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Proposed new diagnoses of anxious depression and bodily stress syndrome in ICD-11-PHC: an international focus group study

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Background. The World Health Organization is revising the primary care classification of mental and behavioural disorders for the International Classification of Diseases (ICD-11-Primary Health Care (PHC)) aiming to reduce the disease burden associated with mental disorders among member countries.

Objective. To explore the opinions of primary care professionals on proposed new diagnostic entities in draft ICD-11-PHC, namely anxious depression and bodily stress syndrome (BSS).

Methods. Qualitative study with focus groups of primary health-care workers, using standard interview schedule after draft ICD-11-PHC criteria for each proposed entity was introduced to the participants.

Results. Nine focus groups with 4–15 participants each were held at seven locations: Austria, Brazil, Hong Kong, New Zealand, Pakistan, Tanzania and United Kingdom. There was overwhelming support for the inclusion of anxious depression, which was considered to be very common in primary care settings. However, there were concerns about the 2-week duration of symptoms being too short to make a reliable diagnosis. BSS was considered to be a better term than medically unexplained symptoms but there were disagreements about the diagnostic criteria in the number of symptoms required.

Conclusion. Anxious depression is well received by primary care professionals, but BSS requires further modification. International field trials will be held to further test these new diagnoses in draft ICD-11-PHC.

Keywords. Anxious depression, bodily stress syndrome, focus group interview, mental health, primary care.

Introduction

The World Health Organization (WHO) is in the process of revising the International Classification of Diseases, currently in its 10th revision (ICD-10). The WHO Department of Mental Health and Substance Abuse is responsible for the technical work associated with the revision of the ICD-10 chapter on Mental and Behavioural Disorders: they are assisted by an International Advisory Group and a series of specific Working Groups. In keeping with WHO's mission and constitution, the usefulness of the classification in helping WHO member countries, particularly low and middle-income countries, to reduce the disease burden associated with mental disorders is among the highest priorities for the revision. WHO has determined that the current revision provides a major opportunity to improve the classification's clinical utility in global primary care settings where there is the greatest opportunity to identify people with unmet needs for mental health treatment.[1]

The WHO Department of Mental Health and Substance Abuse has appointed a Primary Care Consultation group (PCCG) to lead the development of the primary care classification of mental and behavioural disorders for ICD-11 (ICD-11-Primary Health Care (PHC)). The PCCG consists of a small group of primary care professionals and mental health specialists representing developed as well as low and middle-income countries. The PCCG reports to the International Advisory Group. The PCCG has been charged with developing and field testing the full set of disorders to include in ICD-11-PHC.

By definition, primary care settings are those in which people are most likely to come into contact with the health-care system. Across the world, when people with mental disorders do receive care, they are far more likely to receive it in primary care than in specialty mental health settings.[2] Therefore, primary care settings represent the best opportunity to improve the identification and effective treatment of people with mental disorders.

A classification system that is usable and useful for health-care workers in these settings is a fundamental requirement for such an effort. Because most people with mental disorders—if they are treated at all—are treated in primary care settings, it is crucial to the project of reducing disease burden that a disease classification corresponds in easily recognizable ways to the manner in which disorders commonly present. The classification must also be usable by the types of health workers most likely to encounter people with mental health needs. Globally, primary health-care workers are often not physicians, and they are highly unlikely to be trained mental health professionals.[3,4] In many community-based primary care settings in low-income countries, health workers may have limited formal professional training of any kind.[5]

After the publication of ICD-10, WHO created a modified version of the mental and behavioural disorders classification for primary care.[6] However, the usefulness of this system has been limited by the fact that it was adapted from the specialty classification, (primarily by collapsing disorders into larger categories), rather than being created on the basis of the needs and priorities of primary care settings.[7] For this revision, both WHO and the International Advisory Group have strongly emphasized the need to develop the primary care version of the ICD-11 mental and behavioural disorders chapter simultaneously with the specialty version, based on the diversity and particularities of primary care settings and the characteristics of the health-care personnel who work in them. The PCCG is following this path in developing ICD-11-PHC.

The commonest mental disorders encountered in general medical settings are various mixtures of anxious, depressive and somatic symptoms. These disorders have been documented in all global populations and countries in which they have been studied,[8–11] and are consistently found to be more prevalent among women than among men. In practice, there are high correlations (ranging from +0.70 to +0.95) among all three groups of symptoms[8,9] and patients commonly present for care with untidy combinations of anxious, depressive and somatic symptoms.[10,12–14]

Anxious depression

ICD-10 and ICD-10-PHC[15] introduced the concept of "mixed anxiety depression", which was intended to cover those common disorders in which both anxious and depressive symptoms are both present, but each is at just below the necessary threshold for either depressive episode or generalized anxiety. The problem with this disorder as currently defined is that the conjunction of these two sets of symptoms is extremely common. When both anxious symptoms and depressive symptoms are at "case" level of severity, one can either make two quite separate diagnoses and diagnose "co-morbidity", or consider that the patient has "anxious depression". However, primary care professionals in the field rarely make multiple concurrent mental illness diagnoses in the same patient, on the grounds that highly concordant symptoms in an individual more likely represent a single underlying mental health condition.[16] The diagnosis "anxious depression" has been proposed on these grounds. If it is accepted, then what was previously "mixed anxiety depression" will become a sub-threshold version of anxious depression. Two 5-item scales to enable structured assessment for depression, anxiety and anxious depression have been incorporated into the current draft of the ICD-11-PHC by the PCCG (please see Appendix 1 for details).

Bodily stress syndrome

Although somatic symptoms are often accompanied by anxious or depressive symptoms determining that therapeutic attention is directed at these latter symptoms; on some occasions, these patients have either few such symptoms—or none at all. But, whether depression or anxiety is present or not, other management strategies are usually necessary to treat patients with special cluster of symptoms. Recent research conducted in Denmark and elsewhere[17–19] have pointed out the importance of these somatic symptoms that occur in the absence of anxiety and depressive syndromes, and this has also been found in studies done in other cultures.[20] The PCCG has tentatively defined this disorder as Bodily Stress Syndrome (BSS), and has suggested specific criteria which now need to be investigated in other countries. Many patients with persistent somatic symptoms have previously been labelled as having "somatization disorder", "somatoform disorder", or "medically unexplained symptoms", but none of these labels has proven acceptable in use.[17,21] There is now general agreement that these existing labels are unhelpful in describing these symptoms to the patient, since they all carry the suggestion that perhaps the patient exaggerates or even imagines his symptoms and they provide no explanatory link to enhance patients' understanding of cause.

The concept underlying the proposed BSS is that symptoms are caused by autonomic arousal (sympathetic results in cardio-vascular symptoms, parasympathetic results in gastrointestinal symptoms, activation of the reticular formation results in locomotor and sensoric symptoms—and there are general symptoms which often accompany the others).

It is the pattern of symptoms that makes the diagnosis. Patients must have several bothersome arousal symptoms from one system, although they can have more, and clinicians will in practice need to enquire about symptoms, not just "count" spontaneously reported symptoms. This is the same approach as clinicians would take to diagnose diabetes, or lupus: begin with a symptom, then ask about other symptoms known to be associated with the disease.

This is a clear difference from the more agnostic current concept of a somatic symptom—or set of unrelated symptoms—that may occur for any reason, including occult biomedical disease. If this concept of BSS is supported by clinical evidence, it would remove much of the clinical controversy regarding the necessity of searching for disease or setting an arbitrary threshold for symptom persistence to establish the diagnosis of "somatization".

The term replaces "medically unexplained symptoms" in our classification, as this is a label that some patients find unacceptable. BSS, by contrast, allows the clinician to enhance communication with the patient and provide a plausible reason for symptom persistence, so that a constructive therapeutic dialogue can be started (please see Appendix 2 for details).

Together, disorders characterized by anxious, depressive and somatic symptoms form the great majority of mental disorders seen in these settings across the world.[10,12] It is important that appropriate and accurate diagnostic labels and strategies are available for primary care professionals to use, and that these are able to inform antidepressant and psychological therapy options.

The aim of this multicentre focus group study was to collect in-depth data from primary care professionals to modify the suggested changes to ICD-11-PHC before field trials start in 2012.

Methods

Focus groups were organised by members of the team in Austria, Brazil, Hong Kong, New Zealand, Pakistan, Tanzania and the UK in 2011. Focus groups were chosen for their ease of organization and to obtain the in-depth data needed to assess proposed disorder criteria. Each group consisted of four to fifteen participants who were selected based on their interest and knowledge of the topic. The characteristics of the subjects are detailed in Table 1. The focus groups were facilitated by corresponding members of the research team in New Zealand, Pakistan, Tanzania and the UK. One of the focus groups in Brazil with nursing participants only was facilitated by a psychologist with experience in mental health and focus group technique. The other focus group with doctors in Brazil was facilitated by the local team member. The two focus groups in Hong Kong were facilitated by a social worker experienced in qualitative research. The focus group in Austria was facilitated by our UK team member with the assistance of a local doctor. The focus groups were held in local clinic, university or medical association club house, lasting for one to one and a half hours. The draft ICD-11-PHC was introduced to members of the semi-structured focus groups 15 minutes before the interviews started. The participants were encouraged to express their opinions but a standard interview schedule was used to ensure all relevant domains were covered:

1. Regarding the draft ICD-11-PHC, what do you think of the item "anxious depression" versus "depressive disorder" and "anxiety disorder"? Will you use the new scheme? Do you think your colleagues will use it? How useful do you find the new item "anxious depression"? Why? What may prevent you from using this approach? What alternatives do you suggest?
2. The ICD-11-PHC is replacing "medically unexplained symptoms" with "bodily stress syndrome". What do you think of it? Is the definition offered easy to understand? Do you find the four lists of BSS helpful, or could you do equally well without them? Can you distinguish "bodily stress syndrome" from "health pre-occupation syndrome"? Why? Is this a useful distinction to make? Are there modifications or adjustments needed, e.g. naming or expression of BSS and why do you think so?

The discussion was voice recorded and transcribed locally. Accuracy of the transcripts was checked by the local members of the research team. The research team had provisional theories about the diagnosis of anxious depression and BSS from their own research and literature review. The members sent the data to the lead author who then made suggestions on the themes. These were referred back to the team members. After further discussion among all team members, the final decisions on the themes were made. The team then adopted a thematic approach for the qualitative data analysis. Thematic analysis was undertaken via repeated listening and immersion in the data. The analysis was then done by manually coding and indexing

Table 1 *Characteristics of subjects interviewed in the study*

Total number of focus group:	9
Total number of participants:	101 (49 females, 52 males)
Types of participants:	81 doctors, 20 nurses (12 in Brazil and 8 in Tanzania)
Age range:	18–29 (3)
	30–39 (27)
	40–49 (39)
	50–59 (28)
	60–69 (4)

themes into topics and categories by the corresponding team members in different countries. These constructs were then shared among the research team members to identify commonalities and differences. This study was approved by the local Institutional Review Boards in Brazil, Hong Kong, New Zealand and Pakistan.

Results

Both anxious depression and BSS were discussed in detail by the focus group participants. Table 2 presents a summary of main findings.

Anxious depression

There was overwhelming support for the inclusion of this condition at all the focus groups at different parts of the world.

In New Zealand, a 54-year-old male general practitioner said:

> We have been operating very successfully in primary care as if this condition exists.

In Hong Kong, a general practitioner said:

> I think anxious depression is something like 'bread and butter'. Though it's the grey area, it's exactly what we always see in the front line. … I welcome the addition of anxious depression as a new box. I think in reality many patients can fit into it. … As a frontline clinician, I think it allows me to write something down comfortably after seeing the patients, as it portrays something really difficult to describe in the past.

In Brazil, a nurse said:

> It's the commonest that there is.

In Tanzania, the primary care participants felt depression without anxiety was rare. They thought over 90% of times they saw mixed anxiety/depression symptoms in their patients.

In Austria, a Vienna general practitioner said:

> It is very useful and helpful for GP's, when I see a patient and detect a psychological problem, I check the criteria for depression and anxiety and in the end I often get the impression that it is both. The other point is that the treatment is quite similar.

However, some general practitioners in Hong Kong thought 2 weeks was too short to make a reliable diagnosis.

> In my opinion, if we have such a category, it will be possible for us to make a diagnosable disorder in two weeks. However, I wonder if some cases will be over-diagnosed. The approach we choose really matters. If the patient's symptoms persist for two weeks, is it okay for us to be so aggressive and diagnose the patient of some kind of disorder, followed by some treatments?

Similar opinions were expressed by general practitioners in New Zealand as it was felt that while many patients with this condition would be unlikely to present until after two weeks, there may be instances where short duration stress and adjustment reactions would be included within this time frame, thus inflating the prevalence of anxious depression. There was a degree of consensus to regard four weeks as a more clinically appropriate timeframe. There was also the advantage of a four week timeframe aligning with assessment questionnaires.

> Two weeks seems very short – people would hardly ever come at two weeks, they would have had symptoms before that.
>
> The Kessler is four weeks, so you'd want the diagnosis to be made after four weeks. You'd want it to line up.

Bodily stress syndrome

The questions related to BSS were addressed by all the focus groups except in Tanzania. Most participants in Vienna welcomed the new name for a group of patients that were familiar to all of them, one general practitioner remarked:

> You can tell a patient, "You have unexplained medical symptoms" or you can say, "You have a psychosomatic problem but medicine does not really know what it is." That is not helpful for the patient. I think it is better to say: "You have a bodily stress syndrome!" That perhaps is something which has more acceptance … we can take a further step.

In New Zealand practitioners were already using the underlying concepts of BSS to frame discussions with the patients.

> I tell them that adrenaline and other chemicals are putting the body on red alert – that's what is causing the symptoms.

The participants in Pakistan also considered BSS as a good term to define medically unexplained symptoms as psychologically predisposed bodily symptoms or a disease due to distress.

In New Zealand the main advantage of using an overarching framework was felt to be in grouping together patients who might previously have been seen as quite different (e.g. irritable bowel, recurrent migraines and

Table 2 *Overview of opinions towards anxious depression and bodily stress syndrome*

	Austria	Brazil	Hong Kong	New Zealand	Pakistan	Tanzania	United Kingdom
Anxious Depression (AD)	The participants generally supported the concept and classification of AD. Some commented that the symptoms of depression in this diagnosis were more important than the anxiety symptoms.	Most participants identified immediately the category of AD as very common in their practices. Patients were often "travelling" between anxiety and depression, with distinct groups of symptoms from time to time. They often found situations with a mix of symptoms, which were confusing to be classified as anxiety or depression. Besides, the specific list of symptoms was helpful for them to identify AD.	Most participants agreed that the new category described a large group of patients who were seen very often in primary care but difficult to be classified before. The new category could facilitate research into the characteristics and specific pathology of this group of patients. This might result in different or better management. Some considered checklist not a good idea, and queried if more symptoms implied this group of patients to be more severe. Some thought that two weeks was too short to make a reliable diagnosis.	The participants pointed out that the diagnosis of mixed anxiety/depression was already present in their coding system and was frequently used. The classification systems were out of step with practice and needed to catch up. They recognized that psychiatrists were more likely to see cases where anxiety and depression were separated because of severity of symptoms. However, the concept of anxious depression was common in general practice.	Most participants welcomed the new classification. It was useful where they faced difficulty in diagnosing either depression or anxiety. Some felt that making a clear diagnosis was more useful in research than in clinical practice.	Most participants expressed a knowing agreement with the presentation of mixed anxiety and depression. They pointed out the difference between the primary care staff compared to the staff from in-patient psychiatric facility. Over 90% of times they saw mixed anxiety/depression symptoms in their clients. Depression without anxiety was rare.	The participants generally agreed with AD. Some asked whether it would lead to modification of the treatment. Some supported a reduced list of 5 symptoms if it could lead to conclusion in a unified manner.

(*Continued*)

Table 2 *Continued*

	Austria	Brazil	Hong Kong	New Zealand	Pakistan	Tanzania	United Kingdom
Bodily Stress Syndrome (BSS)-*FOR*	Most participants welcomed the new name BSS for a group of patients that were familiar to all of them. Some felt that it was not helpful to tell the patients a diagnosis of unexplained medical symptoms or psychosomatic problems which medicine did not really know. A diagnosis of BSS might receive better acceptance from the patients.	All professionals identified the syndrome immediately as very common in their practice. They considered that the symptoms checklist was quite useful and that the syndrome should be associated with several intense and chronic symptoms; and with a significant level of disability. An important aspect to study would be the association with anxiety and depression as there was a natural evolution from one syndrome to the other.	Most participants pointed out that a lot of patients had mixed symptoms and fitted this category. They thought BSS provided a good checklist, it would help doctors explain to patients and convince them to take medication if necessary. They also thought BSS offered a whole-person perspective and might result in non-drug treatment. It helped to reduce unnecessary investigations.	There was widespread support for the concept and definition of BSS. The definition offered of BSS was perceived as very useful and easy to understand by patients. The main advantage of using an overarching framework was felt to be in grouping together patients who might previously have been seen as quite different (e.g. irritable bowel, recurrent migraines and fibromyalgia) and being able to think more strategically about referrals and investigations.	Many participants thought BSS was a good term to define medically unexplained symptoms as psychologically predisposed bodily symptoms or a disease due to distress.	Not available	Most participants supported a persistent duration instead of a fixed duration.

TABLE 2 *Continued*

	Austria	Brazil	Hong Kong	New Zealand	Pakistan	Tanzania	United Kingdom
Bodily Stress Syndrome (BSS) *-AGAINST*	Some participants thought the idea that a fixed duration might be required was not supported.	Participants considered that only one symptom was not enough to characterize BSS. It needed a certain number of symptoms which should be severe and chronic. The significance of physical symptoms should be specially dealt with as patients did not often accept an emotional origin of them.	Some participants were concerned that the variety of symptoms was too extensive that almost anyone could be labelled as such. They considered many patients had only one symptom which was sufficient to cause great distress, the rule of 3 or 4 symptoms might not be helpful. Some insisted that existing criteria were good enough, while certain diseases such as irritable bowel were under-diagnosed. There were concerns that once a label of BSS was given, the patient's case would be closed and no further investigation/ treatment would be rendered, it might lead to missing underlying/more severe illnesses.	The main concern was felt to be the problem of excluding significant organic pathology in a group of patients who were often very persuasive in their symptom presentations. In their initial consultations it was hard to not begin offering investigations. This was also linked to a concern that making a positive diagnosis of BSS might make it more likely that a significant organic pathology would be missed. There was quite a strong feeling that 'Chronic Fatigue Syndrome' did not fit the paradigm as well as other disorders, particularly when there was a good history of preceding viral infection.	Some disagreed that 'Severity of the BSS' was associated with symptoms from more than one organ group instead a chronic presentation of symptoms from a single organ group. It was also pointed out that duration to establish diagnosis for BSS was missing.	Not available	Not available

fibromyalgia) and being able to think more strategically about referrals and investigations.

However, some general practitioners in Hong Kong felt many patients have only one persistent somatic symptom which is sufficient to cause great distress, and that the rule of 3 or 4 symptoms may not be helpful (please refer to Appendix 2).

> I think it's ridiculous to set "3 symptoms". What if someone's just having one single symptom, say, feeling dizzy, headache, or stomach ache, and it's medically unexplained and does seriously affect his daily life? … Then what should we do to this group of patients? … I think it should be "one symptom" instead, as it's medically unexplained and even such a single symptom can greatly affect the patient's daily life. It's unnecessary to restrict the number.

The participants in Pakistan disagreed that 'Severity of the BSS' should be linked to having symptoms from more than one organ group, believing that the disorder could include the chronic presentation of symptoms from a single organ group. They also felt there was no cultural association with the symptoms or change over time.

Concerns were expressed in New Zealand that there was significant cultural variation in the way that BSS was expressed. A classification and definition would need to take this into account. There was also felt to be the problem of excluding significant organic pathology in a group of patients who were often very persuasive in their symptom presentations. In initial consultations it was hard to not begin offering investigations, sometimes inappropriately, but using the BSS label might then 'blind' the practitioner later to symptoms of serious disease.

> You know they are the very patients who you try and limit the investigations on and then later their stress and irritable bowel turn out to be a cancer.

In Brazil, several aspects were considered important to be studied concerning this new category:

– Intensity and duration of symptoms:

> The important points are the intensity of the symptoms and how much the patients' quality of life is affected.
>
> Having three symptoms at the same time is helpful to get to this diagnosis.

– Disability level:

> These patients' functioning are usually severely affected. They consider themselves to be extremely ill and the fact that they are not correctly treated in several health units makes their situation even worse. This category of BSS can help offer better treatment for them.

– The relationship of BSS to anxiety and depression:

> It seems that all these categories are like one road where you can turn left or right, moving from a general emotional distress to anxiety and depression and to bodily stress syndrome. Several factors will influence the direction the patient goes.

Overall, there was general agreement that this disorder existed, but there was no clear consensus regarding the proposed diagnostic criteria.

Discussion

The revision of the ICD-10-PHC aims to reduce the disease burden associated with mental disorders in WHO member countries, particularly low- and middle-income countries. This revision occurs at a most opportune time. Improving mental health care has become a high priority for governments and health-care workers in many parts of the world, and our understanding of how mental health disorders present in community and primary care settings has grown significantly in recent years. The present study provided useful data to the PCCG as it works to develop and modify its proposed list of disorders for the draft ICD-11-PHC.

The addition of anxious depression was well received by primary care professionals at all the focus groups held in different continents. In fact, it would appear that many primary care professionals have been operating with this concept even without its formal inclusion in the current ICD-10. It is not surprising, as primary care professionals are often very pragmatic practitioners and they have to deal with the full range of symptoms their patients present to them. Furthermore, the discussion of anxious depression and its management has appeared in the literature for over a decade[22,23] and primary care professionals would have been exposed to these discussions.

The participants' comments on the 2-week duration of symptoms for over-diagnosing affective disorder are worthy of note. The basis for the 2-week requirement seems to reflect the needs of specialty psychiatric care in identifying and treating acute high-risk patients at risk for self-harm, based in part on early studies done on in-patient psychiatric care.[24] However, longer duration criteria have also been adopted previously, so the "correct" minimum symptom duration threshold is not clear.[25,26] The problem is compounded when considering "sub-threshold" or mild disorders. In primary care, where mild to moderate severity of disorders is more common and where patients are seen on a continuing basis over time, the adoption of a 2-week threshold for diagnosis would likely result in inclusion of patients with transient symptoms as "cases", creating a new problem of overdiagnosis and overtreatment. This issue

will require careful consideration during the development of clinical field trials for ICD-11.

There was mixed reaction to the proposed addition of BSS. While primary care professionals agreed that troubling somatic symptoms are common and important to address, there was less agreement on the proposed categorization of symptoms to use in assigning that diagnosis. Some professionals believed that a single persistent and severe symptom should qualify, while others disagreed on the number or range of symptoms necessary for diagnosis.

This disagreement reflects a continuing problem with classification at the interface between symptom and disease. Bodily or somatic symptoms have always been a major challenge for health-care professionals to manage in primary care settings. They are extremely common, persistent, cause significant morbidity, and often remain "undiagnosed" after numerous investigations. It is precisely these undiagnosed but persistent symptoms that we have repeatedly attempted to classify, as they represent a major part of the work of primary care worldwide. However, the experience and reporting of symptoms can be socially and culturally influenced,[27] and it is perhaps not surprising that professionals from different countries and cultures have identified distinct and different patterns of symptoms in their patients.

The new diagnosis of BSS is intended to facilitate the identification and management of patients with persistent symptoms in primary care without imposing the additional qualification of being "medically unexplained", which has created significant problems in the past.[28] Its conceptualization as a condition related to autonomic hyperarousal is not yet proven, but provides both a plausible theoretical model and a positive way to talk with patients about their condition. The findings from this study have been used by the PCCG to modify the suggested diagnostic criteria for BSS, and we will test these modified criteria in forthcoming work.

This study was carried out with the objective to collect data to inform the PCCG on the drafting of the ICD-11-PHC. Because of the small number of participants involved, the results are not meant to be generalisable. The participants were selected based on their interests and knowledge on the subject. Their opinions could be different from other primary care professionals who are less interested. However, these interested primary care professionals are also more likely to be taking care of mental health patients than the others. Moreover, the ICD-11-PHC is being prepared for a world-wide adoption, and the wide range of settings in which focus groups were held provided valuable information on the validity of each disorder. International field trials are being planned at present. It is expected that further modifications of the draft ICD-11-PHC will be made after further data are collected. Further studies will also be planned to examine the impact and usefulness of the new ICD-11-PHC and how disease burden associated with mental disorders may be reduced.

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Appendix 1: Anxious depression

Presenting symptoms
The patients commonly present with *somatic symptoms*, but will be found to have both anxious and depressive symptoms accompanying these symptoms. A minority may present with depressive symptoms. In primary care settings this clustering of symptoms is often dependent on and influenced by social determinants of health, making it necessary to consider psycho-social issues in both assessment and management of the patient. Patients may also present with physical symptoms such as loss of weight.

Clinical description
This is a dysphoric disorder in which mixed anxious and depressive symptoms cause significant distress or dysfunction and lead to functional impairment and care-seeking. *"S" indicates a screening question, if both are negative, the others need not be asked*

Required symptoms:
There must be no previous manic episodes, and they must have at least 3 anxious and 3 depressive symptoms from the following list for, at least **two weeks**:

The "*anxiety symptoms*" are:

– feeling nervous, anxious or on edge (S);
– not been able to control worrying (S);
- having trouble relaxing;
- so restless hard to keep still;
- afraid something awful might happen.

The "*depression symptoms*" are:

– persistent depressed mood (S);
– markedly diminished interest or pleasure (S);
- feelings of worthlessness or guilt;
- difficulty concentrating;
- recurrent thoughts of death or suicide.

Associated symptoms:

– weight/appetite loss
– loss of libido
– fatigue/low energy
– panic attacks
– obsessional ruminations
– excessive concern with their health

Severity
Sub-threshold anxious depression has between 3 and 5 symptoms and may experience some difficulty in some activities.

Mild anxious depression has 6 or 7 symptoms every day for the past 2 weeks. They are distressed by their symptoms, but are managing most activities, but with increased difficulty.

Moderate anxious depression has 8 or more symptoms, with marked disability in at least one area. They may also have neuro-vegetative symptoms like changes in appetite and weight, poor sleep, diurnal variation of mood or loss of libido. Patients may also experience panic attacks.

Severe anxious depression has all the above, with severe distress and disability affecting most areas (work, family, activities of daily living). Some of the symptoms are severe in intensity, and may also show *motor agitation.*

Childhood
Before puberty, depression may present with somatic features, irritability and oppositional behaviour, especially in boys - easily mistaken for oppositional defiant disorder. There may also be a decline in school performance.

Differential diagnosis

* Physical diseases: Hyperthyroidism, Cushing's syndrome.
* Side-effects of medication (e.g. beta-blockers, anti-hypertensives, H_2 blockers, steroid treatment) or substance use.

Appendix 2: Bodily stress syndrome (BSS)

Presenting symptoms/complaints
The patient presents with multiple somatic symptoms over time in association with high distress, and accompanied by disability. The symptoms may be influenced by culture and change over time.

Clinical description
The patient suffers from multiple persistent bodily symptoms, which are present at the same time. In order to diagnose BSS, the symptoms must at some stage present as autonomic arousal symptoms, musculoskeletal tension or general/neurological and cognitive symptoms and result in significant disruption in daily life. Symptoms are distressing and/or result in significant disruption in daily life, as well as persistent concerns about the medical seriousness of the symptoms.

Required symptoms:
The patient must have

- At least 3 persistent symptoms over time attributable to autonomic over-arousal (cardio-respiratory, gastrointestinal, musculoskeletal) or as general symptoms of tiredness and exhaustion

- The patient's concern over health expresses itself as excessive time and energy devoted to these symptoms
- The symptoms are distressing and result in significant disability

Symptom patterns may include:

- Examples of cardiopulmonary arousal: palpitations, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, trembling or shaking, dry mouth
- Examples of gastrointestinal arousal: abdominal pains, frequent loose bowel movements, feeling bloated, regurgitations, constipation, diarrhoea, nausea, vomiting, burning sensation in chest or epigastrium
- Examples of musculoskeletal tension: pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache, pain moving from one place to another, unpleasant numbness or tingling sensations
- Examples of general unspecific symptoms: concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness

Exclusion:

Those with anxiety or depression at case level should not be diagnosed as BSS, but sub-threshold anxious depression may be present. If the symptoms are accounted for by a known physical disease this is not BSS.

Severity

Mild: The patient complains of symptoms or problems in only one bodily system, and while there is some disability most activities can be managed, with increased difficulty.

Moderate: There are multiple problems in one or two bodily systems, and there is marked distress or disability associated with the symptoms.

Severe: There are symptoms in multiple bodily systems and disability/distress is severe.

Childhood variations

Bodily distress in children may be mono-symptomatic, and the type of symptoms varies with age, with abdominal pain and headache common in smaller children, whereas the prevalence of fatigue and neurological symptoms seems to increase with age. Bodily distress in children may continue into adult life.

Differential diagnosis

- Consider *physical disease* with multiple symptoms, e.g. multiple sclerosis, hyperparathyroidism, acute intermittent porphyria, myasthenia gravis, AIDS, systemic lupus erythematosus, Lyme disease, connective tissues disease.
- *Psychiatric disorder* with physical symptom presentation, e.g. substance use disorders, psychotic disorders.
- *Health anxiety* if health concerns predominate rather than the symptoms themselves.

Conversion disorder if the symptom picture is dominated of neurological symptoms and the onset of symptoms is related to a severe psychological trauma.