Anxiety Disorders

DSM-IV-TR Diagnostic Code:

300.02 Generalized Anxiety Disorder
300.0 Anxiety Disorder NOS
300.01 Panic Disorder Without Agoraphobia
300.21 Panic Disorder With Agoraphobia
300.23 Social Phobia (Social Anxiety Disorder)
300.29 Specific Phobia

Diagnostic Guidelines

1. Establish diagnostic accuracy as defined in DSM-IV-TR.
2. Assess for co-morbid depression.
3. Assess for family history of mental illness.
4. Consider cultural factors, such as religious or spiritual beliefs.
5. Rule out the effects of intoxication and withdrawal, of prescription and/or street drugs and ETOH.
6. Rule out medical conditions such as: thyroid dysfunction, mitral valve prolapse, cardiac arrhythmias and hypoglycemia.
7. Assess for concomitant Axis II personality disorder indicators, with special attention to the symptomotology associated with cluster B personality disorders.

Treatment Guidelines

1. Cognitive Behavior Therapy (CBT) is an empirically supported treatment recommended by the APA (Chambless et al., 1988), which may include but is not limited to:
   - In-vivo or imaginal exposure (e.g. desensitization) (Barlow, 1996)
   - Changing internal cognitions (e.g., explore cognitive messages that trigger anxiety responses and help retrain client in adaptive responses)
   - Stress Management (e.g., assertiveness training)

2. Psychosocial Education is an important component of this treatment and may include:
   - Self help books
   - Structured homework assignments
   - Family education
   - Support groups

3. Family Therapy to enable family members to establish appropriate ways of dealing with the feared situation and assist the client in the reduction of avoidant behaviors.

4. Psychopharmacological medication is recommended if symptoms are unresponsive to psychotherapeutic interventions, or if the symptoms are incapacitating. Medications used include:

   - Antidepressants – Should be maintained for at least 5 to 6 months, then tapered slowly to avoid reactivation of anxiety symptoms (March et al., 1997; American Psychiatric Association, 1998; Ballenger et al., 1998)
   - Benzodiazepines – (*Contraindicated if assessment reveals significant substance abuse potential or history of substance addiction. See additional comments below.*)
   - Beta-blockers
   - Buspirone – approved by the FDA in the mid-1980s as an anxiolytic, buspirone has the advantage of being non-habit forming and has no abuse potential (Stahl, 1996). It is useful in the treatment of Generalized Anxiety Disorder, often as an adjunct to SSRIs (Lydiard et al., 1996).
   - Mood Stabilizers

5. For benzodiazepines, use lowest effective dose on an as-needed basis. Current standard of practice is to treat for 6-12 months before trying to taper and discontinue. Routine dosing should be reserved for intractable anxiety.

6. When tapering benzodiazepines, go slowly. Do not abruptly discontinue benzodiazepines or permit client to taper/discontinue them without supervision.

   - Monitor for rebound symptoms – these usually abate in 2-4 weeks. If they do, continue tapering. If symptoms do not abate or if client worsens, raise dose, still trying to achieve lowest effective dose.
   - Educate client and family regarding tapering method and possibility of rebound symptoms.

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