Prevalence

- Twice as common in women
- Often persist from adolescence into old age
- >5% of population will be diagnosed
- High comorbidity with range of anxiety disorders and depression

The Aetiology of GAD

Psychological and Cognitive Theories

*Information Processing Biases in GAD*

Evidence to suggest that GAD patients have IPBs which maintain hypervigilance for threat & create further sources of worrying & anxiety

[+] GAD patients preferentially allocate attention to threatening stimuli → occurs pre-attentively/to both verbal and visual stimuli//non-anxious people do the exact opposite (avoid threat & shift attention away)

[+] Evidence that these IPBs may cause GAD → IPBs can be experimentally induced in non-clinical population – leads to anxiety and future interpretation of neutral stimuli in threatening ways

*Cognitions, Beliefs and the Function of Worrying*

Does worrying serve a function? → may outweigh cost of worrying

- GAD patients hold strong belief that worrying is necessary and must be done to avoid future catastrophes:
  → Motivates worrying
  → Distracts them from other negative emotions and even more stressful phobic stimuli

[+] Worrying produces very little emotional arousal & appears to block the processing of emotional images

*Dispositional Characteristics of Worrying*

- Intolerant of uncertainty
- High on perfectionism
- Feel responsible for negative outcomes
  (E.g. Startup & Davey, 2003)

Suggests that they possess characteristics that will drive them to attempt to think about resolving problematic issues

HOWEVER... also have poor problem solving confidence//frame worries in a way that reflects personal insecurities (Davey, 1994)

The Treatment of GAD

Drugs//CBT//combination
- This is thought to be due to the “mood-as-input hypothesis” (Martin & Davis, 1998) → Claims that people use their concurrent mood as information about whether they have successfully completed the task or not.

OCD patients continue with their activity because...

1. They use an implicit “stop rule” → only stop when they think they have completed task fully

2. Undertake this task in strong negative moods → use their mood as an indicator as to how they are doing in the task (feel bad = still not complete)

[+] Inflated responsibility (stop rules) is not sufficient condition for OCD → must have negative mood as well (MacDonald & Davey, 2005)

**Treatment of OCD**

**Exposure & Ritual Prevention Treatments (EPR)**

Involves graded exposure to the thoughts that trigger distress, followed by the development of behaviours designed to prevent the indiv’s compulsive rituals

- Allows anxiety to extinguish by habituating the links between obsessions & their associated distress
- Eliminates ritualistic behaviours that may negatively reinforce distress (Steketee, 1993)
- Disconfirms negative beliefs → force clients to encounter feared situations/experience reality of the outcomes associated with those fears

[+] Highly flexible theory – adapted to group/self-help/family therapy etc

[+] Controlled outcome studies suggest EPR is a long term effective treatment for ~75% of clients treated with ERP (Kyrios, 2003)

[-] Sufferers feel unable to expose themselves

[-] 30% drop out rate (Wilhelm, 2000)

**CBT**

Target dysfunctional beliefs about their fears, thoughts & the significance of their rituals

Beliefs include...

- **Responsibility appraisals** → (sufferers aren’t solely responsible for preventing harmful outcomes)
- **Over-importance of thoughts** → (disregard thought-action fusion)
- **Exaggerated perception of threat** → (challenge probability that these things/fears actually occur)

Use behavioural exercises/intrusive thoughts are normal etc.