Definition: **generalized anxiety disorder** from *The Penguin Dictionary of Psychology*

A subclass of ANXIETY DISORDERS characterized by persistent free-floating anxiety and a host of unspecific reactions such as trembling, jitteriness, tension, sweating, light-headedness, feelings of apprehension and irritability. The term is applied only to functional disorders, not to organic disabilities, which can produce similar symptoms. Also called, simply, *anxiety reaction*.

Summary Article: **Generalized Anxiety Disorder**

From *The Corsini Encyclopedia of Psychology and Behavioral Science*

Generalized anxiety disorder (GAD) is a clinical anxiety disorder that is centrally characterized by excessive, pervasive, and chronic worry. Worry is a cognitive activity that involves repeatedly thinking about potential negative future events, such as “What if I can't finish this task?” “What if I never graduate?” “What if I have some type of illness?” According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, (2000)), in order to warrant a diagnosis of GAD an individual must experience excessive and uncontrollable worry for at least 6 months, as well as three or more associated symptoms that are present, more days than not, over this time period. These associated symptoms include restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, or sleep disturbances (e.g., difficulty falling or staying asleep). Consistent with other DSM-IV diagnostic criteria, both the worry and associated symptoms must cause clinically significant distress or impairment.

Individuals with GAD typically report that the content of their worries is broad and pervasive and spans domains such as interpersonal relationships, physical health, school/work, finances, world events, and minor matters (e.g., punctuality). In addition, these worries cannot solely be accounted for by the presence of another disorder (e.g., worry about having a panic attack in panic disorder, worry about social interactions in social phobia). This is an important diagnostic consideration, as GAD is a highly comorbid disorder and often co-occurs with many anxiety and mood disorders, most commonly major depressive disorder and social phobia (Roemer, Orsillo, & Barlow, (2002)).

Recent epidemiological surveys report 12-month and lifetime prevalence rates for GAD of 2.9% and 6.1% respectively (Kessler et al., (2005)) with approximately twice as many women as men meeting criteria (Roemer et al., (2002)). Further research is needed to determine whether there are any racial and ethnic differences in the prevalence of GAD.

**Models of GAD**

**Behavioral Models of Anxiety**

As in other anxiety disorders, behavioral models of GAD posit that individuals learn to associate fear with certain stimuli. This can occur through stimuli being present during a threatening event, modeling of fearful behavior by others, or negative experiences with unpredictable and uncontrollable events in general. Once these fearful associations are formed, they can spread to similar stimuli. In addition, they are maintained by avoidance, because individuals cannot learn that a stimulus is not threatening if they
Avoidance Theory

As excessive and uncontrollable worry is the central and defining feature of GAD, many researchers have examined the function of worry in order to better understand GAD. Borkovec, Alcaine, and Behar (2004) have proposed that, although worry is itself aversive, it also serves an avoidant function, in that it is associated with reduced somatic arousal, which negatively reinforces its occurrence. In other words, worry seems to damp down physiological arousal and may distract from other sources of distress; this consequence makes worriers engage in worry more often. As Borkovec and colleagues (2004) review in depth, experimental studies have shown that inducing worry is either related to reduced somatic arousal or more gradual increases in activation. Indeed, psychophysiological investigations of individuals with GAD indicate that, unlike other anxiety disorders, it is not associated with increased physiological arousal. Individuals with GAD also report that their worry serves to distract them from more emotional topics (Borkovec et al., 2004). These emotionally avoidant properties of worry may, in fact, prolong distress because they interfere with complete processing of emotional responses.

Cognitive Correlates of GAD and Attempts at Suppression

In addition to the avoidance of somatic activity, there may be a variety of other factors that exacerbate the process of worry in individuals with GAD. Evidence suggests that GAD may be associated with an intolerance of uncertainty. That is, individuals may have a lower threshold for ambiguity, and this may increase the likelihood that they engage in worry in an effort to cope (Dugas, Buhr, & Ladouceur, 2004). In a related concept, individuals may engage in worry in the belief that this helps prepare them for future events. Given the fact that worry is often directed towards events with a low probability of occurrence, the non-occurrence of these feared events can be taken as evidence for the benefits of worry as a preparatory strategy, thereby reinforcing this behavior (Borkovec et al., 2004)).

Although individuals with GAD may hold positive beliefs about worrying, they may also develop secondary worries about worrying itself. This “meta-worry” may perpetuate the cycle of worry by increasing anxiety, as individuals worry about their own worries (Wells, 1999)). Individuals with GAD often find worry extremely distressing and frequently engage in attempts to stop or suppress their worrisome thoughts. Given the lack of rigid control that we have over our internal experiences (e.g., thoughts, emotions), attempts at suppression are often ineffective, and evidence also suggests that suppression may paradoxically increase the thoughts that one is trying to avoid (Purdon, 1999)). Thus, individuals with GAD may be caught in a cycle in which they worry about their own worry and its uncontrollability, but attempts to control the worry actually increase its frequency.

Information Processing Theories

The way that individuals perceive and attend to information in their environment may also contribute to the maintenance of GAD. For example, several studies have demonstrated that individuals with GAD display an attentional bias towards threatening information. That is, they are more likely than individuals without an anxiety disorder to attend to threatening cues in their environment. In addition to this attentional bias, individuals with GAD may also be more likely to interpret ambiguous situations as
threatening and believe negative outcomes to be likely (MacLeod & Rutherford, 2004). Given these tendencies, it is not hard to imagine why individuals may find themselves generally anxious and locked in cycles of worry.

**Treatment**

**Cognitive-Behavioral Treatment**

Cognitive-behavioral therapy (CBT) is currently the first line psychological intervention for GAD. A variety of randomized control trials indicate that CBT results in statistically and clinically significant changes in GAD symptomatology and yields large effect sizes that are maintained at follow up (Borkovec & Ruscio, 2001). Although researchers have tailored specific aspects of the full CBT package to fit their model (e.g., to target “meta-worry” or intolerance of uncertainty), what we present here is the standard approach with the longest history of empirical validation. The common elements of a CBT package include psychoeducation, monitoring, relaxation training, exposure, and cognitive restructuring.

Most CBT treatments begin with a psychoeducation component (although psychoeducation may be a component of later phases as well). During this phase of treatment, clients are provided with information about the functional nature of fear and anxiety, as well as how these processes can become rigid, habitual cycles that are maladaptive. The cognitive, affective, behavioral, and physiological components of the anxiety and worry cycle are highlighted, with examples drawn from the client’s own experiences.

As with all CBT approaches, successful monitoring is an essential component to therapy. Clients are taught how to notice early situational, behavioral, cognitive, or physiological cues to their anxious responding so that they can intervene early on in the worry/anxiety cycle. Monitoring may also allow clients to view their thoughts and emotions as rising and falling, allowing them to be less reactive to their internal experiences. As a consequence, individuals with GAD may be able to observe their worry, rather than worrying more about it. Moreover, consistent monitoring can help clients monitor changes in their mood and anxiety over the course of therapy, thereby reinforcing the benefits of certain interventions.

Clients are also taught various methods of relaxation (e.g., diaphragmatic breathing, progressive muscle relaxation) in session, and are asked to practice these techniques on their own. In addition to developing the skill of relaxation, these techniques may facilitate greater present-moment focus (as worry itself is largely a future or past-focused activity). Gradually, clients are helped to use these relaxation strategies when confronted with fearful situations either imaginally or in vivo (i.e., exposure). However, care must be taken to ensure that clients are not using relaxation as another means of avoidance, as this can maintain threatening associations and interfere with learning new, nonthreatening associations.

A variety of methods of cognitive restructuring are also included in order to counter the rigidity characteristic of individuals with GAD. Clients are taught to identify their tendencies to overestimate the probability of feared outcomes or engage in catastrophic thinking, and they are encouraged to consider alternative ways of conceptualizing feared situations. Elements unique to a given model (e.g., meta-worry or intolerance of uncertainty) may also be added. A common emphasis on early cue detection and implementing alternative responses helps clients to develop new habits and increase their flexibility.
Psychopharmacological Interventions

Three basic classes of drugs have been studied for use with GAD. These include benzodiazepines, azapirones, and antidepressants (e.g., SSRIs). The choice as to which type of drug will be most effective is usually based on a particular client’s presentation and symptom profile. Compared to azapirones and antidepressants, benzodiazepines are relatively fast acting. However, there exists considerable controversy as to the risks of using fast-acting anxiolytics in the treatment of anxiety disorders. Specifically, there is concern about the possible addictive properties of some fast-acting anxiolytics and their use as a means of avoidance. Inasmuch as certain anxiolytics reduce physiological arousal, chronic use can inhibit activation of the fear network in memory and successful emotional processing. Given the frequent co-occurrence of depression in clients with GAD, and the long-term tolerability of such agents, antidepressants are currently considered the first line pharmacological treatment for GAD (Lydiard & Monnier, (2004)). However, it is important to note that interventions that are solely psychopharmacologically based may require individuals to remain on medication over long periods of time, as medication discontinuation can be associated with the return of symptoms.

Newer Treatment Approaches

Despite the efficacy of CBT for GAD, a proportion of those treated continue to experience clinically significant levels of symptoms (Roemer et al., (2002)), leading investigators to pursue additional intervention strategies in order to enhance treatment efficacy. Given the paradoxical effects of suppression, and the tendency to avoid internal experiences that appears to be characteristic of individuals with GAD, recent approaches have incorporated acceptance and mindfulness techniques with behavioral principles. Although there is need for further study, recent empirical investigations have yielded promising results (Roemer & Orsillo, (2007)).

Researchers have also begun to explore whether the addition of interpersonal and experiential elements enhances treatment effectiveness (Newman, Castonguay, Borkovec, & Molnar, (2004)). This approach stems from clinical and research evidence suggesting that GAD is characterized by significant interpersonal problems and emotional avoidance. Therapists use a variety of experiential exercises, as well as the therapeutic relationship, to explore interpersonal concerns and deepen emotional experience. Finally, based on research demonstrating emotion regulation difficulties in individuals with GAD (such as emotional intensity, difficulty understanding emotions, reactivity to one’s emotions, and difficulty modulating emotional responses), researchers have begun to develop treatments that specifically target these difficulties (Mennin, (2006)). Future research is needed to establish the efficacy of these newer approaches.

See also

Anxiety; Anxiety Disorders.

References


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