

CURRENT  
PERSPECTIVES ON THE  
**ANXIETY  
DISORDERS**

IMPLICATIONS FOR DSM-V AND BEYOND

EDITORS

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# Current Perspectives on the Anxiety Disorders

## Implications for DSM-V and Beyond

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A Look Back  
at a Quarter  
Century of the  
Descriptive  
Model of  
Classification



# Current Perspectives on Anxiety Disorders: Models and Methods in Anticipation of *DSM-V*

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1

For over a quarter century, classification of mental disorders, including anxiety disorders, has relied on descriptive systems such as the various editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM; e.g., American Psychiatric Association [APA], 1980)*. These systems emerged to ensure that patients were reliably diagnosed, which was a major shortcoming of the prior diagnostic systems. Reliance on the descriptive approach of *DSM* resulted in greater reliability in diagnoses when structured interviews are utilized (Segal, Hersen, & Van Hasselt, 1994). This included an increase in the reliability of anxiety disorder diagnoses.

The descriptive approach to diagnosis is consistent with the neo-Kraepelinian technique, which relies on symptoms, signs, clinical course, and family history in determining

diagnoses (Kraepelin, 1917).<sup>1</sup> This approach has had much utility over the years, particularly by introducing methodological rigor. In classifying anxiety disorders, it has been particularly useful, setting the occasion for research identifying prevalence of the conditions and specifying distinctions among different behavioral and cognitive manifestations of anxiety conditions. Rich theoretical accounts of different anxiety disorders have emerged that, in turn, have given rise to empirically supported interventions and best practice guidelines. Unprecedented relief from anxiety conditions has been provided to anxiety sufferers as a result, no doubt due in large part to the increased precision accorded clinicians from the improved classification system. At the frontier of this research, specific anxiety problems that were previously underexamined, such as social anxiety disorder and generalized anxiety disorder, now have well-established treatment guidelines.

Recent research, however, has emerged in several anxiety disorders suggesting that the neo-Kraepelinian approach should be augmented with other empirically-driven methods as well as by robust theory-driven approaches to classification. In the case of empirically-driven approaches, considerable research supports an interaction between genetic and environmental factors that contribute to the manifestation of anxiety disorders (Hettema, Neale, & Kendler, 2001). Additionally, the recent widespread use of taxometric methods has taken a purely empirical approach to determining distinct categories of conditions (Waller & Meehl, 1997). The conceptual and methodological developments have led to a richer base from which to develop a revised classification system for the next edition of the *DSM*.

## Multiple Perspectives: Bridging Gaps in Classification Approaches

An assumption underlying the current diagnostic approach (*DSM-IV Text Revision [DSM-IV-TR]*; APA, 2000) is that each diagnosis represents a discrete entity. That is, it is assumed that individuals who meet criteria for a specific disorder are categorically different from those without the diagnosis.

Interestingly, the *DSM-IV-TR* (AAPA, 2000) includes a disclaimer that suggests that this long-held assumption may not be true (Widiger & Mullins-Sweatt, 2007). Calls for dimensional approaches to diagnosis have grown in recent years. For example, statistical analyses of the full range of disorders listed in the *DSM* have led to dimensional schemes. Watson (2005) obtained empirical evidence to distinguish among the following three classes of disorders: bipolar disorders, distress disorders, and fear disorders. Krueger (1999) showed that many of the disorders in the *DSM* may form two broad categories—internalizing and externalizing disorders—with internalizing disorders further classified into anxious-misery and fear conditions.

Dimensional approaches have been widely used in research examining the heritability of different psychiatric problems. Behavioral genetic studies have been conducted to determine the relative contribution of genes versus environment when modeling traits, measured by administering instruments to twins, without necessarily relying on the presence of specific diagnoses (DiLalla, 2004). In addition, many studies have attempted to specify the neural circuitry involved in fear learning. This research has involved brain imaging technology, such as functional magnetic resonance imaging in conjunction with cognitive processing tasks. Research such as this brings together methodology that has been central to biological psychiatry (Malizia & Nutt, 2008) with methods that originated in experimental psychology (Williams, Watts, MacLeod, & Mathews 1997).

## Theory and Mechanisms in Diagnosis

Although the descriptive approach has enhanced the science behind classification by improving the reliability of diagnosis, it does not, in itself, provide a link to treatment. The practice guidelines that have developed for a wide range of psychiatric disorders grew from other theoretical traditions built around the existing diagnoses. Recent years have witnessed a growing interest in determining the underlying mechanisms that result in psychiatric conditions. This movement has, in turn, led to a renewed call for an explicitly theory-based diagnostic system.

An explicitly theory-driven approach to diagnosis in other sciences may function adequately, given the presence of a single or very small set of theories. Psychiatry and psychology, however, are characterized by multiple theories with disparate methodologies. Recently, Kendler (2008) made a compelling case for relying on multiple theories in describing psychiatric disturbance. This would yield a range of possible mechanisms of psychopathology. The examination of any single mechanism may be an effective means of understanding microlevel elements of psychiatric conditions. In their aggregate, the mechanisms may interact in a nonlinear fashion. As a result, Kendler advocated examination of the interactions between psychological and biological mechanisms of psychiatric disturbance.

## Overview of This Book

The impetus for this book was the need to examine empirical approaches to conceptualizing and diagnosing anxiety disorders. The past 25 years have witnessed significant growth in how anxiety disorders are understood. These conceptualizations cut across many theoretical perspectives, each with proposed mechanisms of disorder. The goal of the book is to bring together leading authorities from multiple theoretical traditions, and to present updates on the empirical status of the diagnostic system for specific anxiety conditions. The book is organized into three major sections. Part I examines the recent history of the neo-Kraepelinian approach to diagnosis as applied to the *DSM* and International Classification of Diseases systems of diagnosis, and the progress made within specific areas within the anxiety disorders. There have been considerable changes and advances made in the conceptualization of anxiety disorders, and classification in general, since the publication of *DSM-III*. Part II covers the empirical bases of classification within specific theoretical perspectives on the anxiety disorders. Several approaches have become prominent in the anxiety disorders, such as fear circuitry, genetic and behavioral–genetic, neurochemical, and taxometric methods. Part III examines specific topics that relate to anxiety diagnosis. For example, there has recently

been considerable discussion in the literature regarding the putative obsessive–compulsive spectrum, and how the candidate disorders for the spectrum may be classified for future revisions of the *DSM*. This section will cover some of the areas that have been the source of controversy in classification and conceptualization.

The past quarter century has been extremely productive in advancing our understanding of anxiety disorders. It is hoped that the perspectives included in the chapters in this volume will help usher in another highly productive quarter century of research on the conceptualization, classification, and treatment of anxious conditions. We anticipate that many of the perspectives contained in this book will be relied on in the planning of the next edition of the *DSM* and will be informative as further refinements are undertaken in the future.

## Note

1 Kraepelin is commonly portrayed as someone who was simply interested in descriptive methods of diagnosis. But, in fact, Kraepelin was interested in the possibility of eventually developing an etiology-based classification system.

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# Historical Perspectives on Psychiatric Classification and Anxiety Disorders

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2

## Introduction

This chapter begins with a review of the history of mental illness classification, providing a broader context in which to understand where our current classification of anxiety disorders originated. This general overview includes a discussion of the roots of psychiatric nomenclature going back to the late 1800s, through the first three editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association [APA], 1952, 1968, 1980).

Next, we shift the focus to the classification of anxiety disorders in particular, including a discussion of the ways in which classification of anxiety-based disorders has changed across each edition of the *DSM*, from the

first edition of *DSM* (*DSM-I*; APA, 1952) through the most recent text revision of *DSM*'s fourth edition (*DSM-IV-TR*; APA, 2000). This discussion is followed by more detailed accounts of the major revisions in diagnostic criteria for each of the anxiety disorders, including the rationale for these revisions. Though we include some discussion of the World Health Organization's *International Classification of Diseases* (*ICD*; World Health Organization [WHO], 1992), the emphasis in this chapter is on the *DSM*, because there is little sound historical scholarship available on the classification of mental disorders in *ICD*.

## History of Classification of Mental Illness

In January 1881, the young psychiatrist Emil Kraepelin (1856–1926) wrote to Wilhelm Wundt, founder of modern experimental psychology, "As often before and with your permission I would like to ask for your advice and support and to dedicate myself more and more to psychology, which is really my primary inclination" (Muller, Fletcher, & Steinberg, 2006, p.132). He was asking for support for what we in the 21st century would call a postdoctoral fellowship. Kraepelin had first studied with Wundt in 1877, when he was still a medical student, and sought to return for further studies with Wundt after completing his medical training and briefly serving as an assistant psychiatrist in Wurzburg and Munich. Wundt encouraged his application, and in February 1882, Kraepelin began a nearly 2-year stint in Wundt's laboratory.

Kraepelin took away from his time in Wundt's laboratory a commitment to empirical research and a psychological perspective for understanding a range of human activities, including psychiatric problems, substance abuse, and problems of work life in a rapidly industrializing Germany. Kraepelin is rightly known for his work in developing descriptive psychopathology, especially an innovative system of classification of mental disorders. At the heart of this system was an attempt to understand and classify the disorders in terms of the ways they are experienced psychologically.

In 19th-century psychiatry, diagnostic classification was not considered essential to clinical work. Only a few psychiatrists engaged in research; the great majority were asylum superintendents. In America, they came to call themselves *alienists*, reflecting their belief that their patients had become

alienated from their reason. Among those who did conduct research, classification was of minor concern. Nevertheless, some systems did emerge. For example, Richard von Krafft-Ebbing proposed a classification of sexual disorders in his *Psychopathia Sexualis*. Diagnostic categories such as moon madness, circular insanity, masturbatory insanity, and others had been proposed and used during the century (Shorter, 1997). In the 1880s, Carl Wernicke, known for his neurological work on aphasia, proposed a simple classification system using the concept that in all psychiatric disorders there is always one primary feature from which all others arise (Krahl & Schifferdecker, 1998). So, Kraepelin was not the first to develop a nosology for psychiatric disorders. However, he was the pioneer of a classification system that had clinical utility.

Kraepelin developed his nosology over a period of years, based on extensive clinical experience in various psychiatric settings. Kraepelin sought to understand psychiatric disorders through observing their outcome. What, he wondered, does the course of the disorder tell us about its nature? The growth of his understanding can be traced through successive editions of his textbook, *Psychiatrie*. During the course of his work, he described dementia praecox in terms of its outcome and separated it from other disorders. By the 6th edition (1899), Kraepelin had arrived at a comprehensive classification. Mental disorders were now divided into 13 groups, based on their course and outcome.

Kraepelin continued to refine his nosology until his death in 1926. By that time, his classificatory approach was broadly accepted throughout much of Europe. Following Kraepelin, many European psychiatrists pursued a descriptive approach in diagnosing their patients. In North America, Kraepelin's classification system had a favorable reception early in the 20th century, but by the 1920s and 1930s, it was largely out of favor. Instead, the dynamic psychiatry of Adolf Meyer (1866–1950) had become dominant. Meyer was Swiss born and trained at Zurich under the well-known psychiatrist August Forel (Leys, 1991). Meyer moved to the United States in 1892, where he held a series of increasingly salient positions until he finally landed at Johns Hopkins University in 1910, where he remained until he retired in 1941.

Meyer's rise to the leadership of American psychiatry in the pre-World War II era was facilitated by his eclecticism. For better or worse, Meyer drew from often disparate theoretical

bases to forge what he called dynamic psychiatry. Early on in America, he was a proponent of Kraepelin's descriptive approach, though he later minimized the importance of descriptive psychiatry. He was also receptive to some of the ideas of Sigmund Freud, especially the role of early life experience and sexuality (Burnham, 1967). But underlying all of Meyer's work was an allegiance to the concept of adaptation, drawn loosely from the work of Charles Darwin (Leys, 1991). Meyer, like such American psychologists as William James, Robert Yerkes, John Dewey, and James Angell, was committed to Darwinian notions of function and purpose in mind and behavior. He used the term *psychobiology* to indicate that human mental functioning, both in health and disorder, was a combination of psychological and biological efforts at adapting to the world (Dewsbury, 1991). Meyer worked closely with psychologists, reflecting a broader trend in the development of American psychiatry to attempt to redefine itself as a medical science through alliances with cognate disciplines based in laboratory approaches (Grob, 1983; Pickren, 2007). Indeed, it was in this move that American psychiatrists renamed themselves *psychiatrists* instead of alienists. Meyer's dynamic psychiatry with its psychobiological focus led to attempts in American psychiatry to understand disordered mental functioning in the full context of each person's life. Meyer proposed that his colleagues draw up a "life chart" for each person they treated. This life chart would then facilitate diagnosis and treatment. Such was Meyer's dominant position within American psychiatry, that the mainstream of the profession spent the prewar years concerned with understanding and treating psychiatric disorders as problems of adaptation and function and paid much less attention to issues of classification of mental disorders than many of their European counterparts.

The other major influence that moved North American psychiatry away from a focus on psychiatric nosology was the work of Sigmund Freud. It has been well documented that Freud's ideas began to circulate in North America in the 1890s; and by the first decade of the 20th century, his work was increasingly known among psychologists, psychiatrists, and neurologists (Burnham, 1967; Shakow & Rapaport, 1964). In this same period, psychiatry was redefining itself as a profession concerned with delivery of services in private office settings (Grob, 1983). By the time of World War II American

psychiatry was principally concerned with problems of adjustment, with services conceptualized in an ad hoc mixture of Meyer's dynamic psychiatry and an American adaptation of Freud's psychoanalysis. Increasingly, American psychiatrists worked outside mental hospitals and were less concerned with the treatment of serious mental illness.

The experience of psychiatrists serving in the armed forces during World War II facilitated a greater emphasis on environmental and psychological factors. Many of the young psychiatrists who served in the war became leaders of psychiatry in the two decades after the war. The Menninger brothers, Karl and William, were among this leadership. William Menninger had been chief of military psychiatry during the war. He promoted a psychoanalytic approach to diagnosis and treatment during this time and his influence grew after the war. Because of the influence of the Menningers and the additional influence of many émigré psychoanalysts in American academic departments of psychiatry, the years from 1945 to 1965 were dominated by psychoanalytic theory and praxis (Hale, 1995). This was also the period of the emergence of modern clinical psychology with the growth of clinical training programs based on David Shakow's "Boulder Model," fuelled by generous National Institute of Mental Health (NIMH) funding (Pickren & Schneider, 2005). Popular culture in this period also reflected the influence of psychoanalytic ideas (Hale, 1971). The impact of all these factors was to facilitate the creation of a rich psychologically minded culture that was receptive to psychotherapeutic treatment (Herman, 1995; Pickren, 2005). Practitioners responded to these demands with little emphasis on issues of classification. However, the seeds for change were sown in this period and the document that would reflect that change was published near the beginning of this era.

The first official American classification of mental disorders appeared in 1918 as the *Statistical Manual for the Use of Institutions for the Insane*. It was developed by the American Medico-Psychological Association (immediate precursor to American Psychiatric Association) and the National Committee for Mental Hygiene in response to the needs and demands of the U.S. Census Bureau to enumerate the insane. The first few editions focused almost entirely on the psychoses, but by the tenth edition (1942), various "psychoneuroses," including anxiety states were employed (Grob, 1991b). *DSM* was first published in 1952. It drew upon the earlier manual but its

development was guided by the broad, adaptationist perspective of Adolf Meyer's dynamic psychiatry and the more psychoanalytically oriented perspective of psychiatrists who had served in the war, especially William and Karl Menninger (Friedman, 1990). William Menninger had been involved in the development of the U.S. Army manual for diagnosing mental disorders and his influence is seen in the first *DSM*. The manual uses the broad Kraepelinian classification of endogenous mental disorders with the reaction types found in Adolf Meyer's work. Psychoanalytic constructs of neuroses are threaded throughout the manual. For the time period, this made sense, as most practitioners did not place primary emphasis on diagnostic purity.

The second edition or "revision" of the *DSM* (APA, 1968) followed much the same plan. Now, there were more subdivisions of the major disorders; for example, instead of just listing alcoholism (*DSM-I*), there were now the categories of episodic excessive drinking, habitual excessive drinking, etc. (*DSM-II*). What was different was the need to integrate the *DSM* with the World Health Organization's *ICD*. The eighth edition of the *ICD* was on the horizon and, by treaty, the United States was obligated to coordinate its system of classifying diseases with that of the World Health Organization.

The coordination with the *ICD* was coincident with other forces that led to the creation of an almost entirely new way of classifying mental disorders in America. Briefly, the increasingly psychological culture of postwar America created a demand for psychological services unprecedented in American life (Cushman, 1995). The NIMH's funding for training of mental health professionals—psychiatrists, clinical psychologists, psychiatric nurses, social workers—greatly increased the numerical and political strength of their respective professions. In the 1960s, the federal government and many large corporations responded to the demands of their employees to provide insurance coverage for mental health outpatient services. By the 1970s, many insurers were beginning to complain that the high cost of ongoing psychological care would bankrupt them. From insurers' perspective, many of the illnesses were vaguely defined with widely varied treatments that seemed to have no specifiable end. The federal government, one of the largest employers paying for such services, soon began to demand an assessment of whether such treatments worked and were worth the cost (Rosner, 2005).

Within psychiatry, the environmentalist and social psychiatry, strongly analytic in tone, that had become dominant after WWII, began to lose its hegemony (Grob, 1991a). By the late 1950s, a small group of psychiatrists had begun to see the need for greatly strengthening the research base of psychiatry. David Hamburg, then at NIMH, left for Stanford University where he revitalized the department of psychiatry, making it one of the most research-oriented programs in North America. A similar movement had begun in the 1950s at Washington University in St. Louis, led by Eli Robbins and Samuel Guze. These psychiatrists helped move the profession toward a focus on research. Because NIMH had always favored the funding of psychiatry over the other mental health disciplines, there were abundant resources to facilitate this reorientation. By the late 1970s, there had been a major shift within psychiatry toward a biological, rather than a psychological or psychosocial, understanding of mental disorders. The development of effective psychotropic medications, beginning in the 1950s, provided an important pressure point on psychiatry and psychology to develop identifiable, measurable, and specific diagnostic classifications of mental disorders that would facilitate clinical trials of pharmacotherapies (Baker & Pickren, 2007). Finally, the pressure to conform to an upcoming revision of the *ICD* provided the proximal impetus to revise the *DSM* again.

All of these factors came together in the 1970s to provide the necessary context for a revision of the *DSM* that would reflect the changed social and policy dynamics of North American psychiatry (Horwitz, 2002; Wilson, 1993). The appointment of Robert Spitzer to chair the American Psychiatric Association Task Force on Nomenclature and Statistics in 1974 provided the critical professional leadership that led to the *DSM-III*. Spitzer had a strong commitment to psychiatry as a research-based profession and had strong ties with the Washington University psychiatry department. He and the Task Force built on the work of Washington University researcher, John Feighner, who had articulated 14 clearly specified criteria for diagnosis of mental disorders (Feighner et al., 1972). Spitzer and the Task Force aimed to redesign the *DSM* in such a way that it could become a manual useful in research as well as diagnosis (Spitzer, 2001). Despite controversy over the elimination (then temporary reinstatement) of such vague terms as neurosis, they were able to win over

enough of the American psychiatry establishment to firmly establish their neo-Kraepelin approach to classification.

How does the history of the classification of anxiety disorders fit within this broader history of psychiatric nosologies? Medical writings from the late medieval period until the 19th century made frequent references to what are now termed anxiety disorders, though the specific term is not used. In 1869, American neurologist George Beard first described neurasthenia, or nervous exhaustion, in language that encompassed anxiety as a neurosis. However, it was Sigmund Freud who strongly suggested that anxiety be considered a separate disorder from other neuroses or psychoses (Berrios, 1996). Freud's conceptualization was foundational to the classification system found in the first *DSM*. In the remainder of this chapter, the particular histories of the classification of anxiety disorders are covered.

## History of Anxiety Disorders Classification in the *DSM*

Though the term *anxiety disorders* did not appear in the official psychiatric nomenclature until the publication of *DSM-III* (APA, 1980), both *DSM-I* (APA, 1952) and *DSM-II* (APA, 1968) have included categories for anxiety-based problems. *DSM-I* included three conditions that were precursors to anxiety disorders as they are currently classified. The first was called *anxiety reaction*, which referred to a state of anxiety that is "diffuse and not restricted to definite situations or objects" (APA, 1952, p. 32). As is the case with *DSM-I*, overall, the definition was couched in psychoanalytic terms. For example, the definition of anxiety reaction stipulated that it could not be "controlled by any specific psychological defense mechanism as in other psychoneurotic reactions" (APA, 1952, p. 32). The second anxiety-based condition in *DSM-I* was called a *phobic reaction*, in which anxiety "becomes detached from a specific idea, object or situation in the daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear... The patient attempts to control his anxiety by avoiding the phobic objects or situation" (APA, 1952, p. 33). The third category of anxiety-based conditions in *DSM-I* was *obsessive-compulsive reaction*, which was the forerunner to what is now known as obsessive-compulsive disorder (OCD),

which is discussed later in this chapter. Anxiety reaction, phobic reaction, and obsessive–compulsive reaction were all examples of the broader classification known in *DSM-I* as *psychoneurotic disorders*. *DSM-I* also contained a condition called *gross stress reaction*, which overlapped most closely with what is now referred to as posttraumatic stress disorder (PTSD).

In *DSM-II*, the terminology was revised slightly, though the descriptions continued to be couched in psychoanalytic theory (APA, 1968). The term psychoneurotic disorders was replaced with the term *neuroses*. Anxiety reaction, phobic reaction, and obsessive–compulsive reaction were replaced with the terms *anxiety neurosis*, *phobic neurosis*, and *obsessive–compulsive neurosis*, respectively. Anxiety neurosis referred to “anxious over-concern extending to panic and frequently associated with somatic symptoms... not restricted to specific situations and objects” (APA, 1968, p. 39). Phobic neurosis was defined as “intense fear of an object or situation which the patient consciously recognizes as no real danger to him” (APA, 1968, p. 40). According to the definition, “phobias are generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware” (APA, 1968, p. 40). Obsessive–compulsive neurosis is described in more detail later in this chapter, in the section on OCD.

In 1970, the psychiatrist Isaac Marks published an influential paper on the classification of phobic disorders (Marks, 1970). In it, he proposed that phobias be classified into two broad categories, *phobias of external stimuli* and *phobias of internal stimuli*. Phobias of external stimuli were further divided into four main groups: (a) agoraphobia, (b) social phobias, (c) animal phobias, and (d) other specific phobias. Phobias of internal stimuli were further classified into (a) illness phobias and (b) obsessive phobias. Marks believed that agoraphobia was the most common phobia type, accounting for 60% of phobic patients at the Maudsley Hospital in London, where he was based. In 1980, *DSM-III* was published, incorporating much of Marks’ proposed classification of phobic disorders.

With *DSM-III* (APA, 1980), came the current multiaxial approach to diagnosis. Anxiety disorders were diagnosed on Axis I (of the five axes) and were divided into two broad categories called *phobic disorders* (or phobic neuroses) and

*anxiety states* (or anxiety neuroses), which were flowing directly out of the earlier categories in *DSM-I* and *DSM-II*. However, unlike the categories from the earlier editions of *DSM*, these broad categories were subdivided into particular disorders, criteria were much more explicit, and there was an effort to ensure that criteria were not based on any particular theoretical approach. Therefore, all references to psychoanalytic concepts (e.g., defense mechanisms) were avoided. Phobic disorders included (a) agoraphobia with panic attacks, (b) agoraphobia without panic attacks, (c) social phobia, and (5) simple phobia. Anxiety states included (a) panic disorder, (b) generalized anxiety disorder, (c) obsessive–compulsive disorder, and (d) posttraumatic stress disorder. In addition, there was a category called *atypical anxiety disorder*, reserved for anxiety disorders that did not meet criteria for any of the above specified conditions.

In *DSM-III-R* (APA, 1987), anxiety disorders were no longer classified into the broad categories of phobic disorders and anxiety states. In addition, atypical anxiety disorder was renamed *anxiety disorder not otherwise specified*. Otherwise, very little changed in the overall structure of the anxiety disorders section from *DSM-III* to *DSM-III-R*. However, there were important changes to the diagnostic criteria for specific disorders, as reviewed in the remaining sections of this chapter.

In the mid-1990s, the next major revision of the *DSM* was published (*DSM-IV*; APA, 1994). This event coincided with the publication of the *ICD-10* (WHO, 1992), and some efforts were made to minimize inconsistency between these two publications. In addition, more than ever before, there was an attempt to ensure that revisions were grounded in scientific research, rather than simply professional consensus. A series of position papers were published describing empirical advances in anxiety disorders research and advocating for particular changes stemming from these advances (see Widiger et al., 1996). Some of the most important changes included (a) removal of the panic attack definition from the criteria set for panic disorder and listing it separately (recognizing that panic attacks can occur across anxiety disorders and in the absence of an anxiety disorder); (b) removing agoraphobia from the list of codable disorders, and instead recognizing that it is a feature of panic disorder, though it can also occur in the absence of panic; and (c) addition of the new categories of acute stress

disorder, anxiety disorder caused by a general medical condition, and substance-induced anxiety disorder. In 2000, the *DSM-IV* text revision was published. Though the diagnostic criteria for all disorders remained unchanged, the background text accompanying the description of each disorder was updated to reflect advances in knowledge.

## Panic Disorder and Agoraphobia

*DSM-IV-TR* defines a *panic attack* as a discrete period of fear or discomfort that reaches a peak within 10 minutes and is accompanied by 4 out of 13 possible symptoms (mostly symptoms of arousal, such as increased heart rate, difficulty breathing, and dizziness). *Panic disorder* is a condition characterized by recurrent panic attacks, at least some of which occur unexpectedly, without any obvious situational trigger. To be diagnosed with panic disorder, an individual must experience a period lasting a month or longer in which he or she is concerned about having additional attacks, is worried about the consequences of the attacks, or changes his or her behavior because of the attacks (for example, beginning to rely on safety behaviors or avoid feared situations). *Agoraphobia* is frequently associated with panic disorder and is defined as fear or avoidance of situations in which escape might be difficult or help unavailable in the event of experiencing an unexpected panic attack or panic-like symptoms. In *DSM-IV-TR*, it is possible to receive a diagnosis of (a) panic disorder without agoraphobia, (b) panic disorder with agoraphobia, or (c) agoraphobia without history of panic disorder.

Although the terms panic attack and panic disorder were not introduced until the publication of *DSM-III*, the term agoraphobia was first used more than a century ago by Carl Friedrich Otto Westphal (1833–1890), a German psychiatrist and neurologist. In his classic account, Westphal (1871) described a series of patients who experienced panic in public squares and empty streets, on bridges, and in crowds. The symptoms were very similar to what people with panic disorder and agoraphobia often report today, including anticipatory anxiety and a fear of sudden incapacitation (Kuch & Swinson, 1992). The term “agoraphobia” was the result of combining the Greek words used to describe the open marketplace (*agora*) and fear (*phobos*).

Although the term agoraphobia has been around for some time, it did not come into frequent use until the past few decades and did not enter the formal psychiatric nomenclature until 1980, with the publication of *DSM-III*. Before the publication of *DSM-III*, an individual who might now receive a diagnosis of panic disorder without agoraphobia would likely have received a diagnosis of anxiety reaction (*DSM-I*) or anxiety neurosis (*DSM-II*). The terms phobic reaction (*DSM-I*) and phobic neurosis (*DSM-II*) would likely have been used to describe what is now referred to as panic disorder with agoraphobia or agoraphobia without history of panic disorder.

In *DSM-III*, agoraphobia was defined as a fear of being alone or of being in public places from which escape might be difficult or in which help might be unavailable in the case of sudden incapacitation. Fears of experiencing panic attacks or panic-like symptoms were not part of the definition, as they are today. In addition, the relative importance of agoraphobia versus panic attacks in the conceptualization and classification of panic disorder and agoraphobia were exactly the opposite of what they are now. In *DSM-III*, people could receive a diagnosis of agoraphobia with panic attacks, agoraphobia without panic attacks, or panic disorder. For people with both panic attacks and agoraphobia, the agoraphobia was seen as the hallmark symptom, and panic attacks were viewed as a secondary feature. Furthermore, the fact that panic disorder was classified as an anxiety state and both agoraphobia without panic attacks and agoraphobia with panic attacks were classified as phobic states suggests that these conditions were viewed as conceptually unrelated. A diagnosis of panic disorder required at least three panic attacks during a 3-week period, and the definition of a panic attack was similar to what it is today, with some minor differences (e.g., four symptoms required out of a total of 12; no requirement for the attack to peak within 10 minutes).

By the time *DSM-III-R* was being published, studies were emerging to suggest that that panic disorder and agoraphobia were related, and that agoraphobia was probably secondary to a fear of having panic attacks for most individuals (Craske & Barlow, 1988; Turner, Williams, Beidel, & Mezzich, 1986). For example, agoraphobia usually begins after the first panic attack in clinical samples (e.g., Katerndahl & Realini, 1997). The location of the first panic attack (i.e., whether it

occurs in a situation typically associated with agoraphobia) is predictive of whether an individual will develop panic disorder alone versus panic disorder with agoraphobia, and the expectation of having a panic attack has been found to predict subsequent avoidance (Craske, Rapee, & Barlow, 1988). With the publication of *DSM-III-R*, agoraphobia was seen as a feature of panic disorder, rather than the other way around. Individuals could receive a diagnosis of panic disorder with agoraphobia, panic disorder without agoraphobia, or agoraphobia without history of panic disorder. Additional changes in *DSM-III-R* included the following:

- A requirement of four panic attacks over 4 weeks or at least 1 attack followed by a month of persistent worry about having another attack (this is the first time that worry about having panic attacks was included in the *DSM* criteria for panic disorder)
- A requirement that 4 out of 13 symptoms be present and that at least some of the panic attacks reach a peak within 10 minutes (to distinguish panic attacks from periods of elevated anxiety that increase in intensity more gradually)
- Changing the definition of agoraphobia to specify that fear and avoidance must be related to anxiety over having a panic attack (panic disorder with agoraphobia) or developing a symptom that could be incapacitating or embarrassing, such as dizziness, depersonalization, etc. (agoraphobia without history of panic disorder)
- A number of exclusions (e.g., not caused by an organic factor) and specifiers (e.g., severity) were added to the criteria.

From *DSM-III-R* to *DSM-IV*, the most important changes in the criteria for panic disorder included the requirement that the individual have recurrent panic attacks (but without specifying a particular number), as well as the explicit requirement that there be a period of at least a month in which the individual is worried about having more attacks or about the consequences of the attacks, or in which the individual changes his or her behavior because of the attacks. The decision to remove any reference to a particular number of required panic attacks was based on findings that many individuals experience panic attacks infrequently, but still

experience the other features of panic disorder (Ballenger & Fyer, 1996). Overall, the definition of panic disorder has changed very little from *DSM-III-R* to *DSM-IV*.

In *ICD-10* (WHO, 1992), the organization of panic disorder and agoraphobia is much more similar to the way these conditions are organized in *DSM-III* than more recent versions of *DSM*. Agoraphobia without panic disorder and agoraphobia with panic disorder are listed as examples of *phobic anxiety disorders*. Panic disorder (also called *episodic paroxysmal anxiety*) is listed as an *other anxiety disorder*. The definition of agoraphobia is based on the range of situations avoided (e.g., crowds, public places, etc.), and there is no mention that the avoidance must be caused by a fear of experiencing panic attacks, panic-like symptoms, or incapacitation. The *ICD-10* criteria for these disorders are much less detailed than they are for comparable disorders in recent editions of the *DSM*.

## Specific Phobia

In *DSM-IV-TR*, the key feature of a specific phobia is excessive or unrealistic fear and/or avoidance of specific objects or situations, which is severe enough to cause clinically significant distress or functional impairment. Five types of specific phobia are specified in *DSM-IV-TR*: (a) *animal type* (e.g., fear of animals or insects), (b) *natural environment type* (e.g., fear of storms, heights, or water), (c) *blood-injection-injury type* (e.g., fear of seeing blood, receiving injections, undergoing invasive medical procedures), (d) *situational type* (e.g., fear of flying, driving, enclosed places), and (e) *other type* (fears cued by other specific stimuli; e.g., clowns, balloons).

As mentioned earlier, the term *phobia* is derived from the Greek word for fear, *phobos*, which was also the name of the ancient Greek god of terror (the son of mythological deities Ares and Aphrodite). Working with Ares (the god of war), Phobos was believed to strike fear and horror in one's enemies. Although descriptions of morbid fears go back at least to the time of Hippocrates (Marks, 1970), it was not until the 19th century that the term phobia was used in the clinical literature to describe unrealistic fears (e.g., Freud, 1895; Maudsley, 1879; Westphal, 1871).

The first 2 editions of the *DSM* each grouped all phobic disorders together. A specific phobia would have been

called a phobic reaction in *DSM-I* and a phobic neurosis in *DSM-II*. With the publication of *DSM-III*, specific phobias were distinguished from other phobic disorders and were referred to as *simple phobias*. Simple phobia was considered a residual category of phobic disorder to be assigned when an individual had a persistent and irrational fear of a specific object or situations and when criteria for agoraphobia and social phobia were not met. To distinguish simple phobias from delusional fears, it was required that the individual recognize that his or her fear is excessive or unreasonable, a criterion that has continued to be included in every edition of *DSM* since *DSM-III*. Although *DSM-III* required that the individual experience distress associated with the phobia, there was no mention of functional impairment until subsequent editions of *DSM*.

*DSM-III-R* described the criteria for simple phobia in more detail than *DSM-III*, but the definition was otherwise very similar. In *DSM-III-R*, simple phobia was defined as a persistent fear of a circumscribed object or situation that was unrelated to the content of another anxiety disorder (e.g., fear of having panic attacks, fear of social situations, obsessions, trauma, etc.). The anxiety response had to occur immediately upon exposure to the feared object and had to be associated with either functional impairment or distress over having the fear.

In *DSM-IV*, the changes to this diagnosis were relatively minor. First, the category was renamed specific phobia to more accurately describe the focus of the fear. Second, the five specific phobia types were introduced based on research showing that these types vary with respect to age of onset, sex ratio, familial aggregation, physiological response (e.g., panic attacks, fainting), their relationship with agoraphobia, comorbidity, and groupings among phobias in factor analytic studies (Antony & Barlow, 2002; Craske et al., 1996). Finally, the diagnosis was now permitted in the presence of unexpected panic attacks, as long as the attacks were confined to the phobic object or situation. In *ICD-10*, this category is referred to as *specific (isolated) phobia*. The criteria are similar to those in *DSM-IV*, though they are described in less detail.

There has been little discussion in the literature about possible changes to Specific Phobia criteria in *DSM-V*. However, there are reasons to consider a number of changes. For example, there are a significant number of individuals whose symptoms meet all of the diagnostic criteria for

specific phobia except for insight into the excessiveness of their fear, and for whom phobic beliefs are not of a delusional intensity (Jones & Menzies, 2000; Menzies & Clarke, 1995; Menzies, Harris, & Jones, 1998). Based on these findings, one might argue that the requirement for recognition that the fear is excessive be removed or replaced with a requirement that the fear not be of a delusional intensity. In addition, we have argued elsewhere (Antony, Brown, & Barlow, 1997) that the specific phobia types be removed from *DSM* because of inconsistencies among the data that are often cited to support these types, practical challenges in assigning phobias to types (e.g., is a fear of the dark a natural environment fear or a situational fear?), and because specifying the specific phobia type (e.g., specific phobia, natural environment type) is less descriptive than simply naming the phobia (e.g., specific phobia of storms). It remains to be seen what changes will happen to the criteria for Specific Phobia in *DSM-V*, if any.

## Social Anxiety Disorder

Social anxiety disorder is a condition characterized by a persistent and extreme fear of one or more social or performance situations that cause clinically significant distress or functional impairment. Examples of situations that are often feared by individuals with social anxiety disorder include dating, meeting new people, conversations, being the center of attention, public speaking, and talking to people in authority. In *DSM-IV-TR*, the official name of this disorder is *social phobia*, and the name *social anxiety disorder* appears in parentheses. However, in recent years, the name social anxiety disorder has gained popularity. This change appeared to coincide with the U.S. Food and Drug Administration approving several medications for the treatment of social anxiety disorder and for pharmaceutical companies to use the term social anxiety disorder almost exclusively in their marketing, scientific publications describing clinical trials, and continuing medical education. In addition, a group of prominent social anxiety researchers (including a mix of psychologists and psychiatrists) published a letter in the *Archives of General Psychiatry* calling for social anxiety disorder to be the primary name for this condition, arguing that, compared to the name social phobia, the name social anxiety disorder more strongly conveys a

sense of pervasiveness and impairment, and better differentiates the disorder from specific phobia (Liebowitz, Heimberg, Fresco, Travers, & Stein, 2000).

Social anxiety disorder was first introduced (under the name social phobia) in the official psychiatric nomenclature with the publication of *DSM-III*, following Isaac Marks' classic article in which he identified social phobia as a unique phobic disorder (Marks, 1970). Before *DSM-III*, social anxiety disorder would have been called a phobic reaction in *DSM-I* and a phobic neurosis in *DSM-II*. Although it was not included in any formal nomenclature until recently, there were published reports in the clinical literature on individuals with excessive social anxiety for at least a century, including books by French authors Dugas (1898) and Hartenberg (1901). Of these two books, the better known one was *Les Timides et la Timidité* by French psychiatrist Paul Hartenberg (1871–1949). In this book, Hartenberg described a disorder that corresponds very closely to the current *DSM-IV* description of social anxiety disorder (Fairbrother, 2002). For Hartenberg, social phobia was comprised of two basic emotions: fear and shame. This is not unlike the more modern descriptions in *DSM*, which emphasize the roles of fear, humiliation, and embarrassment. Hartenberg also recognized that exposure-based therapy is an effective method effective for overcoming social anxiety.

In *DSM-III*, the definition of social phobia was similar to what it is today. The core feature was a "persistent, irrational fear of, and a compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing" (APA, 1980, p. 228). Criteria also required that individuals be distressed by the disturbance and that they recognize that the fear is excessive or unreasonable. Finally, the fear could not be caused by another mental disorder. Though the disorder was introduced in 1980, it took a number of years before researchers started paying attention to this common condition. As recently as 1985, social phobia was referred to as a "neglected anxiety disorder" and there was very little known about the nature and treatment of social anxiety (Liebowitz, Gorman, Fyer, & Klein, 1985).

The changes to the criteria for social phobia in *DSM-III-R* paralleled those for specific phobia. During some phase of the disturbance, the anxiety response had to occur immediately upon exposure to the feared situations and had to be

associated with either functional impairment or distress over having the fear. Additional criteria were included to help distinguish social phobia from other *DSM-III-R* conditions. For example, a diagnosis of social phobia could not be made if the fear was primarily of having a panic attack. In addition, the term *generalized* was now used to describe individuals who experienced anxiety in most social situations. This was added in the context of growing evidence concerning differences between generalized versus nongeneralized forms of the disorder, such as discrete fears of public speaking. For example, individuals with generalized social phobia tend to experience greater levels of functional impairment and have higher levels of anxiety and depression than individuals with discrete social fears (for a review, see Schneier et al., 1996).

In *DSM-IV*, the name social anxiety disorder was added (in parentheses), but the description of the disorder otherwise changed very little. The most important changes focused on further delineating the boundaries between social phobia and other conditions, such as avoidant personality disorder, generalized anxiety disorder, and panic disorder. For example, in *DSM-IV*, a diagnosis of social anxiety disorder is permitted even if the fear was focused on having panic attacks, as long as the panic attacks were confined to social situations. In *ICD-10*, the criteria for social phobia are similar to those in *DSM-IV*, though they are less detailed.

## Obsessive–Compulsive Disorder

In *DSM-IV-TR*, OCD is defined by the presence of obsessions or compulsions. Obsessions are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive, inappropriate, and distressing. The individual attempts to ignore or suppress the obsessions or to neutralize them with another thought or action. In addition, the obsession is not simply a worry about real-life problems, and the individual recognizes that the obsession is a product of his or her own mind. Compulsions are repetitive behaviors or mental acts that are performed in response to an obsession or according to rigid rules. Compulsions are meant to reduce distress or to prevent some dreaded event from occurring. The individual recognizes that the obsessions and compulsions are excessive, and these symptoms cause clinically

significant distress or impairment. Finally, *DSM-IV-TR* requires that the symptoms of OCD are not better accounted for by another disorder.

As far back as medieval times, terms such as *obsessio*, *compulsio*, *impulsio*, and *scrupulus* have been used by the medical community to describe OCD-like phenomena (Berrios, 1989). Throughout the 19th century, several authors published detailed descriptions of individuals suffering from OCD (Berrios). For example, Jean-Etienne Esquirol (1772–1840) described the case of a merchant who feared that she would do wrong to others. Specifically, she feared that she might give too little change to customers and felt compelled to shake her hands vigorously to make sure that nothing stuck to her fingers that did not belong to her (Esquirol, 1838, as cited in Stone, 2002).

In *DSM-I*, *obsessive-compulsive reaction* was included as one of the psychoneurotic disorders. This condition was described as anxiety that is “associated with the persistence of unwanted ideas and of repetitive impulses to perform acts which may be considered morbid by the patient. The patient himself may regard his ideas and behaviors as unreasonable, but nevertheless is compelled to carry out his rituals” (APA, 1952, p. 33). Examples of symptoms listed in *DSM-I* include touching, counting, ceremonials, hand washing, and thoughts (often accompanied by a compulsion to repeat some action).

In *DSM-II*, the name of the disorder was changed to *obsessive-compulsive neurosis*, and it was included in the broader category of neuroses. The disorder was described as the “persistent intrusion of unwanted thoughts, urges, or actions that the patient is unable to stop. The thoughts may consist of single words or ideas, ruminations, or trains of thought often perceived by the patient as nonsensical” (APA, 1968, p. 40). Hand washing was provided as an example of a repeated action that may occur in people with this disorder. Although the wording was different, the condition described in *DSM-II* was similar to that in *DSM-I*, and the amount of detail in the description was similar (a total of eight lines, to be exact).

In *DSM-III*, obsessions and compulsions were clearly defined for the first time, and the definitions were quite similar to what they are today in *DSM-IV*. In addition, clinically significant distress or impairment was necessary for the diagnosis. The criteria also stipulated that the symptoms

could not be caused by another mental disorder. The criteria for OCD changed very little from *DSM-III* to *DSM-III-R*, and again, very little with the publication of *DSM-IV*. The most important changes in *DSM-IV* were the mention of mental/covert compulsions, specification of the boundary between obsessions and worry, and addition of the “with poor insight” specifier to identify individuals who do not recognize their obsessions or compulsions as unreasonable or excessive.

There are several important differences in the definition of OCD in *ICD-10* from the various editions of the *DSM*. First, *ICD* does not list OCD as an anxiety disorder; rather, it is listed as a separate category. Second, the symptoms are required to be present most days for at least 2 weeks, whereas no version of the *DSM* has ever stipulated a required duration of symptoms. In addition, *ICD* specifies that the thought of carrying out the act must not be pleasurable (this criterion is meant to differentiate obsessions from pleasurable fantasies). Finally, the definitions of obsession and compulsion in *ICD-10* are much less detailed than they are in *DSM*.

## Generalized Anxiety Disorder

The hallmark feature of *generalized anxiety disorder* (GAD) as defined by *DSM-IV-TR* is worry that is *excessive* and perceived by the individual as *uncontrollable*. Current criteria stipulate that the worry should be about a number of subjects and be present more days than not for a minimum duration of 6 months. In GAD, anxiety and worry are accompanied by the following six symptoms: (a) restlessness or feeling “keyed up” or “on edge,” (b) easy fatigability, (c) concentration difficulties, (d) irritability, (e) muscle tension, and (f) sleep disturbance. Of the associated symptoms, at least three are required for the diagnosis, “with at least some” present more days than not. In GAD, the worry and associated symptoms are not restricted to features of another Axis I condition, cause clinically significant distress and functional impairment, and are not caused by the effects of a substance or to a general medical condition.

Although the diagnosis of GAD was not included in the first 2 editions of *DSM*, the categories of anxiety reaction (*DSM-I*) and anxiety neurosis (*DSM-II*) would likely have captured what is now known as GAD. GAD first appeared in

the third edition of the *DSM* as a *residual diagnosis* intended for individuals with a presenting complaint of persistent anxiety of a nonspecific (i.e., generalized) nature. Symptoms from three of four of the following categories were required: (a) *motor tension* (e.g., eye twitch, muscle aches), (b) *autonomic hyperactivity* (e.g., sweating, heart pounding), (c) *apprehensive expectation* (worry, anticipation of a negative outcome), and (d) *vigilance and scanning* (e.g., irritability, insomnia). In addition, a minimum duration of 1 month was required for the diagnosis. A GAD diagnosis was assigned when an individual's symptoms were judged not to be consistent with another psychological disorder such as a depressive disorder or schizophrenia. At the time of *DSM-III*, functional impairment was considered "rarely more than mild." Problems associated with GAD that was defined by *DSM-III* were the low specificity of its symptoms and its low diagnostic reliability (Di Nardo, O'Brien, Barlow, Waddell, & Blanchard, 1983). In addition, clinicians found it difficult to distinguish GAD from transient reactions to life stressors (Barlow & Wincze, 1998; Breslau & Davis, 1985; Spitzer & Williams, 1984). It was also hypothesized that the 1-month duration criterion was an explanatory factor in the unusually high lifetime prevalence rate of GAD (Breslau & Davis).

Clinical observations and empirical evidence contributed to several important changes to the GAD criteria in *DSM-III-R*. The cardinal feature of GAD that is defined by *DSM-III-R* became *anxiety and worry* (apprehensive expectation). To better distinguish GAD from other forms of anxiety, the revised criteria stipulated that the anxiety and worry be *unrealistic or excessive* and focus on two or more life circumstances. In addition, the minimum duration was extended from 1 month to 6 months based in part on research by Breslau and Davis (1985) (see Barlow & Wincze, 1998). In their community sample, they found that increasing the duration criterion by 5 months led to a reduction in 6-month and lifetime prevalence estimates to rates that were more comparable to those of other psychological disorders. The independence of GAD from other disorders was reflected in criteria that required that the worry should not pertain to aspects of another disorder (e.g., the anxiety and worry is not about having a panic attack) and that it should not occur exclusively during the course of a mood disorder or a psychotic disorder. Three symptom clusters—motor tension,

autonomic hyperactivity, and vigilance and scanning—were retained with the following changes: (a) the symptoms were designated as associated features of GAD, not primary features, as in *DSM-III* and (b) the presence of a minimum of six associated symptoms was required, excluding symptoms that are typically a part of the experience of panic attacks.

The *DSM-III-R* definition raised the status of GAD from residual diagnosis to full-fledged anxiety disorder and gave rise to a marked increase in research on the phenomenology of GAD-type worry. The frequency, temporal characteristics, form, and content of worry were examined extensively (e.g., Borkovec, Shadick, & Hopkins, 1991; Freeston, Dugas, & Ladouceur, 1996; Tallis, Davey, & Capuzzo, 1994). In addition, cognitive-behavioral treatments designed to reduce the frequency and intensity of the condition's main symptom—worry—were developed, which represented a departure from previous treatments that consisted of strategies aimed at reducing tension and anxiety. Nonetheless, problems with the revised definition were noted. Diagnostic agreement was poor to good at best (Di Nardo, Moras, Barlow, Rapee, & Brown, 1993). Furthermore, comorbidity with other forms of anxiety and with mood disorders was exceedingly high (Brown, Di Nardo, Lehman, & Campbell, 2001). Taken collectively, these problems were interpreted as indicators of poor discriminant validity and there was discussion of omitting GAD altogether from subsequent revisions of the *DSM* (Brown et al.).

In an attempt to sharpen the boundaries between GAD and other disorders, the diagnostic criteria were revised for *DSM-IV* (Brown et al., 2001). The surge of research on worry in the 1980s had a significant impact on the revision. Worry was retained as the hallmark feature of GAD. The requirement that the worry must be excessive was also retained but the one stipulating that it should be unrealistic was eliminated. The removal of the “unrealistic” criterion and retention of the “excessive” criterion were based in part on research showing that worry over minor matters distinguishes individuals with GAD from individuals with other anxiety disorders (Craske, Rapee, Jackel, & Barlow, 1989). Based on empirical findings (Abel & Borkovec, 1995; Borkovec, Robinson, Pruzinsky, & DePree, 1983; Craske et al., 1989), the requirement that the worry must be perceived by the individual as uncontrollable was added, as this was shown to be a factor that

distinguished clinically significant worry from normative worry. The 6-month duration criterion was retained. The list of associated symptoms was reduced from 18 to 6 based on work by Marten and colleagues (1993), which showed that restlessness or feeling “keyed up or on edge”, fatigue, concentration difficulties, irritability, muscle tension, and sleep disturbance were the symptoms that were the most commonly endorsed by individuals with *DSM-III-R* GAD. Symptoms of autonomic hyperarousal were discarded in light of empirical evidence indicating that individuals with GAD endorse these symptoms at a lower rate than symptoms of motor tension and vigilance and scanning (Brown, Marten, & Barlow, 1995). In addition, the autonomic symptoms overlapped considerably with symptoms of panic disorder (Brown et al., 1995). The associated symptom criterion was modified to include a requirement that 3 out of 6 symptoms be present. Brown et al. (1995) expressed concern that the “3 out of 6” criterion was not empirically driven. Research employing the *DSM-IV* criteria substantiated this concern by indicating that the criterion was associated with a low level of specificity, as a very high percentage of individuals with other forms of anxiety endorsed a sufficient number of symptoms to meet the criterion (Brown et al., 1995). Given the problems associated with earlier definitions of GAD, it was particularly important to determine what, if any, impact the modifications had on diagnostic agreement. Brown et al. (2001) reported findings indicating that GAD that was defined by *DSM-IV* was associated with improved reliability; however, their findings also suggested that the overlap with major depressive disorder was still problematic. Although the current *DSM-IV* definition of GAD represents an improvement compared to its predecessors, several features of the diagnosis continue to incite debate, in particular, the 6-month duration criterion (e.g., Kessler et al., 2005) and the “excessive” criterion (Ruscio et al., 2005).

The *ICD-10* definition of GAD is closely aligned with the *DSM-III* definition of the disorder. The critical feature of GAD that is defined by *ICD-10* is *generalized and persistent (i.e., “free-floating”) anxiety*. Three symptom clusters are described. The *apprehension* cluster consists of symptoms that correspond with *DSM-III* apprehensive expectation (worry) and vigilance and scanning (difficulty concentrating and feeling “on edge”). The *motor tension* cluster consists

of four symptoms: restless fidgeting, tension headaches, trembling, and inability to relax. With the exception of headaches, all of these symptoms also appear in *DSM-III* under the same header. Finally, the *autonomic overactivity* cluster is consistent with *DSM-III* autonomic hyperactivity. The *ICD-10* requires that the anxiety symptoms be present “most days for at least several weeks at a time, and usually for several months” (WHO, 1992, p. 140). There are two noteworthy differences between the *ICD-10* and *DSM-III* criteria. Although the primary criterion of both *ICD-10* and *DSM-III* GAD is generalized and persistent anxiety, worry is also a part of the *ICD-10* definition. In addition, in *ICD-10*, GAD cannot be diagnosed in the presence of a depressive episode, phobic anxiety disorder, panic disorder, or obsessive-compulsive. This requirement is limited to mood disorders and schizophrenia in the *DSM-III*.

## Posttraumatic Stress Disorder and Acute Stress Disorder

The diagnosis of PTSD that is defined by *DSM-IV-TR* requires the individual to have been exposed to an extreme stressor in which he or she (a) “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of the self or others” and (b) “responded with intense fear, helplessness, or horror” (criterion A).

The symptoms of PTSD are organized into three clusters and the diagnosis requires the presence of symptoms from all three categories. Criterion B stipulates that *at least one* of the following symptoms of persistent reexperiencing must be present: (a) intrusive recollections, (b) nightmares, (c) acting or feeling as if the trauma were recurring, (d) intense psychological distress upon exposure to internal or external cues that represent or are similar to aspects of the trauma, and (e) physiological reactivity upon exposure to external or internal triggers that represent or are similar to aspects of the trauma. Criterion C requires the presence of *at least three* symptoms of persistent avoidance and numbing of responsiveness, not present before the trauma. These include (a) efforts to avoid thoughts, feelings, or discussions of the trauma; (b) efforts to avoid activities, places, or people

that trigger memories of the trauma; (c) difficulty recalling aspects of the trauma; (d) an important reduction in interest or participation in activities; (e) feelings of detachment or disengagement from others; (f) restricted emotional range; and (g) a sense of a foreshortened future. Finally, criterion D requires the presence of *at least two* symptoms of hyperarousal, not present before the trauma. These include (a) sleep disturbance, (b) irritability or anger outbursts, (c) concentration difficulties, (e) hypervigilance, and (e) exaggerated startle response.

In order to receive a diagnosis of PTSD, symptoms must be present for more than 1 month and lead to significant distress and functional impairment. Acute PTSD has a duration of less than 3 months and chronic PTSD has a duration of more than 3 months. The current criteria also include a delayed onset specifier for cases in which the onset of PTSD occurs 6 months after exposure to the trauma.

Prior to its entry into the official nomenclature, PTSD was conceptualized as a war-induced syndrome. Charcot (1825–1893) used the terms *névrose traumatique* and *hystérie traumatique* to describe the constellation of symptoms observed in men who had served in the Franco-Prussian War. The term *shell shock* was popularized in the early 1900s and was eventually replaced with *war neurosis* (Jones & Wessely, 2007). Although PTSD first appeared as a formal diagnosis in *DSM-III*, there are precursors to the disorder in the preceding editions (Jones & Wessely). In *DSM-I*, *gross stress reaction* described reactions to extreme stressors and was conceptualized as a *transient situational personality disorder*. In *DSM-II*, the term *transient situational disturbance* was used to describe responses to extreme stressors. Jones and Wessely note that the introduction of PTSD in *DSM-III* was heavily influenced by the sociopolitical climate in the United States as a result of the Vietnam War, making it “one of the few politically-driven psychiatric diagnoses.”

Overall, changes to the criteria across editions of the *DSM* have been minimal. The prerequisite for the *DSM-III* diagnosis was exposure to an extreme stressor, defined as an event that would “evoke significant symptoms of distress in almost everyone” (APA, 1980, p. 238). The definition also emphasized that the stressor be an event that is outside the range of stressful experiences that are more commonly encountered, such as chronic illness and marital conflict. Sexual assault, combat,

natural disasters, car accidents, and torture were listed as examples of traumatic events. In *DSM-III-R*, this criterion is similar with a more explicit suggestion that the trauma need not have been experienced directly (i.e., witnessing a traumatic event was sufficient). In the text of *DSM-III-R*, subjective responses to trauma (intense fear, terror, and helplessness; APA, 1987, p. 247) are described but are not integrated in the actual diagnostic criteria; whereas in *DSM-IV*, subjective responses are part of criterion A.

Similar to subsequent editions, *DSM-III* required the presence of symptoms from three categories. Criterion B (reexperiencing) is similar to its *DSM-III-R* and *DSM-IV* counterparts. Criterion C referred to symptoms that are consistent with numbing of responsiveness only. Criterion D was more heterogeneous than in subsequent editions and consisted of symptoms of increased arousal, as well as worsening of symptoms upon exposure to trauma cues, avoidance of activities that trigger memories of the trauma, and guilt about surviving the trauma or about behaviors that were engaged in for survival. In the *DSM-III-R*, the list of symptoms increased to 17 (from 12 in the *DSM-III*) and was organized into three clusters. Symptoms of reexperiencing (criterion B) were similar to ones described in *DSM-III* and also included intense psychological distress at exposure to cues resembling the trauma. Criterion C was expanded to encompass symptoms of persistent avoidance in addition to symptoms consistent with numbing of general responsiveness. Persistent avoidance referred not only to avoidance of external reminders of trauma, but also *internal* cues (e.g., thoughts, feelings). Psychogenic amnesia and a sense of a foreshortened future were added to this cluster of symptoms. Criterion D was revised to focus on symptoms of increased arousal. The symptoms are identical to those that appear as part of criterion D in the *DSM-IV* with the exception of physiological reactivity upon exposure to cues of the trauma, which was shifted from criterion D in *DSM-III-R* to criterion B in *DSM-IV*. *DSM-III-R* is similar to *DSM-IV* in that criteria in both editions require the presence of at least one symptom of reexperiencing, three symptoms of avoidance, and two symptoms of arousal.

Interestingly, PTSD that was defined by *DSM-III* had no required minimum duration and the acute specifier applied to cases of PTSD with an onset occurring within 6 months of exposure to the trauma and a duration of less than 6 months.

The delayed specifier applied to cases of PTSD with an onset beyond 6 months after exposure to the trauma and a duration of more than 6 months. The 1-month minimum duration criterion was added in *DSM-III-R* and was retained in *DSM-IV*. In addition, the acute and chronic course specifiers were added to the *DSM-IV* criteria.

A new category, acute stress disorder, was introduced in *DSM-IV*. The diagnosis captures responses to trauma that have a duration between 2 days and 4 weeks, with an onset occurring within 4 weeks of exposure to the event. The main criterion is the same as for PTSD that is defined by *DSM-IV* and the diagnosis requires the presence of symptoms of reexperiencing, persistent avoidance, and hyperarousal. Unlike the PTSD diagnosis, dissociative symptoms such as derealization and depersonalization are emphasized in acute stress disorder.

The main criterion of *ICD-10* PTSD is exposure to (experiencing and/or witnessing) a “stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone” (WHO, 1992, p. 147). The symptoms are not organized into specific clusters as in the *DSM*, but are similar. In addition, the minimum number of symptoms required for the diagnosis is not specified in the *ICD-10*. The *ICD-10* criteria for PTSD differ from the *DSM-IV* criteria in that they apply only to forms of the disorder that have an onset within 6 months from the time of exposure to the trauma. The diagnostic guidelines state that a “probable” diagnosis of delayed PTSD can be assigned only if the individual reports the required symptoms and the symptoms cannot be better accounted for by another disorder (e.g., obsessive–compulsive disorder).

## Looking Ahead

Before long, *DSM-IV-TR* and *ICD-10* will be history. *DSM-V* and *ICD-11* are both expected to be published in the year 2011. It is too early to know how the anxiety disorders will change in these new editions. However, there have been some discussions in the literature about possible revisions. For example, there have been suggestions that OCD no longer be grouped with the anxiety disorders, and that instead it be grouped with other conditions often referred to as obsessive–compulsive

spectrum disorders (e.g., tic disorders, hypochondriasis, body dysmorphic disorder; Bartz & Hollander, 2006). A recent survey of OCD experts (Mataix-Cols, Pertusa, & Leckman, 2007) found broad support for this proposal, particularly among psychiatrists (as opposed to psychologists and other professional groups). In addition, psychologist David Watson and colleagues (Gamez, Watson, & Doebbeling, 2007; Slade & Watson, 2006) have argued based on factor analytic studies, that GAD and PTSD have more in common with depression than they do with other anxiety disorders, and that perhaps these should be grouped together under the umbrella of “distress disorders,” leaving the remaining anxiety disorders to be grouped together as “fear disorders.” If *DSM-V* does include three main types of anxiety-based disorders (distress disorders, fear disorders, obsessive–compulsive based disorders), our diagnostic nomenclature will have come full circle with respect to basic structure (recall that *DSM-I* included anxiety reaction, phobic reaction, and obsessive-compulsive reaction). However, this time, the structure would be based on empirical evidence.

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