

5. Diagnosing anxiety

This chapter will answer the following questions:

- What are the diagnostic criteria of the different anxiety disorders?
- What are the criteria for suspecting anxiety disorders?
- What studies should be done initially with adults suspected to suffer anxiety disorders in order to allow early detection?
- Are there key questions that could help Primary Care professionals to detect anxiety disorders in patient interviews?
- What are the differential diagnoses to be taken into account?

5.1. Diagnostic criteria

This section describes the diagnostic criteria with which anxiety disorders must conform as specified in the DSM-IV-TR ⁴⁰. The proposed system is the one described in the DSM-IV-TR AP ³⁰ manual, in the form of steps, although it has been modified. The criteria of the DSM-IV-TR were taken into account in cases in which they were summarized in the DSM-IV-TR-AP:

Step 1

Consider the role of a medical illness or the consumption of substances and take into account whether the anxiety is better explained by another mental disorder:

1A. Consider the role of medical illnesses

Anxiety disorder due to a general medical condition

- A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Anxiety in which the stressor is a serious general medical condition).
- D. The disturbance does not occur exclusively during the course of a Delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- 1B. If the subject takes abused substances or medication, consider the following:

Substance-induced anxiety disorder (including medication)

- A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.
 - B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):
 - (1) the symptoms in Criterion A developed during, or within 1 month of, Substance Intoxication or Withdrawal.
 - (2) medication use is etiologically related to the disturbance.
 - C. The disturbance is not better accounted for by an Anxiety Disorder that is not substance induced. Evidence that the symptoms are better accounted for by an Anxiety Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence suggesting the existence of an independent non-substance-induced Anxiety Disorder (e.g., a history of recurrent non-substance-related episodes)
 - D. The disturbance does not occur exclusively during the course of a Delirium.
 - E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 1C. Consider the role of other mental disorders that could explain the anxiety symptoms better

Additional comments:

- Differential diagnosis:

In the case of a patient that presents a differential diagnosis with an anxiety disorder, systemic illnesses should be reasonably ruled out. To do this, you should take into account the physical symptoms that predominate, the knowledge of the prior medical and psychological history of both the patient and the patient's family and the illnesses that generate anxiety disorders, as well as the probability of the ones that may be affecting the patient. Do not forget high capacity of toxins such as caffeine, cannabis, or cocaine and other synthetic drugs to induce anxiety attacks and panic in predisposed subjects. It is also necessary to consider the importance of alcohol for many of the people who suffer anxiety (especially generalized anxiety, panic disorder, and social phobia) since it is used as a tranquilizer to relieve the anxiety symptoms. Based on all of these factors, determine the additional tests that should be carried out, depending on the level of suspicion and the immediacy with which the tests must be carried out, depending on the symptoms and the evaluation.

- Medical comorbidity in anxiety disorders:

A wide range of medical illnesses can produce symptoms of anxiety, although this field – comorbidity – is likely to change because an increasing number of somatic disorders are being described in patients affected by pathological anxiety. The current differentiation between primary disorders or those “due” to a medical illness will give way to those that are “associated with somatic pathology”. As is the case of depression or bipolar disorder, the coexistence of auto-immune thyroid pathology, asthma, migraines, etc. progressively highlights the probability that these are different manifestations of a single systemic source⁴³. In the case of patients with diagnosed anxiety disorders, several studies have shown a higher prevalence of gastrointestinal, genitourinary, osteomuscular, thyroid, and allergic disorders, as well as migraines, cardiopathy, and hyperlaxitude in joints, in comparison with patients without anxiety disorders⁴⁴⁻⁴⁷.

Step 2

Panic attack

Panic attacks are defined as follows:

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

Cardiopulmonary symptoms:

1. chest pain or discomfort.
2. sensations of shortness of breath or smothering.
3. palpitations, pounding heart, or accelerated heart rate.

Autonomic symptoms:

4. Sweating.
5. chills or hot flushes.

Gastrointestinal symptoms:

6. Feeling of choking.
7. Nausea or abdominal distress.

Neurological symptoms:

8. trembling or shaking.
9. paresthesias (numbness or tingling sensations).
10. feeling dizzy, unsteady, lightheaded, or faint.

Psychiatric symptoms:

11. derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or going crazy.
13. Fear of dying.

2A. If panic attacks are unexpected (they occur “out of the blue” and are not related to a situational trigger) and they are clinically significant, consider the following:

Panic disorder with agoraphobia

A. Both (1) and (2):

- (1) recurrent unexpected Panic Attacks.
- (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - (a) persistent concern about having additional attacks.
 - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”).
 - (c) A significant change in behavior related to the attacks.

B. The presence of agoraphobia:

- (1) Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

Note: Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia if the avoidance is limited to social situations.

- (2) The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.
- (3) The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

- C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

OR

Panic disorder without agoraphobia

- A. Criterion A of panic disorder with agoraphobia is fulfilled.
- B. Absence of agoraphobia.
- C and D. Same as in the case of panic disorder with agoraphobia.

2B. If the panic attack is related to a situational trigger associated with another mental disorder, consider the following:

Panic attacks that occur in the context of other anxiety disorders (e.g. social phobia, specific phobia, post-traumatic stress disorder, obsessive-compulsive disorder).

Step 3

If the symptom is fear, avoidance, or anxious anticipation of one or more specific situations, consider 3A, 3B, and 3C:

3A. If the symptoms are related to social situations or actions in which the individual is exposed to people from outside the family circle or the possible evaluation by others, consider:

Social phobia

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

3B. If the symptoms include the avoidance of specific situations or objects, consider the following:

Specific phobia

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe

stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder with Agoraphobia, or Agoraphobia Without History of Panic Disorder.

- 3C. If the anxiety or avoidance is related to situations in which escape may be difficult or situations in which there is no help available if a panic attack occurs and there is no history of panic attacks, consider the following:

Panic disorder with agoraphobia

- 3D. If the symptom is related to a situation in which escape may be difficult or situations in which there is no help available if a panic attack occurs and there is no history of panic attacks, consider the following:

Agoraphobia without history of panic disorder

- A. The presence of Agoraphobia related to fear of developing panic-like symptoms (e.g., dizziness or diarrhea).
- B. Criteria have never been met for Panic Disorder.
- C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- D. If an associated general medical condition is present, the fear described in Criterion A is clearly in excess of that usually associated with the condition.

Step 4

4. If the apprehension or anxiety are related to persistent thoughts (obsessions) and/or rituals or recurrent mental acts (compulsions), consider the following:

Obsessive-compulsive disorder

A. Either obsessions or compulsions: **Obsessions** as defined by (1), (2), (3), and (4):

- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
- (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems.
- (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
- (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions as defined by (1) and (2):

- (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
- (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorders; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use

* The multi-axis classification of the DSM-IV-TR⁴⁰ includes five axes:
Axis I Clinical disorders. Other conditions that may be a focus of clinical attention
Axis II Personality disorders. Mental retardation
Axis III General medical conditions
Axis IV Psychosocial and environmental problems
Axis V Global assessment of functioning

Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder)

- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Step 5

If the symptoms are related to reexperiencing of highly traumatic events, consider 5A and 5B:

- 5A. If the symptoms are related to the reexperience of highly traumatic events and the symptoms last less than 4 weeks, consider:**

Post-traumatic stress disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person 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 self or others.
 - (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma.
 - (3) inability to recall an important aspect of the trauma.
 - (4) markedly diminished interest or participation in significant activities.
 - (5) feeling of detachment or estrangement from others.
 - (6) restricted range of affect (e.g., unable to have loving feelings).
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - (1) difficulty falling or staying asleep.
 - (2) irritability or outbursts of anger.
 - (3) difficulty concentrating.
 - (4) hypervigilance.
 - (5) exaggerated startle response.
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5B. If the symptoms persist for at least 2 weeks but not more than 4 weeks, consider:

Acute stress disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) the person 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 self or others.
 - (2) the person's response involved intense fear, helplessness, or horror.

- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
 - (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness.
 - (2) a reduction in awareness of his or her surroundings (e.g., “being in a daze”).
 - (3) Derealization.
 - (4) Depersonalization.
 - (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma).
- C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual’s ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

Step 6

If the symptoms of intense anxiety and worry are related to a variety of events or situations, consider the following:

Generalized anxiety disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children:
 - (1) restlessness or feeling keyed up or on edge.
 - (2) being easily fatigued.
 - (3) difficulty concentrating or mind going blank.
 - (4) Irritability.
 - (5) muscle tension.
 - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep).
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Step 7

If the symptoms appear in response to specific psycho-social stress, consider:

Adjustment Disorder with anxiety

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
 - (1) marked distress that is in excess of what would be expected from exposure to the stressor.
 - (2) significant impairment in social or occupational (academic) functioning.
- C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
- D. The symptoms do not represent Bereavement.
- E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Step 8

If the anxiety is clinically significant and the criteria are not fulfilled for any of the specific disorders described above, consider:

Non-specific anxiety disorder

This includes disorders with prominent symptoms of anxiety or phobic avoidance that do not fulfill the diagnostic criteria for any of the specific disorders described above. The following are several examples:

- (1) *Mixed anxiety-depressive disorder*: this is a persistent or recurring dysphoric mood state that lasts at least 1 month and is accompanied for at least 1 month by other anxious and depressive symptoms (e.g. difficulty concentrating or having your mind blank, sleep disorders, fatigue or lack of energy, irritability, worry, crying easily, hypervigilance, anticipation of danger, desperation, and low self-esteem or feelings of uselessness). These symptoms can cause deterioration of the individual's social or work relations or other important areas of their activities.
- (2) Clinically significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder (e.g., Parkinson's disease, dermatological conditions, stuttering, anorexia nervosa, body dysmorphic disorder).

- (3) Situations in which the alteration is serious enough to require a diagnosis of anxiety disorder, even though the individual does not present a sufficient number of symptoms to fulfill all of the criteria for a specific anxiety disorder.
- (4) Situations in which the clinical evidence confirms the presence of an anxiety disorder, but it is impossible to determine whether it is a primary disorder, due to medical illness, or substance-induced.

Cultural aspects related to anxiety

The immigrant population in Spain is continually increasing. This population presents some specific clinical characteristics in the different psychiatric disorders, with symptoms that are dependent on their individual cultures. In the case of anxiety disorders, many of these disorders are diagnosed as psychosis due to the presence of hallucinations and delirious intense fears. Likewise, panic attacks can be triggered by fear of magic or witchcraft. There are also syndromes connected to culture, which have now been described in our context, that are related to anxiety disorders, such as “Koro” and “nervous breakdown”⁴⁸⁻⁵².

5.2. Semi-structured interview

To achieve an overall understanding of the patient and to be able to establish a diagnosis of anxiety disorders, the ideal instrument is the clinical interview^{53,54}. The interview is used to establish or update the basis of the relationship and gathers or fails to gather the information needed to guideline the diagnosis and the decision as to the strategies to be followed.

By attempting to systematize the technique, between a guided interview and an open interview, the *semi-structured* interview combines both types, adapting to the characteristics of the doctor-patient encounter that takes place in the Primary Care environment (it combines time management, bio-psychosocial approach, and focuses on the patient as the expert on him or herself. It begins with more open questions (the content of which is partially pre-determined by the healthcare professional), supports the patient’s narrative, and later directs the encounter with more specific or closed questions that avoid leaving unanswered questions that are essential to identify and treat the problem. The different parts of a semi-structured interview are described in the table below⁵⁵⁻⁵⁸.

Table 8. Phases of the semi-structured interview⁵⁹⁻⁶¹

Preliminary phase	Exploratory phase	Resolution phase	Final phase
<ul style="list-style-type: none"> • Empathetic reception • Determine the reason for the visit • Avoid the “and while I’m here”, limiting the reasons for the visit 	<ul style="list-style-type: none"> • Obtain basic specific information: <ul style="list-style-type: none"> - What the symptoms are like - Location - Intensity - Chronology and evolution • Gather specific additional information: <ul style="list-style-type: none"> - Presence of organic or iatrogenic pathology - Trigger factors: changes, grieving... - Social-family environment - Personal history: manic episodes, prior episodes of depression - Situations that improve or worsen • Exploration of the psychosocial sphere: <ul style="list-style-type: none"> - Beliefs and expectations - Content of thought - Affectivity - Personality 	<ul style="list-style-type: none"> • Synthesis and listing of the problem(s) • Inform the patient regarding the nature of the problem • Verify that the patient has understood the explanations • Involve the patient in the preparation of a diagnostic-therapeutic plan: <ul style="list-style-type: none"> - Agreements - Negotiation 	<ul style="list-style-type: none"> • Taking precautions • Final agreement • Goodbye

In the exploratory phase, normally the Primary Care professional has already gathered much of the supplementary information and the information on the psycho-social environment of a patient whom the professional and the rest of the team already know, which facilitates the process. In the final phase of the interview, the *final agreement* should be emphasized, as the reconversion of the ideas and agreements reached ⁵⁹⁻⁶¹.

5.3. Use of scales

The confirmation of the aforementioned under-diagnosis of anxiety has given rise to a large number of structured instruments or scales that try to detect “potential cases” of illness.

Many of the scales are intended to serve as filtering instruments, and with all of them, once the potential case has been detected, the corresponding diagnostic procedure can then be applied.

The scales in and of themselves do not generate diagnoses, but rather make it possible to select people with high scores who are suspected of suffering a mental pathology, which justifies the later execution of a more in-depth study ⁶².

These measurement instruments also serve to complete a proper evaluation, since they reinforce the diagnostic judgment prepared after the clinical interview and the psychopathological exploration.

All of these instruments have the limitations of detecting false positives and negatives, since they all have a sensitivity and specificity that is lower than 100%. It is therefore neither feasible nor advisable to use the scales routinely in Primary Care for clinical purposes, and under no circumstances should they substitute the clinical interview, even though they are useful as a guideline for the interview and to support the clinical judgment, and they have also become essential tools in clinical research, and also serve to verify the effect that the different therapeutic interventions have on the evolution of the illness ^{62,63}.

Since the time available to evaluate patients in Primary Care offices is limited, the instruments to be used should be easy to use and interpret. The following sections describe several of the scales related to anxiety ^{59,64,65}.

Goldberg Anxiety and Depression Scale (GADS)⁶⁶

This scale was conceived to allow the detection of the two most frequent psychopathological disorders in Primary Care. It is a simple instrument that is short and easy to use, and is suitable for administration by Primary Care doctors. It can be used as a guideline for the interview, as well as an indicator of the prevalence, gravity, and evolution of these disorders. The Spanish version has demonstrated its reliability and validity in Primary Care use and has adequate sensitivity (83.1%), specificity (81.8%) and positive predictive value (95.3%).

Hospital, Anxiety, and Depression (HAD)⁶⁷

A scale of 14 items designed to evaluate anxiety and depression in non-psychiatric hospital outpatient services. This is a state measurement that contains two scales, one for anxiety and the other for depression. One of the main virtues is the suppression of somatic symptoms so that it is possible to independently evaluate the underlying somatic illness. This is a useful instrument validated in our system and is especially interesting and useful in the context of Primary Care ⁶⁸.

HARS-Hamilton Anxiety Rating Scale (Chamorro)

This scale evaluates anxiety intensity. It consists of 14 items that evaluate mental, physical, and somatic aspects of anxiety. One item will evaluate depressed mood. It is an externally-applied scale. There is a version adapted to Spanish by Carrobbles and cols. (1986). Depending on the type of symptom, it will be measured in terms of seriousness, duration, and dysfunction, from lower to higher.

Clinical Anxiety Scale (CAS) and Physician Questionnaire (PQ)

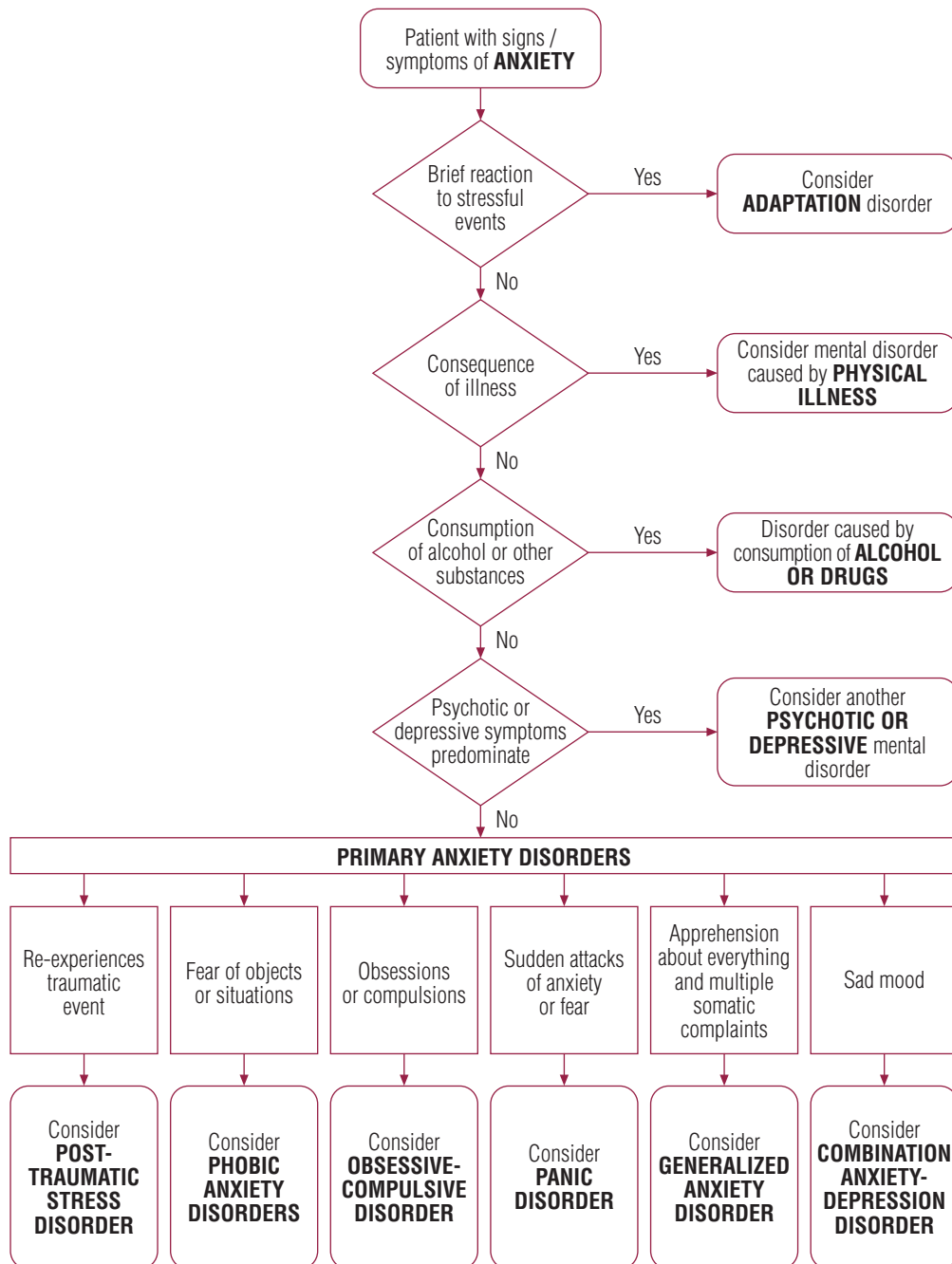
These are externally-administered scales that evaluate the gravity of the symptoms in diagnosed anxiety patients. The evaluation lapse of the CAS covers the last two days, with the PQ covering the last week. The CAS was designed based on the content areas present in the HARS (Hamilton Anxiety Rating Scale) and consists of 7 items. It is specially designed to evaluate psychological symptomatology and is influenced very little by somatic manifestations of anxiety. The PQ includes 14 items and evaluates neurotic symptomatology and response to treatment. The symptomatology covered includes the symptoms that are most familiar to and most commonly observed by general physicians. This test includes a group of emotional symptoms, another group of somatic symptoms, an overall rating, and 1 independent item that evaluates the general gravity of the anxiety disorder. Because they are brief, both scales may be useful in evaluating anxiety disorders in outpatient care, either in hospitals or in Primary Care facilities.

The appendices include two scales, one self-administered (HAD) and the other externally-administered (GADS) (Appendix 2), since they are easy to handle and interpret within the scope of PC, and are useful to provide key questions to guideline the clinical interview and to evaluate the changes achieved with the different interventions, but not to filter the population. These scales have not been validated with the immigrant population, so it is possible that their sensitivity/specificity, as well as their clinical utility for these patients will be more limited ⁴⁸.

Another appendix also includes a series of key questions to be asked during the interview with the patient to assist healthcare professionals to detect anxiety disorders, specifically Generalized Anxiety Disorder and Panic Disorder ⁷⁰ (Appendix 3).

5.4. Diagnostic algorithm

The following diagnostic algorithm provides some initial guidelines when faced with a patient with anxiety symptoms:



Source: Modified from Pascual Pascual P., Villena Ferrer A., Morena Rayo S., Téllez Lapeira J.M., *El paciente ansioso*. Internet. Fisterra.com; 2005.