lability are common in hyperthyroidism (Wayne, 1954; Williams, 1964). The case is interesting because it demonstrates the temporary success of conventional psychiatric treatments in a neurotic syndrome, which in this case was underpinned by an occult endocrine disorder. The potential danger of treating psychiatric disturbances without adequate medical screening is also indicated.

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A DIMENSIONAL CONCEPTUALIZATION OF ANXIETY

DEAR SIR,

The paper by Tyrer (*The British Journal of Psychiatry*, January 1984, **144**, 78–83) nicely discussed the current classification of anxiety. Tyrer pointed out the decline of the use of the anxiety neurosis diagnosis and the incorporation of its former territory into other diagnostic entities. Both the diversity of diagnostic practices with respect to anxiety and their change become apparent from his fine article.

The present authors here propose a conceptualization of anxiety that is an alternative to discrete anxiety entities. Specifically, it is suggested that any anxiety case be plotted on three dimensions—stimulus specificity versus non-specificity, sometimes versus always present, and cognitive versus somatic components.

The matters of stimulus specificity and pervasiveness have long been dealt with by clinicians and by all of the DSM manuals. The phobia is obviously most stimulus specific. The phobia and the panic states are by definition not manifested all the time. Generalized anxiety disorder and the obsessive compulsive states are. Freud spoke of "free floating anxiety", and Wolpe, "pervasive anxiety". The cognitive versus somatic component of anxiety has been described recently by Freedman, Dornbush, and Shapiro (1981) in connection with differential treatment of the various anxiety disorders, and by earlier authors (Salzman, 1978; Weekes, 1978; Beck, 1976; and Schachter & Singer, 1962). The obsessive compulsive disorder would appear to have the highest cognitive component.

One potential advantage of this three dimensional conceptualization over the traditional disease entity based classification is that most anxiety cases do not fall neatly into the pure types. Phobics tend to be generally more anxious than the average person. Patients with a generalized anxiety disorder are not equally anxious at all times and in all circumstances. The presently proposed formulation perhaps especially facilitates the understanding of the DSM III categories of phobias in relationship to each other and to the other anxiety disorders. The simple phobias are the most circumscribed with respect to stimulus and respect to time. Agoraphobia is the least circumscribed and resembles the generalized anxiety disorder. The social phobia occupies an intermediate position.

Therapeutic implications from the three dimensional classifications seem possible. In the previously cited article of Freedman, Dornbush & Shapiro (1981), tricyclic antidepressants and MAO inhibitors were recommended for high cognitive and high somatic symptoms, beta-blockers for low cognitive and high somatic symptoms, psychotherapy for high cognitive and low somatic symptoms, and reassurance for low cognitive and low somatic symptoms. There are a variety of psychotherapeutic, behavioral, and drug treatments for all the anxiety disorders. It is conceivable that eventually a logically formulated and empirically determined system of treatment planning could be based upon scores in three dimension, e.g., 6–2–6 indicates tricyclic antidepressants and behavioural therapy.

This conceptualization not only permits more precision within the realm of anxiety disorders, but allows for greater compatibility with diagnoses in other domains. A person could receive a schizophrenic or personality disorder or depressive diagnosis and yet the nature of his/her anxiety could be specified.

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