Joshua was a high functioning physician who left his wife one year ago for a new partner.

While planning the separation, he worried excessively about a range of matters including the potential financial settlement, access to his children and where he would live. His worries worsened after he left his wife, and his new partner was finding it difficult to cope with his constant worrying. He felt unable to work, as he feared making a mistake due to his physical exhaustion and inability to concentrate. He spent his time contemplating all possible endings to what he described as a 'nightmare' situation. He suffered from frequent headaches, which he attributed to being unable to 'switch off' his mind. He recognized that his worries were excessive.

1.0 The Content of the Therapy

The work of Dugas and colleagues (2003) illustrates the current approach to Cognitive-Behavioural Therapy (CBT) treatment for Generalized Anxiety Disorder (GAD).[1] This approach includes:

- Worry Awareness Training – this is a necessary first step since most people with GAD are either unaware of their worry patterns or they incorrectly consider them to be helpful;
- Coping with Uncertainty – those with GAD fear uncertainty and work to ensure predictability (that is, usually whatever worked before) and so are purposely exposed to increasingly uncertain situations relevant to their worry themes. Trusted others (for example, partners, parents) are instructed not to provide reassurance when the person with GAD requests it, instead are asked to answer with, "I don't know", "I guess you'll see", etc.;

Approximate Lifetime Prevalence: 5%

Diagnostic Criteria for Generalized Anxiety Disorder:
Excessive anxiety and worry (apprehensive expectation) about multiple events/activities.

1. Worry occurs for more days than not over the past 6 months.
2. The worry is hard to control.
3. The anxiety is associated with 3 (or more) of:
   a. Restlessness/being keyed up or on edge
   b. Being easily tired
   c. Difficulty concentrating or mind going blank
   d. Irritability
   e. Muscle tension
   f. Sleep disturbance.
4. The content of the worry and anxiety is not confined to the features of an Axis I disorder for example, being contaminated (as in Obsessive-Compulsive Disorder).
5. The anxiety, worry or physical symptoms cause clinically significant distress or impairment in functioning.

The disturbance is not due to the physiological effects of a substance or general medical condition and does not occur exclusively during the course of a mood disorder, psychotic disorder or pervasive developmental disorder.

- Re-evaluating Beliefs About Worry – people with GAD believe worry is useful and that it is helpful in preventing bad outcomes. Beliefs about the value of worry are challenged and tested;
- Problem-Solving Training – problem-solving is presented as an efficient alternative to worry. People are taught to shift from endless worry, into a problem-solving process; and
- Cognitive Exposure – those with GAD routinely engage in cognitive avoidance of troubling thoughts (they simply get rid of them immediately!) with the result that the associated anxiety remains. Cognitive exposure requires individuals to systematically contemplate their feared thoughts and images until their anxiety drops by about 50% (usually within 20 minutes).[1]

Another approach, developed by Tom Borkovec and his colleagues (2002), focuses more on self-control and relaxation.[2]

Specifically, the treatment involves having the person (a) monitor his or her anxiety; (b) learn and use a range of relaxation strategies; (c) learn and practice new coping strategies within sessions; and (d) learn and use a range of cognitive strategies so that thoughts and perceptions are more accurate and adaptive.

The U.K. National Institute of Clinical Excellence (NICE) has recently issued evidence-based guidelines for the treatment of GAD; http://www.nice.org.uk/pdf/CG022NICEguideline.pdf.[3] Specifically, there is evidence for the following recommendations:

- CBT should be delivered only by suitably trained, supervised and qualified mental health practitioners who follow research-based treatment protocols;
- Research shows the optimal range of CBT duration is 16-20 hours;
- Some research shows that less contact (8-10 hours) is also effective; and
- CBT should take the form of weekly sessions of 1-2 hours and should be completed within a maximum of 4 months of commencement.

2.0 Effects on Symptoms in Different Populations

There is strong research support for the use of CBT for Generalized Anxiety Disorder, such that CBT is the psychological treatment of choice for this disorder.[3] The lowest symptom severity and least amount of future treatment required have been shown by individuals in programs of CBT and applied relaxation.[4] Some individuals reported treatment gains at follow-up periods ranging from 6-12 months. There is some indication that people can maintain their treatment gains for even longer follow-up periods of 8 to 14 years.[4]

CBT treatment has also been found effective with older adults and youth.[5,6] However, many studies of children do not distinguish among different anxiety disorders, therefore, few studies specifically address the usefulness of CBT for children with GAD. Nevertheless, there is some indication that CBT is likely to be helpful for children and adolescents. When assessing GAD in children, differences between parent and child report of physical symptoms, as well as the child's age and developmental level should be considered.[6]

3.0 Group Treatments

Group CBT is an effective treatment for GAD, with individuals showing improvement on all symptoms of GAD maintained at 2-year follow-up.[1] In large group settings, cognitive therapy, behaviour therapy and cognitive-behaviour therapy have been found to be more effective than putting someone in a group which receives periodic attention but no active therapy, both in the short and long term. Group CBT has been shown to be specifically effective for children with anxiety disorders, including GAD.[7]

4.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

Individual CBT appears more effective than no intervention, medication, psychodynamic psychotherapy or non-specific psychological interventions.[4] CBT was associated with the lowest dropout rates and largest improvements when tested against other psychological therapies for GAD.[8] Specific CBT techniques such as anxiety management training, relaxation and breathing-for-relaxation therapies have been found to be more effective than no intervention.[2]

5.0 Comparison with Pharmacological Interventions

Cognitive and behavioural techniques have been shown to be as effective as medication in the short term. More studies are needed to demonstrate the relative effectiveness of each in the long term. A meta-analysis of 35 studies examining cognitive-behavioural therapy and medication for GAD[9] reported no statistically significant differences in drop-out rates or in reduction of GAD symptoms between the two interventions. However, CBT demonstrated a greater positive impact on depressive symptoms that were associated with the GAD with gains maintained over time, whereas drug therapies were of less benefit over time.

6.0 Self-Help and CBT

Self-help approaches have an important role to play in the treatment of GAD, particularly in combination with pharmacological or psychological interventions provided by a qualified CBT practitioner.[3] Computer-aided delivery of CBT is seen to have potential within a combined protocol although in some individuals, self-help approaches may be successful interventions on their own. One study found that participants with GAD had maintained treatment gains from a self-help intervention to control worry at a 2 year follow-up.[10]

7.0 What Predicts a Better Response to CBT?

Findings from Gould's (1997) meta-analysis showed that treatment outcome was unrelated to the severity or duration of GAD symptoms.[9] However, other researchers have suggested that marital status, marital tension and the complexity of other co-occurring disorders can impact on the success of treatment.[11] Average drop-out rates for CBT for GAD are only 10%.[9]

8.0 Role of the Family

Family participation in an individual's CBT treatment could be done in an effort to educate family members on the risks of relapse. Family members can be instructed not to provide reassurance when the person with GAD requests it, helping the individual to learn to cope with uncertainty.[1] As well, interpersonal family functioning can be improved and thus, decreasing an individual's stress to inoculate against risk of relapse.

9.0 Summary

- Individualized CBT for GAD is an effective treatment.
- CBT is as effective as medication for GAD.
- CBT requires specialized training to deliver.
- CBT helps to produce lower symptom severity and less future treatment when compared to other psychological treatments for GAD.
- Treatment has been found to be effective for older adults and youth, and when administered in a group format.
- Adaptations of the treatment to everyday clinical settings and alternative forms of delivery, such as self-help when indicated, appear promising.

Joshua had 16 sessions of CBT for generalized anxiety disorder. It soon emerged that Joshua believed strongly that it was his responsibility to 'think things through' and that it was only by thinking through all possible scenarios that he would be prepared for any eventuality. He believed that since he had caused the problem, he should be able to solve it on his own. Treatment consisted of a thorough assessment of his beliefs about the positive functions of worry. These beliefs were challenged in multiple ways, including collecting information about how other people in similar situations have addressed their concerns, behavioural experiments to see if worrying really was helpful in any way, and cognitive restructuring. An important component of treatment was problem-solving to help Joshua put his thoughts down on paper, be as 'thorough' as he felt was necessary but help him to actually implement a solution and see its effects. Joshua found it hard to tolerate the uncertainty that was pervasive in his situation, and methods to help him manage this were implemented. By the end of treatment, Joshua was able to return to work and had agreed to some financial arrangements with his ex-wife. His new partner had left him during the course of treatment, which both created and alleviated some anxiety! He was, however, able to handle her departure without the excessive worrying that had been so disabling prior to treatment.