Anxiety has been with us since time immemorial. One could even go as far to say that some levels of anxiety and worry are part of the human condition. This is especially the case when our anxieties and worries are reactive to events and situations that warrant such emotional responses. An expert in the field has articulated, it is the “how” anxiety sufferers worry that often determines whether anxiety is pathological and not the “why.”

Generalized anxiety disorder (GAD), a mental disorder marked by persistent anxiety, somatic tension, arousal and excessive worry (albeit about “realistic” domains of life), has a long history but a short past. Beginning with Freud’s seminal article placing a host of related symptoms under the rubric “anxiety neurosis,” such as the following: free floating anxiety, general irritability, excessive worry, anxious expectation, chronic apprehension, anxiety attacks, and phobic avoidance, foreshadowed our current conceptualization of a generalized anxiety syndrome.

However, it was not until almost a century later, with the advent of the Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-III-R) that GAD was teased out from panic disorder (which was also alluded to in Freud’s classification of anxiety neurosis) and given a certain level of legitimacy. Even though GAD has become a “stand alone” psychiatric disorder, it remains misunderstood, and 30 years of multiple evolutions in its criteria have made research efforts challenging.

Having given a brief historical context to GAD, it has only been over the past 10 to 15 years that research on GAD has begun to take off in various academic centers around the world. This is of critical import, as the condition affects about 5% of the population, which translates into millions of individual sufferers. It also exacts a large societal toll and leads to profound impairments in broad areas of functioning. Yet it has been and remains a somewhat neglected diagnosis in contrast to other disorders de jour, such as bipolar disorder, borderline personality disorder, and even attention deficit disorder. The symptoms of GAD are less overt and florid by comparison to other psychiatric conditions, but there is little debate among thought leaders in the field that GAD is a highly debilitating condition.

The timeliness and importance of this special issue cannot be overstated. The overarching purpose of this issue on GAD has been to assemble some of the best in the field in order to provide an array of relevant topics to offer the busy clinician: an increased conceptual knowledge of GAD and practical interventions to better treat these complex patients.

The opening article by Turk and Mennin (see page 71) focuses on the “nuts and bolts” of GAD by addressing such areas as the evolution of GAD, classification issues, worry as a central feature, prevalence, comorbidity, course/prognosis, and impairments caused by the condition. It gives a comprehensive introduction to GAD, laying the groundwork for the other articles. Dr. Mennin is also one of the leaders in emotion-based approaches to psychopathology and the founder of an emotion dysregulation model (see article by Fisher and Wells on page 127) and treatment for GAD.

The follow-up article (Portman et al., see page 78) on the inherent challenges assessing and diagnosing GAD provides a foil to the initial ar-
article by offering a critique that the defining nature of GAD is worry. This article offers a broader and divergent perspective not commonly discussed in the literature, which is that GAD is much more heterogeneous than many experts in the field have believed and articulated over the years. This article, in particular, offers an alternative evidence-based view to current recommendations being advanced by those involved in the anticipated DSM-V criteria. The inclusion and endorsement of Dr. Aaron Beck, one of the pioneers in mental health and founder of cognitive behavioral therapy, has been a great honor for this guest editor. In addition, the article gives the clinician some clues to GAD’s presence and helps in better detecting and diagnosing the disorder, teasing it out from other commonly co-occurring conditions, such as major depression, social anxiety disorder, panic disorder, and posttraumatic stress disorder, to name a few.

The article by Fisher et al. (page 127) discusses the most commonly researched conceptual models for GAD. According to certain authorities, these models have countered the stagnation in treatment for GAD by highlighting the mechanisms driving the disorder and now serving as a vehicle to stimulate subsequent evidence-based treatment approaches. The authors focus on four models describing their basic premises and empirical support to advance the given hypotheses. Both of these experts are steeped in their knowledge of all the models, but in particular the metacognitive model. One of them, Dr. Adrian Wells, also happens to be the founder of this approach.

CBT has been the most studied and effective treatment for GAD. Hoyer et al. (see page 87) review the most basic CBT components in the psychotherapy of GAD but extend their discussion to several “cutting edge” treatment approaches. Other scholars view integration as the wave of the future; integration is what holds the keys to success in the psychotherapy of GAD. These novel approaches have also been referred to as “cognitive hybrids,” offering the best CBT has to offer with integrations focusing on diverse mechanisms that target different aspects of the disorder. Questions still remain about these mechanisms of change and how to find better ways to account for both their explanatory power (see Fisher and Wells on page 127) and the means with which they, in fact, affect positive treatment outcomes.

In turning to the biological side, the article by Katzman et al. (see page 95) addresses first line pharmacotherapy...
treatments for GAD with a focus on antidepressants. Selective serotonin reuptake inhibitors (SSRIs) and selective serotonin-norepinephrine reuptake inhibitors (SNRIs) have become mainstays for GAD sufferers and their effectiveness has been proven in multiple randomized-controlled trials. They are not without problems, as the authors discuss. The added plus of this article is in the mentioning of their use in special populations; children/adolescents, and geriatric GAD.

Given that not all GAD sufferers respond to first lines, the article that follows (Starcevic et al. see page 104) broaches the concept of treatment-refractory GAD and extends the range of pharmacologic options. The article is both realistic about what pharmacotherapy can and cannot do and discusses various evidence-based protocols to enhance response rates. The authors also pave the way for consideration of psychological treatments, either in combination with pharmacologic ones (although there is a paucity of research on combination treatments) or alone.

The next article (see page 113) is one not for the scientifically challenged. Charles Nemeroff, an internationally known psychiatrist and expert on neurobiology of GAD, and his group’s contribution to this article have not gone unnoticed. The subject is a complex one and still in its infancy, but the authors do an excellent job flushing out what is known about both the neurobiology and genetics of GAD.

This topic has provided some evidence to date that certain brain areas, such as the amygdala and others may play a role in the heightened responses of GAD sufferers to perceived and aversive threats. For both the novice and seasoned researcher in this area, the article is an intriguing look at a topic that offers a much needed counterbalance to our already existing knowledge about the psychology of GAD. What we may end up finding out in the end is that, not unlike in most psychiatric conditions, the choice will not have to be made between psychology vs. biology in our approach to GAD. It will prove to be to what degree both influences contribute to the development and maintenance of this condition, which is still difficult to recognize and treat.

Ideally, after reading this issue, the clinician will come away with an enhanced understanding and some better ways to optimize their treatment of these patients. We have come a long way since Freud’s early intimations and thoughts, but we still have a longer way since Freud’s early intimations and thoughts, but we still have a longer distance to travel before the restless mind of those who suffer from GAD has grown even calmer.

I want to end by offering my deepest appreciation to all the editors at Psychiatric Annals for inviting me to be the guest editor for this special issue on generalized anxiety disorder. I am also highly grateful to my expert colleagues who accepted my invitation to participate in this important project. The readers of this publication will ultimately benefit from the breadth and depth of their knowledge and experience on GAD.

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REFERENCES