

Explanatory factors for worries and anxiety among elderly people of Iraq

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Abstract

Generalized anxiety disorder (GAD) is highly prevalent in the elderly and has significant implications for the mental and physical health of this population. Despite this, few studies have investigated the psychological factors behind the tendency to worry, worries about aging and anxiety in elderly. Some works in the cognitive-behavioral approach show significant links between the symptoms of GAD and psychological factors, such as intolerance of uncertainty and erroneous beliefs about worrying in the elderly. The present study verifies the contribution of psychological factors of different explanatory models of GAD in the prediction of the tendency to worry, concerns about aging and symptoms of GAD in the elderly. It takes into account socio-demographic, situational and clinical factors related to their life context (e.g., illness, loneliness). To do this, 176 people aged 60 to 80 living in Baghdad filled out on a voluntary basis, questionnaires measuring the variables under study. Intolerance of Uncertainty (IU) has been shown to be a predictor of general worrying tendency, specific aging concerns, and symptoms of GAD. Erroneous beliefs about worrying have been shown to be significant predictors of the tendency to worry and symptoms of GAD. Experiential avoidance has been shown to be a significant predictor of the tendency to worry. Finally, emotional regulation strategies have been shown to be significant predictors of GAD symptoms. These results offer explanatory avenues for better understanding the specific roles of (IU) and other psychological factors such as erroneous beliefs about worrying, experiential avoidance as well as emotional regulation strategies in predicting heart failure.

Keywords: generalized anxiety disorder (GAD), worries about aging, experiential avoidance, intolerance of uncertainty (IU), psychological factors.

life (social, personal, professional; DSM 5; American Psychiatric Association [APA], 2013). The diagnosis requires that they have been present for at least six months and related to at least three of these six symptoms: restlessness or feeling exhausted problems in

1. Introduction

Generalized Anxiety Disorder (GAD) is expressed by excessive and uncontrollable anxiety and worrying about different spheres of

170 million people around the world (62% of them were women). Maya and colleagues also indicated that women (63% percent) had higher levels of anxiousness than men (40%). Among patients with anxiety, both young and old, anxiety symptoms are more noticeable in elderly adults. (Bano et al., 2021) GAD appears early in life and has a low rate of spontaneous remission (Leroux et al., 2005; Kessler & Wittchen, 2002). Its annual prevalence varies between 1.2% and 7.3% among the elderly (Gum et al., 2009; Prévillé et al., 2008). Some studies indicate that GAD is the most common anxiety disorder among elders, as well as depression disorder (Ibrahim et al., 2017; Stanley & Novy, 2000), and others, the second after specific phobias (Wolitzky-Taylor, Castriotta, Lenze, Stanley, & Craske, 2010).

The variations in the prevalence of GAD among elderly may be explained in particular by their difficulty in recognizing the excessive nature of their concerns and the impact on their functioning (Grenier et al., 2011). Stanley and Beck (2000) also note that many elderly patients with symptoms of GAD prefer to describe their experience using the words hassle or concern rather than worry or anxiety. At the same time, confusing anxiety with physical illness (Beaudreau & O'Hara, 2008) would increase the risk of

concentration, fatigability, irritability, spasm in muscles and disturbed sleep. The symptoms must create distress and impair functioning (APA, 2013).

According to a 2017 World Health Organization (WHO) report, anxiety affects almost 264 million people (3.6 percent) around the world and depression affects roughly 322 million people (4.4 percent) over the world. According to a recent survey from the Iraqi Ministry of Health (MOH), 16.5% of Iraqis over the age of 15 suffer from psychiatric disorders. (Kathem et al., 2021).

Several studies looked on the gender differences in mental diseases among Iraqi men and women. In terms of the types of traumatic experiences that people have, the incidence of post-traumatic stress disorder (PTSD), and the symptoms of common mental disorders (depression, anxiety, and somatization symptoms). Somatic and depression/anxiety symptoms observed to be higher in females than in males. (Taha & Sijbrandij, 2021).

According to Ritchie and Roser research, women suffer from anxiety twice as much as men over the world. Anxiety disorder affected

that anxiety in elderly is not particularly distinguished from anxiety presented by those under 65. On the other hand, Wisocki, Hunt and Souza noted that the majority of participants in their study developed more entrenched and pathological concerns as they aged.

Powers, Wisocki and Whitbourne (1992) have suggested that the concerns of older adults relate to risks and contingencies arising more from present or past problems compared to younger adults. This is partly corroborated by the results of Bax-D'Auteuil, Duhamel, Dupuis and Roussy (2013) suggesting that seniors feel they worry more about current problems and less about past or future aspects. The content of the concerns of the elderly also seems to differ from that of the youngest in relation to developmental changes due to aging. This variation in the content of worries, associated with changing life circumstances according to age, seems to be supported by other authors believing that these different subjects concerns are important to consider in the diagnosis and treatment of GAD in the elderly (Stanley & Beck, 2000). Specifically, elders report more health concerns and fewer worries about work than adults (Powers et al., 1992). The concerns of seniors are also more diverse than those of adults. (Salaz, 2014) Several studies

misdiagnosis. Indeed, seniors experience more physical problems than other age groups, which is why it can be difficult to make a differential diagnosis between physical symptoms, somatoform disorders and anxiety in this clientele (Wijeratne & Hickie, 2001).

Alwahhabi (2003) indicates for his part that one of the major challenges for the health professional is to determine the cause of anxiety in the elderly: normal reaction following a stressful situation, medical condition, medication, specific or non-specific anxiety disorder.

Regarding the course and manifestations of GAD in the elderly, there seems to be a lack of consensus in the studies. While some authors suggest that older people have more somatic symptoms and less excessive worrying (Flint, 2005), others report that they do not observe any difference in intensity levels and in frequency of worrying if one is worried compares seniors to adults (Alwahhabi, 2003).

Fuentes and Cox (2000) observe, for their part, that the instruments used with adults to measure anxiety show good fidelity indices with seniors, leading them to conclude

prevalence among the elderly, this delay in work on GAD would also be attributable to the low rate of request for help from the elderly for this disorder. (Flint, 2004; Prévillé et al., 2008) and the fact that anxiety is often relegated to the background due to its strong comorbidity with depression (Flint, 2005).

Finally, other authors explain the lack of studies on GAD in the elderly by the recency of theoretical models on GAD and validated instruments to measure their anxiety (Babcock et al., 2012; Dugas, 2000; Gerolimos et al., 2015). Therefore, this affects the development and validation of effective therapy.

1.1. Definition and explanatory models of pathological worries of GAD

Anxiety, a central feature of GAD, refers to a cognitive process in which thoughts and images that are difficult to control and laden with negative affect follow one another (Borkovec et al., 1983). It would be activated to solve a problem whose outcome is uncertain and potentially negative. Even if anxiety may arise from present situations, therefore focused on the future and the possible consequences that could occur there (Ladouceur & Dugas, 1999). It becomes pathological when it is uncontrollable, invasive,

suggest that GAD has a significant impact on the mental and physical health of seniors. It is associated with a marked level of disability, a reduction in life quality, a deterioration in sense of vitality as well as the perception of limitations in the ability to socialize with loved ones and to carry out their activities (Porensky et al., 2008). It is also linked to taking psychotropic drugs and medication for somatic ailments as well as the presence of depression and phobias (Beck et al., 1996; Zhang et al., 2015). Without verifying the presence of GAD, studies have also shown links between anxiety, worry, and certain psychological and physical problems in elderly. Alwahhabi (2003); Bryant, Jackson, & Ames, (2008) identify links between anxiety and mental distress, poor well-being, disability, disturbed sleep, hypertension, hyperthyroidism, diabetes, digestive problems and Parkinson's. Anxiety is also linked to a greater risk of suicide (Allgulander & Lavori, 1993) and a risk of a possibly fatal medical diagnosis (Van Hout et al., 2004). Wetherell et al. (2004) add that subclinical anxiety would have effects comparable to those of depression or serious illness in the elderly. Despite the personal and social repercussions of GAD, the study of explanatory psychological factors among the elderly is scarce (Alwahhabi, 2003).

In addition to the reasons mentioned earlier to explain the variations in

concluded that worry was predominantly composed of thoughts and not pictures, as excessive worry reported significantly more thoughts (75.6%) than non-excessive worries (69.6%) and that it did not there was no difference between the groups in terms of images during the worry. Borkovec and Inz (1990) also noted that people with worrying thoughts (versus neutral or relaxing), before exposure to a phobic scene, had a lower heart rate during exposure. They concluded that worry prevents the assimilation of anxious images and prevents physiological reactions. Borkovec et al. (1993) also noted that the verbal content of worries (versus affective or pictorial) further prevents physiological arousal during exposure to the anxiety-inducing stimulus; the amount of verbal thoughts during worry predicting the degree of reduction of anxiety in front of an anxiety-inducing image. Finally, Borkovec, Ray and Stöber (1998) confirmed using electroencephalograms that patients with GAD engage less in a pictorial thought process and have a pre-attention bias, that is, hypervigilance to potential dangers.

This bias would explain the excessive emotion and thought processes of GAD. In the elderly, no study has tested the verbal predominance of worry or the relationship between the degree of abstraction, the pathological trait

excessive, and disproportionate to the current problem (APA, 2013).

1.2. Centered models on worry

Conceptual theories and models have been proposed to explain the development and maintenance of worries. Borkovec et al., (1993) suggest that the verbal content of worry is a form of avoidance of threatening images and that they are negatively reinforced by this avoidance, which inhibits aversive physiological reactions. Borkovec (1994) also postulated that worry aims to prevent and avoiding possible negative situations, after noting that worried people tend to believe that worry prevents or helps prepare for possible disasters. It would also prevent emotionally intense anxiety-inducing thoughts, by providing access to the superficial material of fear (Borkovec et al., 2004). Worried people thus see the benefits of worry, an element taken up in other models (Dugas et al., 1998; Wells, 1995; Wells & Carter, 1999), in the form of positive beliefs about usefulness to worry. In particular, Borkovec and Inz (1990) observed, by comparing patients with GAD to non-anxious ones, that their cognitive content was more semantic in worrying.

Freeston, Dugas and Ladouceur (1996) replicated these results in a non-clinical population. They

anxiety.

1.3. Model focused on the role of intolerance of uncertainty

Dugas et al. (1998) developed a model illustrating the role of intolerance of uncertainty (IU), negative problem orientation (NPO), mistaken beliefs about the usefulness of worrying and avoidance cognitive (AC). It is a tendency to consider unacceptable the slightest possibility of an uncertain negative situation occurring.

It would generate various reactions (e.g., emotional, cognitive) in an uncertain situation (Dugas et al., 2001). It would lead to undue worry in causing the individual to focus his attention on possible negative results, to overestimate the chance of these results happening and to exaggerate their possible effects. Even after reassessing the luck and the feared effects, the person continues to experience worries, which will intensify, given the absence of any guarantee that there will be no consequences (Dugas et al., 2004).

NPO refers, moreover, to a set of pessimistic attitudes leading the individual to doubt his ability to solve a problem and find a solution (Maydeu-Olivares & D'Zurilla, 1996). It includes biases in terms of perception, attribution, evaluation

and somatic activity. Allis and Eysenck (1994) also developed a worry-focused model of GAD. This would develop because of processing a threatening stimulus (e.g., likelihood of it happening, potential consequences, and risk of it happening soon, perceived control). Excessive worries would then perpetually scan for threatening stimuli, given a cognitive bias towards these stimuli and sensitivity to emotional stimuli.

This would cause them to constantly perceive new threats, raising further concerns preventing them from mobilizing to face the initial threat. The arousal, caused by worry, would in turn cause a greater decrease in attentional capacities so that negative information would become increasingly important. There would therefore be a link between increased perception of negative information, physiological excitement and worries. The authors conclude that the worried would also have difficulty in solving problems; these needing more information before you start. The study by Azais, Granger and Debray (1994) supports this model by showing that anxious people take longer to name the color of a word with threatening valence. Among the elderly, only Basevitz (2003) seems to have verified elements of this theory. She noted that a tendency to focus on a potential threat and perceive the ambiguity as threatening related to the level of

(Gosselin, 2006). AC prevents the fears conveyed by mental images from being confronted and processed emotionally, maintaining the worry through negative reinforcement (Dugas et al., 2004).

1.4. Model focused on experiential avoidance

Based in particular on the work of Roemer and Orsillo (2002), supporting the relevance of experiential avoidance in GAD, Mennin et al., (2002) present a more elaborate model of this disorder. This model emphasizes the emotional factors that lead to this avoidance. Experiential avoidance refers to various strategic and automatic mental and behavioral means for escaping internal experiences (physical sensations, emotions, memories, behavioral dispositions) creating distress (Roemer & Orsillo, 2002).

These deficits can be divided into four phenomena; (1) the high intensity emotional experience where the individual has difficulty experiencing intense and rapid negative emotions; (2) poor understanding of their emotions where the individual has difficulty identifying their emotions; (3) negative reactions to their emotions, where the individual experiences great discomfort while experiencing

of the problem as well as in terms of emotional response and beliefs, in relation to his level of control, when faced with a problem. (Nezu et al., 2013). This cognitive disposition would lead the individual to perceive situations requiring a problem-solving approach or a choice in a more threatening way, causing more worry.

Five main positive beliefs, regarding worry, have been identified in people with GAD (Dugas et al., 2004): (1) it helps to find better solutions, (2) it motivates to be proactive, (3) it protects against negative emotions, (4) it helps prevent negative consequences, (5) it is a good personality trait. They linked to avoidance and negatively reinforced by the latter, preventing exposure and the reinterpretation of anxiety-inducing situations (Dugas et al., 1998). Beliefs also reinforced when feared misfortunes do not occur or managed successfully, further reinforcing worry (Behar et al., 2009). AC refers to strategies, aimed at chasing negative valence thoughts, used by the person with GAD, either intentionally or unintentionally. They include the transformation of images into thoughts (Borkovec et al., 1993) and any activity, which distracts oneself from one's cognitions (eg, watching television, stopping thoughts with conscious mental effort or substituting them for other, less anxiety-provoking ones.

explain the onset and maintenance of excessive worry and GAD in adults, empirical support for these models remains limited in seniors, with several authors indicating a lack of studies to better understand GAD in this category (Basevitz, 2003; Bax-D'Auteuil et al., 2013; Nuevo et al., 2009).

1.5. Explanatory models of links between psychological variables, anxiety and GAD

Recent studies, conducted with adults, have attempted to explain the links between different psychological vulnerabilities related to the worries and symptoms of GAD (Gosselin & Magnan, 2010; Ouellet, 2014). First, they attempted to understand the indirect links between IU and worry, which would operate through a series of processes including NPO, mistaken beliefs about worry, and cognitive avoidance.

Intolerance of Uncertainty would lead to NPO by skewing an individual's assessment of a problem and affecting their ability to solve it. The individual with IU would then be more likely to focus on the uncertain aspects of a problem and interpret them as threatening

their emotion and perceives it as threatening and invasive; (4) the use of inappropriate strategies for regulating his emotions where a) the individual harshly identifies when or how to adjust his emotion in a situation, b) where he tries by various means to avoid his emotions and c) where he expresses them inadequately. Concretely, to escape the emotions experienced as intense, a person with GAD uses worry, as the work of Borkovec et al. (1993), because it reduces the attention directed to the emotional experience and therefore allows, in the short term, to regulate the emotion.

Mennin et al., (2000) noted that persons who met the criteria for GAD by questionnaire had higher levels of emotional intensity than their control group. They have significant difficulties in identifying, describing, and accepting their emotional experiences. They would also have deficits in their ability to calm down in presence of negative emotions compared to a non-anxious control group. These authors also showed that a composite score, including various measures of emotional regulation, significantly predicted the classification of GAD after controlling for worry, anxiety and the depression. These results replicated and validated in a group presenting a GAD and non-anxiety in control groups, with social anxiety disorder (Turk et al., 2001). Despite the relevance of models to

IU also thought indirectly influence anxiety by helping to form positive beliefs. For example, an individual with IU might develop the belief that worrying protects them from experiencing negative emotions, because thinking all of the possible negative scenarios; it can escape the uncertain elements linked to these scenarios. This avoidance of uncertainty, through positive beliefs, would then reinforce worries and IU (Dugas et al., 2004). To conclude with the model of Dugas and his colleagues (1998), the authors add that the attentional bias characteristic of people with GAD, further described by Tallis and Eysenck (1994), would be the consequence of the model's three cognitive vulnerabilities: IU, NPO, and mistaken beliefs about the usefulness of worrying.

Finally, other factors specific to aging relevant to consider, research on GAD has gradually produced more detailed and nuanced models for explaining excessive worries, some of which offer support among seniors. Variables specific to their period of life also seem to be considered in order to understand the concerns (e.g., related to health, aging) and GAD of seniors. Of these studies, some specifically target concerns about aging. Levy (2003) describe them as

(Dugas, Freeston, & Ladouceur, 1997), which would interfere with the problem-solving process. Since IU can lead to anxiety, stress and frustration in a problematic situation, IU could reduce resources cognitive and emotional necessary for its resolution according to Dugas and colleagues.

Gosselin and Magnan (2010) explain the relationship between IU and AC as follows: "Uncertainty, related to images of potential threats, helps explain why IU influences AC. Intolerance to these images would generate more thoughts, in verbal form, manifested in worry. IU would contribute to the cognitive avoidance of threatening images in the sense that images of potential negative situations would be difficult to tolerate. As a result, the individual would have difficulty not thinking about the possible negative effects associated with these situations and would try to avoid negative images. Instead of fully experiencing threatening images, the person tries to avoid them, making them all the more threatening. From there, the person with IU will use worry to anticipate negative consequences and avoid anxiety-inducing images; these strategies may reinforce the use of worry (Dugas et al., 2004).

Almost half have a university degree (48.3%) while 51.7% have a college diploma or elementary, secondary. In terms of health, 54.5% say they have at least one health problem while 44.3% do not. Only 8% of elders perceive their health as fair or poor, while 60% perceive it to be excellent or very good. Table 2 summarizes the distribution of data on socio-demographic variables.

2.2. Materials

2.2.1. Measures of GAD symptoms

The instrument used to measure the concerns and symptoms of GAD. The Penn State Worry Questionnaire (PSWQ; Gosselin, Dugas, Ladouceur, & Freeston, 2001). It has 16 items measuring the tendency to worry on a five-point scale. Results obtained from seniors with GAD support its unifactorial validity (Hopko et al., 2003). The abbreviated Arabic version used has eight items. It has strong internal consistency ($\alpha = 0.93$).

The Aging Opinion Survey (AOS; Kafer et al., 1980) has 45 items assessing on a five-point scale: (1) stereotypes related to loss in aging, (2) value social issues of seniors and (3) concerns about aging. Only the third

fears that aging means a threat to their well-being, loss of power and possibly loss of control over their lives.

2. Method

2.1. Participants

176 Iraqi retirees from the community aged 60 to 80. The sizes required varied between 106 and 217 participants. The sample size of the current study therefore considered adequate. To be included, participants had to a) be between the ages of 60 and 80, and b) be able to read and write in order to complete the questionnaires independently. The age limit was set based on studies noting notable differences between seniors aged 60 to 79 and those aged 80 and over in terms of stressful life events (e.g. bereavement, widowhood), physical illnesses and cognitive decline, increasing dramatically after age 80 (Barnes et al., 2014; Brodaty & Pachana, 2014). The sample includes 65.9% women and 34.1% men. The average age is 67.2 years ($SD = 5.6$; Min = 60 years; Max = 80 years). The majority of the sample is retired (85.2%) and of Iraqi origin (98.3%). Almost 62% of elderly are married or single, while 38.1% are single, widowed, separated or divorced. Most live in a retirement home (74.4%), 21.0% live in an apartment and 0.6% in a private house.

scale, an individual's tendency to consider unacceptable. The uncertainties of life. The higher the score (between 15 and 75), the more the individual tends to be intolerant of uncertainty. UII-A has a good factor structure and strong internal consistency ($\alpha = 0.93$). Its temporal stability is adequate ($r = 0.76$; test-retest five weeks apart; Gosselin et al., 2008). The study data allowed verification of internal consistency of UII-A among elderly ($\alpha = 0.94$).

The Attitude Problem Questionnaire (APQ; Gosselin, Ladouceur, & Pelletier, 2005) has 12 items assessing, on a five-point scale, the perception that a person has of his attitude towards his daily problems. The higher the score (between 12 and 60), the more the person has a negative orientation towards his problems. The APQ is faithful ($\alpha = 0.90$). It has a very good factor structure and excellent temporal stability (four-week interval; $r = 0.86$; Gosselin et al., 2001).

The cognitive avoidance questionnaire (CAQ; Roy, Langlois, Gosselin, Rhéaume, & Dugas, nd) has 15 items divided into five subscales measuring, in five points, each a cognitive avoidance strategy: (1) avoidance of triggers, (2) distraction, (3) suppression, (4) substitution, (5) image transformation. The higher

subscale was used (14 items). The score varies between 14 and 70. The higher the score, the more worries there are about aging. The reliability of the translated scale, having a unifactorial structure, is satisfactory ($\alpha = 0.76$).

The Worry and Anxiety Questionnaire (WAQ; Dugas et al., 2001) has six items measuring the criteria for GAD according to the DSM-IV (nine-point scale). The first item makes it possible to note the main concerns of the respondent. The other items each target a diagnostic criterion (excessive worries, somatic symptoms). The score ranges from zero to 56. The higher the score, the greater the symptoms of GAD. The results obtained at the WAQ show adequate sensitivity and specificity and they support its predictive validity and its inter-rater reliability (Dugas et al., 2001).

2.2.2. Measures of psychological variables

Six instruments used to measure psychological variables. The Uncertainty Intolerance Inventory Part A (UII-A; Gosselin et al., 2008) has 15 items assessing, on a five-point

2.2.3. Measures of clinical and situational variables)

The abbreviated Geriatric Depression Scale (Mini-GDS; Clément, Preux, Fontanier, & Léger, 2001) is a short version of the Geriatric Depression Scale (GDS; 30 items; Brink et al., 1982). It has four items measuring the depressive symptoms (dichotomous scale: yes, no). If the score is greater than or equal to one, there is a high likelihood of depression. The study data made it possible to verify the internal consistency of the Mini-GDS with the elderly ($\alpha = 0.69$).

The Attitudes to Aging Questionnaire (AAQ; Laidlaw et al., 2007) has 24 items measuring attitude to aging on a five-point scale. It has three subscales: psychosocial losses, physical functioning and psychological growth related to wisdom. A high score indicates a more negative attitude towards aging. Its structure converges in three factors. The internal consistency of the scales is satisfactory ($\alpha = 0.74$ to 0.81).

2. 3. Procedure

The Baghdad University ethics committee approved the study's recruitment protocol and psychometric tools. Recruitment was carried out throughout Iraq and other cities through social networks (Facebook, Velovia, website), by posting and by direct contact with circles in Baghdad (recreation

the score (between 15 and 75), the greater the cognitive avoidance. Its internal consistency is excellent ($\alpha = 0.95$). Its factor validity is adequate (five-factor structure) and its convergent validity is very good (Roy et al.).

The Why Worry, version 2 (WWI-II; Gosselin et al., 2003) has 25 items measuring, on a five-point scale, five mistaken beliefs about worrying. A high score (between 25 and 125) indicates beliefs that are more mistaken. The WWI-II has very good temporal stability (4 weeks; $r = 0.81$), excellent internal consistency ($\alpha = 0.93$) as well as excellent validity (Gosselin et al., 2003).

The Difficulties in Emotion Regulation Scale (DERS-18; Côté, Carrier, & Dagenais, 2009) is an abridged version of the original 36-item version, DERS, by Gratz and Roemer (2004). It includes 18 items distributed in 6 subscales. It measures ER difficulties on a five-point scale. The score varies between 36 and 180. A low score indicates a better ability to regulate emotion. Its six-factor structure is demonstrated. Its internal consistency ($\alpha = 0.74$ to 0.90) and its temporal stability are good (four to eight weeks; $r = 0.67$ to 0.81 ; Côté et al., 2013).

II) and the dependent variables of the study (PSWQ; AOS; WAQ), Pearson correlations were carried out followed by hierarchical regressions. A Bonferroni correction (α of $0.05 / 36 = 0.001$) was applied to limit the risk of type 1 error, due to the number of analyzes performed at this step. Significant associations moderate and strong observed between the psychological variables and the dependent variables, with the exception of the DERS emotional awareness subscale (DERS cotot) which does not show any significant association with the dependent variables. These results appear in table 1.

centers, associations for the elderly, etc.). Those in charge of the settings contacted by email to explain the terms and ethics of the study. When presenting the study to potential participants, the general goals presented to them. It was said that the data collected would be kept confidential. The volunteers completed the questionnaires on the Lime Survey site or in paper format (90 minutes duration)

3. Results

3.1. Analysis principles

In order to verify the links between the psychological variables (UII-A; APQ; CAQ; PSI-II; DERS; AAQ-

Table 1
Correlations between the variables of study

Variables	UII-A	APQ	CAQ	WWI-II	DERS Consciousness	DERS Clarity	DERS Non-acceptance	DERS Strategies	DERS Objectives	DERS Impulsiveness	AAQ-II
PSWQ	0,69*	0,71*	0,47*	0,42*	-0,09	0,36*	0,53*	0,63*	0,53*	0,50*	-0,68*
WAQ	0,70*	0,72*	0,51*	0,41*	-0,19	0,36*	0,57*	0,70*	0,58*	0,56*	-0,69*
AOS	0,63*	0,62*	0,39*	0,27*	-0,06	0,31*	0,49*	0,60*	0,50*	0,46*	-0,60*

Note. PSWQ : Penn State Worry Questionnaire; AOS : Aging Opinion Survey; WAQ : Worries and Anxiety Questionnaire; UII-A : Uncertainty Intolerance Inventory- Part A; APQ : Attitude Problem Questionnaire; CAQ : Cognitive Avoidance Questionnaire; WWI-II : Why Worry version 2; DERS : difficulties in Emotion Regulation Scale; AAQ-II: Acceptance and Action Questionnaire; AAQ : Attitudes to Ageing Questionnaire; * $P \leq 0,001$.

3.2. Effects of socio-demographic, clinical and situational variables

Pearson correlations and ANOVA were carried out in order to identify independent socio-demographic variables (age, gender, education, social status, employment status, place of residence, place of birth) and clinical (presence of disease, anxiety treatment, presence of depression by questionnaire, presence of loneliness by questionnaire, attitude towards aging and average level of suffering linked to negative events experienced in the last 12 months) linked to the dependent variables of the study. As shown in the table 2.

Table 2
Distribution of participants according to socio-demographic variables

Variables	<i>n</i>	%
Gender		
Man	60	34,10
Women	116	65,90
Age		
60-64 years	69	39,20
65-69 years	55	31,30
70-74 years	26	14,75
75-80 years	26	14,75
Educational level		
Primary	2	1,10
Secondary	39	22,20
College	40	22,70
University	85	48,30
Other	10	5,70
Social status		
Married	71	40,30
Common-law or partner	38	21,60
Single	26	14,80
Widower	19	10,80
Separate	4	2,30
Divorced	18	10,20
Employment status		
Retirement	150	85,20
Full time job	11	6,30
Part-time job	5	2,80
Neither retired nor employed	10	5,70
Place of residence		
Eldery residence	131	74,40

Rented accommodation	37	21,00
Private residence	1	0,60
Other	7	4,00
Health problem		
Yes	96	54,50
No	78	44,30
Perception of health		
Excellent	33	18,80
Very good	73	41,50
Good	54	30,70
Bad	1	0,60
Missing	2	1,10

4. Discussion

(Taha & Sijbrandij, 2021; Bano et al., 2021).

The presence of at least one disease would also lead to a greater tendency to worry in the sample. When an elder suffers from a physical illness, this can lead to various concerns directly related to the physical impairment (Brock et al., 2011).

Brock et al. specifically note that chronic degenerative conditions (e.g., arthritis) are of more concern than a one-time serious health problem (e.g., stroke).

The presence of a depressed mood as well as attitudes towards aging seem, on the other hand, to play a

First, socio-demographic, situational and clinical variables have been shown to be relevant in predicting the tendency to worry, concerns about aging and symptoms of GAD in seniors, even after considering the contribution of important psychological factors. The gender of the participants and the presence of at least one disease play a role in predicting the tendency to worry. Women aged 60 to 80 are more likely to report concerns about various situations and to be overwhelmed by their worries. This is consistent with several studies showing that women of different ages have higher levels of worry than men.

who exhibit a negative attitude about aging would experience various negative emotions on a daily basis, perceiving changes and difficulties as being related to aging.

Worry could then also act as an avoidance mechanism of the physiological reaction. It also appears that seniors, who exhibit negative social attitudes about old age as well as a negative perception of aging, largely due to a lack of knowledge about the reality of aging, will have higher levels of anxiety compared to getting older (Levy, 2003). The maintenance of negative stereotypes towards aging could encourage the emergence of concerns, in particular directed towards the fact of aging (Levy, 2003). It is also possible that the worries of the elderly, provoking unpleasant emotions, promote a negative view of aging. For example, the elderly, feeling a burden on society or living in isolation, will be more concerned with different aspects of their aging (e.g., autonomy, finances). This is in line with the results of Nuevo et al. (2009) observing, in their mediation model, that the lack of knowledge about aging leads to more concern, directly and also indirectly through uncertainty about aging. A group of elders, identified as chronically worried, also exhibited a negative attitude to aging and described aging as a time of isolation, loneliness, physical

role in the prediction of anxiety about aging. The link between depression and GAD, the central construct of which is worry has already demonstrated in the elderly (Ibrahim et al., 2017; Kathem et al., 2021). More specifically, this study indicates that depressed mood has a predictive impact on worries about aging. When a senior is depressed, they may tend to view aspects of their life more pessimistically and filter information from negative attentional biases.

Reflect on the fact of aging, the implications in the different spheres of life will then be tinted by the attitude cognitions and negative reactions specific to depressed people, and could then create additional concerns about this stage of life. Anxiety that arises in particular from negative attentional bias, i.e. paying more attention to negative emotional stimuli (eg, a sad face) than to positive or neutral stimuli (Heeren, 2016). Other authors have shown that both depressive rumination and anxiety can function to avoid unpleasant physiological aspects, in particular by decreasing images associated with thoughts (Turk et al., 2001). This could also explain the link between depressed mood and concerns specific to aging.

This latter explanation also applies to the observed result between negative attitude towards aging and specific worry about aging. People

tendency, specific aging concerns, and symptoms of GAD. It also seems to explain a larger portion of the worries and symptoms of GAD, compared to the other psychological factors involved. The higher the IU level of seniors, the more general the tendency to worry, the specific concerns about aging and symptoms of GAD appear to be elevated.

People between the ages of 60 and 80, who have a greater need to feel in control of the future and its uncertainties, may also worry about entering a new stage in their life that involves changes major (e.g. retirement, physical, cognitive and emotional losses. (Rebok, Parisi, & Kueider, 2014; Nuevo et al., 2009). Worrying about the topic of aging would then be a way for them to try to anticipate changes, in order to feel less uncertain about their future.

IU was also shown to be a significant predictor of symptoms of GAD in seniors in this study. Seniors, who seem to negatively filter ambiguous elements of their environment and experience them as unacceptable, tend to present concerns pathological and somatic symptoms of anxiety. Buhr and Dugas (2002) have already pointed out that IU is linked to a tendency to believe that uncertainty is stressful,

stress and illness (Wisocki, 1994).

Considering psychological factors, participants' gender and medication intake also play a role in predicting symptoms of GAD. It appears that in addition to having higher concerns than men, the women in the study had more overall GAD symptoms and reported more interference from their worries and anxiety symptoms, as measured by the tool used. This result makes sense with what emerges from the literature, for all age groups, including epidemiological studies (Vesga-López et al., 2008). In addition to this previously explained, in terms of gender differences in the tendency to worry, a woman may tend to better assess the disabling nature of her worries and anxiety. Some explain that women are twice as likely to present with GAD as men, because the latter have a higher threshold of social tolerance to suffering and therefore present themselves for therapy in higher suffering conditions than women (Allgulander, 2007). Other authors understand this difference between the sexes through distinct hormonal causes and life events (Howell, Brawman-Mintzer, Monnier, & Yonkers, 2001).

Intolerance of uncertainty is the only variable in this study that predicts both general worrying

specific contribution of different psychological variables which have been considered important by various authors over time. This concern sets it apart from other correlational studies. At the same time, a socio-demographic variable (sex), a clinical variable (presence of at least one disease) as well as psychological factors (II, erroneous beliefs and experiential avoidance) were found to be significant predictors of the tendency to worry in the 60 to 80 age group.

The results also confirmed the importance of depressed mood, attitude towards aging and IU in the prediction of concerns specific to aging. The results also confirmed the importance of being interested in sex, medication, IU, mistaken beliefs, and emotional regulation strategies when it comes to predicting symptoms of GAD elderly. The results also confirmed the importance of depressed mood, attitude towards aging and II in the prediction of concerns specific to aging. The results also confirmed the importance of looking at sex, IU, mistaken beliefs, and emotional regulation strategies when it comes to predicting symptoms of GAD in elderly.

Then, analyzes of indirect effects made it possible to identify significant indirect effects of two constructs, the erroneous beliefs about the fact of worrying and the experiential avoidance, in the bond between the IU and the tendency to

unfair and frustrating, that it leads to an inability to act or to negative events and that it should therefore be avoided at all costs. Elderly, struggling with more IU, may then frequently present with difficult-to-control worries about different areas of their life as well as unpleasant physical sensations affecting their functioning (e.g., nervous nerves, memory loss, tension. muscle).

5. Conclusion

The aim of the present study was to provide preliminary results regarding the psychological and clinical factors associated with the presence and maintenance of symptoms of GAD in people aged 60 to 80 years. More specifically, it aimed to explore how these factors could be associated with each other in order to predict general worrying tendency, specific aging concerns and symptoms of GAD in the aging Baghdad population. In addition, she was checking an effects model indirect used to better understand how certain psychological factors influence each other in the prediction of the tendency to worry.

The results confirmed the importance of several variables in predicting the tendency to worry. The control of several relevant and specific variables in aging allowed verifying in a careful way the

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be worry. This study is the first to verify the indirect effects of key psychological factors, of different explanatory models of GAD, in the bond between IU and the tendency to worry among elderly people of Baghdad. The results could be used in the improvement of treatments cognitive-behavioral with the specific clientele represented by seniors struggling with GAD.

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