COGNITIVE-BEHAVIOUR THERAPY FOR PATIENTS WITH GENERALISED ANXIETY DISORDER

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Generalised anxiety disorder (GAD) is defined by key features of excessive, uncontrollable worry about a number of life events or activities, accompanied by at least 3 of 6 associated symptoms of negative affect or tension.[1] GAD is among the most frequent of anxiety disorders. Recent studies show a prevalence rate of between 1.6% and 9% in the general population.[1] Despite this high rate, mental health professionals report that they seldom see GAD patients compared with other anxiety disorder patients. GAD is often under-diagnosed for two main reasons. First, people with GAD may seek care for medical rather than psychological symptoms. Secondly, GAD patients frequently seek help only once there is a secondary disorder such as depression or substance use. If these consequences become significantly severe, they may be seen as the main problem, with GAD remaining undetected. Most patients with GAD present with a lifelong history of generalised anxiety and cannot report a clear age of onset.

The central concept in GAD is worry. The most widely recognised model of pathological worry was provided by Brokovec in 1994. Brokovec regards worry as a predominantly conceptual verbal or linguistic attempt to avoid future aversive events and aversive imagery.[2] This process is experienced by the worrier as negative, affect-laden and uncontrollable.
Pathological worry (as in GAD) is associated with diffuse perceptions that the world is threatening and that one may not be able to cope with or control future negative events. It is therefore clear that worry is characterised by a predominance of thought activities. According to Brokovec worry is negatively reinforced because it is associated with the avoidance of or escape from more threatening imagery, and more distressing somatic activation. Although the avoidant function of worry brings short-term relief, the long-term consequences include the inhibition of emotional processing and maintenance of anxiety-producing cognitions.
It is therefore clear that the two components that should form the targets of treatment intervention for GAD are excessive, uncontrollable worry and its accompanied persistent overarousal (primarily tension-related central nervous system symptoms). Based on these targets, the description of a treatment programme by Brown, O'Leary and Barlow follows.[2]

TREATMENT PROTOCOL

The treatment protocol for GAD typically averages 12 - 15 1-hour sessions, held weekly. The treatment is

based on the principle of worry exposure, in which the patient is directed to spend a specific period of time daily (usually an hour) processing his/her worry content. The initial sessions are most important, explaining the groundwork and rationale for what is to follow. Included in the first two sessions are the following:

- clarification of patient and therapist expectations
- description of the three components of anxiety (physiological, cognitive, and behavioural) and the application of the three-system model to the patient's symptoms
- discussion of the nature of anxiety
- rationale and description of the treatment components
- instruction in the use of self-monitoring forms.

The importance of regular session attendance and completion of homework assignments is emphasised and the patient is provided with a general idea of what to expect of his/her reactions. The self-monitoring forms have a dual purpose, namely helping the patient to continue with the therapy process between sessions and giving both the patient and the therapist an indication of progress, which serves as motivation.

The treatment protocol includes the following components:

Cognitive therapy

Early in treatment, the patient is provided with an overview of the nature of anxiety cognitions. The patient is helped to understand that his/her interpretation of situations is responsible for the negative effect experienced, and not the situations *per se*. Emphasis is placed on the patient's thoughts of unlikely negative outcomes and catastrophising.

Worry exposure

This entails the following procedures:

- identification of the patient's 2 or 3 main areas of worry
- imagery training via the imagining of pleasant scenes
- practice in vividly evoking the first worry area by having the patient concentrate on his/her anxious thoughts while imagining the worst possible feared outcome
- revoking these images and holding them clearly for 25 - 30 minutes, and
- after 25 - 30 minutes, having the patient generate as many alternatives to the worst possible feared outcome as he/she can think of.

This is assigned as a daily home exercise. When the patient experiences no more than a 2 on the 8-point anxiety scale, he/she moves on to the next area of worry.

Worry behaviour prevention

The focus is to counteract the negative reinforcement behaviour. The patient draws up a list of his/her worry behaviour and is then instructed to refrain from using these worry behaviours.

Relaxation training, time management and problem solving can be included as useful adjuncts to GAD treatment.

Although further research is currently being undertaken, there is strong evidence of the efficacy and effectiveness of this treatment programme. Hereby both the worry and arousal are decreased and maintained at lower levels.

References available on request.

ANXIETY DISORDERS, DISABILITY, AND QUALITY OF LIFE

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Written descriptions of anxiety and anxiety disorders date back to the 4th century BC, but their importance and