CHAPTER 4

Generalized Anxiety Disorder

DESCRIPTION AND DIAGNOSIS

Symptoms

The essential features of generalized anxiety disorder (abbreviated GAD in the text of this chapter) are apprehensive worry and physical symptoms such as restlessness, fatigue, problems with concentration, irritability, muscle tension, and/or insomnia (American Psychiatric Association, 1994). GAD is distinguished from other anxiety disorders in that the individual is worried about a variety of events; in other anxiety disorders, worry is confined to specific stimuli or issues. For example, in panic disorder the worry is focused on panic attacks, in social phobia the worry focuses on embarrassment in public, in obsessive-compulsive disorder the worry focuses on contamination or the fear of the consequences of not performing rituals, and in hypochondriasis the worry focuses on possible illness.

Prevalence and Life Course

Epidemiological studies indicate that the lifetime prevalence of GAD varies between 5.8% and 9%, with greater risk for women (the female-to-male ratio is 2.5:1), young adults, and blacks (Blazer, George, & Hughes, 1991; Breslau & Davis, 1985). Patients presenting with GAD often claim that the onset has been gradual and that they have been anxious since childhood; some studies indicate the average duration of this problem prior to treatment is 25 years (Butler, Fennell, Robson, & Geldeer, 1991; Rapee, 1989, 1991a, 1991b). Because of its chronicity, its self-perpetuating quality, and often its lack of response to treatment, some clinicians and researchers view GAD as a lifelong illness, similar to diabetes or essential hypertension.

Genetic/Biological Factors

Although some estimates indicate that GAD may have a moderate heritability of 30% (Kendler, Neale, Kessler, Heath, & Eaves, 1992), other findings suggest lack of specificity
of transmission (Weissman & Merikangas, 1986). GAD is associated with other specific traits, such as nervousness, depression, low frustration tolerance, and inhibition (Angst & Vollrath, 1991).

**Coexisting Conditions**

Most patients with GAD present with a variety of other diagnoses, including social and specific phobia, major depression, irritable bowel syndrome, and personality disorders (see Borkovec & Roemer, 1996; Brown & Barlow, 1992; Brown, Moras, Zinberg, & Barlow, 1993; Sanderson & Wetzler, 1991). Ninety percent of individuals who develop GAD during their lifetimes also have another psychiatric condition, with 42% qualifying for a diagnosis of major depression or dysthymia (Sanderson, Dinardo, Rapee, & Barlow, 1990). The most common personality disorders associated with GAD are avoidant and dependent, with obsessive–compulsive personality disorder proving most common in one study (Nestadt et al., 1992). In another study, close to 50% of GAD patients qualified for a diagnosis of some personality disorder (Sanderson & Wetzler, 1991). Recent threatening events and recent life stresses are associated with GAD (Finlay-Jones & Brown, 1981; Blazer et al., 1991), although its chronicity suggests that the perception of stress and threat may partly result from GAD.

**Differential Diagnosis**

The nature of GAD is that the individual is worried about a number of things, not simply one or two. Consequently, GAD can be differentiated from specific phobia, in which patients fear a specific, well-defined stimulus (e.g., animals). It can also be distinguished from social phobia, in which patients are specifically worried about or avoid situations in which negative evaluation is expected. Furthermore, GAD can be distinguished from obsessive–compulsive disorder, panic disorder, other anxiety disorders, and disorders in other DSM-IV categories. (Figure 4.1 is a diagnostic flow chart that provides more details about differential diagnosis of GAD.) Note that when the diagnosis is anxiety disorder due to a general medical condition or substance-induced anxiety disorder, the substance use should be the top priority.

**UNDERSTANDING GENERALIZED ANXIETY DISORDER IN COGNITIVE-BEHAVIORAL TERMS**

Several cognitive-behavioral conceptualizations of GAD are of value to the clinician. In this section we first discuss behavioral models, emphasizing conditioned anxiety, and cognitive models, emphasizing information processing and appraisal of stress. We then discuss a number of models that combine cognitive and behavioral elements.
FIGURE 4.1. Diagnostic flow chart for generalized anxiety disorder.
Is the anxiety restricted to fears of having an illness?

Is the anxiety focused on multiple physical complaints?

Is the anxiety restricted to concern about the welfare of others or about being away from home?

Are the worries experienced as intrusive or excessive, accompanied by urges, impulses, or compulsions?

Is the anxiety only associated with a traumatic event?

Generalized Anxiety Disorder

If onset before age 18, separation anxiety disorder

Hypochondriasis

Somatization disorder

Obsessive–compulsive disorder

Posttraumatic stress disorder or acute stress disorder

FIGURE 4.1 (cont.)
Behavioral Factors

Wolpe (1958) proposed that a neutral stimulus becomes conditioned to an unconditioned fear-arousing stimulus, leading to the acquisition of fear. His model of reciprocal inhibition proposes that fear may be "unlearned" by pairing the feared stimulus or response with a response that is incompatible with fear, such as relaxation, assertiveness, or sexual arousal. Other models of fear reduction include extinction, habituation, exposure, changes in expectancy, and self-efficacy. Although applying Wolpe's and other behavioral models of fear and anxiety to treatment may be somewhat more complex in GAD than in other anxiety disorders (because a patient with GAD worries about or fears many things, not just one or a few well-defined stimuli), the clinician treating a patient with GAD may use any number of behavioral techniques, depending on the patient's particular needs. These include the construction of fear hierarchies and planned exposure to various feared situations, images, or ideas; pairing of relaxation with exposure to these feared things, in some instances (i.e., self-directed desensitization); thought-stopping; modeling; vicarious reinforcement (and punishment); assertiveness training; self-efficacy training; and problem-solving training. Several of these techniques are discussed later in this chapter, and some are described in detail in Appendix A and in the CD-ROM accompanying this book.

Cognitive Factors

According to Beck et al. (1985), anxiety responses had adaptive value in the evolution of the human species. Anxiety responses, such as mobilization, inhibition, and demobilization, reflect active defense, avoidance of risky behavior, and collapse, respectively, which were protective responses in the face of various types of threats. Active defense, involving hypervigilance, sensitivity to sound, and increased heart rate, may assist the individual in either flight or fight. Inhibitory responses, such as blocking of thinking, clouding of consciousness, and muscle rigidity, prevent the individual from taking unnecessary risks (as evidenced in fear of heights or in social phobia). Demobilization is reflected in weakness, fatigue, lowered blood pressure, and lowered heart rate, leading to collapsing or freezing in place, which decrease the likelihood that the individual will be detected by predators (see Beck et al., 1985; Marks, 1987).

Responses to threat include flight, flight, freezing, fainting (collapse), retraction, dodging, clinging, calling for help, and other reflexes (eye blinking, gagging, coughing), with corresponding cognitive implications: "I have to get out of here," "I can't move," "What is happening to me?", or "Don't leave me." The cognitive model stresses the importance of various distortions in information processing in anxiety—specifically, hypervigilance, false alarms, loss of objectivity, generalization of danger to other stimuli, catastrophizing, excessive focus on negative outcomes, no tolerance for uncertainty, and "lack of habituation" (Beck et al., 1985). (Like Beck and colleagues, Lazarus emphasizes stress or threat appraisal; see Lazarus, 1991; Lazarus & Folkman, 1984.)

The cognitive model acknowledges that individuals may differ in being biologically predisposed toward the arousal of anxiety symptoms and the perception of threat. How-
ever, once the anxiety is aroused, it is increased or maintained by specific cognitive distortions. Some examples of the three types of these distortions in GAD are provided in Table 4.1.

Other Cognitive-Behavioral Models

Barlow’s Model

The excellent work of Barlow has influenced the clinical treatment of anxiety disorders in general. GAD, with its focus on arousal, hypervigilance, and worry, is explained by reference to five factors operating in interaction with one another (Barlow, 1988): negative life events, biological vulnerability, diffuse stress response, psychological vulnerability (with accompanying sense of lack of control and predictability), and lack of coping skills or support that might mitigate lack of controllability. During the “anxious apprehension cycle,” there may be accompanying “false alarms” that serve to exacerbate the sense of uncontrollability and vulnerability. With the focus on (sometimes) minor life events and the accompanying sense of loss of control over worry, the anxiety may gener-

<table>
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<tr>
<th>TABLE 4.1. Examples of the Three Types of Cognitive Distortions in Generalized Anxiety Disorder</th>
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<td><strong>Distorted automatic thoughts</strong></td>
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<tr>
<td>Catastrophizing: “Something terrible is going to happen,” “I am going to fail.”</td>
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<tr>
<td>Labeling: “I’m a failure,” “My boss is a tyrant.”</td>
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<tr>
<td>Dichotomous thinking: “I am always anxious,” “I’m never good enough.”</td>
</tr>
<tr>
<td>Overgeneralizing: “I can’t handle my anxiety. I can’t handle anything.”</td>
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<tr>
<td><strong>Maladaptive assumptions</strong></td>
</tr>
<tr>
<td>“I must get rid of all anxiety—immediately and forever.”</td>
</tr>
<tr>
<td>“Anxiety and worry are unhealthy.”</td>
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<tr>
<td>“If people knew that I was anxious, they would reject me.”</td>
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<tr>
<td>“Anxiety is a sign of weakness. I should never be weak.”</td>
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<tr>
<td>“I shouldn’t be anxious.”</td>
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<tr>
<td>“I have to watch out for my anxiety so it doesn’t catch me by surprise.”</td>
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<tr>
<td><strong>Dysfunctional schemas</strong></td>
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<tr>
<td>Biological threat: “Anxiety means I’m sick.”</td>
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<tr>
<td>Humiliation: “People will laugh at me.”</td>
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<tr>
<td>Control: “I am either in complete control or I have no control.”</td>
</tr>
<tr>
<td>Autonomy: “Anxiety means I’m weak and dependent. I can’t survive on my own.”</td>
</tr>
<tr>
<td>Abandonment: “I will be abandoned.”</td>
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*Note. Adapted from Leahy (1996). Copyright 1996 by Jason Aronson, Inc. Adapted by permission.*
alize to a variety of innocuous situations and increase. The treatment recommended involves reducing autonomic arousal with relaxation techniques, improving coping skills, and cognitive restructuring.

Borkovec’s Model

The model of worry advanced by Borkovec (Borkovec & Inz, 1990; Borkovec, Shadick, & Hopkins, 1991) stresses the role of attempts at suppression of negative images. The anxious individual, beset by concerns of negative and catastrophic outcomes, attempts to prevent these outcomes by anticipating escape or avoidance, which presumably will suppress the occurrence of the negative outcome image. For example, an anxious individual who begins to worry about going bankrupt examines all the evidence that he or she will not be able to pay her bills, attempting to figure out how these problems can occur and how they can be avoided or solved.

Wells and Butler’s Model

Wells and Butler have advanced a metacognitive model of GAD, emphasizing the central role of worrying in this disorder. Wells and Butler (1997) indicate that GAD patients overestimate the likelihood of negative events, rate the cost of threatening events as very high, and interpret ambiguous events as more threatening than persons without GAD would interpret them. Wells (1994a, 1994b) and Wells and Butler (1997) propose that GAD patients have both positive and negative beliefs about worrying. That is they worry about worrying, but they also believe that giving up worrying may expose them to unforeseen threat or danger. Wells and Butler (1997, p. 167) indicate that these positive attitudes about worrying include the following beliefs: “Worrying helps me cope with future problems,” “If I think of all the bad things that could happen, I’ll be prepared to prevent them,” and “I’ll be tempting fate [if I don’t worry].” Wells and Butler distinguish between Type 1 and Type 2 worry. Type 1 worry refers to concern or vigilance about external or internal (e.g., health) threats. Type 2 worry, or “metaworry,” refers to negative appraisal of one’s own cognitive processes—for example, “Worrying will make me crazy.” According to this model, the anxious individual is locked in a conflict between the fear that worry is uncontrollable and the belief that worry protects him or her.

The therapeutic model derived from this theory involves identification of the patient’s beliefs about the costs and benefits of worrying, the recognition of productive worrying, experiments in “letting go” of worry or postponing worry, challenging avoidance of activities or thoughts about which the patient worries, and constructing positive outcomes in imagery (Wells & Butler, 1997).

Outcome Studies for Cognitive-Behavioral Treatment

Given the apparent chronicity and poor spontaneous remission rates of GAD, it is promising that there are now treatments with some demonstrated efficacy. Borkovec and Whisman (1996) indicate that psychosocial treatments (especially cognitive-behav-
ioral treatment) have proven to be more effective than nondirective treatment, a placebo or a benzodiazepine; that gains are maintained by cognitive-behavioral therapy or behavior therapy; that cognitive-behavioral therapy leads to a reduction of the use of benzodiazepines; that these gains are clinically significant; and that for some patients, gains actually improve even after therapy is discontinued. Schwind and Rickels (1996) indicate that 70% of GAD patients respond to benzodiazepines. Butler et al. (1991) found that cognitive-behavioral therapy was superior to behavior therapy in producing "good outcome" for patients 6 months after treatment ended (42% vs. 5%), respectively, although another study found statistically similar outcomes for cognitive-behavioral therapy and behavior therapy (58% and 38%, respectively) (Durham et al., 1994). When compared with psychoanalytic treatment, cognitive-behavioral therapy was far superior—a "good outcome" rate of 72% versus 31%, respectively (Durham, 1995).

ASSESSMENT AND TREATMENT

Rationale and Plan for Treatment

The patient presenting with GAD has symptoms that include physiological arousal (restlessness, muscle tension, sleep disturbance), as well as cognitive symptoms (worry, difficulty controlling worry, and inability to concentrate). The goals of treatment are to reduce the overall level of autonomic arousal, to decrease the concern about worry, and to assist the patient in reducing worry to a reasonable level. Since the patient is worried about a variety of situations and themes, more "general" interventions are employed. That is, the therapist will use interventions such as progressive muscle relaxation, biofeedback, breathing relaxation, and behavioral treatment of insomnia in order to reduce overall levels of anxious arousal, and will employ a variety of cognitive interventions to address the worry. These cognitive interventions include assisting the patient in distinguishing between productive and unproductive worry, addressing the patient’s concern that worrying too much may be harmful, assessing the patient's tendency to jump to conclusions and catastrophize, and helping him or her learn to distinguish between anxiety and actual facts. We have developed an extensive self-help form called Questions to Ask Yourself If You Are Worrying (see Form 4.5, below), which may be tailored to the needs of the individual patient. In addition, since a patient with GAD is worrying throughout the day, the clinician will assist the patient in limiting worry to "worry time" and will help the patient monitor the different themes of worry. Finally, the treatment approach will help the patient recognize that he or she may be quite able to cope with a variety of problems, should they arise.

The treatment of the patient with GAD often involves addressing more than one disorder, since 83–91% have a comorbid disorder (Barlow, DiNardo, Vermilyea, Vermilyea, & Blanchard, 1986; Sanderson et al., 1990). The treatment package for GAD is outlined in Table 4.2. In practice, the sequence of the elements listed in this table is variable, with the therapist often using several techniques simultaneously. Moreover, since GAD is so often comorbid with depression or other anxiety disorders, the clinician will usually need to employ more than one treatment package.
TABLE 4.2. General Plan of Treatment for Generalized Anxiety Disorder

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<tr>
<td>Relaxation training</td>
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<tr>
<td>Assessing and confronting avoidance: Exposure and other techniques</td>
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<tr>
<td>Desensitization: Pairing (or not pairing) exposure with relaxation</td>
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<tr>
<td>Monitoring worries and assigning “worry time”</td>
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<td>Cognitive evaluation of the nature of worrying</td>
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<td>Other techniques for countering worrying and rumination</td>
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<tr>
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Assessment

Forms 4.1 and 4.2 provide guidance for therapists in the evaluation of GAD. Form 4.1 is a checklist to be completed by the patient that covers the DSM-IV symptoms of GAD, as well as some symptoms of other anxiety disorders. Form 4.2 provides space for recording the patient’s scores on various assessment instruments, for noting other relevant aspects of the patient’s history (substance use, previous anxiety episodes), and for recording treatment recommendations.

Initial Clinical Evaluation of Anxiety Symptoms

Form 4.1, the Leahy Anxiety Checklist for Patients, is a checklist that allows the patient to endorse the specific symptoms of anxiety he or she has been experiencing. The checklist covers not only the symptoms of GAD as specified by DSM-IV, but some symptoms (e.g., shortness of breath, dizziness, pounding heart) of other anxiety disorders (e.g., panic disorder); if these latter symptoms are endorsed, this gives the clinician a preliminary indication that comorbid anxiety disorders may be present and will need to be treated. Scores between 5 and 10 reflect mild anxiety, 11 and 15 moderate anxiety, and 16 or higher significant anxiety.

Tests and Other Evaluations

Evaluation of patients with GAD during the intake and at later points may involve a number of self-report or interview instruments, such as the BAI, BDI, GAF, SCID-II, and Locke–Wallace (see Chapters 2 and 3). The SCL-90-R (also mentioned in Chapters 2 and 3) has a scale (factor) evaluating anxiety that can be distinguished from phobia and obsessive–compulsive symptoms, although there is some overlap between the Obsessive–
FORM 4.1. Leahy Anxiety Checklist for Patients

Patient's Name: ____________________________  Today's Date: __________

Place a number next to the answer that best describes how you have been feeling generally during the past month. Use the scale below:

1 = Not at all    2 = Slightly true    3 = Somewhat true    4 = Very true

1. Feeling shaky
2. Unable to relax
3. Feeling restless
4. Get tired easily
5. Headaches
6. Shortness of breath
7. Dizzy or light-headed
8. Need to urinate frequently
9. Sweating (unrelated to heat)
10. Heart pounding
11. Heartburn or upset stomach
12. Easily irritated
13. Startled easily
14. Difficulty sleeping
15. Worried a lot
16. Hard to control worries
17. Difficulty concentrating

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FORM 4.2. Further Evaluation of Generalized Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient’s Name: ____________________________  Today’s Date: ______________
Therapist’s Name: __________________________  Sessions Completed: __________

Test data/scores
Beck Depression Inventory (BDI) _______  Beck Anxiety Inventory (BAI) _______
Global Assessment of Functioning (GAF) _______  Leahy Anxiety Checklist _______
Symptom Checklist 90—Revised (SCL-90-R) _______  Locke—Wallace Marital Adjustment Test _______
Structured Clinical Interview for DSM-III-R, Axis II (SCID-II) _______
Anxiety Disorders Interview Schedule—Revised (ADIS-R) _______
Other anxiety questionnaires (specify) ________________________________

Substance use
Current use of psychiatric medications (include dosage) ________________________________
Who prescribes? ________________________________
Use of alcohol/other drugs (kind, frequency, amount, consequences) ________________________________

History (intake only)
Previous episodes of anxiety (specify nature):
Onset  Duration  Precipitating events  Treatment

Treatment progress (later evaluations only)
Situations still avoided: ________________________________
Situations approached that were previously avoided: ________________________________

Recommendations
Medication evaluation or reevaluation:
Increased intensity of services:
Behavioral interventions:
Cognitive interventions:
Interpersonal interventions:
Marital/couple therapy:
Other:

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Compulsive and Anxiety scales. The ADIS-R (mentioned in Chapter 3), the Hamilton Anxiety Rating Scale (Hamilton, 1959), and the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) are additional anxiety questionnaires that may be used. Form 4.2 provides space for recording scores on these instruments. It also enables the therapist to record the patient’s medication, alcohol, and other drug use; to record (at intake only) the history of any previous episodes of anxiety (the nature of these should be specified); and to indicate treatment recommendations.

**Consideration of Medication**

Treatment of GAD with medication may involve both acute and chronic (or maintenance) treatment. The three drug classes with proven efficacy for GAD are benzodiazepines, azapirones (especially buspirone), and antidepressants (especially imipramine and SSRIs). There is some evidence that patients presenting with somatic or adrenergic symptoms respond better to benzodiazepines; that patients with psychic symptoms such as worry, tension and irritability respond better to buspirone; and that patients with depressive symptoms and GAD respond better to imipramine (Schweizer & Rickels, 1996). Although beta-blockers are sometimes used with patients with GAD, they have proven inferior to benzodiazepines, and consequently are not currently approved as treatments for GAD.

**Socialization to Therapy**

As we do with most patients, we recommend that patients with GAD read David Burns’s *The Feeling Good Handbook* (Burns, 1980) and/or *Feeling Good: The New Mood Therapy* (Burns, 1989). In addition, specific focus on anxiety is provided by Reid Wilson’s (1987) *Don’t Panic*, an excellent description of the range of anxiety disorders and their treatment. The patient should be told that he or she has an anxiety disorder known as “generalized anxiety disorder” or “GAD.” This means that the patient worries about a variety of things and may experience muscle tension, insomnia, physiological arousal, fatigue, and other symptoms. The patient may also experience depression or other anxiety disorders. We find it helpful to explain that everyone has worries some of the time, and that some worrying is productive (useful) while other worries are unproductive and cause unneeded anxiety. We indicate that medication may be included in the treatment plan, which will emphasize teaching the patient how to relax, improving his or her ability to handle stress, enhancing his or her ability to cope with interpersonal issues, evaluating how the patient is thinking about his or her worrying and other problems, and providing the patient with useful self-help techniques. Form 4.3 is an information handout about generalized anxiety disorder that can be given to patients. Our handout about cognitive-behavioral therapy in general (Form B.1 in Appendix B) can also be used.

**Relaxation Training**

The therapist may indicate to the patient that anxious thoughts and feelings are more likely to occur when the patient is physiologically aroused. Consequently, the patient can
FORM 4.3. Information for Patients about Generalized Anxiety Disorder

What Is Generalized Anxiety Disorder?

All of us feel anxious at times. We may worry about things that might happen. We may have a restless night of sleep. But people with generalized anxiety disorder (or GAD) have physical symptoms that interfere with their normal lives. These problems may include restlessness, fatigue, problems with concentration, irritability, muscle tension, and/or insomnia. In addition, these individuals worry about a variety of events, such as health, financial problems, rejection, and performance, and they find it difficult to control their worry. Many people with GAD feel that their worry is “out of control” and that it will make them sick or make them go insane.

Who Has Generalized Anxiety Disorder?

About 7% of the population will suffer from GAD. Women are twice as likely as men to have this problem. This is a chronic condition, with many people saying that they have been “worriers” all their lives. Most people with GAD have a variety of other problems, including phobias, depression, irritable bowel syndrome, and relationship problems. Many people who have this problem find that they avoid others because of fear of rejection, or that they become overly dependent on others because of their lack of confidence.

What Are the Causes of Generalized Anxiety Disorder?

Only about 30% of the causes of GAD are inherited. There are certain traits that may make people more likely to develop this problem; these include general nervousness, depression, inability to tolerate frustration, and feeling inhibited. People with GAD also report more recent life stresses (such as conflicts with other people, changes in their work, and additional demands placed on them) than those without GAD do. People with GAD may not be as effective in solving problems in everyday life as they could be, or they may have personal conflicts in which they may not be as assertive or effective as they could be.

How Does Thinking Affect Generalized Anxiety Disorder?

People with GAD seem to be worried that bad things are going to happen most of the time. They predict that “terrible” things will happen, even when there is a very low probability of bad things happening. They think that the fact that they feel anxious means that something bad is going to happen—that is, they use their emotions as evidence that there is danger out there somewhere. Many people who worry believe that their excessive worry may keep them from being surprised, or that worrying may prepare them for the worst possible outcome. If you are a chronic worrier, you probably notice yourself saying, “Yes, but what if . . . ?” This “what-iffing” floods you with a range of possibly bad outcomes that you think you have to prepare yourself for. There seems to be no end to the things that you could worry about. In fact, even when things turn out to be OK, you may say to yourself, “Well, that’s no guarantee that it couldn’t happen in the future!”

In addition to worrying about things that might happen “outside of yourself,” you may think that

(cont.)

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FORM 4.3. Information about Generalized Anxiety Disorder (p. 2 of 2)

"worrying will make me crazy" or "worrying will make me sick." If you have GAD, you may be locked in a conflict between the fear that worry is uncontrollable and the belief that worry protects you.

**How Can Cognitive-Behavioral Therapy Help?**

Cognitive-behavioral therapy for GAD can help you identify your beliefs about the costs and benefits of worrying, and show you how to recognize the difference between productive and unproductive worrying. Your therapist will help you carry out experiments in "letting go" of worry and postponing worry. In addition, you will learn how to overcome your avoidance of activities or thoughts about which you worry. Your therapist may also use interventions such as muscle relaxation, biofeedback, breathing exercises, time management techniques, and treatment of insomnia in order to reduce your overall levels of anxious arousal. Other interventions may include addressing your concern that worrying too much may be harmful, assessing your tendency to jump to conclusions that awful things will happen, and helping you learn to distinguish between anxiety and actual facts. Your therapist can teach you to use an extensive self-help form ("Questions to Ask Yourself If You Are Worrying") that can help you get a better perspective on worrying. Finally, since you are worrying throughout the day, your therapist will assist you in limiting worry to "worry time" and will help you keep track of the different themes of worry.

**How Effective Is Cognitive-Behavioral Therapy for Generalized Anxiety Disorder?**

Given the apparent long course of GAD, it is promising that new forms of treatment are proving to be effective. In some studies, cognitive-behavioral therapy has proven to be more effective than medications in the treatment of GAD. It leads to a reduction of the need to use medications, and in some cases patients continue to improve even more after therapy is completed. About 50% of patients with GAD show significant improvement.

**Are Medications Useful?**

Many patients with GAD also benefit from the use of medication, which can decrease the feeling of anxiety and apprehension. The value of medication is that it can make you feel less anxious very rapidly. Medication may be an essential part of your treatment, while you learn—in therapy—how to handle your problems more effectively.

**What Is Expected of You as a Patient?**

Because you may have been a worrier all your life, you may be pessimistic about the chances that anything will help you. It is true that you won’t get better overnight, so you will have to work on your worries and anxiety on a regular basis. Your therapist will want you to come to sessions on a weekly basis, to keep track of your worries, to practice relaxation or breathing exercises at home, and to work on managing your schedule so that you are not overburdened. In addition, your therapist will help you identify your worries and help you view things in a more realistic perspective. To do this, you will be asked to write down the things that you are worried about, and to use self-help homework techniques to challenge your negative thinking. You may also be asked to work on solving problems more effectively and on learning how to interact with people more productively.
learn any number of relaxation techniques, such as progressive muscle relaxation, breathing relaxation, guided imagery, or meditation (see Appendix A and the CD-ROM for full discussions of the first two types). The patient can be encouraged to practice more than one relaxation technique. In addition, the use of stimulants (e.g., caffeinated beverages) should be discouraged, as should the excessive use of alcohol. Patients complaining about insomnia should be given the patient information handout on insomnia presented in Chapter 2 (Form 2.8); the use of the bed for sleep and sex only should be emphasized. Finally, overall relaxation is increased if the patient can engage regularly in aerobic exercise.

Assessing and Confronting Avoidance: Exposure and Other Techniques

A GAD patient may sometimes actually present with few anxious symptoms. On closer inquiry, the clinician may find that numerous situations are avoided and that the patient is underperforming at work or in personal relations because he or she fears an increase in anxiety. When this is the case, therapist and patient may construct a hierarchy of avoided situations, rate the SUDs for each situation, and identify the negative thoughts associated with these situations. (Forms 3.5 and 3.7 in Chapter 3 can be used for this purpose.) The therapist may then use behavioral rehearsal, cognitive rehearsal, and/or modeling of confronting avoidance. Or the therapist may guide the patient through imaginal exposure to the feared situations. Homework assignments may involve planned in vivo exposure to avoided situations. (See Appendix A and the CD-ROM for fuller discussions of exposure.)

Desensitization: Pairing (or Not Pairing) Exposure with Relaxation

The foregoing interventions (exposure, etc.) may be viewed as a form of desensitization. In addition, the patient may be trained in pairing his or her relaxation response with imaginal exposure to the feared stimulus, with the patient moving up the hierarchy from less to more feared thoughts or images. The patient may practice pairing relaxation with exposure in the actual situations. Alternatively, the patient may be instructed not to pair exposure to the stimulus with relaxation, so as to allow the patient the opportunity to learn that anxiety will decrease with increased length of exposure to the feared stimulus. One can view the difference between these two approaches as the difference between the “reciprocal inhibition” model advocated by Wolpe and the “cognitive disconfirmation” model advocated by Beck, Wells, and their associates.

Monitoring Worries and Assigning “Worry Time”

A distinguishing element for many patients with GAD is that their worries focus on more than one theme. A clinician and patient should assess various characteristics of worries: their content areas and situational elicitors, the specific predictions they entail, the level of anxiety these predictions generate, and the strength of the patient’s confidence in these predictions. The Patient’s Worry Log (Form 4.4) is useful in evaluating these specific
## FORM 4.4. Patient's Worry Log

<table>
<thead>
<tr>
<th>Content area for each worry</th>
<th>Factors in situation that bring out the worry</th>
<th>Prediction (Specify exactly what you think will happen and when it will happen)</th>
<th>Anxiety rating for each prediction (0–10)</th>
<th>Rating of confidence in accuracy of prediction (0–10)</th>
<th>Actual outcome (Exactly what happened?)</th>
<th>Anxiety rating at outcome (0–10)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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worries and in helping the patient recognize his or her tendency to make "false predictions." As suggested by Borkovec and by Wells and Butler, worries are reinforced by the nonoccurrence of negative events and by the magical belief that worries are protective and preparatory.

In addition, "worry time" should be assigned to the patient. That is, the patient should be required to worry for a specific period of time (e.g., 20 minutes) at an assigned time and place. Other worries that occur during the day are to be delayed until worry time. This allows stimulus control of worries; it also helps the patient recognize that worries are about finite themes, and that worrying can be curtailed but not completely eliminated.

Cognitive Evaluation of the Nature of Worrying

Patients with GAD invest in worry as a hypervigilant strategy to avoid negative outcomes. They often think that worrying prepares them for the worst, helps them avoid negligence, and keeps them from regretting not having done something. With such a patient, the therapist can evaluate the costs and benefits of worrying, and can distinguish between "productive worry" (e.g., "Do I have enough gas in my car to make this trip?") and "unproductive worry" ("What if I were to get cancer?", "What if my business were to fail completely?"). In addition, the therapist should examine the patient's worrying about worrying, such as "I'm worrying so much I might go crazy" or "I should never worry" or "I have no control over my worrying."

The therapist can give the form called Questions to Ask Yourself If You Are Worrying (Form 4.5) to the patient. This allows the patient to evaluate specific predictions; the tendency to jump to conclusions; the difference between possibility and probability; the safety or protection factors available; the tendency to catastrophize outcomes; and other questions that may challenge the sense of negativity, imminence, and exaggerated outcome. (This form may be simplified, expanded, or modified by the therapist to fit the needs of the individual patient.) The therapist can also address the categories of distorted automatic thoughts evident in worries, such as labeling ("I'm incapable of handling stress"), catastrophizing ("I'm going to lose everything"), fortunetelling ("I'll get rejected"), dichotomous thinking ("Nothing is working out"), and discounting the positives ("I don't have anything going for me"). In addition, the therapist can focus on the patient's underlying maladaptive assumptions (his or her "rule book" about approval, perfectionism, certainty, and other "shoulds" and "musts"), as well as his or her dysfunctional schemas about self and others (involving such themes as rejection, defectiveness, demanding standards, or abandonment). Finally, the nature of the patient's rhetorical questions that reflect worrying, such as "What if it doesn't work out?" or "What's wrong with me?", can be examined and rephrased as "propositional statements" that can be tested, such as "Nothing will work out" or "Everything is wrong with me." Specific techniques for identifying and challenging the cognitive distortions involved in worries are outlined in Table B.3 of Appendix B, in the CD-ROM accompanying this book, in Leahy (1996), as well as in Judith S. Beck's (1995) Cognitive Therapy: Basics and Beyond.
### FORM 4.5. Questions to Ask Yourself If You Are Worrying:
A Self-Help Form for Patients

Specific worry: 

<table>
<thead>
<tr>
<th>Questions to ask yourself:</th>
<th>Your response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specifically, what are you predicting will happen?</td>
<td></td>
</tr>
<tr>
<td>How likely (0–100%) is it that this will actually happen?</td>
<td>Likelihood:</td>
</tr>
<tr>
<td>How negative an outcome are you predicting (from 0% to 100%)?</td>
<td>How negative:</td>
</tr>
<tr>
<td>What is the worst outcome?</td>
<td>Worst:</td>
</tr>
<tr>
<td>The most likely outcome?</td>
<td>Most likely:</td>
</tr>
<tr>
<td>The best outcome?</td>
<td>Best:</td>
</tr>
<tr>
<td>Are you predicting catastrophes (awful things) that don’t come true? What are some examples of the catastrophes that you are anticipating?</td>
<td></td>
</tr>
<tr>
<td>What is the evidence (for and against) your worry that something really bad is going to happen?</td>
<td>Evidence for:</td>
</tr>
<tr>
<td>If you had to divide 100 points between the evidence for and against, how would you divide these points? (For example, would it be 50–50? 60–40?)</td>
<td>Evidence against:</td>
</tr>
<tr>
<td></td>
<td>Points: Evidence for — Evidence against —</td>
</tr>
<tr>
<td>Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, “I feel anxious, so something really bad is going to happen”?</td>
<td></td>
</tr>
<tr>
<td>Is this a reasonable or logical way to make predictions? Why/why not?</td>
<td></td>
</tr>
<tr>
<td>How many times have you been wrong in the past about your worries? What actually happened?</td>
<td></td>
</tr>
</tbody>
</table>

(cont.)

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**FORM 4.5. Questions to Ask Yourself If You Are Worrying (p. 2 of 2)**

<table>
<thead>
<tr>
<th>Questions to ask yourself:</th>
<th>Your response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the costs and benefits to you of worrying about this? If you had to divide 100</td>
<td></td>
</tr>
<tr>
<td>points between the costs and benefits, how would you divide these points? For example,</td>
<td></td>
</tr>
<tr>
<td>would it be 50–50? 60–40?)</td>
<td>Costs:</td>
</tr>
<tr>
<td></td>
<td>Benefits:</td>
</tr>
<tr>
<td></td>
<td>Points: - ___ (costs)</td>
</tr>
<tr>
<td></td>
<td>___ (benefits)</td>
</tr>
<tr>
<td></td>
<td>Subtract costs from benefits: ___ - ___ = ___</td>
</tr>
<tr>
<td>What evidence do you have from the past that worrying has been helpful to you and</td>
<td></td>
</tr>
<tr>
<td>hurtful to you?</td>
<td></td>
</tr>
<tr>
<td>Are you able to give up any control in order to be worried less?</td>
<td></td>
</tr>
<tr>
<td>Is there any way that worrying really gives you any control, or do you feel more out of</td>
<td></td>
</tr>
<tr>
<td>control because you are worrying so much?</td>
<td></td>
</tr>
<tr>
<td>If what you predict happens, what would that mean to you? What would happen next?</td>
<td></td>
</tr>
<tr>
<td>How could you handle the kinds of problems that you are worrying about? What could you</td>
<td></td>
</tr>
<tr>
<td>do?</td>
<td></td>
</tr>
<tr>
<td>Has anything bad happened to you that you were not worried about? How were you able to</td>
<td></td>
</tr>
<tr>
<td>handle that?</td>
<td></td>
</tr>
<tr>
<td>Are you usually underestimating your ability to handle problems?</td>
<td></td>
</tr>
<tr>
<td>Consider the thing you are worried about. How do you think you’ll feel about this 2</td>
<td></td>
</tr>
<tr>
<td>days, 2 weeks, 2 months, and 2 years from now? Why would you feel differently?</td>
<td></td>
</tr>
<tr>
<td>If someone else were facing the events that you are facing, would you encourage that</td>
<td></td>
</tr>
<tr>
<td>person to worry as much as you? What advice would you give him or her?</td>
<td></td>
</tr>
</tbody>
</table>
Other Techniques for Countering Worrying and Rumination

A variety of other techniques, both behavioral and cognitive, can be used as necessary to counter a patient's worrying and rumination. The patient can be trained in behavioral activation (reward planning and activity scheduling) as a means of both elevating mood and decreasing rumination time. Both Appendix A and Chapter 2 describe behavioral activation, and Chapter 2 provides forms for monitoring actual activities (Form 2.5) and for predicting the amount of pleasure and mastery that will result from planned activities (Form 2.6). Engaging in distraction can also be encouraged (this is also described in Appendix A). Finally, the patient can be helped to develop an "antirumination script," which might go something like this: "Instead of sitting here and fretting, I could be solving my problems, distracting myself, doing something productive, calling a friend, or challenging my negative thinking."

Interpersonal Interventions

Patients with GAD often have interpersonal problems that contribute to their worries and general discomfort. The clinician can assist such a patient in learning appropriate skills, such as assertiveness; rewarding and attending to others instead of complaining; mutual problem solving; active listening and other aspects of effective communication; acceptance of others; and negotiation and conflict resolution. Specific cognitive interventions may focus on various cognitive distortions (see above) as these are manifested in interpersonal relationships. The clinician may assist the patient in learning appropriate behavior through modeling and behavioral rehearsal and through constructing specific interpersonal goals, such as complimenting five people every day or calling up three people each week to pursue rewarding behaviors. Finally, many GAD patients experience conflict with their spouses or partners, partly because of their tendency to view neutral events as potentially negative or even dangerous. If necessary, a patient's spouse or partner may be included in the treatment; the emphasis in conjoint sessions should be on increasing positive reinforcement and positive tracking for both members of the couple, and on encouraging the anxious individual to avoid enunciating too many worrisome thoughts.

Stress Reduction and Problem-Solving Training

We indicate to patients the difference between a stressor (such as a demand by the boss) and the experience of stress (emotional discomfort) (see Lazarus & Folkman, 1984). The experience of stress or discomfort will result from increased arousal and the perception that one does not have the ability to handle the demands one is confronting. The therapist may utilize self-instructional training (Meichenbaum, 1977) and problem-solving training (Nezu & Nezu, 1989c), to reduce stress. In addition, time management (especially being careful not to plan too many things), introduction of "stress breaks," self-contingency contracting (e.g., establishing positive self-rewards), anger control (see Novaco, 1978), and other techniques are useful.
Troubleshooting Problems in Therapy

The majority of patients presenting with GAD have experienced significant anxiety for most of their lives. Consequently, they may be impatient, demanding, skeptical, hopeless, or minimally compliant with treatment. The following problems are often confronted in treatment.

Excessive Focus on Negative Feelings

Many anxious patients focus on how bad they feel—especially their physical sensations, their apprehension, and their general discomfort. The clinician can indicate to such a patient that the goal of therapy is to help the patient feel better, but that in order to accomplish this several goals must be addressed. The clinician can help the patient label feelings accurately (rating their intensity, tracking their variation, and gaining distance from them by “observing” their quality and variation across the day); can help the patient identify how feelings are related to situations and thoughts; can emphasize the difference between a feeling and a thought (“I feel anxious because I think I’ll fail”); and can help the patient evaluate how feelings change as negative thoughts become less credible.

Difficulty in Identifying Automatic Thoughts

Because of the intensity of patients’ feelings or because of their exclusive focus on their discomfort, many anxious patients claim that they cannot identify their thoughts. The therapist may ask such a patient to slow down the process through the use of guided imagery in the session, in which anxiety-provoking situations are described and the patient slowly goes through his or her feelings, images, and thoughts. If the patient describes visual images, these can then be used as primes for automatic thoughts, as in this example:

**Therapist:** You said that you had the image of your head exploding. Complete this sentence: “When I think of my head exploding, it makes me anxious because I think that what is happening is . . .”

**Patient:** I’m losing control. I’m going crazy.

Another technique that can be useful is to suggest automatic thoughts that the patient may or may not have had and ask, “Could this be what you were thinking?” (See J. S. Beck, 1995, for a description of these techniques.)

Demand for Immediate Results

Anxious patients often demand immediate, total relief from their negative feelings, hoping for a “magic bullet.” This demand can be addressed in the following ways: clarifying that anxiety has been a lifelong problem that requires an investment of time and effort to treat; stressing that old habits of thinking, feeling, and behaving do not change overnight; examining the costs and benefits of demanding immediate results; examining what
will happen if immediate results are not obtained and what will happen if results are obtained gradually; evaluating how the demand for immediate results (low frustration tolerance) actually results in greater vulnerability to anxiety; and indicating how these demands contribute to feelings of hopelessness.

**Perfectionistic Beliefs in Anxiety Reduction**

Similar to the demand for immediate results is the dichotomous belief about anxiety: “Either I am totally anxious, or I should have no anxiety.” We tell patients that eliminating all anxiety is impossible, except for dead people! Reducing, moderating, coping with, and not catastrophizing anxiety are suggested as alternative appropriate goals. Furthermore, a patient can examine how small amounts of anxiety can be useful to motivate the self or to indicate that something may be problematic.

**Demands for Certainty**

Patients who ask rhetorical “What if . . . ?” questions may demand certainty about feared events or about the outcome of therapy. These demands for certainty in an uncertain world are modified in therapy to statements about probability: “What is the probability that you will fail? Be rejected? Have cancer?” Patients who dwell on “what if?” are asked to examine the costs and benefits of demanding certainty about every possible imagined event. The therapist may describe many situations—for example, driving a car, eating chicken in a restaurant, or walking across the street—that are possibly dangerous, but that are tolerated as acceptable risks. Magical, absolutistic beliefs about negligence and responsibility, which contribute to the demand for certainty (Salkovskis, 1996), are evaluated; the therapist indicates to the patient that responsibilities are not about all possible events, but about reasonable precautions taken by reasonable people.

**Beliefs That Worries Are Realistic**

Some patients believe that their worries are realistic. For example, a 45-year-old woman who was being treated for hypertension with medication thought that her blood pressure was still hypertensive because it was 135/80. She claimed that an ideal blood pressure was 120/70 (and that an ideal cholesterol reading was less than 140). These perfectionistic and incorrect beliefs that hypertension is defined by the absence of an ideal rating were directly addressed in treatment by providing the patient with corrective information. Other patients may claim that their worries are “realistic” because the things they worry about “could happen.” This may be addressed by having such patients assign subjective probabilities to feared events and evaluating whether these are related to actual facts. For example, having heard of an airplane crash on the news, one patient estimated her chances of being in a similar crash at 10%. She was surprised to learn that the facts indicate that one can take a round trip on a commercial airliner every day for 45,000 years and expect one fatal accident. Confusing subjective feelings of anxiety with probabilities often contributes to extreme estimates of danger. Furthermore, a patient may be
asked to estimate the sequence of probabilities of feared events: "I have a headache $\rightarrow$ I have something seriously wrong with me ($p = .10$) $\rightarrow$ It could go undiagnosed $\rightarrow$ ($p = .05$) $\rightarrow$ It could be a brain tumor $\rightarrow$ ($p = .001$) $\rightarrow$ I could die from it ($p = .10$)." Multiplying these sequential probabilities (each of which is exaggerated in its own right) yields the following: $$.10 \times .05 \times .001 \times .10 = .0000005.$$ Thus, the chances of a headache's signaling a fatal brain tumor are rather remote.

**Difficulty in Relaxing**

Some patients describe difficulty in relaxing, even when given relaxation training. The therapist may increase a patient's ability to relax by including relaxation training in every session for several weeks to evaluate whether the patient is rushing through the exercises or not doing them properly. In addition, it is wise to train a patient in more than one exercise, to make sure that the patient does not have time pressures following the exercises, and to check whether he or she is practicing relaxation with distracting stimuli (such as music or TV). Some anxious patients fear that their relaxation will leave them vulnerable and unaware of danger, and these thoughts, when elicited, may be evaluated via the cognitive techniques described earlier. With patients with concomitant panic disorder, the decrease in tension may actually evoke a panic attack (see Chapter 3); the patients should be informed that this may happen in some cases, but that relaxation-induced panic usually subsides with continued practice of the exercises.

**Refusal to Engage in Exposure**

Some patients fear exposure so greatly that they refuse to confront feared situations. Interventions that may be helpful include using guided imagery in sessions before actual exposure is employed, extending the fear hierarchy downward to include even less anxiety-provoking events, modeling exposure, accompanying the patient in the feared situation, cognitive rehearsal of coping statements in the session, eliciting and challenging (through role plays and role reversals) the feared exposure, and using time projection ("How will you feel 30 minutes, 1 hour, 2 days after you have completed this task?").

**Phasing Out Treatment**

As in the case of panic disorder and agoraphobia, we caution against premature termination of treatment for GAD—especially since GAD in many cases has been chronic for years and is resistant to treatment. Accordingly, the treatment package described in this chapter calls for 20 sessions, although it may sometimes be possible to provide adequate treatment in fewer sessions. Phasing back to biweekly or monthly sessions after the patient shows some improvement helps the patient to begin functioning independently of therapy. During phase-out, as noted in connection with other disorders in other chapters, the patient is encouraged to self-assign homework; this can focus on various aspects of treatment that have been particularly challenging for the patient.
CASE EXAMPLE

Sessions 1–2

Assessment

Jill was a 29-year-old manager, married with no children, who complained of having had anxiety and worries since she was a young adolescent. On intake, she indicated a moderate level of depression (her BDI score was 21); a high level of anxiety (her BAI score was 29); and elevations on the anxiety, obsessive-compulsive, and depression scales of the SCL-90-R. On the SCID-II and on interview, she gave indications of having obsessive-compulsive personality disorder. Her Locke–Wallace score (137) suggested a very high level of marital satisfaction, although later developments in the case called this into question (see below).

The patient indicated that she consumed no more than one cup of coffee per day and refrained from drinking alcohol. Recent stressors included her brother’s recurring and spreading cancer, her own diagnosis and treatment for melanoma, a recent miscarriage, and pressures on her job. She had been married for 6 years and indicated that her husband had a history of alcohol abuse, but that his drinking was less in the last 2 years. In addition, she and her husband occupied the upper floor of a two-family house while her parents lived in the lower floor, and she indicated that she was often disturbed by her father’s depression.

In socializing Jill to treatment, the therapist gave her handouts on generalized anxiety and depression (Forms 4.3 and 2.4, respectively). The patient was provided with David Burns’s The Feeling Good Handbook and was told that her diagnosis was GAD and major depression, with the focus on her anxiety and worries. She decided that she would work on her problems in therapy and declined medication as a treatment. Her short-term goals were to reduce her worries about work and to decrease her self-criticism. Both long-term and short-term goals focused on dealing with her feelings about her brother’s illness and any fears of a recurrence of her own cancer. The therapist indicated that thoughts often create feelings, and that the overall goal of therapy would be to help her reduce her general level of anxiety through relaxation techniques and through identifying and modifying her habitual ways of thinking. A distinction was made between Jill’s productive and unproductive worry, with the emphasis that her unproductive worry often focused on things that were beyond her control. In addition, her “worry about worry” was addressed by indicating that she not only worried about bad things happening, but also worried about her worrying’s being out of control.

Comorbid conditions

Caffeine and alcohol use; recent stressors

Socialization to treatment

Monitoring worries
was asked to keep track of her worries with the Patient's Worry Log (Form 4.4).

Sessions 3–5

Progressive muscle relaxation

Jill was trained in progressive muscle relaxation and encouraged to examine how she could be assertive at work and set limits on her time schedule. Her Patient’s Worry Log indicated that she was not worried about a recurrence of her melanoma, but that she feared that her brother’s cancer was terminal. Her initial focus in therapy was on her worries and pressures at her job. She was instructed in the use of “worry time”—that is, limiting her worrying, as much as possible, to a specific time and place (usually a 30-minute period at home after work).

The pressures on Jill’s job resulted in part from daily time pressures to complete tasks with inadequate technical and personnel support. However, they were also partly caused by her perfectionistic automatic thoughts, such as “It's not perfect. It's not the way it should be. I'll fail. I'm a failure. I can't get control over this.” The therapist helped Jill categorize these thoughts (as fortunetelling, labeling, personalizing, catastrophizing, etc.) and had her rate (1) her confidence in their accuracy and (2) the intensity of the emotions associated with them (both on a scale of 0–100%). The therapist then employed various cognitive techniques to assist her in challenging the thoughts. These techniques included examining their costs and benefits, examining the evidence for and against them, vertical descent, decatastrophizing, the double-standard technique, and problem solving. In addition, Jill and the therapist examined her tendency to personalize the work problems. First, they evaluated sources of the problems other than herself (e.g., lack of support, technical limitations, unrealistic demands, prior workers’ mistakes); Jill then divided up responsibility for the problems, using the “pie” technique. Finally, she rerated her original thoughts and emotions, and worked on developing new and more adaptive thoughts.

The therapist also examined Jill’s underlying maladaptive assumptions about worrying (specifically, “Worrying will drive me crazy” and “I have to stop worrying completely”) and about the utility of worrying (“I’ll be prepared for the worst” and “I’ll be motivated to do a better job”). Techniques that proved useful for challenging these assumptions were examining costs and benefits, evaluating the evidence for and against each assumption, rational role play, and the double-standard technique.
Sessions 6–8

Further monitoring of worries

Jill continued to track her worries with the Patient’s Worry Log (Form 4.4), which indicated that she worried about things that were beyond her control (e.g., the amount of work assigned) and about incurring complaints from her boss (which seldom occurred). Jill was then given the Questions to Ask Yourself If You Are Worried form (Form 4.5) and instructed in its use; her filled-out version of this form for one worry is presented here as Table 4.3.

The continuing challenges to Jill’s negative thoughts proved extremely helpful. She reported feeling much less depressed and anxious, and she indicated that she felt better able to “leave the work at work” when she went home. After eight sessions, there was a dramatic decrease in both her anxiety (BAI = 8) and her depression (BDI = 5). Therapy was phased back to once every 2 weeks and then once per month.

Sessions 9–15

Interpersonal interventions

During the course of Jill’s treatment, her husband’s drinking increased, resulting in an increase in marital conflict. She was encouraged to assert herself with him, and she was trained in active listening skills (especially rephrasing, empathy, and validation), as well as avoiding labeling and judging her husband when she was speaking. (It is interesting that her rating of the marriage before therapy was very favorable; note her high Locke-Wallace score as reported at the beginning of the case. Some patients enter treatment focused on specific worries or physical discomfort, but eventually acknowledge marital problems of considerable significance.) She was able to become appropriately assertive with her husband, which was moderately helpful in reducing the conflict and in encouraging him to decrease his drinking.

Jill was also now able to summarize her old and new schemas about herself and others. Her old schemas were “I’m totally responsible” and “I’m inadequate.” By contrast, her new, revised schemas were as follows: “I am only responsible for what is reasonable. I am human. I am competent, but not perfect. I don’t have to please everyone. Others can take responsibility.” She could now see how her worries at work were related to her schema about excessive personal responsibility, and she was able to attribute most of the problems at work to inadequate personnel. She modified her demands on time pressure and productivity, and began to accept a certain amount of “error” in the work environment.
TABLE 4.3. Questions to Ask Yourself If You Are Worrying: A Self-Help Form for Patients (Form 4.5), as Filled Out by Jill

Specific worry: I've got too much work to do.

<table>
<thead>
<tr>
<th>Questions to ask yourself:</th>
<th>Your response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specifically, what are you predicting will happen?</td>
<td>I'll fail to get the work done.</td>
</tr>
<tr>
<td>How likely (0–100%) is it that this will actually happen?</td>
<td>Likelihood: 90%</td>
</tr>
<tr>
<td>How negative an outcome are you predicting (from 0–100%)?</td>
<td>How negative: 85%</td>
</tr>
<tr>
<td>What is the worst outcome?</td>
<td>Worst: The boss will get so angry he'll fire me. Most likely: I'll get most of the work done and no one will say anything. Best: I'll get everything done.</td>
</tr>
<tr>
<td>The most likely outcome?</td>
<td>Yes, I won't get fired. I'm doing better than anyone else who's had this job.</td>
</tr>
<tr>
<td>The best outcome?</td>
<td>The computer will crash, my brother will die, I'll get fired, I'll never be able to have a kid, my marriage will break up.</td>
</tr>
<tr>
<td>Are you predicting catastrophes (awful things) that don't come true? What are some examples of the catastrophes that you are anticipating?</td>
<td>Evidence for: The work seldom gets completely done.</td>
</tr>
<tr>
<td>What is the evidence (for and against) your worry that something really bad is going to happen?</td>
<td>Evidence against: This is part of the job. There's more work than there are resources to get it done. They need me and they won't fire me. They already know that the problem exists, and they decided it's cheaper to absorb the costs than pay to have everything overhauled. Points: Evidence for = 5 Evidence against = 95</td>
</tr>
<tr>
<td>If you had to divide 100 points between the evidence for and against, how would you divide these points? (For example, would it be 50–50? 60–40?)</td>
<td>Yeah, I'm doing a lot of emotional reasoning. The fact is that nothing really terrible is happening at work.</td>
</tr>
<tr>
<td>Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, &quot;I feel anxious, so something really bad is going to happen&quot;? Is this a reasonable or logical way to make predictions? Why/why not?</td>
<td>I've always been wrong about my worries at work, because I'm able to get most of the work done and no one has ever thought of firing me.</td>
</tr>
<tr>
<td>How many times have you been wrong in the past about your worries? What actually happened?</td>
<td>(cont.)</td>
</tr>
<tr>
<td>What are the costs and benefits to you of worrying about this?</td>
<td>Costs: Anxious, frustrated, self-critical, angry. Benefits: Maybe I’ll try harder to get it done. Points: (-80) (costs) (20) (benefits) Subtract costs from benefits: (-80 - 20 = -60)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What evidence do you have from the past that worrying has been helpful to you and hurtful to you?</td>
<td>Worrying about this hasn’t helped me. It just makes my job more difficult.</td>
</tr>
<tr>
<td>Are you able to give up any control in order to be worried less?</td>
<td>I can try. I feel better when I accept what I can’t control.</td>
</tr>
<tr>
<td>Is there any way that worrying really gives you any control, or do you feel more out of control because you are worrying so much?</td>
<td>No, it doesn’t give me any control. It only makes me frustrated and then I try to do a perfect job—which is impossible.</td>
</tr>
<tr>
<td>If what you predict happens, what would that mean to you? What would happen next?</td>
<td>It means I’m incompetent. People will think I can’t do my job.</td>
</tr>
<tr>
<td>How could you handle the kinds of problems that you are worrying about? What could you do?</td>
<td>I could be assertive and ask for support at work.</td>
</tr>
<tr>
<td>Has anything bad happened to you that you were not worried about? How were you able to handle that?</td>
<td>When I learned I had cancer I got treatment and I got better.</td>
</tr>
<tr>
<td>Are you usually underestimating your ability to handle problems?</td>
<td>Yes, I’m actually good at solving problems.</td>
</tr>
<tr>
<td>Consider the thing you are worried about. How do you think you’ll feel about this 2 days, 2 weeks, 2 months, and 2 years from now? Why would you feel differently?</td>
<td>It always feels better later. Two days from now I’ll really have forgotten about this.</td>
</tr>
<tr>
<td>If someone else were facing the events that you are facing, would you encourage that person to worry as much as you? What advice would you give him or her?</td>
<td>No—I wouldn’t encourage them to worry. It’s useless. I’d tell them, “You can only do so much. If they don’t care enough to provide the support you need, it’s their problem.”</td>
</tr>
</tbody>
</table>
Sessions 16–20

Life stressors

In the later months of her treatment, Jill got pregnant, and her brother’s cancer became more ominous. She took a couple of months off from work to take care of him, and then he died. Her grief during this time was appropriate; she felt that she had done all that she could to support him during the difficult last months. She summarized her need to continue to be assertive at work and at home, to accept limits on her responsibility and time, to continue using the forms she had been given to challenge her negative thoughts, and to recognize that others shared responsibility for their problems. The therapist played “devil’s advocate” in role plays to help her continue recognizing that the problems at work, and in her family, were often out of her control and beyond her responsibility. Therapy was terminated by mutual consent, and Jill indicated that she would continue to use her self-help tools and assertion as needed.

DETAILED TREATMENT PLAN
FOR GENERALIZED ANXIETY DISORDER

Treatment Reports

Tables 4.4 and 4.5 are designed to help you in writing managed care treatment reports for patients with GAD. Table 4.4 shows sample specific symptoms; select the symptoms that are appropriate for your patient. (Zuckerman’s [1995] Clinician’s Thesaurus can be consulted for additional words and phrases.) Be sure also to specify the nature of the patient’s impairments, including any dysfunction in academic, work, family, or social functioning. Table 4.5 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Session-by-Session Treatment Options

Given the long-standing, chronic, and often treatment-resistant nature of GAD, we advocate that the treatment plan include at least 20 sessions of individual cognitive-behavioral treatment, with the opportunity for periodic follow-ups once regular treatment has been completed. Table 4.6 provides options for 20 treatment sessions for a patient with GAD. (As noted earlier, the sequence of interventions presented here may vary, depending on individual patients’ needs.)
### TABLE 4.4. Sample Symptoms for Generalized Anxiety Disorder

Anxious mood  
Excessive worry  
Irritable mood  
Restlessness  
Feeling on edge  
Fatigue  
Impaired concentration  
Muscle tension  
Insomnia  
Specify length of time symptoms have been present

---

### TABLE 4.5. Sample Treatment Goals and Interventions for Generalized Anxiety Disorder

<table>
<thead>
<tr>
<th>Treatment goals</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing physical symptoms of anxiety</td>
<td>Relaxation training</td>
</tr>
<tr>
<td>Reducing time spent worrying (&lt;30 minutes/day)</td>
<td>Distraction, “worry time”</td>
</tr>
<tr>
<td>Reducing negative automatic thoughts</td>
<td>Cognitive restructuring</td>
</tr>
<tr>
<td>Eliminating avoidance (specify)</td>
<td>Exposure</td>
</tr>
<tr>
<td>Eliminating assumptions about dangerousness of anxiety, positive value of worry, or other assumptions (specify)</td>
<td>Cognitive restructuring, behavioral experiments</td>
</tr>
<tr>
<td>Modifying schemas of threat/vulnerability/need for control (or other schemas—specify)</td>
<td>Cognitive restructuring, developmental analysis</td>
</tr>
<tr>
<td>Eliminating impairment (specify—depending on impairments, this may be several goals)</td>
<td>Cognitive restructuring, problem-solving training, or other skills training (specify)</td>
</tr>
<tr>
<td>Eliminating all anxiety symptoms (SCL-90-R scores in normal range)</td>
<td>All of the above</td>
</tr>
<tr>
<td>Acquiring relapse prevention skills</td>
<td>Reviewing and practicing techniques as necessary</td>
</tr>
</tbody>
</table>
## TABLE 4.6. Session-by-Session Treatment Options for Generalized Anxiety Disorder

### Sessions 1–2

**Assessment**
- Evaluate presenting problems
- Evaluate specific anxiety symptoms with the Leahy Anxiety Checklist for Patients (Form 4.1)
- Identify specific content of worries
- Administer standard battery of intake measures (see Form 4.2), plus additional anxiety questionnaires as appropriate
- Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
- Evaluate substance use (including use of caffeine or tobacco); evaluate need for counseling or detoxification if patient has substance abuse or dependence
- Assess need for medication
- Evaluate sleep disorders

**Socialization to Treatment**
- Inform patient of diagnosis
- Provide patient with information handouts on anxiety disorders (Form 4.3) and on cognitive-behavioral therapy in general (Form B.1, Appendix B)
- Indicate how GAD involves motor tension and arousal
- Indicate that worries are a central part of GAD, and that worries are reinforced by their nonoccurrence
- Develop short-term and long-term goals

**Cognitive Interventions**
- Normalize worrying—review productive versus nonproductive worrying
- Determine whether patient “worries about worrying” (e.g., “Worrying means I’m going crazy or have no control over my thoughts and feelings.”)
- Introduce Patient’s Worry Log (Form 4.4)

**Homework**
- Have patient begin reading Burns’s *The Feeling Good Handbook* or Wilson’s *Don’t Panic*
- Assign use of Patient’s Worry Log to monitor worries

### Sessions 3–5

**Assessment**
- Evaluate anxiety (BAI) and depression (BDI)
- Continue to identify themes of patient’s worries
- Review Patient’s Worry Log—frequency, duration, situations, precursors, and consequences of worries

**Behavioral Interventions**
- Train patient in progressive muscle relaxation and/or breathing relaxation
- Instruct patient in reward planning/activity scheduling
- Describe and encourage “worry time”
- Evaluate need for assertion training
- Evaluate need for exposure to avoided situations; discuss exposure with patient
- Encourage exercise
- Treat insomnia, if necessary

(Cont.)
TABLE 4.6 (cont.)

Cognitive Interventions
Introduce Questions to Ask Yourself If You Are Worrying form (Form 4.5)
Begin to identify and categorize automatic thoughts (with specific emphasis on
fortunetelling, catastrophizing, discounting positives, etc.)
Begin challenging thoughts by evaluating costs and benefits of worrying, using other
cognitive techniques (see Table B.3, Appendix B)

Medication
Evaluate side effects of medication
Evaluate need to increase dosage
If no improvement, either increase dosage, add another medication, or change class of
medication (consider the need to taper or discontinue one class of medication when
adding another class)

Homework
Assign breathing relaxation, progressive muscle relaxation
Have patient follow self-help tips for insomnia (Form 2.8)
Assign "worry time"
Have patient increase exercise
Have patient reward planning/activity scheduling
Have patient continue to monitor worries, test predictions, track negative thoughts, and
categorize these thoughts
Assign continued reading

Sessions 5–8

Assessment
As in Session 3–5
Review homework

Behavioral Interventions
Train patient in generalizing relaxation to new situations
Have patient engage in self-directed desensitization (exposure with or without relaxation) to
avoided situations, as appropriate
Encourage patient to decrease rumination time—develop an antirumination script
Examine situational/life sources of stress (e.g., financial, interpersonal, work, family, etc.)
Encourage patient to schedule stress breaks, self-reward for behavior
Introduce problem-solving skills

Cognitive Interventions
Identify patient’s underlying maladaptive assumptions
Challenge assumptions via cost–benefit analysis, other cognitive techniques (see Table B.3)
Continue challenging automatic thoughts via cognitive techniques and use of Form 4.5
Introduce Daily Record of Dysfunctional Thoughts
Use vertical descent
What is the ultimate outcome or fear that the patient anticipates?
Distinguish between possible and probable outcomes
Examine worries for probability, plausibility
Introduce idea of “sequential probabilities” (i.e., multiplying the probabilities of negative events predicted)

**Medication**
As in Sessions 3–5

**Homework**
As in Sessions 3–5
Have patient schedule stress breaks, self-reward for behavior
Assign use of problem solving
Decrease rumination through distraction, reward planning/activity scheduling, rational responding

**Sessions 9–15**

**Assessment**
As in Sessions 6–8

**Behavioral Interventions**
Continue with self-directed desensitization
Continue with assertion training and introduce anger control training, as appropriate
Continue with problem-solving training
Begin self-efficacy training: Have patient list personal positives, take credit for positives, continue with self-reward

**Cognitive Interventions**
Continue evaluating and challenging automatic thoughts and assumptions
Identify, evaluate, and modify dysfunctional schemas
Examine how worries are related to schemas (about defectiveness, failure, biological vulnerability, control, abandonment, responsibility, etc.)
Continue to evaluate and modify maladaptive assumptions (about excessive responsibility, time pressure, what is “essential,” and imminence of “disasters”)

**Medication**
As in Sessions 3–5

**Homework**
As in Sessions 3–5 and 6–8
Have patient increase exposure to feared situations as appropriate
Assign assertion and anger control practice
Have patient increase self-reward
Have patient identify and challenge maladaptive assumptions and dysfunctional schemas

**Sessions 16–20**

**Assessment**
As in Sessions 6–8

(cont.)
<table>
<thead>
<tr>
<th>TABLE 4.6 (cont.)</th>
</tr>
</thead>
</table>

**Behavioral Interventions**
- Plan phase-out of treatment
- Have patient identify short-term and long-term goals for self-help
- Identify how behavioral techniques can be used in future

**Cognitive Interventions**
- Review what has been learned about automatic thoughts, assumptions, and schemas
- Use rational responding to play “devil’s advocate” for patient

**Homework**
- Have patient self-assign homework focused on troubleshooting future problems