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The Clinical Application of Emotion Research in Generalized Anxiety Disorder: Some Proposed Procedures

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Major psychological theories of generalized anxiety disorder (GAD) have begun to suggest that worry may function as avoidance of emotions. On the basis of these findings, a number of researchers have begun to develop techniques to address emotional deficits in GAD. However, most techniques suggested to date have been from outside a cognitive-behavioral (CBT) model of treatment, making the integration of these techniques more difficult for CBT therapists. We propose a CBT model of addressing emotional avoidance through (a) learning to identify emotions and their possible evolutionary functions, (b) creating an emotion hierarchy to systematically address different emotions, (c) using imaginal exposure to increase tolerance to different emotions, and (d) eliminating behavioral avoidance of emotional experiences.

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Continuing Education Quiz located on p. 447.

RECENT CONCEPTUALIZATIONS of generalized anxiety disorder (GAD) have begun to emphasize the fact that worry may interfere with the processing of emotional information (Borkovec & Inz, 1990; Mennin, Turk, Heimberg, & Carmin, 2004; Roemer & Orsillo, 2002). When

individuals worry, their cognitive resources become engaged with the content of the worry, thereby inhibiting them from processing other information, including emotions. Evidence for this has been demonstrated through self-report measures (Borkovec & Roemer, 1995; Roemer & Orsillo, 2002; Schut, Castonguay, & Borkovec, 2001), physiological reactivity to fear during worry (Borkovec & Hu, 1990; Thayer, Friedman, & Borkovec, 1996), and experimental studies (Mennin, Turk, Heimberg, & Carmin, 2004). It is hypothesized that worry is a form of avoidance, which may become automatic, as many other forms of avoidance do (Borkovec, Alcaine, & Behar, 2004). As opposed to the other anxiety disorders, such as panic disorder and obsessive-compulsive disorder, in which avoidance serves to decrease or prevent anxiety or fear, worry has been conceptualized as an attempt to avoid either negative affect or all affect (Borkovec, 1994).

Given these conceptualizations, a number of researchers have attempted to add new treatment techniques to standard cognitive-behavioral therapy (CBT) to improve outcome, which has been good, but not excellent (see Borkovec & Ruscio, 2001; Roemer, Orsillo, & Barlow, 2002). Borkovec and colleagues have added the interpersonal and emotion-focused psychotherapies from Safran and Segal (1990) and Greenberg and Safran (1987) in order to determine whether this addition improves outcome (Newman, Castonguay, Borkovec, & Molar, 2004). Similarly, Mennin, Heimberg, and colleagues (2002) are working on integrating concepts from Greenberg and Safran (1987) and Greenberg (2001) into CBT in order to address a fear of emotions in GAD (Mennin et al., 2002). Roemer and Orsillo (2002) have proposed integrating principles from Acceptance and Commitment Therapy (Hayes, Strohsahl, & Wilson, 1999) in order to deal with the experiential, cognitive, and behavioral avoidance commonly associated with GAD. Freeston, Dugas, and Ladouceur (1996) have proposed dealing directly with intolerance with uncertainty. Dugas (2002) has recently worked on updating this model by considering emotional arousal as another important aspect of GAD to be addressed in treatment. Finally, McGinn, Young, and Sanderson (1994) have suggested that addressing early maladaptive schemas may facilitate change in patients with GAD (Huppert & Sanderson, 2002). Many of the techniques used in their schema-focused therapy attempt to facilitate emotional processing, which may be the core ingredient to their treatment.

Common to all the above conceptualizations is the notion that GAD reflects deficits in the ability to identify, tolerate, process, and/or regulate emotional experiences. These emotional experiences may involve anxiety or a variety of other emotions such as guilt, shame, anger, sadness, or joy. These core deficits address other difficulties suggested by other theories of GAD. Interpersonal deficits likely reflect a core difficulty with emotional experiences such as guilt, shame, or anger. Fear of emotions is likely due to a difficulty with predicting or controlling emotions. Experiential, cognitive, and behavioral avoidance may be attributable to misconceptions about the meaning of emotions that are elicited by specific experiences (e.g., that any experience of guilt is unmanageable or intolerable). Experiences are therefore avoided, creating a vicious cycle. Intolerance of uncertainty may be predominantly triggered by uncertainty about what emotion one is experiencing or how to cope with it. Finally, identifying early maladaptive schemas may be helpful by eliciting emotions (e.g., shame, guilt, anger, fear, etc.) that GAD patients may have difficulty identifying or regulating. Incomplete processing of such emotions may therefore maintain the schemas. Clearly, more data are needed to support the notion that deficits in identifying, processing, tolerating, and regulating emotional experiences constitute the core maintenance mechanism of GAD, though preliminary reports are encouraging (Mennin, Turk, Fresco, & Heimberg, 2001; Turk, Mennin, Fresco, & Heimberg, 2001).

Through our experience in treating patients with GAD, we have worked to develop treatment techniques that address emotional processing that are easily incorporated into standard CBT procedures for GAD (see Borkovec et al., 2004; Craske, Barlow, & O'Leary, 1992; Huppert & Sanderson, 2002). These techniques continue to be developed and do not have outcome data yet. However, our clinical experience suggests that the techniques may be useful for a significant proportion of patients with GAD.

Procedures

As an addition to the basic psychoeducation for patients with GAD, we explain to the patient that worry may serve many functions, including to avoid or escape from emotional experiences that may feel difficult to manage (c.f., parasuicidal behaviors in patients with borderline personality disorder; Linehan, 1993). This serves to prepare the patient later in treatment for a more in-depth discussion of worry and emotional avoidance. The first six sessions include standard CBT procedures: (1) psychoeducation; (2) self-monitoring of emotions, worry/thoughts, sensations, and behaviors; (3) breathing retraining and progressive muscle relaxation; (4) cognitive challenging; (5) worry exposure; and (6) worry behavior prevention. After the sixth session, the therapist begins to use the self-monitoring to determine whether certain emotions tend to be elicited or avoided in situations that are related to increased worry. This leads to the first of the more structured emotion procedures, which begins with a more in-depth discussion of emotions and their function.

The process of identifying worry and negative emotions