

Generalized Anxiety Disorder Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-IV-TR Diagnostic Codes: 300.2

The Clinical Guidelines are meant to assist providers in making the best decisions about appropriate treatment in specific clinical circumstances. You are not required to follow them nor are you expected to be proficient in all of the therapeutic models described below. However, following the guidelines is one way to help ensure that your care is consistent with the most current research and best practices and that it is medically necessary.

Diagnostic Considerations:

1. Review diagnostic criteria in DSM-IV-TR:

Generalized Anxiety Disorder (GAD) is defined as:

- Excessive anxiety and worry, about a number of events or activities, occurring more days than not for a period of at least 6 months
- Difficulty controlling the worrying or anxiety
- Additional symptoms that accompany worry include: restlessness, easily fatigued, muscle tension, sleep disturbances, irritability, and difficulty concentrating
 - Underlying anxiety, particularly in men, may manifest as externalizing behaviors, such as irritability and anger and/or an aggressive or controlling temperament.
 - If a client reports these additional symptoms or exhibits externalizing behaviors as the presenting problem, but does not mention anxiety or worry, be sure to assess further.

2. **Differentiate between GAD and other anxiety disorders.** Assess whether the anxiety is specific or general to rule out other anxiety disorders. Unlike other anxiety disorders, in which there is a clear stimulus to be avoided (e.g., spiders, social situations), in GAD there is no clear threat from which to escape or attack. As a result, people with GAD use their cognitive capabilities to find ways to avoid the anticipated danger. Worrying is positively reinforced as it results in a decreased physiological and emotional response. It is negatively reinforced as the feared outcomes are so catastrophic, they generally do not come true. As a result, clients may come to believe that worrying is a helpful strategy.

3. **Co-occurring disorders** include mood disorders, substance-related disorders, and somatic complaints. Rule out substance-induced anxiety disorder. Depression can be particularly confounding. It's not uncommon for depressive symptoms to motivate seeking treatment, although an underlying anxiety disorder can precede depressive symptoms for months or years and go undiagnosed and untreated.

4. **The lifetime prevalence** rate for GAD is around 9% with an annual prevalence rate of 3%. This disorder is diagnosed slightly more in women than in men, with the majority of individuals diagnosed in mid-adulthood. Over half of individuals who receive treatment for GAD reported an onset in childhood or adolescence.

5. **Consider risk factors** such as a history of trauma and certain childhood temperaments. Trauma, whether a single catastrophic event or a series of exposures, can result in many of the symptoms and behaviors associated with GAD. For example, a person who has experienced repeated sexual abuse may approach daily life with a sense that danger is always present, experience hypervigilance, muscular tension, physiological arousal, difficulty sleeping, and feeling on edge. This level of arousal was probably useful to them when the potential for re-traumatization was present, but it may be dysfunctional when no threat is likely. The temperaments or traits of behavioral inhibition, neuroticism, negative affectivity and harm avoidance, have been hypothesized to be linked with anxiety disorders. Some researchers postulate that temperament and psychopathology exist along a single continuum. Similarly, these temperaments might be seen as inherent vulnerabilities that are magnified and expressed as psychopathology under specific environmental conditions.

6. **GAD in children** is often over diagnosed and a thorough evaluation should be completed. Many times children worry about school performance due to fear of failure which would be better described as Social Phobia. Children with GAD may be overly conforming, perfectionist, and unsure of themselves and tend to redo tasks because of the excessive dissatisfaction with a less-than perfect performance. They are typically overzealous in seeking approval and require excessive reassurance about their performance or other worries. Children with GAD worry excessively about many areas such as schoolwork (getting things right, being on time), family relationships and finances, friendships, health, safety (burglars) and new situations. They have a tendency to repeatedly seek reassurance from parents or others about fears and will repeat questions in new situations (e.g., “What is going to happen?” “What if...”). The constant worrying may lead to stomachaches, headaches, tiredness, and inattention.
7. **Complete a psychosocial and diagnostic assessment**, including social and family history, as increasing research shows a familial pattern for GAD. Other psychosocial factors that should be explored include: potential fears, acute precipitants to excess worrying episodes (as many report increased anxiety at times of stress). To understand the severity of anxiety and symptoms in children, it is important to get information from the child, parents or caregivers, and teachers. Gathering information can be done through diagnostic interviews, anxiety ratings scales, and observations. Assess the following 3 dimensions: anxious behaviors, thoughts, and physical symptoms. Diagnostic assessments and rating scales can be used to diagnosis GAD, measure the severity of the symptoms, and monitor treatment progress. The following are widely available assessment tools for adults and children:
 - **For Adults:** Generalized Anxiety Disorder Assessment (GAD-7), Generalized Anxiety Disorder Severity Scale (GADSS), Beck Anxiety Inventory (BAI), and the Penn State Worry Questionnaire (PSWQ)
 - **For Children:** Multidimensional Anxiety Scale for Children (MASC) and Screen for Child Anxiety Related Emotional Disorders (SCARED)
8. **Cultural factors** should be considered when assessing the expression of anxiety. In some cultures, anxiety is expressed through somatic symptoms, in others through cognitive symptoms. Use caution to not assume GAD based on the presence of somatic complaints alone, as some cultures tend to over-report physical concerns, even outside of the context of anxiety. In cultures where the expression of mental illness is associated with significant stigma, terms such as “anxiety disorder” may be seen as pejorative. When working with clients from such cultures, it may be helpful to use their culture’s particular idiom of distress, rather than using the clinical term. For example, a particular patient might be more comfortable discussing their experience of tension, stress, or nerves than they are describing anxiousness.
9. **Review medical history**, as anxiety disorders are significantly associated with thyroid disease, respiratory disease, gastrointestinal disease, arthritis, migraine headaches, and allergic conditions. Provide psychoeducation as to how worrying can affect and be affected by medical conditions in order to facilitate motivation to address these co-occurring conditions. Be sure to coordinate with primary care when appropriate.

Treatment Guidelines

1. **Complete a functional assessment.** Assess the client’s belief about the benefits or function of worry, the costs of avoidant behavior relevant to social functioning and engagement in valued activities. Articulate to the client that while worry may have been functional at one time in their lives, it may not be working to serve that purpose any more. Trauma informed care approaches suggest it is important to respect and honor the client’s use of these survival mechanisms, while also leading them to assess threats in their environment more realistically and find more adaptive ways to cope with their feelings.

2. **Prevent dropout** by proactively identifying and challenging thoughts or expectations that may serve as barriers to change. Talk with clients about what to expect from treatment, to be patient and not give up, and acknowledge and discuss barriers (cognitive and otherwise) that arise. Use motivational enhancement or interviewing techniques to engage where appropriate.
3. **Several evidence based practices** have demonstrated effectiveness at reducing symptoms of anxiety. Clinicians should be trained in these practices in order to implement the therapies effectively. Cognitive behavioral therapy, including worry exposure (see manual in resources), has been widely supported by research, both in individual and group formats, with studies demonstrating up to two years of symptom remission. Significant positive outcomes have also been found using mindfulness and stress reduction models, such as Mindfulness Based Therapy (MBT), applied relaxation, and progressive muscle relaxation, as well as short term psychodynamic therapy.
4. **CBT for children** with GAD involves:
 - Helping children to identify the physical, cognitive, and behavioral components of their anxiety.
 - Helping the child to challenge unrealistic thoughts about worries.
 - Working with children and caregivers to create a stepladder (i.e. exposure hierarchy) with steps that involve facing safe situations that are increasingly worry provoking while decreasing reliance on safety cues such as lucky charms or comfort objects (see <http://centreforemotionalth.com.au/pages/resources-generalized-anxiety-kids.aspx> for an example)
 - Having the caregiver provide rewards for successfully completing each step on the stepladder
 - Working with caregivers on limiting the amount of reassurance they provide in response to the child's repetitive questions as these questions maintain the child's worrying in the long run.
 - Working with caregivers on encouraging their child to face, not avoid, their feared situations.
5. **Consider referral for pharmacologic treatment** if therapeutic approaches have been unsuccessful or not enough progress has been achieved, as there is no current evidence to support the combination of the two treatments above psychotherapy alone.

References and Resources for Clinicians

American Academy of Child and Adolescent Psychiatry (2007). Practice Parameter for the assessment and treatment of children and adolescents with anxiety disorders. *J Am Acad Child Adolesc Psychiatry*, 46(2), 267-283.

Magellan Health Services (2012). Magellan Clinical Practice Guideline for the Assessment and Treatment of Generalized Anxiety Disorder in Adults.

Martin M. Antony (compiled by) (2013). *Recommended readings and DVD's: Anxiety disorders, depression and related problems*. Retrieved from <http://www.martinantony.com/wordpress/wp-content/uploads/2013/08/Anxiety-and-CBT-Reading-List.pdf>

Nathan, P.E. & Gorman, J.M. (2007). *A guide to treatments that work (3rd edition)*. New York, NY: Oxford University Press, Inc.

Rapee, R.M. Anxiety disorders in children and adolescents: Nature, development, treatment and prevention. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012. Retrieved from <http://iacapap.org/wp-content/uploads/F.1-ANXIETY-DISORDERS-072012.pdf>

Van der Heiden, C., Methorst, G., Muris, P., and van der Molen, H.T. (2011). "Generalized anxiety disorder: Clinical presentation, diagnostic features, and guidelines for clinical practice," *Journal of Clinical Psychology*, 67; 58-73.

Manuals:

Treating Anxious Children and Adolescents: An Evidence Based Approach by Ronald Rapee, Ann Wignall, Jennifer Hudson and Carolyn Schniering (2000).

The Clinical Research Unit for Anxiety and Depression (CRUFAD) (2010). *Generalized Anxiety Disorder: Patient Treatment Manual*. Retrieved from <http://crufad.com/index.php/treatment-support/treatment-manuals>

San Francisco bay area Center for Cognitive Therapy (2013). *Worry exposure: Strategies for treating GAD*. Retrieved from <http://www.sfbacct.com/training-and-consultation/clinical-tips/other-anxiety-disorders-generalized-anxiety-ocd-and-hypochondriasis/156-worry-exposure-strategies-for-treating-gad> (Manual for Worry Exposure)

Screening/Assessment Tools and References:

American Psychiatric Association (2012). *Online Assessment Measures*. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>

Screen for Child Anxiety Related Emotional Disorders (SCARED): http://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/cap_resources_for_medical_student_educators/screen_for_child_anxiety_related_disorders_child_version.pdf

Parent

Version: http://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/cap_resources_for_medical_student_educators/screen_for_child_anxiety_related_disorders_parent_version.pdf

GAD-7: <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>

GADSS: <http://www.theresarader.com/userfiles/1634494/file/GAD%20Severity%20Scale%20PDF.pdf>

BAI: <http://dih.wiki.otago.ac.nz/images/8/80/Beck.pdf>

PSWQ: <https://outcometracker.org/library/PSWQ.pdf>

MASC: <http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=masc2>

Silverman, Wendy K. & Ollendick, Thomas H. (2005) "Evidence-based assessment of anxiety and its disorders in children and adolescents," *Journal of Clinical Child and Adolescent Psychology*, 34(3); 380-411.

Appendix A

Aid for Assessment and Differential Diagnosis

In order to accurately diagnose generalized anxiety disorder (GAD), it is important to carefully assess differential diagnoses. Individuals with GAD can exhibit features that appear similar to depression or other specific anxiety disorders at first glance, and may not report symptoms of generalized anxiety without being prompted. Below are some specific questions that can begin to differentiate between the most commonly confounding diagnoses.

To rule out GAD:

- If clients answer no to the following questions, GAD is not likely
 - Do you worry excessively or have repetitive racing thoughts about minor things?
 - Do you often find yourself feeling irritable, jittery and/or stressed?
 - Do you worry excessively about everyday things such as your family, health, work or finances?
 - Do you feel overwhelmed and feel like daily tasks are unmanageable?
 - Do your friends or loved ones tell you that you worry too much?
 - Do you have difficulty controlling your worry, such as worry keeps you from falling asleep, makes you physically ill with headaches, stomach trouble, fatigue?
 - Do you think your worries will be over once the topic you are currently worrying about is resolved?
 - Clients with GAD tend to respond that they anticipate that there will be another thing to worry about once the area they are currently worried about is resolved.

To rule out other Anxiety disorders:

- What kinds of things do you worry about?
 - One or some major issues may indicate either normal worrying or another anxiety disorder
 - Being perceived negatively by others or fear of embarrassment (social phobia)
 - Worry about safety in response to history of trauma and re-experiencing the traumatic event (PTSD)
 - Worry about having a panic attack (feeling of fainting, dying, having a heart attack, loss of control) and/or being in public (Panic disorder, Agoraphobia)
 - Focused on certain objects or topics (OCD)
 - Worry about health or the body (hypochondriasis)

To rule out Depression:

- What came first, the anxiety or the depression?
- Rumination related to the past? (GAD more worry about negative things that will happen in the future)
- Predominance of depressed mood
- Presence of anhedonia