Clinical Experiences in Conducting Empirically Supported Treatments for Generalized Anxiety Disorder

Lauren E. Szkodny

The Pennsylvania State University

Michelle G. Newman

The Pennsylvania State University

Marvin R. Goldfried

Stony Brook University

Knowledge of the efficacy of cognitive-behavioral therapy (CBT) for generalized anxiety disorder (GAD) predominantly derives from randomized controlled trials (RCTs). However, there may be unique or complex issues encountered in practice, but not necessarily in the context of a controlled clinical trial. Therefore, launching a systematic dialogue between researcher and practicing clinician can be instrumental in augmenting evidence-based therapies through identification of variables that promote and interfere with clinical effectiveness. Through an initiative sponsored by the American Psychological Association's Divisions 12 (Society for Clinical Psychology) and 29 (Psychotherapy), this study aimed to examine clinical experiences conducting CBT for GAD. The participants were 260 psychotherapists who completed an online survey on assessment and therapeutic intervention utilization and their experience of factors that limit successful GAD treatment and symptom reduction. The majority of respondents reported 20 years or less experience using ESTs for GAD, typically treating clients in outpatient clinics, treatment centers, and private practice. Some of the most commonly used interventions address clients' maladaptive cognitions and elevated anxiety and muscle tension typical of GAD. Approximately one half of respondents reported incorporating integrative techniques into treatment. Factors perceived as limiting effective GAD treatment included severity and chronicity of GAD, presence of comorbid conditions, stressful home and work environments, client motivation and resistance to treatment, and issues encountered when executing therapy techniques. This study provides researchers with clinically derived directions for future empirical investigation into enhancing efficacy of GAD treatment.

GENERALIZED ANXIETY DISORDER (GAD) is a chronic problem marked by pathological worry, and typically associated with a variety of physical, emotional, and cognitive symptoms, including restlessness, fatigue, irritability, muscle tension, concentration difficulty, and sleep disturbance (American Psychiatric Association, 2000). It is a highly prevalent anxiety disorder (Kessler et al., 2005), and likely to be encountered in both clinical and primary care settings. GAD is characterized by later onset than other anxiety disorders (Kessler et al.) and comprises fluctuations in symptom severity and impairment that may not be indicative of recovery (Wittchen, Lieb, Pfister, & Schuster, 2000; Yonkers, Warshaw, Massion, & Keller, 1996). GAD is also associated with a high degree of comorbidity that can interfere with its natural remission (e.g., Bruce et al., 2005). Finally, the disability and impairment associated with

Address correspondence to Lauren E. Szkodny, M.S., Department of Psychology, 378 Bruce V. Moore Building, The Pennsylvania State University, University Park, PA 16802-3103; e-mail: les233@psu.edu

GAD is analogous to major depressive disorder and can be more extensive than pure substance use disorders, some anxiety disorders, and personality disorders, even taking into account sociodemographic variables and comorbid conditions (Grant et al., 2005).

GAD is unique in that behavioral avoidance commonly observed in other anxiety disorders is not one of its cornerstone symptoms. Rather, individuals with GAD display a tendency to perceive threat in neutral or ambiguous stimuli (Mathews & MacLeod, 1994), and engage in worry to cope with the occurrence of negative events and alterations in emotional reactivity (Newman & Llera, 2011). This process is maintained through connecting their worry with the nonoccurrence of the feared event and subsequent reduction in anxiety. Temporally linking these events then fosters positive beliefs regarding worry's functionality, such as worry helping them to anticipate negative outcomes or worst-case scenarios or avoid shifts in negative emotions (Borkovec & Roemer, 1995; Newman & Llera). In the absence of interventions to address the aforementioned information processing biases and maladaptive cognitions, GAD has a poor prognosis captured by a low probability of symptom remission and a high likelihood of recurrence (Rodriguez et al., 2006), thereby underscoring the need for effective treatment.

Based on treatment outcome studies adhering to rigorous scientific standards (Chambless & Hollon, 1998), cognitive-behavioral therapy (CBT) is the only empirically supported treatment for GAD to date. Cognitive-behavioral interventions target principle and associated symptoms of GAD, and include identifying early anxiety triggers; challenging and disrupting individuals' misconceptions and factors maintaining worry; actively testing the validity of erroneous beliefs; using desensitization methods (e.g., imaginal exposure to worry triggers, relaxation); improving skills to manage worry and anxiety; and developing more adaptive ways of responding to neutral and ambiguous situations (Newman & Borkovec, 2002; Newman, Stiles, Janeck, & Woody, 2006).

CBT for GAD also emphasizes fostering positive expectations of treatment to predict and influence therapeutic alliance and treatment outcome (Newman & Fisher, 2010). To increase level of expectancy, clinicians educate clients about their symptoms by discussing the underlying mechanisms of the symptoms and the treatment goals. Furthermore, clients develop an alternative, more adaptive view of themselves and the world, are taught to confront their negativistic views, and learn to become more adept at identifying and understanding the function

of any forms of resistance to treatment (e.g., understanding how avoidance may interfere with the completion of homework assignments).

Extensions of these cognitive-behavioral interventions have focused on addressing individuals' intolerance of uncertainty (IU), a process marked by a heightened sensitivity to ambiguous and uncertainty-relevant information and situations (Dugas & Ladouceur, 2000). Likewise, metacognitive therapy (MCT; Wells, 2006) addresses worry (Type 1 worry) and individuals' negative interpretations of their worry (Type 2 worry or "meta-worry"). Specifically, MCT aims to identify and modify metacognitive appraisals and beliefs about worry and enhance use of adaptive coping strategies in response to worry triggers (Wells).

Although randomized controlled trials (RCTs) demonstrate the efficacy of cognitive-behavioral interventions for worry and GAD in adults and older adults (e.g., Borkovec & Ruscio, 2001; Covin, Ouimet, Seeds, & Dozois, 2008; Gonçalves & Byrne, 2012; Hanrahan, Field, Jones, & Davey, 2013), GAD still remains the least successfully treated anxiety disorder (Brown, Barlow, & Liebowitz, 1994; Heimberg, Turk, & Mennin, 2004; Newman & Borkovec, 2002). On average, only 50% of individuals still no longer meet criteria for clinically significant change at 6 and 12-month follow-up (Borkovec & Costello, 1993; Borkovec, Newman, Pincus, & Lytle, 2002; Borkovec & Whisman, 1996; Dugas et al., 2003; Ladouceur et al., 2000; Wells et al., 2010). Therefore, the research community has since endeavored to enhance CBT through investigations into both the structure and focus of interventions. CBT protocols typically stipulate length and number of sessions. However, to improve end-state functioning, Borkovec and colleagues (2002) increased the amount of client contact time from a previous study (Borkovec & Costello) with the aim that individuals would further benefit from treatment. Despite additional contact time with the therapist, the rate of remission did not improve.

Likewise, CBT has been efficacious in reducing the core diagnostic symptoms of GAD, but researchers have raised concerns that cognitive-behavioral interventions do not adequately address other factors that potentially contribute to the development and maintenance of GAD. Recognizing that individuals with GAD do not simply struggle with chronic worry and anxiety, conceptual models of GAD predominantly focusing on clients' intraindividual cognitive and behavioral experiences have recently expanded to include interpersonal and affective domains of functioning. Accordingly, a more integrative therapeutic approach has been applied that addresses aspects of GAD not commonly included in a traditional CBT