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Characteristics of worry in Generalized Anxiety Disorder

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ABSTRACT

Background & objectives: Groups of clients and community volunteers with Generalized Anxiety Disorder (GAD) and clients with Panic Disorder were compared to a group with elevated worry but without GAD on a range of measures, to identify individual differences beyond a high propensity to worry.
Method: Participants completed standardised questionnaires and a behavioural worry task that assesses frequency and severity of negative thought intrusions.
Results: Relative to high worriers, clients with GAD had higher scores on trait anxiety, depression, more negative beliefs about worry, a greater range of worry topics, and more frequent and severe negative thought intrusions. Relative to community volunteers with GAD, clients in treatment reported poorer attentional control. Compared to clients with Panic Disorder, clients with GAD had higher trait anxiety, propensity to worry, negative beliefs and a wider range of worry content.
Conclusions: Results confirmed expectations of group differences based on GAD diagnostic criteria, but also revealed other differences in mood, characteristics of worry, and perceived attentional control that may play a role in the decision to seek treatment.

1. Introduction

Worry is characterised by the repeated experience of thoughts about potential negative events, and reported proneness to worry varies continuously across the normal population (Ruscio, Borkovec, & Ruscio, 2001). Chronic, excessive and uncontrollable worry about multiple topics is the main defining feature of Generalized Anxiety Disorder (GAD; Diagnostic and Statistical Manual of Mental Disorders 4th Edition: DSM IV; American Psychological Association, 1994), often causing severe incapacity. In addition to excessive and uncontrollable worry, a diagnosis of GAD requires endorsement of at least three other associated symptoms (e.g., concentration problems, sleep difficulties, fatigue). However, given that excessive, uncontrollable worry is the central requirement for a diagnosis of GAD, it was the focus of the current study.

Ruscio et al. (2001) reported that worry propensity lies on a normal continuum. Individuals with GAD are characterised by the presence of severe and uncontrollable worry. Some excessive worriers without GAD also report other associated symptoms although (necessarily) not in sufficient number to meet diagnostic criteria (Ruscio, 2002). Whether or not an individual experiencing high levels of worry also meets diagnostic criteria for GAD thus depends on multiple criteria that include the presence of somatic as well as cognitive symptoms. When multiple criteria must all be met to achieve a categorical distinction, it is not clear which among them are essential, or even useful, in distinguishing between diagnosed and non-diagnosed groups. The main aim of the present study was to test hypotheses derived from the worry-related criteria currently used to diagnose GAD, by assessing the extent to which they actually distinguish individuals with this diagnosis from a non-clinical group with similarly high levels of worry, or another anxiety disorder in which worry is not thought to be central, such as Panic Disorder. Failures to find predicted differences would have potentially important implications for the clinical or theoretical usefulness of the assumed central criteria. Furthermore, other differences emerging could inform attempts to formulate a comprehensive model of GAD and the development of more effective treatments. Summarized below are the main issues and questions to be addressed in the present study.

(1) Range of worry topics. Although frequent worry about multiple topics is the central requirement for diagnosing GAD, it does not necessarily follow that the number of topics worried about

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actually distinguishes high worriers meeting diagnostic criteria for GAD from high worriers who do not meet all the required criteria; nor that frequency of worry distinguishes those with GAD from those with other anxiety disorders not defined in terms of the worry about many topics. We therefore explicitly tested the previously unexamined hypothesis that the range of worry topics would be greater in a group meeting diagnostic criteria for GAD than a matched high worry group not meeting these criteria or clients with Panic Disorder.

(2) Perceived and actual control. Similarly, the fact that reported lack of perceived control over worry is required for diagnosing GAD does not necessarily mean that non-GAD high worriers actually have any greater control over worry than do those with GAD. Consequently, a further hypothesis tested in the current study was that those with GAD would be less able to prevent worrisome thoughts intruding when attempting to focus their attention elsewhere, and possibly also have a more general inability to control attention, based on a self-report questionnaire designed to assess ability to control attention across a range of everyday activities.

(3) Beliefs about worry. Inappropriate beliefs about either the positive benefits or the negative consequences of excessive worry are not part of the diagnostic criteria for GAD, although some previous researchers (e.g., Ruscio & Borkovec, 2004; Wells & Carter, 2001) have found evidence suggesting that such beliefs may be both characteristic of the disorder and possibly play a part in maintaining it. Given these previous suggestions, we included a further examination of this issue using an established questionnaire measure (Meta Cognitions Questionnaire; MCQ; Wells & Carter, 2001) to test the extent to which beliefs about worry distinguish those meeting GAD diagnosis on clinical interview from equally high worriers not so diagnosed.

(4) Other emotional differences. High levels of anxiety and depression often accompany excessive worry, although again the question of whether or not such mood disturbances accompany all elevated worry states, perhaps as a consequence of worry itself, or are more likely to occur in those meeting current criteria for GAD as assessed by clinical interview has not previously been examined. It is possible that it is only the emotional symptoms that are presently required for diagnosis of GAD which distinguish those meeting diagnostic criteria for GAD from others with equally intrusive and uncontrollable worries about similarly diverse topics. We assessed this possibility by comparing GAD and matched high worriers using standard questionnaire measures of trait anxiety (State-Trait Anxiety Inventory Trait version; STAI-T; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) and depression (Beck Depression Inventory; BDI; Beck & Steer, 1987).

(5) Finally, not all those meeting criteria for GAD enter or even seek treatment and it is unclear how those not seeking help differ from similarly diagnosed groups in treatment, or for that matter from high worriers not so diagnosed. Little is known about the factors influencing individuals with similar symptoms to enter treatment or otherwise, but one obvious possibility is that those seeking treatment are experiencing greater severity in the worry-related or emotional symptoms discussed above. Another previously suggested hypothesis to be tested here is that the perceived failure of control over intrusive negative thoughts in worry is the critical factor leading high worriers to seek help (Mathews, 1990).

In earlier work, Ruscio and Borkovec (2004) addressed some (but not all) of the issues discussed above, by individually matching pairs on overall worry severity (based on their Penn State Worry Questionnaire scores; PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990), with one of each pair meeting GAD criteria (as assessed using the Generalized Anxiety Disorder-Questionnaire; GAD-Q-IV; Newman et al., 2002), while the other did not. Rather than relying on reported inability to control worry, Ruscio and Borkovec (2004) used a behavioural test in which participants attended to their breathing before and after instructed worry (cf. Borkovec, Robinson, Pruzinsky, & DePree, 1983), and when signalled on four occasions participants reported if they had been distracted by a negative, positive or neutral thought at the time of the signal. Those with a GAD diagnosis (based on questionnaire) were more likely to report a negative thought than were others not so diagnosed, but only on the first occasion immediately following instructed worry. Although consistent with impaired control in GAD the effect was surprisingly short-lived, so that reported lack of control may be more perceived than real and could partly reflect stronger negative beliefs about worry in the GAD group.

Part of the present study (see Section 2 above) was similarly directed to the question of whether the characteristics of worry in clients diagnosed with GAD differ from those in a group of volunteers matched on overall reported worry severity. However, to further examine whether these groups differed in perceived or real ability to control thoughts (or both) we included a questionnaire measure of perceived control (Attentional Control Scale: Derryberry & Reed, 2002), and increased the frequency of thought samples in the behavioural worry measure to enhance sensitivity to actual control differences. Thought intrusions were also categorised in terms of valence by an assessor who was not informed about group membership to determine if negative intrusions were objectively more common in the diagnosed groups. Negative intrusions were also categorised by an assessor in terms of severity to assess whether people with GAD reported particularly negative thoughts. In addition, we distinguished between those in treatment for GAD and a community sample meeting GAD criteria (using the structured clinical interview for DSM-IV in addition to the GAD-Q-IV used by Ruscio & Borkovec, 2004 with their student sample) who were not seeking treatment.

We also contrasted those in treatment for GAD with a group being treated for Panic Disorder, to determine whether any differences found applied generally to all those seeking treatment, rather than being specific to GAD. Clients with Panic Disorder are concerned about the potential occurrence of future panic attacks, so they may worry frequently about this specific issue. They are, however, less likely to worry about a wide range of worry topics, or be as concerned about the process of worrying itself, when compared to clients with GAD. Hence, inclusion of this latter group also allowed us to test the assumption that GAD (compared to panic disorder) is associated with a greater *range* of worries, and greater *concern* about worrying, but not necessarily with a higher *frequency* of worrying. Finally, to check whether groups also differed in mood state we also obtained measures of anxiety and depression at the time of testing.

2. Method

2.1. Participants

Participants comprised 32 clients in treatment for GAD, 24 clients in treatment for Panic Disorder, 28 community volunteers who met criteria for GAD but who were not currently seeking treatment, and 35 community volunteers reporting equivalent levels of worry to the GAD groups, but who did not meet criteria for GAD. Both GAD and Panic Disorder clients were receiving a recognised treatment (e.g., medication or psychological therapy) or were on a waitlist (three clients in the GAD group and one in the Panic Disorder group). They were recruited via either the South London & Maudsley National Health Service Foundation Trust or advertisements for volunteers who were in treatment for GAD or Panic Disorder. To be included in the GAD group, on the day of testing participants had to