Generalised anxiety disorder (gad): theories and treatment

Introduction

Modern cognitive-behavioural therapy (CBT) grew out of the merging of behavioural therapy, developed in the 1950s to 1970s, and cognitive therapy developed in the 1960s (Graham, 2004). Broadly, it attempts to deal directly with a client's manifest symptoms through both cognitive and behaviour strategies. Cognitive theories target particular irrational beliefs which are thought to be the source of behavioural and emotional problems. Historically, CBT is well-established in the treatment of anxiety disorders, but has only been adapted more recently for use in psychosis (Tarrier, 2002). This essay will first examine the theory and practical treatment of generalised anxiety disorder (GAD) using CBT. Then the treatment of psychosis will be considered in the same way, but concentrating on the similarities and differences to the treatment of anxiety.

CBT Treatment of Generalised Anxiety Disorder

The main feature of GAD is excessive and uncontrollable worry (Wells, 2002). The DSM-IV states that for a positive diagnosis of GAD, the worry must occur more days than not over a period of six months (American Psychiatric Association, 1994). The DSM-IV also lists a number of somatic and cognitive symptoms which include, for example, muscle tension. A variety of different treatments have been used for GAD including both directive and non-directive therapies. Fisher & Durham (1999) examine the effectiveness of different treatment methods and the number of clients making a full recovery. The most successful treatments in their meta-analysis were CBT

which achieved a recovery rate of 51% and applied relaxation which achieved a 60% recovery rate.

To understand how GAD is treated using CBT, it is necessary to understand the model of worry that it is based upon. Beck (1976) produced the most widely referenced model of anxiety which links emotions and thinking. In this model it is the patient’s thoughts and images relating to anticipated danger that immediately precede, and cause, anxiety attacks. In appraising their environment, anxious patients overestimate both the likelihood and severity of a negative event occurring and so take defensive action (Blackburn, 1995).

Under the umbrella term of CBT a number of different approaches to treating GAD have been used. They normally focus on two main factors: cognitive work aimed at challenging the client’s beliefs and thought processes as well as behavioural work teaching anxiety management strategies (Wells, 2002). Borkovec (2002) describes the cognitive aspect of CBT as focussing on how the client perceives the world and attempting to move this onto a more accurate footing. Generally, this is done by eliciting how the client is perceiving events in an anxious way. Then, the client is encouraged to apply logical thought processes to their own perceptions – to ‘ challenge’ the way they are thinking. The therapist attempts to supplant these original thought processes with cognitive interpretations that do not lead to increased anxiety. Clients are usually given homework in which they attempt to identify anxiety attacks, what preceded them and what followed them. Hopefully, by demonstrating to the client that their catastrophic predictions

do not occur in reality, it is possible to break down the automatic negative thoughts.

Some researchers have been critical of this basic cognitive approach as it does not focus on meta-cognitive factors (Wells, 2002). A revision to the model has been added by Wells (1995) who introduces the distinction between Type 1 and Type 2 worry. Type 1 worry is that referred to above – the worry about physical symptoms and external events. Type 2 refers to worrying, as it were, about worrying: meta-worrying. Type 1 worrying is dealt with in approximately the same manner described above, but greater focus is given here to Type 2 worrying. Type 2 cognitive interventions focus on two factors: the uncontrollability of the worrying and appraisals and beliefs about the dangers of worrying. Once negative meta-cognitions have been elicited, they can be challenged and worked with in the same way as before. An example of this type of metacognition is that a client can believe that worrying is harmful because it increases blood pressure and thereby this is harmful to the body (Wells, 2002). The therapist would address this by explaining that occasional high blood pressure is not associated with chronic health problems.

The second aspect in treating anxiety by CBT is the use of behavioural strategies (Borkovec, 2002). This involves teaching the client techniques for relaxing their body such as meditation, progressive muscle relaxation and relaxing imagery. Clients are encouraged to practice these techniques even when they are not anxious so they feel comfortable with their implementation. In addition, in some circumstances clients will be exposed

to situations which make them anxious in order to provide realistic practice opportunities (Borkovec, 2002).

A further type of behavioural strategy employed is a stimulus control method. This involves the client in deciding on a period of the day in which worrying will be carried out, carrying out monitoring of their daily worrying, and trying to only worry in the designated period. Then, in the designated period of worrying, clients practice their cognitive skills. Two other techniques used are behavioural activation strategies – encouraging the client to engage in more pleasant activities – and imagery rehearsal techniques which involve practicing new responses to environmental cues likely to cause worry (Borkovec, 2002).

CBT Treatment of Psychosis

Unlike the symptoms of anxiety which can be stated relatively succinctly, the experiences of those with psychosis vary to a large degree. Those with schizophrenia-spectrum disorders, for example, can suffer from hallucinations, delusions, perceptual anomalies as well as some associated problems like depression and anxiety itself (Garety, Fowler & Kuipers, 2000). The CBT therapist will, therefore, be targeting a greater variety of symptoms than with anxiety, and usually over a much longer period: perhaps three or more times as many sessions as for anxiety. The use of CBT in psychosis was nevertheless developed from the techniques used to treat conditions like depression and anxiety (Tarrier, 2002). CBT is generally used in addition to powerful antipsychotic medications and is aimed at helping clients to better cope with their psychoses. CBT has been investigated in a number of

different patient groups, the largest body addresses those with chronic conditions that are treatment-resistant, with studies generally finding it to be effective (Sensky et al., 2000). More recent studies have found it to be effective in acute and recent-onset schizophrenia (Lewis et al., 2002).

The theoretical model for CBT in psychosis is necessarily much broader than that used for anxiety. While the relations between thoughts, feelings and behaviour are important, these have to be set against wider issues. The causes of psychosis are usually multi-factorial and thought to stem from the social environment, biological vulnerability and psychological processes (Garety et al., 2000; see also the stress-vulnerability model: Strauss & Carpenter, 1981). In order to reach an effective case formulation, therefore, the therapist needs to examine the confluence of these different factors along with the client’s stresses, vulnerabilities and responses.

Like anxiety, at the centre of the cognitive model of psychosis lies the idea that the therapist can address all the different types of symptoms by examining cognitive processes. One example Garety et al. (2000) point to was made by Frith (1992), which claims that symptoms of thought insertion are a result of deficits in normal cognitive self-monitoring processes. Similarly, the anxious component of psychosis is seen as resulting from maladaptive appraisals. At heart, the theoretical model of CBT for psychosis relies on the same fundamentals as that for anxiety: that making the client aware of these problematic thought processes will provide some relief. Where it differs theoretically is that it is addressing a wider variety of factors – social and biological as well as psychological – and so the treatment has to reflect this fact.

Turning now to the practical aspects of CBT for psychoses, Garety et al. (2000) outline a six-stage process. The first involves building and maintaining a therapeutic relationship. This was taken for granted in the discussion of anxiety because, to a therapist, this is a given. With psychotic clients, though, there are significantly greater barriers to the building of a therapeutic relationship. The client may well suffer psychotic symptoms during sessions as well as being paranoid about and suspicious of those trying to help them.

The second stage is providing cognitive-behavioural coping strategies for the positive symptoms of psychosis (Garety et al., 2000). Similarly to anxiety treatment, this might include reality testing on delusional thoughts, self-monitoring of symptoms and using distraction and withdrawal (Phillips & Francey, 2004). The third stage involves attempting to understand the experience of psychosis. Here, the therapist attempts to bring together strands from the client's life and experiences and link them to their psychotic symptoms. Further, however, the therapist also looks to provide some sort of normalisation to the already high level stigmatisation associated with psychosis. This third stage in treating psychosis differs considerably from the treatment of anxiety, which generally does not address wider social issues in depth.

Fourthly, the therapist will specifically examine hallucinations and delusions (Garety et al., 2000). This will often be hard as the client will have developed a series of beliefs that are heavily reinforced. These are addressed using standard CBT techniques such as those used in anxiety. Where the approach for psychosis differs, however, is that attempts to change long-held thoughts

are not made until well into the therapeutic process and the therapist's manner is slower and softer. In addition, compared to CBT for anxiety, there is less emphasis on the patient generating their own alternative interpretations, and more on the therapist providing them. Some clients may not even agree their beliefs are delusional and so the therapist has to work within the boundaries set by the client.

The fifth aspect of CBT for psychosis as laid out by Garety et al. (2000) focuses on depression, anxiety and negative self-evaluations. Those suffering from psychosis will often have low self-esteem. This can be the result of long-standing negative self-evaluations which can be targeted by cognitive therapy techniques of reviewing how they arose and then providing a challenge to the thinking. Both depression and anxiety are also treated in this way. Finally, Garety et al. (2000) look at issues of social desirability and risk of relapse. Throughout therapy, the therapist is looking to the future and helping the client to think about their short and medium-term plans.

While Garety et al.'s (2000) model is influential, it should be noted that the treatment of psychoses, like that for anxiety, is not monolithic – there are a variety of different formulations and approaches. Some focus more on particular aspects such as the delusions or coping strategies. Garety et al. (2000) argue, however, that many treatments are now becoming more integrated in order to address the wide range of symptoms in psychosis.

Outcomes and Comorbidity

The outcome research varies across different types of psychosis and so it is difficult to compare with anxiety outcomes. A further complication is the

different methods used and the rapidly developing nature of CBT as an intervention. Psychosis is certainly harder to work with than anxiety because of the sheer number of factors involved and, as a consequence, the outcomes are generally not nearly as good as those for anxiety.

One clear similarity between the CBT treatment of psychosis and that for anxiety is their comorbidity in psychotic disorders. Looking across bipolar disorder, schizoaffective disorder and schizophrenia, Cosoff & Hafner (1998) found 43% to 45% of psychotic patients had a form of anxiety disorder. Indeed, in their sample, Cosoff & Hafner (1998) found that, even though anxiety disorders are often responsive to treatment, none of the patients had been treated for it. Research has questioned whether anxiety might be a dimension of a psychotic disorder like schizophrenia while others suggest they form a subgroup of the patient population (Braga, Petrides & Figueira, 2004). Supporting the dimensional view, Lysaker & Hammersley (2006) have found a relationship between both delusions and inflexible thought (characteristic of psychosis) and higher levels of social anxiety. Further, looking at schizophrenia in particular, Braga, Petrides & Figueira (2004) argue that much of the research shows better outcomes for those treated for comorbid anxiety.

While the repertoire, order and specific implementation of techniques used in CBT differs between psychosis and anxiety, the therapeutic relationship will be central to success in both treatments. Factors that Beck & Emery (1990) highlight include trust on the part of the client in the therapist, a collaborative approach and a focus on educational issues.

Conclusion

The treatment of both anxiety and psychosis with CBT is based on identical underlying principles. Theoretically, both approaches involve focussing on the types of attributions and automatic negative thoughts the client is experiencing as well as aspects of behaviour. Similarly, both approaches require a strong therapeutic alliance in order to be successful. The practical implementation of each intervention is, however, tailored for the disorder. The client suffering from psychosis is likely to have a much wider range of symptoms to deal with and, as such, CBT for psychosis generally takes longer and addresses more complex issues. Part of this will involve the therapist in attempting to understand and interpret the experience and causes of psychosis. This is in contrast to CBT for anxiety which will focus more on problem solving. There is evidence to suggest, however, that anxiety forms a part of certain psychoses, and in this situation its treatment should form part of a wider integrated approach. Finally, outcomes in CBT for psychosis are generally more modest than in anxiety as psychotic symptoms are considerably more challenging for the therapist.

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