BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

ANXIETY DISORDERS

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for customers with Anxiety Disorders. It may also assist clinicians treating customers with problematic anxiety symptoms, but do not meet full criteria for an anxiety disorder. The Treatment Guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral health department and represent a consensus recommendation for service provision for this group of disorders. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is:

- Effective
- Efficient
- Culturally relevant
- Acceptable to clinicians, program managers, and customers

Definition of disorder

There are a number of disorders in which anxiety or fear interfering with daily activities is the focus of concern and treatment. The anxiety disorders include Panic Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder and Phobias (Including Social Phobias, also called Social Anxiety Disorder). Because of the unique context of the Alaska Native population and our clinic, Post Traumatic Stress Disorder is covered in its own treatment guideline. Because of the number of disorders in this category, we chose not to list the full definition for each one. Please refer to the DSM for detailed criteria. These disorders are sometimes persistent, overwhelming, and can interfere with a persons daily life. The etiology of these disorders is a combination of biological and environmental factors.

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore function. The more specific goals of treatment for anxiety disorders are to reduce the frequency and intensity of anxiety so that daily functioning is not impaired, to better manage the full variety of life's anxieties and to resolve core conflicts that may be the source of anxiety.

Summary of 1st, 2nd and 3rd line treatment

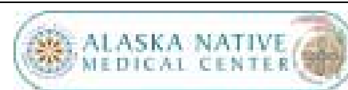
Based on our own clinical experience and review of the literature, the BHS clinicians feel that the first line of treatment for anxiety disorders involves both medication and psychotherapy, specifically an SSRI and CBT. CBT should include components of psychoeducation, rational self talk and exposure. More specific guidelines follow for each disorder:

General Anxiety Disorder: 1st line of treatment is a combination of medication (specifically an SSRI) along with individual and/or group psychotherapy which utilizes rational self talk and applied relaxation.

Social Phobia: Social Phobia is the most common mental health problem and is a risk factor in the development of depression and substance abuse. The recommended 1st line of treatment would be exposure therapy (possibility of individual or group exposure), with medication (specifically an SSRI).

Obsessive Compulsive Disorder: The recommended 1st line of treatment is individual therapy focusing on exposure and/or response prevention along with medication, again with an SSRI.

Panic Disorder: Cognitive Behavioral Therapy in combination with medication management is first line. Exposure is a critical part of CBT.



In regards to medication, please note that benzodiazapines have the potential to be addictive, and long term treatment with an SSRI is effective and non addictive.

Although there is no research base to demonstrate the effectiveness of specific culturally based practices, BHS clinicians encourages providers to incorporate Alaskan Native cultural idioms of care into treatment of these disorders; i.e. storytelling, talking circle, etc. We would like encourage program development in this area.

Approaches for customers who do not respond to initial treatment

A first step in evaluating lack of progress is consultation with the treatment team, (i.e., school, family, other supports, and other behavioral health or medical providers). If a customer is not making progress towards their treatment goals, the clinician should consider the possibility of misdiagnosis and/or re-evaluate customer's clinical status. Consider adding or combining modalities. If there is a co-existing disorder, consider how this may interfere with treatment of the anxiety disorder. Consider focusing on these other problems or barriers.

Clinical and demographic issues that influence treatment planning

There are high rates of comorbidity with anxiety disorders and depression. By increasing our recognition of comorbid disorders, we increase our ability to provide more effective treatment. Medical problems can precipitate or exacerbate anxiety conditions and the best treatment may require close collaboration between the customer, the behavioral health clinician, and the medical providers.

Age, gender, and culture effect choices of treatments. Some of our group therapy treatments group customers by these demographics in addition to or instead of diagnosis. This can be important to developing or improving the treatment alliance, to encouraging participation, and so on.

There is no available literature on the prevalence of anxiety disorders in the Alaskan Native Population; clinical experience suggests the correlation between other minority groups with similar socioeconomic status. The subjective sense of the clinical staff is that social phobia is more common and may, in some ways, be normative. Again, cultural awareness is needed in order for the clinician to provide effective, efficient and relevant care.

Flow Diagram

Assessment Completed

Review
DSM-IV criteria
for this disorder

Does customer meet criteria for this disorder?

UNCERTAIN → Reference Assessment in the Treatment Guidelines → Review case at your clinical team meeting and with your clinical supervisor. → Recommend customer for psychiatric Assessment, Psychological Testing and/or utilize screening scales to aid your in our assessment.

NO → Review other diagnoses and/or treatment guidelines

YES → Are manifestations of this disorder the most pressing aspect of the clinical presentation?

NO → Review other diagnoses and/or treatment guidelines

YES → Does customer want treatment for this disorder?

NO → Ensure Patient Safety → Recommend 4 PM Gatherings, PsyhoEd groups and/or Primary Care (BHC)

YES → Reference Treatment Guidelines → Read Executive Summary → Review each treatment modality → Determine treatment indicated for this customer. → Customize standard treatment plans for this customer.

Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Customers is already on psychotropic medication and is requesting continuation ▪ Customer or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if customer has guardian) ▪ Customer or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In customers with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the customer's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

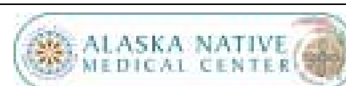
STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above, consider grouping by age, gender, or other categories.

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

- CBT
  -Identifying problematic thoughts, feelings, and behaviors
  -Learn and practice skills to modify problematic thoughts, feelings, and behaviors
  -Exposure
  -Psychoeducation
    - Relaxation
    - Labeling of Anxiety – Related Cognition
    - Problem Solving
    - Role playing
    - Homework assignments
- Expressive/Supportive
- Psychoeducation
- Exposure Therapy
- IPT
- Topical d/o focused



Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Group therapy contraindicated ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Moderate to Severe severity ▪ Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older ▪ Recent sexual, physical, abuse and/or neglect ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Play therapy concurrent with Family Therapy to address CBT goals. ▪ Recommend concurrent parenting class or family therapy.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

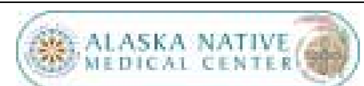
STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- CBT – skills building component
- IPT
- Expressive/Supportive
- Exposure Therapy

This guideline is designed for general use for most patients but may need to be adapted to meet the special needs of a specific patient as determined by the patient's provider.



Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- CBT – skills building component
- IPT
- Expressive/Supportive
- Systems Theory: Structural – Strategic

When a child has an anxiety disorder, family therapy should include parent and psychoeducational components. Treatment should also help identify the core issues contributing to the anxiety.

Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available. ▪ Recommended concurrent with psychotherapy and/or psychoeducation	▪ Refuses Medication Management ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Disorder is caused by an untreated general medical condition.

STRUCTURE

Duration	30 minutes
Frequency	Weekly to once every 3 months depending upon acuity of the patients symptoms.

TREATMENT MODEL

Anxiety disorders are often most effectively treated with both medication therapy and psychotherapy. SSRIs, SNRIs, benzodiazepines and buspirone, have found a primary role in the medication treatment of anxiety disorders. MAOIs, TCAs, certain atypical anti-depressants (mirtazapine, nefazadone) and some anti-convulsants (gabapentin, valproic acid, topiramate) have all been reported to be effective in the treatment of various anxiety disorders, though in off label applications.

The following table will offer class examples with common dosages used to treat anxiety disorder:

Medication Class	Medication	Starting Dosage	Usual Maintenance Dosage
SSRI	Fluoxetine	5 to 10 mg per day	20 to 60 mg per day
	Paroxetine	5 to 10 mg per day	20 to 60 mg per day
SNRI	Venlafaxine / XR	25 to 37 mg per day	75 to 150 mg per day
Benzodiazepines (Long term use can cause dependence and this risk is greater in patients with alcohol and substance use disorders. Alcohol and substance use disorders are over-represented in the Alaska Native population.)	Clonazepam	0.25 to 0.50 mg twice per day	0.50 to 2.0 mg three times per day
	Alprazolam	0.25 to 0.50 mg three times per day	0.50 to 2.0 mg three times per day
	Lorazepam	0.25 to 0.50 mg twice times per day	0.50 to 2.0 mg twice times per day
TCAs (ECG is recommended in patients over 40 years of age prior to starting TCA.)	Clomipramine	5 to 12.5 mg per day	50 to 125 mg per day (FDA approved for OCD)
	Imipramine	10 to 25 mg per day	150 to 300 mg per day

Medication Class	Medication	Starting Dosage	Usual Maintenance Dosage
MAOIs (Not currently on ANMC/PCC Formulary.) CAUTION: Review dietary, over-the-counter and prescription contraindications before prescribing MAOIs. Also observe necessary wash out periods before switching to or from MAOIs and other medications which may cause drug to drug interactions.	Phenalzine	15 mg twice per day	15 to 45 mg twice per day
Other agents	Buspirone	5 mg three times per day	10 to 20 mg per three times per day
	Propranolol CAUTION: Avoid beta-blockers in patients with asthma, CHS or diabetes.	10 mg twice per day	20 to 60 mg twice per day (Most commonly used for social phobia)

Some points to consider when using medications to treat anxiety; Panic Disorders patients may require a lower starting dosage and gradual titration to improve tolerability. It is also important to remember that non-benzodiazepines may take longer to demonstrate effectiveness in treatment of anxiety disorders (4 to 12 weeks) when compared to pharmacotherapy of depression.

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old. For adults, consider group appointments for medication management as below:

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and customer cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ Severe untreated hyperactivity	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • No child care available

STRUCTURE

Duration	▪ 90 minutes ▪ 8 to 12 months for customer over 17 years old ▪ 6 to 12 months minimum for customer with acute adjustment disorders with anxious features.
Frequency	Once a week
Size	Maximum of 8 customers per clinician
Open vs. Closed	Open

Psychoeducational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain customer and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct customer initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current customers in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide some aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

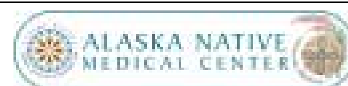
- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to customer or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder



Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder, or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
ANXIETY DISORDERS

Diagnosis: Anxiety Disorders 300. _ _ : Disorders that include excessive worry or anxiety (abnormal fear, reactivity, exaggerated stress reactions or hyperarousal or vigilance.

Generalized Anxiety Disorder: Six months of excessive worry or anxiety about a number of general life or productivity events. Symptoms are restlessness, fatigued, poor concentration irritability, physical tension or sleep disturbances.

Specific Phobia Disorder: Six months of self recognized worry or fear to a specific cue in the environment like: blood, snakes, flying, elevators, heights etc.

Social Phobia Disorder: Six months of marked or persistent fear of social situations where exposure to unfamiliar people or scrutiny (judgment or performance critique)

Panic Disorder: With or Without Agoraphobia is a discrete manifestation of intense fear, anxiety and somatic symptoms related to stress reactions. This is punctuated by the fear of death, losing control or going crazy.

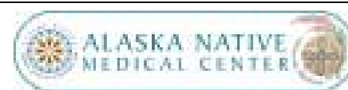
Obsessive Compulsive Disorders: A pattern of recurrent and persistent thoughts impulses or images that cause anxiety that exceed normal worry or real life situations, creates effort so avoid or suppress such mental events that are recognized as originating within themselves. These mental events are followed and relieved by compulsions or repetitive behaviors, strictly followed rules or performances that don't directly neutralize the related cue in a naturalistic way.

General Information: Anxiety disorders represent the largest category of disorders and symptoms diagnosed in the USA. They are twice as prevalent in older adults than affective disorders (Barrowclough et al, 2001), and very prevalent with children and adolescent (Kendall, 2004). Generally recognized by worries, fears and reactivity excesses, anxiety disorders are related to affective, substance abuse and externalizing behavior disorders. The range of anxiety disorders necessitates good clinical judgment, refined diagnostic skills and a complement of therapeutic skills (Velting et al, 2004). Evidence based practices are in development with much empirically supported treatment models available.

Group Therapy and Anxiety Disorders: Dugas et al, (2003) reviewing the literature on group cognitive-behavioral therapy for generalized anxiety cautiously concluded that group therapy is as effective a CBT individual therapy. Barrowclough et al (2001) note that supportive groups and CBT groups are baseline and effective methods for dealing with GAD in older populations. Barrett outlines numerous group programs for children in various settings. Groups are generally accepted in the literature across clinical populations except PTSD.

Structure of Groups: The group format includes a therapist with good supportive skills as well as direct cognitive-behavioral knowledge. Group size varied with the range running from 4 to 10 with the mean around 6. Age grouping with children is important for developmental concerns. Not specific information gathered on this search about gender specific or mixed gender groups. The absence of such delineations leads to the cautious conclusion that mixed genders would be appropriate. All references to evidence-based therapies included fidelity to a structured, psychoedcuational format that include Manualized treatments. Practice, outside group homework, relaxation response skills and exposure (in vivo and imaginal) are consistent components of successful treatment.

Professional Status and Effectiveness in Groups: There is no significantly different outcome in customer rated depressive symptoms based on professional or paraprofessional status in either cognitive-behavioral therapy or mutual support group therapies (Bright, 1999). There is a moderate difference in clinician-based symptom relief based on two factors 1) professionally lead CBT groups and 2) adherence to a manual based



format of group. This review also concluded that group is as effective as individual therapy regardless of clinician orientation.

Brief Therapy Models and Anxiety: Most reviews outlined therapies, both individual and group, that fall within the definition of brief therapy (DeRubeis and Crits-Christoph, 1998; Schaefer, 1999). Dewan explains the brief therapy models and provides evidence that between 8-20 sessions is sufficient for most diagnostic categories.

Professional Status in Brief Therapy: Although no specific research was found, brief therapy mechanics can be taught. There is no evidence that I found, that paraprofessionals could not be taught to execute the foci of treatment. There are obviously some advantages to experience and education in that the theoretical underpinnings are understood, ability to draw on numerous models, and diagnostic abilities are more honed. Some of the common factors supporting all good therapy though are not the exclusive domain of professionally trained practitioners.

Structure of most Brief Therapy: CBT principles were the most studied and researched. The empirical support is that the CBT created better outcomes than wait list, placebo pills or unstructured interventions. Supportive/expressive components and interventions were also noted to be effective. The comparative literature is clear that no model is superior. Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: "there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations" (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more "pluralistic" methodology in developing evidence based and culturally sensitive treatments. The overall consensus is that, even lacking specific cultural treatments, the application of evidence supported interventions is better than using non-supported techniques.

Pharmacological Interventions: Rivas-Vazquez (2001) notes that SSRIs and other anti-depressants are the first line of pharmacological intervention with anxiety. Comparative studies with Busprion and SSRIs suggest no significant differences but responses based on individual differences.

Manuals: Carmin and Albano (2003) and Velting (2004) provide references to many manuals for specific anxiety disorders. Also, Schaefer, In Short-Term Psychotherapy Groups for Children outline structured interventions in step-wise manner.

Literature Summary References:

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Appendix C: Sample Treatment Plans

Treatment Plan for Separation Anxiety

Problem #1:

Separation Anxiety

As evidenced by:

Excessive worry, fear, tension, restlessness, nausea, sleep problems, concentration difficulties, friction between parents, stomach aches, refusal to go to school, low self-esteem, drug/alcohol use

Goals:

1. Reduce the overall frequency and intensity of the anxiety response so that daily functioning is not impaired.
2. Stabilize the anxiety level while increasing the ability to function on a daily basis.
3. Customer will increase scheduled attendance from _____ to ______.
4. Customer will decrease experience of _____ somatic symptoms from _____ frequency to ______ frequency.

Objectives:

1. Reduce the overall frequency and intensity of the anxiety response so that daily functioning is not impaired.
    a. Develop a working relationship with the therapist in which the customer openly shares thoughts and feelings
    b. Increase participation in daily social, academic activities, and community/family support

2. Stabilize the anxiety level while increasing the ability to function on a daily basis.
    a. Parents will develop specific ways to emphatically help the customer with the anxiety and fear
    b. Customer will learn and/or practice appropriate relaxation, diversion, and stress management techniques
    c. Self-monitoring through the use of diaries/journaling n top 10 anxiety provoking situation

Treatment Plan for Relaxation Group

Problem #1:

Anxiety interfering with work

As evidenced by:

Manifested by; tardiness, absence, fatigue, and difficulty staying on task.

Goals:

Significantly reduce anxiety

Objectives:

1. Customer will learn to recognize symptoms associated with onset of anxiety/stress response
2. Customer will effectively learn guided imagery and relaxation breathing as coping
3. Customer will effectively reduce anxiety/stress response by half

Treatment Plan for Panic Disorder (Child)

Problem #1:
Panic Disorder

As evidenced by:
Fear of being in a place or situation from which escape may be difficult or symptom development (dizziness, depersonalization or de-realization, nausea, diarrhea, sweating, heart palpitation, or weakness) may be incapacitating or embarrassing.

Goals:
1. Reduce the fear such that the customer can independently and freely leave home and comfortably be in public environments with people present.
2. Reduce the fear of the specific stimulus object or situation that previously provoked immediate anxiety.
3. Eliminate the interference from normal routines and remove the distress over the feared object or situation.

Objectives:
1. Verbalize the fear and focus on describing the specific stimulus for it.
2. Construct a hierarchy of situations that evoke increasing anxiety.
3. Become proficient in progressive deep-muscle relaxation.
4. Identify a non-threatening, pleasant scene that can be utilized to promote relaxation using guided imagery.
5. Cooperate with systematic desensitization to the anxiety-provoking stimulus object or situation.
6. Engage in "in vivo" desensitization to the stimulus object or situation
7. Encounter the phobic stimulus object or situation feeling in control, calm, and comfortable.
8. Increase the family's support for the customer as he/she tolerates more exposure to the phobic stimulus.
9. Differentiate real from distorted, imagined situations that can produce rational and irrational fear.
10. Verbalize the cognitive beliefs and messages that mediate the anxiety response.
11. Develop positive, healthy and rational self-talk that reduces fear and allows a behavioral encounter with the avoided stimulus.
12. Responsibly take prescribed psychotropic medication to alleviate the phobic anxiety.

Treatment Plan for Panic Disorder (Adult)

Problem #1:
Panic Disorder

As evidenced by:
1. Unexpected, sudden, debilitating panic symptoms that have occurred repeatedly resulting in persisting concern about having additional attacks or behavioral changes to avoid attacks.
2. Fear of being in an environment that customer believes may trigger intense anxiety symptoms.
3. Persistence of fear in spite of recognition that the fear is unreasonable.

Goals:
1. Reduce fear so that customer can independently and freely leave home and comfortably be in public environments.
2. Reduce fear of the specific stimulus object or situation that previously provoked immediate anxiety.
3. Eliminate interference in normal routines and remove distress from feared object or situation
4. Remove panic symptoms and the fear that they will recur without an ability to cope with and control them.

Objectives:
1. Verbalize fear and focus on describing the specific stimuli for it.
2. Construct hierarchy of situations that increasingly evoke anxiety.
3. Become proficient in progressive, deep-muscle relaxation.
4. identify a non-threatening pleasant scene that can be utilized to promote relaxation using guided imagery
5. Cooperate with systematic desensitization to the anxiety-provoking stimulus object or situation.
6. Undergo in vivo desensitization to the stimulus object or situation
7. Encounter the phobic stimulus object or situation feeling in control, calm, and comfortable.
8. Differentiate real from distorted, imagined situation that can produce rational and irrational fear.
9. Develop behavioral and cognitive mechanisms that reduce or eliminate irrational anxiety.

Treatment Plan for Overanxious Disorder (OAD)

Problem #1:
Overanxious Disorder

As evidenced by:
1. Feeling on the edge, fatigued, mind going blank, irritability, muscle tension, sleep disturbance, difficulty controlling worry,
2. Social and academic difficulties

Goals:
1. Resolve the issue that is the source of the anxiety or fear
2. Reach a point where the customer can interact with the world without excessive fear or anxiety

Objectives:

4. Resolve the issue that is the source of the anxiety or fear
    a. Implement positive self-talk to reduce or eliminate the anxiety
    b. Provide psychoeducation to the family to increase understanding of the nature of anxiety
    c. Teach the customer new ways to approach fear situations with greater ease and confidence
    d. Customer is to become a detective and uncover the triggers to anxiety along with identification of reactions.
5. Reach a point where the customer can interact with the world without excessive fear or anxiety
    a. Complete psychiatric evaluation and comply with recommendations
    b. Develop relapse prevention plan
    c. Develop and implement appropriate relaxation, diversion, and stress management techniques
    d. Identify maladaptive thoughts, beliefs, and images and replace with realistic coping-focused thinking

Treatment Plan for Generalized Anxiety Disorder (GAD)

Problem #1:
Excessive anxiety and worry about life circumstances.

As evidenced by:
- Tension such as restlessness, tiredness and shakiness
- Hyperactivity such as palpitations and shortness of breath
- Hyper-vigilance such as constantly feeling on edge, difficulty concentrating and/or sleep problems.

Goals:
Reduce excessive anxiety and worry about life circumstances.

Objectives:

3. Develop insight into causes/effects of anxiety and cognitive strategies to reduce or eliminate the irrational anxiety.
   Therapeutic Interventions:
   a. Customer will increase awareness of and resolve the core conflict that is the source of anxiety.
   b. Customer will increase awareness of triggers and anxiety responses to stimuli.
   c. Customer will accurately identify and label anxious cognitions
   d. Customer will learn and utilize thought-stopping technique to self-manage anxious cognitions and self-soothe anxiety.
   e. Customer will learn relaxation techniques as a response to anxiety triggers (i.e feelings check, breathing, counting, and visualization)
   f. Customer will learn and utilize though replacement technique as a response to anxious cognitions. (i.e. positive affirmations and/or self-soothing statements)
   g. Customer will participate in Guided Imagery Group.
   h. Customer will monitor self-interventions during the week and proves with therapist during sessions.

4. Develop behavioral strategies to reduce and extinguish anxiety
   Therapeutic Interventions:
   a. Customer will identify and participate in components of a healthy lifestyle and/or self-care. (i.e regular sleep. wake cycle, healthy nutrition (reduced sugars and stimulants), exercise, and leisure/socialization)
   b. Customer will use thought-soothing and mindfulness to eliminate intrusive thoughts and to remain in here-and-now during work and/or productive periods.
   c. Customer will utilize visualization/desensitization or rehearsal prior to anxiety provoking events.
   d. Customer will verbally process thoughts/feelings regarding self performance during anxious events with significant other or therapist.