Generalized Anxiety Disorder
By Pilar D’Asto

GAD is characterized by excessive and uncontrollable worry and anxiety about a number of topics. To conform to the diagnostic criteria for GAD, the worry must be experienced more days than not for at least 6 months and must be accompanied by somatic symptoms such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance. The disorder affects 1.5% to 3% of the general population, is more common in women than in men, most often onsets in early middle age, and frequently presents with comorbid anxiety and mood disorders. It is also associated with substantial impairment and is highly chronic (Sexton, Francis, & Dugas, 2008, p.291). Whereas other anxiety disorders often emerge in adolescence or young adulthood, the onset of GAD is usually in early middle age; as such, GAD prevalence rates tend to increase with age. For women, the likelihood of GAD onset increases substantially after the age of 35, whereas for men such increase most often occurs after the age of 45. Although little cross-cultural studies have been done it has been proven that women are twice as likely to develop anxiety than men (Sexton et al., 2008, p.292). It may be, therefore, that women are more likely to engage in cognitive processes such as cognitive avoidance, or may possess a more negative problem orientation, which puts them at greater risk of developing high levels of worry. The reason for the gender differences in these cognitive processes, however, is not yet well understood (Sexton et al., 2008, p.298-299).

Several researchers have noted that GAD is one of the most disabling anxiety disorders with levels of impairment comparable to depression and chronic physical illness. The disorder has also been associated with a substantial increase in use of the health care services and greater employment-related disability costs compared to nonclinical populations. Furthermore, compared to those with other anxiety disorders, patients with primary GAD seem to worry significantly more about the future (Sexton et al., 2008, p.291-292). There are many conceptual models of GAD though the model outlined developed by Dugas, Gagnon, Ladouceur, and Freeston has the most empirical evidence presents that: “a higher order dispositional characteristic, intolerance of uncertainty, contributes directly to worry while also influencing other worry-related processes. Three lower order factors—positive beliefs about worry, negative problem orientation, and cognitive avoidance—are also included as processes that contribute to worry” (Sexton et al., 2008, p.293).

Through this research process, I have discovered a better idea of how prevalent Generalized Anxiety Disorder (GAD) is in our culture. I believe it is difficult to purely identify it as a truly pathological despite the DSM-IV criteria that we, as therapists, use for common language and reference. Anxiety seems to be akin to our American identity, the standards we have created as well as what naturally exists, rooted in human, eternal existential issues. So, is anxiety overlooked in our culture and
mistreated? Or is it a true disorder? I agree with the former assessment as does Patricia Pearson, the author of her memoir A Brief History of Anxiety: Yours and Mine. I don’t think that in our present time in history, anxiety will be recognized as having such clear ties to these existential questions and fears. However, I am determined, more clearly now after this process, to not only face directly my fears, but to ultimately work within my chosen therapeutic modality of drama therapy to listen, validate and offer healing. Although Drama Therapy offers a unique perspective, one of communion and ritual, and action, Cognitive Behavioral Therapy (CBT) and Relaxation Therapy (RT) have been the only therapeutic approaches that have proved empirically to provide relief from GAD. Furthermore, GAD still is sadly ‘incurable’ though one may learn to find healing through contexts that are meaningful to the individual.

In her book, Pearson traces the emergence and growth of her anxious symptoms from childhood to present day with eloquence. She weaves targeted research of cultural perspectives on the disorder as well as comparisons of the American experience to that of varying countries such as Mexico. She notes that in childhood she developed what Neuropsychiatrists call “anxiety sensitivity” which is thought to be a precursor to development of anxiety disorder (Pearson, 2008, p.23). In her early childhood her father moved the family to India where she describes that her “personal landscape of fear” was developed (Pearson, 2008, p.18). Certain fears, she believes received their “cue” from this period of her development there in the height of the Indo-Pakistani war. In Pearson’s adolescence she experiences an “indefinable sense of responsibility to the darkness” where she felt she needed to “stand guard at the portal of darkness for what seemed half the night (Pearson, 2008, p.21)

Pearson notes that her childhood fears did not go away when the family moved to Ottawa, rather her “formless waves” of objectless anxiety and her “fear went in search of new causes” throughout her life (Pearson, 2008, p.22) It was at age 23 that was first diagnosed with GAD (Pearson, 2008, p.22). It was after her first major break-up in college. She had a nervous breakdown, left school and started pharmaceutical treatment. Pearson describes her first experience with a psychiatrist who told her that “there was nothing wrong with my world. What was wrong, and fixable with chemicals, was me” (Pearson, 2008, p 48). She did not stay on the initial medication long as it made her feel ill, instead she coped by creating a very busy life as a journalist. She ponders the co-morbidity of anxiety with other disorders in particular OCD. She describes her current symptoms as “trying to gain traction through fierce analysis, I wound up in an Obsessive-Compulsive groove” which she has heard this described as Retroactive Anxiety featuring intrusive thoughts (Pearson, 2008, p.43).
She experienced a brief remission from anxiety and panic until it’s return after she was married and a mother. She had been shocked by the death of a close friend. Patricia lists her current fears: phone bills, ovarian cancer, black bears, climate change, walking on golf courses at night, being blundered into by winged insects, running out of gas, mole on back turn to malignant cancer and flying. Pearson rejects prescription treatment after trials with Effexor, Paxil, Zyban and Xanax. She describes, in particular, her unsettling experiences such as with Effexor as it created a lack of moral sense and extreme withdrawal effects even after only missing one dose. Pearson asserts that a serotonin/chemical imbalance is an “urban legend” propagated by the pharmaceutical companies due to financial gain (Pearson, 2008, p.149). Further, drug companies are now encouraging the use of antipsychotic drugs because the antidepressants lose their patent. Profits are indefinite if people stay on these medications whose long-term effects are unknown. Pearson cites that the World Health Organization’s studies of rates of recovery from mental illness shows that in developing world nations such as India, patients recover “better from their anguish and madness than people in the first world” because there are a variety of treatment choices available non being considered “alternative” or “subcultural”(Pearson, 2008, p.163).

Some of Pearson’s ‘alternative’ treatments of are mindfulness/mindful breathing, exercise, CBT with psychologist, ritual/church/prayer and community. Pearson believes that community is a crucial element to creating a society not plagued with anxiety. She compares, “Mexico is calling: “Come sing with us, come pray with us, come celebrate”. The other worlds I have lived in snarl: “Get out of my way.” She cites Psychologist Rollo May who once wrote, “Competitive individualism militates against the experience of community, and the lack of community is a centrally important factor in contemporaneous anxiety”(Pearson, 2008, p.83). She goes on to summarize that it has been observed by some psychologists interested in cross-cultural research that the more a culture insists upon rational control, the more it will tend to generate anxiety, because it is that much more fearful of losing control. She furthers her point by saying that “As Jung pointed out nearly a century ago, rationalism will persistently try but it cannot, ultimately, win out because the human experience is not entirely rational” (Pearson, 2008, p. 113). The intense value we give rationalism, Pearson feels has not helped us deal with fear but rather “invalidated meaning, which merely served to heighten our dread” (Pearson, 2008, p.96) Pearson is convinced that connecting ourselves to a larger narrative such as a church community with a set of beliefs has helped her cope with her anxiety. She reports that studies have shown that people who engage in some religion are less prone to debilitating anxiety (Pearson, 2008, p.88).

Again she refers to psychologist Rollo May who drew upon the works of such great thinkers as Karen Horney, Eric Erickson, and Kurt Goldstein while also engaging in discussions with the German theologian Paul Tillich. Pearson quotes May, again, who integrated the existentialist perspective into his work as a clinical psychologist 50 years ago. He proposes that pathological anxiety was “cued off by a threat to some value that the individual holds essential to his existence as a personality” (Pearson, 2008, p.40). In human history artists have also suffered greatly from depression and anxiety, Pearson points out certain creative types who have suffered Keats, Abe Lincoln, T.S. Eliot, Charles Darwin. She focuses on Edvard Munch’s The Scream and says he, “who was plagued by it all his life, captures dread on canvas as if he were pinning a moth, an artist whose genius approached science in its precision in revealing the extent to which anxiety is both unbearably vivid yet insanely abstract” (Pearson, 2008, p. 11).

Perspective on what anxiety is and treatment options vary from within culture as been discussed briefly, but it has also varied in history. Pearson gives a general overview that
ranges from King David 3,525 years ago with his response to fear and anxiety explaining it in his prayer to God, “My soul is alarmed” (Pearson, 2008, p.49). She peels through her description of our history generally noting the 1800’s marked by hysteria and nerve tonics to the 1900’s brain disorders and Rx treatment to our current state which comes full circle to King David, is anxiety an issue of the soul more than anything else? In our collective historical relationship to anxiety the American slave lullaby sums up this rather universal commentary on the frailty of human life, “Hush lil’ baby don’ yo’ cry/ Fadder an’ mudder born to die.” Don’t soothe fears by denying the! Teach children how to cope by offering strategies to children - teach them to YELL!! Let them fantasize too. She references her own young daughter, Clara, who is prone to anxiety. Clara works in her room to set up “boobie” traps for burglars. I will note here that this is akin to techniques of drama therapy – Pearson supports her daughters taking creative action to protect herself. If I were to consult on this ‘case’ I would lead as therapist acting out scenarios where someone might play a scene out to further practice defensive behavior.

Clinical psychologist Barry Wolfe expresses that in the last 30 years with several hundred patients suffering with anxiety disorders has “led me to two broad conclusions. The first is that anxiety disorders are typically generated by failed efforts to confront and solve a finite number of unavoidable existential dilemmas that every human being will experience” (Wolfe, 2008, p.204). He notes that when people confront the reality of death this awareness may unearth other primal emotions such as “despair, humiliation, helplessness, or rage” (Wolfe, 2008) [p.205]. The fear of death has often been the source of panic in patients with obsessive-compulsive disorder (OCD), GAD, panic disorder with or without agoraphobia, and specific phobias. “The awareness of one’s mortality is typically a frightening experience”. (Wolfe, 2008, p.205)

An example of this experience occurred with a man who had a severe bridge phobia who contacted his despair over the thought of his death through imagery work. The man was afraid he would hurl himself over a bridge as top of its height and so Wolfe asks him to imagine that taking place, “as he saw himself plummeting to his death, he began to cry despairing tears because he felt totally incapable of living a satisfactory life. At that moment he contacted his belief that he would die before he had lived” (Wolfe, 2008, p206)

I believe that drama therapy could, again, take this experience further in embodying the experience. A scene could be set up where the man plays himself and another member of the voluntary therapy group could play the role of ‘the bridge’ and yet others could play the sky or ground or the man’s friend. Through this dramatic expression of his fear, I propose the man may achieve a more full, more embodied catharsis. One in which he could share with a community of players on the journey of healing. To refer back to Pearson’s memoir she benefited from a “sympathetic community” through listening to music and dancing at a blues club. She notes that she was, “connecting to an essential human tradition of ameliorating personal sorrow through communal ritual. The deep comfort you draw from being swept up in some joined purpose or exaltation, in a chorus, a protest, a dance – of knowing that you’re not alone” (Pearson, 2008, p.46).

Wolfe recognizes that studies and literature has not caught up to what we
intuitively know regarding anxiety and existential crisis. Therefore, traditional treatments that taut brain disorder as the cause will prevail. CBT has been able to uncover some of the fears that seems to charge anxiety which reveal concerns around existential terrors. He describes the behavioral technique “interoceptive exposure” which is the systematic process of a client focusing his or her mind on the somatic sensations of anxiety in the body until they go away. However the root of anxiety still remains in existential issues (Wolfe, 2008, p.204).

Every human being experiences varying levels of anxiety at times throughout life and is accepted as a natural course of growth and development. The awareness and knowledge about one’s self and others gained by dealing with life’s episodes of anxiety can help a person deal with “subsequent anxiety-provoking situations in the future; however, for some, anxiety may become persistent, unrelenting, and disabling” (Helsley, 2008, p.183). Dr. Randi McCabe, a professor of psychiatry, notes that some worry normal but the persistent worrying from an empathetic person can turn into worry that is focused on only negative outcomes. She also states, "we know that anxiety disorders run in families, but [we’re] not sure why exactly that is...perhaps the explanation is that there's a live-wire connection every woman has with her mother, her aunt or her daughter - the propensity to take on too much of an emotional burden, and to have it manifest as fretting (Sanati, 2007).

Clients tend to believe that getting rid of the uncertainty will alleviate the symptoms but this would not due ultimately since it is a natural state of life to have uncertainties and worry. The only option it seems, if authentic healing is to occur if for the client to “become more tolerant of uncertainty through small steps to expose themselves to low-risk events with an uncertain outcome such as ordering a new dish from a familiar restaurant (Sexton et al., 2008, p.303). Again, this scenario can easily be practiced utilizing drama therapy – acting out this scene to give practice to new roles and new choices for behavior for the client. Doing and practice are highly effective ways to overcome avoiding upsetting scenarios or mental content. (Sexton et al., 2008, pp. 304-305) This study examined the efficacy of CBT across the anxiety disorders. One hundred eight trials of CBT for an anxiety disorder met study criteria. Cognitive therapy and exposure therapy alone, in combination, or combined with relaxation training, were efficacious across the anxiety disorders, with no differential efficacy for any treatment components for any specific diagnoses. However, when comparing across diagnoses, outcomes for generalized anxiety disorder and posttraumatic stress disorder were superior to those for social anxiety disorder, but no other differences emerged. CBT effects were superior to those for no-treatment and expectancy control treatments, although tentative evidence suggested equal effects of CBT when compared with relaxation-only treatments (Norton & Price, 2007, p.521).

Further empirical support was found in the evaluation, Dugas, Savard, and colleagues in 2004 compared the CBT to RT (Relaxation Technique) and found that both treatment groups demonstrated reduced somatic symptoms associated with GAD which included the intolerance of uncertainty but only the CBT group showed reductions in “the other targeted processes, namely, positive beliefs about worry, negative problem orientation, and cognitive” (Sexton et al., 2008, p.306).

Co-morbidity with major depression, other anxiety disorders, and other psychiatric disorders may be as high as 90%. (Helsley, 2008, p.183). Research on the potential genetic basis of GAD suggests that approximately 32% of the variance in GAD symptomatology may be due the genetic factors. Research also indicates that GAD and other anxiety disorders share a common genetic vulnerability to anxiety. However, GAD seems to have a stronger genetic relationship to Major Depressive Disorder than to other anxiety disorders. It may be most accurate, therefore, to conceptualize GAD as having a shared underlying vulnerability to anxiety, while still possessing a specific genetic
relationship to depression (Sexton et al., 2008, p.297).

GAD and PD are related, and, until the introduction of the Diagnostic and Statistical Manual of Mental Disorders though some studies evaluating CBT and RT in treating anxiety have used mixed GAD–PD samples. GAD and PD are common and costly. The National Comororbidity Survey found lifetime prevalence rates of approximately 5% and 3.5% for GAD and PD as it is often chronic, resistant to change, and characterized by early onset. GAD has proven particularly difficult to treat, with clinical trials producing clinically significant improvement in only about 50% of participants (Siev & Chambliss, 2007). Treatment for generalized anxiety disorder, notes Dr. McCabe, generally includes a course of an SSRI, CBT and talk therapy focused on isolating negative thoughts and fears. However GAD, reports Dr. McCabe, is “one of the most challenging disorders to treat” and we may “blame this on the deeply engrained nature of the condition, and its roots in childhood. Those who suffer are said to have gone through early life with a sense that the world was a scary place, full of threatening elements that were out to get them” (Sanati, 2007).

In conclusion, there is no mainstream option of treatment that gives an absolute curative result to individuals that have been diagnosed with GAD. However the combination of CBT, RT and medication are helpful. But without some kind of therapist or community led experience of catharsis that reaches deep into the existential meaning of life, I do not belief there is true relief. Relief comes from knowing we are not alone in our experience and that our experience is valid. I believe that drama therapy in its use of more primal modes of expression is most useful and successful in dealing with the spectrum of human issues. As with any symptom that one experiences, it only becomes an issue to the degree it interferes with one’s life – but we are a culture of symptoms in America with a skewed awareness of emotional value. We generally do not make room for authentic emotion and tend to pass judgment on extreme, creative expressions of it in mainstream society. I hope that I can contribute to a world that is more sensitive to issues of the soul and help make room for individuals to express what “alarms” them as King David did over 5,000 years ago.

References


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