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Specificity of Generalized Anxiety Disorder Symptoms and Processes

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This study's main goal is to test the broad specificity of generalized anxiety disorder (GAD) symptom and process variables. These variables were compared in four groups of participants: (1) 24 patients with primary GAD, (2) 24 patients with secondary GAD, (3) 38 other anxiety disorder patients, and (4) 20 nonclinical control

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subjects. Each participant received a structured diagnostic interview and a series of standardized questionnaires. The results show that *DSM-IV* GAD symptoms (worry, GAD physical symptoms, and interference due to worry and anxiety) distinguish GAD patients from those with other anxiety disorders. Two process variables, problem orientation and intolerance of uncertainty, also differentiated GAD patients from other anxiety disorder patients. Overall, these results support the *DSM-IV* definition of GAD and the broad specificity of problem orientation and intolerance of uncertainty as GAD process variables.

It is now widely acknowledged that specificity is a key issue in many fields of psychology. In particular, specificity issues have been extensively discussed in the field of psychopathology (e.g., Ganellen, 1988; Hollon, Kendall, & Lumry, 1986; Sher & Trull, 1996). Classification systems such as the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (*DSM*) are based on the idea that emotional disorders represent distinct nosological categories (i.e., that every disorder has its own specific features). Each revised version of *DSM* has strived to better delineate its listed disorders by increasing the specificity of its diagnostic criteria. For instance, in *DSM-III-R* (APA, 1987), the diagnostic criteria for Generalized Anxiety Disorder (GAD) included a list of 18 physical symptoms. In *DSM-IV* (APA, 1994), the GAD physical symptom list was reduced to 6 in order to eliminate symptoms such as shortness of breath and tachycardia, which are more characteristic of Panic Disorder and thus provide greater specificity to the definition of GAD (see Marten et al., 1993; Noyes et al., 1992; Starcevic, Fallon, & Uhlenhuth, 1994). Since the publication of *DSM-IV,* other changes have been suggested in order to further increase the specificity of GAD diagnostic criteria without decreasing their sensitivity (see Brown, Marten, & Barlow, 1995).

The identification of distinct process variables has also received much attention from researchers. It is believed that the identification of disorder-specific symptom clusters and process variables will lead to more reliable diagnosis and more effective treatments. The past decade has produced an impressive amount of evidence for specific cognitive process variables in many anxiety disorders. For example, Salkovskis (1985) has identified exaggerated responsibility as a key cognitive process variable in Obsessive-Compulsive Disorder. It has recently been shown that a cognitive treatment that exclusively targets excessive responsibility leads to clinically significant therapy gains for patients with Obsessive-Compulsive Disorder (Ladouceur, Léger, Rhéaume, & Dubé, 1996). Other anxiety disorder process variables that have been identified include anxiety sensitivity (see Maller & Reiss, 1987). After reviewing the empirical data on anxiety sensitivity, Taylor (1996) concludes that anxiety sensitivity is a specific marker of fear of anxiety and panic-related sensations. Obviously, exposure to interoceptive cues, a key treatment component for Panic Disorder (see Barlow, 1988), targets anxiety sensitivity.

Considering that the diagnostic criteria for GAD have undergone significant change over the past 10 years (e.g., excessive worry was first identified