

INVESTIGATING **CAM** APPROACHES TO GENERALIZED

ANXIETY DISORDER

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The focus of the worry is on potential future danger, harm, or negative outcomes, but the negative thoughts are rarely thoroughly formulated or addressed.

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Abstract

Generalized anxiety disorder (GAD) is characterized by persistent, incapacitating worry without significant resolution of troubling questions or thoughts. Standard treatment approaches to GAD include pharmaceutical preparations or psychotherapeutic approaches such as cognitive-behavior therapy. While both treatment protocols have shown some level of efficacy, adverse effects produced by prescription medications and impediments to therapy related to time and cost have encouraged increased use of Complementary and Alternative Medicine (CAM) approaches. Many CAM treatments exist for GAD, although few have sufficient strength of empirical studies to fully support their use within the current medical model. This article explores GAD and the intersection of standard and CAM approaches to this debilitating mental health disorder.

Learning Objectives:

1. Explore Generalized Anxiety Disorder (GAD) as a psychological condition, including common presenting signs and symptoms.
2. Discuss the rise of Complementary and Alternative Medicine as both a popular and viable approach to the treatment of GAD.
3. Analyze data regarding the use of various CAM treatment approaches to GAD, Examining efficacy and viability.
4. Compare the benefits of and barriers to CAM use with standard medical and psychotherapeutic approaches to treating GAD.

KEYWORDS: Generalized Anxiety Disorder, GAD, anxiety, CAM, complementary and alternative medicine, aromatherapy, CBT, Cognitive-Behavior Therapy, lemon balm, lavender oil, Biofield Therapy, Mindfulness-Based Therapy, passionflower, kava

TARGET AUDIENCE: Physicians, nurses, psychologists, psychiatrists, health and wellness consultants, and any other CAM practitioners, as well as anyone in the allied health care fields

PROGRAM LEVEL: Basic

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Investigating CAM Approaches to Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is a common and widespread psychiatric disorder characterized by incessant, debilitating worry. Due to its high prevalence, many studies have focused on GAD in terms of its etiology, assessment, and treatment. Yet, definitive biological explanations (i.e., genetic, neurobiological, neurochemical, neuroanatomical, etc.) remain elusive (Beidel & Stipelman, 2007). As a result, treatment of GAD continues to evolve with increased and improved research. Standard treatment protocols employ the use of prescription medications, psychotherapy, or both, resulting in low-to-modest remission rates, but often at the price of undesirable adverse health effects. A current increase in public interest in Complementary and Alternative Medicine (CAM) has given rise to novel treatment suggestions for GAD. While additional research into CAM interventions may be warranted, the integration of standard and CAM approaches may best meet the needs of the GAD population at this time.

Generalized Anxiety Disorder

Characterized by “uncontrollable, unrealistic worry about more than one topic” (Huppert & Walther, 2007, para. 4) in combination with a range of physiological symptoms “including muscle tension, difficulty sleeping, fatigue, restlessness or feeling keyed up or on edge, irritability, and difficulty concentrating” (Huppert & Walther, 2007, para. 4), GAD is a common diagnosis in the United States. Zoberi and Pollard (2010) noted that within a 12-month period, just over 3% of the population (or 6.8 million people) ages 18 and older suffer from GAD, the majority of whom are women. With lifetime prevalence rates falling between 3.6% and 12.7%, GAD is one of the most common debilitating mental health disorders experienced in the United States (Huppert & Walther, 2007).

One among a variety of more specific anxiety disorders, GAD symptoms are experienced not in response to phobias or social situations, but are more globally present throughout the day, expressed in terms of unrelenting, incapacitating anxiety across a range of concerns. Those with GAD are often labeled “worrywarts” and describe themselves as unable to tolerate uncertainty. GAD sufferers believe that worrying will actually improve their ability to handle negative experiences that may occur in the future, yet Smitherman (2007) reported that “there is no strong consistent evidence that excessive worry improves problem-solving or coping skills” (para. 28). To the contrary, the chronic worrying that people with GAD experience



Biofield Therapy

Mindfulness Based Therapy
Aromatherapy

Herbal Remedies

may lead to a number of negative results, including overall lower quality of life; increased risk of suicide or suicide attempts; somatic complaints such as tension, fatigue, chest pain, sleep disturbance, and irritable bowel syndrome; and comorbid physiological conditions including diabetes and heart disease (Katzman, 2009, p. 106).

As Huppert and Walther (2007) suggested, “worry is the major cognitive component of GAD” (para. 6), but this worrying is not relegated to one facet of the person’s life (i.e., work, family, home, finances, medical problems, etc.). Rather, it occurs in relation to any number of aspects. The focus of the worry is on potential future danger, harm, or negative outcomes, but the negative thoughts are rarely thoroughly formulated or addressed. More commonly, the GAD sufferer has a worrisome thought that then cartwheels into other negative thoughts without ever reaching a conclusion, answer, or end. Huppert and Walther (2007) gave an illustration: “...one may think, ‘My husband is late. What if something happened to him on his way home? What if it was a car accident? How will I manage with the kids? What will happen to us financially? Is our insurance sufficient?’” (para. 6). For the GAD sufferer, this spiraling of worry is marked by a consistent failure to actually seek answers to the troubling questions; rather, the worries are left intact with no reduction of their

threatening, yet ambiguous, force. Further, people with GAD may also find themselves worrying about worrying, a condition called “metaworry” (Huppert & Walther, 2007, para. 85). Something of a cognitive trap, individuals with GAD experience this cycle of worry most of the day, each day.

Compounding this burden, comorbid disorders, which are commonly found with anxiety disorders in general, are even more likely with GAD (Huppert & Walther, 2007). Zoberi and Pollard (2010) wrote that “66% of those with GAD have at least 1 additional psychiatric condition – most frequently, major depression” (p. 148). Indeed, Katzman (2009) suggested that “prior history of GAD increases the risk of developing MDD (Major Depressive Disorder)” (p. 106). Taken together, the high rate of comorbid psychiatric and somatic illnesses may explain why “GAD is associated with overuse of medical services” (Zoberi & Pollard, 2010, p. 148).

The high prevalence of comorbid disorders is one reason why assessment of GAD must be carefully completed. A second is GAD’s prognosis: considered a condition with a “chronic course during the first 5 years that may last up to 20 years” (Katzman, 2009, p. 104), GAD may be a long-term debilitating condition potentially presenting differently in different patients. This is further complicated by the difficulty in treat-

ing GAD; Katzman (2009) noted treatment typically evinces only “low rates of remission and moderate rates of relapse/recurrence following remission” (p. 104). Accordingly, proper assessment of GAD is important so as to determine appropriate and effective treatment protocols, which may need to include a variety of therapeutic strategies and approaches.

Fortunately, a host of reliable and valid instruments for assessment of GAD are available. These include structured and semi-structured interviews; the Hamilton Rating Scale for Anxiety (HAM-A, considered the gold standard for evaluating GAD symptoms); the Penn State Worry Questionnaire (PSWQ, a widely used self-report measure of GAD symptoms); the Metaworry Inventory; the Generalized Anxiety Disorder Inventory (GADI) and its relative, the GAD-7 (recent scales specific for assessment of GAD); and the Depression, Anxiety, and Stress Scales (DASS, useful for measuring comorbid depression, as well as GAD) (Huppert & Walther, 2007; Katzman, 2009). Because GAD sufferers may not be able to articulate their worries or may be less aware of the content of their worries than of the correlated physiological symptoms, speaking with family members and close friends may be helpful. Additionally, as those with GAD tend to over-utilize health services, consulting with the patients’ doctors and other health spe-

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cialists may also help shed light during the assessment phase.

Upon diagnosis, GAD is typically treated via medication, psychotherapy, or both. Reinblatt and Riddle (2007) noted that barbiturates were the first medications used to treat GAD, but that they were replaced by benzodiazepines due to their being safer, particularly in cases of overdose. As with most medications, benzodiazepines can have adverse health effects, the most common of which include “sedation and disinhibition (such as aggressivity and irritability)” (Reinblatt & Riddle, 2007, p. 78). This drug class also carries the potential for abuse, and withdrawal symptoms can include “insomnia, anxiety, gastrointestinal symptoms, and seizures” (Reinblatt & Riddle, 2007, p. 78). Tricyclic antidepressants, SSRIs (selective serotonin reuptake inhibitors), and SNRIs (serotonin-norepinephrine reuptake inhibitors) have also been used to treat GAD. While each of these has demonstrated efficacy in relieving symptoms of GAD, each has its list of potential side effects, as well. Tricyclics are associated with sedation and anticholinergic side effects; patients taking SSRIs commonly report nausea, headaches, sweating, weight gain, and sexual dysfunction; and SNRIs evince side effects seen in SSRIs as well as somnolence (Zoberi & Pollard, 2010).

While the above represent the most common usage of prescription medications for the treatment of anxiety disorders such as GAD, it is not necessarily an exhaustive list. In a meta-analysis of data obtained from the 2005 National Disease and Therapeutic Index, Mark (2010) found that several additional classes of drugs were routinely administered to patients with anxiety dis-

orders. These included the aforementioned antidepressants, as well as anxiolytics and anti-psychotics. While anti-anxiety medication had the highest rate of prescription for those with anxiety disorders (39.6%), antidepressants were prescribed to this population 16.4% of the time, and anti-psychotics, 5.5% (Mark, 2010). Indeed, Mark (2010) highlighted that “approximately 31% of the 18 million psychiatric drug mentions were for ‘off-label’ diagnoses” (p. 324), and that “most off-label prescribing of psychiatric medications are for psychiatric conditions” (p. 325). At the very least, this seeming experimentation with medications for the treatment of anxiety disorders signifies the elusive etiology of GAD and the difficulty medical science has had in finding a cure. At the same time, the potential adverse health effects of medications prescribed for GAD may discourage patients from taking their medication, which can in turn lead to withdrawal or rebound symptoms, as well as relapses. Further, as many as 30% to 40% of GAD patients may receive no direct benefit from the medications prescribed to them, and 30% to 60% will not achieve full remission (Katzman, 2009).

In terms of a psychotherapeutic approach, cognitive-behavior therapy (CBT) has arisen “as the only psychotherapy to meet criteria as an empirically supported treatment for generalized anxiety disorder” (Newman et al., 2011, p. 171). An approach “designed to alter behaviour and cognition that produces and maintains emotional distress” (Katzman, 2009, p. 113), CBT for GAD may include psychoeducation, the active cognitive reframing of negative and unhelpful ideas (i.e., correction of false beliefs), worry exposure therapy, and instruction in self-monitoring techniques (Beidel & Stipelman, 2007; Butcher, Mineka, & Hooley, 2010; Katzman, 2009). CBT has been shown to reduce symptoms of GAD and to promote improvements that last 6 to 12 months post-treatment (Beidel & Stipelman, 2007; Katzman, 2009). Still, Newman et al. (2011) noted that “a marked percentage of [CBT] clients continue to experience clinically significant anxious symptoms after treatment and fail to demonstrate sustained reduction in GAD symptoms” (p. 171). Some attempts to refine CBT therapy for GAD have met with negative results; authors of a study examining the efficacy

reiki

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of adding components such as emotion-focused interpersonal therapies and skilled listening to standard CBT protocols suggested the addition of the interventions might have been “at best irrelevant, a possible waste of time and energy, or even a potential detractor from the benefits of the CBT” (Newman et al., 2011, p. 179).

CAM Approaches to GAD

Promoted by the public’s growing interest in finding solutions to their health problems that are more natural and less likely to produce unwelcome adverse effects,

Complementary and Alternative Medicine has arisen as a field of study and practice within contemporary health care systems. Indeed, White (2009) noted that growing dissatisfaction with the costs of prescription medications and their potential side effects turn 36% to 42% of the U.S. adult population toward the utilization of some form of CAM each year. Additionally, White (2009) stated that people suffering with anxiety disorders such as GAD are among the highest users of CAM in the United States.

CAM is a wide umbrella term that covers a large array of therapeutic modalities from Ayurvedic medicine to yoga. Consequently, CAM approaches to anxiety disorders are as varied as are CAM practitioners; what follows is not intended as an exhaustive list of CAM interventions appropriate for treating GAD, but a review of some of the existing research on the subject. Some studies that invite attention and further research include the use of biofield therapies, mindfulness therapy, aromatherapy, and treatment with herbal remedies.

Biofield Therapy for Anxiety

In a meta-analysis of 66 clinical studies investigating the use of biofield therapies in different medical populations, Jain and Mills (2010) conducted a quality assessment to determine a best evidence approach to the use of CAM therapies that fall under this particular designation. Biofield therapies “purport to specifically use subtle energies for the process of healing another” (Jain & Mills, 2010, p. 2). These energies have been variously referred to as *prana*, *qi*, and *spirit* by different cultures around the world, and their direct application to healing – typically by the laying on of hands or through distance administration such as prayer – is thought to affect biophysiological systems. Some of the most well-known biofield therapies include Reiki, Qigong, and Therapeutic Touch.

Of the 66 studies investigated, “52 were between-subjects randomized controlled trials and 14 were within-subject repeated measures designs with appropriate baseline/control conditions” (Jain & Mills, 2010, p. 6). Of these, six examined the effects of biofield therapies on pain and anxiety in hospitalized or postoperative patients. The findings suggested that biofield therapies may result in a moderate level of anxiety re-

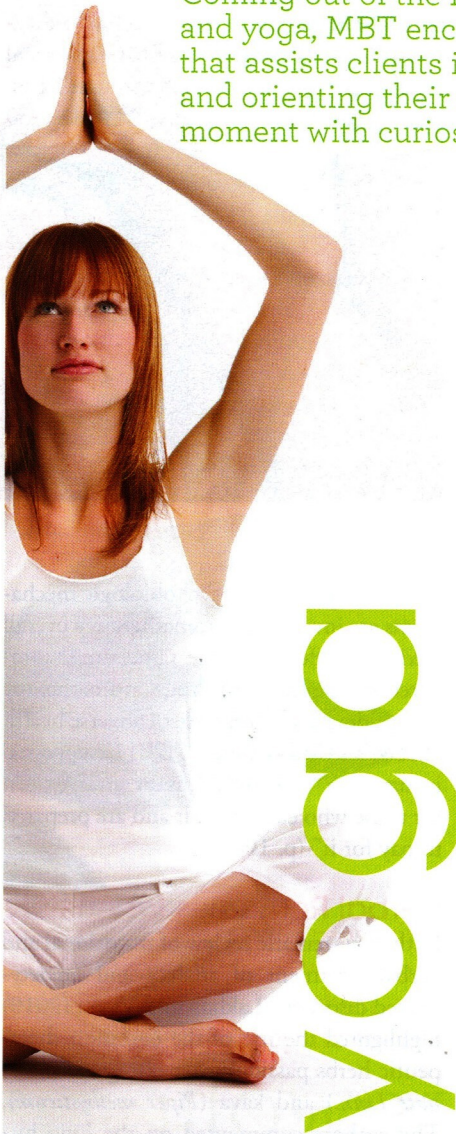
duction. One group that received Reiki treatments both pre- and post-operation evinced significantly decreased levels of anxiety at a 72-hour follow-up, compared to controls. Another group of burn victims that received Therapeutic Touch (TT) reported decreased anxiety compared to a control group that received mock TT. Jain and Mills (2010) concluded that biofield therapies may help reduce anxiety in hospitalized patients.

Mindfulness-Based Therapy for Anxiety

Hoffman, Sawyer, Witt, and Oh (2010) “conducted an effect size analysis of [mindfulness-based therapy] for anxiety and mood symptoms in clinical samples” (p. 169). A literature review provided 39 stud-

ies with a total of 1,140 participants who received mindfulness-based therapy (MBT) for a range of symptoms, including GAD. Coming out of the Eastern traditions of Buddhism and yoga, MBT encompasses a treatment strategy that assists clients in self-regulating their attention and orienting their awareness toward the present moment with curiosity, openness, and acceptance (Hoffman, Sawyer, Witt, & Oh, 2010). Clients learn how to counter anxiety and stress by responding to stressful situations “more reflectively rather than reflexively” (Hoffman et al., 2010, p. 169). Slow, deep breathing is often involved, as well, which may help alleviate symptoms of anxiety by balancing and harmonizing the sympathetic and parasympathetic nervous systems.

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Hoffman et al. (2010) found that MBT utilization in groups with anxiety disorders was associated with large effect sizes for improving symptoms. Even in groups without anxiety disorder diagnoses, MBT reduced symptoms of anxiety. Hoffman et al. (2010) concluded that “MBT improves symptoms of anxiety and depression across a relatively wide range of severity and even when these symptoms are associated with other disorders, such as medical problems” (p. 179). Accordingly, Hoffman et al. (2010) recommended that, while MBT may not be diagnosis-specific, their study supports the use of MBT for anxiety and depression in clinical populations.

Aromatherapy and Anxiety

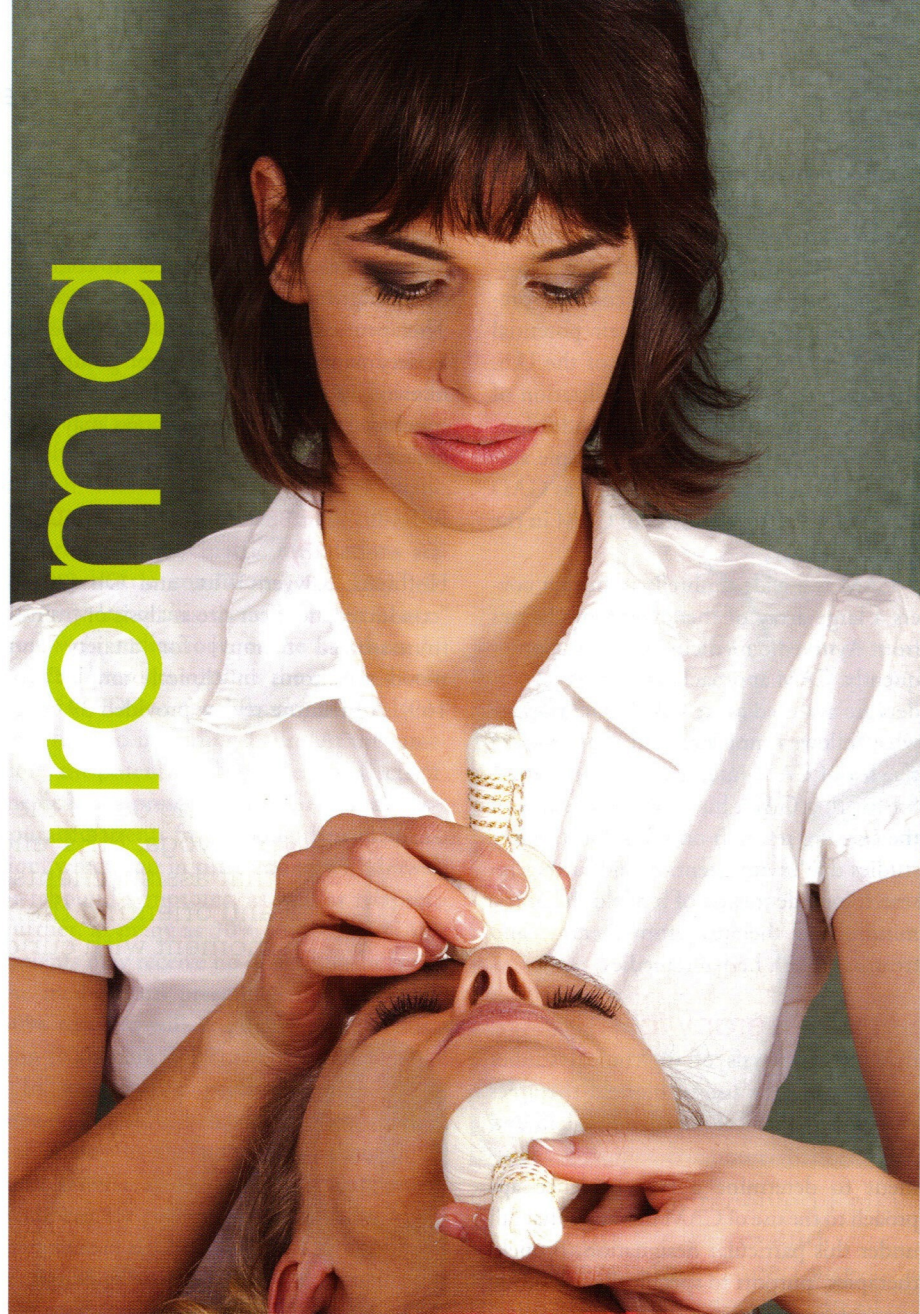
Yuk-Lan, Ying, Tsang, Leung, and Cheung (2011) conducted a meta-review of 16 randomized controlled studies from 1990 to 2010 on the use of aromatherapy for the treatment of anxiety and anxiety-related disorders. Aromatherapy is the most commonly used CAM therapy around the world for anxiety, involving “the therapeutic use of essential, aromatic oils, commonly combined with therapeutic massage and ex-

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citation of the olfactory system, to induce relaxation and thus quell certain anxiety symptoms” (Yuk-Lan, Ying, Tsang, Leung, & Cheung, 2011, p. 101). Within the 16 studies examined, aromatherapy massage, inhalation, tablet intake, and footbaths were employed with lavender (most likely *Lavandula angustifolia*) the most common essential oil used.

Of the 16 studies, 14 used control groups that received either conventional therapy or placebo; the remaining two used control groups that received no active treatment. Study results were mixed. Yuk-Lan et al. (2011) reported that seven studies produced benefits superior to conventional treatment or placebo, and one study found that an oral capsule containing lavender oil was “as effective as lorazepam, a benzodiazepine, in adults with generalized anxiety disorder” (p. 103). At the same time, five studies showed no difference between groups that were massaged with or without aromatherapy oil, one study found massage without aromatherapy more effective than with its inclusion, and two studies with follow-up data suggested no long-term treatment gains had been achieved via aromatherapy treatment (Yuk-Lan et al., 2011).

Overall, Yuk-Lan et al. (2011) noted that aromatherapy “shows a positive anxiolytic effect for patients with anxiety symptoms” (p. 106), with the best results achieved by those who are under high levels of psychological distress. Many questions remain as a result of weaknesses inherent in most of the studies examined and Yuk-Lan et al. (2011) recommended further investigation to determine what mode of delivery is most effective, whether effects are comparable across



the sexes, and which psychobiologic mechanisms are involved in aromatherapy’s overall anxiolytic effects. At the same time, compared to prescription drugs, aromatherapy is considered relatively free of adverse health effects, and Yuk-Lan et al. (2011) suggested it may be a “safe and pleasant intervention for those who can afford it and are prepared to pay for it” (p. 107).

Herbal Remedies for Anxiety

In their systematic review of nutritional and herbal treatment of anxiety and anxiety-related disorders, Lakhan and Vieira (2010) highlighted the use of the common therapeutic herbs passionflower (*Passiflora incarnate* Linn.) and kava (*Piper methysticum*). The authors commented on the long his-

tory of passionflower’s use in folk medicine as an anxiolytic agent and noted that recent studies have investigated the biochemical makeup of this herb, which was listed in official pharmacopeias of America, Britain, Germany, France, Switzerland, Egypt, and India between the 1970s and the 1990s.

In one double-blind, placebo-controlled study, no difference was noted between the therapeutic effects of passionflower and the prescription benzodiazepine oxazepam with regard to treatment of GAD (Lakhan & Vieira, 2010). Additionally, although oxazepam provided faster symptom relief, participants in the group receiving passionflower “reported lower job impairment performance than those in the benzodiazepine group” (Lakhan & Vieira, 2010, p. 8).

lavender oil

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Mild adverse reactions including dizziness, drowsiness, and confusion were noted in only one study at levels insignificant enough that the authors concluded “passionflower may have a role in the treatment of anxiety and warrants future research” (Lakhan & Vieira, 2010, p. 9).

Kava (also commonly known as “Kava kava”) has been used by various cultures for centuries to relieve anxiety, restlessness, and insomnia (Lakhan & Vieira, 2010). The authors reported that kava is unique among herbs and prescriptions with anxiolytic properties because it reduces anxiety without sedative or cognitive-impairing effects. In a placebo-controlled, double-blind study on the use of kava in treating patients diagnosed with anxiety disorder, “kava extract showed improvement in [participant] primary and secondary anxiety symptoms based on the [HAM-A]...and a CGI [Clinical Global Impression]” (Lakhan & Vieira, 2010, p. 9).

Five other studies confirmed kava’s use in treating anxiety disorders with specific use as a monotherapy for treating GAD, as well as for patients who are being titrated

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off benzodiazepines (Lakhan & Vieira, 2010). Although four studies suggested that kava was no better at alleviating anxiety symptoms than placebo, and there has been some concern about kava’s potentially hepatotoxic properties, Lakhan and Vieira (2010) noted that the majority of studies on kava have found it an effective treatment for GAD and, when taken in doses less than 400 mg/day, does not seem to be toxic.

Another herb that has been studied for its anxiolytic effects is lemon balm (*Melissa officinalis*), a common garden weed in some parts of the United States. Johnson (2008) noted that animal studies of lemon balm indicate the herb can be used to help decrease anxiety-related behaviors, as well as to relieve pain and induce sleep. Subsequent studies in humans have shown lemon balm’s ability to increase alpha wave activity associated with relaxation and attention (Johnson, 2008). One study, in which participants were administered a standard-

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passionflower

CAM interventions, many of which have been employed in folk medicine for centuries, are seeing an increase in patient usage despite the relative paucity of empirical data supporting them.

ized stress-simulation test after receiving either 300 mg or 600 mg of lemon balm, or a placebo, showed that “the higher (600 mg) dose ameliorated the stress induced by the test, and produced significantly improved self-ratings of calmness and alertness” (Johnson, 2008, p. 28). Finally, in a double-blind, placebo-controlled trial, participants given 300 mg of lemon balm extract twice daily showed a “49% reduction in their state of anxiety, a 72% reduction in anxiety-associated symptoms, and a 39% decrease in insomnia,” without the production of unwanted daytime drowsiness (Johnson, 2008, p. 28).

Treatment Comparisons

Traditionally, GAD is treated either with pharmaceuticals, psychotherapy, or some combination of both. Yet, research suggests that neither common prescriptions (e.g., benzodiazepines, SSRIs, SNRIs) nor CBT is curative; non-response and relapse rates are high enough in such treatment protocols to warrant further investigation for more efficacious treatment. Because of the wide scope of CAM, there exist a large unknown number of CAM approaches to GAD; some of those which have been empirically studied and explored, as highlighted in this paper, may prove useful.

According to Katzman (2009), although the long-term goal of medication therapy is remission, only 60% to 70% of those treated with first-line treatment drugs (i.e., SSRIs, SNRIs) respond, leaving 30% to 40% without any related benefit from taking medications. Additionally, Katzman (2009) noted that 30% to 60% of patients treated with pharmaceuticals fail to

achieve remission, and even for those who do achieve remission, risk of relapse is as high as 10% to 20%. At the same time, side effects from prescription medications are common and can vary widely; this may be due, in part, to the widespread use of off-label drug use (Mark 2010). With SSRIs alone, Zoberi and Pollard (2010) noted that 22% of patients experience nausea, 12% report headaches, and 11% experience sexual dysfunction. Other adverse effects of prescription drugs used to treat GAD include gastrointestinal problems, sweating, increased nervousness, vomiting, weight gain, blood pressure changes, insomnia, memory impairment, somnolence, dizziness, and edema (Johnson, 2008; Katzman, 2009; Zoberi & Pollard, 2010); however, prescription medication remains highly available to most people and, if taken regularly, represents a relatively easy, if questionably effective, way to treat GAD.

CBT has been extensively studied in relation to its efficacy in treating GAD. Sources report that CBT has strong clinical relevance, reducing GAD symptoms and achieving effects that last 6 to 12 months post-treatment (Beidel & Stipelman, 2007; Katzman, 2009). Further, CBT may have significant advantages over medication. Katzman (2009) suggested GAD patients prefer CBT over prescription medications, at least in part, because of the side effects common to drug use. Unfortunately, as Katzman (2009) pointed out, “CBT is not widely available, requires specialist training, and entails weekly contact with the patient for 12-20 weeks, with the latter two factors having implications on both cost and availability” (p. 113).

Most CAM approaches, while novel, are as yet understudied. Preliminary research confirms that many of these alternative approaches to GAD may be effective at reducing symptoms, although long-term efficacy studies have yet to be completed. This represents a particularly significant impediment to the widespread adoption of CAM interventions by the broader medical community; some have noted numerous barriers and challenges that make the study and research of CAM treatments more difficult than their pharmaceutical or psychotherapeutic counterparts (see Rosner, 2000; Tonelli & Callahan, 2001; Verhoef, Mulkins, Kania, Findlay-Reece, & Mior, 2010). Still, usage of CAM therapies by the public has

increased with patients' dissatisfaction with prescription medications and the potential side effects they produce. Yet, because CAM approaches have not yielded a body of research accepted widely enough within the mainstream medical model to warrant best-practices protocols, the majority of CAM interventions are not covered by health insurance, unlike prescription medication and some psychotherapy, placing additional burdens of time and cost on GAD sufferers. For example, an over-the-counter lavender oil supplement is currently available, based on a study that showed its superiority over placebo in improving the “quality and duration of sleep and improved general mental and physical health without causing any unwanted sedative or other drug specific effects” (Kasper et al., 2010, p. 277). This supplement is not a prescription medication, however, as a result, it is unlikely to be covered by standard medical insurance. Consequently, GAD patients who would like to try this more natural treatment approach may be kept from doing so, particularly if financial resources are an issue or if attending health care providers are unaware of its availability or unsupportive of its use.

Having suggested that CAM is not fully prepared to overtake traditional treatment approaches, one study that seems to stand alone in terms of its successful institution-wide use of CAM therapies took place through Utah's Veterans Affairs Salt Lake City Health Care System (VASLCHCS). Smeeding, Bradshaw, Kumpfer, Trevithick, and Stoddard (2010) conducted a longitudinal outcome research study to determine the effectiveness of the Integrative Health Clinic and Program (IHCP) administered within the VASLCHCS. The IHCP offered its patients 10 nonmedical, researched-based CAM therapies including acupuncture, aquatic bodywork, stress management, hypnosis, meditation, Qigong, yoga, herb-drug interaction counseling, multidisciplinary weight management, and tobacco cessation classes. Patients were enrolled in various programs based on their needs and interests. Results indicated the integrated CAM approach reduced depression and anxiety and improved quality of life for participants for up to six months or more, post-treatment. High-anxiety patients reported improvements up to 24 months following treatment. Smeeding et al. (2010) concluded that “IHCP mind-body and

CAM therapies are gender neutral, benign or low-risk, gentle, 'low tech' treatments requiring no costly equipment, have minimal side-effects, are self-empowering, providing patients with skills usable whenever needed, and acceptable to patients of all ages" (p. 834). Even so, although this presents itself as a successful model for the implementation of CAM therapies within a health care facility framework, most similar facilities have not created comparable programs and may not be prepared to do so, making the IHCP an exception to the general trend of medical treatment today.

Discussion

GAD remains a complex and difficult psychological disorder to treat. While standard treatment approaches have met with low-to-moderate success, medications may elicit undesirable side effects that result in patient non-compliance, and psychotherapy may not be feasible for clients who would regularly need to travel distances for sessions or who do not have the financial means to complete a round of therapy. CAM interventions, many of which have been employed in folk medicine for centuries, are seeing an increase in patient usage despite the relative paucity of empirical data supporting them. Patients appreciate the reduced risk of adverse effects as well as the greater control they have over the selection of CAM treatments they would like to use. Unfortunately, the majority of CAM therapies lack the rigorous, controlled trials called for by the established medical model, resulting in their not being covered by most medical insurance plans. This places additional financial strain on some GAD patients who would like to use CAM treatments.

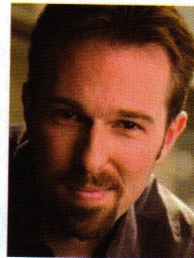
For GAD patients who wish to explore CAM therapies and are able to do so, one approach would be to use a combination of standard medical or psychological interventions with adjuvant CAM treatments. For example, using anxiolytic herbal preparations in tandem with lowered dosages of prescription medications or CBT may prove effective, while reducing drug-related adverse effects. Regardless of which approaches are blended in the treatment of GAD, health practitioners should be aware of the treatments their patients are pursuing in order to preclude potential drug-herb-vitamin interactions, address anxiety associated with financial stress, and

ensure patient compliance with treatment interventions. Given the wide and evolving nature of CAM and the public's increased interest in CAM interventions, a growing number of clinical research studies exploring CAM approaches to GAD and related anxiety disorders is expected. In time, and with increases in funding and research, as well as with changes in health care and insurance policies, those living with GAD can anticipate improved treatment options with less adverse effects and more positive outcomes surpassing present GAD treatment approaches.

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