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Generalized anxiety disorder in dysfunctional families

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Abstract

The purpose of this study was to investigate the relation between persistent prolonged dysfunction in parents and the development of Generalized Anxiety disorder (GAD). Initially, 940 adult subjects from a general practice were studied. Thirty-two parents aged 24 to 61 yr diagnosed with GAD served as the experimental group, while 117 healthy normal parents aged 24–66 yr made up the control group. The rate of dysfunctional families with parents diagnosed with GAD was significantly higher than in families with parents not diagnosed with GAD. Family dysfunction was associated with parents' age both in men and in women. GAD was not connected with (1) parents' age, (2) education, (3) employment, (4) country of origin or (5) number of children in the family. There was no significant difference between men and women in onset and duration of GAD. Implications for diagnostic and treatment issues are discussed. © 1998 Elsevier Science Ltd. All rights reserved.

1. Introduction

GAD, as defined in DSM-III-R (American Psychiatric Association, 1987) is one of the anxiety states persisting for six months or more, and includes physiologic and psychologic manifestations of anxiety (Diamond and Grauer, 1987). The prevalence of GAD is estimated at between 2% and 5% of the normal population and 6–27% of psychiatric outpatients (Marks and Lader, 1973).

There are reports in the literature suggesting an association between significant, unexpected, negative events and the onset of GAD (Blazer et al., 1987), and the presence of a genetic factor in GAD (Noyes et al., 1987; Torgersen, 1983).

Currently, there are no systematic studies relating persistent, severe, prolonged, intercouple conflicts and the development of GAD in one or the other partner. This

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study was conducted (1) to test the validity of the relationship between GAD and severe family dysfunction and, (2) to investigate whether or not intercouple dysfunction generates GAD.

2. Method

The present study was conducted at a Family Medicine clinic in a Southern Israeli urban district by a family physician (specialist in Family Medicine) with training in psychiatry, caring for 940 patients whose ages ranged from 18 to 80 yr. It encompassed families which represent married parents living together with their children. Widows and widowers, divorcees, single and childless parents were excluded. Information relating to the diagnosis of GAD was obtained from medical files. Patients were evaluated using the Structured Clinical Interview for DSM-III-R Patient Version (SCID-P) (Spitzer and Williams, 1985), which is a validated instrument for the diagnosis of anxiety disorders (Skre et al., 1991).

Forty four patients were diagnosed with GAD. Ten of these patients were excluded from the study because (a) some of the features related to GAD could have been due to a physical illness (e.g., hyperthyroidism), (b) the patient showed features of another psychiatric illness (e.g., depression) (Noyes and Clancy, 1976), or (c) GAD existed before marriage. The remaining 34 patients were interviewed by a senior family physician (L.B.) in order to confirm the diagnosis of GAD. Subsequently, every patient was interviewed by a senior psychiatrist in the regional psychiatric clinic. Two other patients suspected of having a panic attack were excluded leaving 32 patients (9 men and 23 women) in the study. The final diagnosis was made on the basis of medical records and notes, and from the follow-up examinations during the course of the study.

A control non-GAD group was selected from the same practice, and comprised 117 patients (56 men and 61 women) who had never suffered GAD, and who happened to visit the clinic during a single month (October, 1994) for reasons unrelated to GAD. Patients were not included in the control group if the symptoms of their physical illness resembled in any way to those of GAD (Noyes et al., 1980).

In this research study two levels of a family function were defined: families with disturbed function (moderate and severe dysfunction), and families functioning well. This assessment was based on Smilkstein's Family Apgar (Smilkstein, 1978) which is a reliable, valid and clinically practical assessment instrument (Doherty and Baird, 1983). The acronym APGAR stands for Adaptation Partnership Growth Affection and Resolve which are core elements of family functioning that are purported to be tapped by the instrument. The Family Apgar is a five-item paper and pencil test designed to elicit the patient's perceptions of his or her family relationships. The scores for each of the five questions are totaled. A score of 7–10 indicates a highly functional family; a score of 4–6 indicates a moderately dysfunctional family; a score of 0–3 indicates a severely dysfunctional family (Smilkstein, 1984).

The dichotomous classification of a family function represents a clinical research experience as described in previous studies (Ben-Noun, 1989, 1991, 1993). The families from both groups were followed from October 1994 until December 1995. Prevalence

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