2
Treating Generalized Anxiety in a Community Setting

J. Gayle Beck

Despite the fact that older adults are more prevalent than ever before in history, our knowledge about mental health disorders in this segment of the population is surprisingly thin. Anxiety disorders are a case in point. Although our knowledge about anxiety in the elderly is growing steadily, progress has been slow which has impacted knowledge about how to best treat these problems among older adults. Additionally, steadily accumulating evidence suggests that traditional definitions of anxiety disorders, as exemplified by the Diagnostic and Statistical Manual of Mental Disorders (*DSM*; American Psychiatric Association, 2000), may not best capture the symptom profiles reported by seniors, which could potentially result in inappropriate treatment (e.g., Jeste, Blazer, & First, 2005). This chapter begins by reviewing what current research indicates with respect to the symptom profile of generalized anxiety among community elders, with particular reference to the interrelationship between anxiety and depression. An overview of available assessment strategies will be included, with emphasis on the importance of conceptualizing the patient's problem using a functional analysis, in order to understand the interplay between specific symptoms in the context of the older adult's life circumstances. Current information about treating generalized anxiety in community-dwelling elders will be reviewed, to pinpoint potentially useful treatment avenues. Although we have made some significant strides towards understanding how to treat generalized anxiety in older adults, the empirical literature does not yet point to specific treatments that have established support for obtaining good outcomes. As such, the practitioner needs to be mindful in constructing treatment so as to maximize potential benefits, which may result in treatment models that involve considerable individualization. In many respects, it is an exciting era to work clinically with older adults, as the potential for discovery and innovation is high.

Generalized Anxiety in Older Adults – Prevalence, Definitions, and Conundrums

The available knowledge concerning the prevalence of anxiety disorders in general and generalized anxiety disorder (GAD) in particular presents a complex picture. This complexity derives from a number of factors. For example, the

Epidemiological Catchment Area (ECA) studies (e.g., Regier et al., 1988) reported an overall 1-month prevalence rate of 5.5% for the anxiety disorders, which is lower than the 7.3% rate reported for younger adults. With respect to GAD, the 6-month and lifetime prevalence rates for older adults were 1.9% and 4.6%, respectively (Blazer, George, & Hughes, 1991). Although these rates are lower than those obtained with younger adult samples, the ECA studies relied on hierarchical exclusionary criteria, as suggested by the *DSM-III* (American Psychiatric Association, 1980), wherein a diagnosis of GAD was not given if another Axis I disorder was diagnosed. Thus, it is difficult to extrapolate from these prevalence figures to estimate the "true" prevalence of GAD in the community. It is very likely that these rates may underestimate the prevalence of GAD in the community. In support of this speculation, Beekman et al. (1998) reported a 7.3% prevalence rate of GAD among community-dwelling older adults in the Netherlands, who were assessed without any diagnostic exclusionary criteria. As cogently discussed by Hyberls and Blazer (2004), the prevalence of anxiety disorders (and GAD) among older adults and the subsequent demand for mental health services is likely to increase, particularly as life expectancies increase.

In considering the epidemiology of GAD among older adults, an additional concern about most of the available data deserves mention. As discussed by Fisher, Zeiss, and Carstensen (2001), the ECA studies did not differentiate among older adults; individuals aged 65 or older were included in a single group. However, related studies suggest there are age-related differences in the prevalence of anxiety. As noted by Himmelfarb and Murrell (1984) and Feinson (1985), anxiety-based complaints appear to decrease from middle age to the beginning of older adulthood but then increase with advancing age, with individuals reporting more difficulties with symptoms beginning around age 75. This finding has been confirmed by Teachman (2006) in a cross-sectional community sample of 335 adults aged 18–93. Thus, it is difficult to convincingly state the prevalence of GAD among older adults, in light of the non-linear pattern that has been noted by these authors.

To compound this issue further, some writers have argued that the current diagnostic criteria do not fit well for older adults (e.g., Jeste et al., 2005). There are several aspects of this issue. First, differences have been observed between younger and older patients who suffer from the same anxiety disorder (e.g., Sheikh, Swales, Carlson, & Lindley, 2004). This would suggest that although the diagnostic criteria may accommodate both younger and older adults, there may be some phenotypic differences in symptomatology across age groups. Second, in considering the diagnostic criteria, there can be difficulty in distinguishing between "true" anxiety symptomatology and anxiety-related behaviors that are secondary to other factors (such as fear of falling in a frail older adult or reluctance to venture outside of the house owing to visual limitations, Jeste et al.). Although at a descriptive level, anxiety-based behaviors are indistinguishable from one another and from diagnosable disorders, the function of these behaviors is central for treatment formulation. As will be discussed in a later section, it is possible that the success of treatment can hinge on addressing the specific functional relationships among anxiety-based behaviors, particularly in the context of aging-related health and lifestyle changes.

The notable prevalence of subthreshold presentations of anxiety disorders also suggests that our diagnostic criteria might not apply well to older adults. For example, Wetherell, LeRoux, and Gatz (2003) and Diefenbach et al. (2003) have noted that considerable distress is reported by individuals reporting subthreshold levels of GAD, suggesting that despite failure to meet DSM criteria for the disorder, these individuals may benefit from clinical attention. Related work has suggested that subthreshold anxiety symptoms are common among older adults (e.g., deBeurs et al., 1999, Schuurmans et al., 2005) and potentially reflect a different nosology of anxiety disorders among the aged. In considering subthreshold presentations of anxiety, it is notable that longitudinal studies have documented that anxiety symptoms may progress over time into diagnosable depression, either alone or with comorbid GAD among older adults (Schoevers, Deeg, vanTilburg, & Beekman, 2005; Wetherell, Gatz, & Pedersen, 2001). The prevalence and apparently fluctuating course of subclinical anxiety symptoms suggests that refinement in our understanding of generalized anxiety in community-dwelling elders could inform future revisions to available diagnostic systems.

Additionally, an interesting study involving 167 younger–older family member pairs suggested that older adults are significantly less likely to report anxiety symptoms, both in themselves and in others (Levy, Conway, Brommelhoff, & Merikengas, 2003). Related conclusions have been drawn by Gallo, Anthony, and Muthén (1994). The tendency for older adults to minimize reporting of anxiety symptoms contributes to concern about the specific language used to define anxiety syndromes within the *DSM*. It is possible that these findings are unique to the specific cohort of older adults who are being studied and that the next generation of elders will be more likely to report anxiety symptoms. Notwithstanding this possibility, the fact that older adults are less likely to report anxiety symptoms suggests an additional complication in use of the current diagnostic system with this age group.

What emerges from these data and dialogs is a sense that although diagnosable GAD is lower among older adults, less specific anxiety complaints may actually be more prevalent. Given concerns about the fit of our current diagnostic system in describing anxiety disorders in senior adults, it may be reasonable not to adhere rigidly to the DSM criteria when assessing an older adult with anxiety complaints. Additionally, the interplay between generalized anxiety and depression becomes relevant, when considering clinical conundrums in diagnosing older adults. It is entirely possible that differential diagnosis may be considerably more complex with older adults, as articulated by Sheikh (1992). As well, we have very little information about racial and ethnic differences in the prevalence of GAD among older adults. Peng, Navaie-Waliser, and Feldman (2003), in a study of service utilization and health outcomes, reported that Caucasian older adults had the highest rates of anxiety and depressive symptoms, relative to all other racial and ethnic groups. Clearly, it would seem important for future epidemiological studies to more closely examine racial differences in the occurrence of GAD and the anxiety disorders in general.

Understanding Diversity Issues

As the reader might suspect, examination of cultural and ethnic influences on anxiety among older adults has barely begun. Mehta et al. (2003) examined the prevalence and correlates of anxiety symptoms in 3,075 African-American and Caucasian individuals, aged 70–79. Among people without concurrent depressive symptoms, Caucasian women reported the highest rate of anxiety symptoms (20%), followed by African-American women (17%). No racial differences were noted among men in reporting anxiety symptoms (12% for both African-American and Caucasian samples). Importantly, there were no ethnic differences in correlates of anxiety symptoms, suggesting that race does not seem to differentially impact the associated features of anxiety among older adults. More recently, Tolin, Robison, Gaztambide, and Blank (2005) examined anxiety disorders among 303 older Puerto Rican patients within a primary care setting. The rates of GAD were relatively equal among men (15%) and women (10%), with considerable comorbidity noted. Clearly, greater examination of the impact of cultural and ethnic factors on the prevalence and associated features of generalized anxiety is warranted. As will be noted in the next section, where issues pertaining to assessment of older adults for generalized anxiety complaints will be presented, there are preliminary data about diversity issues for several measures. As our awareness of cultural diversity expands, this is an area that is ripe for further work.

Assessment Strategies

Generally speaking, two different approaches have been used in considering strategies for assessing anxiety in older adults. One approach involves determination of the measurement properties of measures that have established utility for younger adults. Although this approach builds upon the existing research base for each of these measures, it may miss phenomenological features of anxiety that are especially salient among older adults. The second approach involves the development of anxiety measures specifically for older adults.

Clinician-Administered Measures

The most commonly used type of clinician-administered measure is the structured diagnostic interview. To date, two interviews have been used successfully to reliably diagnose anxiety disorders in older adults, the Anxiety Disorders Interview Schedule (ADIS-R; DiNardo, Brown, & Barlow, 1994) and the Structured Interview for DSM (SCID; First, Spitzer, Gibbon, & Williams, 2002). Both of these interviews contain structured questions that are designed to help the clinician to determine both primary and secondary diagnoses. The SCID assesses a broader range of diagnoses relative to the ADIS, although the ADIS contains more detailed questions with respect to the various anxiety disorders.

Both interviews have been shown to be useful with older adults (e.g., Beck et al., 2003; Segal, Hersen, Van Hasselt, Kabacoff, & Roth, 1993), although each can be time-consuming to administer. In a clinical setting, these structured interviews can facilitate the initial evaluation of a patient, particularly for a practitioner who is not experienced with older adults.

Other clinician-rated measures that are useful with older adults include general ratings of anxiety symptoms. The advantage of these measures is that they can be used to gauge general levels of anxiety, irrespective of diagnosis. Included in this category are the Hamilton Anxiety Rating Scale (HAM-A, Hamilton, 1959) and the Short Anxiety Screening Test (Sinoff, Ore, Zlotogorsky, & Tamir, 1999), both of which are relatively short and do not require administration by a trained professional. Properties of the HAM-A have been examined in older adults with and without GAD, with some support for their utility (Beck, Stanley, & Zebb, 1999; Diefenbach et al., 2001). These clinician-administered rating scales seem well-suited for tracking a patient's progress during treatment.

Self-Report Measures

Self-report measures are by far the easiest way to assess generalized anxiety in a clinical practice setting. A number of measures have been examined to determine their psychometric properties and utility with older adults, including the Penn State Worry Questionnaire (PSWQ, Meyer, Miller, Metzger, & Borkovec, 1990), the State Trait Anxiety Inventory (STAI, Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), the Beck Anxiety Inventory (BAI, Beck, Epstein, Brown, & Steer, 1988), and the Worry Scale (WS; Wisocki, Handen, & Morse, 1986).

The PSWQ, BAI, and STAI are established measures within the anxiety literature. The PSWQ was designed to assess perceived controllability of worry and as such, reflects a salient dimension of GAD as defined within the current *DSM*. As reported by Watari and Broadbeck (1997), no differences have been noted in scores reported by Japanese American and European Americans on the PSWQ. Stanley, Beck, and Zebb (1996) and Stanley, Novy, Bourland, Beck, and Averill (2001) reported that the PSWQ shows good internal consistency and evidence of convergent validity, although test–retest reliability was not strong for the scale (unlike similar data with younger adults). The BAI is regarded as a well-validated measure of the severity of anxiety symptomatology. Several studies have suggested that this scale is useful in discriminating anxiety from depression in older adults (e.g., Kabacoff, Segal, Hersen, & VanHasselt, 1997; Morin et al., 1999). Importantly, Wetherell and Arean (1997) documented that scores on the BAI are unrelated to ethnicity, gender, and educational level. The STAI assesses both state and trait levels of anxiety and has been widely used for a number of years within the anxiety literature. Stanley et al. (1996, 2001) documented good internal consistency and evidence of convergent validity for both subscales of the STAI, although test–retest reliability was questionable. Related studies (e.g., Fuentes & Cox, 2000; Kabacoff et al., 1997) also suggest the utility of these measures for use with older adults.

The WS was developed expressly to assess worries of particular significance to older adults (specifically concerns about financial, health, and social issues). Initial normative data and support for concurrent validity have been provided (Wisocki et al., 1996) and replicated by Stanley et al. (1996, 2001). A subsequent revision to the WS expanded this measure to include more domains of worry (Wisocki, 2000). Unlike the PSWQ, the WQ focuses on the content of worry and is designed expressly for older adults. Given this focus, the scale can assist the practitioner in an initial assessment of specific worry domains.

Recently, two additional measures have been introduced that are designed expressly for older adults. Although these scales are too new to have extensive psychometric support, the clinician may wish to consider their use, particularly given their topical focus. Kogan and Edelstein (2004) presented preliminary information on the Fear Survey Schedule – II for older adults, which is designed to assess self-reported fears. Initial data support the internal consistency, test–retest reliability, and convergence with related anxiety questionnaires. This measure may be particularly useful for assessing aging-related fears in the context of heightened worry among individuals with GAD. As well, an older adult version of the Adult Manifest Anxiety Scale (termed the Adult Manifest Anxiety Scale – Elderly version, Lowe & Reynolds, 2006) has been recently published. This scale has four factors (fear of aging, physiological anxiety, worry/oversensitivity, and a lie scale) and appears to have preliminary support for its temporal stability, construct validity, and factor invariance across gender. It will be interesting to determine how this scale performs with individuals with diagnosable GAD.

In assessing older adults with generalized anxiety, it is important to evaluate related aspects of functioning. Inclusion of a measure of depression is necessary, given the overlap between anxiety and depressive symptoms. Two measures are available, the Beck Depression Inventory (BDI, Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Geriatric Depression Scale (GDS, Yesavage & Brink, 1983). The GDS was developed to fit the depressive symptom profile of older adults and so, eliminates the assessment of somatic symptoms which may reflect normal aging. The BDI is arguably the most widely used self-report of depression. In considering which measure to select, the strengths and limitations of both the GDS and the BDI are described by Gallagher (1986) and Sheikh and Yesavage (1986). Snyder, Stanley, Novy, Averill, and Beck (2000) report that both measures possess adequate internal consistency and provide support for convergent, discriminant, construct, and discriminative validity for both scales, when administered to older adults with GAD. As well, clinical assessment of general lifestyle factors are essential for a thorough evaluation of older adults with generalized anxiety, including the presence and availability of social support, dietary and exercise habits, alcohol consumption, and financial circumstances. A thorough assessment of the individual's medical conditions and their associated medications is critical, particularly given the fact that aging-related medical problems may create anxiety-like symptoms.

As suggested previously, the clinician's job in evaluating an older adult's complaint of generalized anxiety is not simple. As cogently discussed by Fisher and Noll (1996), anxiety can be conceptualized as a syndrome, as a sign, or as a symptom. In particular, anxiety-like symptoms can be the result of medication or a physical disease process, can be related to aging-related changes in perception or physical ability, or can represent a form of generalized anxiety complaint or GAD. In drawing together assessment sources, it is essential for the clinician to establish functional associations between anxiety problems and related aspects of the individual's presentation. In particular, establishing links between specific anxiety complaints and issues within medical, social, financial, and family spheres requires careful questioning. Without understanding the functional associations between specific symptom reports and functioning within these domains, it is likely that treatment may not be formulated accurately. As will be discussed in the next section, standardized treatments do not appear to have the same efficacy for older adults with GAD as has been reported for younger adults with the disorder. As such, current clinical and research trends are moving towards more individualized treatments, which require a solid conceptualization of the individual's symptoms when placed in context.

Psychosocial Treatments for Generalized Anxiety

Efforts to develop and test psychosocial treatments for generalized anxiety in older adults have increased exponentially in the past 10 years. As reviewed by Mohlman (2004), these efforts have focused on cognitive behavioral therapy (CBT), conducted in individual and group formats. Within controlled trials of CBT with older adults, supportive group therapy and a general discussion group intervention have also been examined, which typically are conceptualized as comparison conditions.

In this literature, the emphasis on CBT stems from two sources. First, there is a general consensus within the larger field of anxiety disorders that CBTs are of documented efficacy (e.g., Barlow, 2002). With particular reference to GAD, CBT has produced superior results when contrasted with supportive psychotherapy and antianxiety medications in younger adults (e.g., Barlow, Rapee, & Brown, 1992; Gould, Otto, Pollak, & Yap, 1997). Given this research background, it seems natural to examine the effect of CBT for GAD in older adults, expecting similar levels of efficacy. A second reason behind this focus on CBT is that this approach to therapy fits well with the needs of older adults. As articulated by Zeiss and Steffen (1996), CBT does not require considerable "psychological mindedness" from a client. As well, this treatment approach does not pathologize the client, can be modified to accommodate age-related changes in memory, and is time-limited, fitting well with the economic constraints that some older adults live within. CBT can be used anywhere, including primary care offices or the patient's home (see the chapter by Brenes, Wagener, and Stanley in this volume).

Based on a small collection of well-designed studies, CBT has been shown to be somewhat effective in the treatment of older patients with GAD (see Mohlman, 2004 for a detailed review). CBT has been shown to lead to decreases in anxiety, worry, and depression. Response rates, however, are lower than expected and often are less marked than what is seen in younger adults. Importantly, group CBT has not been shown to be significantly more effective than supportive therapy or a discussion group intervention, suggesting that some aspect of the group setting might be salient in producing these positive outcomes. In response to this and related concerns, Wetherell, Sorrell, Thorp, and Patterson (2005) have presented a modified CBT protocol that is oriented towards addressing the specific needs of older adults. In this modified intervention, an individual treatment format is used, allowing the therapist to tailor the specific elements of treatment to a specific patient's needs. Although this approach still can be characterized as a form of CBT, the amount of emphasis on cognitive interventions is reduced, relative to previously examined CBTs. Fourteen skills-oriented modules are contained within this treatment approach, each included to address a specific feature of generalized anxiety that has been observed to occur within anxious older individuals. These modules include psychoeducation, progressive muscle relaxation (PMR) training, problem-solving skills training, mindfulness, stimulus control and thought-stopping, cognitive restructuring, exposure, and relapse prevention. As well, modules are presented which address sleep hygiene, behavioral activation (to address depression), life review (to help foster an alternative view of self and the world), assertiveness training, pain management, and time management, interventions which address associated features of generalized anxiety. As noted by Wetherell and colleagues, these interventions are not typically included in CBTs for anxious older adults but are intended to address features that may enhance treatment outcome. The therapist selects specific modules, based upon comorbid diagnoses, the patient's perceptions of their own problems, and responses to self-report questionnaires. In considering this newer form of CBT, it is flexible and can be modified to address individual concerns. As acknowledged by Wetherell and colleagues, greater work needs to be undertaken to determine how to select specific modules and how to integrate these various approaches in the treatment of generalized anxiety.

In considering treatments for generalized anxiety in older adults, it seems that the field has made a solid beginning with the initial research on CBT. At present, this literature has not evolved to the point where comparison of anxiolytic medication and CBT has occurred. Although promising, this approach to CBT is clearly not a panacea. The approach taken by Wetherell and colleagues exemplifies what easily could represent the next generation of CBTs for anxious older adults. In particular, individualized treatment which is constructed to address specific complaints and symptoms, appear potentially more efficacious than inflexible "package" treatments. Given the amount of heterogeneity among older adults, a functional analysis can aid in the selection of specific interventions for specific individuals and in conceptualizing treatment in its entirety. This approach will be illustrated in the following case example.

The Case of Evie and Her Angst

Evie[1] presented for individual treatment with the opening statement "I am full of angst – can you make it stop?" At age 77, Evie was seeking treatment for anxiety which had pervaded her life for the past 20 years. Careful evaluation using the ADIS-R indicated that Evie reported elevated levels of generalized anxiety and uncontrollable worry, an occasional panic attack, and intervals of extreme dysphoria and lack of interest in her usual activities. From a diagnostic perspective, Evie met criteria for GAD although she did not meet criteria for Dysthymic Disorder, owing to the intermittent nature of her depression. Evie was a self-described "Jewish princess" who had been widowed 10 years before presenting for treatment. A strong, active woman, Evie was immersed in the arts community and played a central role on the board of director's of the local gallery. She enjoyed an active social life and maintained good relationships with her two grown children, both of whom lived in other cities. She reported a number of medical problems, including high blood pressure, hypothyroid, an ulcer, and recent treatment for skin cancer. Most of these conditions were managed well by her physicians.

A functional assessment of Evie's "angst" indicated daily worry that lasted most of the day, with acute exacerbations if she was confronted with one of her worry triggers (see below). She reported difficulty in concentrating, inability in making decisions, irritability, muscle tension, and restlessness when worried. Her worry focused on health-related topics, minor matters such as being on time, traveling far from home, particularly during inclement weather, being surrounded by large crowds in areas that were unfamiliar to her, and money, as assessed using the WQ, as well as self-monitoring records. Several of these worry domains were grounded in actual concerns (e.g., her health, her financial situation); others appeared to stem from aging-related concerns, such as being lost in a strange place or surrounded by individuals whom she did not know if she were lost. This distinction had implications for treatment planning, as will be discussed further. She reported becoming depressed when faced with problems that "wouldn't go away," including uncertainty about whether she would outlive her savings and persistent symptoms from her ulcer. At these moments, she indicated that she felt overwhelmed, helpless, and demoralized by the recurrent nature of these problems. These feelings were reflected in an elevated score on the BDI at the beginning of treatment. Occasionally, she would worry to such an extent that she would experience a panic attack. She was not concerned about the panic attacks and understood them as a part of her larger anxiety problem.

Evie's GAD symptoms were conceptualized as a stemming from two sources, the first being areas of actual concern that she had not addressed effectively (e.g., her financial situation, her health problems) and the second being areas where her worry was clearly centered on aging-based concerns (e.g., traveling in unfamiliar

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[1]This individual's name and identifying information have been modified to protect her confidentiality and privacy.

areas, being surrounded by unfamiliar people) and was excessive and debilitating. Treatment was formulated around these two foci, with different interventions being targeted at each. In particular, it was felt that worry which was centered on concrete issues would best be approached with more concrete, behavioral strategies, whereas worry that was more ethereal would be better addressed using exposure and cognitive strategies. Treatment began with psychoeducation about the nature of GAD and its treatment. Although Evie was fairly psychologically minded, she was not certain that the generalized anxiety symptoms were not part of her personality and so, was given several self-help books to read, in order to learn more about the disorder. Evie was taught how to use PMR, in order to provide a concrete skill to begin to control her anxiety. Evie reported that she had been using meditation for years and so, PMR was adapted in order to be integrated into her usual form of meditation. Throughout treatment, Evie was intermittently asked to complete the PSWQ, WQ, and BDI, in order to track her progress. These measures provided a concrete index of Evie's progress.

In considering which aspect of her worry to start treatment with, Evie reported greater anxiety about concerns that were based on actual problems (her health and finances). Because these topics were extremely anxiety-provoking, it was preferable to begin with interventions designed to address less anxiety-provoking worries (e.g., travel, being in unfamiliar places, being late, car repairs), much as one does with any form of gradual exposure. Evie was taught worry exposure (Craske, Barlow, & O'Leary, 1992) and was compliant with using this technique at home. She was able to notice reductions in the degree of anxiety generated by minor issues, travel, and meeting unfamiliar people within 3–4 weeks of steady exposure-based practice. In one of these sessions, Evie expressed some frustration at the need to target these concerns, as they had not characterized her thoughts when she was younger. In exploring this concern, Evie revealed that she had occasionally worried when she was younger, albeit about different topics. This was used as an entry to teach Evie some basic cognitive skills, including evidence gathering and how to recognize and correct logical errors. Evie acquired these cognitive skills easily and indicated that they helped her to put the worries into a better perspective.

Given Evie's success with basic exposure and cognitive therapy skills, it was felt appropriate to move on to those worries that had a concrete facet, focusing on health and financial concerns. Evie reported having a difficult time discussing either of these issues, given the level of anxiety that they would generate, and so, she was taught how to use mindfulness as a way of "staying in the moment" during treatment and at-home homework. Using a problem-solving framework, Evie explored these topics, with particular focus on defining the problem and developing a strategy for finding effective solutions. This led to her contacting a financial advisor to assist with financial planning and switching to work with a primary care physician who had particular expertise in treating ulcers in older adults. Her use of problem solving was so successful that she extended this approach to a range of other issues (not all of which had been the focus of worry). Included in this problem-solving spree was making plans for liquidating her art collection as

her children were not interested in inheriting this, negotiating a new lease on a car, and structuring her time so that she could begin to write the story of her life, a goal that she wanted to achieve while she was still active and vibrant. In some respects, this goal shares some features with focused reminiscence (e.g., Zauszniewski et al., 2004) and other forms of life review, which are designed to help the older adult to attain a positive understanding of their life and accomplishments. It was interesting to see Evie pursuing this goal on her own, as it appeared to be important for her to evaluate her life with a different (nonanxious) perspective.

   At the termination of treatment, Evie reported considerably less worry. This report was augmented by significantly reduced scores on the PSWQ and the WQ. She acknowledged that she would have moments of angst, which would serve as a cue to use one of the skills that she gained from therapy. It is salient that no interventions were included to target her depressed mood. Rather, considerable generalization was noted; as she grew more skilled in managing her worry, the frequency of dysphoric mood decreased, which was also reflected on the final BDI that she completed. As such, it was felt unnecessary to add additional sessions to target depression.

Commentary

This case highlights some of the issues discussed throughout this chapter. As noted, Evie reported a panoply of symptoms which included both anxiety and depressive symptoms. Technically, Evie met diagnostic criteria for GAD, without any secondary mental health diagnoses. Although the specific features of depression did not meet diagnostic criteria for Dysthymic Disorder, this aspect of her presentation was significant and had the potential to reduce her motivation during treatment. Treatment was structured around two foci, one being more "pure" worry (which was addressed with PMR, exposure-based techniques, and cognitive therapy approaches) and the second being a mixture of "real-life" problems to which Evie responded with worry and depression. Problem-solving techniques were used in an effort to help Evie seek alternative solutions to these problems. Importantly, these techniques provided this patient with an action-oriented approach to real-life problems, which seemed important in addressing her feelings of being overwhelmed and subsequent dysphoria. Although it is salient to recognize that the interventions used in Evie's treatment are all contained within package CBT approaches, their application was different and was tailored to meet the unique facets of this woman's situation. As noted, this approach to treatment was successful and importantly, showed radiating effects throughout several domains of her life.

Conclusion

As highlighted at the beginning of this chapter, it is an exciting time to be working clinically with older adults, particularly given increased awareness of the mental health needs of this segment of the population and greater

emphasis on establishing mental health policy that is age-sensitive (e.g., Bartels, Dums, & Shea, 2004). In many respects, one of the more challenging features of clinical work with older adults is developing a framework for understanding when to use existing, empirically supported treatments, when to modify these treatments, and when to start anew in the development of age-specific interventions. When considering GAD, the field is just now beginning to examine the second option (modification of existing treatments), with the hope of improving efficacy for older patients. As we gain further knowledge about the psychopathology of GAD and begin to understand further the nuances of this diagnosis in older adults, it is likely that our treatments will be refined and improved. Certainly, this is an ideal point for clinicians and researchers to learn from one another towards the shared goal of enhancing outcomes of anxiety treatments.

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