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Classification of Anxiety

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Summary: Current psychiatric classifications of anxiety are examined critically. In the European literature a specific cluster of symptoms is diagnostic of anxiety neurosis and their subsidiary classification is based on precipitating factors and duration of symptoms. In the American literature, exemplified by DSM-III, greater emphasis is placed on symptomatic classification and panic is given separate diagnostic status, both alone and in conjunction with agoraphobia. In both classifications generalized anxiety is at the bottom of a diagnostic hierarchy so that all other symptoms take precedence. It is argued that neither classification properly identifies a discrete syndrome of pathological anxiety that is recognizable in clinical practice.

Anxiety neurosis, a diagnostic category first given prominence by Hecker (1893) and Freud (1894), has been a stable component in psychiatric classifications throughout the first 80 years of this century. The cardinal features of awareness of threat, irritability and lack of concentration (psychic component) and palpitations, difficulty in breathing, tremor, sweating, giddiness, paraesthesiae and gastrointestinal disturbance (the somatic component), are excellently described by Freud. He also described how chronic anxiousness could easily develop into phobias and obsessions if 'transposition of affect' allowed anxiety to be linked to specific (external) situations or (internal) thoughts. This separation of anxiety neurosis from the body of neurasthenia was taken up with alacrity, so much so that anxiety neurosis and hysteria together account for all aspects of functional psychiatric illness in Osler's classical medical textbook published in the decade after Freud's paper (Osler, 1912). There was little change in the nomenclature of anxiety disorders in the ensuing years, although the delineation of depressive illness, obsessional neurosis, the affective psychoses and personality disorders probably reclassified many patients who might otherwise have been labelled as anxiety neurosis. This was altogether for the good, as it restricted the diagnosis to a more homogeneous population.

Twenty years ago phobic anxiety was also detached from the anxiety syndrome. The impetus for this change developed from the introduction of behaviour therapy in the form of desensitization as a specific treatment for phobic anxiety (Wolpe, 1958). The subsequent demonstration that generalized anxiety not only failed to respond to desensitization but actually hindered improvement in phobic symptoms (Marks, Gelder and Edwards, 1968) emphasised the practical importance of making the diagnostic distinction between phobic and generalized anxiety. Later evidence accumulated that simple or monosymptomatic phobias showed a more favourable response to both desensitization and exposure treatment (Watson *et al*, 1971) than agoraphobia. Phobias were therefore classified into two groups, and further subdivision of illness phobia and social phobia followed (Marks, 1970).

The process of attrition has continued and now the diagnosis of anxiety neurosis is restricted to a small group of conditions that cannot be satisfactorily labelled in any other way. The hierarchical system of classification, explicitly argued by Foulds (1976) and accepted by implication in most other systems, puts anxiety on the lowest tier. Thus if other psychiatric symptoms are present the diagnosis of anxiety neurosis is discarded and the disorder classified according to the nature of the new symptoms (Figure).

Classification solely on the basis of descriptive psychopathology has been recognized to be of limited use, particularly in the less severe psychiatric disorders, as other factors are often more important in determining their course and outcome (Huxley *et al*, 1979; Goldberg and Huxley, 1980). Thus in the latest edition of the International Classification of Disease (ICD-9) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) the anticipated duration, severity of precipitating factors and personality of the patient are all taken into account in diagnosing adjustment and stress reactions. Stress reactions (post traumatic stress disorders in DSM-III) are acute

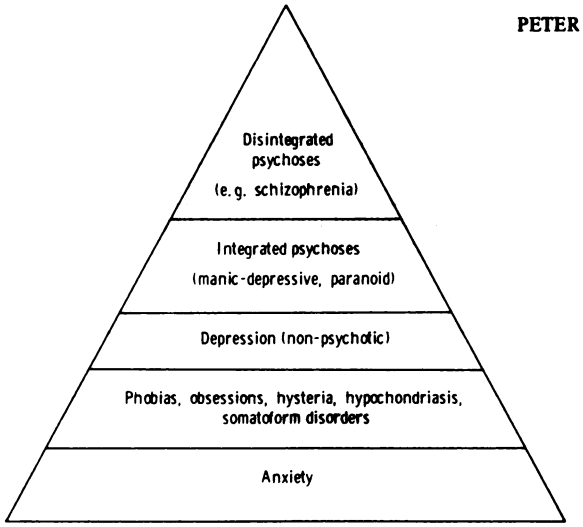

FIG.—The hierarchical submission of clinical anxiety.

episodes of anxiety (or other mood and behaviour disturbance) that follow extreme stresses in otherwise normal personalities, and in this form are almost a natural consequence of the trauma. Adjustment reactions are more prolonged, lasting up to several months, and also occurring in response to major stresses such as bereavement or separation.

In the United States further erosion of the characteristic symptoms of anxiety neurosis has taken place. Sudden and unpredictable episodes of anxiety accompanied by many bodily symptoms are usually defined as panic attacks. In Europe these are usually regarded as part of the symptomatology of anxiety although 25 years ago there were suggestions that they should be incorporated with hysterical, hypochondriacal and phobic features in the syndrome of atypical depression (West and Dally, 1959; Sargant, 1962; Sargant and Slater, 1962). Although further development of this concept has taken place there is still very little agreement about its cardinal features and the place of anxiety within atypical depression (Paykel *et al,* 1983).

Panic

Panic as a primary symptom is now classified as Panic Disorder in the United States. In keeping with the hierarchical approach patients with anxiety symptoms who have panic attacks no longer have a generalized anxiety syndrome but are separately classified. If panic symptoms persist the syndrome is said to lead to phobic avoidance (American Psychiatric Association, 1980) and for this reason a separate category of Agoraphobia with Panic Attacks is included in DSM-III as well as Agoraphobia alone. Other phobias are not linked with panic attacks although there is no real evidence to support a specific relationship between agoraphobia and panic alone.

Somatic anxiety

The old concept of anxiety presenting primarily in the guise of somatic symptoms, or 'anxiety equivalents' has also been reclassified. When Freud (1894) commented that "the proportion in which these (somatic) elements are mixed in anxiety attack varies to a remarkable degree, and that almost every accompanying symptom alone can constitute the attack just as well as can the anxiety itself", he recognized the many modes of presentation of anxiety. Anxiety presenting primarily as somatic symptomatology or somatosthenic anxiety (Tyrer, 1982) would now in all probability be classified as Somatisation Disorder in DSM-III or Briquet's syndrome in St. Louis. The somatic symptoms of anxiety can flit from one organ system to another at different times and often arouse hypochondriacal concern because of their intensity. As anxiety neuroses commonly present before the age of 35, have a tendency to become chronic, and have no demonstrable organic basis, all the criteria for these diagnoses are present (Perley and Guze, 1962; Woodruff, 1967; Woodruff *et al,* 1971; American Psychiatric Association, 1980).

Thus anxiety that is particularly severe (panic), situational, somatic, mixed with other symptoms, or is a consequence of major stress, now merits a new label (Table I). As these features are all important in the original criteria for classifying anxiety neurosis it is not surprising that the category left after removing them, Generalized Anxiety Disorder in DSM-III, is an atavistic ghost of its predecessor that can hardly stand alone as a diagnostic entity.

Anxiety neurosis as a clinical psychiatric syndrome

There are many advantages in separating anxiety symptoms along the lines of DSM-III. The division allows testable hypotheses to be generated that would otherwise not be examined. If, for example, Panic Disorder is shown to have a different genetical predisposition, natural history and response to treatment from other forms of anxiety the diagnostic separation will be justified. To date only the genetical predisposition shows any support for the separation (Leckman *et al,* 1983). Whatever the findings, the wholesale slaughter of anxiety neurosis as a diagnostic entity appears premature. The boundaries of anxiety neurosis have been restricted too much, and even if they are satisfied, when anxiety meets any other psychiatric symptom during its course the new symptom will take precedence in the definition of the psychiatric disorder. Like Aubrey Lewis's description of paranoia (Lewis, 1970) clinical anxiety has become "a preliminary to a diagnosis" rather than a clinical disorder in its own right.

This does not square with clinical experience. There

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TABLE I

Classifications of pathological anxiety

Summarised from latest revisions of the International Classification of Disease (World Health Organisation, 1978) and Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980)

ICD-9	DSM-III	Main diagnostic features
Acute stress reaction (308.0)	Post-traumatic stress disorder—acute (308.3)	Time-limited anxiety linked to marked stressful events
Adjustment reaction (309.2)	Post-traumatic stress disorder—chronic or delayed (309.81)	
Anxiety states (300.0)	Generalised Anxiety Disorder (300.02)	Non-situational anxiety
Phobic state (300.2)	Agoraphobia (300.22)	Situational anxiety
	Social Phobia (300.23)	
	Simple Phobia (300.29)	
	Agoraphobia with Panic (300.21)	
	Panic Disorder (300.01)	Acute attacks of anxiety
Hypochondriasis (300.7)	Somatisation Disorder (300.81)	Somatic anxiety with fears of physical disease

TABLE II

Differences between anxiety neurosis and related disorders in which anxiety is a prominent symptom

Key feature	Anxiety neurosis	Other disorders
Severity of symptoms	Shows great variability and includes episodes of unpredictable and severe anxiety.	Panic attacks occur against a non-anxious background (Panic Disorder).*
Duration of symptoms	Long-term with tendency to relapse.	Acute stress and adjustment reactions are short-term and relapse is rare.
Relationship to external stress	Episodes of increased symptoms related to stressful precipitants, but no close temporal relationship.	Clear-cut temporal relationship between major external stress and symptoms (Acute stress and Post-traumatic Stress Disorders).
Additional symptoms	Secondary depressive, phobic and hypochondriacal symptoms common at times of greater anxiety.	Anxiety symptoms common in depressive, obsessional, phobic and hypochondriacal neuroses but not persistent.
Somatic symptomatology	Includes all types and grades of symptoms, provided psychic anxiety is also present.	Somatic symptoms primary and not associated with autonomic arousal (Somatisation Disorder, hypochondriacal neurosis).
Premorbid personality	Abnormal, with dependent and asthenic features.	Personality normal or, if abnormal, does not show dependent and asthenic features.

* This is not yet a diagnostic criterion for Panic Disorder in DSM-III.

is a homogeneous population of psychiatric patients that deserves the diagnosis of anxiety neurosis. This has also been termed "endogenous anxiety" (Sheehan *et al*, 1980) or "vital anxiety" (Lopez Ibor, 1969).

Mixed anxiety states

One implication of raising anxiety in the hierarchy of psychiatric symptomatology is that anxiety is allowed diagnostic coexistence with other symptoms of neurosis. Thus mixed anxiety-phobic, anxiety-obsessional, anxiety-hypochondriacal, anxiety-hysteria, anxiety-depersonalization and anxiety-depressive disorders may all justify separate descriptions, but only if they satisfy other diagnostic criteria. The importance of clinical anxiety in determining the course and management of different phobic disorders is well established

(Gelder *et al,* 1967), but the diagnostic status of agoraphobia may have been accepted too readily because of the hierarchical precedence of phobic symptoms. Hallam (1978) has presented a sound case for agoraphobia as a variant of anxiety neurosis, and if a diagnostic grouping of mixed anxiety-phobic states was allowed many patients with agoraphobia would qualify for inclusion. There is less evidence that the presence or absence of anxiety in obsessional neurosis is of key diagnostic importance or a factor influencing treatment (Marks, 1976). Somatic anxiety has long been recognized as a cause of hypochondriasis (Brown, 1936) and anxiety-hysteria has an even older pedigree (Freud, 1895), and is still sometimes used in the description of agoraphobic symptoms. Anxiety-depersonalization as a syndrome is also well recognized (Roth, 1959).

A more common combination is that of anxiety with non-psychotic depressive symptoms, and there has been much controversy over its diagnostic validity. Under present rules of classification mixed anxiety-depressive states cannot occur and are all subsumed under depressive disorders. Although the *symptoms* of anxiety and depression can be separated by appropriate statistical tests successfully (Roth *et al,* 1972; Roth and Mountjoy, 1982) *patients* cannot be separated quite so easily. Prusoff and Klerman (1974) found that patients with anxiety and depressive neuroses could be separated but although those defined as anxiety had typical anxiety symptoms, the depressive group included many with mixed anxiety and depressive symptoms and 35 per cent could not be allocated satisfactorily. Further support for mixed anxiety-depressive states has come from studying life events in anxious and depressive disorders. When life events are separated into those of danger and loss anxiety states are more often preceded by an excess of danger, patients with depressive neurosis experience events of loss, and a mixed anxiety-depressive group experience both severe danger and loss (Finlay-Jones and Brown, 1981).

Response to treatment might appear to be a suitable way of either validating the existence of mixed-anxiety depressive states, or supporting their separation into anxiety and depressive disorders. The data from response studies do not permit any definite conclusion but in general they suggest that there are more similarities than differences between the two disorders. Thus in one study amitriptyline was found to be equally effective for both anxiety and depressive symptoms in neurotic disorders. Diazepam was less effective than amitriptyline in both anxious and depressed patients and the authors concluded that 'a distinction between anxiety and depression in neurotic outpatients is of no practical value' (Johnstone *et al,* 1980). Monoamine oxidase inhibitors are the only therapy that may have preferential therapeutic effectiveness on the anxious component of mixed anxiety-depressive states as there is accumulating evidence that they are somewhat superior to tri-cyclic antidepressants in these disorders (Sheehan *et al,* 1981; Nies *et al,* 1982; Roth and Mountjoy, 1982).

In summary there appear to be many advantages in introducing a formal classification of mixed states of anxiety with other neurotic symptoms. It makes good clinical sense but the categories need much better definition before they would be acceptable in nosological systems. A parsimonious classification procedure is also needed to prevent the diagnostic sloth of allocating every patient with mixed symptoms to a mixed category without considering other factors.

Reasons for the demise of anxiety neurosis

If anxiety neurosis exists as a syndrome, why is it so unpopular? The short answer appears to be that there are no specific treatments for anxiety neurosis. When one looks back over the nosological changes that have taken place in psychiatry in the last 60 years almost all have been preceded by the development of a new treatment, a fact that firmly stamps psychiatric diagnosis with the empirical label. We live in an era in which advances in treatment take precedence over all else. Unfortunately anxiety neurosis is not fertile ground for the therapist. Dynamic psychiatry has made little progress since the somewhat pessimistic later views of Freud (1926) and although Bowlby's studies have shown the possible link between separation anxiety in childhood and anxiety in adult life (Bowlby, 1973) this remains to be established and developed in therapeutic terms. Although insecurity is the fuel of anxiety dynamic psychotherapy rarely cuts off the supply.

Behaviour therapy has nothing for anxiety to compare with the treatments available for phobias although anxiety management training (Suinn and Richardson, 1971) may be a specific therapy. Cognitive therapy has been mainly developed for the treatment of depression although the principles of treatment apply equally to anxiety (Beck and Emery, 1979) (personal communication). Physical treatments are also generally disappointing. Unfortunately most of the drugs specifically marketed for the relief of anxiety carry with them the dangers of pharmacological dependence. The latest, and for many years, the most commonly prescribed drugs in the world, the benzodiazepines, are much safer than the drugs that preceded them but they too carry a risk of pharmacological dependence after long term regular dosage (Tyrer *et al,* 1981; Petursson and Lader, 1981, 1983; Owen and Tyrer, 1983).

The recent interest in the nosology of panic stems

directly from therapeutic studies. Donald Klein first described the efficacy of imipramine in treating agoraphobia associated with panic over 20 years ago (Klein and Fink, 1962; Klein, 1964) and since then there have been many studies that confirm this finding (Zitrin *et al*, 1978, 1980; McNair and Kahn, 1981; Zitrin *et al*, 1983; Liebowitz, 1983). There is also evidence that monoamine oxidase inhibitors are at least as effective as imipramine and other tricyclic antidepressants in treating panic and phobic disorders (Sheehan *et al*, 1980; 1981). Klein has also suggested that the primary action of imipramine is to block the symptoms of panic and thereby improve phobic symptoms secondarily (Klein, 1976). This hypothesis is accepted by implication in the DSM-III classification of panic and phobic disorders but has been criticised because of evidence showing that improvement in panic symptoms occurs simultaneously with improvement in depression and other mood disturbance (Marks, 1983). This suggests that the primacy of panic may have been overstated. These arguments show the unsatisfactory nature of a diagnostic system based on response to treatment, particularly when alternative aetiological hypotheses can be developed from studies of behaviour therapy (Matuzas and Glass, 1983).

In the absence of a specific therapy for anxiety neurosis it is understandable for the clinician to look for an alternative diagnosis that offers positive treatment, however ephemeral improvement may be. This is not a sufficient reason for abandoning any psychiatric diagnosis. The boundaries of anxiety neurosis need to be redefined as they are not satisfactorily delineated by any current classification. There is a particular dearth of longitudinal studies that plot the course of anxiety neurosis systematically and accurately. Until these have been carried out it would be unwise either to sound the death knell of a condition that has served nosology well or to trumpet too loudly the arrival of the new diagnoses.

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