worry area by having the patient concentrate on his/her anxious thoughts while imagining the worst possible feared outcome

- revoking these images and holding them clearly for 25 - 30 minutes, and
- after 25 - 30 minutes, having the patient generate as many alternatives to the worst possible feared outcome as he/she can think of.

This is assigned as a daily home exercise. When the patient experiences no more than a 2 on the 8-point anxiety scale, he/she moves on to the next area of worry.

Worry behaviour prevention
The focus is to counteract the negative reinforcement behaviour. The patient draws up a list of his/her worry behaviour and is then instructed to refrain from using these worry behaviours.

Relaxation training, time management and problem solving can be included as useful adjuncts to GAD treatment.

Although further research is currently being undertaken, there is strong evidence of the efficacy and effectiveness of this treatment programme. Hereby both the worry and arousal are decreased and maintained at lower levels.

References available on request.

ANXIETY DISORDERS, DISABILITY, AND QUALITY OF LIFE

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Written descriptions of anxiety and anxiety disorders date back to the 4th century BC, but their importance and impact on quality of life (QOL) were underestimated until less than 2 - 3 decades ago. In reality, research suggests that anxiety disorders have the highest overall prevalence among the mental disorders, with a lifetime rate of 14.6%,[1] affecting as many as 26.9 million individuals in the USA at some point in their lives with associated costs amounting to $46.6 billion in 1990.[2] Both epidemiological and clinical studies highlight the extensive burden and markedly compromised QOL and psychosocial functioning associated with anxiety disorders.

Although no single definition of QOL is universally accepted, it is a concept that has become increasingly used in mental health care. It was developed in the social sciences and first applied in medical practice to determine whether available treatments could not only increase survival time of cancer patients but also enhance their psychological well-being. Later the concept of QOL was increasingly applied in studies comparing different treatments in terms of the patient's level of functioning, well-being and life satisfaction. However, most experts agree that the concept of QOL covers an individual's subjective sense of well-being as well as objective indicators such as health status and external life situations, all reflecting his/her global physical and mental well-being, and including family and social relationships, scholastic and work functioning, financial and health status, and living situation. QOL data are useful to: (*i*) assess the impact of a disorder(s) on an individual's functioning in a number of domains and on overall well-being; (*ii*) compare outcomes between different treatment modalities; and (*iii*) differentiate between therapies in terms of mortality and/or morbidity.

Currently, information on QOL is derived from the following two sources: (*i*) epidemiological studies such as the Epidemiological Catchment Area (ECA) survey and the National Comorbidity Survey in the USA which provide a number of indicators (e.g. income, level of education) from which QOL can be inferred;

and (*ii*) clinical studies using specifically designed scales to assess QOL.

QOL in panic disorder (PD)

It has been suggested that more than one-third of patients with PD feel that they are in fair or poor physical or emotional health, with as many patients receiving welfare or some form of disability compensation. This suggests an association between PD and significant functional impairment and reduced QOL. One of the most widely used QOL measures that assesses both mental and physical health is the Medical Outcomes Study 36-item Short-form Health Survey. Other QOL measures also used for patients with PD include the Sheehan Disability Scale. Consistent with epidemiological findings, clinical studies using these scales suggest that PD is associated with significant impairment in physical and mental health functioning, with QOL being markedly worse than that of healthy controls.

QOL in social anxiety disorder (SAD)

Until quite recently, the magnitude of disability associated with SAD was under-recognised. However, findings from the ECA and National Comorbidity surveys suggested that SAD was a common disorder associated with significant disability and impairment. In particular, SAD was found to be associated with elevated rates of financial dependency, lower income, education level, and social support. The Disability Profile and the Liebowitz Self-rated Disability Scale are QOL rating scales that have been used for SAD patients. Their findings suggest that more than half of these patients report as least moderate impairment at some time in their lives due to social anxiety and avoidance in areas of education, employment, family relationships, marriage or romantic relationships, friendship or social network, and other interests.

QOL in obsessive-compulsive disorder (OCD)

The ECA study found that OCD was much more prevalent than previously thought, ranging between 1.9% and 3.3%.[3] This and a number of other clinical studies suggest that OCD is associated with moderate to severe interference in social activities, family relationships and ability to study/work, as well as with decreased self-esteem and suicidal thoughts.

QOL in generalised anxiety disorder (GAD)

There continues to be considerable debate around the diagnostic criteria for GAD. Nevertheless, using the *DSM-III* and *DSM-III-R* criteria for GAD, lifetime prevalence rates for GAD are considered to be between 4% and 7%, respectively. Findings from the community studies as well as clinical studies suggest that GAD may lead to marked impairment in role functioning and social life, and reduction in emotional health and overall life satisfaction.

QOL in post-traumatic stress disorder (PTSD)

Epidemiological studies have suggested that persons with PTSD are at a higher risk of diminished well-being, fair or poor physical health or physical limitations, or current unemployment, and are more likely to report marital/parental/family adjustment problems, compared with persons without PTSD. Relatively few clinical studies have investigated the impact of PTSD on QOL; however, the existing studies portray a picture of PTSD as a condition that significantly compromises QOL.

Conclusion

Disability and QOL measures used in epidemiological and clinical studies almost uniformly portray anxiety disorders as conditions that markedly compromise functioning in several domains, and consequently overall QOL. While some studies suggest that the extent of impairment may be similar across a number of different anxiety disorders, symptoms that characterise each of the disorders may be associated with differential impairment on various domains of function, and may require specifically tailored inter-ventions. There is growing awareness that disability and decreased QOL associated with anxiety disorders is comparable with that seen in serious medical conditions, but that such disability may respond to treatment.

References available on request.

SCREENING TOOLS FOR ANXIETY IN PRIMARY CARE

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In recent years increased attention has been paid to the development of brief diagnostic or screening tools. These screening instruments may be useful and time-saving in the recognition of anxiety disorders, especially in busy primary care settings.

Anxiety disorders

Anxiety disorders are among the most prevalent of psychiatric illnesses. These disorders are disabling, often co-morbid with other medical and/or