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Generalized anxiety disorder: is there any specific symptom?

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Abstract

Objective: The main aim of the present research was to evaluate the coherence of generalized anxiety disorder (GAD) psychopathological pattern, the robustness of its diagnostic criteria, and the clinical utility of considering this disorder as a discrete condition rather than assigning it a dimensional value.

Method: The study was designed in a purely naturalistic setting and carried out using a community sample; data from the Sesto Fiorentino Study were reanalyzed.

Results: Of the 105 subjects who satisfied the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) criteria for the diagnosis of GAD, only 18 (17.1%) had no other comorbid *DSM-IV* disorder. The most frequent comorbid condition was major depressive disorder (70.4 %). Only 2 of the GAD diagnostic symptoms (excessive worry and muscle tension) showed a specific association with the diagnosis itself, whereas the others, such as feeling wound up, tense, or restless, concentration problems, and fatigue, were found to be more prevalent in major depressive disorder than in GAD.

Conclusion: Our study demonstrates that GAD, as defined by *DSM-IV* criteria, shows a substantial overlap with other *DSM-IV* diagnoses (especially with mood disorders) in the general population. Furthermore, GAD symptoms are frequent in all other disorders included in the mood/anxiety spectrum. Finally, none of the GAD symptoms, apart from muscle tension, distinguished GAD from patients without GAD.

1. Introduction

Generalized anxiety disorder (GAD) was introduced as a separate diagnosis in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) [1]. Since its introduction, GAD has been criticized based on the following considerations:

- A clear clinical prototype has not been identified [2].
- Comorbidity is extremely frequent; GAD is frequently comorbid with major depressive disorder (MDD), panic disorder (PD), social anxiety disorder, and specific phobia, and it is often associated with chronic pain conditions, medically unexplained somatic symptoms, and sleep disorders [3,4].
- The specificity of the symptoms of GAD is poor; in fact, 4 of the 6 associated physical symptoms of GAD (ie, restlessness, fatigue, difficulty concentrating, sleep difficulties, obsessive rumination, and somatization) are also part of the diagnostic criteria for MDD [2,5]. Conversely, 4 of the symptoms required for MDD (ie, sleep difficulties, psychomotor agitation, fatigue, and difficulty concentrating) overlap with GAD ones [2]. Moreover, symptoms required for the diagnosis of GAD are also present in other anxiety disorders because closer overlaps probably exist between GAD and PD or social anxiety disorder [6].

In the subsequent editions of *DSM* (viz, *DSM-III-R* and *DSM-IV*) [7,8], the American Psychiatric Association changed substantially the diagnostic criteria of GAD, but none of the above issues were solved. Reasonably, the continuous changes of the diagnostic criteria seem to reflect the difficulties in defining a stable constellation of interrelating symptoms associated to a specific population.

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Therefore, many authors challenged that GAD, as an independent disorder, may represent the best conceptualization for organizing and explaining the complexity of a heterogeneous cluster of psychopathologic conditions [2]. It has been proposed that GAD should be considered as a prodromal condition, a residual form, a severity marker for other psychiatric disorders (such as MDD), or simply an indicator of general distress rather than a syndrome [9-17].

On the other hand, other authors claim that GAD should be considered as an independent disorder [4,15,16,18-20].

According to the first definition stated by Sydenham in 1742, a syndrome consists of several interrelated symptoms showing a stable characteristic structure and a peculiar prognosis [21]. Patients affected by a specific syndrome should share a sufficiently pathognomonic (specific) cluster of symptoms that should be more frequent in these subjects compared with patients having other morbid conditions. The concept of *discontinuity among different syndromes* was conceptualized by Sneath [22], who introduced the term *point of rarity*, which referred to precise clinical boundaries among disorders, and was later revised by Kendell [23] and Kendell and Jablensky [24], who preferred the concept of *zone of rarity*. According to this definition, if a syndrome corresponds to a natural entity, then we should find a natural boundary or a discontinuity between this condition and its clinical "neighbors." Mixed conditions can exist, but they have to be less common than the pure forms [25].

According to this construct, a cluster of proposed criteria (eg, symptoms, laboratory markers, exclusion criteria, course, and outcome) [26-28] should be associated with a specific population of patients to establish the validity of a diagnosis [21,23,29].

Moreover, individuals included into a diagnostic category should share other distinctive features in addition to those used to include them in that category.

In line with previous observations, Brown and Barlow [30] have recently considered the problem of sensitivity and specificity of GAD and have concluded that *DSM-IV* criteria for GAD do not differentiate a patient with GAD from a patient with clinical depression [31] because the exclusion of the autonomic symptoms from *DSM-IV* criteria for GAD might obfuscate the boundary between MDD and GAD. In fact, muscle tension appeared to be uniquely related to worry, whereas difficulty concentrating appeared to have a very strong relationship with depression [2].

Moving from these concepts, the main aim of the present research was to evaluate the coherence of GAD psychopathological pattern, the robustness of its diagnostic criteria, and the clinical utility of considering this disorder as a discrete condition rather than assigning it a dimensional value. The approach we adopted resembled similar researches in this field, attempting to corroborate the validity of the constructs of different diagnoses, such as major depression [32].

The study was designed in a purely naturalistic setting, using a community sample (the Sesto Fiorentino Study, Faravelli et al [33]) with a "bottom-up" design in which symptoms were assessed by clinical psychiatrists according with a nosographic system of reference, unlike most large community surveys.

2. Methods

Data from the Sesto Fiorentino Study, which has been described in detail elsewhere [33], were reanalyzed. Briefly, a representative sample of 2500 subjects aged older than 14 years and living in the municipality of Sesto Fiorentino (close to Florence, central Italy) has been interviewed by their own general practitioners. A total of 609 subjects who resulted positive at a first screening with the Mini-International Neuropsychiatric Interview [34] as well as a subsample of the cases who resulted negative were reassessed by interviewers with clinical experience by means of the Florence Psychiatric Interview (FPI) [35]. The FPI is a fully validated instrument that combines several well-established and validated assessment procedures (rating scales and semistructured interviews) into a single interview, aimed at exploring the psychopathology and its connected factors in nonclinical samples. Because the FPI is a typical bottom-up procedure where symptoms are explored regardless of any predefined diagnostic system, the study of the natural relationship of symptoms and/or sets of symptoms is well suited. Because all questions of the Structured Clinical Interview for *DSM-IV* [36] are included in the FPI, the *DSM-IV* diagnoses generated by computerized diagnostic algorithms, using these data, were totally coherent to those derived by the Structured Clinical Interview for *DSM-IV* [33]. The FPI is primarily centered on the episode:first, it attempts to isolate a period of illness, and then, it explores the aspects of that episode. The FPI was built without relying on any predefined classifications, and one of its goals is to collect ample sets of data to test, verify, and hypothesize different proposal for classifying cases.

A total of 121 symptoms, including most of those listed in the *DSM-IV*, are explored independently of their diagnostic value. All subjects were asked to provide written, informed consent, and the Sesto Fiorentino Study was approved by the local ethical committee. For the present study, all patients who reported at least 1 of the symptoms of GAD during the last 2 years were selected: (1) feeling wound up, tense, or restless; (2) easily becoming fatigued; (3) difficulty concentrating; (4) irritability; (5) muscle tension; and (6) sleep disturbance (difficulty falling or staying asleep or restless and unsatisfying sleep). The final sample was composed by 375 subjects (201 women, or 53.6%) with a mean age of 47.2 ± 14.7 years (years ± SD).

3. Results

Of the 375 subjects considered, 105 met the *DSM-IV* diagnosis of GAD. The other diagnoses were MDD (n = 130), dysthymia (n = 24), depression not otherwise specified