

Craig D. Marker · Alison G. Aylward

Generalized Anxiety Disorder



Advances in
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Generalized Anxiety Disorder

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Advances in Psychotherapy – Evidence-Based Practice

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Preface

Generalized anxiety disorder (GAD) refers to a condition in which someone has excessive worry that is uncontrollable. This disorder is one of the most common anxiety disorders; left untreated, it can lead to a significant impairment in a person's life. It is often a chronic condition, and it is associated with functional disability, poor quality of life, and increased health care costs (Borkovec & Ruscio, 2001). However, there are effective treatments for GAD, including psychological and pharmacological treatments. This book describes the components of an empirically supported psychological therapy for GAD. This treatment integrates components of cognitive techniques and exposure techniques, as well as newer techniques of mindfulness and acceptance practices. This book is intended for a variety of mental health professionals including psychologists, psychiatrists, social workers, general medical practitioners, other mental health professionals, and trainees in all of these fields.

People with GAD experience uncontrollable worry about a range of topics

This book is divided into six chapters. The first two chapters are designed to provide a theoretical and descriptive overview of generalized anxiety disorder (GAD). Chapter 1 reviews prevalence, comorbidity, and differential diagnosis. GAD is often difficult to diagnose and some of the diagnostic confusion can be traced back to earlier diagnostic definitions that considered GAD a residual diagnosis if other anxiety disorders did not fit. The diagnosis of GAD is now much more reliable, and a reliable diagnosis is vital in treatment planning (Brown, Di Nardo, Lehman, & Campbell, 2001; Starcevic & Bogojevic, 1999). In Chapter 1, descriptions of common differential diagnoses are discussed in an attempt to assist the practitioner in providing the correct diagnosis. Chapter 2 reviews the leading theoretical models and research on the development and maintenance of GAD. Specifically, an attempt is made to discuss the most researched and theoretically relevant models, including intolerance of uncertainty, worry as cognitive avoidance, and positive beliefs about worrying.

Chapter 3 describes an overview of the key domains that should be considered when assessing someone with GAD. These domains are an important aspect of diagnosis. However, they are also vital to treatment in that the assessments can assist treatment planning in focusing on specific areas of difficulty. In Chapter 4, cognitive behavioral therapy (CBT) techniques for GAD are discussed. Each of these techniques is linked with theoretical models to provide a background of possible reasons each technique might work. Evidence on the efficacy of these techniques and practical suggestions for their application are also provided. Clinical descriptions are presented throughout the book, and Chapter 5 is dedicated to a clinical case vignette in which treatment is described from start to finish. Chapter 6 includes suggestions for further reading. The Appendix provides many useful assessment measures and clinical forms that can be utilized in treatment.

The empirical support for CBT for GAD is promising. This book attempts to bridge the divide between the research and day-to-day practice. Ideally, a

practitioner will use this book with other readings, support from workshops and colleagues, and supervision opportunities.

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This book is based on numerous experts' work on GAD, including that of Aaron T. Beck, Thomas D. Borkovec, Michel J. Dugas, Richard G. Heimberg, Robert Ladouceur, Colin MacLeod, Michael W. Otto, Susan M. Orsillo, Elizabeth Roemer, and many others.

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CM

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AA

Table of Contents

| | |
|--|-----------|
| Preface | v |
| Acknowledgments | vi |
| 1 Description | 1 |
| 1.1 Terminology | 1 |
| 1.2 Definition | 1 |
| 1.3 Epidemiology | 3 |
| 1.4 Course and Prognosis | 3 |
| 1.5 Differential Diagnosis | 4 |
| 1.5.1 Depression | 4 |
| 1.5.2 Social Anxiety | 5 |
| 1.5.3 Specific Phobia | 5 |
| 1.5.4 Panic Disorder with Agoraphobia | 5 |
| 1.5.5 Obsessive Compulsive Disorder | 6 |
| 1.5.6 Posttraumatic Stress Disorder | 6 |
| 1.6 Comorbidities | 7 |
| 1.7 Diagnostic Procedures | 7 |
| 1.7.1 Interviewer-Administered Measures | 8 |
| 1.7.2 Self-Report Severity Measures | 8 |
| 1.7.3 Assessing Suitability for Treatment | 11 |
| 2 Theories and Models of Generalized Anxiety Disorder | 12 |
| 2.1 Worry as Cognitive Avoidance | 12 |
| 2.2 Positive Beliefs About Worry | 14 |
| 2.3 Uncertainty and Worry | 15 |
| 2.4 Information-Processing Biases Associated with GAD | 16 |
| 2.5 Metaworry | 17 |
| 2.6 Implications for Treatment | 18 |
| 3 Diagnosis and Treatment Indications | 20 |
| 3.1 Key Features to be Assessed | 20 |
| 3.1.1 Situational Triggers | 20 |
| 3.1.2 Physical Features | 21 |
| 3.1.3 Information Processing | 21 |
| 3.1.4 Cognitive Avoidance Strategies | 22 |
| 3.1.5 Intolerance of Uncertainty | 22 |
| 3.1.6 Function of Worry | 22 |
| 3.1.7 Interpersonal Issues | 23 |
| 3.1.8 Behavioral Avoidance | 23 |
| 3.1.9 Metaworry | 23 |
| 3.1.10 Comorbidities | 24 |
| 3.1.11 Functional Impairment | 24 |
| 3.2 Overview of Effective Treatment Strategies | 24 |

| | | |
|----------|---|-----------|
| 3.3 | Factors that Influence Treatment Decisions | 26 |
| 3.3.1 | Age, Sex, and Ethnicity | 26 |
| 3.3.2 | Education | 26 |
| 3.3.3 | Family and Relationship Factors | 27 |
| 3.3.4 | Client Preference | 27 |
| 3.3.5 | Treatment History | 27 |
| 3.3.6 | Ability to Articulate Cognitions | 27 |
| 3.3.7 | Severity of Positive Beliefs About Worry | 27 |
| 3.3.8 | Comorbidities | 28 |
| 4 | Treatment | 29 |
| 4.1 | Methods of CBT | 29 |
| 4.1.1 | Psychoeducation | 33 |
| 4.1.2 | Cognitive Strategies | 35 |
| 4.1.3 | Exposure-Based Strategies | 37 |
| 4.1.4 | Relaxation and Acceptance-Based Strategies | 40 |
| 4.2 | Mechanisms of Action | 41 |
| 4.2.1 | Cognitive Models | 41 |
| 4.2.2 | Behavioral and Emotional Processing Models | 42 |
| 4.2.3 | Acceptance-Based Models | 43 |
| 4.3 | Efficacy and Prognosis | 44 |
| 4.3.1 | Efficacy of CBT | 44 |
| 4.4 | Combination Treatments | 45 |
| 4.4.1 | Medication Treatments | 45 |
| 4.4.2 | Comparing and Combining Medications and CBT | 45 |
| 4.5 | Overcoming Barriers to Treatment | 45 |
| 4.5.1 | Treatment Ambivalence | 45 |
| 4.5.2 | Homework Noncompliance | 47 |
| 4.5.3 | Adapting Treatment for Comorbidities | 47 |
| 4.6 | Adapting Treatment for Different Age Groups | 48 |
| 4.6.1 | Children and Adolescents | 48 |
| 4.6.2 | Older Adults | 48 |
| 4.7 | Adapting Treatment for Different Cultures | 49 |
| 5 | Case Vignette | 50 |
| 6 | Further Reading | 57 |
| 7 | References | 58 |
| 8 | Appendix: Tools and Resources | 65 |

1

Description

1.1 Terminology

Generalized anxiety disorder (GAD) is characterized by excessive worry that is difficult to control. Worry is defined as an attempt to engage in mental problem solving on an uncertain issue with a potential threat outcome (Borkovec, Robinson, Pruzinsky, & Depree, 1983). GAD is diagnosed when the worry causes significant impairment and distress in the person's life, and it impairs the person's ability to function (e.g., at work or school, in relationships, etc.). Some common content areas of worry include:

- family/home/relationships
- finances
- work/school
- illness/health
- psychological/emotional
- future
- success/failure
- travel
- world issues
- minor matters.

The key difference between this diagnosis and “regular worry” is that the worry must be excessive (much more frequent than normal worry) and difficult for the person to control. The worries are not focused on one situation (e.g., having a panic attack or feeling embarrassed), but extend to a number of events.

People use worry to solve potential problems

In GAD, normal worry becomes excessive and difficult to control

1.2 Definition

GAD has undergone several changes within the last few editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 1980, 1987, 1994). The term *GAD* first emerged with the publication of the DSM-III (American Psychiatric Association, 1980). At the time, GAD was described as “persistent anxiety,” with symptoms of motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance. The current *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organization, 1992) describes GAD in a very similar manner to the DSM-III, with generalized and persistent anxiety as the primary features. However, poor reliability of the DSM-III diagno-

Both the DSM-III-R and DSM-IV expanded and improved the diagnostic criteria for GAD

sis of GAD was seen using these features. Also, GAD was seen as mainly a residual category for those patients who did not experience phobic avoidance or panic attacks. The DSM-III-R (American Psychiatric Association, 1987) improved upon the diagnostic criteria for GAD by shifting the primary feature from persistent anxiety to excessive or unrealistic worry (Starcevic & Bogojevic, 1999). The DSM-IV (American Psychiatric Association, 1994) further improved upon the definition of GAD and defined it as excessive worrying that is difficult to control (see Table 1). Thus, GAD is a chronic condition that is different from regular worry in that it is excessive (i.e., occurs with greater frequency than normal worry) and uncontrollable. Furthermore, a person with GAD must also endorse three or more of the following six symptoms: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance. Another important feature is that the excessive worry must cause significant distress and impairment. The text revision of the DSM-IV (American Psychiatric Association, 2000) did not make any changes to the

Table 1.
DSM-IV-TR 300.02 Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.
 - (1) restlessness or feeling keyed up or on edge
 - (2) being easily fatigued
 - (3) difficulty concentrating or mind going blank
 - (4) irritability
 - (5) muscle tension
 - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

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2

Theories and Models of Generalized Anxiety Disorder

This chapter covers a number of models that have been proposed to explain how GAD, and more specifically worry, develops and how it is maintained. Each of these models has been substantially supported by research. These models cover three basic components of worry: predispositions to worry (one's intolerance of uncertainty and positive beliefs about worry), perceptions of threat (information-processing biases), and reinforcers of worry (worry as cognitive avoidance and metaworry). For the most part, these models are complimentary in that they can fit together within an overarching framework in which each model explains an important element in the origin or maintenance of excessive worry. This section presents the descriptions of each model followed by an attempt to integrate these models into one comprehensive model, which is presented at the end of the chapter. To illustrate these models, some case examples are included. Chapter 5 also includes a case vignette describing Laura, a 36-year-old mother of two, who was diagnosed with GAD.

2.1 Worry as Cognitive Avoidance

Tom Borkovec believes worry is a superficial mechanism that can be used to avoid deeper emotional content

One model of GAD, originally posited by Thomas Borkovec and colleagues, posits that worry is used as a means to avoid threatening cognitive and emotional content. Although this model may be counterintuitive at first, it posits that worry has an important function for people with GAD. Specifically, worry is thought to be a linguistic process that does not tap into deeper mental images (and thus anxiety related to these images). Thus, worrying does not allow deeper emotional processing. To say it another way, worry is used to avoid processing an emotional experience completely. Although the worry is troubling to the person with GAD, it may actually be serving as a way for the person to process negative information on a superficial level with less emotional intensity and distress. The person can avoid some of the negative emotions associated with the worry if he or she processes it only linguistically and without mental imagery. Indeed, studies have found that people who were worrying did not create imagery; rather worry was experienced as a negative verbal/linguistic activity (e.g., Borkovec & Inz, 1990). Additionally, Vrana, Cuthbert, and Lang (1986) found that people verbally articulating fear material created much less heart rate activity than when imagining the same frightening situation. Moreover, individuals have reported that they use worry to avoid

more distressing topics (Borkovec & Roemer, 1995). Thus, worry is thought to only activate the verbal linguistic network and may be less distressing than other negative emotions.

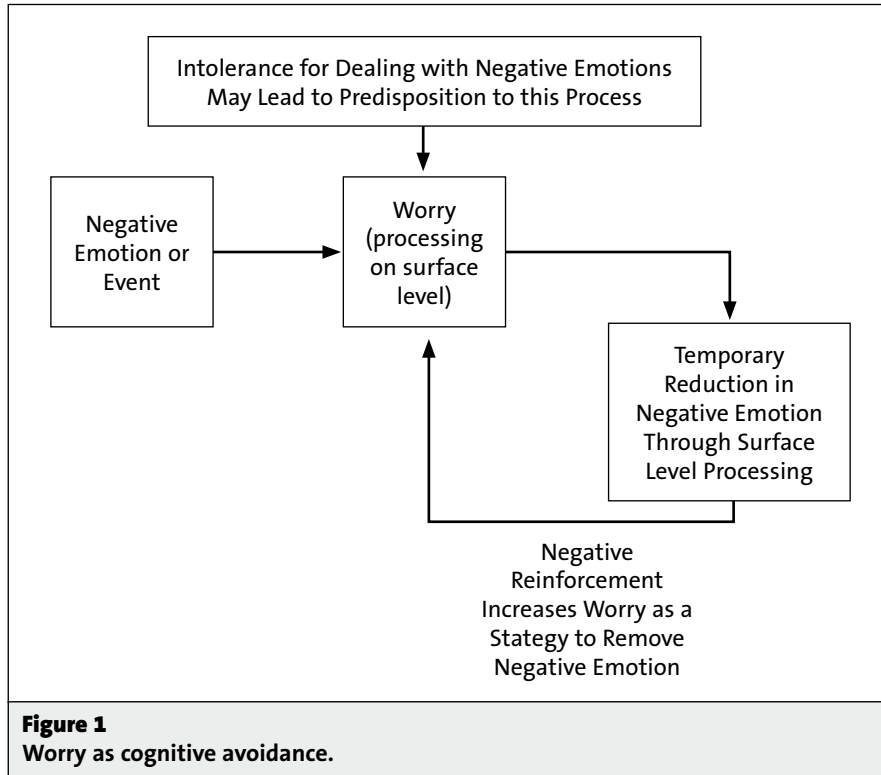
In this model, worry is viewed as a negative reinforcer. Just as taking an aspirin gets rid of a headache, worry gets rid of negative emotions. Often, these negative emotions arise from a previous worry. Thus, the person may jump from worry to worry without fully processing any worry. In the short-term, the person feels relief from not experiencing the anxiety at a deeper level. However, in the long-term, worry inhibits the person from emotionally processing the information (see Figure 1). In addition, because of the reinforcement associated with worrying, the person may actually worry more. Thus, for people with GAD, worry is a paradox. The worry has short-term benefits of reducing negative emotion, but the worry has long-term consequences of causing greater distress. There is also some indication that people may be more susceptible to this process if they have greater intolerance for dealing with negative emotions. Thus, assessment of how one copes with negative emotions may also be important (see also the AAQ-II in the subsection “Emotional Avoidance” in Section 1.7.2). An important treatment implication stemming from this model is that a person with GAD may benefit from processing negative emotions more deeply to reduce levels of worry in the long-term (see also Section 4.1.3).

Additionally, others have also highlighted that verbal processing impedes other environmental and experiential information from being processed (e.g., Roemer & Orsillo, 2002), which can prevent the learning of nonthreatening associations. Hayes, Strosahl, and Wilson (1999) purport that verbal processes initiate behavior through verbal contingencies rather than contact with contingencies that are present in the environment. Consequently, individuals may be relying on verbally rule-based behaviors while the environment presents contradictory information. Moreover, behavior that is verbally rule-based can be very resistant to disconfirming environmental evidence and will thus persevere (Hayes & Ju, 1998). As a result, worry prevents the extinction of fear because experiential avoidance is reinforced and the verbal-linguistic processes prevent experiential disconfirming associations from being learned.

For instance, let’s consider a client, Mary, who came into treatment complaining of constant anxiety. She reports that she is “terrified of feeling anxiety” as soon as she wakes up in the morning and does “whatever I can to avoid it.” She reports that she worries “all the time.” And indeed, in session, she cannot seem to focus on detailing one worry but rather “jumps” from worry to worry. The therapist has a hard time focusing Mary because so many threatening worries are coming to her mind. When the therapist asks Mary if she ever focuses on the frightening images associated with one worry, she states, “I couldn’t bear doing that” and “I avoid picturing anything related to my worries.” Mary notices that she worries all the time, and she reports that she deliberately avoids focusing on the frightening images associated with her worry. Moreover, she feels that she is totally unable to control the constant worry she experiences. Mary’s treatment will focus on helping her process these emotions more fully through the use of exposure (i.e., exposure to her worries).

Worry helps people avoid experiencing negative emotions

Worry is a verbal process that prevents people from attending to important environmental information



2.2 Positive Beliefs About Worry

**Worry can help
someone anticipate
and plan for the
future**

Worry is thought by many people to have many positive qualities, such as aiding in anticipating and planning for bad outcomes in the future. For people with GAD, these positive qualities of worrying may be highly valued. People with GAD report that worry functions as a way to (1) avoid or prevent bad events, (2) motivate oneself to get things done, (3) prepare for the worst, (4) problem-solve, (5) distract oneself from even more emotional topics, and (6) superstitiously lessen the likelihood of bad events. Distracting oneself from more emotional topics coincides with the model of worry as an avoidance strategy (see above Section 2.1).

For people with GAD, their belief in the superstitious efficacy of worry is reinforced both by the nonoccurrence of feared outcomes and those situations in which they effectively deal with the stimuli triggering their worries. Consequently, their belief that worry is positive may be strengthened, and the frequency of worries may increase (see Figure 2). However, recent research has found that inducing positive beliefs about worry does not necessarily lead to more worry (Prados, 2010). That said, this research was done on a nonclinical population, and the results may not generalize to individuals with GAD. Therefore, it is recommended that changing these beliefs be an important component of CBT (see Section 4.1.2).

For example, Mary expressed that she “has to” worry because otherwise she would not effectively handle important situations. She reports that if she

Diagnosis and Treatment Indications

This chapter provides the clinician with a framework for understanding a client's GAD and for selecting an appropriate course of treatment. It begins with a discussion of key features to be assessed, followed by an overview of effective treatment strategies and guidelines on how to use information from the assessment to help guide a plan for treatment.

3.1 Key Features to be Assessed

Key features that should be assessed include situational triggers, physical features, information processing, cognitive avoidance strategies, intolerance of uncertainty, beliefs about the function of worry, interpersonal issues, behavioral avoidance, and metaworry. The extent that these various features are present will influence the type of strategies that are used. Many of the instruments that are mentioned to assess these features are discussed in Chapter 1 and are available in the Appendices.

3.1.1 Situational Triggers

GAD presents itself differently than other anxiety disorders in regards to situational triggers. In specific phobia or social anxiety, there is a clear identifying situational trigger that brings about fear, and this trigger is often avoided. However, triggers for worries can come from many sources. A careful assessment of situational triggers would include asking questions such as those below.

Questions to Ask

"In what situations do you notice yourself worrying more?"

"In what situations do you find yourself worrying less?"

"Does anything you do lead to more (or less) worrying?"

"Can you control your worries?"

"When do worries come into your mind for no apparent reason?"

In GAD, situational triggers are more diffuse and may be harder to identify than in other anxiety disorders

Knowing when the client's worry is worse and what helps lessen the worry has important therapeutic implications. These situational triggers may

aid in determining which strategies will be helpful in reducing the client's worry.

3.1.2 Physical Features

GAD presents a different physiological profile than other anxiety disorders. Although people with GAD may have panic attacks, the physiological symptoms related to fear might not be commonly experienced in those with GAD as they are in other anxiety disorders. People with GAD do, however, often experience a great deal of muscle tension from worrying over a long period. Muscle tension is unique to GAD, and it is not a diagnostic criterion for other anxiety disorders or depression. Although one could provide a comprehensive electromyography exam to assess muscle tension, a self-report of where and when muscle tension is commonly felt is usually sufficient.

The experience of muscle tension is only seen in GAD

3.1.3 Information Processing

As mentioned in Section 2.4, people with GAD often process ambiguous stimuli as threatening. More specifically, this might mean that people with GAD will worry about things that other people do not perceive as threatening. Some examples include worrying about minor matters or world events. One study (Barlow, 1988) found that the question "Do you worry excessively about minor things?" effectively discriminated individuals with GAD from other disorders. Furthermore, another study by Roemer, Molina, and Borkovec (1997) found that minor matters was a category of worry that people with GAD endorsed significantly more often than a nonclinical group (see Table 4).

Patients with GAD worry about relatively minor matters

Table 4
Content of Worries (Percentages of Worries)

| Subject of Worries | GAD | Nonclinical |
|-------------------------------------|------|-------------|
| Family/Home/Relationships | 31.4 | 28.2 |
| Work/School | 22.0 | 36.6 |
| Illness/Health | 9.6 | 9.9 |
| Finances | 10.8 | 5.6 |
| Miscellaneous (subcategories below) | 26.3 | 19.7 |
| Success/Failure | 14.8 | 35.7 |
| Future | 12.2 | 14.3 |
| Psychological/Emotional | 20.9 | 28.6 |
| Minor Matters / Routine | 45.2 | 7.1 |
| Travel | 6.9 | 14.3 |

Note. GAD = generalized anxiety disorder. Adapted from Roemer, Molina, Litz, & Borkovec (1997).

4

Treatment

4.1 Methods of CBT

Treatment of GAD typically lasts between 10 and 15 weekly sessions. Sessions usually last between 50 min and an hour, but exposure-based sessions may last somewhat longer, frequently between 90 min and 2 hr. Therapy often includes a variety of strategies, including psychoeducation procedures, cognitive strategies, exposure-based strategies, relaxation and acceptance strategies, as well as methods to reduce or prevent relapse. This section discusses each of these strategies in detail.

This structure is quite flexible in that clients will be able to progress through therapy topics at a different pace. Thus, this structure can be seen as a recipe, which will be modified based on the “tastes” of the client. At times, the client may not fully understand or be able to fully implement the techniques associated with a particular approach. We like to think that even though the client has not fully grasped the concept involved, a seed has been planted that may germinate in time. That is, the client may not fully understand how to implement the technique in practice until time has passed. Additionally, the structure presented herein is specified for a person with only a diagnosis of GAD. For people with comorbid disorders, additional time might need to be spent on specific topics. Finally, other events can occur in a person’s life that might take away attention from the following structure. Hence, this structure is seen as a rough sketch of a therapy structure for someone with GAD. The boxes below provide an example of a session-by-session summary of topics covered in a 10-session therapy.

Session 1

- Develop agenda in collaboration with client
- Discuss assessment and diagnosis
- Discuss and develop initial case conceptualization in collaboration with client
- Introduce GAD treatment strategies
- Assign homework of reading over case conceptualization

Overall, the goal of this session is to plan the course of therapy with the client. We find that it is very important to provide the client with a great deal of hope in this session. That is, it is important to raise the client’s expectancies that this therapy is designed for him or her and has been quite successful in

previous clients and in research studies. It is also important to have the client take responsibility for change. Having the client participate in conceptualization and treatment planning can help him or her feel responsible for change and enhance his or her sense of self-efficacy. As mentioned above, clients may not fully understand everything that is discussed immediately. Thus, it is important to let them know that some topics might not instantly lead to change and that it takes time for those ideas to germinate before they are fully formed.

Session 2

- Develop agenda in collaboration with client
- Review of homework and cognitive model of GAD
- Discuss intolerance of uncertainty model and how it influences client's worry
- Identify manifestations of intolerance of uncertainty
- Assign homework of monitoring worry and situations with need for certainty

The focus of this session is explaining the model of intolerance of uncertainty. This topic can be difficult sometimes for clients to understand. Bringing in examples from the client's life can be helpful. The therapist should explain that no one loves uncertainty, and it is normal to want to know what is going to happen. However, this need to know, in the extreme, leads to problems. It is important to emphasize that much of what the client does is normal, but that doing too much of it (e.g., excessive worry) leads to problems (distress).

Session 3

- Develop agenda in collaboration with client
- Review of homework and intolerance of uncertainty model
- Discuss positive beliefs about worry model
- Identify and evaluate positive beliefs about worry
- Assign homework of pros and cons of worry

A review of the intolerance of uncertainty model is very important in this session. We encourage the client to bring up instances in the past week when he or she noticed intolerance of uncertainty. Investigating what happened during those situations is vital. The new topic for this session is positive beliefs about worry. That is, the client is asked to identify how worry is beneficial. The WWS-II and the COWS can be helpful to generate positive beliefs about worry. As mentioned above, worry is part of normal adaptive functioning. However, for a person with GAD, worry has diminishing returns (and harmful effects).

In this session, multiple topics are investigated. Reviewing positive beliefs about worry and intolerance of uncertainty is important. Furthermore, new topics such as metaworry, overestimates of the probability of risk, and catastrophizing are discussed. We find that keeping old newspaper clippings of headlines describing doomsday scenarios are helpful in illustrating the idea that all of us are prone to worry. Although the headlines may have led to a great deal of

5

Case Vignette

This chapter describes a case example of an individual with GAD, along with a treatment plan. Treatment lasted for 12 sessions. The client experienced a reduction in symptoms as evidenced by lower scores on self-report symptom questionnaires.

Case Vignette: Laura's Worry

Laura, a 36-year-old mother of two children and an administrative assistant, presented with concerns about worrying too much. Her worry reportedly was causing difficulties in sleeping, muscle tension, and difficulties in getting her work completed. She came to treatment because "I am worrying that I worry too much."

The clinician conducted a structured clinical interview using the Anxiety Disorders Interview Schedule for DSM-IV. Laura indicated a significant amount of distress and impairment with regard to GAD. She also indicated some mild depression symptoms, but not enough to qualify for a major depressive episode or major depressive disorder.

Assessment

On the Worry Domains Questionnaire, Laura indicated significant levels of worry across many domains (obtaining a total score of 97 out of 125). Her score of 74 on the Penn State Worry Questionnaire was very similar to the mean of a clinical sample of people with GAD. Similarly, she self-reported having many of the criteria of GAD on the Worry and Anxiety Questionnaire.

Laura indicated a high level of intolerance of uncertainty as measured by the Intolerance of Uncertainty Scale (score of 84). She also indicated many positive beliefs about worry as assessed by the Why Worry Scale and the Consequences of Worry Scale. She indicated some reluctance to experience negative internal states as evidenced by the Acceptance and Action Questionnaire. Additionally, she indicated worry about worry on the Meta-Worry Questionnaire.

Laura's self-reported depression was in the mild range (z score of -1.5 compared with a clinical group). Her stress score was in the moderate range and her anxiety score was in the mild range.

Below is an example of a conversation with the therapist during the assessment. It illustrates one of Laura's worries and how she attempts to avoid thinking about her situation too deeply. It also demonstrates her tendency to jump from worry to worry.

Therapist: Tell me something that you worried about recently.

Client: Last night, the phone rang at 10:00. The phone really causes me to worry a lot, but someone calling that late makes me think that something bad has happened. It was actually a wrong number, but it made me start worry about my Mom. I have been worried that she is getting older. She turned 62 in July.

Therapist: So when the phone rang, what was your worry about your mother?

Client: The ringing of the phone startled me. It got me thinking that something might have happened to my Mom. I started to worry about her. I worry because she has fallen in the past, and I think she might fall and break a hip or something. Or maybe she might get sick ... or get cancer. I worry about all of these things.

Therapist: What do you picture happening if your mom did pass away?

Client: Well ... I don't even know. I don't even want to think about that. It gets me really anxious. I would rather think about something else. I wouldn't even know what to do. I would have so many responsibilities....

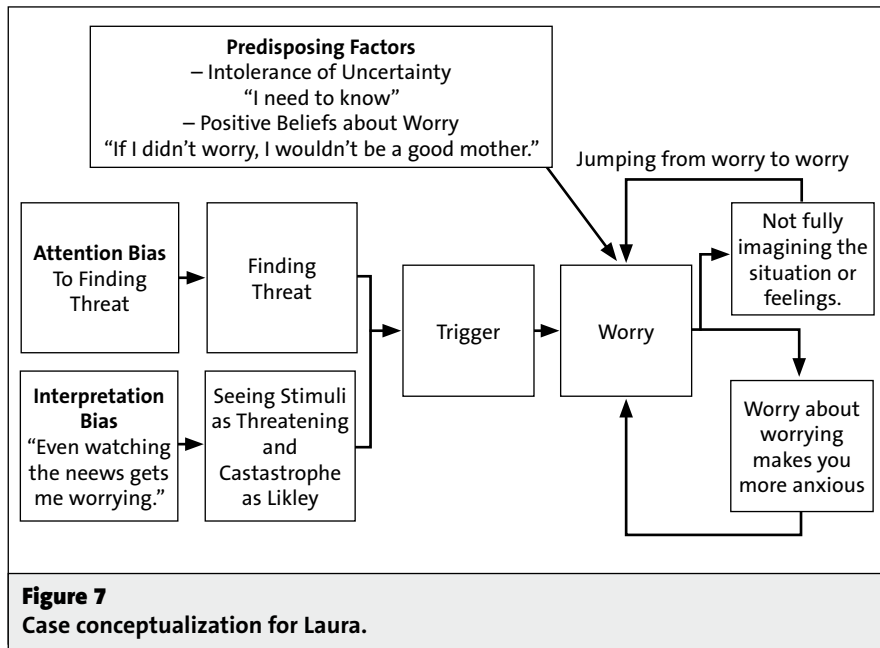
Psychoeducation and Treatment Conceptualization Discussion

Following her assessment, the clinician and Laura discussed treatment options and her case conceptualization (see Figure 7). The client agreed that her worry was excessive, and she wanted treatment. Laura and her therapist agreed that weekly sessions would be best based on Laura's schedule. A discussion of the general format of treatment was discussed (e.g., length of sessions, homework) and psychoeducation about GAD began. A big part of the psychoeducation was to discuss Laura's case conceptualization (see Figure 7). Part of the discussion about how different factors maintained Laura's high amount of worry is presented below.

Therapist: Jumping from worry to worry can reduce anxiety in the short run but may actually be maintaining your anxiety over the long run. That is, by not fully imagining how the worry could unfold, you are actually getting rid of the anxiety like an aspirin gets rid of a headache. However, there is a consequence of trying to get rid of the anxiety – it actually makes the worry seem much worse than it truly is. That is, you never see that you could handle the situation because you never let yourself fully imagine it. That said, it is quite natural and understandable to want to get rid of the anxiety.

[...]

Therapist: Worry can help us prepare for future danger or threat. It helps us to figure out what we can do to fix the situation. There are several factors that maintain excessive worry. One is the tendency to try to distract yourself from worrying without feeling as though you've resolved anything in your mind. Worrying through one situation completely can lead us to come up with a variety of solutions. When we don't allow ourselves to think things through



and to imagine our worst possible fears coming true, worry can spiral into increased worry and anxiety. Do you ever find yourself trying to think about something else when you start worrying?

Cognitive Components of Treatment

Following the psychoeducation portions of treatment, the therapist explained thoughts and how they affect Laura's worry. A transcript of some of that discussion is presented below.

Therapist: Thoughts are instrumental in affecting emotions like anxiety. The key question to ask yourself is whether your judgment of risk is true. Or is this worry really likely or probable? For the most part, people with excessive worry overestimate the likelihood that their worry will come true. We are going to challenge the worries and anxious thoughts when they are out of proportion with the actual risk. Thinking is often an automatic process, so it may be difficult at first to identify these thoughts when you're anxious. Let's look at one of your worries you mentioned, the one that your daughter might get hurt ice-skating. What specifically were you worried about?

Client: That she would get seriously hurt. She skates so fast and now she is skating with a male partner. So not only is she at risk of falling, but now she is supposed to be tossed and spun by her partner.

Therapist: How specifically do you imagine your daughter getting hurt?

Client: Probably a broken neck. Something that will result in paralysis or death. It has happened before.

Therapist: What injuries have happened to your daughter previously?

Client: Nothing, really. She has jammed her fingers and gotten scratched a bit falling on the ice. But it is so slippery, and she moves so fast.

8

Appendix: Tools and Resources

- Appendix 1: Penn State Worry Questionnaire (PSWQ)
- Appendix 2: Worry Domains Questionnaire (WDQ)
- Appendix 3: Why Worry Questionnaire (WW-II)
- Appendix 4: Consequences of Worry (COWS)
- Appendix 5: The Acceptance and Action Questionnaire (AAQ-II)
- Appendix 6: Intolerance of Uncertainty Scale (IUS)
- Appendix 7: Depression, Anxiety, and Stress Scale (DASS-21)
- Appendix 8: Meta-Worry Questionnaire (MWQ)
- Appendix 9: Worry and Anxiety Questionnaire (WAQ)
- Appendix 10: Case Conceptualization Form for Client
- Appendix 11: Intolerance of Uncertainty Monitoring Form
- Appendix 12: Example of Pie Chart Representing Valued Areas

Penn State Worry Questionnaire (PSWQ)

Enter the number that best describes how typical or characteristic each item is of you, putting the number next to the item.

- | 1 | 2 | 3 | 4 | 5 |
|--|---|---------------------|---|-----------------|
| Not at all typical | | Somewhat typical | | Very typical |
| 1. _____ | | | | |
| If I don't have enough time to do everything, I don't worry about it. | | | | |
| 2. _____ | | | | |
| My worries overwhelm me. | | | | |
| 3. _____ | | | | |
| I do not tend to worry about things. | | | | |
| 4. _____ | | | | |
| Many situations make me worry. | | | | |
| 5. _____ | | | | |
| I know I shouldn't worry about things, but I just cannot help it. | | | | |
| 6. _____ | | | | |
| When I am under pressure I worry a lot. | | | | |
| 7. _____ | | | | |
| I am always worrying about something. | | | | |
| 8. _____ | | | | |
| I find it easy to dismiss worrisome thoughts. | | | | |
| 9. _____ | | | | |
| As soon as I finish one task, I start to worry about everything else I have to do. | | | | |
| 10. _____ | | | | |
| I never worry about anything | | | | |
| 11. _____ | | | | |
| When there is nothing more I can do about a concern, I don't worry about it anymore. | | | | |
| 12. _____ | | | | |
| I've been a worrier all my life. | | | | |
| 13. _____ | | | | |
| I notice that I have been worrying about things. | | | | |
| 14. _____ | | | | |
| Once I start worrying, I can't stop. | | | | |
| 15. _____ | | | | |
| I worry all the time. | | | | |
| 16. _____ | | | | |
| I worry about projects until they are done. | | | | |

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