Entitlement Eligibility Guideline

Anxiety Disorders

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ICD-11 **code:** 6B00

VAC medical code:

03000 Anxiety disorders, including panic disorder/generalized anxiety disorder

Definition

Anxiety disorders are a category of conditions in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition- Text Revision* (*DSM-5-TR*). Anxiety disorders share features of fear, anxiety, and related behavioural disturbances. Fear is the emotional response to real or perceived imminent threat. Anxiety is the anticipation of future threat. Fear and anxiety can overlap but differ.

Fear is often associated with surges of arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviours. Anxiety is more often associated with vigilance in preparation for future danger and cautious, avoidant behaviour. Anxiety disorders differ from one another in the types of objects or situations that may induce fear, anxiety, or avoidance behaviour, with the associated cognitive response.

Anxiety disorders differ from transient fear or anxiety by being persistent, typically lasting six months or more. Anxiety disorders are diagnosed only when the symptoms are not developmentally appropriate, attributable to the physiological effects of a substance, medication, or another medical condition—and are not better explained by another mental disorder.

For the purposes of this entitlement eligibility guideline (EEG), the following anxiety disorders are included:

- generalized anxiety disorder (GAD)
- panic disorder.

Note: Anxiety disorders other than those listed may be considered, though these should be adjudicated on the evidence provided and their own merits. Consultation with a disability consultant or medical advisor is recommended.

Diagnostic standard

A diagnosis from a qualified medical practitioner (family physician or psychiatrist), nurse practitioner, or a registered/licensed psychologist is required.

The diagnosis is made clinically. Supporting documentation should be as comprehensive as possible.

Clinical features

The pathophysiology of an anxiety disorder involves many considerations thought to contribute to the development of the condition. The considerations include, but are not limited to, genetic predisposition, neurochemical balance, environmental influences, and cognitive processes. None of these alone is sufficient for the development of an anxiety disorder, and they operate at various levels to contribute to the onset and progression of an anxiety disorder. The exact mechanisms leading to an anxiety disorder are not fully understood and remain a topic of research.

Biological considerations: Genetic factors predispose individuals to the development of GAD. Specific genes related to neurotransmitter regulation, the stress response, and anatomical parts of the brain's functioning have been shown to be associated with anxiety disorders. Gene-environment studies have shown early developmental trauma and recent stressful life events may interact with genetic markers to contribute to the onset of anxiety disorders.

Neurotransmitters such as serotonin, gamma-aminobutyric acid (GABA), and norepinephrine play a role in regulating mood and anxiety. In anxiety disorders there may be imbalances in these neurotransmitters, contributing to excessive anxiety.

Advances in brain imaging are contributing to new knowledge about the differences in various parts of the brain for people living with anxiety disorders. For example, a study using functional magnetic resonance imaging (MRI) found that patients with GAD showed lower engagement in particular anatomic regions in the brain during emotional regulation tasks.

Psychological considerations: Cognitive processes such as biased thinking patterns, excessive worry, and catastrophic interpretations of situations can contribute to the persistence and exacerbation of anxiety disorders. These cognitive processes can cause a cycle of anxious thoughts and behaviours.

Environmental considerations: Traumatic events, chronic stress, and adverse life experiences can increase the risk of developing anxiety disorders. These influences can impact brain functioning and contribute to the dysregulation of neurochemical processes involved in anxiety, as well as exacerbate abnormal thinking patterns.

Lifetime prevalence of GAD is approximately twice as high among females. Females and males who experience GAD appear to have similar symptoms, though

demonstrate different patterns of comorbidity. For example, males with GAD are more likely to experience co-occurring substance use disorders. Sexual minority Veterans, including transgender Veterans, are at increased risk for anxiety disorders compared to their heterosexual, cisgender peers. Sexual minority encompasses anyone whose sexual orientation differs from heterosexuality.

Criteria sets

The anxiety disorders criteria sets are derived from the *DSM-5-TR*.

This EEG provides the *DSM-5-TR* Diagnostic Criteria; however, the *International Classification of Diseases 11th Revision (ICD-11)* is also considered an acceptable diagnostic standard.

Generalized anxiety disorder

The essential feature of GAD is excessive anxiety and worry about a number of events or activities. The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event. The individuals find it difficult to control their worry and to keep worrisome thoughts from interfering with tasks. Adults with GAD often worry about routine life circumstances, such as possible job responsibilities, health and finances, the health of family members, misfortune to their children, or minor matters.

In contrast, an individual without a diagnosed anxiety disorder may experience symptoms of anxiety related to worries of everyday life. These are not excessive, are perceived as more manageable, and may be dismissed when dealing with more pressing matters. Everyday worries are much less likely to be accompanied by physical symptoms.

Criteria set for generalized anxiety disorder

Criterion A

Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).

Criterion B

The individual finds it difficult to control the worry.

Criterion C

The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past six months):

1. restlessness or feeling keyed up or on edge
2. being easily fatigued
3. difficulty concentrating or mind going blank
4. irritability
5. muscle tension
6. sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

Criterion D

The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criterion E

The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

Criterion F

The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder, contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Panic disorder

Panic disorder is characterized by recurrent unexpected panic attacks that are not restricted to particular stimuli or situations. Panic attacks are discrete episodes of intense fear or apprehension accompanied by the rapid and concurrent onset of several characteristic symptoms, for example, palpitations or increased heart rate, sweating, trembling, shortness of breath, chest pain, dizziness or lightheadedness, chills, hot flushes, fear of imminent death.

In addition, panic disorder is characterized by persistent concern about the recurrence of panic attacks, or behaviours intended to avoid their recurrence. This

results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. The symptoms are not a manifestation of another medical condition and are not due to the effects of a substance or medication on the central nervous system.

Criteria set for panic disorder

Criterion A

Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feelings of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, light-headed, or faint
9. chills or heat sensations
10. paresthesia (numbness or tingling sensations)
11. derealization (feelings of unreality) or depersonalization (being detached from oneself)
12. fear of losing control or “going crazy”
13. fear of dying.

Note: Culture-specific symptoms (such as tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

Criterion B

At least one of the attacks has been followed by one month (or more) of one or both of the following:

- persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”)
- a significant maladaptive change in behaviour related to the attacks (e.g., behaviours designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

Criterion C

The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

Criterion D

The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

Entitlement considerations

Section A: Causes and/or aggravation

Causal or aggravating factors versus predisposing factors

Causal or aggravating factors directly result in the onset or aggravation of the claimed psychiatric condition.

Predisposing factors make an individual more susceptible to developing the claimed condition. They are experiences or exposures which affect the individual's ability to cope with stress. For example, severe childhood abuse may be a predisposing factor in the onset of a significant psychiatric condition later in life. These factors do not cause a claimed condition. Partial entitlement should not be considered for predisposing factors.

Physical/constitutional symptoms are prevalent in people living with psychiatric diagnoses and are often associated with psychological distress. Physical and mental health symptoms frequently co-occur. Physical symptoms associated with psychiatric conditions are included in entitlement/assessment. However, once a symptom has developed into a separate and distinct diagnosis, the new diagnosis becomes a separate entitlement consideration.

For Veterans Affairs Canada (VAC) entitlement purposes, the following factors are accepted to cause or aggravate the conditions included in the Definition section of this EEG, and may be considered along with the evidence to assist in establishing a relationship to service. The factors have been determined based on a review of up-to-date scientific and medical literature, as well as evidence-based medical best practices. Factors other than those listed in Section A may be considered, however consultation with a disability consultant or medical advisor is recommended.

The timelines cited below are for guidance purposes. Each case should be adjudicated on the evidence provided and its own merits.

Factors

1. Being a **prisoner of war** before the clinical onset or aggravation of an anxiety disorder.

2. Directly experiencing a **traumatic event(s)** within the five years before the clinical onset or aggravation of an anxiety disorder.

   Traumatic events include, but are not limited to:

   - exposure to military combat
   - threatened or actual physical assault
   - threatened or actual sexual trauma
   - being kidnapped
   - being taken hostage
   - being in a terrorist attack
   - being tortured
   - being in a natural or human-made disaster
   - being in a severe motor vehicle accident
   - killing or injuring a person
   - experiencing a sudden, catastrophic medical incident.

   Note:

   - Moral injury related to service may occur in response to a traumatic event. Moral injury refers to the psychological, emotional, and spiritual distress that arises from actions, or the witnessing of actions, that challenge one's moral and ethical values or beliefs. The resulting distress may contribute to the development of an anxiety disorder. Morally injurious events are often associated with situations where individuals feel a profound sense of guilt, shame, or betrayal due to their own actions or the actions of others. These certainly may occur in the context of war, combat, or other high-stakes, morally challenging experiences.
   - Repeated exposure to prejudicial or unjust treatment may be considered a traumatic event.

3. **In-person witnessing** of a traumatic event(s) as it occurred to another person(s) within the five years before the clinical onset or aggravation of an anxiety disorder.

   Witnessed traumatic events include, but are not limited to:

- threatened or serious injury to another person
- an unnatural death
- physical or sexual abuse of another person
- a medical catastrophe in a close family member or close friend.

4. Learning a **close family member or close friend experienced a violent or accidental traumatic event(s)** within the two years before the clinical onset or aggravation of an anxiety disorder.

   Traumatic events include, but are not limited to:

   - physical assault
   - sexual trauma
   - serious accident
   - serious injury.

   Note: The relationship between individuals in a leadership role and subordinates should be considered akin to close family or friend.

5. Experiencing **repeated or extreme exposure** to aversive details of a traumatic event(s) within the five years before the clinical onset or aggravation of an anxiety disorder.

   Exposures include, but are not limited to:

   - viewing and/or collecting human remains
   - viewing and/or participating in the clearance of critically injured casualties
   - repeated exposure to the details of abuse and/or atrocities inflicted on another person(s)
   - dispatch operators exposed to violent or accidental traumatic event(s).

   Note: If the exposure under factor five is to electronic media, television, movies and pictures, the exposure must be work-related.

6. Living or working in a **hostile or life-threatening environment** for a period of at least four weeks before the clinical onset or aggravation of an anxiety disorder.

   Situations or settings which have a pervasive threat to life or body, including but not limited to:

   - being under threat of artillery, missile, rocket, mine, or bomb attack
   - being under threat of nuclear, biologic, or chemical agent attack
   - being involved in combat or going on combat patrols.

7. Experiencing the **death of a close family member or close friend** within the two years before the clinical onset or aggravation of an anxiety disorder.

   Note: The relationship between individuals in a leadership role and subordinates should be considered akin to close family or friend.

8. Experiencing a **stressful life event** within one year before the clinical onset or aggravation of an anxiety disorder.

   Stressful life events include, but are not limited to:

   - being socially isolated and unable to maintain friendships or family relationships due to physical location, language barriers, disability, or medical or psychiatric illness
   - experiencing a problem with a long-term relationship including the break-up of a close personal relationship, the need for marital or relationship counselling, marital separation, or divorce
   - having concerns in the work or school environment including ongoing conflict with fellow work or school colleagues, perceived lack of social support within the work or school environment, perceived lack of control over tasks performed and stressful workloads, or experiencing bullying in the workplace or school environment
   - experiencing serious legal issues including being detained or held in custody, ongoing involvement with law enforcement concerning violations of the law, or court appearances associated with personal legal problems
   - having severe financial hardship including, but not limited to, loss of employment, long periods of unemployment, foreclosure on a property, or bankruptcy
   - having a close family member or close friend experience a major deterioration in their health
   - being a full-time caregiver to a family member or close friend with a severe physical, mental, or developmental disability.

9. Having a **clinically significant psychiatric condition** within the 10 years before the clinical onset or aggravation of an anxiety disorder. A clinically significant psychiatric condition as defined in the *DSM-5-TR* is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

10. Having a **serious medical illness or injury** which is life-threatening or which results in serious physical or cognitive disability within the five years before the clinical onset or aggravation of an anxiety disorder.

11. Having **chronic pain** of at least three months duration at the time of the clinical onset or aggravation of an anxiety disorder.

12. Having **epilepsy** at the time of the clinical onset or aggravation of an anxiety disorder.

13. Inability to obtain **appropriate clinical management** of an anxiety disorder.

Section B: Medical conditions which are to be included in entitlement/assessment

Section B provides a list of diagnosed medical conditions/categories which are considered, for VAC purposes, to be included in the entitlement and assessment of an anxiety disorder.

- Adjustment disorder
- All other anxiety disorders
- All other trauma-and stressor-related disorders
- Bipolar and related disorders
- Depressive disorders
- Dissociative disorders
- Feeding and eating disorders
- Neurodevelopmental disorders
    - Attention-deficit/hyperactivity disorder
- Obsessive-compulsive and related disorders
- Pain disorder (*Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Revision [DSM-4-TR]* Axis I Diagnosis)
- Personality disorders
- Posttraumatic stress disorder
- Schizophrenia spectrum and other psychotic disorders
- Sleep-wake disorders
    - Insomnia disorder
    - Hypersomnolence disorder
- Somatic symptom disorder with predominant pain (previously pain disorder in the *DSM-4-TR*)
- Substance use disorders

Note:

- If specific conditions are listed for a category, only these conditions are included in the entitlement and assessment of an anxiety disorder. Otherwise, all conditions within the category are included in the entitlement and assessment of an anxiety disorder.
- Separate entitlement is required for a *DSM-5-TR* condition not included in Section B of this EEG.

- Somatic symptom and related disorders, such as functional neurological symptom disorder (conversion disorder), somatic symptom disorder, illness anxiety disorder, and bodily distress disorder (*ICD-11* diagnosis) are entitled separately and assessed on individual merits.

Section C: Common medical conditions which may result, in whole or in part, from anxiety disorders and/or their treatment

Section C is a list of conditions which can be caused or aggravated by anxiety disorders and/or their treatment. Conditions listed in Section C are not included in the entitlement and assessment of an anxiety disorder. A consequential entitlement decision may be considered where the individual merits and the medical evidence of the case support a consequential relationship.

Conditions other than those listed in Section C may be considered; consultation with a disability consultant or medical advisor is recommended.

- Bruxism
- Irritable bowel syndrome
- Ischemic heart disease
- Obstructive sleep apnea
- Periodic limb movement disorder
- Restless leg syndrome
- Salivary gland hypofunction disorder (xerostomia)
- Sexual dysfunction

If it is claimed a medication required to treat an anxiety disorder resulted in whole, or in part, in the clinical onset or aggravation of a medical condition the following must be established:

- The medication was prescribed to treat an anxiety disorder.
- The individual was receiving the medication at the time of the clinical onset or aggravation of the condition being claimed to the medication.
- The current medical literature supports the medication can result in the clinical onset or aggravation of the condition being claimed to the medication.
- The medication use is long-term, ongoing, and cannot reasonably be replaced with another medication or the medication is known to have enduring effects after discontinuation.

Note: Individual medications may belong to a class of medications. The effects of a specific medication may vary from the grouping. The effects of the specific medication should be considered.

Links

Related VAC guidance and policy:

- Adjustment Disorder - Entitlement Eligibility Guidelines
- Bipolar and Related Disorders - Entitlement Eligibility Guidelines
- Bruxism – Entitlement Eligibility Guidelines
- Depressive Disorders - Entitlement Eligibility Guidelines
- Feeding and Eating Disorders - Entitlement Eligibility Guidelines
- Ischemic Heart Disease - Entitlement Eligibility Guidelines
- Posttraumatic Stress Disorder - Entitlement Eligibility Guidelines
- Salivary Gland Hypofunction Disorder (Xerostomia) - Entitlement Eligibility Guidelines
- Schizophrenia - Entitlement Eligibility Guidelines
- Sexual Dysfunction - Entitlement Eligibility Guidelines
- Sleep-Related Breathing Disorders – Entitlement Eligibility Guidelines
- Substance Use Disorders - Entitlement Eligibility Guidelines
- Pain and Suffering Compensation - Policies
- Royal Canadian Mounted Police Disability Pension Claims - Policies
- Dual Entitlement – Disability Benefits - Policies
- Establishing the Existence of a Disability - Policies
- Disability Benefits in Respect of Peacetime Military Service – The Compensation Principle - Policies
- Disability Benefits in Respect of Wartime and Special Duty Service – The Insurance Principle - Policies
- Disability Resulting from a Non-Service Related Injury or Disease - Policies
- Consequential Disability - Policies
- Benefit of Doubt - Policies

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