Clinical Practice Review for GAD

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

For diagnostic criteria and codes, visit the Anxiety Disorders page of the *DSM-5;* requires subscription and login.

Generalized Anxiety Disorder (GAD)

GAD is a condition characterized by persistent, excessive, uncontrollable and unrealistic worry about everyday things. Individuals meeting criteria for GAD mostly worry about the same material that the average person worries about, such as finances, their health and the health of their loved ones, and safety concerns, but people diagnosed with GAD spend much more time worrying. Whereas a healthy person may worry up to an hour a day, it is usually 3 to 10 hours per day for a person with GAD.

Everyone worries sometimes but one has entered the realm of GAD with the following symptoms:

- One finds it difficult to control his or her worries.
- One experiences physical symptoms of anxiety such as feeling restless, fatigued, irritable, difficulty concentrating, and disturbed sleep.
- The excess, uncontrollable worry causes significant distress.
- The excess, uncontrollable worry impairs one's ability to function.
- One experiences excessive worries, about several spheres of life, for more days than not, for at least six months.

Diagnostic Criteria

People meeting criteria for GAD experience exaggerated worry and tension, often expecting the worst, even when there is no apparent reason for concern. Whereas patients with panic disorder show the very intense and short-lived fight-flight reaction experienced in case of immediate danger, patients with GAD experience the constant anxious reaction that would be normal entering unfamiliar terrain (e.g. being in an unfamiliar town at night alone), not

knowing what dangers await them, they are hypervigilant. A common report is that they feel a moderate level of anxiety (such as a 60 on a 0 to 100-point anxiety scale) at all times, regardless of the situation. Although people with GAD often report social anxiety, the focus is not only on negative evaluation (as in social anxiety disorder). GAD patients dislike uncertainty and unpredictability, and what is less predictable than another person? They anticipate disaster and are overly concerned about money, health, family, work, or daily hassles — the small things that complicate life (e.g., traffic, parking). They don't know how to stop the worry cycle and feel it is beyond their control, even though they usually realize that their anxiety is more intense than the situation warrants. Therefore, they do their best to control the worry by distraction, by using safety behaviors (e.g., drinking alcohol; phoning loved ones for reassurance; asking many questions about events such as who will be there, how long, who is driving), and avoidance behaviors (e.g., not opening mail, not answering their phone, not answering texts).

Individuals can continue to function with mild GAD and assume they are just worriers and this is how they will always be. It is often not until symptoms increase and they are having a more difficult time meeting the requirements of daily life or serious sleeping problems that they seek help. It is common for those experiencing GAD symptoms to see several medical providers to obtain assistance with the physical symptoms of anxiety such as an upset stomach, headaches, sleep disturbances, and muscle tension. Once physical causes for these symptoms have been ruled out, it may be time to consult a mental health specialist to discuss cognitive-behavioral therapy, or CBT.

Individuals often begin CBT for GAD believing the following:

- Their worrying is out of their control.
- Worrying offers some protective value.
- Through worrying, they will be better able to manage future negative scenarios.

As people move through treatment, they come to understand:

- They cannot control their fears, but they can control how they respond to their fears by engaging in the behavior of worrying.
- Worrying offers **no** protective value, and in fact it reinforces negative thinking and increases the likelihood that they will experience more anxiety in the future.
- Worrying does **not** assist in managing negative future scenarios, but instead they are equipped to handle whatever future challenges come their way.

Effective treatment for GAD entails assisting clients in developing new strategies to manage their worries and cope with life stressors, and how to reduce the physical symptoms of anxiety.

Treatment Options

	Adults	Children

First-Line Treatments: Psychotherapy	**Cognitive-behavioral therapy (CBT)** usually combines several different interventions: psychoeducation, worry exposure, relaxation, applied relaxation, problem-solving, cognitive re-structuring, and interpersonal psychotherapy. The most important ingredient is thought to be the exposure procedures. Format: individual Sessions: usually 12–20 **Cognitive therapy (CT)** teaches patients to evaluate their anxious thoughts objectively. Variants include pure cognitive therapy, cognitive restructuring, meta-cognitive therapy, and intolerance of uncertainty therapy. Format: individual Sessions: usually 15–20 **Applied relaxation** teaches the patient a coping skill that will enable him or her to relax rapidly, in order to counteract and eventually abort the anxiety reactions better. This therapy is different from relaxation alone, which is not helpful. Applied relaxation entails having people relax in actual anxiety-provoking situations. Format: individual Sessions: usually 15	**Cognitive-behavioral therapy for children (CBT)** is aimed at the child and the parents. Children: psychoeducation, coping skills training (including relaxation skills, positive self-talk, and thought challenging), imaginal, and in vivo exposure Parents: reducing reinforcement of child's anxious behaviors and family conflict, managing their own anxiety Ages: 6–17 Format: group or individual Sessions: usually 12–20; some treatment packages are as short as 8 sessions.
First-Line Treatments: Pharmacotherapy	**SSRI and SNRI** *FDA approved* Venlafaxine XR 75-225 qd Duloxetine 60 mg qd, max 120 mg/day; 7-17 yo 30-60 qd, max 120 Paroxetine 20 qAM, max 50 mg/day, max elderly 40mg/day, Escitalopram 10 mg qd, max 20 mg/day, max elderly 10 mg/day *Not FDA approved* Sertraline 50-200 qd Fluoxetine 20-80 qd	**Medications** *Not FDA approved* Sertraline (5-17) 25-150 mg qd children 12 and under; 50-200 mg qd adolescents 13-17 Fluvoxamine (6-17 yo) max 300 mg qd Fluoxetine (7-17 yo) 10-60 mg qd *FDA approved* Duloxetine (7 to 17 yo) 30-60 mg PO qd; start: 30 mg PO qd x2wk; max: 120 mg/day; may incr. dose in 30 mg increments

First-Line Treatments: Combined	A very few scientific studies have compared the combination of medication (benzodiazepine, buspirone, or antidepressant) with CBT. Most of them failed to show any advantage of combined therapy over monotherapy. One study involving older adults did show that augmentation of escitalopram with CBT was superior to continued escitalopram alone.	Combination therapy can be more effective than mono therapy. A large study showed that both sertraline and CBT were more effective than placebo in treating childhood anxiety (including GAD). In addition, the combination of CBT and sertraline was more effective than either treatment alone.
Second-Line Treatments: Psychotherapy	**Acceptance and commitment therapy (ACT) and mindfulness** are newer types of cognitive-behavioral therapy, and initial studies are promising. They teach patients to focus on the present moment and follow actions guided by their values rather than by emotions and anxiety. Format: individual Sessions: usually 10–15 Internet-based interventions, usually CBT via web, cognitive restructuring, exposure, problem solving, applied relaxation Sessions: 6–8	**Cognitive therapy for children** includes worry-awareness training; worry interventions (planned exposure to uncertainty; modification of dysfunctional beliefs regarding worry; modified problem-solving training; imaginal exposure) Format: individual Ages: 14–18
Second-Line Treatments: Pharmacotherapy	**Benzodiazepines** Diazepam 2-10 mg bid-qid Alprazolam 0.25-0.5 tid, max 4 mg/day; elderly start 0.25 bid-tid Lorazepam 2-6 divided bid-tid, max 10 mg/day; elderly start 1-2 mg bid-tid Clonazepam 0.25-0.5 bid-tid, max 4 mg/day; **Buspirone** 20-30 divided bid-tid, max 60 mg/day; 6-17 yo 15-60 divided bid, max 60	*Not FDA approved* Venlafaxine XR (6-17 yo) 37.5-225 mg
Other Medications	*FDA approved* Hydroxyzine 50-100 q6h, max 600 mg *Not FDA approved* Imipramine 150-300 qd, elderly max 100 mg/day Trazodone 50-100 bid-tid, max 400/day Mirtazapine 15-40 qd	*FDA approved* Diazepam* 1-2.5 mg tid-qid initially, increase gradually asneeded and tolerated Hydroxyzine* < 6 yo 12.5 mg q6-8h; >6 yo 12.5-25 mg q6-8h *Note: These medications were

	Bupropion XL 150-300 qd Pregabalin 150-600 divided bid-tid Quetiapine 50-300 qd Vortioxetine 5 mg qd	approved for the treatment of anxiety in children before *DSM-III* and the introduction of the GAD category. They should be considered third-line treatment.
Adjunctive Treatments	Augmentation Agents (pharmacological; not FDA approved) Olanzapine 5-10 mg qd Risperidone 0.5-1.5 mg qd Quetiapine see above Pregabalin see above Interpersonal psychotherapy (IPT) and motivational interviewing (MI) Both IPT and MI have been evaluated for augmentation of CBT, albeit in a limited number of studies, and no evidence of positive results. Exercise: A large body of work supports the beneficial effects of exercise on mood and anxiety disorders. However, currently only small pilot trials are specific to GAD.	N/A
Complementary and Alternative	Currently no treatment guidelines recommend widespread use of complementary and alternative treatments for GAD. • Passionflower: Generally considered safe when taken as directed, but some studies have found it can cause drowsiness, dizziness, and confusion. A few small clinical trials suggest that passionflower might help with anxiety. In many commercial products, passionflower is combined with other herbs, making it difficult to distinguish the unique qualities of each herb. • Kava: Avoid using until more rigorous safety studies are done, especially if you have liver problems or take medications that affect your liver. Some studies showed kava was helpful for anxiety reduction, and others did not. More importantly, reports of serious liver damage even with short-term use caused European countries and Canada to pull it off the market. The Food and Drug Administration has	N/A

Treatments	issued warnings, but not banned sales in the United States. • Valerian: Generally well-tolerated, with a few case reports of people developing liver problems when taking preparations containing valerian. In some studies, people reported less anxiety and stress, but in other studies, people reported no benefit. Discuss valerian with your doctor before trying it. If you've been using valerian for a long time and want to stop, many authorities recommend tapering down to prevent withdrawal symptoms. • Theanine: Preliminary evidence shows that theanine may make some people feel calmer, but limited evidence shows that it helps treat anxiety. This amino acid is found in green tea and may be found in some supplements. Before taking herbal remedies or supplements, talk to your doctor to make sure they're safe for you and won't interact with any medications you take.	
Contraindicated Treatment	It should be noted that while relaxation training alone is not effective, practicing relaxation while in highly anxious situations can be effective. This is called applied relaxation (see above). • A non-prescribing clinician should consider asking a referring physician if there is any contraindication to prescribing exposure therapy with the patient. Generally, if the patient has not received instructions to avoid sex or exercise, exposure therapy is likely also safe.	N/A

GAD Clinical Practice Review Task Force
Mark Powers, PhD, The University of Texas at Austin – Chair
Eni Becker, PhD, Radboud University Nijmegen
Jack Gorman, MD, Franklin Behavioral Health Consultants
Debra Kissen, PhD, Light on Anxiety Treatment Center of Chicago
Jasper Smits, PhD, The University of Texas at Austin

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8701 Georgia Avenue
Suite #412
Silver Spring, MD 20910
Phone: 240-485-1001
Fax: 240-485-1035
information@adaa.org
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