

## Behavioral Health and Cognitive Impairment Screening and Assessment Tools

### Generalized Anxiety Disorder (GAD-7) Screening Tool

**Resource summary:** This well-established diagnostic tool diagnoses anxiety and measures its severity. It is a self-report scale that asks individuals to rate symptoms over the past 2 weeks. The GAD-7 has been validated with older adults with a cutoff score of 5 for older adults indicating a need for further assessment.<sup>1465</sup> For more on the GAD-7 and its questions, see the article “A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7” by Spitzer and colleagues at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326>.<sup>1466</sup>

### Geriatric Anxiety Scale (GAS)

[www.uccs.edu/agingandmentalhealthlab/scale](http://www.uccs.edu/agingandmentalhealthlab/scale)

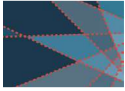
**Resource summary:** The Geriatric Anxiety Scale is a 30-item measure developed for and validated in older adult populations.<sup>1467</sup> It is a self-report measure that assesses somatic, affective, and cognitive symptoms of anxiety over the past 7 days. A shorter 10-item version is also available; it is also valid and reliable for older adults.<sup>1468</sup>

### Geriatric Anxiety Scale (GAS)

Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the **PAST WEEK, INCLUDING TODAY**, by checking under the corresponding answer.

|  | Not at all<br>(0) | Sometimes<br>(1) | Most of<br>the time<br>(2) | All of<br>the time<br>(3) |
|--|-------------------|------------------|----------------------------|---------------------------|
| 1. My heart raced or beat strongly.                                  |                   |                  |                            |                           |
| 2. My breath was short.  |                   |                  |                            |                           |
| 3. I had an upset stomach.   |                   |                  |                            |                           |
| 4. I felt like things were not real or like I was outside of myself. |                   |                  |                            |                           |
| 5. I felt like I was losing control.                                 |                   |                  |                            |                           |
| 6. I was afraid of being judged by others.                           |                   |                  |                            |                           |
| 7. I was afraid of being humiliated or embarrassed.                  |                   |                  |                            |                           |
| 8. I had difficulty falling asleep.                                  |                   |                  |                            |                           |
| 9. I had difficulty staying asleep.                                  |                   |                  |                            |                           |
| 10. I was irritable.   |                   |                  |                            |                           |
| 11. I had outbursts of anger.  |                   |                  |                            |                           |
| 12. I had difficulty concentrating.                                  |                   |                  |                            |                           |
| 13. I was easily startled or upset.                                  |                   |                  |                            |                           |
| 14. I was less interested in doing something I typically enjoy.      |                   |                  |                            |                           |
| 15. I felt detached or isolated from others.                         |                   |                  |                            |                           |

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Continued

|   | Not at all<br>(0) | Sometimes<br>(1) | Most of<br>the time<br>(2) | All of<br>the time<br>(3) |
|---|-------------------|------------------|----------------------------|---------------------------|
| 16. I felt like I was in a daze.                                |                   |                  |                            |                           |
| 17. I had a hard time sitting still.                            |                   |                  |                            |                           |
| 18. I worried too much.   |                   |                  |                            |                           |
| 19. I could not control my worry.                               |                   |                  |                            |                           |
| 20. I felt restless, keyed up, or on edge.                      |                   |                  |                            |                           |
| 21. I felt tired.   |                   |                  |                            |                           |
| 22. My muscles were tense.                                      |                   |                  |                            |                           |
| 23. I had back pain, neck pain, or muscle cramps.               |                   |                  |                            |                           |
| 24. I felt like I had no control over my life.                  |                   |                  |                            |                           |
| 25. I felt like something terrible was going to happen to me.   |                   |                  |                            |                           |
| 26. I was concerned about my finances.                          |                   |                  |                            |                           |
| 27. I was concerned about my health.                            |                   |                  |                            |                           |
| 28. I was concerned about my children.                          |                   |                  |                            |                           |
| 29. I was afraid of dying.                                      |                   |                  |                            |                           |
| 30. I was afraid of becoming a burden to my family or children. |                   |                  |                            |                           |

### GAS Scoring Instructions

Items 1 through 25 are scorable items. Each item ranges from 0 to 3. Each item loads on only one scale. Items 26 through 30 are used to help clinicians identify areas of concern for the respondent. They are not used to calculate the total score of the GAS or any subscale.

**Total Score** = sum of items 1 through 25.

**Somatic subscale** (9 items) = sum of items 1, 2, 3, 8, 9, 17, 21, 22, 23

**Cognitive subscale** (8 items) = sum of items 4, 5, 12, 16, 18, 19, 24, 25

**Affective subscale** (8 items) = sum of items 6, 7, 10, 11, 13, 14, 15, 20

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