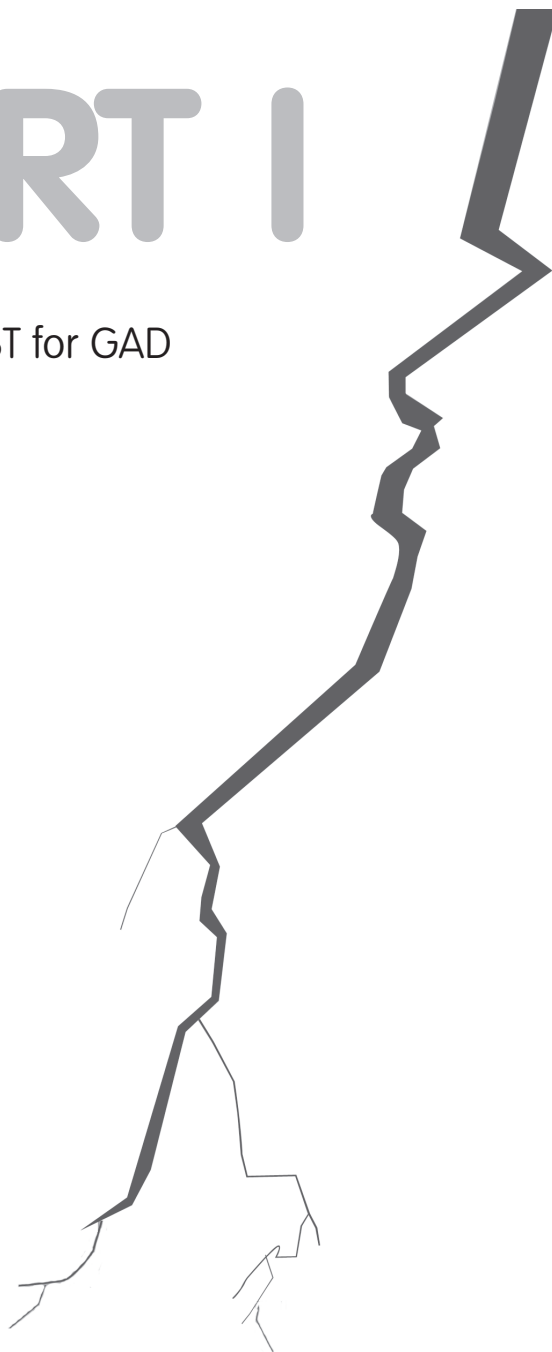


PART I

Introducing CBT for GAD





1

Introducing Generalised Anxiety Disorder

What is Generalised Anxiety Disorder?

Generalised Anxiety Disorder (GAD) is one of the most common mental health problems, and arguably also one of the most misunderstood and misdiagnosed. As a diagnostic category, GAD is relatively recent compared with other anxiety disorders. Historically, GAD was virtually a diagnosis of exclusion: when the client was anxious, but other anxiety disorders were not applicable, they tended to be given the label of GAD. More recently, the diagnostic criteria have been revised and sharpened and GAD can now be understood as a discrete diagnosis in its own right.

Figure 1 below outlines the formal diagnostic criteria for Generalised Anxiety Disorder as defined in the DSM-IV-TR (APA, 2000). Worry and the perceived uncontrollability of worry are considered to be essential features of GAD. Furthermore, there is the observation that the intensity, frequency and duration of the anxiety and worry are disproportionate to the actual likelihood or impact of the subject of the worry.

Prevalence and co-morbidity

GAD affects a significant number of people, both in its own right and in combination with other psychological disorders. In a UK prevalence study, Jenkins et al. (1997) found a current prevalence rate of 3.1 per cent. A US survey of mental health prevalence in the community found a one-year GAD prevalence rate of 3.1 per cent (Wittchen et al., 1994). An

A.	Excessive anxiety and worry (apprehensive expectation, occurring more days than not for at least six 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 six months). Note: only one item is required in children. <ol style="list-style-type: none"> 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 1 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 Hypochondriasis), and the anxiety and worry do not occur exclusively during Post-traumatic 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.

Figure 1 Diagnostic criteria for Generalized Anxiety Disorder.

Source: APA (2000). Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*

Australian survey found a one-year GAD prevalence of 3.6 per cent (Hunt et al., 2002). In keeping with observations of other anxiety disorders, it appears that GAD is more commonly seen in women than it is in men. For example, in two large-scale US studies of mental health prevalence rates in the community, it was found that twice as many women were identified with GAD compared to men (Blazer et al., 1991; Wittchen et al., 1994).

Further evidence of the prevalence of GAD comes from Katon et al. (1990) who, in a study of high users of medical care, found that of those

people reporting significant emotional distress, 21.8 per cent met criteria for a current diagnosis of GAD and 40.3 per cent of them met the diagnostic criteria for GAD at some point in their lives. It is also worth bearing in mind that prevalence studies typically measure rates of a particular disorder against formal diagnostic criteria, such as those in the DSM-IV (APA, 2000) and the ICD-10 (World Health Organization, 1990). However, a client would not need to meet the full diagnostic criteria of either system for the GAD symptoms they have to make a significant impact on their well-being and quality of life.

Not only is GAD a common psychological problem in its own right, it is also often encountered in combination with one or more other psychological disorders. Dugas and Robichaud (2007) note that over 90 per cent of people with GAD will have at least one other disorder, with over half having depression as well as GAD, and almost a third having social phobia as well as GAD. Davey and Wells (2006) also cite clinical studies of GAD showing people with GAD having other disorders, most commonly depression, followed by social phobia, specific phobia and panic disorder. It isn't only Axis 1 disorders that often co-occur with GAD; Dyck et al. (2001) report that 37.7 per cent of their patients with GAD also met the diagnostic criteria for one or more personality or Axis II disorders, with avoidant personality disorder being the most frequent.

Worry: the cardinal symptom of GAD

Diagnostically (see Figure 1 above), and in our clinical experience, the cardinal symptom of GAD is worry, and as diagnostic criteria for GAD have evolved, worry has taken an increasingly prominent role. In GAD, the worry is excessive, perceived (by the worrier) to be uncontrollable and difficult to interrupt, and has a significant emotional and physiological impact on the client and their quality of life. In this section, we will look at what worry is, at what distinguishes 'normal' worry from the worry seen in GAD, and at some of the issues that clients tend to worry about.

One of the pioneers of work on worry as a psychological disorder was Professor Tom Borkovec. His work produced one of the early attempts to define worry:

Worry is a chain of thoughts and images, negatively affect-laden and relatively uncontrollable; it represents an attempt to engage in mental problem-solving on an issue whose outcome is uncertain but contains the possibility of one or more negative outcomes; consequently, worry relates closely to the fear process. (Borkovec et al., 1983: 10)

More recently, Sibrava and Borkovec (2006) summarise what they perceive to be the central cognition in GAD:

The world is potentially dangerous and I may not be able to cope with whatever comes from the future, so I must anticipate all bad things that might happen so that I can avoid them or prepare for them. (Sibrava and Borkovec, 2006: 239)

These definitions highlight a number of important characteristics about worry. The chain of thoughts is a succession of fearful scenarios, building upon each other, and chaining into new and increasingly catastrophic directions, each trying to foresee and trouble-shoot multiple catastrophes or disasters. What you will notice, then, is that worriers spend much of their time in a theoretically possible but as yet non-existent future (Borkovec, 2002). And because of what the worrier is generally thinking about and responding (emotionally and physically) to, they are by definition spending less time attending to and engaging with the real world that is around them.

So what do people with GAD worry about? People with GAD tend to worry about health, finances, relationships, family, work, school. Relationships seem to be a consistent source of worry in people with GAD. For example, Dugas et al. (1998a) found that over 70 per cent of people with GAD endorsed frequent worry about family and relationships. And if we look at the major worry themes cited above, all of them could potentially have significance for a person's family and social network.

An important point here is that people with GAD worry about the same issues that any one of us can worry about from time to time. If the themes of worry do not distinguish 'normal' worry from clinical levels of worry, what does? Rather than thinking of normal and pathological worry as separate categories, it is perhaps more helpful to understand them as being at opposite ends of a continuum or spectrum (Ruscio et al., 2001). However, there are some characteristics of 'pathological' worry that distinguishes it from 'normal' worry. Pathological worry is usually about more unlikely and/or remote future events (Dugas et al., 1998a). Compared to pathological worriers, normal worriers generally worry in response to a specific trigger, have a subjective sense of more control over their worry and, compared to pathological worriers, devote less time to worrying (Craske et al., 1989). People without GAD may have times when particular circumstances arise or events unfold and they experience worry. Their worry is generally time-limited: there will come a point when they stop worrying, and at these points their worrying may actually serve a purpose. People with GAD tend to worry about

most things, most of the time: they get locked into a spiral of worry and find it difficult to disengage from the worry process.

Beyond worry and other diagnostic criteria: other indicators of GAD

In addition to the diagnostic criteria mentioned above, there are other common symptoms or experiences that are seen clinically. These include experiences such as an upset stomach, headaches, frequent urination or diarrhoea. Some symptoms can be problems in their own right, and these will be dealt with in later chapters, for instance alcohol problems (see Chapter 12). Others are more like behavioural manifestations of worry, such as pacing, smoking more cigarettes or nail biting. There are yet other symptoms that seem to relate to the idea of living in worry rather than in the here and now – for instance, feeling tuned out or separated from the world, having a sense of impending doom or experiencing psychic or psychological isolation. Importantly, the therapist should think beyond the diagnostic criteria when assessing a client's problems. On the other hand, we also know that some individuals do not meet full diagnostic criteria but still suffer with high levels of worry, and in such cases these clients may still benefit from treatment.

CBT for GAD: a brief history

In the next chapter, we will outline a cognitive-behavioural model of GAD that has been in development since the early 1990s and that guides the treatment methods we cover in this book. We refer to it as the Laval model of GAD because it was originally developed by clinicians and researchers at l'Université Laval in Canada. However, further work on this model and the derived treatment continues in other research centres around the world. Before looking at the Laval model in detail, it may be helpful to offer a brief history of cognitive therapy for GAD and excessive worry.

Early cognitive-behavioural treatments for GAD were strongly influenced by Beck's work on depression (e.g. Beck, 1967, 1976) and his subsequent applications of it to anxiety (e.g. Beck et al., 1985). This was, therefore, not a model that was designed specifically for GAD, but rather it constituted a generic cognitive model of anxiety.

The generic cognitive model of anxiety was built on the premise that anxious individuals exhibit both a preoccupation with danger and an underestimation of their capacity to cope. This preoccupation with danger is evident in a number of cognitive ways. Firstly, it is evident at the level of negative automatic thoughts. These are appraisals or interpretations of events, often characterised by identifiable cognitive biases, e.g. overgeneralisation, emotional reasoning, personalising, etc. However, the preoccupation with danger is also said to be represented at 'deeper' cognitive levels, such as unconditional beliefs (e.g. 'I am ...', 'the world is ...') and conditional assumptions, i.e. 'if ... then' statements. Early cognitive-behavioural treatments of anxiety worked with these levels of cognition alongside behavioural approaches such as graded exposure and applied relaxation.

In time, cognitive therapy moved beyond these generic processes and models based on emerging knowledge about specific cognitive and behavioural processes in particular disorders began to emerge, for example panic disorder (Clark, 1986), obsessive-compulsive disorder (Salkovskis, 1985) and social phobia (Clark and Wells, 1995).

Early treatments of GAD, due to limited understanding of the specific psychological processes in the disorder, tended to retain elements of a generic cognitive-behavioural approach. Treatments such as those developed by Gillian Butler and colleagues (e.g. Butler et al., 1987, 1991), Tom Borkovec and colleagues (e.g. Borkovec and Costello, 1993) and David Barlow and colleagues (e.g. Zinbarg et al., 2006) include applied relaxation and incorporate many of Beck's cognitive techniques into their overall treatment package for GAD, with a view to helping the client attain a more realistic perspective on their problems and worries and to modify their perceptions of vulnerability, for example by eliciting probability estimates for the likelihood of the feared situation arising. We could consider these as first-generation treatments.

Second-generation treatments of GAD such as the Laval protocol and the metacognitive model advanced by Adrian Wells (e.g. Wells, 1997) developed these earlier treatments. One could summarise the factors that influence the change in CBT for GAD over the years as an increasing emphasis on cognitive *process* rather than simply cognitive *content*. Because the focus of worry shifts in GAD, any techniques that work with a specific concern will have limited use. It may be possible to correct someone's anxious predictions about Event A, but we know from the nature of GAD that people tend to worry about lots of everyday situations; when one particular situation is re-evaluated, they are very likely to begin worrying about the next. More recent approaches to worry

treatment have therefore targeted the cognitive process of worry itself, rather than the content of particular worries.

CBT for GAD: the evidence base

Compared to other anxiety disorders, the evidence base for GAD is relatively small. We have chosen the Laval model and treatment protocol for GAD for the purposes of this book because, although its evidence base is still growing, it is nevertheless arguably stronger than other contemporary models and treatments for GAD at the time of writing. The evidence base is of two types. First, there is a significant evidence base for the different components of the model, both from the initial Laval team and then by various groups led by alumni of that team, particularly Michel Dugas and his research team at Concordia University in Montreal. Second, there are a number of treatment studies, both randomised control trial (RCT) studies and single case designs (with adolescents and older adults), testing the treatment in both individual and group formats against waitlist and against credible control treatments. As an individual therapy, the Laval protocol was found to be superior to a waiting-list control condition on all outcomes (Ladouceur et al., 2000b). Furthermore, as a group therapy it was also found to decrease the level of worry in the post-treatment phase (Dugas et al., 2003a). In comparison to non-directive therapy, the Laval protocol had a more significant impact on medication discontinuation in long-term benzodiazepine users and led to greater gains in terms of diagnostic remission and symptomatic improvement than the non-directive therapy (Gosselin et al., 2006). Dugas et al. (2009) compared this CBT treatment with applied relaxation and found that, once again, CBT was a successful treatment in comparison to waiting-list controls. The success of the CBT and the applied relaxation were similar; however, unlike the applied relaxation protocol, CBT following the Laval model led to continued improvement during the follow-up period.

There are, of course, other CBT treatment approaches for GAD for which the evidence base is increasing. The first RCT for metacognitive therapy for GAD was published in 2010 (Wells et al., 2010), there is one RCT for an acceptance-based approach to GAD (Roemer et al., 2008), and there are trials of later variants of the basic approach developed by Borkovec and colleagues with various adjunct treatments (e.g. Newman et al., 2008). These studies all support the overall efficacy of CBT approaches for GAD and may provide therapeutic options in some circumstances.

However, particularly when developing the knowledge, skill and confidence to treat particular disorders, we believe that it is preferable to learn one treatment approach first. Thus, we have chosen the Laval protocol. It is one of the three treatments for GAD scoped by Roth and Pilling (2008) for the CBT competencies framework, one which has a good evidence base within the GAD field, and one which we believe is readily understandable to therapists trained in both the UK and elsewhere.

Living with GAD

We would like to offer some clinical descriptions of people we have met who had problems with excessive worry to help you get a feel for the clinical presentation of GAD. The following case vignettes are based on real clients we have worked with. They have kindly given their permission for us to use their stories, and in order to protect the clients' identities, we have changed some details. Notice how depressive symptoms overlap with those of GAD and how checking or paranoid thoughts might be part of a worry profile, rather than OCD or social phobia. As we have mentioned, the cardinal symptom is that of excessive and, from the client's perspective, uncontrollable worry.

Jane

Jane was a middle manager; she headed up a large team of people. She was referred with mixed anxiety and depression and had been signed off work. She had lost confidence and felt that she could not think straight or make decisions. In fact, she reported putting off even small decisions while she collected together excessive amounts of information to help her make the right choice. Her sleep had been affected and she noticed she was waking early in the morning; once awake, she struggled to get back to sleep. She felt that she had lost her enjoyment of life and had noticed that she had started to withdraw socially. Before she left work, she noticed that she was not delegating tasks and was getting behind and stressed as a consequence. She tended to start several jobs at once and would then only partially complete them. She noticed that she started to defer to others' views all too easily. At first, she did not agree with the idea that worry was a problem. However, following a homework task in which she asked her friends and family, she was surprised by what she learned. She realised that she worried about her work and her family. This made her anxious as she also worried a great deal about what people thought of her. Jane thought that worrying showed that she cared about her job and she felt that it helped her to solve problems.

Maya

Maya was referred by her GP with 'mixed anxiety and depression with obsessive features caused by occupational stress'. She worked in a college and was responsible for delivering the evening classes to the general public. She did a

very thorough job and the programme was well respected and popular. However, she was never sure that things would run smoothly and each evening she worried about all the things that could go wrong; she was always convinced that something bad was around the next corner. This led Maya to triple-check her work and check in on the lecturers and students – consequently, she worked later and later and became exhausted. Despite being very successful and running virtually hundreds of problem-free courses, Maya never seemed to be able to develop confidence in her ability and the idea that things could run without major hiccups. She was starting to hate her job. She reported drinking much more red wine than she thought she ought to, saying that this helped to slow her mind down and help her to relax at the end of a busy day.

Raj

Raj noticed that his decisions were not his own and that he had drifted from one life event to another without considering his needs. While he described himself as laid-back, he also felt tense and 'revved up' nearly all of the time and could not put his finger on what was causing this. He felt that he either jumped into decisions or just went with the flow. He now felt that his life had been 'the sum of a series of choices that he had not made'. He wondered about who he really was and what he really liked, and feared what he would discover, saying 'what if no one likes the person I really am, what if I am boring?' If he wasn't worrying, he tended to ruminate on past choices. He wanted to get on with his life, solve his own problems, stamp his authority on his life and find himself but he avoided thinking too much or taking things too far ahead, for fear of what he might find or what might happen. He felt paralysed by the fear of the unknown and added that he 'hated uncertainty'. Interestingly, he did solve many of life's problems without realising it and his avoidance seemed to circulate around problem solving within social and family relationships.

Roger

Roger was referred with a pan-affective disorder with elements of obsessive-compulsive disorder and panic with significant major depressive symptoms. He had consulted his GP weeks before the birth of his baby. At the time, he was checking information on the Internet about things his pregnant partner should avoid eating but was overwhelmed by what he found. His partner was starting to get irritated with him as he had become unhelpfully overprotective. He experienced flashes of intense worry which centred on the possibility that the baby might have something seriously wrong with it, which he then tried to push to the back of his mind. He thought that worrying about such things would make them happen which made him worry all the more (*what if I am wishing this on myself?*). In addition to concerns about his baby, the referrer also mentioned some 'bizarre and paranoid thoughts'. For example, at work Roger thought that others might think him 'weird or worse' because he mentioned in passing that he loved spending time with his nephews. Or, that he could lose his job, his family and get sued because he had told a slightly 'racy joke' at a meeting. He felt wound up and tense the whole time and could not sit still which further irritated his partner.

Ali

Ali reported concerns about his job, his relationship and his health. He reported spending several hours a day wondering about what would happen if he lost his job or if he got ill. He recognised himself as a worrier and noticed that his concerns chained from everyday events into larger worries that usually circulated around threats to his ability to maintain security and stability for his family. He worried about his finances, his work and his health (*what if I am ill and I can't provide?*). At work, he noticed that he sought the reassurance of his colleagues for jobs he knew to be correct; he also checked his work excessively. While he did not enjoy worrying, he said that it felt familiar and he wondered what he would do if he didn't worry so much. He felt that worrying was part of his personality and he felt ambivalent about changing this.

As the case studies above suggest, worry comes in many guises and referral letters or the problems clients describe may not even mention worry as a main problem. In fact, as in Jane's case above, sometimes the client is unaware of the extent of their worry or that worry plays such a key role in their presentations. In the coming chapters, we will introduce the ideas that help make sense of these different presentations. You may like to return to these cases as you learn more about the elements of the cognitive model of worry that we will present.

Chapter summary

- GAD is a common mental health problem that can also co-exist with other common mental health problems.
- Although the GAD client can present with a number of anxiety symptoms, the key element of GAD is excessive and seemingly uncontrollable worry.
- CBT for GAD has developed considerably over the years from generic anxiety treatments to treatments developed specifically for GAD. In contrast to older treatments, contemporary models and treatments for GAD place a greater emphasis on cognitive process (e.g. worry) than on cognitive content (e.g. what the client is worrying about).