Generalized Anxiety Disorder

Diagnostic Criteria 300.02 (F41.1)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Diagnostic Features

The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation) about a number of events or activities. The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event. The individual finds it difficult to control the worry and to keep worrisome thoughts from interfering with attention to tasks at hand. Adults with generalized anxiety disorder often worry about everyday, routine life circumstances, such as possible job responsibilities, health and finances, the health of family members, misfortune to their children, or minor matters (e.g., doing household chores or being late for appointments). Children with generalized anxiety disorder tend to worry excessively about their competence or the quality of their performance. During the course of the disorder, the focus of worry may shift from one concern to another.

Several features distinguish generalized anxiety disorder from nonpathological anxiety. First, the worries associated with generalized anxiety disorder are excessive and typically interfere significantly with psychosocial functioning, whereas the worries of everyday life are not excessive and are perceived as more manageable and may be put off when more pressing matters arise. Second, the worries associated with generalized anxiety disorder are

more pervasive, pronounced, and distressing; have longer duration; and frequently occur without precipitants. The greater the range of life circumstances about which a person worries (e.g., finances, children's safety, job performance), the more likely his or her symptoms are to meet criteria for generalized anxiety disorder. Third, everyday worries are much less likely to be accompanied by physical symptoms (e.g., restlessness or feeling keyed up or on edge). Individuals with generalized anxiety disorder report subjective distress due to constant worry and related impairment in social, occupational, or other important areas of functioning.

The anxiety and worry are accompanied by at least three of the following additional symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and disturbed sleep, although only one additional symptom is required in children.

Associated Features Supporting Diagnosis

Associated with muscle tension, there may be trembling, twitching, feeling shaky, and muscle aches or soreness. Many individuals with generalized anxiety disorder also experience somatic symptoms (e.g., sweating, nausea, diarrhea) and an exaggerated startle response. Symptoms of autonomic hyperarousal (e.g., accelerated heart rate, shortness of breath, dizziness) are less prominent in generalized anxiety disorder than in other anxiety disorders, such as panic disorder. Other conditions that may be associated with stress (e.g., irritable bowel syndrome, headaches) frequently accompany generalized anxiety disorder.

Prevalence

The 12-month prevalence of generalized anxiety disorder is 0.9% among adolescents and 2.9% among adults in the general community of the United States. The 12-month prevalence for the disorder in other countries ranges from 0.4% to 3.6%. The lifetime morbid risk is 9.0%. Females are twice as likely as males to experience generalized anxiety disorder. The prevalence of the diagnosis peaks in middle age and declines across the later years of life.

Individuals of European descent tend to experience generalized anxiety disorder more frequently than do individuals of non-European descent (i.e., Asian, African, Native American and Pacific Islander). Furthermore, individuals from developed countries are more likely than individuals from nondeveloped countries to report that they have experienced symptoms that meet criteria for generalized anxiety disorder in their lifetime.

Development and Course

Many individuals with generalized anxiety disorder report that they have felt anxious and nervous all of their lives. The median age at onset for generalized anxiety disorder is 30 years; however, age at onset is spread over a very broad range. The median age at onset is later than that for the other anxiety disorders. The symptoms of excessive worry and anxiety may occur early in life but are then manifested as an anxious temperament. Onset of the disorder rarely occurs prior to adolescence. The symptoms of generalized anxiety disorder tend to be chronic and wax and wane across the lifespan, fluctuating between syndromal and subsyndromal forms of the disorder. Rates of full remission are very low.

The clinical expression of generalized anxiety disorder is relatively consistent across the lifespan. The primary difference across age groups is in the content of the individual's worry. Children and adolescents tend to worry more about school and sporting performance, whereas older adults report greater concern about the well-being of family or their own physical heath. Thus, the content of an individual's worry tends to be age appropriate. Younger adults experience greater severity of symptoms than do older adults.

The earlier in life individuals have symptoms that meet criteria for generalized anxiety disorder, the more comorbidity they tend to have and the more impaired they are likely to

be. The advent of chronic physical disease can be a potent issue for excessive worry in the elderly. In the frail elderly, worries about safety—and especially about falling—may limit activities. In those with early cognitive impairment, what appears to be excessive worry about, for example, the whereabouts of things is probably better regarded as realistic given the cognitive impairment.

In children and adolescents with generalized anxiety disorder, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events, even when their performance is not being evaluated by others. There may be excessive concerns about punctuality. They may also worry about catastrophic events, such as earthquakes or nuclear war. Children with the disorder may be overly conforming, perfectionist, and unsure of themselves and tend to redo tasks because of excessive dissatisfaction with less-than-perfect performance. They are typically overzealous in seeking reassurance and approval and require excessive reassurance about their performance and other things they are worried about.

Generalized anxiety disorder may be overdiagnosed in children. When this diagnosis is being considered in children, a thorough evaluation for the presence of other childhood anxiety disorders and other mental disorders should be done to determine whether the worries may be better explained by one of these disorders. Separation anxiety disorder, social anxiety disorder (social phobia), and obsessive-compulsive disorder are often accompanied by worries that may mimic those described in generalized anxiety disorder. For example, a child with social anxiety disorder may be concerned about school performance because of fear of humiliation. Worries about illness may also be better explained by separation anxiety disorder or obsessive-compulsive disorder.

Risk and Prognostic Factors

Temperamental. Behavioral inhibition, negative affectivity (neuroticism), and harm avoidance have been associated with generalized anxiety disorder.

Environmental. Although childhood adversities and parental overprotection have been associated with generalized anxiety disorder, no environmental factors have been identified as specific to generalized anxiety disorder or necessary or sufficient for making the diagnosis.

Genetic and physiological. One-third of the risk of experiencing generalized anxiety disorder is genetic, and these genetic factors overlap with the risk of neuroticism and are shared with other anxiety and mood disorders, particularly major depressive disorder.

Culture-Related Diagnostic Issues

There is considerable cultural variation in the expression of generalized anxiety disorder. For example, in some cultures, somatic symptoms predominate in the expression of the disorder, whereas in other cultures cognitive symptoms tend to predominate. This difference may be more evident on initial presentation than subsequently, as more symptoms are reported over time. There is no information as to whether the propensity for excessive worrying is related to culture, although the topic being worried about can be culture specific. It is important to consider the social and cultural context when evaluating whether worries about certain situations are excessive.

Gender-Related Diagnostic Issues

In clinical settings, generalized anxiety disorder is diagnosed somewhat more frequently in females than in males (about 55%–60% of those presenting with the disorder are female). In epidemiological studies, approximately two-thirds are female. Females and males who experience generalized anxiety disorder appear to have similar symptoms but

demonstrate different patterns of comorbidity consistent with gender differences in the prevalence of disorders. In females, comorbidity is largely confined to the anxiety disorders and unipolar depression, whereas in males, comorbidity is more likely to extend to the substance use disorders as well.

Functional Consequences of Generalized Anxiety Disorder

Excessive worrying impairs the individual's capacity to do things quickly and efficiently, whether at home or at work. The worrying takes time and energy; the associated symptoms of muscle tension and feeling keyed up or on edge, tiredness, difficulty concentrating, and disturbed sleep contribute to the impairment. Importantly the excessive worrying may impair the ability of individuals with generalized anxiety disorder to encourage confidence in their children.

Generalized anxiety disorder is associated with significant disability and distress that is independent of comorbid disorders, and most non-institutionalized adults with the disorder are moderately to seriously disabled. Generalized anxiety disorder accounts for 110 million disability days per annum in the U.S. population.

Differential Diagnosis

Anxiety disorder due to another medical condition. The diagnosis of anxiety disorder associated with another medical condition should be assigned if the individual's anxiety and worry are judged, based on history, laboratory findings, or physical examination, to be a physiological effect of another specific medical condition (e.g., pheochromocytoma, hyperthyroidism).

Substance/medication-induced anxiety disorder. A substance/medication-induced anxiety disorder is distinguished from generalized anxiety disorder by the fact that a substance or medication (e.g., a drug of abuse, exposure to a toxin) is judged to be etiologically related to the anxiety. For example, severe anxiety that occurs only in the context of heavy coffee consumption would be diagnosed as caffeine-induced anxiety disorder.

Social anxiety disorder. Individuals with social anxiety disorder often have anticipatory anxiety that is focused on upcoming social situations in which they must perform or be evaluated by others, whereas individuals with generalized anxiety disorder worry, whether or not they are being evaluated.

Obsessive-compulsive disorder. Several features distinguish the excessive worry of generalized anxiety disorder from the obsessional thoughts of obsessive-compulsive disorder. In generalized anxiety disorder the focus of the worry is about forthcoming problems, and it is the excessiveness of the worry about future events that is abnormal. In obsessive-compulsive disorder, the obsessions are inappropriate ideas that take the form of intrusive and unwanted thoughts, urges, or images.

Posttraumatic stress disorder and adjustment disorders. Anxiety is invariably present in posttraumatic stress disorder. Generalized anxiety disorder is not diagnosed if the anxiety and worry are better explained by symptoms of posttraumatic stress disorder. Anxiety may also be present in adjustment disorder, but this residual category should be used only when the criteria are not met for any other disorder (including generalized anxiety disorder). Moreover, in adjustment disorders, the anxiety occurs in response to an identifiable stressor within 3 months of the onset of the stressor and does not persist for more than 6 months after the termination of the stressor or its consequences.

Depressive, bipolar, and psychotic disorders. Generalized anxiety/worry is a common associated feature of depressive, bipolar, and psychotic disorders and should not be di-

agnosed separately if the excessive worry has occurred only during the course of these conditions.

Comorbidity

Individuals whose presentation meets criteria for generalized anxiety disorder are likely to have met, or currently meet, criteria for other anxiety and unipolar depressive disorders. The neuroticism or emotional liability that underpins this pattern of comorbidity is associated with temperamental antecedents and genetic and environmental risk factors shared between these disorders, although independent pathways are also possible. Comorbidity with substance use, conduct, psychotic, neurodevelopmental, and neurocognitive disorders is less common.

Substance/Medication-Induced Anxiety Disorder

Diagnostic Criteria

A. Panic attacks or anxiety is predominant in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following:

   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced anxiety disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and they are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced anxiety disorders are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced anxiety disorder, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced anxiety disorder (e.g., "mild cocaine use disorder with cocaine-induced anxiety disorder"). If a moderate or severe substance use disorder is comorbid with the substance-induced anxiety disorder, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder. If there is no comorbid substance use disorder (e.g., after a one-

time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced anxiety disorder.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.89	F10.180	F10.280	F10.980
Caffeine	292.89	F15.180	F15.280	F15.980
Cannabis	292.89	F12.180	F12.280	F12.980
Phencyclidine	292.89	F16.180	F16.280	F16.980
Other hallucinogen	292.89	F16.180	F16.280	F16.980
Inhalant	292.89	F18.180	F18.280	F18.980
Opioid	292.89	F11.188	F11.288	F11.988
Sedative, hypnotic, or anxiolytic	292.89	F13.180	F13.280	F13.980
Amphetamine (or other stimulant)	292.89	F15.180	F15.280	F15.980
Cocaine	292.89	F14.180	F14.280	F14.980
Other (or unknown) substance	292.89	F19.180	F19.280	F19.980

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: This specifier applies if criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: This specifier applies if criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced anxiety disorder begins with the specific substance (e.g., cocaine, salbutamol) that is presumed to be causing the anxiety symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., salbutamol), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset during medication use). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of anxiety symptoms occurring during withdrawal in a man with a severe lorazepam use disorder, the diagnosis is 292.89 lorazepam-induced anxiety disorder, with onset during withdrawal. An additional diagnosis of 304.10 severe lorazepam use disorder is also given. When more than one substance is judged to play a significant role in the development of anxiety symptoms, each should be listed sep-

arately (e.g., 292.89 methylphenidate-induced anxiety disorder, with onset during intoxication; 292.89 salbutamol-induced anxiety disorder, with onset after medication use).

ICD-10-CM. The name of the substance/medication-induced anxiety disorder begins with the specific substance (e.g., cocaine, salbutamol) that is presumed to be causing the anxiety symptoms. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., salbutamol), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced anxiety disorder, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset during medication use). For example, in the case of anxiety symptoms occurring during withdrawal in a man with a severe lorazepam use disorder, the diagnosis is F13.280 severe lorazepam use disorder with lorazepam-induced anxiety disorder, with onset during withdrawal. A separate diagnosis of the comorbid severe lorazepam use disorder is not given. If the substance-induced anxiety disorder occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F16.980 psilocybin-induced anxiety disorder, with onset during intoxication). When more than one substance is judged to play a significant role in the development of anxiety symptoms, each should be listed separately (e.g., F15.280 severe methylphenidate use disorder with methylphenidate-induced anxiety disorder, with onset during intoxication; F19.980 salbutamol-induced anxiety disorder, with onset after medication use).

Diagnostic Features

The essential features of substance/medication-induced anxiety disorder are prominent symptoms of panic or anxiety (Criterion A) that are judged to be due to the effects of a substance (e.g., a drug of abuse, a medication, or a toxin exposure). The panic or anxiety symptoms must have developed during or soon after substance intoxication or withdrawal or after exposure to a medication, and the substances or medications must be capable of producing the symptoms (Criterion B2). Substance/medication-induced anxiety disorder due to a prescribed treatment for a mental disorder or another medical condition must have its onset while the individual is receiving the medication (or during withdrawal, if a withdrawal is associated with the medication). Once the treatment is discontinued, the panic or anxiety symptoms will usually improve or remit within days to several weeks to a month (depending on the half-life of the substance/medication and the presence of withdrawal). The diagnosis of substance/medication-induced anxiety disorder should not be given if the onset of the panic or anxiety symptoms precedes the substance/medication intoxication or withdrawal, or if the symptoms persist for a substantial period of time (i.e., usually longer than 1 month) from the time of severe intoxication or withdrawal. If the panic or anxiety symptoms persist for substantial periods of time, other causes for the symptoms should be considered.

The substance/medication-induced anxiety disorder diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A are predominant in the clinical picture and are sufficiently severe to warrant independent clinical attention.

Associated Features Supporting Diagnosis

Panic or anxiety can occur in association with intoxication with the following classes of substances: alcohol, caffeine, cannabis, phencyclidine, other hallucinogens, inhalants, stimu-

lants (including cocaine), and other (or unknown) substances. Panic or anxiety can occur in association with withdrawal from the following classes of substances: alcohol; opioids; sedatives, hypnotics, and anxiolytics; stimulants (including cocaine); and other (or unknown) substances. Some medications that evoke anxiety symptoms include anesthetics and analgesics, sympathomimetics or other bronchodilators, anticholinergics, insulin, thyroid preparations, oral contraceptives, antihistamines, antiparkinsonian medications, corticosteroids, antihypertensive and cardiovascular medications, anticonvulsants, lithium carbonate, antipsychotic medications, and antidepressant medications. Heavy metals and toxins (e.g., organophosphate insecticide, nerve gases, carbon monoxide, carbon dioxide, volatile substances such as gasoline and paint) may also cause panic or anxiety symptoms.

Prevalence

The prevalence of substance/medication-induced anxiety disorder is not clear. General population data suggest that it may be rare, with a 12-month prevalence of approximately 0.002%. However, in clinical populations, the prevalence is likely to be higher.

Diagnostic Markers

Laboratory assessments (e.g., urine toxicology) may be useful to measure substance intoxication as part of an assessment for substance/medication-induced anxiety disorder.

Differential Diagnosis

Substance intoxication and substance withdrawal. Anxiety symptoms commonly occur in substance intoxication and substance withdrawal. The diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom presentation. A diagnosis of substance/medication-induced anxiety disorder should be made in addition to substance intoxication or substance withdrawal when the panic or anxiety symptoms are predominant in the clinical picture and are sufficiently severe to warrant independent clinical attention. For example, panic or anxiety symptoms are characteristic of alcohol withdrawal.

Anxiety disorder (i.e., not induced by a substance/medication). Substance/medication-induced anxiety disorder is judged to be etiologically related to the substance/medication. Substance/medication-induced anxiety disorder is distinguished from a primary anxiety disorder based on the onset, course, and other factors with respect to substances/medications. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings for use, intoxication, or withdrawal. Substance/medication-induced anxiety disorders arise only in association with intoxication or withdrawal states, whereas primary anxiety disorders may precede the onset of substance/medication use. The presence of features that are atypical of a primary anxiety disorder, such as atypical age at onset (e.g., onset of panic disorder after age 45 years) or symptoms (e.g., atypical panic attack symptoms such as true vertigo, loss of balance, loss of consciousness, loss of bladder control, headaches, slurred speech) may suggest a substance/medication-induced etiology. A primary anxiety disorder diagnosis is warranted if the panic or anxiety symptoms persist for a substantial period of time (about 1 month or longer) after the end of the substance intoxication or acute withdrawal or there is a history of an anxiety disorder.

Delirium. If panic or anxiety symptoms occur exclusively during the course of delirium, they are considered to be an associated feature of the delirium and are not diagnosed separately.

Anxiety disorder due to another medical condition. If the panic or anxiety symptoms are attributed to the physiological consequences of another medical condition (i.e., rather than to the medication taken for the medical condition), anxiety disorder due to another

medical condition should be diagnosed. The history often provides the basis for such a judgment. At times, a change in the treatment for the other medical condition (e.g., medication substitution or discontinuation) may be needed to determine whether the medication is the causative agent (in which case the symptoms may be better explained by substance/medication-induced anxiety disorder). If the disturbance is attributable to both another medical condition and substance use, both diagnoses (i.e., anxiety disorder due to another medical condition and substance/medication-induced anxiety disorder) may be given. When there is insufficient evidence to determine whether the panic or anxiety symptoms are attributable to a substance/medication or to another medical condition or are primary (i.e., not attributable to either a substance or another medical condition), a diagnosis of other specified or unspecified anxiety disorder would be indicated.

Anxiety Disorder Due to Another Medical Condition

Diagnostic Criteria **293.84 (F06.4)**

A. Panic attacks or anxiety is predominant in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coding note: Include the name of the other medical condition within the name of the mental disorder (e.g., 293.84 [F06.4] anxiety disorder due to pheochromocytoma). The other medical condition should be coded and listed separately immediately before the anxiety disorder due to the medical condition (e.g., 227.0 [D35.00] pheochromocytoma; 293.84 [F06.4] anxiety disorder due to pheochromocytoma.

Diagnostic Features

The essential feature of anxiety disorder due to another medical condition is clinically significant anxiety that is judged to be best explained as a physiological effect of another medical condition. Symptoms can include prominent anxiety symptoms or panic attacks (Criterion A). The judgment that the symptoms are best explained by the associated physical condition must be based on evidence from the history, physical examination, or laboratory findings (Criterion B). Additionally, it must be judged that the symptoms are not better accounted for by another mental disorder, in particular, adjustment disorder, with anxiety, in which the stressor is the medical condition (Criterion C). In this case, an individual with adjustment disorder is especially distressed about the meaning or the consequences of the associated medical condition. By contrast, there is often a prominent physical component to the anxiety (e.g., shortness of breath) when the anxiety is due to another medical condition. The diagnosis is not made if the anxiety symptoms occur only during the course of a delirium (Criterion D). The anxiety symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E).

In determining whether the anxiety symptoms are attributable to another medical condition, the clinician must first establish the presence of the medical condition. Furthermore, it must be established that anxiety symptoms can be etiologically related to the medical condition through a physiological mechanism before making a judgment that this is the best explanation for the symptoms in a specific individual. A careful and compre-