

# The ANX-8: A Brief Multi-Diagnostic Measure of Anxiety Disorders

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## Abstract

This is a companion article to the previous article in this Journal that introduced the DEP-6 depressive disorders screening measure. The present article introduces a similarly brief screening measure for anxiety disorders, called the ANX-8, which distinguishes post-traumatic stress disorder, obsessive-compulsive disorder, body dysmorphic disorder, panic disorder, generalized anxiety disorder, social anxiety disorder, and specific phobia. The article begins by criticizing the main measures of anxiety disorders in use at present and arguing for a brief yet comprehensive multi-diagnostic measure to replace them. The main part of the article explains the rationale for this new measure which, like the DEP-6, is based on the author's core symptom theory, and provides the ANX-8 questionnaire and explains its interpretation. The final part of the article suggests best-practice treatments for the various anxiety disorders identified by the measure. The ANX-8 questionnaire, like the DEP-6 questionnaire, is freely available in this article for translation into other languages.

## Keywords

Anxiety Disorders, PTSD, OCD, Body Dysmorphic Disorder, Panic Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Specific Phobia, Problems with Existing Measures, New 8-Item Anxiety Disorder Screener

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## 1. Introduction

In this article, the present author offers a new, comprehensive yet efficient measure for screening anxiety disorders, called the ANX-8. The ANX-8 follows on from the author's DEP-6 depression screening measure (Rossiter, 2022b) and is to be used in two circumstances. The first is if the presenting patient has received a clinician's rating of "no" on all six depression disorder screening questions in the DEP-6, thus ruling out psychosis, bipolar disorder, biological depression, and reactive depression. The second usage situation is if the clinician is absolutely

clear from talking to the patient, and if necessary to a parent, spouse or close friend, that the patient's primary complaint is overwhelming uncontrollable anxiety.

Anxiety disorders are all learned disorders of the stimulus-response, S-R, type, acquired by classical conditioning, evaluative conditioning, or in the case of obsessive-compulsive disorder, operant learning by negative reinforcement (see Rossiter, 2022a, for an account of these processes). In this respect, anxiety disorders are similar to the learned basis of the reactive form of depression, in contrast to the more serious and always dysfunctional biologically based form of depression and of bipolar disorder (Rossiter, 2022b). The learned nature of anxiety disorders suggests that most of the treatments will consist of some form of psychotherapy or one of the many available self-help techniques, although in severe cases anti-anxiety medication may have to be prescribed.

The seven anxiety disorders screened for in the ANX-8 include, in approximate order of seriousness:

- Post-traumatic stress disorder
- Obsessive-compulsive disorder
- Body dysmorphic disorder
- Panic disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Specific phobias

The S-R learning mechanism is the best way to distinguish these disorders. Each type of anxiety disorder has a different set of stimulus causes and a different observable response (see Table 1). The purpose of the ANX-8 is to allow the clinician to diagnose the most serious anxiety disorder before deciding on the best method of treatment.

**Table 1.** S-R conceptualization of the major anxiety disorders.

Anxiety disorder	Stimulus	Response
Panic disorder	No warning for first one but usually an ongoing stressor; can become conditioned to situational stimuli.	Stark terror. Fear of dying at first, until you learn they are non-fatal and will pass.
Post-traumatic stress disorder	Direct experience of an event that would horrify or lastingly upset most people.	Recurring vivid flashbacks or nightmares about the event.
Obsessive-compulsive disorder	Excessive worry about the perceived noxious stimulus.	Repetitive, time-consuming behavior to remove it.
Body dysmorphic disorder	Perceived defect in body shape.	Eating disorder, usually starvation or bingeing-purging.
Generalized anxiety disorder	Almost all impending events.	Constant uncontrollable anxiety.
Social anxiety disorder	Any situation in which strangers can see you or hear you.	Arousal of uncontrollable anxiety, resulting in avoidance.
Specific phobia	Particular situation or object, usually feared at first sight.	Intense fear and avoidance.

The present article consists of three parts. In the first part, aimed primarily at researchers, the main measures of the common and more manageable anxiety disorders, and of the rarer and harder-to-treat anxiety disorders, are briefly reviewed and shown to be inadequate, with the recommendation that they should not be used. In the second part, the author introduces the rationale and design procedure for a new multi-diagnostic anxiety disorder screening measure, the ANX-8, and explains its hierarchical interpretation. In the final part, aimed mainly at practitioners, the author summarizes best-practice treatment recommendations for the seven disorders.

## 2. Problems with Current Measures of Anxiety Disorders

The overall problem is that there exists no brief yet comprehensive screening measure for diagnosing anxiety disorders. The alternatives available at present are very time-consuming. These are the clinician-related DSM-based SCID-5 structured clinical interview (First, Williams, Karg, & Spitzer, 2016) and its counterpart, the ICD-based CIDI structured clinical interview (World Health Organization, 1993), each of which can take up to 90 minutes to administer for a patient with multiple disorders, or the MINI, a shorter version of the CIDI which can take up to 50 minutes (Lecrubier et al., 1997). Researchers should note that the CIDI and the MINI are inferior because the ICD-10 diagnostic system, unlike the DSM-5 diagnostic system, besides having much vaguer symptom descriptions than the DSM-5, inexplicably does not require that the symptoms result in dysfunction. Moreover, the time-consuming nature of structured interviews means that practitioners never use them but rely instead on intuitive judgment made on the basis of a few unstructured questions (Morrison, 2013). Clearly, a more systematic, brief, and accurate screening measure for anxiety disorders is needed.

Researchers, too, face a problem with anxiety measures. All existing measures have uncorrectable problems with their overall structure and item content. Following are criticisms of those most-used at present. Note that the present author is not going to promote these measures in any way by giving their references, but interested researchers can easily find them in the clinical psychology and psychiatry journals.

### 2.1. Mixed Depression and Anxiety Measures

A common mistake is to attempt to measure depression symptoms and anxiety symptoms in the same measure. Major measures that do this include the Hospital Anxiety and Depression Scale, HADS; the Hopkins Symptom Checklist, HSCL; the SF-36 and SF-12; the PHQ-9, PHQ-8, and PHQ-2; the K-10 and K-6; and the less often used Depression Anxiety and Stress Scale, DASS, originally a 42-item scale but usually employed as the 21-item half-length version. With the exception of the DASS, discussed below, all these mixed measures use total scores so that you *cannot tell whether the primary complaint is anxiety or depression*. It is

also possible to obtain quite a high score on these depression and anxiety measures by having the depression items rated as severe and the anxiety items rated as low level or nonexistent.

The DASS-21 is an exception because it consists of three 7-item *subscales* allegedly measuring, respectively, depression, anxiety, and something broadly called stress (which is a frequent cause of anxiety but is not in itself a mental disorder). The big problem with the DASS is that these subscales were derived from ex-post factor analysis instead of from an a priori content analysis that aligns the items with the symptoms of depression and anxiety, respectively. Factor analysis is misleading because, for example, the stress subscale includes items that should be in the anxiety subscale, such as “I found it difficult to relax,” “I felt that I was using a lot of nervous energy,” and “I found myself getting agitated,” while the anxiety subscale itself is made up of an indefensible mixture of three autonomic arousal items, a skeleto-muscular effect item, a situational anxiety item, and two questionably named subjective-experience-of-anxious-affect items.

All mixed measures are unsuitable because they confuse depression and anxiety, and while the latter measure does not, it measures anxiety incorrectly.

## 2.2. Dedicated Anxiety Measures

There are many purportedly dedicated or specialized measures of anxiety symptoms, including the Manifest Anxiety Scale from the 1950s, the Beck Anxiety Inventory and the Hamilton Anxiety Rating Scale from the 1960s, and the two measures that seem to be used most often these days, the State-Trait Anxiety Index, STAI, and the Generalized Anxiety Disorder measure, the GAD-7. These measures, including the state-anxiety version of the STAI, besides including unnecessary items, are all intended to measure the individual’s current *level* of anxiety, which they do incorrectly because they assume that the more symptoms the person has, the higher the person’s level of anxiety. This assumption is plainly wrong because the person could have a large number of low-level symptoms, all of which are controllable.

All that matters in measuring anxiety disorders is whether or not the symptoms are severe enough to cause *significant dysfunction*—in school or at work, or with normal social or domestic activities. On the other hand, if you want to measure the individual’s current level of anxiety independently of functionality—for example, in research in experimental psychology that conceptualizes anxiety as arousal or drive—then you need to use a *physiological* measure, such as skin conductance or heart rate.

## 2.3. Panic Disorder Measures

You don’t need a measure of panic attacks—they are all too distressingly obvious once you know what they are. The first one is always unexpected and you very likely will not know what’s happening to you—for apparently no reason at all

your heart starts thumping, you start sweating profusely, the blood rushes out of your head and you become lightheaded, dizzy and disoriented and you fear that you are about to die. You very rarely can stop it and you usually black out and fall to the floor, being lucky if you don't hit your head and injure yourself. You will come round in a few minutes and although experiencing immense relief that you are still alive you will still feel as though you've been hit by a truck or had a heart attack. If you are lucky, there will be someone there to reassure you that panic attacks are not fatal, or you will learn this afterwards. Panic *disorder*, on the other hand, can set in if you feel the symptoms coming on again and you dread that you might have another attack.

If not successfully self-treated or medically treated (see section 4 of this article), panic disorder can become a conditioned avoidance response that results in fear of the situation in which you had the first attack, or social anxiety disorder if you constantly fear having another attack in public.

#### 2.4. PTSD Measures

There are two widely used measures of post-traumatic stress disorder: the PTSD Symptom Scale (PSS) and the Clinically Administered PTSD Scale (CAPS), with the latest version of the latter, the CAPS-5, being based on the symptoms for PTSD listed in the DSM-5. They both have similar problems which can be exposed by considering the CAPS-5, the measure that has become the one most widely used by researchers. The big problem with the CAPS-5 is that it counts all symptoms equally and fails to distinguish necessary symptoms from derivative symptoms. A further problem is that the CAPS-5 can take 45 to 60 minutes to administer and requires substantial open-ended probing on the clinical researcher's part, meaning that it is not a standard measure. There is no way that a primary-care physician, the first port of call for most suspected PTSD sufferers, would use it, and neither would a practicing psychiatrist.

The diagnosis of PTSD has only one requirement on the stimulus side (see **Table 1** earlier), which is reasonable verification of being exposed to a normally traumatic event or series of such events. The other requirement, this time on the response side, is that the person must have experienced at least *one* of three so-called intrusion symptoms—bad memories of, or troublesome dreams about, or vivid flashbacks of the trauma-causing event. At least one of these intrusion symptoms must be experienced for at least one month immediately after the event *and* the symptom must cause clinically significant distress or dysfunction at school or work, socially, or domestically ([American Psychiatric Association, 2013](#)). The problem with the CAPS-5 is that the patient is asked about no fewer than 20 symptoms, only three of which are memories, dreams, or flashbacks. To cloud the diagnosis further, the 20 symptoms' severity ratings are added so that a person could have a high total score without having any of the three intrusion symptoms at a functionally severe level.

Researchers using the CAPS-5 typically accompany it with a *separate* measure

of dysfunction, such as the Sheehan Disability Scale, SDS. This is incorrect because the two measures' scores are recorded separately so that the dysfunction is not tied to the PTSD symptom.

## 2.5. OCD Measures

The standard measure of OCD used by researchers (see [Wikipedia, 2022a](#)) is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) of which there is also a children's version (CY-BOCS). This is one of the worst measures ever devised. Firstly, it has five questions about obsessions and five questions about compulsions that are scored *without* linking the specific obsession to the specific compulsive behavior. And although the Y-BOCS looks brief with only 10 items, the actual wording of the items is complex, and idiosyncratic open-ended questioning is needed before the clinician makes a severity rating. No physician would bother with this measure and researchers shouldn't use it either.

## 2.6. Body Dysmorphic Disorder Measures

Bodily dissatisfaction only becomes a disorder if you do something dysfunctional about it. Obesity, for example, only becomes a psychiatric disorder if it leads to an eating disorder, or to social anxiety disorder, or to obsessive-compulsive disorder, or serious reactive depression, and is not a mental disorder *per se* ([American Psychiatric Association, 2013](#)). That it is not a serious concern for most Americans is suggested by fact that 42% of them are now technically obese, up from 31% two decades ago ([Centers for Disease Control, 2022](#)) and yet the prevalence of serious mental disorders has not increased.

What has not changed, either, is the most problematic consequence of body dysmorphic disorder, sometimes abbreviated BDD, namely *eating disorders*. Eating disorders pose the biggest problem because so few sufferers admit to having them and only an estimated 10% seek treatment (see the comprehensive coverage of eating disorders in [Wikipedia, 2022b](#)). Moreover, only in the case of anorexia—deliberate self-starvation resulting in dangerously low weight—does the problem become evident to others. Accordingly, the diagnosed prevalence of eating disorders is very low: in young *women*, who suffer from eating disorders in a ratio of about 10 to 1 over young men, the annual prevalence of anorexia is estimated to be 0.4%, and the annual prevalence of bulimia, which is binge-eating and then purging regardless of actual weight loss, is estimated to be 1.5% ([American Psychiatric Association, 2013](#)). Fortunately, according to the Wikipedia entry, about 70% of anorexia sufferers and 50% of bulimia sufferers recover, with or without treatment, within five years, although in the worst cases, particularly when the consequence is major depression, these eating disorders carry a relatively high risk of suicide.

Among young *men*, in sharp contrast, a new disorder has emerged that has been dubbed “bigorexia” ([Hansen, 2022](#)), or more technically *muscle dysmorphia*, which leads them to binge on protein, endlessly lift weights, and sometimes

take harmful steroids. A survey of high schools in Australia found a diagnosed prevalence of muscle dysmorphia among teenage boys of 2.2%, or approximately one in 50.

Measures of body dysmorphic disorder are typically mis-targeted and far too general. The biggest problem is referring to “appearance” in general rather than distinguishing between body shape dissatisfaction, the cause of most body dysmorphia, and facial appearance or hair appearance dissatisfaction (see Rossiter, 2022c). The Appearance Anxiety Inventory, for example, consists of the self-rated frequency of 10 behaviors resulting from simply “my appearance.” A different approach is taken in the Adolescent Appearance Rejection Scale, which measures the degree of anxiety and perceived likelihood of social rejection resulting from 10 hypothetical interpersonal interaction scenarios—such as with friends, peers, romantic partners, or strangers—without measuring dysfunction.

Surely all the clinician needs to diagnose body dysmorphic disorder in its various forms is a self-admission or parental report as to why the clinician was approached in the first place.

In summary, the various anxiety disorders at present are measured with separate, usually lengthy, too generally worded, and wrongly scored measures that go into depth about a particular disorder without providing the all-important overall diagnosis of which type of anxiety disorder is primary for the patient, and without verifying dysfunction. Mental health professionals—and researchers—should adopt the new multi-diagnostic anxiety disorder screener, the ANX-8, as given next.

### **3. An Efficient Multi-Diagnostic Screener for Anxiety Disorders: The ANX-8**

#### **3.1. Derivation of the New Measure**

To derive the ANX-8 measure, the author, as he did with the DEP-6, employs what he calls *core symptom theory* (Rossiter, 2020). The principle underlying core symptom theory is as follows: *If the prospective patient does not have the core symptom(s) of a given disorder, then he or she cannot possibly have that disorder.*

The core symptoms in the ANX-8 are basically compatible with those specified in the DSM-5 diagnostic manual (American Psychiatric Association, 2013) with the important modification that they exclude most of the specified duration requirements. This modification is made under the argument that if the patient has the core symptoms now, it does not really matter for treatment purposes how long he or she has had them. In this respect the modification follows the work of expert U.S. psychiatrist Allen Frances (2013) who emphasizes the importance of focusing on what is happening now.

#### **3.2. The ANX-8 Questionnaire**

The ANX-8, shown in **Table 2**, is a clinician-rated questionnaire. There are

eight questions, the first of which is a general question to establish that severe and uncontrollable anxiety is indeed present, before the clinician moves on to questions about the type of anxiety disorder that the anxiety most likely represents.

Question 1 is designed to verify that the person is indeed suffering from frequent, semi-paralyzing, uncontrollable anxiety. As Frances (2013) notes, fear as a normal response to real-life dangers must be ruled out because anxiety, psychologically speaking, is a response to *future imagined* dangers. The anxiety must be extreme to qualify as a disorder. As is well known in the psychology literature, anxiety follows an “inverted-U” pattern, whereby too little anxiety does not get you motivated; while the other extreme, too much anxiety is paralyzing. Moderate anxiety, sometimes called the “optimal stimulation level,” is the most useful level behaviorally because it puts you in the right energy state and mental state to take appropriate action. Again, it is only very high anxiety that can cause a mental problem.

Question 2 is about *panic disorder*, which is the easiest of the anxiety disorders to diagnose and probably the easiest to treat, as we’ll see later. It requires the recall of having had a panic attack in which you blacked out or would have done so had there not been a knowledgeable other person nearby to help. A panic attack turns into a disorder only if you live with the fear of having another one.

Question 3 is about the most serious and dysfunctional anxiety disorder, PTSD, which used to be called by the wartime term “shell shock” but as most people know nowadays refers to *post-traumatic stress disorder*. As Frances (2013) comments, the bar for diagnosing PTSD has been lowered way too much in the DSM-5 to allow indirect or hearsay exposure to a potentially traumatic event, which means that it is far too often over-diagnosed. It is only direct first-hand exposure that can result in genuine PTSD which, as covered in Section 4, is very difficult if not impossible to treat and has often dire consequences. Also, although memories of the event are listed in the DSM-5 as an intrusion symptom, most reports from sufferers refer not just to memories but to recurrent horrific visual imagery in the form of nightmares or during-the-day flashbacks.

Question 4 refers to another serious disorder, *obsessive-compulsive disorder*, OCD, in which the sufferer typically wastes about an hour of the day with compulsive behavior (Wikipedia, 2022a). In the early stages of the disorder there are obsessive thoughts that lead to the compulsion to stop them with routine behavior that seems to work via an operant learning process known as negative reinforcement (Rossiter, 2022a). But, after a while, the reinforcing performance of the compulsive behavior can become habitual *without* the initial obsessive thought arising. It is for this reason that the question on OCD focuses on the repetitive behavior itself.

Question 5 is designed to detect in a broad manner the overall problem of *body dysmorphic disorder*, or BDD. As discussed earlier, body dysmorphic disorder

**Table 2.** An efficient anxiety disorder screener (ANX-8) based on the core symptoms of each disorder according to the DSM-5 and the book by Frances (2013). “Dysfunctional” means that the disorder substantially interferes with usual daily activities—at home, or at school or work, socially, or going out in public.

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CLINICIAN \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT \_\_\_\_\_

INFORMANT IF NEEDED (& RELATIONSHIP) \_\_\_\_\_

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Screening question—ask for clarification if necessary, also for deciding on dysfunction	Present to a dysfunctional level?	
1) <u>Semi-paralyzing anxiety</u> : (a) Do you often find yourself becoming very, very anxious and cannot easily calm yourself down? (b) Have you ever been diagnosed with—or do you suffer from—serious depression? (NO to both: EXIT)	Yes	No
2) <u>Panic disorder</u> : Have you ever had what is called a panic attack—your heart races, you get all dizzy, and think you’re having a heart attack and are going to die? IF YES: Do you get scared about having another panic attack?	Yes	No
3) <u>PTSD</u> : Do you ever have recurring vivid flashbacks or nightmares about something horrible or upsetting that you’ve seen or been through?	Yes	No
4) <u>OCD</u> : Would you describe yourself as an overly obsessive-compulsive person—Is there something you cannot resist doing over and over so that you get very anxious until it’s done?	Yes (GO TO 8)	No
5) <u>Body dysmorphic disorder</u> : Are you uncomfortable with your physical appearance? IF YES: What causes you the most worry? WRITE IN: _____	Yes (GO TO 8)	No
6) <u>GAD</u> : Getting back to that uncontrollable anxiety that you mentioned at the start—Are there many things that you constantly worry about rather than one thing in particular?	Yes (GO TO 8)	No
7) <u>Social anxiety disorder</u> : Do you find yourself avoiding social situations or public speaking situations if you possibly can?	Yes (GO TO 8)	No
8) <u>Specific phobias</u> : Do you have great fear of any of the following? TICK ( ✓ ) IF YES: Flying? ___ Having an accident when driving? ___ Fear of heights? ___ Fear of elevators or tight spaces? ___ Having an injection? ___ Seeing live wounds or blood? ___ Sharks? Dogs? ___ Snakes? ___ Spiders? ___ Other animals? ___ IF YES, What’s the main one? WRITE IN: _____ Other insects? ___ IF YES, What’s the main one? WRITE IN: _____	Yes (GO TO 8)	No

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can result from dissatisfaction with overall body shape or from dissatisfaction with a specific perceived defect, usually to do with the appearance of one's face or hair. The question uses a general start about discomfort with your physical appearance and then seeks to determine the main source of that discomfort.

Question 6 is concerned with GAD, *generalized anxiety disorder*. This disorder gets its name from the fact that the anxiety response becomes a conditioned reaction to almost every ambiguous stimulus situation or future event that is feared to result in a negative consequence. Frances (2013) states that this disorder is too readily diagnosed and that the diagnosis of GAD should be reserved "for people whose worries are extensive, pervasive, beyond the ordinary, disabling, enduring for six months or more, and are not better accounted for by another diagnosis" (p. 71). His comments indicate the sorts of things the clinician should ask about to establish whether the anxiety is truly dysfunctional.

Question 7 focuses on *social anxiety disorder*, which is much more common at about 13% lifetime prevalence, even in the usually extraverted U.S.A., than generalized anxiety disorder at about 4% lifetime prevalence (Sadock & Sadock, 2007). The 13% is surprisingly the highest in the world. Compare, for example, 8% social anxiety disorder lifetime prevalence in The Netherlands and less than 1% in Korea and Taiwan.

Question 8, the final question in the questionnaire, asks about *specific phobias*. Although nine of these are listed plus two "other" stimulus categories for animals and insects, this section usually proceeds quite rapidly because most sufferers have only one strong phobia. Also, this section is seen by many as a rather amusingly self-deprecating way to finish.

For the seven anxiety disorder questions, the clinician has to make a judgment, with the aid of clarification questions if necessary, of whether or not *significant dysfunction* has resulted—that is, ongoing interference with one's schoolwork or job performance, or with one's intimate or social relationships, or with performance of normal domestic duties. Whereas the DSM-5 also allows causing "significant distress" as an alternative to behavioral dysfunction, this seems obvious and redundant in the case of anxiety disorders. Note, however, that there is no dysfunction judgment required for specific phobias. This is because the question is worded as *great* fear and the patient will almost always say if it is dysfunctional.

### 3.3. Overall Interpretation of the ANX-8

The ANX-8 questionnaire (again see Table 2) is arranged in what may be called a semi-hierarchical order. Question 1 is a general screening question to check whether dysfunctional anxiety is the primary complaint. This screening question is in two parts: part (a) is to check that severe uncontrollable anxiety is indeed present; and part (b) is to determine—by switching immediately to the present author's DEP-6 questionnaire—whether major depression is present as well, because depression takes precedence over anxiety in terms of treatment. Only if the

rating is Yes to part (a) on anxiety and No to all items on the DEP-6 questions in part (b) should the clinician proceed with the rest of the ANX-8 questionnaire.

Question 2, on panic attacks and panic disorder, is not hierarchical but is asked first because panic attacks can happen to anyone. This is also an easy way to introduce the patient to the questioning method as well as reassuring if the clinician explains the high chance of successful treatment.

Thereafter, the next five questions—Questions 3 to 7—are hierarchical, beginning with the usually most serious anxiety disorder, PTSD and, if that's not a Yes for dysfunction, proceeding to the next most serious, OCD, and so forth (as indicated by the branching lines). The first Yes answer to these five questions will indicate the anxiety disorder that is the primary complaint and serves as a stopping point in the hierarchy.

The last question, Question 8 on specific phobias, is asked of everybody with an anxiety problem, partly because it's quite common to have at least one phobia, though rarely to a truly dysfunctional level, and partly because it is a relatively nice and harmless way to finish.

Each question is scored binary, Yes or No, by the clinician, by circling the appropriate answer option after first asking the patient about dysfunction. The minor exceptions are Question 5 on body dysmorphic order, where a brief written response is necessary if there is a Yes answer, and Question 8 where the clinician makes a tick or check mark only if the phobia produces great fear and thus likely dysfunctional avoidance.

## 4. Best-Practice Treatment Recommendations

The following best-practice treatment recommendations for the various disorders are taken from several sources including the [Sadock & Sadock \(2007\)](#) psychiatry textbook, expert reviews in Wikipedia, several major research articles, [Kazdin's \(2012\)](#) book on behavior modification, and occasionally from sensible suggestions made in health reports in the media.

### 4.1. Treatment for Panic Attacks

In a panic attack, blood containing blood sugar rushes from the brain into the body to try to fight against intense fear and other anxiety symptoms. This in turn causes rapid breathing—hyperventilation—which in turn produces a drop in CO<sub>2</sub> in the lungs and then the brain and causes you to black out. The standard self-treatment when you feel a panic attack coming on is to breathe into a paper bag to restore the CO<sub>2</sub>. However, according to a very good review in [Wikipedia \(2022c\)](#) bag-breathing is no longer recommended because it may perversely worsen the panic symptoms.

The preferred self-treatment treatment now is *measured breathing*—the so-called 5-2-5 method (again see [Wikipedia, 2022c](#)):

- 1) *Inhale* slowly and deeply into your diaphragm (stomach), not your chest—counting to 5 secs

- 2) *Hold* the breath—counting to 2 secs
- 3) *Exhale* slowly—counting to 5 secs
- 4) Do this twice in a row and then resume normal in-out breathing for a few cycles
- 5) Repeat the two-times 5-2-5 measured-breathing if necessary.

If you can extend this to 7-5-7 timing, the measured breathing technique will be even more effective, especially when the shorter period doesn't seem to work.

It's also a good idea to lie down on your back if you are feeling very faint or dizzy—this helps the blood flow go back to your brain. It's a good idea also because it might prevent injury from falling. Another standard recommendation is to try to avoid the situation in which you last had a panic attack but this is not always possible because the attacks often occur in the home and the panic symptoms come on very quickly.

In any case, go to see your doctor for a checkup in case there is something physically wrong that's causing or contributing to the problem.

#### **4.2. Treatment for PTSD**

Post-traumatic stress disorder is the anxiety disorder that has the lowest cure rate. The annual prevalence of PTSD in the U.S. among adults is estimated to be 3.5% (Wikipedia, 2022d) but rises to 30% or so among combat soldiers, firefighters, policemen, and paramedics (Sadock & Sadock, 2007).

What is not sufficiently emphasized in the PTSD literature is that treatment differs depending on whether the trauma event is physical, as in the above professions, or sexual, as in molestation or rape. For the former, *virtual reality-based prolonged exposure therapy* is the most promising treatment but it is very specialized—mainly in the selection of trauma stimuli to show and the technical facilities required—and very expensive outside of government-funded treatment in veterans' hospitals. Antidepressant medication is almost always prescribed, usually an SSRI such as sertraline (e.g., Zoloft) or paroxetine (e.g., Paxil). Several psychedelic drugs have also been cleared for trial with PTSD patients by the FDA in the U.S., including ketamine and MDMA, but these are very dangerous because of the risk of addiction after treatment is finished. Psychotherapy alone, even so-called trauma-focused CBT, does not reliably work and in any case the multiple sessions required are beyond the patience and affordability of most sufferers.

Sexual trauma is a different matter. The clinician would be ill-advised to get children or adults to relive the sexual assault because this is almost sure to worsen the PTSD symptoms. Bluntly put, the best treatment is probably *to try to forget about it and not say anything*. Report the offender only if it is a family member or relative and then only to a medical doctor who will advise you further. Children should leave anything to do with molestation by school teachers, sports coaches, or babysitters, to their parents to take private legal action if appropriate. However, no one wins by taking these matters to court and making

them public, least of all the victim.

One form of therapy that should be warned about following a mass shooting, natural disaster, or any form of physical assault, is “psychological debriefing,” whereby the individual is encouraged to confront the event in order to “safely reprocess it” with the help of a counselor. Psychological debriefing has been shown not only to be unhelpful but possibly harmful (see [Wikipedia, 2022d](#), for references).

### 4.3. Treatment for OCD

Obsessive-compulsive disorder is typically apparent in unnecessary repetitive behaviors such as nail-biting, hand washing, household over-cleaning, and obsession with arranging things “just so” in the home or office, and checking blinds and locks every time you leave home. There is only one treatment recommended for obsessive-compulsive behaviors, and this is *exposure and response prevention* ([Wikipedia, 2022a](#)) or what is more simply described as “response blocking” ([Rossiter, 2022a](#)). Response blocking is most effective if you set up a *consequence* for successful blocking, preferably some sort of reward (e.g., a barista coffee for an adult, or a soda or ice cream for a child), although in some cases, especially with children, punishment may be necessary in the form of a swift verbal rebuke or what most parents know as “time-out” punishment from one of the child’s preferred activities. For technical details of these learning-based techniques, see [Kazdin \(2012\)](#).

If you are an adult and the self-control techniques keep failing, then you might have to see a doctor or psychiatrist, who will generally prescribe an SSRI antidepressant. However, the evidence is strong for prescribing St John’s Wort, a natural, mild monoamine oxidase inhibitor (MAOI) antidepressant and antianxiety remedy. In most countries, St John’s Wort is a widely available over-the-counter medicine, with the exception of Germany where it is strictly a prescription drug. However, all antidepressants, including St John’s Wort, rely on a large placebo effect (see [Rossiter, 2022b](#)). Therefore it is safer and actually works better if prescribed by a medical professional.

### 4.4. Treatment for Body Dysmorphic Disorder

The only thing that matters with body dysmorphic disorder is if it develops into an *eating disorder*, such as anorexia or bulimia. For this the patient needs to be referred to a specialized eating disorder clinic.

For milder appearance-dissatisfaction problems that result in a worrying loss of *self-esteem*, see the specific self-treatment recommendations listed in the article by [Rossiter \(2022c\)](#).

### 4.5. Treatment for Generalized Anxiety Disorder

Generalized anxiety disorder, GAD, remains one of the most difficult disorders to treat. This is because, as shown in [Table 1](#) earlier, the uncontrollable anxiety

becomes conditioned to many different stimulus triggers, so that psychotherapy directed at any one or any one subgroup of the stimulus triggers will not work. As a result, treatment is directed to preventing or minimizing the anxiety *response*.

The best non-medical treatment for GAD is vigorous exercise. This is best engaged in whenever you feel really anxious and will help even if it's just a fast 10-minute walk around the block. Two or three short sessions of vigorous exercise, especially as high-intensity interval training, or even a once-a-week longer session, will provide the additional benefit of releasing feel-good endorphins.

However, really frequent and really overwhelming and hard to control generalized anxiety should be treated with medication. Again, St John's Wort is the safest and most effective first-line choice. In clinical trials it has been found to be superior to a placebo for all forms of depression and just as effective as SSRI antidepressants for mild to moderate depression (see references in [Wikipedia, 2020e](#)). This is important because GAD is far and away the most common accompaniment of major depressive disorder, MDD. The container instructions also say that you should take one tablet only when you need it, to see a doctor if the anxiety persists, and to definitely not take St John's Wort if you are taking any other antidepressant medications.

#### **4.6. Treatment for Social Anxiety Disorder**

The treatment recommendations for social anxiety disorder, sometimes abbreviated SAD, are somewhat different. Taking a St John's Wort tablet if you feel really anxious before an interview or a speech or meeting someone important can do no harm and is usually effective as a conditioned stimulus for relaxation in addition to the mild unconditioned stimulus of its medical effect as a mild MAOI antidepressant.

Several self-help techniques are also worth trying in addition to or in lieu of St John's Wort. The best ones to try are good grooming and what is called "power-status dressing" and to remember [Jordan Peterson's \(2018\)](#) admonition to "stand up straight with your shoulders back" (see [Rossiter, 2022a](#), for more detail on these techniques). Fist-clenching and counting silently up to 10 several times is also worth trying and may be effective because it distracts you from your anxious thoughts.

#### **4.7. Treatment for Specific Phobias**

Phobias are usually harmless unless they interfere with your job or leisure activities. If the phobia is a real problem, then you need to look for a clinical psychologist who specializes in *behavior therapy* and is familiar with techniques such as flooding, systematic desensitization, and prolonged exposure therapy.

Fear of flying is the most common problem and St John's Wort can help with this. Otherwise, as [Frances \(2013: p. 70\)](#) comments with regard to phobias: "For the most part, people prefer adjusting their lives to accommodate the fear."

## 5. Conclusion

The major advantage of the ANX-8 anxiety measure over all other measures of anxiety is that it is the only *multi-diagnostic* anxiety measure available. Existing anxiety measures are too general and fail to distinguish the different anxiety disorders; many of them wrongly mix in depression symptoms; and most of them do not correctly record dysfunction resulting from the symptom.

It is recommended that clinicians administer the DEP-6 depression measure (see Rossiter, 2022a) first. This is because depression disorders take precedence over anxiety disorders in terms of treatment. Only if the six depression questions are answered in the negative does the ANX-8 questionnaire need to be administered.

Whereas the ANX-8 is designed primarily for practitioners—notably general physicians, clinical psychologists who counsel or dispense psychotherapy, and psychiatrists—it should also be used by researchers. This is because, given the non-valid alternative measures, it will prevent misleading research findings on anxiety disorders being published.

As with the DEP-6 measure, the ANX-8 measure is freely available in this article and can easily be translated into other languages by using a program such as Google Translate, although local pretesting to ensure adequate comprehension is recommended.

## Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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