Improving Homework Compliance in the Treatment of Generalized Anxiety Disorder

Robert L. Leahy
American Institute for Cognitive Therapy
New York and Weill-Cornell University Medical College

Generalized anxiety disorder is a chronic condition characterized by beliefs that worry prepares and protects, but that excessive worry is out of control. In this article, I review the cognitive-behavioral model of generalized anxiety, focusing specifically on problems related to excessive worrying. Noncompliance in self-help homework is reflected in the patient's excessive focus on negative feelings, difficulty identifying automatic thoughts, demand for immediate results, and the belief that worries are realistic. Interventions for these problems are illustrated in the case of the treatment of a patient characterized by persistent worries, low self-confidence, procrastination, and avoidance. © 2002 Wiley Periodicals, Inc. J Clin Psychol/In Session 58: 499–511, 2002.

Keywords: generalized anxiety; treatment; non-compliance; cognitive therapy; metacognition, self-help

The essential features of generalized anxiety disorder (GAD) are physical symptoms and apprehensive worry. The GAD patient worries about several different issues and reports difficulty controlling worry. Symptoms often include restlessness, irritability, fatigue, difficulty concentrating, muscle tension, and insomnia. The patient is worried about a variety of events, unlike other disorders where worry is confined to specific stimuli or issues. Lifetime prevalence of GAD varies between 5.8% and 9%, with greater risk for women (2.5:1, females:males), young adults, and African Americans. Patients presenting with GAD often relate that onset has been gradual and that they have been anxious since childhood. Some studies indicate the average length of this problem to be 25 years prior to treatment. Because of its chronicity, its self-perpetuating quality, and its frequent non-

Correspondence concerning this article should be addressed to: Robert L. Leahy, Ph.D., American Institute for Cognitive Therapy, 136 East 57th Street, Suite 1101, New York, New York 10022; telephone: (212) 308–2440; e-mail: AICT@aol.com.

JCLP/In Session: Psychotherapy in Practice, Vol. 58(5), 499–511 (2002) © 2002 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.10028

response to treatment, some clinicians and researchers view GAD as a life-long illness, similar to diabetes or essential hypertension.

In the current article, I outline the cognitive model of anxiety with specific focus on the metacognitive model of worry. We will then examine a number of factors that interfere with self-help homework compliance and examine how cognitive-behavioral techniques and conceptualization can assist the patient in overcoming these problems. A clinical case is presented that describes how these interventions can help reduce current worry and procrastination and how future self-help can be improved at the termination of treatment.

Cognitive Model of Anxiety

The cognitive-behavioral model of anxiety has traditionally focused on two aspects of generalized anxiety disorder—physiological arousal and worry. Physiological arousal is often addressed using breathing exercises and relaxation, with the assumption that relaxation is incompatible with anxiety. Generalized anxiety disorder poses a problem for the arousal model in that the worries that characterize this disorder are for a variety of possible problems, many of which never occur. The initial cognitive model of worry proposed by Beck and his associates emphasized the tendency of these individuals to overestimate the probability and negativity of possible outcomes. Interventions focus on having the worried patients stipulate their negative predictions ("I am going to get fired"), examine the costs and benefits of these predictions, weigh the evidence for and against (e.g., the patient often uses emotions as evidence—"I feel anxious, therefore it's likely to happen"), and then evaluate coping strategies ("If I get fired, then I can get a new job") .

Borkovec's model stresses the patient's belief that worry is out of control and will lead to sickness or insanity. Beliefs in the uncontrollability of worry are addressed by having the patient assign "worry time," such that a specific time and place is set aside daily for intensive worry. This helps the patient recognize that worries are controllable and the content of worries is limited to a few repeated themes (e.g., finances, sickness, interpersonal conflicts). Other methods of demonstrating control include interrupting worry with distraction techniques—for example, instructing the patient to describe all the objects in the office.

Borkovec's model marked the beginning of what we will call a "metacognitive" model of worry. "Metacognitive" refers to beliefs about how the mind or emotions function. For example, the belief that "my worry will drive me crazy" is a metacognitive belief. Wells and his associates have expanded beyond this model to propose that worriers maintain beliefs that worry prepares them, helps them find solutions, prevents bad things from happening, and is uncontrollable. Moreover, the worries are often expressed as "possible" statements about which the patient worries ("I might lose my job."), thereby making them resistant to disconfirmation. Since almost none of the worries come true, the patient may hold a tacit belief that "My worry kept it from happening." Some patients indicate that they fear not worrying, lest they become so confident that they either tempt the fates or let their guard down about possible danger.

Because of the patient's belief that worry prepares, protects, and prevents bad things from happening, these individuals are reluctant or unable to relinquish these cognitive "strategies." Indeed, pointing out that the events about which they worry are improbable often elicits the strategy: "Even if it is improbable, it still is possible and I should make sure it never occurs. I could be that one in a million." From the patient's emotional perspective, the worry must be "working," since the bad things never happen.

Noncompliance with Homework

A central reason for noncompliance with homework for GAD patients involves their "positive views" of worry. These positive views are reflected by beliefs that worry prepares, protects, and prevents bad things from happening. Worry is viewed by these individuals as a problem-solving strategy. The protective function of worry is reinforced by the fact that bad things are generally not happening, thereby leading to the implicit belief that worry has prevented and protected the individual. As a consequence of patients' belief in the "positive" function of worry, many patients may resist changing their patterns of worry.

Leahy and Holland have identified additional reasons for noncompliance that include: (a) excessive focus on negative feelings, (b) difficulty identifying automatic thoughts, (c) demand for immediate results, (d) perfectionist beliefs about anxiety reduction, (e) demands for certainty, and (f) beliefs that worries are realistic.

Excessive focus on negative feelings is part of the self-focus and ruminative bias of these patients, such that the self-focus dramatically increases the accessibility of negative beliefs and anxious sensations. Thus, people who focus on their negative thoughts and feelings will find it easier to experience increasingly negative thoughts and feelings. This is similar to opening a file labeled "danger" and reading everything in the file, only to notice later how anxious you feel. Had you opened additional files named "quiet country scenes" or "pictures of puppies," you might come away with more relaxed and pleasant feelings. Since self-focus on worry increases the accessibility of the negative thoughts and feelings, a major goal of cognitive-behavioral therapy is to modify self-focus into more productive, often action-oriented behaviors. The implication for homework noncompliance is that patients may focus on how bad they feel, ruminating about their emotions and their problems, rather than focusing on how to change the situation. The therapist may explore with the patient the costs and benefits of this self-focused rumination. Many worried individuals believe that their anxious rumination is a type of problem solving rather than being a type of problem magnification.

Interventions for this bias include examining positive beliefs about self-focus (for example, "worry prepares me"), evaluating the costs and benefits, and examining the evidence that this self-focus has actually prevented anything bad from happening. This is the first step in modifying the "emotional schemas" that the patient employs—the patient's beliefs and strategies about how to handle an unpleasant emotion . Individuals prone to anxiety are more likely to ruminate and focus on their negative feelings and to believe that their feelings and thoughts are out of control.

Some worried patients have difficulty identifying automatic thoughts. This presents difficulty in homework compliance in that the patient will not be able to challenge thoughts he or she cannot identify. Part of the problem is that patients are so focused on feelings that they have difficulty slowing down their reflection to their thoughts. Another problem is that anxious thoughts are quite rapid and the patient may simply notice the outcome, that is, the anxious feelings, because they are more accessible and more uncomfortable. Helpful interventions include experiential or emotional evocation techniques, such as having patients, in session, close their eyes, imagine a situation associated with anxiety, describe as many physical and sensation details as possible, and project visual images onto an imaginary screen. The therapist can encourage the patient to project a series of images and examine the thoughts and feelings associated with these images. In addition, the therapist can suggest to the patient that he or she may be having negative thoughts with such questions as: "Are you thinking that you'll fail?"

A frequent demand for immediate results may appear quite ironic to the therapist who can note to the patient that the anxiety has persisted for years and that it may be

unrealistic to expect immediate results. These demands for immediate results often discourage patients from completing thought records or engaging in exposure or assertion. The therapist can use this demand as an example of how the anxiety persists. Since patients are demanding immediate results that are not forthcoming, they tend to give up quickly, thereby convincing themselves that things are hopeless. The therapist and patient can develop measurable criteria for "progress" (for example, subjective ratings of anxiety each hour for each day, decreased percent belief in automatic thoughts, and self-monitoring effective behavior).

The patient's demand for certainty is related to the foregoing. As part of the emotional and cognitive perfectionism of these individuals, this demand further exacerbates the anxiety and serves to discourage homework compliance. The patient's beliefs about certainty can be examined by asking:

- "What are the costs and benefits of demanding certainty?"
- "Does anyone have certainty?"
- "What will happen if you do not have certainty?"
- "What are some things that you have done in the past for which you did not have certainty?"
- "What is the probability of something bad happening?"
- "Where do you get evidence about probabilities?"

The latter questions about probabilities are central in reducing anxious predictions and modifying homework noncompliance. Patients who predict "I may have cancer" because they have a headache or, "I may lose everything" because of a 20% drop in their stock portfolio, can be asked to look at the population "base rates" for that particular problem. For example, "What percent of people have headaches today in New York City and how many of them will have a brain tumor?" The demand for certainty is often reflected in the belief that "rational" responses cannot provide a guarantee and, therefore, are not relevant. These noncompliant beliefs can be examined for their contribution to anxiety vulnerability.

Most GAD patients believe that their worries are realistic. This may lead them either not to challenge their negative thoughts or to view the challenges as a form of denial, conferring the risk of being caught off guard. The therapist does not want to be in the position of Pollyannaish denial, claiming that everything will work out. We have found it useful to have patients distinguish between "productive" and "unproductive" worry. The former refers to predictions or concerns with a higher probability and for which one can take action. For example, "April 15th is rolling around, so I should take some action about my taxes." Unproductive worries are often expressed as "what-ifs," often reflecting low-probability, implausible events over which one has no control. "What if the plane crashes?" or "What if the stock market drops 90%?" are two examples.

Case Study

Presenting Problem and Client Description

The patient, Tom, was a 41-year-old, single male who was an accountant in private practice. He reported having difficulty with work, decision-making, procrastination, self-esteem, regrets, social skills, assertion, obsessive thoughts, suicidal thoughts, anxiety, and depression. He had an intake score of 25 on the Beck Depression Inventory and a score of 24 on the Beck Anxiety Inventory. He had elevated scores on the SCID II (for

personality disorders) for avoidant, obsessive-compulsive, and self-defeating personality. He indicated that he worried about not completing his own tax returns, not finishing the work for his clients, his clients getting angry at him, losing clients, going bankrupt, never achieving anything, and being viewed as a failure. He reported regrets about past investments and personal decisions in relationships and was afraid to make decisions now lest he regret them later.

Tom indicated that he believed that he needed to worry about these things to avoid making future mistakes. On the other hand, he indicated that his worry was "out of control" and he worried that he was making himself incapable of taking any action if he worried. When he considered doing things that might be productive, such as completing his tax returns or contacting a client about an unpaid bill, he reported feeling anxious and subsequently avoided doing these things.

Case Formulation

Tom presented with generalized anxiety disorder with co-morbid major depression. However, I viewed the depression as a consequence of his worries and his use of procrastination and avoidance to handle his anxiety. Whenever he thought about a problem, he would begin to worry, escalate this to a catastrophic prediction, and then avoid carrying out productive action. His low self-esteem contributed to and was a consequence of his worry. Thus, he worried because he believed that he was incompetent and he avoided doing things because avoidance temporarily reduced his anxiety.

In cognitive therapy, we distinguish between automatic thoughts, maladaptive assumptions, and underlying personal beliefs about the self and the world (schemas). For Tom, the automatic thoughts were: "I'll never get better" (fortune telling); "I'll lose everything" (catastrophizing); "I'm a total loser" (all-or-nothing labeling); "You think I'm a failure" (mind-reading); "Nothing I've done counts if I don't get my taxes done" (discounting positives); and "My client is angry, so I must have failed" (personalizing). His assumptions were: "I should always do it perfectly;" "It's terrible if people are angry at me;" "If I don't do everything right, then I am a failure;" and "I should only do things if I'm certain about the outcome and I'm not anxious." His coping rules were: "I should wait for all the information before taking action;" "I should reduce my anxiety immediately by avoiding;" "I can appease my clients by not asking for payment;" and "I can satisfy clients only if I do extra work for which I don't charge them." His personal beliefs or schemas about himself included *defective, incompetent,* and *pathetic.* His beliefs about others were that they were judgmental and rejecting.

From the meta-cognitive model of worry, Tom's belief was that he needed to worry to avoid exposing himself to making bad decisions ("worry protects and prepares"). However, he also believed that he had no control over worry, and he worried about this. His tendency to procrastinate was based on a number of his beliefs: (a) he would make a mistake if he took action; (b) if he carried out the action, it would lead to worse consequences; (c) these anticipated, often unnamed consequences would be catastrophic; (d) he needed to be absolutely sure, therefore he must collect as much information as possible; (e) he was unique with his worries and problems and, therefore, highly defective; (f) he needed to ventilate with the therapist how bad things were to make himself clear; and (g) he had "deeper issues" that would need to be resolved before he could change his behavior.

Given his history of making catastrophic predictions and his use of avoidance and procrastination as coping mechanisms, Tom was a likely candidate for noncompliance

with self-help homework assignments. However, the therapeutic strategy would be to use his noncompliance as a window to his general problem and to use homework assignments to test his negative beliefs. Therapy focused on identifying specific tasks to be accomplished, such as completing his own taxes, completing his clients' work, billing clients, and developing marketing plans. Each task was broken down into smaller steps and assigned as homework tasks to be completed. Noncompliance with these task requirements would be used as a way of eliciting his negative thoughts and challenging them. Individuals with generalized anxiety believe that their worry may protect them and, at the same time, their worry is out of control. Therefore, Tom's therapy focused on examining and testing these beliefs by using cost-benefit analysis and examination of evidence (to address his positive views of worry) and to test the belief in the uncontrollability of worry by imposing delays and constraints on worry.

Course of Treatment

During the first meeting, Tom indicated his uncertainty about whether therapy would be helpful, since he had been in therapy with a Jungian therapist and had not found it helpful. He also believed that he was a "hopeless case," since he had experienced his problems of low self-esteem, worry, and procrastination since early adulthood. The first task was to develop a "problem list" that included low self-esteem, worry, procrastination, hopelessness, and lack of organization of his practice. The immediate problem was that he had not filed his tax returns for three years. Tom expressed embarrassment, acknowledging that as an accountant he was negligent with his own taxes.

Excessive Focus on Negative Feelings

Tom displayed great emotional intensity when he discussed his problems. This preoccupation with feelings rather than on changing behavior was reflected in his noncompliance with homework. For example, he indicated that gathering information about his taxes made him feel anxious, resulting in his avoidance of working on his taxes. We examined a number of "off-task" behaviors that he pursued, rather than working on his own taxes. These included perfectionistic and obsessive work on a client's taxes, watching television, and sitting and ruminating. Like many people who ruminate, he indicated that he believed that worrying about his problems might lead to a solution. I suggested that ruminating made him think his problems were worse. An alternative would be, "Break down the problem into steps, take one step at a time, even if you are anxious, and carry out the steps. If you take action on your problems, they might seem more manageable." Since he had been focusing on his feelings rather than his actions, he made little progress and his problems seemed worse, thereby justifying more procrastination.

Another implication of his focus on negative feelings was that Tom used his emotions as evidence that things were going badly. This focus on negative feelings would impede homework compliance since self-help required his ability to step back from his feelings, identify his thoughts, and challenge them or take action that might raise discomfort. Thus, when he considered doing the homework of collecting information for his tax returns, he became anxious and chose not to do the homework. He then jumped to the conclusion that his anxiety was a good predictor of bad outcomes. To increase homework compliance, I asked him to monitor his anxiety every hour and to write down any anxious thoughts. We then examined if the evidence for his negative thoughts was based on his feelings or the facts that were available. Tom said, "I realized that I didn't have any facts

a lot of the time, just my feelings. But I used my feelings as if they were facts." This circularity kept him locked in avoidance, procrastination, and worry.

Catastrophic Predictions

Tom's first homework assignment was to collect information about what steps needed to be taken to get his tax returns completed. This assignment was not completed. His automatic thoughts were, "It's too late. The IRS will accuse me of tax evasion and I'll lose my license." These catastrophic predictions led him to avoid doing anything about his taxes, adding further to his avoidance. We examined the evidence that his predictions might not be true. At this point, he had no evidence either way.

Since Tom had been rehearsing stories about negative outcomes, I suggested that he needed to construct some detailed stories about positive outcomes. His homework assignment was to develop a detailed plan about how his tax situation could be resolved satisfactorily and secondly, how he could build his practice. I suggested that his worried thoughts often led him off on tangents of catastrophic predictions and frightening narratives and that this made him even more sure that things were really terrible. He had to come up with new stories about positive outcomes that began with "What if things really do work out well for me? How could that happen?" This intervention proved quite helpful to him, since he had automatically begun stories with "What if it doesn't work out?" and either jumped to catastrophic images of bad outcomes or distracted himself with off-task behaviors.

Another challenge to his catastrophic predictions included "coping" possibilities. Since he believed that there were no solutions to the terrible problem facing him, he was reluctant to gather the information he needed to pursue his tax filing. We examined his prediction that he might be penalized for not filing on time. He had read about an accountant who was penalized by having his license suspended for six months (for violations more excessive than Tom's) and he knew of several cases where the accountant had simply been reprimanded without further penalty. In examining the possibility that his license could be revoked, he considered the possibility that he could work for someone else for a year, which would only mean having less income for that period. This reduced the negative implication of his predictions.

Avoidance of Anxiety

The next step was to get legal advice. He indicated that he could contact legal counsel associated with his professional organization. However, the next two sessions revealed that he had not done anything about this. He indicated that thinking about it made him anxious and he avoided calling because he thought it would make him more upset. We examined his noncompliance and procrastination rule, "If it makes me anxious, then avoid it." This procrastination/avoidance rule applied to a number of his problem areas, including the tax returns, requesting payments from clients, marketing his practice, making investments, and making commitments to women.

Many anxious individuals appear to be "near-sighted" about their anxiety, believing that they have to reduce their anxiety immediately. Therefore, they have a difficult time doing things while they are anxious. Since his highest priority was to avoid an increase of discomfort, Tom would avoid doing things that might raise his level of anxiety. Thus, when he considered collecting information for his tax returns as a homework assignment he avoided doing this. His thoughts were, "This makes me anxious" and "I don't want to

do this." We identified an "anxiety rule" that Tom employed: "If it makes me uncomfortable, then avoid doing it." We examined the costs and benefits of this belief. He noted that the costs of this belief were that he never got these things done, it lowered his self-esteem, and it made him more anxious later. The benefit was that he could reduce his immediate level of anxiety. I compared this to the use of alcohol as a short-term solution for anxiety that becomes a long-term problem that contributes further to low self-esteem and increased anxiety. I suggested a new anxiety rule: "Identify things you need to do. If they make you anxious, do them anyway." We examined the costs and benefits of this new rule and he concluded that although it might make him anxious over the short term, it might help him immensely over the long term. We identified a number of things he had accomplished when he was anxious, such as excelling at competitive sports (he had been an accomplished athlete), passing his professional licensing exam, and asking women for dates.

I asked him, "What would happen if you did something and it made you anxious? What will the anxiety do to you that's so terrible?" This proved to be a very helpful question for him to consider. He recognized that it would make him uncomfortable but that the discomfort might decline over time. This was then assigned as a homework task: "Do something every day that makes you anxious and then write down the outcome." At the next session he indicated that he had collected some information about his past taxes and that he had called legal counsel regarding his tax liability. He described himself as feeling somewhat less anxious and less depressed.

Beliefs that Worries Protect and Prepare

As Wells has asserted, many anxious individuals may resist giving up their worries because of their "positive views" that worries confer the advantages of protecting them from the worst and preparing them. Worries act as early warning signals that help prevent terrible things from happening. Part of the noncompliance in homework for these patients is their belief that they would be relinquishing a protective strategy. I suggested to Tom that we distinguish between "productive and unproductive worry." Productive worry involves thoughts about things that are plausible and about which you can do something. For example, if I were to drive from New York to Washington, D.C., I might worry whether I had the right directions to get to where I want to go. This is plausible, and it is something that I can do something about. I can get directions or a map. Unproductive worry involves worry about implausible or unlikely events over which I have no control, such as worries about being attacked on the street without provocation. This is something that could happen but which is very unlikely and there is nothing that I could do about it. Before making this distinction, Tom indicated that between sessions he often worried about implausibles. Now his homework assignments included examining each worry to determine if it was productive or unproductive. He was to ask himself, "Is there anything concrete and specific that I can do?" This helped him set aside some of his worries.

"Writing Down My Thoughts Will Make Me More Anxious"

Cognitive therapy homework involves writing down negative thoughts and challenging them by looking at the evidence, their logic, and available solutions. A common belief among anxious patients is that writing these thoughts will make them more powerful and upsetting. Tom's reluctance to write down his thoughts and challenge them reflected his belief that confronting his problems would only make him feel worse. We examined this

in the session by having him write down his thought "I am a complete failure," identifying his level of anxiety (95%), and then examining the evidence for and against this thought. The evidence in favor was that he was not making as much money as some people he knew and that he had problems with depression and anxiety. The evidence against his thought was that he was self-supporting, had a nice apartment, a girlfriend he liked, lots of friends, and that he was in excellent physical condition. He then re-rated his anxiety at 35%. I asked him, "How is this consistent with your prediction that writing down your thoughts will make you feel worse?" He acknowledged that he felt better but added that at home he often felt worse as he began focusing on his negative thoughts. I told him, "There is a difference between challenging your thoughts and just dwelling on how bad you think and feel. We call this rumination. It's like chewing over the same negative stuff over and over. It only makes you feel worse. So you are right. You do feel worse when you ruminate and dwell. The question is will you feel better if you challenge and even attack your negative thoughts with logic, evidence, and action to solve your problems?"

Belief That Worry Is Out of Control

Many worried individuals believe that worry is out of control and will make them physically ill or lead to permanent insanity. This can be a source of noncompliance in homework if the therapist asks the patient to write down worries and challenge them. Consequently, establishing that control can be manifested is essential. This was accomplished in Tom's case by identifying his beliefs: "I worry all the time" and "I have no control over these worries, they seem to happen to me." Next, I asked Tom to do two things: (1) set aside a worry time every day at 4:30 PM for 30 minutes and write down his worries; and (2) categorize his worries, such as worries that he won't get his taxes done and worries that he will lose his clients. The advantages of this assignment are that the patient learns that he can delay most worries until worry time, his worries appear limited in number, and he can use the other time for productive behavior. This establishes some sense of control. It is also important to examine the ideas that control is not "all-or-nothing." Control can be viewed along a continuum from 0% to 100%, and the perception of control of worry also varies.

Putting Self-esteem and Readiness before Change

Like many individuals who have been in Jungian insight-oriented therapy, Tom held the belief that "deeper changes" in his self-esteem would have to occur before he could change his behavior and that he needed to feel ready to change. We examined these noncompliant assumptions for their advantages and disadvantages. The advantages of readiness and self-esteem requirements were that he believed he would be less anxious when he finally did something and that it would assure that things would work out. The disadvantages were that nothing changed, nothing got done, and that he felt worse about himself. I indicated to him that the cognitive therapy approach was the opposite of readiness demands: "In this kind of therapy we encourage you to do things that you don't feel ready to do and that make you anxious. We view self-esteem as a consequence of facing your fears, not as a prerequisite." We examined the costs and benefits of this approach. He indicated that a major benefit was that it gave him something concrete that he could do and that his other approach had failed him anyway. We also examined evidence of times that he acted against his anxiety and things improved. We looked at when he first

learned how to drive, when he took the licensing exam, and when he asked his girlfriend for a date.

Demands for Certainty

When Tom considered the steps to be taken in getting his tax returns completed, he responded with a series of what ifs—"What if they don't allow me to file now? What if they take away my license? What if I lose my practice? What if I go bankrupt?" When he considered doing his cognitive-therapy homework, he procrastinated because of these what-ifs. I indicated that his rule was, "If it is uncertain, then it is bad." I suggested that we could consider the following: "Uncertainty is neutral." This actually proved to be a revolutionary concept for him, one that he repeated to me for the next three months in therapy. He had automatically assumed that any uncertainty was automatically negative, leading him to require complete information and emotional readiness before making a decision. We examined the many things that he did for which he did not have certainty, such as taking his licensing exam, asking women out, even coming to therapy with me.

"If I Assert Myself, I'll Be Rejected or Attacked"

Tom had been procrastinating with a client who owed him a significant amount of money. He was afraid that if he asserted himself and requested payment the client would get angry with him and fire him. He had avoided this homework for two months, which contributed to his anger and anxiety whenever he thought about it and helped make him feel that he was a loser. I suggested that we examine his goals in dealing with clients: "Is your goal to have the approval of your clients on everything, to make a decent living, or to do a good job on their accounts?" He indicated that he knew the latter two goals were important but that he seemed to focus on the first goal, which made him more anxious.

I suggested that a major source of anxiety was the lack of assertion of his rights. This contributed to feelings of low self-esteem, helplessness, and resentment. I suggested that he could control his professional behavior by doing the accounts properly and requesting payment but that he could not control his clients' response. Furthermore, he did not know how they would respond. I suggested that by not requesting payment he was communicating to the client that his work was not of value, thereby making payment more difficult to collect in the future. Finally, I suggested that no matter what he does, some clients will respond inappropriately, sometimes because of their sense of entitlement and sometimes from their preconceptions that they are exploited by people providing services. We examined the normalization of requesting payment. What did other accountants do, or lawyers, and how did he feel about my request for payment each session? He indicated that he admired this assertion on my part.

We then identified his string of automatic thoughts: "If I demand payment, she'll get angry. She won't pay. She'll fire me. I'm a loser." Indeed, Tom had reason to believe that this client might be argumentative, since she had argued about a prior bill. We examined the possibility that this could be a great opportunity to clarify the current situation and the future relationship, if any, with this client. We role-played his asking for payment by providing a detailed bill. We also examined a statement that he could issue to clients that identified mutual obligations—that the client would provide information and pay the bills rendered and that Tom would provide specific tax services. Clients would also be billed for all telephone contact. When he confronted the client, she did express anger at being billed for telephone consultations, and Tom explained that he was compensated for

his time and telephone consultations involve his time. The client eventually paid the bill. He provided the client with a short summary of future mutual obligations, including the charges for telephone consultations, and the client complained, “I’ll just spend less time talking on the phone.” Tom told me that this was a good outcome for him, since he would feel resentful providing free services anyway. We examined this experience for its lessons, which Tom concluded were: make the mutual expectations clear, and be assertive earlier about collecting payments.

Outcome and Prognosis

After 18 sessions over six months, Tom decided to terminate therapy because he had realized most of his goals and achieved considerable improvement. He had filed all of his tax returns (without penalty) and obtained an insurance policy for himself and his office. Also, he had hired an administrative assistant, raised his billing rates, and gotten more assertive with past-due accounts. His self-esteem was much improved. Tom had begun marketing his practice and had acquired some new, more lucrative business.

Like many individuals who have been chronically worried, there is a good chance that Tom will have upsetting worries in the future. It is important to leave the door open for these individuals to return for follow-up or booster sessions if they so desire. Many worried individuals view “cure” as the goal, as opposed to improvement as a desirable and realistic achievement. The important advantage of a cognitive-therapy approach is that it provides the patient with both a conceptualization of why they have their problem and the tools to manage their problems in the future.

Building homework into termination is an essential feature with this recurrent and chronic condition. This self-help strategy can be reinforced in three ways. First, review the presenting problems with the patient and identify which techniques had been useful. In the reported case, the patient found the following techniques helpful:

- Identifying his automatic thoughts
- Asking himself, “What is the problem to be solved?”
- Reviewing the costs and benefits of alternatives
- Assigning specific behaviors at specific times
- Distinguishing between productive and unproductive worry
- Recognizing that “uncertainty” was not the same thing as a negative outcome
- Focusing on longer-term payoffs rather than shorter-term anxiety and comfort
- Using the double-standard technique (e.g., “what advice would I give a friend?”)

Second, the therapist and patient can troubleshoot problems that may reoccur, such as procrastination and predicting catastrophes. The patient’s task in session is to develop a plan of action, such as “What problem-solving strategy can I use?” or “How can I identify and challenge my negative thinking?” Finally, the therapist should indicate to the patient that periodic revisits to therapy are important as a “check-up” to support the maintenance of gains.

Clinical Issues and Summary

Generalized anxiety disorder patients may be viewed as having a chronic vulnerability to worry in the future. These individuals describe themselves as “worriers” who have worried all their lives. They have an increased likelihood of jumping to the most negative

conclusions about terrible things happening, most of which never occur. Ironically, they reason backward, concluding that their worry has protected them and that it is necessary to worry in the future. Thus, with these patients therapy may initially raise anxiety by virtue of asking them to consider the possibility of reducing worry and attempting behaviors that may make them more anxious.

Homework noncompliance is likely to be greater with patients with chronic problems who wish to avoid discomfort. This characterizes the generalized anxiety patient who uses worry to protect and prepare and who seeks to avoid discomfort. Self-help homework, such as taking action against procrastination or identifying and challenging worries, may raise the patient's anxiety and result in noncompliance. Moreover, the belief that their worries are realistic may confer greater anxiety for the patient when he is asked to place his thinking in perspective.

The case study reported here reflects many of the problems of the chronic worrier. Because the individual worries and avoids, his low self-esteem is further eroded, contributing to greater worry about future anticipated mistakes. The excessive focus on feelings, either by complaining about feeling badly or focusing on avoiding any negative feelings, may make therapy seem challenging. However, as Tom's case illustrates, directly confronting this predisposition may be helpful. Encouraging patients to do things that are helpful but which raise anxiety allows them to test their assumptions that they must be "ready" to change before they can change.

Another advantage of the current approach is to help patients understand how they may have viewed worry as an attempt to "adapt" or protect themselves. This helps patients feel less criticized and helps make their problems comprehensible. Focusing on distinguishing "productive" from "unproductive" worry can assist the patient in turning worry into problem-solving and the ability to place "what-ifs" in perspective. Simply telling these people not to worry or to engage in thought stopping only exacerbates the issue, since individuals cannot willfully abandon worries and thought-stopping does not work.

Thus, cognitive therapy of generalized anxiety provides a conceptualization which is shared with the patient and that directs the plan of therapy. As useful as this approach may be for the current patient, one must recognize that chronic conditions tend to reoccur, requiring reimplementing the techniques that have worked.

Select References/Recommended Readings

Barlow, D.H. (1988). Anxiety and its disorders: The nature and treatment of anxiety and panic. New York: Guilford.

Beck, A.T., Emery, G., & Greenberg, R.L. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books.

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford.

Blazer, D., George, L., & Winfield, I. (1991). Epidemiologic data and planning mental health services. A tale of two surveys. Social Psychiatry and Psychiatric Epidemiology, 26, 21–27.

Borkovec, T.D. (1994). The nature, functions, and origins of worry. In G.C.L. Davey & F. Tallis (Eds.), Worrying: Perspectives on theory, assessment and treatment (pp. 5–33). Chichester, UK: Wiley.

Borkovec, T.D., & Roemer, L. (1994). Generalized anxiety disorder. In M. Hersen & R.T. Ammerman (Eds.), Handbook of prescriptive treatments for adults. (pp. 261–281). New York: Plenum Press.

Breslau, N., & Davis, G.C. (1985). DSM-III generalized anxiety disorder: An empirical investigation of more stringent criteria. Psychiatry Research, 15, 231–238.

Butler, G., Fennell, M., Robson, P., & Gelder, M. (1991). Comparison of behavior therapy and cognitive behavior therapy in the treatment of generalized anxiety disorder. Journal of Consulting and Clinical Psychology, 59, 167–175.

Craske, M.G., Rapee, R.M., Jackel, L., & Barlow, D.H. (1989). Qualitative dimensions of worry in DSM-III–R generalized anxiety disorder subjects and nonanxious controls. Behaviour Research and Therapy, 27, 397–402.

Leahy, R.L. (2001). Overcoming resistance in cognitive therapy. New York: Guilford.

Leahy, R.L. (in press). A model of emotional schemas. Cognitive and Behavioral Practice.

Leahy, R.L., & Holland, S.J. (2000). Treatment plans and interventions for depression and anxiety disorders. New York: Guilford.

Papageorgiou, C., & Wells, A. (2001). Metacognitive beliefs about rumination in major depression. Cognitive and Behavioral Practice, 8, 160–163.

Wells, A. (1997). Cognitive therapy of anxiety disorders: A practice manual and conceptual guide. Chichester, UK: Wiley.

Wells, A., & Carter, K. (2001). Further tests of a cognitive model of generalized anxiety disorder: Metacognitions and worry in GAD, panic disorder, social phobia, depression, and nonpatients. Behavior Therapy, 32(1).

Wells, A., & Matthews, G. (1994). Attention and emotion: A clinical perspective. Hillsdale, NJ: Lawrence Erlbaum.