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 at 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%. 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 interventions. 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.

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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...
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Adequate treatment of anxiety disorders begins with early detection and diagnosis.

Psychiatric illnesses, and can lead to substantial functional impairment. The DSM-IV recognises a number of distinct anxiety disorders, including panic disorder with and without agoraphobia, agoraphobia without panic, generalised anxiety disorder, phobias, social anxiety disorder, post-traumatic stress disorder, and obsessive-compulsive disorder. Most anxiety disorders have their onset in childhood or adolescence, but those afflicted typically do not seek treatment until well into adulthood.

It has been suggested that only one-third of people with anxiety disorders seek treatment for their illness,1 with GPs failing to diagnose half of all cases of anxiety.2 It is unfortunate that a large number of people with anxiety disorders — commonly encountered in primary care — still remain undiagnosed, untreated or inadequately treated.3 People who are diagnosed accurately can be treated effectively with pharmacotherapy and/or psychotherapy in the primary care setting. If adequately treated earlier in their illness their prognosis will be better.4

Screening tools
Adequate treatment of anxiety disorders begins with early detection and diagnosis. Owing to time constraints typical in most primary care settings, increased attention has been given to the development of brief diagnostic or screening tools for use in busy practices. Brief, easy-to-administer/interpret, self-report psychiatric screening instruments may be useful and time-saving in the recognition of anxiety disorders in primary care. Positive screening can consequently be confirmed with brief follow-up questions. This 2-step method may be effective in detecting mental health disorders at the primary care level.

There are many standardised structured instruments/diagnostic tools used in research settings. However, administration and scoring of these instruments usually take considerable time and expertise, making them unsuitable for use in clinical practice. That said, there is increasing need for diagnostic precision and accountability in clinical (non-research) settings.

There are currently a few valid and reliable screening instruments available for use in primary care. In general, these screening instruments are 1-2-page, paper and pencil tools intended to be completed by patients, then hand-scored and interpreted by the doctor. For example, the Primary Care Evaluation of Mental Disorders (PRIME-MD) is a brief screening tool used by many primary care doctors, demonstrating high validity and reliability for identifying patients with anxiety and depressive disorders. Other frequently used screening instruments include the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC). A number of these brief, algorithm-scored, easily interpretable, self-report screening instruments for anxiety disorders are available on the Internet, e.g. the Web-based Depression and Anxiety Test (WB-DAT), although additional work is needed to determine their psychometric properties.

Problems with screening tools
Unfortunately, there remain a number of problems associated with the widespread use of the abovementioned and other screening instruments in primary care. Many of the available screening tools are very narrow in their scope of assessment. For example, there are a number of 1- or 2-page screening instruments designed to assess only one disorder, e.g. panic disorder (with/without agoraphobia), social anxiety disorder or obsessive-compulsive disorder. Therefore, more broadly focused diagnostic screening tools may be useful in primary care.

Conclusion
A number of screening tools for anxiety disorders are available for use in primary care settings. However, more work is needed to overcome some of the barriers associated with their use, for example by designing comprehensive, yet brief, valid and reliable, easy-to-score and interpret self-report screening instruments that are efficient in terms of their sensitivity and specificity for anxiety symptoms. Easier access to screening tools for anxiety disorders for primary health care professionals and patients and wider access to these tools on the Internet are also needed. Where indicated, it is important that screening be followed by thorough assessment and treatment by a doctor.

References available on request.