Generalized Anxiety Disorder

Description/Etiology

Anxiety is fear, apprehension, worry, and often physiological distress in response to perceived threats, uncertainty, critical decisions, and major life events. Normative anxiety allows individuals to be more alert and aware regarding their situation. However, for some individuals, anxiety can become excessive and problematic. Even when the client realizes that his or her anxiety has gone beyond a normal or typical reaction, the client may still have trouble controlling the anxiety and as a result his or her day-to-day functioning may be compromised.

All anxiety disorders have the common elements of disproportionate fear and behavioral disturbances. Generalized anxiety disorder (GAD) is characterized by extreme anxiety and worry about numerous events, situations, or activities. The duration, intensity, and/or frequency are disproportionate to the probability of the event occurring and to the actual negative impact of the event or activity (American Psychiatric Association [APA], 2013). According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), this extreme anxiety or worry happens more days than it does not, is present for a minimum of 6 months, and is focused on a variety of events or activities (e.g., work, school, family relationships). The anxiety and worry present in GAD most often is accompanied by physical and cognitive symptoms. DSM-5 diagnostic criteria for GAD are trouble maintaining control over this anxiety or worry and at least three of the following symptoms: restlessness or being “on edge”; being easily tired; trouble concentrating; irritability; muscle tension; and sleep disturbances (e.g., trouble falling asleep, trouble staying asleep, poor sleep quality). Clients may be worrying about their abilities at school or work, finances, relationships, natural disasters, or the personal safety of themselves or loved ones. To meet diagnostic criteria, the anxiety, worry, or symptoms must have a noticeable impact on the client’s functioning socially and at work or school and be causing the client distress. Anxiety disorders frequently co-occur with other mental health diagnoses, physical health problems, and alcohol and substance abuse, so the clinician needs to be thorough when assessing clients for an anxiety disorder; if anxiety is a secondary diagnosis, it must be determined if the primary diagnosis needs to be addressed first (APA, 2013).

In addition to experiencing worry and anxiety that are difficult to control, clients in whom GAD is diagnosed tend to be future oriented, worrying about what is to come rather than focusing on the reality of the present. They tend to have a negative cognitive bias (i.e., an automatic negative focus to their thoughts and feelings). They are vulnerable to somatic arousal (e.g., “butterflies” in their stomachs, sweaty palms, increased heart rate, muscle tension) occurring as a physical response to their mental worries and anxieties. Clients with GAD often first seek medical treatment for somatic symptoms. Clients with GAD may also have relationship stressors that contribute to their anxiety.

The etiology of GAD is not known, but is generally agreed to be a combination of biological, psychological, and environmental factors. Treatment may include evaluation, psychotherapy, anti-anxiety medications, relaxation therapy, and education on wellness and stress management.
Facts and Figures

*DSM-5* states that the 12-month prevalence rate of GAD among adults in the United States is 2.9% and among adolescents is 0.9%, with individuals of European descent reporting symptoms more frequently than individuals of non-European descent. *DSM-5* reports a 12-month prevalence rate outside the United States of between 0.4% and 3.6%, with individuals in developed countries more likely to report GAD symptoms than individuals in less developed countries (APA, 2013).

The National Institute of Mental Health (NIMH), using data from the 2000–2004 National Comorbidity Survey Replication, reports 12-month prevalence of GAD at 3.1% in adults in the United States, of whom 32.3% (approximately 1% of all adults) have GAD that is severe. Lifetime prevalence of GAD by age group is 4.1% among 16–29-year-olds; 6.8% among 30–44-year-olds; 7.7% among 45–59-year-olds; and 3.6% among those 60 years and older (NIMH, n.d.).

Risk Factors

Women are more likely than men to develop anxiety disorders. A family history of anxiety is an additional risk factor. Clients with a history of physical or psychological trauma, current stressful life events, and/or poor coping strategies have an increased risk for GAD. Environment can be a contributing factor for risk: certain life or work environments are inherently more stressful. Nutritional deficiencies (e.g., niacin, thiamin, vitamin B12) may increase the risk for GAD. Use of alcohol and substances can increase the likelihood of developing anxiety or may be a means of coping with anxiety that already exists. Physical health problems, whether caused by a chronic illness or a recent diagnosis of illness, can trigger GAD. Epidemiology surveys have shown that GAD is more commonly found in unmarried adults versus married adults, members of racial and ethnic minorities, and individuals of lower socioeconomic status.

Signs and Symptoms/Clinical Presentation

- Psychological: difficulty concentrating, excessive worry or fear, panic, irritability, impatience, negative cognitions
- Behavioral: restlessness, sleep and appetite disturbances
- Physical: sweating, muscle tension, shaking, shortness of breath, tightness in chest, gastrointestinal distress, rapid heartbeat
- Social: withdrawal, isolation, problems with academic, occupational, or social functioning, lost work time

Social Work Assessment

- **Client History**
  - Assess client by taking a complete biopsychosocial/spiritual history in order to explore all potential symptoms and causes of anxiety
  - Explore and assess social and family functioning for negative and positive aspects and measure available social supports
  - Assess for risk of suicide or self-harm
- **Relevant Diagnostic Assessments and Screening Tools**
  - Beck Anxiety Inventory to assess the severity of client’s self-reported anxiety
  - Generalized Anxiety Disorder 7-Item Scale (GAD-7)
  - The Short Anxiety Screening Test (SAST), a 10-item scale that may be clinician-scored or self-report
  - The Geriatric Anxiety Inventory (for older adult clients), a 20-item self-report
  - The Hamilton Anxiety Rating Scale, a 14-item, clinician-scored scale
  - The Spence Children’s Anxiety Scale (SCAS) Child and Parent Version
  - The Multidimensional Anxiety Scale for Children (MASC) is a 39-item self-report for children and adolescents ages 8 to 19
  - The Revised Children’s Manifest Anxiety Scale (RCMAS) is a 37-item self-report measure that uses true-false questions to measure anxiety
- **Laboratory and Diagnostic Tests of Interest to the Social Worker**
  - The social worker will want to be aware of any tests that reveal alcohol or substance use

Social Work Treatment Summary

Some clients may benefit from pharmacotherapy alone but the majority will benefit from a combination of psychotherapy that involves behavioral, psychological, and lifestyle changes and/or psychoeducational interventions and medication if it is indicated. Cognitive-behavioral therapy (CBT) and psychodynamic therapy are the most common psychological interventions for clients with GAD. CBT teaches clients how to identify and change the thoughts and behaviors that trigger or exacerbate their anxiety. CBT can also incorporate imaginal exposure and work to improve the client’s problem-solving skills. Psychodynamic therapy helps clients uncover, explore, and work through unresolved emotional conflicts or traumas.
that may be contributing to their anxiety. Clients may also benefit from stress-management programs that reduce overall stress while promoting a healthier lifestyle. Examples include yoga; exercise programs; healthy, non-extreme diet changes; relaxation training (e.g., progressive muscle relaxation); and meditation. For clients for whom pharmacotherapy is indicated, the most common medications prescribed are antidepressants (e.g., tricyclic antidepressants, SSRIs), which although developed for depression have shown effectiveness in treating anxiety symptoms. Benzodiazepines are anti-anxiety medications that act immediately and can be potent, and usually are prescribed only for short periods to reduce the risk of dependency.

CBT is most effective as a face-to-face intervention. For individuals who are not able, or willing, to participate in face-to-face therapy, CBT may take the form of self-help, in which the client uses audio- or videotapes, computer programs, written exercises, or group meetings to self-administer the therapeutic intervention. Guided self-help interventions, which include minimal contact with a professional, also are available.

National guidelines recommend a stepped-care model to organize services for the client with GAD. Stepped care aims to have the right person providing the right care at the right time, “stepping up” services as required by the client’s needs. The stepped care model for GAD consists of four steps.

› Step 1 is to identify if there is a need to screen for anxiety disorders. Once the screening is completed, if anxiety is identified the social worker will assess the client
› Step 2 is to provide treatment and referral for symptoms that are sub-threshold or meet criteria for mild or moderate anxiety. These interventions are considered low intensity and may be a computerized CBT program, structured group physical exercise, or group-based peer support
› Step 3 takes place if there has been an inadequate response to step 2 or if the symptoms are moderate to severe instead of mild to moderate. This step includes possible medications or a more intensive therapeutic intervention (e.g., CBT, interpersonal therapy). This step also involves developing local care pathways (e.g., mental health, primary care doctor, specialist) and treatment planning to prevent relapse or reduce the risk of relapse
› Step 4 is to assess and treat complicated, treatment-resistant GAD, for clients with extreme functional impairment or for clients who are at a high risk for self-harm. At this step, social workers should be offering clients any interventions involved in the previous steps that have not yet been tried. This may be the time to combine drug treatment with therapeutic interventions

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.
| Client has signs and symptoms of GAD | Client will have improved functioning, a reduction in anxiety and worry, and a reduction in any negative physical or cognitive symptoms related to GAD | Provide CBT or psychodynamic therapy dependent on client’s needs or refer if unable to provide services. Encourage client to maintain a present focus for his or her thoughts, not a future focus. Determine if client’s anxieties are related to situations that could be addressed by step-by-step problem-solving skills training or if they are anxieties regarding hypothetical situations, which are harder to change with problem solving. Utilize cognitive restructuring to logically analyze client’s anxieties and change automatic thoughts or negative cognitions. Help client improve self-monitoring and self-awareness. Provide relaxation training. Have client utilize image rehearsal of new coping strategies. Utilize imaginal exposure if appropriate. Address areas of psychosocial functioning that are causing anxiety for client and help client consider lifestyle changes where possible. Work with client on stress-management techniques. Encourage mindfulness to help enhance self-awareness. Address somatic complaints and refer to primary care physician if indicated |

**Applicable Laws and Regulations**

- There are international guidelines set by the UN regarding involuntary psychiatric holds when self-harm or harm to others is a risk. In the United States each state has its own legislation regarding involuntary holds. The social worker is responsible for understanding the rules of his or her jurisdiction.
- Since social workers are mandated reporters for child abuse and maltreatment, the social worker needs to be aware of reporting guidelines for his or her state, region, or nation and recognize and report any suspicions of abuse, which may be triggering the client’s anxiety symptoms, to the appropriate authorities.
- Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their own governing body (e.g., National Association of Social Workers in the United States, British Association of Social Workers in England) and practice accordingly.
Social workers should practice with awareness of, and adherence to, the social work principles of respect for human dignity, social justice, and professional conduct as described by the International Federation of Social Workers (IFSW) Statement of Ethical Principles

Available Services and Resources

- The Anxiety and Depression Association of America, [https://www.adaa.org/](https://www.adaa.org/), offers support and resources for clients and professionals.
- The National Alliance on Mental Illness (NAMI) has online community support groups for anxiety, [https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders](https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders).

Food for Thought

- Brain research is implicating the amygdala and hippocampus as having a role in anxiety disorders. These two centers of the brain influence how the brain creates anxiety and fear.
- The Patient Health Questionnaire, which is a common screening tool in primary care settings, has been found to underdiagnose anxiety disorders. Physicians may need education regarding alternative tools.
- Spirituality can have a beneficial impact on GAD for some clients. Investigators in Pakistan found that when study participants with GAD had a strong sense of spiritual well-being their GAD symptoms were less intense than those of participants without a strong sense of spiritual well-being (Amjad & Bokharey, 2015).
- Older adults with anxiety reported that CBT was more acceptable as a treatment than pharmacotherapy (Gaudreau et al., 2015).
- Older adults with GAD were found to use alcohol at a higher rate than older adults without GAD. Those whose alcohol use was considered mild or moderate were less likely to experience sleep difficulties (Ivan et al., 2014).

Red Flags

- Clients who wish to pursue lifestyle changes for improved stress management (e.g., yoga, diet changes, beginning to exercise) should get medical clearance from their physician.
- Certain SSRIs (e.g., Paxil) have been found to be an inappropriate choice for adolescents because of a possible increased risk for suicide. Any pharmacotherapy with children or adolescents should be accompanied by therapy to monitor for any signs or symptoms of suicide risk.
- Adolescents in whom GAD is diagnosed should be screened for alcohol and substance use, since in this age group the two often co-occur.
- Pregnant women should be screened for anxiety disorders. Researchers found that 24.1% of pregnant women studied reported an anxiety disorder and 8.5% of those met criteria for GAD. The GAD-7 was found to be appropriate for screening this population as there was satisfactory validity. Heightened anxiety during pregnancy can result in negative long-term effects for the fetus (Simpson et al., 2014).
- Adolescents who use two or three illicit substances simultaneously for long periods have an increased risk for GAD in adulthood. Both the functional impairment (e.g., cognitive impairments) and interpersonal relationship problems (e.g., trouble getting along at work, partner conflict) that may result from substance use may contribute to GAD (Brook et al., 2014).

Discharge Planning

- Provide client with instructions to follow up with primary care physician to address somatic complaints and any other health issues that are exacerbating the anxiety or may be causing the anxiety.
- Locate community resources to support client and potentially reduce stress (e.g., group exercise, yoga classes, support groups).
- Educate family members on GAD and teach them how they can support client and reduce stress and anxiety.
- If client is a child or adolescent, work with the school if desired by the client and parents to minimize potential sources of stress there (e.g., test anxiety, bullying).
- Educate client about potential negative effects of alcohol and substance use on anxiety symptoms.
- Discourage client from engaging in avoidance behaviors related to school, work, friends, and family.
- Social workers should continually educate themselves on empirically supported treatments that may be available for their clients.
References


