

in press). Several studies have shown a close link between IU and worry. For example, high worriers are slower at categorizing ambiguous stimuli (Metzger, Miller, Cohen, Sofka, & Borkovec, 1990; Tallis, Eysenck, & Mathews, 1991), and IU is significantly correlated with the tendency to worry in nonclinical participants (Freeston, Rhéaume, Letarte, Dugas, & Ladouceur, 1994). Furthermore, GAD patients have higher scores on a measure of IU than other anxiety disorder patients (Ladouceur et al., 1999). Results such as these have led Dugas, Gagnon, et al. (1998) and Ladouceur et al. (1999) to conclude that IU is a key process variable that makes a significant contribution to our understanding of GAD.

A second variable in the model is the positive beliefs patients hold about worry. GAD patients mention that worrying helps them prepare for anticipated negative events that are often unlikely to occur (Brown, O'Leary, & Barlow, 1993; Roemer & Borkovec, 1993). Unfortunately, possessing these types of positive beliefs about worry is associated with poor mental health (Davey, Tallis, & Capuzzo, 1996). Although negative beliefs about worry also share an important relationship with worry and GAD (see Wells, 1995; Wells & Carter, 2001), the model proposed by Dugas, Gagnon, et al. (1998) focuses mainly on positive beliefs about worry given that these beliefs may lead directly to the maintenance of worrying behavior through both positive and negative reinforcement.

A third variable that makes an important contribution to the model is negative problem orientation, which refers to a negative or dysfunctional cognitive set involving the tendency to appraise problems as threats, to view problems as unsolvable, and to doubt that one has the ability to solve problems. Research has shown that worry is closely linked to negative problem orientation but not to problem-solving skills per se (Davey, 1994; Dugas, Letarte, Rhéaume, Freeston, & Ladouceur, 1995; Ladouceur, Blais, Freeston, & Dugas, 1998). It has been suggested that negative problem orientation may interfere with the adequate application of problem-solving skills, which would in turn maintain worry (Davey, 1994; Dugas & Ladouceur, 1998; Robichaud, Dugas, & Conway, 2003).

A final variable in the model is cognitive avoidance. Several studies have revealed that worry generally consists of verbal-linguistic thought (Borkovec & Lyonfields, 1993; Freeston, Dugas, & Ladouceur, 1996), and that worry is associated with a decrease in peripheral somatic activity (Borkovec & Inz, 1990). Borkovec (1994) suggested that one of the functions of worry may be the avoidance of feared negative images. Avoidance would impede emotional processing of these images by preventing the full activation of the fear network in memory, which is an important condition for fear reduction (see Foa & Kozak, 1986). Thus, cognitive exposure to these presumably avoided negative images may have a positive impact in reducing

worries, which is supported by preliminary results with non-clinical worriers (Borkovec, Wilkinson, Folensbee, & Lerman, 1983) and GAD patients (Dugas & Ladouceur, 2000; Ladouceur et al., 2000; O'Leary, Brown, & Barlow, 1992).

The preceding results have led to the development of a treatment package based on the model proposed by Dugas, Gagnon, et al. (1998) that targets IU via the re-evaluation of positive beliefs about worry, problem-solving training, and cognitive exposure (for a detailed description of how IU is addressed in all treatment components, see Dugas, 2002). The treatment package has shown efficacy in a single case study (Dugas & Ladouceur, 2000) and in two randomized controlled trials (Dugas et al., 2003; Ladouceur et al., 2000).

One of the innovations in this treatment resides in distinguishing between worries that concern current problems and those that concern "hypothetical" situations that might or might not occur. A different intervention is applied depending on the type of worry. For worries that concern current problems, problem-solving training with an emphasis on correcting negative problem orientation is applied. For worries that concern hypothetical situations, cognitive exposure using a looped tape is applied. As mentioned by Dugas and Ladouceur (2000), "teaching patients to distinguish between both types of worry and apply the correct strategy to each type may be a key contributor to the treatment's efficacy" (pp. 652–653). This claim is supported by informal data of a previous clinical trial in which patients reported that it was very useful for them to distinguish between both types of worry (Ladouceur et al., 2000).

The goal of this study is to evaluate the efficacy of problem-solving training and the efficacy of cognitive exposure for patients presenting with GAD. Consistent with the model proposed by Dugas, Gagnon, et al. (1998), problem-solving training will be used for patients reporting mainly worries concerning current problems, and cognitive exposure will be used for patients reporting mainly worries concerning hypothetical situations. The first hypothesis is that it will be possible to reliably categorize worries into both proposed types. The second hypothesis is that both interventions will lead to statistically and clinically significant improvements on measures of GAD symptoms and that treatment gains will be maintained at 6-month follow-up. It is expected that even though all worries for a given patient are not targeted by treatment, patients will improve by intensively focusing treatment on their main worries with a well-defined and specific technique.

METHOD

Participants and Procedure

Following a description of the research project in a local newspaper, 76 people contacted our research center

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