Chapter 9

AN ACCEPTANCE-BASED BEHAVIOR THERAPY FOR GENERALIZED ANXIETY DISORDER

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Generalized anxiety disorder (GAD) is a disorder characterized by chronic, pervasive, uncontrollable worry (as well as associated somatic complaints; American Psychiatric Association, 1994) for which we have yet to develop sufficiently successful interventions. The National Comorbidity Study yielded a lifetime prevalence estimate of 5.1% for GAD, and revealed, contrary to the common assumption that it is a mild disorder, that GAD is associated with significant psychosocial impairment (Wittchen, Zhao, Kessler, & Eaton, 1994). GAD is unlikely to remit on its own (Yonkers, Warshaw, Massion, & Keller, 1996) and remains more chronic than panic disorder after pharmacotherapy (Woodman, Noyes, Black, Schlosser, & Yagia, 1999). In addition, GAD is associated with high rates of comorbidity (most commonly other anxiety or mood disorders), and this comorbidity is associated with increased functional impairment (Wittchen et al., 1994) and health care utilization/cost (Souetre et al., 1994). Further, GAD has been associated with impaired well-being and life satisfaction beyond its association with major depression in a community study of 15–64 year olds (Stein & Heimberg, 2004), as well as with impaired quality of life, beyond that accounted for by comorbid diagnoses, among older
adults (Wetherall et al., 2004). Recent studies in primary care settings have consistently found that “pure” (noncomorbid) GAD is associated with impairment in multiple domains (see Kessler, Walters, & Wittchen, 2004, for a review).

GAD differs from other anxiety disorders in that it is not characterized by a focal target of fear, anxiety, and worry or by behavioral avoidance. Studies attempting to uncover a specific focus of worry among individuals diagnosed with GAD have shown that GAD worry is not characterized by any particular fears, but instead by more frequent worries about a range of topics, as well as idiosyncratic and minor worries (Brown, Barlow, & Liebowitz, 1994; Roemer, Molina, & Borkovec, 1997). These worries take the form of catastrophic predictions of low-probability negative events in the future (Borkovec, Shadick, & Hopkins, 1991; Dugas et al., 1998), which are readily accessible due to information-processing biases toward threatening information (Matthews, 1990) and a tendency to overestimate risk (Butler & Matthews, 1987). The pervasive nature of worry is also evident in the consistent clinical observation that individuals with GAD seem to move from one worry domain to another, rather than worrying exclusively on one topic for an extended period of time (Borkovec & Roemer, 1994; Butler, 1994). Studies have also revealed that GAD worry is characterized by worry about worry or meta-worry (Wells & Carter, 1999). These findings have been incorporated in the *DSM-IV* definition of GAD, in which worry is characterized as pervasive and uncontrollable, but no specific content of worry is defined.

Just as GAD is not characterized by reactions to circumscribed phobic stimuli, it is also not generally considered to be associated with specific phobic behavioral avoidance (Borkovec, Hazlett-Stevens, & Diaz, 1999; Butler, Gelder, Hibbert, Cullington, & Klimes, 1987). However, the majority of individuals with GAD do report some form of behavioral avoidance (Butler et al., 1987), suggesting that the absence of focal avoidance behaviors should not be seen as evidence for the irrelevance of behavioral avoidance to this disorder (as discussed more fully below).

**EFFICACY OF EXISTING TREATMENTS FOR GAD**

Several cognitive-behavioral treatments have been developed for GAD. These cognitive-behavioral treatments typically include psychoeducation, self-monitoring, and either applied relaxation, cognitive therapy, coping imagery, or some combination of these elements. Borkovec and Ruscio (2001) review 13 controlled GAD treatment outcome studies and conclude that cognitive-behavioral approaches yield significant changes (with large