

ADJUSTMENT AND GENERALIZED ANXIETY DISORDER: AN EMPIRICAL STUDY

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Abstract:

Background: Anxiety disorders are two of the most common mental health concerns in our society. They are often experienced as a complex set of emotional and functional challenges. In the daily life of people, they are exposed to stressful situations; sometimes these stressors may develop to be an illnesses and mental disorders like clinically significant anxiety and other negative psychological states.

Generalized Anxiety Disorder is one of the most common anxiety disorders. Its core features are constant apprehension and worry about the future. These patients experience a group of cognitive, affective, behavioural and physical symptoms. Recent research has shown that meta-cognitive processes are often involved in the etiology of generalized anxiety disorder.

Once the symptoms arise, it slowly leads to poor adjustment of the patients in the different domains of their lives. The clinical symptoms of this disorder often lead to significant impairment in the patients' day to day functioning.

Method: The current study aimed to examine adjustment in the patients with generalized anxiety disorder. The researcher used a cross sectional design in the current study. The measure used was Adjustment scale by Barakat (2006).

Result and Conclusion: The results of the study found that patients with generalized anxiety disorder were poor and low in the adjustment. The study has implications for training these patients in effective psychological skills to enhance their adjustment and better deal with the clinical conditions and thereby improve their well-being.

Keywords: Anxiety, generalized anxiety disorder, adjustment

INTRODUCTION

According to Nijhawan (1972), anxiety is one of the most pervasive psychological phenomena of the modern era, refers to a "persistent distressing psychological state arising from an inner conflict". Similarly, May (1950) defined anxiety as "the apprehension cued off by a threat to some value which the individual holds essential to his existence as personality".

Anxiety is "a reaction to an unknown danger and it is undecided intense apprehension that is usually reflected in a characteristic combination of visceral-motor disturbances and skeletal tensions" (Rubin & Krochak, 1988).

Anxiety is a normal, emotional, reasonable and expected response to real or potential danger, also, it is the environment we are living in is physically, mentally, emotionally, socially and morally dynamic and challenging; we possess effective mechanisms to meet every day stress (Shri, 2010).

ANXIETY DISORDERS

Anxiety disorders are designated by distorted beliefs about the dangerousness of certain situations and/or internal motivations (Clark, 1999).

Anxiety disorders are characterized by extreme fear and subsequent avoidance, usually in response to a definite object or situation and in the absence of real danger. Generally, the researcher noticed that there is a difference between anxiety and anxiety disorders; whereas anxiety is a normal responses and reactions for dealing with our daily activities, but when these responses become uncontrolled, this is a sign of an anxiety disorders.

TYPES OF ANXIETY DISORDERS

Anxiety disorder is a serious mental illness. For people with anxiety disorders, worry and fear are constant and overwhelming, and can be crippling. There are several types of anxiety disorders which are briefly explained here.

Generalized Anxiety Disorder: This disorder involves persistent and excessive worry, often about daily activities like work, family or health, with associated physical symptoms. This worry lasts for at least six months; that makes it difficult to control and lead to problems in concentration, restlessness and difficulty sleeping.

Phobias: Phobias are a disabling fear that not really dangerous; this fear may lead to avoid some objects or circumstances that cause feeling of dread. Common (specific) phobias include fear of particular things such as: flying, some animals; spiders, pets and other animals, heights or small or enclosed spaces, fear of blood and injury.

Panic Disorder: Panic disorder or panic attack occurs repeatedly without warning. A person suddenly gets overwhelmed with fear and displays symptoms like fear of dying, feeling disconnected, upset stomach, heart palpitations, and chest pain.

Obsessive Compulsive Disorder (OCD): People with OCD perform compulsions several times each day in order to temporarily release their anxiety that something bad might happen to themselves or to someone they love.

Social Anxiety Disorder: This type is common in people that fear of social situations that may lead to some problems in personal relations and at work. People with SAD have severe anxiety about being criticized or negatively evaluated by others for "saying something stupid". However, this leads them to avoid social events and being afraid of doing something that embarrasses them.

Post-Traumatic Stress Disorder (PTSD): It is caused by exposure to traumatic or frightening event. Severe symptoms include flashbacks, nightmares, being easily scared or startled, feeling irritable / angry / numb.

GENERALIZED ANXIETY DISORDER (GAD)

Generalized Anxiety Disorder is a type of anxiety disorders, and it is called “Basic” anxiety disorder, which is a component of other anxiety disorders (Brown et al., 2001).

Generalized anxiety disorder considered as a condition of ongoing anxiety and worry about many happenings or feelings that the patient generally identifies as extreme and unsuitable.

Anxiety in GAD is a sense of uncontrollability focused largely on possible future threat, danger, or other potentially negative events. Thus, this state can be roughly characterized as a state of helplessness, because of a perceived inability to predict, control, or obtain desired results or outcomes in certain upcoming personally salient situations or contexts. This negative affective state is accompanied by a shift in attention toward focusing on self or a state of self-preoccupation in which evaluation of one’s inadequate capabilities to deal with the threat is prominent. After this negative state, is a strong physiological or somatic component that may reflect activation of distinct brain circuits associated with engagement of the corticotropin-releasing factor (CRF) system and Gray’s behavioural inhibition system (BIS) (Sullivan, Kent, & Coplan, 2000; Gray & McNaughton, 1996; Chorpita & Barlow, 1998). This somatic state may be the physiological substrate of “readiness,” which may underlie a state of preparation to counteract helplessness. Vigilance (hypervigilance) is another characteristic of anxiety that suggests readiness and preparation to deal with potentially negative events. Anxiety if put into words will be, “that terrible event could happen again, and I might not be able to deal with it, but I’ve got to be ready to try”. It is often termed as “anxious apprehension.” It means that anxiety is a *future-oriented* mood state in which one is ready or prepared to attempt to cope with upcoming negative events.

DIAGNOSTIC CRITERIA FOR DSM-IV GENERALIZED ANXIETY DISORDER

1. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
2. The person finds it difficult to control the worry and
3. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).
 - restlessness or feeling keyed up or on edge
 - being easily fatigued
 - difficulty concentrating or mind going blank
 - irritability
 - muscle tension
 - sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning for the diagnosis to be made.

GAD is found more in females than males and the onset is early adulthood in the early 20s. Reddy and Chandrashekhara (1998) in their meta-analysis of 13 psychiatric epidemiological studies with a total sample size of 33,572 subjects, yielded an estimated prevalence rate of 20.7% (18.7-22.7) for all anxiety disorders, which was reported to be highest among all psychiatric disorders. Their meta analysis found different prevalence rates of different anxiety disorders. The study found that 4.2% were phobias, 5.8% was GAD, 3.1% was OCD and 4.5% was conversion disorder.

SYMPTOMS OF GENERALIZED ANXIETY DISORDER

There are three main symptoms of GAD.

Emotional Symptoms: Emotional symptoms include non-stop worrying and uncontrollable anxiety. The individual is not able to stop thinking about those thoughts that cause anxiety. The individual also loses the ability to tolerate uncertainty and desperately wants to know the future.

Physical Symptoms: These symptoms are physiological changes that include biological effects on the body that resulted from anxiety. Generally, these symptoms reflect elevated sympathetic autonomic nervous system activity (blood pressure, muscle tension and so on) (Reuschel, 2011).

Behavioral Symptoms: The behavioral symptoms influencing the act of the patients; they have no ability to relax, or enjoy quiet time (e.g. being easily fatigued) (Barlow et al, 1992).

These three types of symptoms include the following symptoms: difficulty concentrating, difficulty sleeping, irritability, fatigue/exhaustion, muscle tension repeated stomach aches or diarrhea, sweating palms, shaking, rapid heartbeat and neurological symptoms such as complaints of numbness/tingling of different parts of the body.

Cognitive model of GAD: Cognitive theories posit that appraisal plays the pivotal role in anxiety. The appraisal process involves two stages, a primary appraisal in which an individual determines the threat posed by the environment and following a threatening primary appraisal a secondary appraisal where the individual evaluates his or her ability to cope with the demand imposed by the environment. Beck and Emery (1985) suggests that maladaptive anxiety results from distortions in the appraisal process. People who suffer from chronic anxiety are those who misperceive benign situations as threatening. Barlow (1988) extends the appraisal model and suggests that anxiety is cognitive-affective phenomena, at the core of which is negative affect. Perceptions of threat are influenced by early experiences with uncontrollability that creates a psychological vulnerability to anxiety and a biological disposition to experience anxiety in the face of negative events. Specifically, negative events; activate the biological vulnerability to stress, leading trait-anxious individuals to perceive the environment as threatening even in the absence of identifiable stressor.

Meta-cognitive Model: Wells (2009) developed the metacognitive model of generalized anxiety disorder (GAD). This model focuses on the role of metacognitive beliefs (i.e., thoughts about thinking) in the development and maintenance of emotional disorders and suggests that positive beliefs about the benefits of worry (e.g., “Worrying helps me cope”) and negative beliefs about the danger and uncontrollability of worry (e.g., “my worrying is bad for me”) are associated with pathological worry. This model has led to the development of new treatments for pathological worry, with research suggesting that modifying beliefs about worry enhances treatment outcome in anxiety disordered adults (Wells & King 2006).

Worry and Generalized anxiety Disorder: Worry has been described as “a chain of thoughts and images, negatively affect-laden and relatively uncontrollable” (Borkovec et al. 1983, p. 10). Similarly, Vasey and Daleiden (1994, p. 186) describe worry as “primarily an anticipatory cognitive process involving repetitive, primarily verbal thoughts related to possible threatening outcomes and their potential consequences.” Worry is also a feature of other anxiety disorders, including separation anxiety disorder and social phobia (Perrin & Last 1997). For example, a child with separation anxiety disorder may worry about losing or separating from his or her parent, and so may have difficulties attending school or sleeping on his or her own. Clinical worry is also associated with risk of comorbidity with other anxiety disorders and depression.

THE ROLE OF METACOGNITION IN WORRY

Wells (2004) defined metacognition as “the cognitive processes, strategies, and knowledge that are involved in the regulation and appraisal of thinking itself” (p. 167). Vasey (1993, p. 23) suggests that metacognition “involves introspective knowledge about (1) one’s cognitive states and abilities and their operation, and (2) strategies and procedures for effective problem solving”, and is “the nonconscious operations of a central executive that organizes and guides cognitive activity such as problem solving”. The main focus of the model has been on the metacognitive factors associated with pathological worry in adults with GAD. Wells hypothesized that worry is maintained by metacognitive beliefs concerning the benefits and dangers of worrying. Initially, it is triggered as a coping response by an intrusive thought (e.g., “What if I get cancer?”) and is primarily focused on a range of issues including physical health, social, or financial concerns. This is known as Type 1 worrying. Positive metacognitive beliefs are linked to the usefulness of worry as a coping strategy, and these beliefs include “Worrying helps me cope” or “If I worry I’ll be prepared”. Wells suggests that positive beliefs about worry are normal and should be observed in clinical and non-clinical populations.

Individuals with GAD are differentiated by the activation of negative beliefs about worry, specifically the uncontrollability (e.g., “my worrying thoughts persist, no matter how I try to stop them”) and the danger (e.g., “Worrying will make me go crazy”) of worry. The activation of these beliefs contributes to negative appraisals of worry, including worrying about worry, which is known as Type 2 worry or meta-worry. Negative emotions associated with meta-worry, such as increased anxiety, make it increasingly difficult for the individual to recognize that it is safe to stop worrying.

Wells (2009) posits that type 2 worry contributes to two feedback cycles that maintain the worry process. First, behaviours such as reassurance seeking or avoidance of cues that trigger worry maintain negative beliefs about the danger and uncontrollability of worry. This is because the individual relies on external information to control their thoughts, they miss out on opportunities to learn that worrying is controllable and harmless, and they are prevented from learning more adaptive coping strategies. The second feedback cycle relates to thought control strategies, such as suppression of thoughts that trigger worry. Thought-control strategies are hypothesized to actually increase the number of thought intrusions and reinforce the belief that worry is uncontrollable. There is also a failure to interrupt the worry process.

ADJUSTMENT

In psychology, adjustment refers to the behavioural process by individuals to keep equilibrium within their different needs and requirements or between their needs and the difficulties of their environment. In addition, when a need is felt; the adjustment process begins, and it ends when that need is satisfied (Ganai & Mir, 2013). The concept of adjustment is originally a biological one and was a cornerstone in Darwin’s theory of evolution (1859). Darwin maintained that only those organisms most fitted to adapt to the hazards of the physical world survive. Everyone is facing such situations for his survival or growth which arise of individual’s physiological, psychological or social needs. The strategy used by an individual to accommodate oneself to changing circumstances is called Adjustment. When an individual is successful and satisfied with his efforts then it is a case of good adjustment.

Adjustment is a continual process by which a person varies his behaviour to produce a more harmonious relationship between himself and his environment (Gates & Jersild, 1970).

Adjustment is a “continuous process that tends to carry out more or less changing attitudes throughout the individual’s life, and it is a lifelong process and can be defined as a person’s interaction with his environment, also It is a process in which an individual learns certain ways of behavior determinants of mental health” (Mohan & Singh, 1989).

Adjustment process involves four parts (Mundada & Hatkanagalekar, 2013):

- 1) a need or motive in the form of a strong persistent stimulus;
- 2) the thwarting or no fulfillment of this need;
- 3) varied activity, or exploratory behavior accompanied by problem solving; and
- 4) some response that removes or at least reduces the initiating stimulus and completes the adjustment.

Adjustment to a changing situation or to any clinical disorder is a function of multiple factors including one’s personality style, coping strategies, nature of the disease, support system available, patient’s own internal resources and perception toward the illness.

METHODOLOGY

The aim of the current study was to examine adjustment in patients diagnosed with Generalized Anxiety Disorder.

Research Design

The present study used cross-sectional design to examine the variables.

Participants

The participants were selected from Psychiatric Hospitals and Psychological clinics. The size of the clinical sample was 114, out of which 40 (35.08%) belonged to major depressive disorder, 39 (34.21%) to generalized anxiety disorder and 35 (30.70%) patients having mixed anxiety and depression. Purposive sampling was used to collect the data. Each group was further divided with respect to demographic variables (age, gender, marital status and residential area). 20 patients belonged to an age group 18-21 years, 15 patients to 22-25 years and 4 patients belonged to a group more than 25 years. In terms of gender, 29 patients were male while 10 were females. In terms of marital status, 28 patients were single and 11 were married. Of the total sample, 31 patients were from urban while 8 from countryside background. The patients between the age group of 18 to 35 years were included in the study. The current paper will focus only on the adjustment of clinically diagnosed GAD patients.

The data was taken after taking written permission from the patients and following ethical guidelines including confidentiality of the results, and informing them that the findings may or may not be beneficial for them.

MEASURES

a) Sociodemographic Data Sheet

This was prepared by the investigator for collecting information about the patients' name, gender, age, city, countryside or urban and marital status.

b) Adjustment Scale

It was developed by Barakat (2006) and adopted by the researcher to measure the university student's ability on social and psychological adjustment. It is a 30 item scale with two point response categories. If the patient agrees with the item, score of 2 was given and if he/she disagrees then the score of 1 was given. It has a reliability of 0.74 and the content validity was satisfactory. The internal consistency of the scale on the current sample was found to be 0.99. In the current research, the researcher translated the English version of the scale into the Arabic language because the patient group was fluent in Arabic.

PROCEDURE

The researcher translated the original English Adjustment test questionnaire into Arabic language to match sample of the study. Expert opinion was taken and their suggested comments were incorporated so the items conveyed the same meaning and made them easy to understand. The researcher met the hospital management and sought written permission from them before the collection of data. The management and the patients were also explained the purpose of the research. The data was collected by mean of face to face interaction.

DATA ANALYSIS

The protocols were scored and the mean and standard deviation of the scales were calculated. Cronbach alpha was used to calculate reliability of the scale on the current sample. Frequency distribution was also used to describe the sociodemographic details.

ETHICAL CONSIDERATIONS

1. Written informed consent was taken from all the participants.
2. The clinics and hospital managements were assured that the confidentiality of the results will be maintained.
3. The researchers reassured the patients and hospital/clinic management that the research processes would not in way increase the symptoptology of the patients and hamper their clinical interventions.
4. The clinics and the hospital managements were informed about the implications of the study.
5. The patients were informed that they could contact the investigator in case they need any psychological help.

RESULT AND DISCUSSION

Table 1: Showing Mean and S.D scores on the level of Adjustment in the patients of generalized anxiety disorder

	Adjustment		Level	Possible Value
	Mean	S.D		
Generalized anxiety disorder	1.15	0.33	Low	1.00-1.33

The study used Mean and S.D to show the level of adjustment in the patients of generalized anxiety disorder.

- The Low degree from 1.00- 1.33
- The Medium degree from 1.34 – 1.67
- The High degree from 1.68 – 2.00

Table 1 indicates that the level of adjustment in the patients of generalized anxiety disorder was found to be the low with mean as 1.15 and SD as 0.33. Clinical condition like GAD significantly impairs their overall day to day functioning. People with generalized anxiety disorder are pre occupied with constant worry, tension and threat of an unknown. This often led them to avoid many situations related to their interpersonal, and occupational functioning. This in turn might lead to their poor and low adjustment. GAD patients have cognitive threat perception and so often have pessimistic outlook, they do not experience pleasures of their usual pleasurable activities. They often experience irritability and anger because of their clinical condition. This might often lead others to avoid them which in turn increase their irritability and anger toward people. This vicious cycle goes on and leads to their poor interpersonal relationship and adjustment.

Patients with anxiety in general and GAD specifically often have poor social skills, and have difficulty initiating relationship, communicating effectively which often might be the cause of their poor adjustment. These patients also have difficulty in attention and memory. This could also be the reason of their poor functioning in their day to day life and hence poor adjustment.

CONCLUSION

The findings of the current study indicated that patients with generalized anxiety disorder were found to be poor and low in their adjustment in their day to day functioning. Besides focusing on psychological interventions, mental health professionals need to train these patients in effective coping skills like acceptance, re framing, seeking social support and active engagement in the therapeutic process which will aid in their faster recovery and decrease the chances of their relapse.

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