. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.

Enter the degree of well-being you have experienced over the *last 4 weeks* by circling the corresponding number in the columns below. Circle one number in each column.

	4 Weeks Ago	3 Weeks Ago	2 Weeks Ago	The Last 7 Days (*Including* Today)
Better than I normally feel	+1	+1	+1	+1
Normal	0	0	0	0
	-1	-1	-1	-1
	-2	-2	-2	-2
	-3	-3	-3	-3
Worse than I normally feel	-4	-4	-4	-4

List all medications you have taken, including over-the-counter drugs, during the *last 4 weeks*.

❑ Check here if you did not take any medication since your last visit.

❑ Check here if you did (list medications):

Medications Taken	Daily Dosage	Start Date	Taken As Needed
			❑
			❑
			❑
			❑

List any changes that occurred with your medication (i.e., stopping medication, missing a prescribed dose, side effects, etc).

❑ Check here if there were no changes in your medication.

_____

_____

_____

Did you drink any alcohol during the *last 4 weeks*?

❑ Yes ❑ No

If yes, check the type of alcoholic beverage(s) you drank and the average quantity for a given day.

Alcoholic beverage(s) consumed:

	Average Bottles Per Day			
❑ **Beer**	❑ 1–2	❑ 3–4	❑ Over 4	
	Average Glasses/Drinks Per Day			
❑ **Wine** ❑ **Liquor**	❑ 1–2	❑ 3–4	❑ Over 4	

Did you use any tobacco during the *last 4 weeks*?

❑ Yes ❑ No

If yes, list the type of tobacco (i.e., cigarettes, pipe, chewing) and approximate daily use:

_____

_____

Would you like to privately discuss with your doctor any other drugs you may have taken during the *last 4 weeks*?

❑ Yes ❑ No

SIGNIFICANT LIFE EVENTS LIST

Check off any of these life events which have influenced your well-being during the *last 4 weeks*.

OCCUPATIONAL
- ❑ New job
- ❑ Job difficulties
- ❑ Job loss
- ❑ Interpersonal problems at work
- ❑ Pay raise
- ❑ Change of job status or responsibilities
- ❑ Change of hours at work
- ❑ Change of conditions at work
- ❑ Positive job review
- ❑ Negative job review
- ❑ Retirement
- ❑ Change of job status of a household member

FINANCIAL
- ❑ Recent financial demands
- ❑ Outstanding bills
- ❑ Loan(s)
- ❑ Completion of a loan or mortgage
- ❑ Taking out a mortgage
- ❑ Loss of money
- ❑ Recent financial gain

RELATIONSHIP
- ❑ Difficulty with significant other
- ❑ Difficulty with friend or relative
- ❑ New relationship
- ❑ Marriage
- ❑ Divorce
- ❑ Marital separation
- ❑ Break-up of relationship
- ❑ Death of a relative or friend
- ❑ Sex difficulty
- ❑ Major life event of friend, family or significant other
- ❑ Household member leaving home
- ❑ Pregnancy
- ❑ Pregnancy-related issues
- ❑ Birth of a child

HOME
- ❑ Buying new home
- ❑ Selling home
- ❑ Recent change of living situation
- ❑ New household member

PERSONAL
- ❑ Personal injury
- ❑ Personal illness
- ❑ Illness or injury of a family member
- ❑ Problems with the law
- ❑ Change of a personal habit
- ❑ Personal achievement

SCHOOL
- ❑ Beginning of new session
- ❑ End of session
- ❑ Exam
- ❑ Change of school
- ❑ Positive achievement
- ❑ Negative achievement

SOCIAL
- ❑ Vacation
- ❑ Holiday
- ❑ Recreational activity
- ❑ Family get-together
- ❑ Religious activity
- ❑ Social event

SYMPTOMS LIST

Check off any of these symptoms which have been most bothersome or frequent during the *last 4 weeks.*

GENERAL SYMPTOMS
- ❑ Fatigue-lack of energy
- ❑ Weakness
- ❑ Sleep problems (falling asleep, restless sleep, waking too early)
- ❑ Sleeping too much
- ❑ Increase or decrease in appetite
- ❑ Increase or decrease in weight
- ❑ Fever
- ❑ Repetitive, senseless thoughts
- ❑ Repetitive, senseless behaviors
- ❑ Sad/depressed/down in the dumps
- ❑ Irritability
- ❑ Nervousness
- ❑ Fearful feelings
- ❑ Frequent crying or weeping
- ❑ Frequent negative thinking
- ❑ Frequent thoughts of death or suicide
- ❑ Fainting or feeling faint
- ❑ Tremors, trembling or shakiness
- ❑ Seizures
- ❑ Easy bruising
- ❑ Skin rash
- ❑ Violent behavior
- ❑ Seeing or hearing things that are not real
- ❑ Trouble making decisions
- ❑ Trouble concentrating
- ❑ Memory problems
- ❑ Worthless feelings
- ❑ Excessive feelings of guilt
- ❑ Hopeless feelings
- ❑ Helpless feelings
- ❑ Sweating
- ❑ Dizziness/light headedness
- ❑ Unsteady feelings
- ❑ Lack of/loss of interest in things
- ❑ Jumpiness
- ❑ Keyed up/on edge
- ❑ Restlessness
- ❑ Constant worry
- ❑ Feeling life is not worth living
- ❑ Decrease in sex drive
- ❑ Fear of going crazy
- ❑ Fear of doing something uncontrollable
- ❑ Fear of dying
- ❑ Chills
- ❑ Feelings of unreality
- ❑ Feeling in a dream-like state

EYES AND EARS
- ❑ Double vision
- ❑ Difficulty in focusing vision
- ❑ Eye pain
- ❑ Eye discomfort when looking at bright light
- ❑ Sinus pain
- ❑ Increase or decrease in tearing
- ❑ Decrease in hearing
- ❑ Increased sensitivity to sounds
- ❑ Earache
- ❑ Ear infection

MUSCOLOSKELETAL/EXTREMITY
- ❑ Joint pain or stiffness
- ❑ Muscle tension
- ❑ Backache
- ❑ Muscle pain/soreness
- ❑ Muscle weakness
- ❑ Leg cramps
- ❑ Numbness and tingling of arms or legs
- ❑ Foot problems
- ❑ Trouble walking
- ❑ Problems with balance
- ❑ Twitching
- ❑ Cold, clammy hands
- ❑ Unable to sit still

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Chest discomfort
- ❑ Heart pounding
- ❑ Flushing

GASTROINTESTINAL
- ❑ Difficulty swallowing - "lump in throat"
- ❑ Nausea
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Vomiting
- ❑ Rectal bleeding
- ❑ Black, tarry stools
- ❑ Stomach pain
- ❑ Food intolerance
- ❑ Abdominal bloating
- ❑ Frequent belching
- ❑ Frequently passing gas
- ❑ Rectal pain
- ❑ Inability to control bowel movements
- ❑ Fear of losing control of bowels

RESPIRATORY/NOSE/THROAT/MOUTH
- ❑ Cold (influenza)
- ❑ Sore throat
- ❑ Nasal congestion
- ❑ Nose bleeds
- ❑ Hay fever
- ❑ Cough
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Choking sensations
- ❑ Pain when breathing
- ❑ Hoarseness
- ❑ Mouth sores
- ❑ Tooth or gum problems
- ❑ Dry mouth
- ❑ Unusual taste sensations
- ❑ Sore tongue
- ❑ Too much saliva in mouth

GENITAL/URINARY
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Difficulty in passing urine
- ❑ Blood in urine
- ❑ Inability to control urine
- ❑ An unusual increase in sex drive

❑ MALES:
- ❑ Discharge from penis
- ❑ Sores on penis
- ❑ Painful erections
- ❑ Difficulty achieving or maintaining erections
- ❑ Testicular pain or discomfort
- ❑ Difficulty in controlling ejaculation
- ❑ Delay or inability to ejaculate
- ❑ Painful ejaculation

❑ FEMALES:
- ❑ Vaginal discharge
- ❑ Vaginal itching
- ❑ Vaginal sores
- ❑ Pain during intercourse
- ❑ Difficulty in achieving orgasm
- ❑ Unusually heavy menstrual bleeding
- ❑ Irregular menstrual periods
- ❑ Painful menstruation
- ❑ Breast tenderness or soreness
- ❑ Breast discharge
- ❑ Premenstrual physical symptoms
- ❑ Premenstrual psychological symptoms

OTHER SYMPTOMS NOT LISTED ABOVE-PLEASE SPECIFY:

_____ _____

_____ _____

MEDICAL DISCLAIMER: This chart is intended as a screening device to assist you in informing your doctor about your medical condition. Zadox® Health Care Corporation advises the patient to check with a physician before beginning any program which impacts your well-being. This chart does not take the place of your physician's recommendations, and Zadox® takes no responsibility for consequences from the use of this chart.