COGNITIVE MODELS OF GENERALIZED ANXIETY DISORDER

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Cognitive models of generalized anxiety disorder

GAD generally comes from worry and is a disabling condition that is both common and difficult to treat. Recent studies have shown that for an individual to worry, two cognitive abilities are required. The first ability is being able to anticipate future events. rather, it having the vague idea of a possible occurrence of a threat. This ability has even been observed in young children suggesting their ability to worry. Although the ability in young children below seven years to predict future events is but very vague(Balow, et al...,1986). The second ability is to go beyond directly observable occurrences and predicting elaborated catastrophic possibilities. This ability is thought to occur in later stages of life and, it increases with increase in age.

However, the likelihood of considering only one solution to a problem is prevalent in young children and it becomes complex during the middle childhood. During this time, children are able to use deductive reasoning to consider a wide range of different outcomes. Several studies and researches have been conducted and experts have come up with different models to try and understand and formulate treatment for GAD. These models include; Intolerance of Uncertainty Model (IUM), and Metacognitive Model(MCM). A meta- cognitive analysis and classification is presented about factors contributing to the development of problematic worry.

Intolerance of Uncertainty (IUM)

According to this model, uncertain situations become upsetting and stressful to people suffering from GAD and in response, they experience chronic worry. These people hold a belief that, worry will either help overcome or prevent from happening the events they fear. The worry, coupled with the resultant feeling of anxiety, leads to cognitive avoidance and an orientation of negative problems. These two elements facilitate in the maintenance of the worry (Dugas, et al..,2007). As a result of this orientation of negative problem, these people see problems as threats, are frustrated easily while solving

problems, are not confident while trying to solve problems, and are pessimists when it comes to solving problems. Further studies have shown that, cognitive strategies such as distraction, replacement of thought and suppression of thought facilitate in cognitive arousal avoidance and threatening too (Casidy, et al..,2007). The IUM model assumes that there are four factors that distinguish individuals suffering from GAD from healthy controls. These include; cognitive avoidance, positive beliefs regarding worry, negative problem orientation, and intolerance of uncertainty

Treatment

Based on this model, treatment involves the development of an increase in tolerance for uncertainty and acceptance. Treatment methods include educating patients about IU, improvement in problem orientation, self-monitoring, and processing of core fears. Further, clients are taught to distinguish problematic situations from emotions surrounding a situation. They are also taught to embrace problems as normal part of life and problems may not necessarily threats but rather opportunities. Once the patients are educated about cognitive framework regarding their worry and disease perceptions have been addressed, there is a final step of core fears processing (Balow, et al...,1986). To address this problem, patients are exposed to mental imagery that is threatening as a way of confronting their fears and prevent avoidance. Studies that have been conducted to test whether four constructs really distinguish people diagnosed with GAD from people diagnosed with other anxiety disorders. The results showed that IU was specific to GAD. Further, problem orientation and UI gave clear prediction of symptoms severity among people with GAD. Through several randomized controlled trials (RCT) to evaluate IUM-based treatment, the clinical efficacy of this model has been proved (Dugas, et al..,2007). As such, results indicated that there was significant improvement in worry and anxiety as opposed to applied relaxation and wait-list control. The use of benzodiazepines among people with GAD showed a decreased use after one year in IUM-based treatment as compared to metacognitive treatment.

Metacognitive Model (MCM)

This model assumes that people with GAD experience two types of worry. When faced with situations that are anxiety- provoking, individuals with GAD beget positive beliefs. They believe that worry will help them deal with the problem. This process is referred to as type 1 worry and defined as worry regarding non-cognitive events (Casidy, et al..,2007). These events include physical symptoms and external situations. Initially, type 1 worry invokes an anxiety response but later depending on whether the situation has been resolved may increase or decrease anxiety. In the course of type 1 worry, negative thoughts about worry are activated. People with GAD start to worry about their worry and get a feeling that it is uncontrollable or even dangerous. The worry about worry (meta-worry) is referred to as type 2 worry(Hatton & Wells, 1997). According to MCM type 2 worry and negative beliefs about worry distinguish normal worries and people with GAD. Hypothetically, type 2 is associated with many strategies that ineffective in aim to avoid worry by controlling thoughts, emotions , and behaviours. Engaging in these strategies, prohibits individuals form experiencing events likely to eliminate beliefs that worry is uncontrollable and dangerous. Furthermore, the efforts that people with GAD use to control thoughts are often not successful. As a result, they tend to lose confidence in themselves and feel that they cannot control worry. This serves to reinforce the belief that worry is dangerous and uncontrollable. Finally, type 2 worry leads to increased anxiety symptoms.

Treatment

To try and treat GAD, Metacognitive Therapy (MCT) is used. The aim of the therapy is to alter type 2 worry rather trying to reduce it. In addition, patients are taught alternative strategies of coping with worry. All in all, emphasis is put on cognition altering in relation to reliance f a client on worry as a positive force in their life. Further emphasis is put on clients' cognitions that worry is dangerous and uncontrollable (Hatton & Wells, 1997). The treatment components used include socialization, discussions about worry uncontrollability, case formulation, formulating positive beliefs and the danger of worry.

Case formulation is the process of designing probing questions that seek to establish the thoughts triggering worry and the client's reaction towards them and any attempts to stifle them.

The answers give therapists a clear view of worry triggering situations and the client's negative and positive beliefs. Socialization on the other hand focuses on introducing clients to MCM goals and the emphasis by therapists on the importance of alteration of worry beliefs as opposed to worry reduction. MCM uses different strategies to reduce worry such as worry modulation experiments and mismatch strategy. Studies regarding nonclinical worry have been supported by a subset of tenets. However, studies seeking to specifically put MCM to the test in terms of clinical samples have been relatively few. Results have shown that people with other anxiety disorders do not substantially differ with people suffering from GAD. Further, through evaluation of MCM using extant studies, it has been found that people with type 2 worry have been used to treat people suffering from other disorders(Dugas, et al..,2007).

Evaluations have been conducted on the efficacy of MCT for GAD. Results have shown that with treatment, 75% of the clients have displayed significant reduction in mood, anxiety and worry with a successful 12-monthspost-treatment recovery rate.

Conclusion

As opposed to emotional models that focus on behavioural and emotional impact in the maintenance of GAD, cognitive models focus on behavioural emotional components. specific cognitions are the key mechanisms of GAD that are pathogenic. Furthermore, problem orientations that are negative are also known as negative thoughts and people with GAD have core beliefs about their ability to solve problems. In the same note, MCM emphasises on the importance of eliminating negative meta-beliefs about worry and subsequently type 2 worry(Hatton & Wells, 1997). However, specific evidence pointing to the relationship between negative beliefs about meta-worry and worry are mixed. Further people with GAD with relation to people experiencing other anxiety disorders, experience more negative beliefs.

These factors contribute to greatly diminished control resulting from these combinations of meta-cognitive beliefs which are dysfunctional.

As such, the focus of these two models on cognitions impacts directly on the types of techniques used for treatment. Of the several RCT tests conducted between MCT, IUM and wait-list condition, results showed MCT yielded significant improvements as opposed to IUM on anxiety and worry n relation to wait-list control. Finally, no there were no significant symptom-reduction differences observed between MCT and IUM(Casidy, et al..,2007).

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