

# Anxiety Disorders

## Agoraphobia

- The patient has anxiety about being in a place or situation from which either or both
  - Escape was difficult or embarrassing or
  - If a panic attack occurred, help might not be available
- The patient:
  - Avoids these situations or places (restricting travel) or
  - Endures them, but with material distress (a panic attack might occur) or
  - Requires a companion when in the situation
- Other mental disorders don't explain the symptoms better. \*

### Coding Notes

By itself, agoraphobia is not a codable DSM-IV diagnosis. Criteria for it (and, below, panic attack) are presented to help clarify the picture of this common clinical condition.

\* These include Social Phobias (the patient avoids eating for fear of embarrassment); Specific Phobias (avoids certain limited situations, such as telephone booths); Obsessive-Compulsive Disorder (avoids dirt for fear of contamination); Posttraumatic Stress Disorder (for example, the patient avoids movies about Vietnam). Children who avoid leaving home should be evaluated for Separation Anxiety Disorder.

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## Agoraphobia Without History of Panic Disorder

- The patient has agoraphobia (page 206) related to the fear of experiencing panic-like symptoms.
- The patient has never fulfilled criteria for Panic Disorder (page 215).
- The symptoms are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.
- If the patient does have a general medical condition, the fears clearly exceed those that usually accompany it.

### Coding Note

The "panic-like symptoms" mentioned above can include any of the panic attack symptoms plus any other symptoms that could embarrass or incapacitate the patient. For example, the patient might refuse to leave home for fear of losing bladder control.

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## Panic Attack

- The patient suddenly develops a severe fear or discomfort that peaks within 10 minutes.
- During this discrete episode, 4 or more of the following symptoms occur:
  - Chest pain or other chest discomfort
  - Chills or hot flashes

- Choking sensation
- Derealization (feeling unreal) or depersonalization (feeling detached from self)
- Dizzy, lightheaded, faint or unsteady
- Fear of dying
- Fears of loss of control or becoming insane
- Heart pounds, races or skips beats
- Nausea or other abdominal discomfort
- Numbness or tingling
- Sweating
- Shortness of breath or smothering sensation
- Trembling

### **No-Coding Note**

By itself, panic attack is not a codable DSM-IV diagnosis. Criteria for it (and, above, agoraphobia) are presented to help clarify the picture of this common clinical condition.

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## **Panic Disorder With Agoraphobia**

- The patient has recurrent panic attacks that are not expected.
- For a month or more after at least 1 of these attacks, the patient has had 1 or more of:
  - Ongoing concern that there will be more attacks
  - Worry as to the significance of the attack or its consequences (for health, control, sanity)
  - Material change in behavior, such as doing something to avoid or combat the attacks
  - The patient also has agoraphobia
- The panic attacks are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.
- The panic attacks are not better explained by another Anxiety or Mental Disorder.\*

### **Coding Note**

\*DSM-IV specifically notes that panic attacks can occur in the following Anxiety Disorders, which should be ruled out before diagnosing agoraphobia: Social Phobias; Specific Phobias; Obsessive-Compulsive Disorder; Posttraumatic Stress Disorder. Children who have panic attacks on leaving home should be evaluated for Separation Anxiety Disorder.

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## **Panic Disorder Without Agoraphobia**

- The patient has recurrent panic attacks that are not expected.
- For a month or more after at least 1 of these attacks, the patient has had 1 or more of:
  - Ongoing concern that there will be more attacks
  - Worry as to the significance of the attack or its consequences (for health,

control, sanity)

-Material change in behavior, such as doing something to avoid or combat the attacks

- The patient does not have agoraphobia
- The panic attacks are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.
- The panic attacks are not better explained by another Anxiety or Mental Disorder.\*

## Coding Note

\*DSM-IV specifically notes that panic attacks can occur in the following Anxiety Disorder, which should be ruled out before diagnosing agoraphobia: Social Phobias; Specific Phobias; Obsessive-Compulsive Disorder; Posttraumatic Stress Disorder. Children who have panic attacks on leaving home should be evaluated for Separation Anxiety Disorder.

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## Specific Phobia

- The patient experiences a strong, persistent fear that is excessive or unreasonable. It is set off (cued) by a specific object or situation that is either present or anticipated.
- The phobic stimulus almost always immediately provokes an anxiety response, which may be either a panic attack or symptoms of anxiety that do not meet criteria for a panic attack.
- The fear is unreasonable or out of proportion, and the patient realizes this.\*
- The patient either avoids the phobic stimulus or endures it with severe anxiety or distress.
- Patients under the age of 18 must have the symptoms for 6 months or longer.
- Either there is marked distress about this fear or it markedly interferes with the patient's usual routines or social, job or personal functioning.
- The symptoms are not better explained by a different mental disorder, including Anxiety Disorders,\*\* Dysmorphic Disorder, Pervasive Developmental Disorder or Schizoid Personality Disorder.

Specify type:\*\*\*

Situational Type (airplane travel, being closed in)

Natural Environment Type (thunderstorms, heights, for example)

Blood, Injection, Injury Type

Animal Type (spiders, snakes)

Other Type (situations that might lead to illness, choking, vomiting)

## Coding Notes

\*Children with Specific Phobia may express the anxiety response by clinging, crying, freezing or tantrums. They may not have insight that their fear is unreasonable or out of proportion. "Other Type" in children can include avoiding loud noises or people in costumes.

\*\*DSM-IV specifically notes some of the other Anxiety Disorders that should be ruled out before diagnosing Specific Phobia: Social Phobias (the patient avoids public eating or other activities for fear of embarrassment); Obsessive-Compulsive Disorder (fears dirt or contamination); Posttraumatic Stress Disorder (for example, the patient avoids movies about Vietnam); agoraphobia (with or without Panic Disorder). Children who avoid leaving home should be evaluated for Separation Anxiety Disorder.

\*\*\*The types of Specific Phobia are arranged in descending order of frequency (as found in adults). If more than one type is present, code them all.

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## Social Phobia

- The patient strongly, repeatedly fears at least one social or performance situation that involves facing strangers or being watched by others. The patient specifically fears showing anxiety symptoms or behaving in some other way that will be embarrassing or humiliating.
- The phobic stimulus almost always causes anxiety, which may be a cued or situationally predisposed panic attack.
- The patient realizes that this fear is unreasonable or out of proportion.
- The patient either avoids the situation or endures it with severe distress or anxiety.\*
- Either there is marked distress about having the phobia or it markedly interferes with the patient's usual routines or social, job or personal functioning.
- Patients under the age of 18 must have the symptoms for 6 months or longer.
- The symptoms are not better explained by a different mental disorder, including Anxiety Disorders, Dysmorphic Disorder, Pervasive Developmental Disorder or Schizoid Personality Disorder.
- The symptoms are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.
- If the patient has another mental disorder or a general medical condition, the phobia is not related to it.

Specify whether Generalized. The patient fears most social situations.

### Coding Notes

\*Children cannot receive this diagnosis unless they have demonstrated the capacity for social relationships. Their anxiety must occur not just with adults, but with peers. They may express the anxiety response by clinging, crying, freezing or withdrawing. They may not recognize that the fear is unreasonable, or out of proportion.

If the Social Phobia is Generalized, evaluate the patient for an Axis II diagnosis of Avoidant Personality Disorder.

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## Obsessive-Compulsive Disorder

- The patient has obsessions or compulsions, or both.  
**Obsessions. The patient must have all of:**
  - 1 Recurring, persisting thoughts, impulses or images inappropriately intrude into awareness and cause marked distress or anxiety.

- 2 These ideas are not just excessive worries about ordinary problems.
- 3 The patient tries to ignore or suppress these ideas or to neutralize them by thoughts or behavior.
- 4 There is insight that these ideas are a product of the patient's own mind.

**Compulsions. The patient must have *all* of:**

- 1 The patient feels the need to repeat physical behaviors (checking the stove to be sure it is off, handwashing) or mental behaviors (counting things, silently repeating words).
  - 2 These behaviors occur as a response to an obsession or in accordance with strictly applied rules.
  - 3 The aim of these behaviors is to reduce or eliminate distress or to prevent something that is dreaded.
  - 4 These behaviors are either not realistically related to the events they are supposed to counteract or they are clearly excessive for that purpose.
- During some part of the illness the patient recognizes that the obsessions or compulsions are unreasonable or excessive.\*
  - The obsessions and/or compulsions are associated with at least 1 of:
    - Cause severe distress
    - Take up time (more than an hour per day)
    - Interfere with the patient's usual routine or social, work or personal functioning
  - If the patient has another Axis I disorder, the content of obsessions or compulsions is not restricted to it.
  - The symptoms are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.

Specify if With Poor Insight. During most of this episode the patient does not realize that these thoughts and behaviors are unreasonable or excessive.

### **Coding Notes**

\*Children do not need to have insight.

DSM-IV specifies preoccupations typical of other Axis I disorders that must be ruled out: appearance (Body Dysmorphic Disorder); food (Eating Disorders); being seriously ill (Hypochondriasis); guilt (Mood Disorders); sexual fantasies or urges (Paraphilias); drugs (Substance Use Disorders); hair pulling (Trichotillomania).

## **Posttraumatic Stress Disorder**

- The patient has experienced or witnessed or was confronted with an unusually traumatic event that has *both* of these elements:  
The event involved actual or threatened death or serious physical injury to the patient or to others, *and*  
The patient felt intense fear, horror or helplessness\*
- The patient repeatedly relives the event in at least 1 of these ways:
  - Intrusive, distressing recollections (thoughts, images)\*
  - Repeated, distressing dreams\*
  - Through flashbacks, hallucinations or illusions, acts or feels as if the event were

recurring (includes experiences that occur when intoxicated or awakening)\*

-Marked mental distress in reaction to internal or external cues that symbolize or resemble the event.

-Physiological reactivity (such as rapid heart beat, elevated blood pressure) in response to these cues

- The patient repeatedly avoids the trauma-related stimuli and has numbing of general responsiveness (absent before the traumatic event) as shown by 3 or more of:
  - Tries to avoid thoughts, feelings or conversations concerned with the event
  - Tries to avoid activities, people or places that recall the event
  - Cannot recall an important feature of the event
  - Marked loss of interest or participation in activities important to the patient
  - Feels detached or isolated from other people
  - Restriction in ability to love or feel other strong emotions
  - Feels life will be brief or unfulfilled (lack of marriage, job, children)
- At least 2 of the following symptoms of hyperarousal were not present before the traumatic event:
  - Insomnia (initial or interval)
  - Irritability
  - Poor concentration
  - Hypervigilance
  - Increased startle response
- The above symptoms have lasted longer than one month.
- These symptoms cause clinically important distress or impair work, social or personal functioning.

Specify whether:

Acute. Symptoms have lasted less than 3 months

Chronic. Symptoms have lasted 3 months or longer

Specify if:

With Delayed Onset. The symptoms did not appear until at least 6 months after the event.

### **Coding note**

\*In children, response to the traumatic event may be agitation or disorganized behavior. Young children may relive the event through repetitive play, trauma-specific reenactment or nightmares without recognizable content.

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## **Acute Stress Disorder**

- The patient has experienced or witnessed or was confronted with an unusually traumatic event that has *both* of these elements:
  - 1 The event involved actual or threatened death or serious physical injury to the patient or to others, *and*
  - 2 The patient felt intense fear, horror or helplessness.
- Either during the event or just afterward, the patient experiences 3 or more of these symptoms of dissociation:

- Feels numbed or detached or is unresponsive emotionally
- Seems less aware of surroundings, as in a daze
- Derealization
- Depersonalization
- Amnesia for important aspects of the event
- The patient repeatedly reexperiences the event in one or more of these ways:
  - Recollections (dreams, flashbacks, illusions, images, thoughts)
  - The sense of reliving the event
  - Mental distress as a reaction to reminders of the event
- The patient strongly avoids activities, conversations, feelings, people, places or thoughts reminiscent of the trauma.
- There are marked symptoms of anxiety or hyperarousal, such as hypervigilance, insomnia, irritability, poor concentration, restlessness or increased startle response.
- At least 1 of the following applies:
  - The patient feels marked distress from the symptoms
  - They interfere with usual social, job or personal functioning.
  - They block the patient from doing something important such as getting legal or medical help or telling family or other supporters about the experience
- The symptoms begin within 4 weeks of the trauma and last from 2 days to 4 weeks.
- The symptoms are not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.
- They are not merely a worsening of another Axis I or Axis II disorder.
- Brief Psychotic Disorder is ruled out.

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## Generalized Anxiety Disorder

- For more than half the days in at least 6 months, the patient experiences excessive anxiety and worry about several events or activities.
- The patient has trouble controlling these feelings.
- Associated with this anxiety and worry, the patient has 3 or more of the following symptoms, some of which are present for over half the days in the past 6 months:\*
  - Feels restless, edgy, keyed up
  - Tires easily
  - Trouble concentrating
  - Irritability
  - Increased muscle tension
  - Trouble sleeping (initial insomnia or restless, unrefreshing sleep)
- - Aspects of another Axis I disorder do not provide the focus of the anxiety and worry.\*\*
- The symptoms cause clinically important distress or impair work, social or personal functioning.
- The disorder is not directly caused by a general medical condition or by substance use, including medications and drugs of abuse.

- It does not occur only during a Mood Disorder, Psychotic Disorder, Posttraumatic Stress Disorder or Pervasive Developmental Disorder.

### **Coding Notes**

\*Children need fulfill only 1 of these 6 symptoms.

\*\*Aspects of another Axis I disorder include worry about: weight gain (Anorexia Nervosa); contamination (Obsessive-Compulsive Disorder); having a panic attack (Panic Disorder); separation from home or relatives (Separation Anxiety Disorder); public embarrassment (Social Phobia); having physical symptoms (Somatoform Disorders).

## **Anxiety Disorder Due to A General Medical Condition**

- The patient has prominent anxiety, compulsions, obsessions or panic attacks.
- History, physical exam or laboratory findings suggest a general medical condition that seems likely to have directly caused these symptoms.
- No other mental disorder better accounts for these symptoms.\*
- The symptoms cause important clinical distress or impair work, social or personal functioning.
- The symptoms don't occur solely during a delirium.

Depending on the dominant symptomatology, specify whether:

With Generalized Anxiety

With Panic Attacks

With Obsessive-Compulsive symptoms

### **Coding Notes**

\*DSM-IV specifically mentions an Adjustment Disorder With Anxiety, precipitated by the stress of a serious medical illness.

In the Axis I diagnosis, include the name of the actual general medical condition (not the term "general medical condition").

On Axis III code the specific general medical condition.

## **Substance-Induced Anxiety Disorder**

- The patient has prominent anxiety, compulsions, obsessions or panic attacks
- History, physical exam or laboratory data substantiate that *either*
  - These symptoms have developed within a month of Substance Intoxication or Withdrawal, *or*
  - Medication use has caused the symptoms
- No other anxiety disorder better accounts for these symptoms.\*
- The symptoms cause clinically important distress or impair work, social or personal functioning.
- The symptoms don't occur solely during a delirium.

Codes for Substance-Induced Anxiety Disorders

291.8 Alcohol

292.89 Amphetamine [or Amphetamine-Like Substance], Caffeine, Cannabis, Cocaine, Hallucinogen, Inhalant, Phencyclidine [or Phencyclidine-Like Substance], Sedative, Hypnotic, or Anxiolytic, Other [or Unknown] Substance

Depending on the dominant symptomatology, specify whether:

With Generalized Anxiety

With Obsessive-Compulsive symptoms

With Panic Attacks

With Phobic Symptoms

Depending on time of onset, specify (see page 57):

With Onset During Intoxication

With Onset During Withdrawal

### **Coding Notes**

\*No other anxiety disorder must account for the symptoms better than does substance use. A variety of historical information could suggest that this is the case:

a. Anxiety disorder symptoms precede the onset of substance abuse.

b. There have been previous episodes of an anxiety disorder.

c. The symptoms are much worse than you would expect for the amount and duration of the substance abuse.

d. Anxiety disorder symptoms continue long (at least a month) after substance abuse or withdrawal stops.

The diagnosis of a Substance-Induced Anxiety Disorder should be made only when the anxiety symptoms considerably exceed what you would expect from an ordinary case of Intoxication or Withdrawal from that specific substance.

Anxiety Disorder caused by most medications taken in therapeutic doses would be coded as, for example:

Axis I 292.89 Thyroxin-Induced Anxiety Disorder, With Generalized Anxiety, With Onset During Intoxication

Axis III E932.7 Thyroid replacement (Thyroxin)

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## **300.00 Anxiety Disorder NOS**