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Original Article

Life Experiences of Patients with Generalized Anxiety Disorder (GAD) Comorbid with Emotional Disorders: A Qualitative Study

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Abstract

Introduction: A deeper understanding of generalized anxiety disorder (GAD) provides many clues to what causes anxiety disorders and what treatment is needed. The present study aimed to investigate the life experiences of patients with GAD comorbid with emotional disorders.

Methods: The present research was a qualitative one carried out based on the phenomenological approach. The participants in the study were 10 patients with GAD comorbid with emotional disorders who were selected using purposive sampling method based on data saturation. A semi-structured face-to-face interview was used to collect data. The texts of the interviews were analyzed by the phenomenological approach using Colaizzi's seven-step method.

Results: The results of analysis of data derived from the interviews revealed four main themes and 13 subthemes including components of illness (worry, cognitive component, behavioral component, emotional component, physiological component), influential factors (sociocultural factors, psychological vulnerability, developmental history), consequences of illness (quality-of-life impairment, interpersonal problems), and treatment (self-care, expectations of treatment, limitations and barriers to treatment(.

Conclusion: The themes identified in this study by phenomenological method based on lived experiences of patients provided new information about the etiology, consequences, and treatment of this disorder.

Keywords: Life experiences, Phenomenology, General anxiety disorder, Emotional disorder

Introduction

Emotional problems as common, chronic, costly and debilitating disorders, affect the lives of millions of people around the world (1). Among these, anxiety disorders are highly prevalent ian the adult population and are associated with increased disability, poor quality of life, and cognitive impairment (2). Generalized anxiety disorder (GAD) is one of the most common chronic and unpleasant anxiety disorders (3) in primary care settings, characterized by persistent anxiety and worry (4-6). A recent study in Iran reported a 2.6% lifetime prevalence of GAD (7).

Studies show that GAD can rarely be seen without comorbid disorders (8, 9). Around 90% of patients with GAD experience at least one other psychological disorder at the same time (10). GAD has a high comorbidity with other anxiety disorders and depression (11-14). Compared to people with an anxiety or depression disorder, people with comorbid anxiety and depression have higher rates of suicidal ideation, higher levels of psychological trauma, and worse prognosis (15), academic dysfunction, and more job and social problems (16). In general, the presence of comorbid psychiatric disorder can affect various clinical aspects of the disorder, such as the complexity of the clinical appearance and diagnosis, treatment choice, and even response to treatment and acceptance of treatment by patients (17). Since comorbidity always exists between GAD and other emotional disorders, and comorbidity is always associated with a poor prognosis and more devastating consequences than other disorders, this issue needs more clinical attention (18).

Despite still being defined as extreme anxiety and worry upon performance and about one's health, GAD seems to be a general umbrella of anxiety, covering even social anxiety and panic disorder (PD) and even when not treated and chronic, leading to major depressive disorder (MDD) (19). As GAD is one of the major disorders in psychopathology and its basic features can reflect the main processes in all emotional disorders (8), a better understanding of GAD provides many clues as to what causes anxiety disorders and what needs to be done for treatment.

On the other hand, culture has been confirmed by researchers as an influential factor in the clinical manifestation of symptoms, etiology, expectation of treatment, adaptation to the disease, and the process of psychotherapy. Culture also influences the way illness experiences are described and understood as observable in clinical practice. There is strong data on intercultural variability in all symptoms of GAD. For example, in some cultural contexts, somatic symptoms predominate in the expression of the disorder, whereas in other cultural contexts cognitive symptoms tend to predominate (20).

Moreover, as diagnostic classes cannot penetrate patients' lived experiences, the need to examine lived experiences is highlighted. Studies on psychiatric patients have shown that many of these patients believe that the description of the disorder focuses on the external symptoms and pays less attention to the internal experiences. In many cases, the diagnostic description is far away from what patients perceive about their physiological, emotional, and psychological experiences, and they have a sense of incomprehensibility or neglect (21). For this reason, in order to better understand generalized anxiety disorder, future studies should address the phenomenological underlying mechanisms and treatment of this disorder (3).

It is of particular importance to study patients' experiences and efforts so as to find key components in the course of the generalized anxiety disorder and its psychopathology, as well as treatment plans based on these components that can improve treatment outcomes. Given the lack or absence of research on the lived experiences of these patients and the need for more information to understand the disorder, the present study was conducted to explain the lived experiences of patients with generalized anxiety disorder comorbid with an emotional disorder.

Methods

This study was a qualitative one conducted using a descriptive phenomenological method. Purposive sampling was adopted to select the participants and the sample size was determined according to the data saturation. At this stage, the researcher spent two months visiting the psychological service centers in Isfahan and Kermanshah to interview patients diagnosed with generalized anxiety disorder. After 10 interviews, no new information was added and the analysis was performed on 10 participants.

In this study, semi-structured interviews were used. For this purpose, a list of questions was prepared in advance and then asked during the interview. Interview questions were about patients' symptoms, factors involved in the onset and persistence of the illness, negative consequences of illness, patients' strategies for controlling or reducing symptoms, and their expectation of effective treatment. After giving a brief description of when the disease started and the current condition of the patients, the interview started with questions such as "Tell us about your experiences with generalized anxiety disorder" and "How has this disease changed your life?" Further probing questions were asked based on the interview route and the interviewees' answers. The interviews lasted between 17 and 40 minutes depending on patients' physical condition, mental state, occupation, and desire to talk as well as the process of the interview.

In qualitative research, the concept of trustworthiness

is used instead of two criteria of validity and reliability to evaluate the scientific rigor of research (22). This concept consists of four indices including credibility, transferability, conformability, and dependability (23). Therefore, the four indices were used in this study to assess the trustworthiness of the data. To ensure the credibility of the research findings, the researcher was long engaged with the topic, the data, and the participants. Moreover, after analyzing the data, the extracted codes were presented to the participants to verify their content. To ensure the transferability of the findings, the research process and all its steps were described in detail to allow other researchers to understand how the findings were obtained. To ensure conformability, the researcher tried not to interfere in the data collection process with her assumptions. To ensure the dependability of the findings, a number of experts were asked to review the interview transcripts and the extracted codes, verify their consistency with the participants' statements, and ensure the quality of the classifications.

Data analysis procedure was performed according to Colaizzi's seven-step method. This method has great potential and reliability and is a suitable way to discover, study, and analyze the details of people's lives (24). The seven steps were applied as follows: In the first step, at the end of each interview, the researcher first listened to the participants' recorded statements and put them verbatim on paper. In the second step, each note was referenced and important terms were extracted. The concept of each important phrase was developed in the third step, which was referred to as the adjusted concept. In the fourth step, the adjusted concepts were organized into subject categories. The findings were then integrated into a comprehensive description of the intended phenomenon. In the sixth step, a comprehensive description of the intended phenomenon was obtained in the form of an explicit statement. The final validation step was evaluated on the basis of validity and reliability criteria (25).

Results

In this study, semi-structured interviews were conducted with 10 participants (2 males and 8 females). The participants' level of education ranged from elementary to master's degree and most of the participants had a bachelor's degree. Table 1 depicts the demographic information of the participants.

The results of analysis of the interviews revealed 4 main themes including components of illness, influential factors, consequences of illness, and treatment as presented in Table 2.

Components of illness

This main theme points out to patients' experiences of various problems in the illness process. Symptoms and problems experienced by participants in different areas were classified into 5 subthemes including worry, cognitive component, behavioral component, emotional component and physiological component.

Worry: According to the results of the interviews, the participants reported worry in the personal and interpersonal domains. The content of worry in the present study was related to the occurrence of negative and traumatic events, health of oneself and others, work and occupation, education, financial issues, family members' safety and interpersonal relationships. Each of these codes had supporting semantic units that were mentioned by almost all interviewees. For instance, one of the participants stated, "*I have been worried as long as I can remember and anything can worry me. It seems that my worries are not over and there is always something to worry about*" (Participant 1).

Table 1. Demographic characteristics of the participants

Participant's Code	Age	Gender	Marital status	Education	Comorbid disorder
1	30	Male	Single	Bachelor's degree	Social anxiety
2	55	Female	Married	Elementary school	Depression
3	34	Female	Married	High school diploma	Depression
4	22	Female	Single	Bachelor's degree	-
5	24	Female	Married	Bachelor's degree	-
6	30	Male	Single	Master's degree	Social anxiety
7	21	Female	Married	Bachelor's degree	Depression
8	29	Female	Single	Bachelor's degree	Depression
9	27	Female	Single	Master's degree	Depression
10	45	Female	Single	Elementary school	Post-traumatic stress disorder

Table 2. Main themes and subthemes

Theme	Subtheme	Semantic codes
Components of illness	Worry	Occurrence of negative and traumatic events, Health of oneself and others, Work and occupation, Education, Financial issues, Family members' safety, Interpersonal relationships
	Cognitive component	Inability and uncertainty in decision-making, Doubt, Intolerance of Uncertainty, Futuristic thinking and negative perception of the future, Thought focused on threats and vulnerabilities, Lack of concentration and distraction, Disappointment
	Behavioral component	Fighting uncontrollability, Behavioral avoidance, Aggression, Isolation, Alertness, Safety behavior
	Emotional component	Irritability, Negative Emotion, Crying, Feeling guilty, Sadness, Shame, Emotional avoidance
	Physiological component	Physiological arousal, Sleep disturbances, Gastrointestinal problems, Muscle tension or muscle aches, Fatigue
Influential factors	Sociocultural factors	Instability and unpredictability of social and economic conditions, Sense of increased environmental threat, Superstitious beliefs, Religious beliefs
	Psychological vulnerability	Self-esteem, Social communication deficits, Meta-emotional components, Inability to tolerate ambiguity and uncertainty, Positive beliefs about worry, Future-oriented temporal orientation, Vulnerability schemas, Anxious temperament
	Developmental history	Experiencing trauma of childhood, Parenting style and Reverse parenting, Family history of illness
Consequences of illness	Quality-of-life impairment	Decreased performance, Decreased motivation, Self-blame and self-criticism, Experience of negative emotions, Irritability, Procrastination, Poor socioeconomic status, Chronic pain, Mental health problems
	Interpersonal problems	Worrying about what others think, Social isolation, Aggression, Interpersonal control, Stigmatization, Insecurity, Needing reassurance, Difficulty in expressing emotions
Treatment	Self-care	Safety behavior, Spiritual coping, Avoidance, Distraction, Self-relaxation, Rumination, Self-blame, Physical activity, Drug use, Seeking social support, Learning about illness, Accepting and seeking treatment
	Expectations of treatment	Improve performance, Increase quality of life, Eliminate worries and symptoms, Receive short-term and comprehensive treatment
	Limitations and barriers to treatment	Lack of awareness of the disorder, Stigma of mental illness, Lack of sufficient motivation

Cognitive component: Inability and certainty in decision-making, doubt, intolerance of uncertainty, futuristic thinking and negative perception of the future, thought focused on threats and vulnerabilities, lack of concentration and distraction, and disappointment were reported by the participants. Accordingly, one of the participants stated, *"The unpredictability makes me angry. I hate uncertainty; it worries me a lot"* (Participant 1).

Behavioral component: Fighting uncontrollability, behavioral avoidance, aggression, isolation, alertness, and safety behavior were some of the behavioral problems mentioned by participants. For instance, a participant said, "*Because I call my family a lot and give them so much advice about taking care of themselves, I have upset them too and there are often annoyances about these issues"* (Participant 5).

Emotional component: Emotional problems such as irritability, negative emotions, crying, feeling guilty, sadness, shame, and trying to control or avoid these emotions are manifested in the symptoms, etiology, and consequences of the illness. *"Basically, I cannot be happy like everyone else, I often suffer from a guilty conscience. If I get a little happy or excited in a certain environment, I immediately feel guilty*" (Participant 9).

Physiological component: This component was obtained from the semantic codes of physiological arousal, sleep disturbances, gastrointestinal problems, muscle tension or muscle aches, and fatigue. Accordingly, one of the participants stated, *"I have heart palpitations when I am worried, I have shortness of breath and gastrointestinal problems" (Participant No. 1).*

Influential factors

This theme includes factors that have been influential in onset and persistence of the disorder, which were obtained from 4 subthemes of psychological vulnerability, developmental history, sociocultural factors, and family history of the disease.

Sociocultural factors: One of the subthemes obtained regarding factors affecting the disorder was sociocultural factors. The factors related to culture and society included instability and unpredictability of social and economic conditions, sense of increased environmental threat, superstitious beliefs, and religious beliefs. *Participant 3 said, "How society views and how people judge me will definitely have an effect".*

Psychological vulnerability: This subthemes was obtained from the semantic codes of self-esteem, social communication deficits, meta-emotional components, inability to tolerate ambiguity and uncertainty, positive beliefs about worry, future-oriented temporal orientation, vulnerability schemas, and anxious temperament. Participant 7 reported having extreme and excessive worries about the possibility of not having children in the future, poor financial situation, and not finding a job. *Participant 2 said, "Sometimes, anxiety is very good and can save you from carelessness and you can do a lot of things. It makes me more focused, always ready and listening".*

Developmental history: The semantic codes of this subtheme included experiencing trauma of childhood, parenting style and reverse parenting, and family history of illness. In this regard, one of the participants stated, *"Mostly, the family environment was the cause of my anxiety because it was stressful; an unpleasant event in my childhood is also one of the causes of my illness"*) Participant 2(. Another participant said, *"My childhood and adolescence were full of hardship and stress; it was very difficult. Something happened to my Mather and father that affected me. For example, I was always afraid that they would die and I would be alone and helpless"* (Participant 5). Almost all participants in the present study acknowledged that their mother, father, or one of their family members also had the same illness or had a high level of anxiety.

Consequences of illness

This theme includes the shortcomings, limitations, and individual and interpersonal effects of the disorder on different functions of patients obtained from the subthemes of quality-of-life impairment and interpersonal problems.

Quality-of-life impairment: Decreased performance, decreased motivation, self-blame and self-criticism, experience of negative emotions, irritability, procrastination, poor socioeconomic status, chronic pain, and mental health problems were some of the factors that lowered the quality of life of patients causing most of them dissatisfied with their lives. For instance, one of the participants said, *"I am totally bored, tired, and unmotivated. I really do not have energy. I feel I do not have half the energy and motivation that everyone has and this issue has hit me so hard. With all the intelligence and talent I have, I could do many things and reach many things"* (Participant 5).

Interpersonal problems: The manifestations of interpersonal problems were mostly associated with worrying about what others think, social isolation, aggression, interpersonal control, stigmatization, insecurity, needing reassurance, and difficulty in expressing emotions. Participant 7 stated, *"Usually I do not have many relationships with others, I am always lonely; except with a few people, my friendships and relationships usually break down after a while".*

Treatment

This theme included various factors related to the control and reduction of anxiety and treatment such as self-care, expectations of treatment, and limitations and barriers to treatment.

Self-care: The semantic codes of this subtheme included safety behavior, spiritual coping, avoidance, distraction, self-relaxation, rumination, self-blame, physical activity, drug use, seeking social support, learning about illness, and accepting and seeking treatment. Participant 6 said, *"I do not know much about how to reduce anxiety or improve my condition. I pray more, I give alms, sometimes I listen to music, and sometimes I do sports and go for a walk to have some fun."* Another participant said, *"When I'm worried, I call people around me and my friends and check nothing bad happened. Sometimes, I consult with them and I calm myself by praying"* (Participant 8).

Expectations of treatment: The semantic codes of this subtheme included improve performance, increase quality of life, eliminate worries and symptoms, and receive short-term and comprehensive treatment. Most of the interviewees wanted to receive a treatment that, in addition to eliminating the symptoms of anxiety and illness, is tailored to their personal needs, is short-term and comprehensive, and empowers them in various

areas of personal life. Participant 1 said, *"I expect that as a result of the treatment, I will be able to get rid of my worries, reduce my anxiety, progress in life, and do things in my life well.* Participant 5 said, *"If there is a treatment that is ultimately 5-6 sessions, I would welcome it".*

Limitations and barriers to treatment: Lack of awareness of the disorder, stigma of mental illness, and lack of sufficient motivation were derived from semantic codes. For example, one of the participants said, *"The stigma of participating in psychotherapy is one of the reasons for not pursuing treatment and psychotherapy"* (Participant 10).

Discussion

The objective of this study was to explain the lived experiences of patients with generalized anxiety disorder (GAD) comorbid with emotional problems. The results of analyzing the interviews with these patients revealed four main themes and supporting subthemes and semantic units. The four main themes and 13 subthemes included components of illness (worry, cognitive component, behavioral component, emotional component, physiological component), influential factors (sociocultural factors, psychological vulnerability, developmental history), consequences of illness (quality-of-life impairment, interpersonal problems), and treatment (self-care, expectations of treatment, limitations and barriers to treatment).

There is research evidence on intercultural variability in the symptoms, etiology, and treatment of GAD. Several studies have shown that people in nonwestern societies are more likely to show physiological symptoms as a prominent manifestation of this disorder (26). In line with these studies, the participants in the present study reported physiological symptoms and according to the results of interviews, in most cases, these physiological symptoms were considered as a motivation for treatment. Asian and Eastern cultures, including Iran, are more likely to report physiological symptoms of mental disorders such as muscle problems, headaches, and heart problems (27). One of the possible reasons that was also found in the quotes of the interviewees of the present study was the stigma that exists in mental disorders in these countries.

Psychiatric disorders are among the most stigmatizing disorders (28). Stigma-related factors can even affect the way anxiety disorders are expressed. They often become a barrier to treatment since in these countries, having a physical illness is more acceptable than having a mental disorder. This problem is manifested by preferring to refer to a psychiatrist instead of a psychologist in developing countries, the tendency to use drugs instead of psychotherapy, and also the tendency to label it "disease" instead of "mental disorder" (29). Mental illness stigma can lead to a wide range of negative consequences including delayed treatment. Ridiculous remarks, taunts, sympathetic stares, and speculation about the causes of mental illness are all part of a patient's lived experience of encountering others in the environment. Individuals voluntarily limit their social relationships with others to prevent the stigma of mental illness (30). Due to the psychological stress caused by the illness, as well as the social effects of stigma and the resulting social isolation, these patients are emotionally and psychologically prone to problems such as depression and irritability, and their quality of life decreases.

According to the findings of the interviews, emotional problems were one of the main components involved in the disease process. In other words, people with generalized anxiety disorder had difficulty experiencing both negative and positive emotions. They reported high levels of negative emotion and low levels of positive emotion. They also reported common negative emotions associated with depression such as crying, sadness, irritability, and frustration. These findings are consistent with the results of the research by Eskandari et al. (31) indicating that for most Iranians, anxiety is accompanied by symptoms of depression such as hopelessness, sadness and loneliness, irritability, and crying.

Moreover, due to the limitations, they have no motivation for progress and treatment. Patients with GAD often have debilitating costs at some point in their lives. Worrying has a significant negative effect on professional-level productivity and individual pleasurable behaviors. Furthermore, due to the chronic nature of this disorder, it has an increasing effect on the daily functioning of patients, and feeling boredom and exhaustion is often the result of years of being worry. Anxiety, worry, and lack of courage lead to the impairment of general functions such as academic performance, intelligence and learning abilities, abstract thinking, and talent stagnation and provide ground for experiencing negative emotions such as fear, sadness, self-blame, anger, etc. in these patients (32).

Patients with GAD experience a variety of cognitive

dysfunctions. What was obtained from the main themes and subthemes of this section indicated that these patients have negative thoughts and beliefs about the future and themselves. These beliefs and thoughts guide the way people process environmental information causing confusion, distraction, lack of concentration and problem-solving power, and poor decision-making. Besides, these people are not able to tolerate ambiguity and uncertainty. People who were intolerant of uncertainty believed that uncertainty is stressful and upsetting; uncertainty about the future is unfair; and negative events are unexpected and should be avoided. Uncertainty also interferes with a person's ability to act. These people have functional problems in ambiguous situations. In the cognitive model of uncertainty intolerance, it was argued that people's beliefs about uncertainty, positive beliefs about anxiety, and cognitive avoidance strategies play an important role in the development and persistence of generalized anxiety disorder (33).

Avoiding stressful or unpredictable situations, behavioral problems such as aggression and isolation, interpersonal problems, fighting with lack of control, having a strong desire to protect loved ones, constantly giving advice to others, and ensuring the normalcy of the surrounding conditions and the health status of family and relatives were among the main manifestations of safety behaviors in the participants. Safety behaviors are used as a coping style and as a way to reassure people who suffer from ambiguity and anxiety. Interpersonal behavioral symptoms and interpersonal problems and limitations that are commonly associated with GAD may contribute to the chronicity of this disorder with a negative impact on psychological and physical well-being (34) and potentially prevent collaborative therapy and response to treatment (6).

According to the participants, having controlling and overly caring parents making the world look dangerous, shifting the role of the child and parents (reverse parenting), traumatic events, parents suffering from anxiety disorders and depression, unforeseen rewards, and punishments were all factors that contributed to the development of worry and GAD.

The findings of this study indicated that generalized anxiety disorder, especially in comorbid conditions, is a multidimensional disorder that affects the symptoms, etiology, and consequences of the disease in different areas of life. Strategies used by these patients included protection against threats (immunization), spiritual coping, avoidance of stressful situations, distraction, self-relaxation, rumination and self-blame, physical activity, drug use, seeking social support, obtaining information about the disease, acceptance of the disease, and seeking treatment. These results were consistent with the results of a study by Zarean (35) stating that Iranians first use informal therapists such as relatives, friends, religion, and traditional healers when they are anxious and depressed. Barriers to treatment and patients' expectations of treatment were also investigated in this study. It is essential for an effective treatment of this disorder to cover these factors. In this regard, it is suggested that specific treatment protocols be developed according to the components discovered from the lived experiences of patients with GAD.

One of the limitations of the present study was the short and telegraphic answers of the participants to the interview questions, and also the specific type of sample was associated with difficulties in accessing. It is suggested that future researches, while removing the limitations of the present study, repeat this research in other regions, for males and females separately, and on different Iranian ethnicities, in order to draw a more accurate and comprehensive model of this disorder in Iranian culture. It is also suggested that the validity of the identified components be assessed among a larger group of patients.

Conclusion

In this study, investigation of generalized anxiety disorder (GAD) comorbid with emotional disorders using the phenomenological method based on lived experiences of patients provided with new information about the etiology and treatment of the disorder. The identified themes emphasized the need for in-depth explanation of the lived experiences of patients by psychologists and specialists and the development of prevention methods and effective psychotherapy. According to the results of this study, psychologists and psychiatrists are recommended to adopt a comprehensive approach to the treatment of this disorder and for each of the symptoms and consequences of this disease, have effective treatment models and scientific techniques. Moreover, based on the findings of the present study, it can be said that considering culture can help to create a more effective conceptual framework in prevention programs or interventions for populations at risk of emotional disorders.

Acknowledgments

This study has been registered in the Iranian clinical

trial site with the code IRCT20200918048749N1 and approved by Research Ethics Committees of University of Isfahan (code: IR.UI.REC.1398.013). Ethical principles included full awareness of the participants about the research process and the confidentiality of their information. The authors would like to thank everyone who contributed to this research.

Conflict of Interest

The authors declared no conflict of interest.

References

1. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005; 62(6):617-27. doi: 10.1001/archpsyc.62.6. 617.
2. Bower ES, Wetherell JL, Mon T, Lenze EJ. Treating Anxiety Disorders in Older Adults: Current Treatments and Future Directions. Harv Rev Psychiatry. 2015; 23(5):329-42. doi: 10.1097/HRP. 0000000000000064.
3. Newman MG, Przeworski A. The increase in interest in GAD: Commentary on Asmundson & Asmundson. J Anxiety Disord. 2018; 56:11-13. doi: 10.1016/ j.janxdis.2018.04.006.
4. Bobes J, Caballero L, Vilardaga I, Rejas J. Disability and health-related quality of life in outpatients with generalised anxiety disorder treated in psychiatric clinics: is there still room for improvement? Ann Gen Psychiatry. 2011; 10(1):7. doi: 10.1186/1744-859X-10-7.
5. Roberge P, Normand-Lauzière F, Raymond I, Luc M, Tanguay-Bernard MM, Duhoux A, Bocti C, et al. Generalized anxiety disorder in primary care: mental health services use and treatment adequacy. BMC FAM Pract. 2015; 16:146. doi: 10.1186/s12875-015-0358-y.
6. Millstein DJ, Orsillo SM, Hayes-Skelton SA, Roemer L. Interpersonal Problems, Mindfulness, and Therapy Outcome in an Acceptance-Based Behavior Therapy for Generalized Anxiety Disorder. Cogn Behav Ther. 2015; 44(6):491-501. doi: 10.1080/16506073.2015. 1060255.
7. Mohammadi MR., Pourdehghan P, Mostafavi SA, Hooshyari Z, Ahmadi N, Khaleghi A. Generalized anxiety disorder: Prevalence, predictors, and comorbidity in children and adolescents. J Anxiety Disord. 2020; 73:102234. doi: 10.1016/j.janxdis.2020. 102234.
8. Newman MG, Przeworski A, Fisher AJ, Borkovec TD. Diagnostic comorbidity in adults with generalized anxiety disorder: Impact of comorbidity on psychotherapy outcome and impact of psychotherapy on comorbid diagnoses. Behav Ther. 2010; 41(1):59-72. doi: 10.1016/j.beth.2008.12.005.
9. Wittchen HU. Generalized anxiety disorder: Prevalence, burden, and cost to society. Depress Anxiety. 2002; 16(4):162-71. doi: 10.1002/da.10065.
10. Blanco C, Rubio JM, Wall M, Secades-Villa R, Beesdo-Baum K, Wang S. The latent structure and comorbidity patterns of generalized anxiety disorder and major depressive disorder: a national study. Depress Anxiety. 2014; 31(3):214-22. doi: 10.1002/ da.22139.
11. Khani M, Dadashi M, ghoreishi A. Comparison of brain/behavioral system activity, intolerance of uncertainty and cognitive avoidance among individuals with generalized anxiety disorder and normal subjects. J Adv Med Biomed Res. 2017; 25(111):67-81. [In Persian].
12. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry (11th Ed). New York: Wolter Kluwer; 2015.
13. Shihata S, McEvoy PM, Mullan BA. Pathways from uncertainty to anxiety: An evaluation of a hierarchical model of trait and disorder-specific intolerance of uncertainty on anxiety disorder symptoms. J Anxiety Disord. 2017; 45:72-9. doi: 10.1016/j.janxdis.2016. 12.001.
14. Coussement C, De Longueville X, Heeren A. Attentional networks in co-occurring generalized anxiety disorder and major depression disorder: Towards a staging approach to the executive control deficits. Compr Psychiatry. 2022;113:152294. doi: 10.1016/j.comppsych.2021.152294.
15. Ranta K, Kaltiala-Heino R, Pelkonen M, Marttunen M. Associations between peer victimization, self-reported depression and social phobia among adolescents: the role of comorbidity. J Adolesc. 2009; 32(1):77-93. doi: 10.1016/j.adolescence.2007.11.005.
16. Kashdan TB, Roberts JE. Comorbid social anxiety disorder in clients with depressive disorders: Predicting changes in depressive symptoms, therapeutic relationships, and focus of attention in group treatment. Behav Res Ther. 2011; 49(12):875-84. doi: 10.1016/j.brat.2011. 10.002.
17. Kessler RC, Ustün TB. The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). Int J Methods Psychiatr Res. 2004; 13(2):93-121. doi: 10.1002/mpr.168.
18. Saha S, Lim CCW, Cannon DL, Burton L, Bremner M, Cosgrove P, … & McGrath J. Co-morbidity between

mood and anxiety disorders: A systematic review and meta-analysis. Depress Anxiety. 2021; 38(3):286-306. doi: 10.1002/da.23113.

19. Showraki M, Showraki T, Brown K. Generalized anxiety disorder: Revisited. Psychiatr Q. 2020; 91(3): 905-14. doi: 10.1007/s11126-020-09747-0.

20. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th Edition, Text Revision. Washington, DC: American Psychiatric Association; 2022.

21. Hackmann C, Balhara YPS, Clayman K, Nemec PB, Notley C, Pike K, Reed GM, Sharan P, Rana MS, Silver J, Swarbrick M, Wilson J, Zeilig H, Shakespeare T. Perspectives on ICD-11 to understand and improve mental health diagnosis using expertise by experience (INCLUDE Study): an international qualitative study. Lancet Psychiatry. 2019; 6(9):778-785. doi: 10.1016/S2215-0366(19)30093-8.

22. Clissett P. Evaluating qualitative research. Journal of Orthopaedic Nursing 2008; 12(2):99-105. doi: 10.1016/j.joon.2008.07.009.

23. Guba EG, Lincoln YS. Fourth generation evaluation. Thousand Oaks, CA: Sage Publications; 1989.

24. Macnee CI. Understanding nursing research: Using research in evidence-based practice. Philadelphia: LWW Publications; 2004.

25. Polit DF, Beck CT, Hungler BP. Nursing Research: Principles and methods. 7thed. Philadelphia: LWW Publications. 2004.

26. Varela RE, Sanchez-Sosa JJ, Biggs BK, & Luis TM. Anxiety symptoms and fears in Hispanic and European American children: Cross-cultural measurement equivalence. *Journal of Psychopathology and Behavioral Assessment.* 2008; *30*(2):132-45. doi: 10.1007/s10862-007-9056-y.

27. Zarani F, HaghighiF, Alizade H, Shiri E. The role of culture in the dimensions of anxiety disorders based on DSM-5. Cultural Psychology. 2017; 1(2):95-111. [In Persian].

28. Hiedari A, Meshkinyazd A, Soodmand P. Broken Personality: Lived experiences of patients with psychiatric disorders on self-stigma. J Qual Res Health Sci. 2020; 9(3): 221-28. doi: 10.22062/jqr.2020.91515.

29. Vries J, Stein DJ, Kamuya D, Singh, I. Psychiatric genomics: Ethical implications for public health in lower-and middle-income countries. The American Journal of Bioethics 2017; 17(4):17-19. doi: 10.1080/15265161.2017.1284938.

30. Batterham PJ, Griffiths KM, Barney LJ, Parsons A. Predictors of Generalized Anxiety Disorder stigma. Psychiatry Res. 2013; 206(2-3):282-6. doi: 10.1016/j.psychres.2012.11.018.

31. Eskandari H, Farid Hosseini F, Khalili S. Symptomatology of anxiety disorder in visitors to tehran medical centers with emphasis on iranian culture. [Dissertation]. Tehran: Allameh Tabatabai University; 2010. [In Persian].

32. Dugas MJ, Robichaud, M. Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice. London, UK: Routledge; 2012.

33. Beach SR, Wamboldt MZ, Kaslow NJ, Heyman RE, Reiss D. Describing relationship problems in DSM-V: toward better guidance for research and clinical practice. J FAM Psychol. 2006; 20(3):359-68. doi: 10.1037/0893-3200.20.3.359.

34. Kiecolt-Glaser JK, Loving TJ, Stowell JR, Malarkey WB, Lemeshow S, Dickinson SL, et al. Hostile marital interactions, proinflammatory cytokine production, and wound healing. Arch Gen Psychiatry. 2005; 62(12):1377-84. doi: 10.1001/archpsyc.62.12.1377.

35. Zarean M. Dimensions of depression and anxiety in Iranian culture [dissertation]. Tehran: Shahid Beheshti University; 2015. [In Persian].