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Generalized Anxiety Disorder

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Description of Generalized Anxiety Disorder (GAD)

Definition

- GAD is one of 11 major diagnosable anxiety disorders included in the *DSM-IV-TR* categorically-based system of classifying mental disorders (APA, 2000).
- "GAD is categorized by at least 6 months of persistent and excessive anxiety and worry" (APA, 2000; p. 429).
- The prominent features of GAD are: "excessive worry or undue anxiety about multiple life events or situations at a level that causes clinically significant distress or interferes with social or occupational functioning or other important life roles; [having] difficulty controlling the worry; and [experiencing] several characteristic symptoms such as restlessness, fatigue, difficulty thinking or concentrating, irritability, muscle tension, and sleep difficulty" (ACA, 2009; p.26).

Resources:

American Psychiatric Association (2000). *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)*. Washington, DC: Author.

Anxiety and Depression Association of America (ADAA):
http://www.adaa.org/understanding-anxiety/generalized-anxiety-disorder-gad

National Institute of Mental Health (NIMH):
http://www.nimh.nih.gov/health/topics/generalized-anxiety-disorder-gad/index.shtml

Prevalence

- The DSM-IV-TR (APA, 2000) suggests prevalence rates ranging from 3% to 5% in community samples.
- More recent American epidemiological data suggest a lifetime prevalence rate of 4% (Grant, et al., 2005), and suggest an estimated 7 million adults experience GAD during a given calendar year (Kessler, et al., 2005).

IDENTIFICATION/ASSESSMENT STRATEGIES

Structured and Semi-Structured Interviews

Structured and semi-structured clinical interviews can be employed to conduct behaviorally oriented assessments of client GAD presentations. Behavioral assessments are used to ascertain a "topography of the presenting problem complex", including elements such as symptoms, frequency, and intensity, in order to infer a problem syndrome like GAD (Deffenbacher, 1992; p. 632). Clinical interviews with the purpose of establishing GAD as the primary diagnosis can be highly structured or semi-structured (Rygh & Sanderson, 2004a). Such interviews should be conducted when they fall within the counseling professional's practice competencies.

A widely recommended evidence-based, empirically validated, and reliable clinical interview protocol is the Anxiety Disorder Interview Schedule Adult Version (ADIV-IV; Brown, DiNardo, & Barlow, 2004). The ADIV-IV provides in-depth evaluation of anxiety, mood, and substance-related disorders – and

is especially useful for differentiating GAD from other diagnosable anxiety disorders. Another long-standing, evidence-based, empirically validated, and reliable clinical interview protocol for use with GAD and other anxiety disorders is the Structured Clinical Interview for *DSM-IV* Axis I Disorders, Clinical Version (SCID-CV; First, et al., 1997). The SCID is a broader evaluation tool that more comprehensively assesses all adult disorders, including the anxiety disorders. For semi-structured interviews, Rygh & Sanderson (2004a, 2004b) developed a two-step loose interview protocol that can be incorporated into a typical diagnostic intake interview. Their approach is based on a series of interview questions that form two decision trees used to, first, rule out competing differential diagnoses, and then, second, assess for specific GAD diagnostic criteria.

Resources:

Rygh, J. L., & Sanderson, W. C. (2004). *Treating Generalized Anxiety Disorder: Evidence-based strategies, tools, and techniques.* The Guildford Press.

Anxiety Disorder Interview Schedule Adult Version (ADIV-IV) Website: http://www.us.oup.com/us/corporate/aboutoupusa/?view=usa

Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) Website: http://www.scid4.org/index.html

Client Self-Report Measures

Three longstanding, widely utilized, empirically validated and reliable evidence-based client self-report instruments with good psychometric properties can be used for relatively quick and efficient initial screening or assessment of GAD and associated anxiety and worry: The Beck Anxiety Inventory (BAI; Beck, et al., 1988; Beck & Steer, 1990) is a short self-report measure of the primary psychological and somatic symptoms of general anxiety, and is helpful since "general anxious arousal is an essential feature of GAD" (Rygh & Sanderson, 2004a; p. 36). The Penn State Worry Questionnaire (PSWQ; Meyer, et al., 1990) is a brief measure of worry and is helpful for distinguishing clients with GAD from clients with other anxiety disorders. The Generalized Anxiety Disorder Questionnaire – IV (GADQ-IV; Newman, et al., 2002) is another self-report measure and is helpful because it is designed around GAD diagnostic criteria.

In addition, designed specifically for use with children, the Screen for Child Anxiety Related Emotional Disorders (SCARED; Berhamer, et al., 1999) is an empirically validated and reliable evidence-based client self-report instrument demonstrating good psychometric properties across various cultures (Essau, et al., 2002;Su et al., 2008; Essau, et al., 2013).

Beck Anxiety Inventory (BAI) Website: http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail htm?Pid=015-8018-400

Measurement Instrument Database for the Social Sciences: Penn State Worry Questionnaire: http://www.midss.ie/content/penn-state-worry-questionnaire-pswq

Generalized Anxiety Disorder Questionnaire-IV (GADQ-IV) Psychometric Investigation: http://dx.doi.org/10.1016/S0005-7894(02)80026-0

Resources The California Evidence-Based Clearinghouse for Child Welfare: Screen for Child Anxiety Related Emotional Disorders (SCARED): http://www.cebc4cw.org/assessment-tool/screen-for-childhood-anxiety-related-emotional-disorders-scared/

INTERVENTION STRATEGIES

Cognitive Behavioral Therapies (CBT)

Today there is a substantial literature based on clinical evidence, including a substantial accumulation of studies employing randomized controlled treatment designs, which supports the effectiveness of

cognitive-behavioral therapies (CBT) (including various techniques which fall under the CBT umbrella) with GAD. "CBT … is the only form of psychological treatment for GAD that has been repeatedly subjected to rigorous, well-controlled treatment outcome research (Rygh & Sanderson, 2004; p. 8). Still, it should be noted that even for evidence-based treatments, there are differences in symptom improvement outcomes among different clinicians (Baldwin, et al., 2007; Lutz, et al., 2007) and with GAD, the counselor's CBT competence was found to be a limiting factor in client outcomes (Westra, et al., 2011); therefore, CBT approaches for GAD may be more effective when they fall within the counseling professional's practice competencies.

CBT approaches to GAD are based on the assumption that negative beliefs play an important role in the development of excessive worry; correspondingly, the treatment targets negative beliefs about uncertainty, and worries (Dugas & Robichaud, 2007). For instance, evidence suggests clients with GAD tend to experience more verbal thoughts than images, which may be problematic (Hirsch, et al., 2012), embrace the negative belief that their worries are uncontrollable and threatening (Penney, Mazmanian, & Rudanycz, 2011), and consequently have somatic anxiety for which worry and negative affect are main contributors (Donegan & Dugas, 2012; Llera & Newman, 2010).

Early treatment studies and meta-analytic studies comparing cognitive therapies with other psychosocial approaches (such as analytic and psychodynamic psychotherapies, behavior therapy and anxiety management training, and, cognitive therapy concluded that, generally speaking, CBT provided the most improvement (Borkovec and Ruscio, 2001; Chambless & Ollendick, 2001). Subsequently, the efficacy of CBT seems to have been well-established (Stewart & Chambless, 2008). CBT approaches have been associated with such intermediate and long-term outcomes as: enhancing access to benign meanings in place of worrisome intrusive thoughts (Hirsch & Hayes, 2009), decreased threatening interpretations of the intrapersonal and interpersonal worlds (Amir & Taylor, 2012; Reinecke, et al., 2013), increases in self-efficacy and reduction of social anxiety (Goldin, et al., 2012), and reduction of worry and consequential somatic anxiety symptoms (Donegan & Dugas, 2012). Further, at least one study reported positive outcomes developmentally modified CBT in the treatment of 4 – 7 year old child clients with anxiety disorders (Hirschfeld-Becker, et al., 2010); and family CBT has been reported to be effective with clients aged 7 – 14 years old (Kendall, et al., 2008).

In practice, the CBT approach targets modifications in the client's cognitive distortions, anxious affect, behavioral components of GAD, and to restructure client assumptions (Beck, Emery, & Greenberg, 2005). CBT for GAD sets intermediate outcome goals and utilizes intermediate interventions to: socialize the client for counseling; treat the cognitive component using restructuring, positive imagery, worry exposure, improving problem orientation, setting worry-free zones and other tactics; treating the physiological component with relaxation and sensitization; and treat the behavioral component with response prevention, practice and *in vivo* exposure, and planning (Rygh & Sanderson, 2004). Well-established resources are listed below.

Resources:

Beck, A. T., Emery, G., & Greenberg, R. (2005). *Anxiety disorders and phobias: A cognitive perspective (Revised edition)*. Cambridge, MA: Basic Books.

Kendall, P. C., Gosch, E., Hudson, J. L., & Flannery-Schroeder, E. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology, 76,* 282-207. doi: 10.1037/0022-006X.76.2.282.

Rygh, J. L., & Sanderson, W. C. (2004a). *Treating Generalized Anxiety Disorder: Evidence-based strategies, tools, and techniques.* The Guildford Press.

Rygh, J. L., & Sanderson, W. C. (2004b). *Treating Generalized Anxiety Disorder.* NY: The Guildford Press.

Reprint: Newman, M. G., & Borkovec, T. D. (1995). Cognitive-behavioral treatment of generalized anxiety disorder. The Clinical Psychologist, 48(4), 5-7: http://www.apa.org/divisions/div12/rev_est/cbt_gad.html

Psychiatry Online: CBT for GAD with Integrations from Interpersonal and Experiential Therapies: http://focus.psychiatryonline.org/article.aspx?articleid=49792

Supplemental and Integrative Approaches

Although CBT for GAD has been shown to be efficacious and has been reported to produce significant improvement, CBT is not beneficial for all clients and does not always facilitate the client's return to high endstate functioning (Newman, et al., 2008; Waters & Creaske, 2005). In response, integrative psychotherapeutic approaches sometimes are used and some have been subject of clinical research (Heimberg, Turk, & Mennin, 2004; Roemer, Orsillo, & Salters-Pedneault, 2008).

Integrating Mindfulness-based or Self-awareness-based Approaches. Some authors and researchers recommend integrating mindfulness-based or self-awareness-based approaches into GAD counseling. For example, Connolly Gibbons, et al. (2008) conducted a large client database analysis and concluded that across counseling approaches, interventions which focus on improvements in self-understanding, compensatory skills, and improved views of self, all were associated with positive symptom change. Generally speaking, these approaches attempt to facilitate within the client a "an open attention to one's present experience, accompanied by a nonjudgmental, accepting attitude toward whatever one encounters", including internal and external experiences (Brown, Marquis, & Guiffrida, 2013; p. 96). Hofman et al. (2010). conducted a meta-analytic review of mindfulness-based therapy with anxiety and depression, found relatively robust effect sizes for improvement in anxiety and depression symptoms, and concluded that these counseling approaches were "moderately effective for improving anxiety" (p. 169). In a somewhat similar vein, Roemer & Orsillo (2008) evaluated the effects of an acceptance-based behavior therapy for GAD which targeted clients' "experiential avoidance", that is, their "attempts to alter the intensity or frequency of unwanted internal experiences", by "using strategies aimed at increasing awareness and intended action in important life domains" (Roemer, Orsillo, & Salters-Pedneault, 2008). They reported the treatment resulted in decreased experiential avoidance and increases in mindfulness – and statistically significant reductions in GAD and mood symptoms in a large percentage of the clients studied (Roemer, Orsillo, & Salters-Pedneault, 2008).

Resources:

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development, 91,* 96-104.

Hoffman, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78,* 169-183. doi: 10.1037/a0018555.

Roemer, L., Orsillo, S. M., & Salters-Pedneault, K. (2008). Efficacy of an acceptance-based behavior therapy for Generalized Anxiety Disorder: Evaluation in a random controlled trial. *Journal of Consulting and Clinical Psychology, 76, 1083*-1089. doi: 10.1037/a0012720.

Integrating Interpersonal Approaches. Since interpersonal problems play a role in maintaining GAD symptomotology, some other authors and researchers recommend integrating interpersonal therapy approaches into GAD counseling (Borkovec, et al, 2004; Crits-Christoph, 2002; Eng & Heimberg, 2006; Salzer et al, 2011). For example, Salzer, et al. (2011) conducted a pilot clinical study which led to the conclusion that interpersonal subtype may be a complex factor among GAD clients and may be associated with counseling outcomes. Generally speaking, these approaches attempt to reduce the

maintenance of GAD symptoms by the client's "emotional processing avoidance" and "interpersonal problems" (Newman, et al., 2011; p. 171). Newman and colleagues (2008) reported evidence suggesting integrative approaches employing interpersonal therapy components leads to significant decreases in GAD symptoms.

Resources:

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. S. (2008). An open trial of integrative therapy for Generalized Anxiety Disorder. *Psychotherapy: Theory, Research, Practice, Training, 45,* 135-147. doi: 10.1037/0033-3204.45.2.135.

Salzer, S., Pincus, A. L., Hoyer, J., Kreische, R., & Leibing, E. (2008). Interpersonal subtypes within Generalized Anxiety Disorder. *Journal of Nervous and Mental Disease, 185,* 314-319. doi: 10.1037/a0022013.

Supplemental and Integrative Approaches: Informed Practice. Although there is growing evidence for GAD counseling that integrates mindfulness and self-awareness approaches, interpersonal methods, and other strategies, to date there is a smaller body of clinical evidence for these than for CBT. In fact, in one recent randomized controlled trial with an integration of CBT with emotion-focused and interpersonal counseling, Newman et al. (2011) reported that "interpersonal and emotional techniques may not augment CBT" equally well for all GAD clients (p. 171). Therefore, counselors must make their own informed decisions about these practices. Informative resources include:

Heimberg, R. G., Turk, C. L., & Mennin, D. S. (2004). *Generalized anxiety disorder: Advances in research and practice.* NY: Guilford Press.

Jongsman, A. E., Jr. (Ed.). (2004). *The complete anxiety treatment and homework planner.* Hoboken, NJ: Wiley.

Portman, M. E. (2009). *Generalized anxiety disorders across the lifespan: An integrative approach.* NY: Springer.

Rygh, J. L., & Sanderson, W. C. (2004a). *Treating Generalized Anxiety Disorder: Evidence-based strategies, tools, and techniques.* The Guildford Press.

Psychopharmacology

Psychopharmological intervention also may a part of treatment for GAD, usually with psychoactive medication being prescribed alongside psychological counseling (Rygh & Sanderson, 2004; Sussman & Stein, 2001).). Treatment with medication usually should be an adjunct to counseling intervention, with exclusive psychopharmacological treatment of GAD being reserved for client situations that prove to be "highly refractory psychological interventions" (Rygh & Sanderson, 2004; p. 7). As a rule of thumb, treatment with medication is most indicated in situations where: counseling intervention has already been tested but has produced insufficient improvement ; the client's daily functioning is significantly impaired by GAD, or the client's anxiety level is intolerable; or waiting out a trial of psychological counseling would create extreme difficulties for the client (Rygh & Sanderson, 2004 In situations where psychopharmacology is part of GAD treatment, the counseling professional has responsibilities for assisting the client to: cooperate with referrals, evaluations, and testing; understand the treatment options, including expected results and possible side effects of medication; take medications as prescribed and adhere to the medication regimen; report of medication effectiveness and side effects; attend and cooperate during counseling sessions as well as appointments with the physician; and work towards a treatment goal of reduction of symptoms or remission without or with a minimum amount of medication (Purselle, Nemeroff, & Jongsma, 2003).

Common medication approaches to the treatment of GAD include the following: Buspirone is a medication of choice for GAD. Unlike other benzodiazepines, Buspirone is slow-acting, requiring 2 – 6 weeks to produce symptom change; therefore, clients may tend to discontinue use prematurely and so the counselor can assist successful Buspirone treatment by educating and supporting the client in their adherence to the regimen. Also, although Buspirone reduced GAD symptoms, it does not usually decrease panic attacks if they are present. Clients much take this medication on an ongoing basis, not just when anxiety symptoms worsen. If anxiety symptoms are severe, other Benzodiazepines (such as Ativan, Valium, Xanax) commonly are used to provide immediate anxiety symptom relief; however, Benzodiazepines may produce problems with tolerance and dependence when used long-term, and they are inadvisable when the client has a history of alcohol or other substance abuse. SSRIs or venlafaxine also sometimes are prescribed for GAD when Buspirone does not produce intended outcomes (Dziegielewski, 2006; Preston & Preston, 2004; Rygh & Sanderson, 2004).

Resources:

Dziegielewski, S. F. (2006). *Psychopharmacology handbook for the non-medically trained.* NY: Norton.

Preston, J., & Preston, J. (2004). *Clinical psychopharmacology made ridiculously simple: Edition 5.* Miami, FL: Medmaster.

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Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75,* 75, *842-852.*

Brown, A. P., Marquis, A., & Guiffrida, D.A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development, 91,* 96-104.

Beck, A. T., Emery, G., & Greenberg, R. (2005). *Anxiety disorders and phobias: A cognitive perspective (Revised edition).* Cambridge, MA: Basic Books.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56,* 893-897.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory (2nd ed.).* San Antonio, TX: Psychological Corporation.

Bernal, G., & Saez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34,* 121-132. doi: 10.1002/jcop.20096.

Bernhamer, B., Brent, D., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): A replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38,* 1230-1236.

Borkovec, T. D., Alcaine, O. M., & Behar, E. (2004). Avoidance theory of worry and Generalized Anxiety Disorder. In R. G. Heimberg, & C. L. Turk & D. S. Mennin (Eds.), *Generalized anxiety disorder: Advances in research and practice* (pp.77-108). NY: Guilford Press.

Borkovec, T. D., & Ruscjio, A. M. (2001). Psychotherapy for generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 62,* 37-42.

Brown, T. A., DiNardo, P., & Barlow, D.H. (2004). *Anxiety Disorder Interview Schedule Adult Version (ADIV-IV): Clinical interview schedule.* NY: Oxford University Press.

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2013). Mindfulness-based interventions in counseling. *Journal of Counseling & Development, 91,* 96-104.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52,* 685-716.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., Wiltsey Stirman, S., Gallop, R., Goldstein, L. A., Termes, C. M., & Ring-Kurtz, S. (2008). Unique and common mechanisms of change across cognitive and dynamic psychotherapies. *Journal of Consulting and Clinical Psychology, 77,* 801-813.

Crits-Christoph, P. (2002). Psychodynamic interpersonal treatment of generalized anxiety disorder. *Clinical Psychology: Science and Practise, 9,* 81-84.

Deffenbacher, J. L. (1992) A little more about behavioral assessment. *Journal of Counseling & Development, 70,* 632-634.

Donegan, E., & Dugas, M. J. (2012). Generalized Anxiety Disorder: A comparison of symptom change in adults receiving cognitive-behavioral therapy or applied relaxation. *Journal of Consulting and Clinical Psychology, 80,* 490-496.

Dugas, M. J., & Robichaud, M. (2007). *Cognitive-behavioral treatment for generalized anxiety disorder: From science to practice.* NY: Routledge.

Eng, W., & Heimberg, R. G. (2006). Interpersonal correlates of generalized anxiety disorder. Self versus other perception. *Journal of Anxiety Disorders, 20,* 380-387.

Essau, C. A., Muris, P., & Ederer, E. M. (2002). Reliabilty and validity of the "Spencer Children's Anxiety Scale" and the "Screen for Child Anxiety Related Emotional Disorders" in German children. *Journal of Behavior Therapy and Experimental Psychiatry, 33,* 1-18.

Essau, C. A., Anastassiou-Hadjicharalambous, X., & Munoz, L. (2012). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED) in Cypriot children and adolescents. *European Journal of Psychological Assessment, 29,* 19-27.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1997). *Structured Clinical Interview for DSM-IV Axis I Disorders, Clinical Version (SCID-CV).* Washington, DC: American Psychiatric Association.

Goldin, P. R., Ziv, M., Jazaieri, H., Werner, K., Heimberg, R. G., Kraemer, J., & Gross, J. J. (2012). Cognitive reappraisal self-efficacy mediates the effects of individual cognitive-behavioral therapy for social anxiety disorder. *Journal of Consulting and Clinical Psychology, 80,* 1034-1040.

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Hirsch, C. R., Mathews, A., Hayes, S., Perman, G., & Borkovec, T. (2012). The extent and nature of imagery during worry and positive thinking in Generalized Anxiety Disorder. *Journal of Abnormal Psychology, 121,* 218-243.

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