24-7 SHALOM PSYCHIATRY PLLC

Comprehensive Anxiety Disorders Evaluation, Diagnosis & Treatment Program

Children | Adolescents | Adults

Document purpose: Proposed clinical service framework, diagnostic reference, medication safety guide, and patient-facing program description. Specialized services are offered only when qualified personnel, equipment, licensing, and referral arrangements are actually in place.

Clinical scope: DSM-5-TR criteria below are summarized rather than reproduced verbatim. Diagnosis requires clinical assessment and differential diagnosis; rating scales alone do not establish a disorder. Medication information is educational and must be individualized.

1 | Program philosophy and diagnostic workflow

24-7 Shalom Psychiatry can use a developmentally sensitive, trauma-informed, measurement-based approach to identify anxiety disorders, distinguish them from other conditions, assess impairment and risk, and provide collaborative treatment. The evaluation must establish the feared stimulus or worry, severity, duration, avoidance and safety behaviors, degree of distress, and effects on school, work, relationships, sleep and daily activities.

• 1. Intake and triage: Presenting concerns, onset, precipitating events, previous episodes, medical/psychiatric history, medications, caffeine/nicotine/substance use, sleep and functional impairment. Screen urgent safety concerns.

• 2. Diagnostic interview: Map symptom patterns to DSM-5-TR criteria; assess developmental context and cultural factors; document impairment and alternative explanations.

• 3. Measurement: Use age-appropriate validated instruments and collateral reports where relevant.

• 4. Differential diagnosis: Evaluate mood, psychotic, trauma-related, obsessive-compulsive, neurodevelopmental, sleep, substance-related and medical causes.

• 5. Shared plan: Discuss psychotherapy, medication when indicated, self-management, accommodations, referral and monitoring.

• 6. Follow-up: Track symptom scales, functioning, adherence, adverse effects, safety, and response; revise the formulation as needed.

2 | Standardized assessment tools

Population / purpose	Examples and interpretation
Adults - generalized anxiety	GAD-7; HAM-A for clinician-rated severity; OASIS for overall anxiety severity/impairment. Screening scores support, but do not replace, interview.
Children / adolescents	SCARED (child and parent); SCAS; RCADS; PARS clinician-rated measure; school and caregiver collateral.
Social anxiety	SPIN; Liebowitz Social Anxiety Scale (LSAS); Social Phobia Inventory variants as age appropriate.
Panic / agoraphobia	Panic Disorder Severity Scale (PDSS); Mobility Inventory for Agoraphobia; panic diary.
Specific phobia / selective mutism	Fear hierarchy, functional behavioral assessment; Selective Mutism Questionnaire (SMQ) and school observation when relevant.
Associated symptoms	PHQ-9/PHQ-A, PCL-5 where appropriate, AUDIT-C, DAST-10/CRAFFT; C-SSRS or other structured suicide risk assessment when indicated.

Use licensed tools according to publisher restrictions. The same instrument and functional targets should be reassessed over time where feasible.

3 | DSM-5-TR anxiety disorders: criteria and individualized care

Separation Anxiety Disorder | F93.0

DSM-5-TR diagnostic criteria (clinical paraphrase): Developmentally inappropriate and excessive fear or anxiety about separation from attachment figures, with at least three characteristic manifestations (for example recurrent distress on separation, worry about losing an attachment figure, worry about events causing separation, refusal to leave home or go to school/work, fear of being alone, refusal to sleep away, separation nightmares, or physical complaints). Symptoms persist at least 4 weeks in children/adolescents and typically 6 months or more in adults; clinically significant distress/impairment; not better explained by another mental disorder.

Assessment and treatment: Family-supported CBT with graded separation exposures, parent coaching to reduce accommodation, school reintegration; consider an SSRI for persistent, impairing symptoms when clinically appropriate, especially with comorbidity. Evaluate attachment, trauma and family context.

Selective Mutism | F94.0

DSM-5-TR diagnostic criteria (clinical paraphrase): Consistent failure to speak in particular social situations where speech is expected despite speaking in other situations; interferes with educational/occupational achievement or social communication; lasts at least 1 month (not limited to the first month of school); not due to inadequate knowledge or comfort with the spoken language; not better explained by a communication disorder or exclusively occurring during autism spectrum disorder, schizophrenia or another psychotic disorder.

Assessment and treatment: Behavioral treatment with gradual exposure, stimulus fading, shaping and reinforcement; coordinated parent, teacher and speech-language input. Assess social anxiety and language disorders. SSRIs may be considered in selected severe or refractory cases; evidence is more limited.

Specific Phobia | F40.2xx (subtype-dependent)

DSM-5-TR diagnostic criteria (clinical paraphrase): Marked fear/anxiety about a specific object or situation (animal, natural environment, blood-injection-injury, situational, other); exposure almost always causes immediate fear; actively avoided or endured with intense fear; fear disproportionate to actual danger and sociocultural context; persistent, typically 6 months or longer; clinically significant impairment; not better explained by another mental disorder.

Assessment and treatment: First-line: exposure-based CBT, including in-vivo, imaginal or virtual-reality exposure as appropriate. Applied tension may help blood-injection-injury phobia with vasovagal fainting. Medication is not routinely the primary treatment.

Social Anxiety Disorder (Social Phobia) | F40.10 / F40.11 (coding by presentation)

DSM-5-TR diagnostic criteria (clinical paraphrase): Marked fear/anxiety about one or more social situations involving possible scrutiny, with fear of negative evaluation; social situations almost always provoke fear and are avoided or endured with intense anxiety; fear disproportionate to threat/context; typically lasts 6 months or longer; significant distress/impairment; not attributable to substances, medical illness or another mental disorder. If a medical condition exists, fear must be unrelated or excessive. Specify performance only when limited to public speaking/performing.

Assessment and treatment: Individual or group CBT with graduated social exposures, cognitive restructuring and reduction of safety behaviors; SSRIs or SNRIs for moderate-to-severe generalized impairment. For narrowly defined performance anxiety, situational propranolol may sometimes be used off-label after cardiovascular review; it does not treat generalized social anxiety.

Panic Disorder | F41.0

DSM-5-TR diagnostic criteria (clinical paraphrase): Recurrent unexpected panic attacks with abrupt intense fear/discomfort peaking within minutes and at least four of 13 symptoms (palpitations, sweating, trembling, breathlessness, choking, chest discomfort, nausea, dizziness, chills/heat, paresthesias, derealization/depersonalization, fear of losing control, fear of dying). At least one attack followed by 1 month or more of persistent concern about additional attacks/consequences and/or maladaptive behavioral change; not substance/medical induced or better explained by another mental disorder.

Assessment and treatment: Panic-focused CBT with interoceptive exposure, cognitive restructuring and avoidance reduction; SSRI/SNRI treatment when indicated. Rule out cardiopulmonary and other acute conditions when symptoms warrant. Benzodiazepines are generally not preferred as ongoing first-line treatment.

Agoraphobia | F40.00 / F40.01 (depending on panic association/coding)

DSM-5-TR diagnostic criteria (clinical paraphrase): Marked fear/anxiety about at least two of: public transportation, open spaces, enclosed places, standing in line/being in a crowd, or being outside home alone. Fear centers on escape being difficult or help unavailable if panic-like or other incapacitating/embarrassing symptoms occur; situations almost always provoke fear, are avoided, require a companion or are endured with intense anxiety; disproportionate; typically 6 months or longer; impairment; not better explained by other conditions. Diagnose separately from panic disorder when both criteria are met.

Assessment and treatment: Exposure-based CBT with graded community re-entry, reduction of avoidance and companion dependence; SSRIs/SNRIs when indicated; practical functional goals and monitoring.

Generalized Anxiety Disorder (GAD) | F41.1

DSM-5-TR diagnostic criteria (clinical paraphrase): Excessive anxiety and worry across multiple activities/domains, more days than not for at least 6 months, difficult to control; at least three of six associated symptoms (restlessness, fatigue, poor concentration, irritability, muscle tension, sleep disturbance), with one sufficient for children; significant distress/impairment; not substance/medical induced or better explained by another mental disorder.

Assessment and treatment: CBT focused on intolerance of uncertainty, worry management and behavioral experiments; SSRIs/SNRIs are common first-line medications. Buspirone is an option for GAD; consider psychotherapy alone for mild illness and combined treatment for substantial impairment.

Substance/Medication-Induced Anxiety Disorder | F19.980 or substance-specific ICD-10-CM code

DSM-5-TR diagnostic criteria (clinical paraphrase): Prominent anxiety or panic symptoms; evidence from history, examination or tests that symptoms arose during/soon after intoxication, withdrawal or medication exposure and the agent can cause them; not better explained by independent anxiety disorder; not exclusively during delirium; clinically significant distress/impairment. Code by implicated substance and clinical circumstances.

Assessment and treatment: Review stimulants, corticosteroids, decongestants, thyroid medications, caffeine, cannabis and withdrawal syndromes; manage exposure/withdrawal safely and treat the underlying condition. Avoid abrupt withdrawal of alcohol or benzodiazepines.

Anxiety Disorder Due to Another Medical Condition | F06.4

DSM-5-TR diagnostic criteria (clinical paraphrase): Prominent anxiety or panic; evidence that the disturbance is a direct pathophysiological consequence of a medical condition; not better explained by another mental disorder; not exclusively during delirium; clinically significant distress/impairment.

Assessment and treatment: Evaluate indicated causes such as hyperthyroidism, arrhythmia, pulmonary illness, hypoglycemia, neurologic disease and medication effects; coordinate treatment of underlying condition and anxiety symptoms.

Other Specified Anxiety Disorder | F41.8

DSM-5-TR diagnostic criteria (clinical paraphrase): Clinically significant anxiety symptoms causing distress/impairment that do not meet full criteria for a specific anxiety disorder; clinician explicitly documents the reason criteria are unmet (for example limited-symptom attacks or insufficient duration).

Assessment and treatment: Treat the demonstrated symptom pattern and impairment with targeted psychotherapy, functional supports and carefully selected medication if appropriate; reassess diagnosis over time.

Unspecified Anxiety Disorder | F41.9

DSM-5-TR diagnostic criteria (clinical paraphrase): Clinically significant anxiety symptoms without enough information or without specifying why criteria for a particular anxiety disorder are unmet; may be used when full evaluation is not possible.

Assessment and treatment: Clarify diagnosis at follow-up; assess safety, differential diagnosis and function; avoid treating an unspecified code as a substitute for comprehensive evaluation.

Other relevant DSM-5-TR concepts: A panic attack is a specifier that can occur with many disorders and is not by itself panic disorder. Anxiety presentations in OCD, PTSD/acute stress disorder, illness anxiety disorder, body

dysmorphic disorder, adjustment disorder and separation-related grief require their own diagnostic evaluation; these are not all classified within the DSM-5-TR Anxiety Disorders chapter.

4 | Differential diagnosis and medical evaluation

• Evaluate depressive and bipolar disorders, psychosis, OCD, PTSD, autism, ADHD, eating disorders, somatic symptom disorders, sleep deprivation and substance-related conditions.

• Medical review: vital signs, medication reconciliation, thyroid/cardiac/pulmonary/neurological symptoms, caffeine and other stimulants, pregnancy considerations and relevant physical examination.

• Order CBC, TSH, metabolic studies, ECG, pregnancy testing or other studies only when clinically indicated; there is no universal laboratory panel that diagnoses anxiety.

• Assess suicidality, self-harm, homicidality, psychosis, mania, domestic violence, substance withdrawal and capacity to function when relevant. Document what was actually assessed and the disposition.

5 | Medication classes, indications and adverse effects

The table describes common or clinically important adverse effects. Not every agent is FDA-approved for every anxiety diagnosis, age or population. Selection must account for labeling, contraindications, drug interactions, prior response, pregnancy/lactation, medical illness and shared decision-making.

Class / examples	Typical clinical role	Common adverse effects and major precautions
SSRIs: sertraline, escitalopram, fluoxetine, paroxetine, fluvoxamine	Common first-line options for GAD, panic and social anxiety; pediatric use depends on indication and age.	Nausea, diarrhea, headache, insomnia or somnolence, sweating, tremor, sexual dysfunction; possible initial activation. Important: suicidality warning in younger people, serotonin syndrome, hyponatremia, bleeding risk, discontinuation symptoms (especially paroxetine), QT concern with higher-dose citalopram/escitalopram in susceptible people.
SNRIs: venlafaxine XR, duloxetine	First-line alternatives for several adult anxiety disorders.	Nausea, dry mouth, constipation, sweating, insomnia, sexual dysfunction, BP/pulse increase; discontinuation syndrome (especially venlafaxine), serotonin syndrome, hyponatremia, bleeding risk. Duloxetine: caution with significant liver disease.
Buspirone	GAD; scheduled dosing, not immediate panic rescue.	Dizziness, nausea, headache, lightheadedness, restlessness; serotonin interaction risk with serotonergic combinations; delayed onset of benefit.
Hydroxyzine	Short-term or intermittent symptomatic anxiety; not preferred as sole long-term treatment.	Sedation, dry mouth, constipation, blurred vision, impaired driving; anticholinergic burden in older adults and QT prolongation risk in susceptible patients.
Benzodiazepines: lorazepam, clonazepam, alprazolam, diazepam	Selected short-term situations or limited adjunctive use; not routine first-line chronic treatment.	Sedation, dizziness, memory/cognitive impairment, falls, impaired driving, tolerance, physical dependence, withdrawal (including seizures), misuse; potentially fatal respiratory depression with opioids/alcohol or other sedatives. Avoid abrupt discontinuation after sustained use.

Class / examples	Typical clinical role	Common adverse effects and major precautions
Beta blockers: propranolol (off-label)	Selected performance-only physical symptoms; not a general treatment for GAD or panic disorder.	Fatigue, dizziness, low BP, bradycardia, exercise intolerance; may worsen asthma/bronchospasm and mask hypoglycemia signs.
Pregabalin (off-label in US for GAD)	Selected refractory GAD situations; not FDA-approved for anxiety in the US.	Dizziness, somnolence, edema, weight gain, blurred vision, ataxia; dependence/misuse potential, withdrawal, respiratory depression with CNS depressants; adjust for renal function.
Gabapentin (off-label)	Limited evidence for primary anxiety disorders; not standard first-line.	Drowsiness, dizziness, ataxia, edema, cognitive slowing; respiratory depression risk with opioids/CNS depressants, misuse potential; renal adjustment.
Tricyclics: imipramine, clomipramine	Selected panic/OCD-related indications or refractory cases; clomipramine is principally used for OCD.	Dry mouth, constipation, urinary retention, sedation, weight gain, orthostasis, sexual effects; arrhythmias/QT or conduction effects, overdose toxicity, drug interactions.
MAOIs: phenelzine (specialist use)	Rare refractory social anxiety/panic cases.	Orthostasis, weight gain, sleep changes, sexual dysfunction; hypertensive crisis with tyramine or interacting drugs, serotonin syndrome, mandatory washout precautions.
Mirtazapine (off-label)	Selected comorbid anxiety with depression/insomnia; not routine first-line anxiety monotherapy.	Sedation, increased appetite, weight gain, dry mouth, constipation, dizziness; caution with additive sedation.
Atypical antipsychotics (off-label for primary anxiety)	Generally avoid routine use for uncomplicated anxiety; reserved for specific comorbidity/refractory circumstances.	Weight gain, metabolic syndrome, sedation, akathisia, extrapyramidal symptoms, tardive dyskinesia, QT effects; agent-specific risks.

Medication counseling and monitoring standards

• Explain expected onset: SSRIs/SNRIs often require several weeks; dose optimization and a full adequate trial may take longer. Review initial activation, adherence and discontinuation effects.

• Assess for bipolar disorder/mania before antidepressants; monitor emerging agitation, mood switching, suicidality and unusual behavioral changes.

• Review serotonin syndrome risk with multiple serotonergic agents and relevant interactions (including tramadol, linezolid, MAOIs and some migraine therapies).

• For benzodiazepines, document indication, alternatives, PDMP review where applicable, sedation/respiratory risks, substance use risk, safe storage and a reassessment/taper strategy when appropriate.

• For children/adolescents, use developmentally appropriate evidence-based treatment, discuss the antidepressant suicidality boxed warning, involve caregivers appropriately and arrange closer early monitoring.

• Avoid presenting pharmacogenomic testing as a diagnostic test for anxiety or a reliable method to choose the best medication; use it only for limited, clinically supported questions.

6 | Psychotherapy and nonpharmacologic treatment

Intervention	How it is used
CBT	Identify threat predictions, cognitive distortions, avoidance, reassurance-seeking and safety behaviors; use behavioral experiments and structured homework.
Exposure therapy	Graded, collaborative exposure to feared situations, bodily sensations or separation; core for phobias, panic, agoraphobia and social anxiety. Avoid coercive exposure.
ACT and mindfulness	Support values-guided action and tolerance of internal experiences as adjuncts; do not replace indicated exposure-based care.
Parent-based interventions	Reduce family accommodation, reinforce brave behavior, coordinate school plans; particularly important in childhood anxiety and selective mutism.
Applied relaxation / breathing skills	Help manage arousal, while avoiding reliance on breathing or relaxation as safety rituals that maintain panic avoidance.
Lifestyle and supports	Regular sleep, physical activity, caffeine reduction, consistent routines, social support, accommodations and gradual return to functioning.

7 | Age-specific pathways

Children (including preschool-aged)

Use caregiver and school collateral, developmental and language assessment, school refusal and family accommodation review. CBT with caregiver participation is a principal treatment; consider SSRI treatment for moderate/severe symptoms or inadequate response to therapy after careful risk-benefit discussion. Assess bullying, trauma, learning issues and neurodevelopmental differences.

Adolescents

Assess social evaluation fears, school attendance, panic, sleep, substance use, online/social stress, depression, suicidality and autonomy. Offer adolescent-adapted CBT/exposure, family participation with appropriate confidentiality, and medication when clinically indicated. Coordinate 504/IEP recommendations when functional impairment supports them.

Adults and older adults

Assess occupational and relationship functioning, medical contributors, chronic stress, substance use, sleep, perinatal considerations and prior treatment. In older adults, review cognition, falls, polypharmacy, renal/hepatic function and anticholinergic/sedative burden; prioritize nonpharmacologic treatment and cautious medication selection.

8 | Follow-up, outcomes and safety

• Set individualized targets: fewer panic attacks, improved school attendance, reduced avoidance, better work performance, restored sleep, greater independent activity.

• Repeat a validated scale (for example GAD-7, SCARED, PDSS or LSAS) and assess actual functioning at clinically appropriate intervals.

• During initiation/titration, reassess tolerability, activation, mood, sleep, adherence and safety relatively soon; adjust visit frequency to severity and risk.

• Document medication decisions and counseling, psychotherapy actually performed and duration when applicable, informed consent/shared decisions when established, and safety planning only if completed.

• Escalate care for acute suicidality, mania, psychosis, severe substance withdrawal, medical instability or inability to maintain safety; emergency instructions should reflect the actual situation.

9 | Telepsychiatry, referrals and implementation

Telepsychiatry can support interviews, rating scales, psychotherapy, collateral discussions and medication management where legally and clinically appropriate. In-person evaluation or referral may be needed for physical examination, diagnostic uncertainty, urgent risk, intensive exposure treatment or complex comorbidity. Comply with applicable state licensing, prescribing, privacy and consent requirements.

Service tier	Implementation standard
Core practice services	Psychiatric diagnostic interview; DSM-5-TR formulation; age-appropriate screening; risk assessment; medication management; psychotherapy if actually offered by trained clinicians; measurement-based follow-up.
Enhanced practice services	Structured anxiety-specific interviews, specialty CBT/exposure training, parent-based protocols, coordinated school/work recommendations and collaborative care.
Referral partnerships	Pediatric behavioral health, licensed psychologists, exposure specialists, speech-language pathologists for selective mutism, sleep medicine, primary care/cardiology/endocrinology as indicated.
Governance	Written workflows, staff competencies, consent and confidentiality procedures, validated assessment licensing, controlled-medication policy, documentation quality review and outcomes tracking.

10 | Patient-facing service description

Comprehensive Anxiety Evaluations and Personalized Treatment at 24-7 Shalom Psychiatry PLLC

Anxiety can affect concentration, sleep, physical comfort, relationships, school performance and the ability to participate fully in everyday life. At 24-7 Shalom Psychiatry PLLC, our proposed anxiety care program is designed to understand the unique pattern behind each person's fears, worries, panic symptoms and avoidance - not simply label symptoms.

Our approach combines a comprehensive psychiatric interview, evidence-based diagnostic criteria, appropriate symptom measures, medical and psychiatric review, and individualized treatment planning for children, teenagers and adults. Depending on clinical need and actual service availability, treatment may include cognitive behavioral therapy, exposure-based approaches, parent and family guidance, medication management, and coordinated educational or workplace support.

We work toward practical outcomes: improved daily functioning, greater confidence, healthier coping, reduced avoidance and sustained progress. When specialized testing or treatment is needed, appropriate referrals may be recommended.

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References and clinical sources

• American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). American Psychiatric Association Publishing.

• American Academy of Child and Adolescent Psychiatry. (2020). Clinical practice guideline for the assessment and treatment of children and adolescents with anxiety disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 59(10), 1107-1124.

• National Institute for Health and Care Excellence. (2011, updated). Generalised anxiety disorder and panic disorder in adults: Management (CG113).

• National Institute for Health and Care Excellence. (2013). Social anxiety disorder: Recognition, assessment and treatment (CG159).

• U.S. Food and Drug Administration. Prescribing information and boxed warnings for individual medications; consult current product labeling at accessdata.fda.gov.

• American Psychological Association. Clinical practice guideline resources for psychological treatment; consult current condition-specific guidance.

Document note: This is a practice-adaptation framework, not a claim that all named modalities or instruments are currently offered, and not a substitute for current product labeling or full DSM-5-TR text. Diagnostic codes and drug approvals should be confirmed against current ICD-10-CM and FDA references before clinical or billing use.