

# Systems-Centered Therapy: A Protocol for Treating Generalized Anxiety Disorder

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**Abstract** The systems-centered short-term therapy protocol was adapted and applied in three single case studies with generalized anxiety disorder (GAD) patients in a ten-session individual treatment over a two week period. All three subjects showed substantial improvement and no longer met diagnostic criteria post-treatment. Changes were maintained

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at follow up both six months and one year later. These results are promising and suggest the importance of further research on SCT as a viable, alternative treatment for generalized anxiety disorder.

**Keywords** Systems-centered therapy · SCT · Generalized anxiety disorder · Short-term therapy

The success of both cognitive behavioral therapy (e.g., Borkovec & Ruscio, 2001) and relaxation therapy (e.g., Arntz, 2003; Forsyth & McNeil, 2002) in the treatment of Generalized Anxiety Disorder (GAD) has been well documented. Fisher and Durham (1999) reviewed six randomized controlled studies and determined that both cognitive-behavioral therapy and applied relaxation do relatively well, with recovery rates of 50–60 percent. Despite the documented potency of these treatments and notwithstanding the listing of CBT as an empirically supported treatment for GAD (Chambless & Ollendick, 2001), there is room for improvement: Borkovec, Newman, Pincus and Lytle (2002) showed that only 50 percent of participants in clinical trials of GAD were markedly improved by the end of treatment; and Westen and Morrison (2001) stressed that only a very few studies on GAD have demonstrated sustained efficacy rates of 25–30 percent over 12–24 months post treatment.

The current paper provides a brief overview of systems-centered therapy (SCT) (Agazarian, 1992, 1997) and explores its usefulness as an alternative treatment for GAD. Three case studies are presented that support the effectiveness of SCT in the treatment of GAD, with treatment gains maintained over a one-year follow-up period.

## System-centered therapy

### Overview of systems-centered treatment

SCT is a systems approach to therapy which was developed from a theory of living human systems (Agazarian, 1997). A theory of living human systems defines a hierarchy of isomorphic systems that are energy-organizing, goal-directed, and self-correcting. The SCT methods and techniques were developed from these theoretical constructs and then honed by clinical practice.

For example, the SCT construct of *hierarchy* defines any system as a set of three subsystems. This can be diagrammed as three concentric circles, with the middle system existing in the context of the larger system and being the context for the smaller system. Applying hierarchy to an individual GAD patient, the person is the larger system which contains the primary human experience of energy, affects, and motivations (the smaller system level) that are variously organized in subsystems (the middle system). These subsystems which SCT calls “roles” are similar to what Siegel (1999) calls “states of mind,” which “contain the clustering of perceptual biasing, behavioral response patterns, emotional tone and regulation, memory processing and mental models” (p. 234). Alternatively, applying the construct of hierarchy to the patient interpersonally, the larger context of the relationship is the superordinate system, the roles each person takes in the relationship comprise the middle system level, and each person with his or her range of potential is the smaller system. These roles can be functional like boss and employee or non-functional like bully and victim.

SCT hypothesizes that intervening to the middle system is the point of greatest influence on all three subsystems, as the middle system has contiguous boundaries with both other systems. Notably, within a GAD patient’s interpersonal context, intervening to the middle system of the patient’s interpersonal roles influences both the relationship and the person. Working with the patient from the intrapersonal perspective then points to influencing the states of mind or roles that organize internal experience.

SCT defines *isomorphy* as similarity in structure and function for the systems in a defined hierarchy. *Structure* is defined as boundaries. For example, SCT techniques for clarifying boundaries help separate past from present. *Function* is defined as the process by which living human systems survive, develop and transform by discriminating and integrating differences. SCT methods influence this developmental process using techniques which develop the ability of the patient to discriminate and integrate. For example, SCT teaches patients to discriminate the difference between a defense and the experience being defended against, between thoughts and feelings, between feelings generated by opin-

ions and speculations versus those that are spontaneously related to experience or reality. SCT teaches patients to explore their experience so that they can develop and integrate greater resources in themselves.

SCT also assumes that human systems develop homeostatic resistances to this inherent process of development, in which the structure (defined as boundaries) or function or goal orientation of the system does not support development. For example, boundaries that are too open or too closed influence whether differences can be integrated in a development process.

To pace development, SCT proceeds sequentially: simpler defenses are resolved before the more complex defenses are addressed. As each defense is reduced, the SCT therapist works with the patient to explore the experience or conflict that the defense avoided. This exploration enables patients to develop new cognitive, emotional, and behavioral skills for relating to the experiences and conflicts previously avoided.

### Rationale for applying SCT to the treatment of GAD

SCT is an integrative systems therapy, thus, aspects of the techniques will be familiar. For example, SCT builds on psychodynamic understandings yet reframes them in terms of system dynamics. It uses techniques similar to cognitive behavioral therapy in modifying problems in thinking; techniques similar to mindfulness practice in teaching centering into the bodily experience and redirecting attention; techniques similar to some in gestalt therapy and relaxation training in modifying the defenses of the body; and techniques similar to those of short-term dynamic therapy in weakening the defenses against anger and the impulse to retaliate. It is the integration of these techniques into a coherent systems framework that sets SCT apart in several ways that might be expected to provide superior maintenance of treatment gains for GAD patients.

First, SCT assumes that anxiety symptoms frequently function as defenses against other experiences. SCT works to modify defenses, not only to lower the symptoms generated by the defenses, but also to make it possible for the patient to explore the experiences avoided by the defenses. This exploration develops new capacities in the patient. Second, by not only weakening the predictable defenses but also strengthening the patient’s capacity to relate to their present, SCT adds an emphasis on emotional intelligence. Patients are taught to be active observers of their experience and to use information derived from observing the knowledge implicit in emotional experience in problem solving and decision making (Agazarian, 1997). This emphasis is relevant here in that lack of emotional knowledge has been noted as a deficit for many patients with GAD (Borkovec & Newman, 1999). Finally, SCT addresses interpersonal

problems, which preliminary evidence suggests may be involved in the maintenance of GAD (Borkovec et al., 2002). SCT views repetitive interpersonal roles as serving defensive functions that often perpetuate anxiety. Thus, failing to modify the roles makes it likely that the various interpersonal systems in the patient's life will reinforce the old roles which maintain the anxiety.

### Description of SCT modules

SCT organizes its therapy in a sequence of modules, with each of the five modules designed as a stand-alone treatment. The modules are determined by the presenting problems and diagnosis as well as the reality of the resources available for treatment. Thus, a patient could finish the module one work, stop treatment and return at a later time to do the work of the later modules. Each of the SCT modules are described below, with more detail provided for modules one and two as they were used in the present study. A more complete description of the SCT methods can be found in *Systems-Centered Therapy for Groups* (Agazarian, 1997).

#### Module one

Module one addresses (1) social defenses against communication; (2) cognitive defenses against reality-testing and uncertainty that provoke anxiety; (3) somatic defenses against emotions that generate tension and somatic distress; and (4) defenses against discharging anger and the impulse to retaliate that generate depression or hostile acting out. Each is described below.

#### *Social defenses against communication*

The SCT therapist educates the patient about the social behaviors that make it harder to communicate authentically. The patient learns to explore their impact as well as to consider alternative, more effective, communications. For example, SCT identifies explanations as redundant when they retrace what is already known and thus hinder discovery of new information relevant to improving functioning. When the patient starts to explain, the SCT therapist might ask him or her to choose instead *what* to explore: whether to explore the experience itself or to explore the impact of explaining it. SCT calls this the fork-in-the-road of choice, where the patient is always choosing what to explore and the therapist sets the structure for the patient's choosing.

As patients weaken the social defenses, they learn to discriminate between *apprehensive experience*, the apprehension of the moment to moment data that includes information from the body (sensations, images, and emotions), versus

*comprehensive* knowledge, ideas or theories about experience. Exploring apprehensive experience accesses information from emotional and physical states, an ability which is underdeveloped in many GAD patients.

#### *Cognitive defenses against reality-testing and uncertainty*

The SCT therapist weakens the cognitive defenses to lower anxiety symptoms and increase reality testing abilities. Patients learn to shift away from speculations and opinions and instead to collect data about what is actually happening. Patients are taught to notice how their constructed meanings and predictions about what might happen (e.g., negative predictions, speculations, and unchecked "mindreads" of others) are often the source of anxiety. In weakening these cognitive defenses, patients learn to discriminate whether the source of their anxiety is from "thoughts, feelings in the body, or the edge of the unknown." If, for example, the anxiety is being generated by a thought about the future (a negative prediction), the patient is asked if he or she believes it is possible to know the future. Once the patient's anxiety is decreased, the SCT therapist refocuses him or her toward exploring and reality-testing in the present ("Are you curious what you moved away from in the present by going to your negative prediction?"). In this, the patient often moves from the anxiety generated by negative predictions to realizing that inevitably, some anxiety comes from "apprehension at the edge of the unknown." SCT normalizes the challenge of living in uncertainty and encourages a shift from passivity with this reality to active curiosity.

#### *Tension and somatic defenses against emotions*

As patients begin to address the real situations previously avoided by cognitive defenses, frustration and tension tend to increase in response to the difficult realities. SCT sees tension, which is often equated with the experience of frustration, as actually a defense against fully experiencing frustration. The SCT therapist teaches techniques for relaxation that both lower the muscular tension and redirect the patient's attention to the emotional information that the muscular tension has blocked. In learning to discriminate between tension and emotional experiences such as frustration, patients gain an increasing tolerance and familiarity with the bodily sensations that contain emotional knowledge, and learn techniques for centering into their bodily experience.

#### *The defenses against discharging the retaliatory impulse*

When frustration goes on too long for a patient's tolerance, frustration shifts into irritation and anger and the impulse to blame and retaliate is aroused. SCT builds on Davanloo

(1987) in identifying the defenses against the retaliatory impulses. One common defense is to turn the impulse to retaliate against the self in self-blame (the boomerang defense), resulting in discouragement, low self-esteem, and/or depression. Another defense is hostile outrage or discharge against others (verbal or physical aggression). Both defenses, targeting out against others or in against the self, interrupt the spontaneous experience of anger, which is full of energy and emotional knowledge.

## Module two

Module two shifts from a focus on the intrapsychic defenses to a focus on the interpersonal role defenses often aroused in response to frustration. Habitual interpersonal roles simultaneously maintain intrapsychic defenses and shape the behavior of others into reciprocal roles which creates an interpersonal system that maintains the old habitual roles. The prototypic roles identified by SCT theory are dominant/submissive or one-up/one-down or victim/bully (Agazarian, 1997). SCT works with patients to identify and name their habitual roles, the experience and perceptions the patient has when in the role, and the behavioral, cognitive and postural patterns that maintain the repetitive experiences. Patients learn to discriminate these from the experience of themselves when they are centered into their apprehensive experience.

SCT conceptualizes *role* as an organizing system that governs the dynamic interplay of perceptual, affective, cognitive, and somatic subsystems. For example, when a patient is in a “victim” role, the patient describes and perceives others as having mistreated him or her in some way, has a characteristic posture (often slumped or collapsed), and uses language that reflects the passive, helpless relation to the world: “I have to . . . ,” “they made me . . . ,” “I need to . . . ” Further, when in a victim role, the patient behaves and relates in ways that elicit the complementary role in others that maintains the “victim” perceptions of the world. For example, “victim” role often elicits the “bully” role which reinforces the perception of being mistreated by others. Thus, the role system manifests both in the individual’s intrapsychic organization and experience as well as in the interpersonal behavior that “trains” others to reinforce the role system.

Additional SCT treatment components (not employed in the present study) are: module three, which addresses the resistance to change defenses and the pull to externalize and blame someone else for one’s difficulties; module four, which focuses on the conflicts in intimacy with one’s self and with others, and the challenges in separation/individuation; and module five, which addresses the challenges in using one’s increased self knowledge in the various roles and contexts in one’s life.

## Method

In the present investigation we used single case methodology as a starting point for generating efficacy data for a new treatment approach and as a step toward developing controlled studies (Moras, Telfer & Barlow, 1993). Three patients with GAD were treated using ten individual treatment sessions across a two week period.

## Participants

Participants were recruited through private psychotherapy practices (some referring therapists had training in SCT and some did not), clinics and from a university based counseling center. Clinicians were told that the study was specifically for people with anxiety and used a type of therapy called systems-centered therapy. Eight participants volunteered and were assessed with the SCID and three of these met the criteria for inclusion in the study. Inclusion required meeting the criteria for Generalized Anxiety Disorder on the Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1997), and completing all treatment and measurement sessions. Individuals were not excluded on the basis of co-morbid conditions as these are commonplace in GAD diagnoses and representative of everyday clinical reality. All participants provided written informed consent and paid for their treatment. Participants did not receive any additional therapeutic treatments during the course of the treatment or during the subsequent year prior to the follow-up assessment.

## Measures

### Assessment

Participants completed the self-report measures described below during three baseline sessions (approximately one week apart); after five sessions of treatment and again after ten sessions; and at one week, six months, and 12 months post-treatment. The SCID was completed at the first meeting and one week after treatment ended.

### Structured clinical interview diagnostic (SCID)

The SCID (First et al., 1997) is a standardized interview that assesses current and lifetime psychiatric status for major Axis I psychiatric disorders based on criteria from the Diagnostic and Statistical Manual of Mental Disorder IV (DSM-IV) (American Psychiatric Association, 1994). The psychometric properties of this instrument are acceptable and have been well documented (Skre, Onstad, Torgersen & Kringlen, 1991; Segal, Hersen, Van Hasselt, & Vincent, 1994). All interviews were conducted by a fourth year psychology

graduate student who had prior training and experience using the SCID. Interviews were supervised by a Ph.D. psychologist.

#### *State-trait anxiety inventory trait (STAI-T)*

The STAI-T (Spielberger, 1983) is a 20-item self-report scale assessing current and personality anxiety symptoms. The STAI-T is a valid (convergent validity from 0.73–0.85) and reliable (test re-test reliability from 0.73–0.86) measure of anxiety. One limitation of this scale, however, is that factor analysis has shown that it also measures sadness and self-deprecation (Bieling, Antony, & Swinson, 1998).

#### *Beck anxiety inventory (BAI)*

The BAI (Beck & Steer, 1992) is a 21-item, self-report measure of somatic, cognitive, and affective anxiety symptoms. The BAI is a valid (convergent validity: mean  $r = 0.51$ ) and reliable (test re-test reliability:  $r = 0.73$ ). The score range is 0–63. Scores of 8–15 are considered to represent mild anxiety symptoms. Scores in the ranges 16–25 and 26–63 are considered to represent moderate and severe levels of anxiety, respectively.

#### *Outcomes questionnaire (OQ-45)*

The OQ-45 (Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1996) is a 45-item self-administered questionnaire. This study used the total score (range of 0 to 180). Total scores above 62 are considered clinically significant with a Reliability Change Index (RCI) of 14 points or greater for clinically meaningful change. Kadera, Lambert & Andrews (1996) reported an internal consistency of .93, a test-retest reliability of .84, and concurrent validity with similar instruments ranging from .53 to .88.

#### *Adherence ratings for treatment*

Five raters (two social workers, two psychologists, and one psychiatrist) with at least five years of SCT training viewed videotapes of the first, fourth, and ninth sessions of each case and separately checked the occurrence of 12 categories of interventions within four minute intervals. These included building behaviors intended to develop the therapeutic relationship system (including normalizing interventions, therapist verbal builds and reinforcements, paraphrases, non-verbal behavior, and eye contact), discriminating thoughts from feelings; identifying and reducing social communications; and the SCT techniques for reducing anxiety, tension and depression. There was good agreement among the five

independent judges of protocol adherence for all three cases as determined by values ranging from .74 to .86 for Kendall's  $W$ , a coefficient of concordance.

#### Therapists

Two senior licensed clinical psychologists (the second and fourth authors of this study) conducted the treatments. Both clinicians are female, one with over 25 years of clinical experience and the other with over 40 years of clinical experience, and have worked extensively with the systems-centered method for the last 15 years.

#### Treatment

The modules one and two treatment protocols were used. The treatment is described in the SCT text (Agazarian, 1997). A treatment manual (Gantt & Agazarian, 2002), developed as an adjunct to the SCT text, outlined the systems-centered protocol for the treatment. We conducted the treatment in a ten session format, each session lasting 60 minutes, once a day for each of the work days (Monday through Friday) for a two-week period. All sessions were videotaped. The two week format was based on practicalities of the research project rather than theoretically guided.

#### Treatment descriptions

##### *Case A*

Allison (pseudonym) was a 52 year-old married Caucasian female who held an advanced graduate degree and was employed in her field. She had a history of outpatient psychiatric care spanning 20 years. Her presenting complaints included severe anxiety, procrastination, performance anxiety, and many physical difficulties including migraines and lower gastrointestinal problems. She had poor concentration, attention problems, vivid nightmares, night panic, and sleepwalking. She reported having been in a constant state of anxiety for “as long as she could remember” that worsened with interpersonal stress. At the initial testing she was taking propranolol hydrochloride, oxazepam, trazadone, and bupropion, and drinking about 16 ounces of wine daily. Her primary social support was her husband.

During baseline assessment, Allison's STAI-T scores (55, 56, 53) were all at or close to the 100 percentile. Her BAI scores (25, 27, 23) were in the moderate to severe range. On the OQ-45, she scored in the clinically significant range (82, 89, 96).

Early on, Allison reported feeling the pull to respond to the therapist with what she saw as “socially acceptable”

answers rather than what she knew. The therapist framed this social defense as a “fork-in-the-road” with two sides to explore: the pull to socially acceptable answers, or the answers she would discover if she shifted away from “socially acceptable.”

The therapist then worked with Allison to notice the actual moment-by-moment experience she was calling anxiety. Learning to discriminate her moment-by-moment experience laid the groundwork for a second discrimination, between explaining her anxiety versus exploring to discover its source. With this “fork-in-the-road,” Allison discovered that many of her “explanations” were upsetting to her. For example, she was able to identify that her thoughts about what her nightmares meant were in fact more upsetting to her than the nightmares themselves. Similarly, the therapist worked with Allison to recognize when she was misidentifying her opinions as feelings. She then learned to reality test her opinions by collecting data, whereupon she discovered she often had different, and less upsetting, feelings about the facts. Allison also learned to differentiate her anxiety symptoms from bodily tension.

Over the ten sessions, Allison learned to lower her anxiety and undo her tension. She learned to shift to curiosity when she did not know something as the therapist normalized the inevitable anxiety that comes with not knowing. She learned how to “center” into her body by sitting squarely and paying attention to her breath and to her bodily experience with a relaxed, flexible attention. This released her from the habitual postures related to old roles. In her work, she discovered that her tension not only defended her from feeling her frustration and anger but also blocked her from having her full experience of excitement and joy.

Allison explored her anger and retaliatory impulse first toward co-workers, and later toward the therapist. Accessing anger toward the therapist allowed her to recognize that she had put the therapist on a “pedestal,” gone into “mindreads” about the therapist’s expectations, and become compliant with what she thought the therapist expected at the expense of herself. As she weakened this “one-down” role, she recognized how it led to pressuring herself and then getting anxious. She also explored the posture she takes when in the role, with her neck collapsed and as she put it, “expecting to be yelled at.” She then understood that the tension and collapse in her neck in this role posture caused her frequent headaches and neck aches.

This led to exploring the role she often assumed with her boss: outwardly compliant and internally defiant. In this work, she accessed her retaliatory impulse and feelings of rage and the sadistic impulses she had been unaware of. This exploration allowed her to integrate these feelings, leaving her feeling calmer, less angry and with a sense of herself

as powerful and competent. Freed from the conflict between her angry feelings and her compliant defense, she then understood how to work with her boss with her full power and authority.

One week post-treatment, Allison was reassessed with the SCID and no longer met criteria for GAD. In addition, her self-reported symptoms changed in the predicted direction. On the STAI-T, her score fell from the 100th percentile at the initial baseline assessment to the 76th percentile post-treatment and to the 39th percentile at the 12 month follow-up (55, 37, and 29 respectively). Similarly, her BAI score fell from 25 at the first baseline session to 10 at the end of treatment and 2 at the one year follow-up, shifting her from the moderate-severe to the mild range. On the OQ-45, she earned a score of 82 at the first baseline assessment which decreased to 45 at the end of treatment and to 53 at the 12 month follow-up, exceeded the RCI of 14.

### Case B

Barbara (pseudonym) was a 26 year-old Caucasian female, married, with a one-year-old son. She was a full time graduate student who also did graduate level teaching. She reported lifetime anxiety with fluctuating intensity. She had taken citalopram for anxiety until two years ago when she stopped to have a baby. She reported a history of health problems, most notably repeated problems with kidney stones, and had seen a psychiatrist for the first time three years prior to this study. She described herself as unhappy, very stressed, always in a rush, in “a terminal bad mood.” and just “waiting for the weekends.” Her social life focused on her son and husband and a few family members. She rarely saw friends.

Barbara’s STAI-T scores during baseline assessment were 52, 57, and 52, respectively (93rd and 100th percentile). Her BAI scores were 14, 16, and 10, respectively (mild to moderate range), and her OQ-45 scores were 68, 66, and 47, respectively, all clinically significant.

At the start of therapy, Barbara reported feeling anxious most of the time, and stated: “I put myself in a frame of inadequacy about my anxiety and then feel worse versus when I can see the context and remain objective.” The therapist built on her existing view and framed the therapy as learning skills to regain her objectivity and ability to see the context.

The therapist taught her to identify the source of her anxiety. She also learned to discriminate opinions from facts; to recognize when she was making stereotyped judgments about herself at the cost of her experience; to recognize the impact of reporting her experience with qualifiers, like “I think” or “maybe” (that she later coined as “waffle words”) that kept her anxious and uncertain; and of staying with generalizations that perpetuated her anxiety rather than checking the specifics in her reality and experience. By the end of the

third session, Barbara could undo her tension and access more of her emotional responses. She then learned to undo the boomerang defense of turning her anger back on herself, and discovered her irritation with several people that the boomerang defense had bypassed. In reclaiming her anger she experienced some satisfaction and enjoyment.

In session four, she reported having been very anxious since earlier in the morning. She identified its source as two negative predictions: (1) that she would be late for her therapy and (2) that her husband had been in an automobile accident. After weakening her negative predictions, she explored what she had avoided by going into her negative predictions. She had been feeling calm and happy that morning until she had noticed that her husband was not yet home and then recognized how late it was. In this work, the therapist helped her notice her tendency to explain her husband's lateness (and recognize that her explanations and speculations had generated her anxiety) as opposed to exploring her feelings about her husband's lateness. As she moved from explaining to exploring, she discovered she was irritated about his lateness, and simultaneously that she had "judgments" that she should not be irritated. Building on earlier work, she quickly let her judgments go and then experienced a great excitement in recognizing that it was simpler to be irritated than to add her anxiety-provoking thoughts into the mix. As she made this discrimination, she felt energetic, "big and open" and spontaneously began relating that her aunt also plays a "martyr" role instead of getting angry. Barbara recognized how she herself boomerangs judgments against herself and then linked her own withdrawal when she is angry as being her way of retaliating, much as her aunt does. She then revisited her anger with her husband from the morning and discovered with pleasure and fun that she wanted to "kick him in the butt." At the end of the session, she described a sense of inner connection to herself that felt new, where she could "see herself" and see "outside herself" at the same time.

This laid the groundwork for working explicitly with her compliant role. Barbara identified a compliant role with her doctor when she gets angry with him and then withdraws. As she explored this role, she accessed her irritation and rebellion with her physician about his attitude and began, as she put it, to "flex unused muscles" in exploring her feelings toward him. She explored wanting to retaliate against him, and then, freed from her compliant role, understood how she would relate differently to him now. She later did the same work with the therapist in her session, coming out of her compliance with the therapist and exploring her rage about all the cameras and equipment associated with the research protocol.

She also explored the actual posture she assumes when in her compliant role and how from this posture, she related to the therapist expecting that the therapist would dominate

her. This led to identifying the behaviors she used that invited the therapist to take the complementary role of dominating. As she weakened the role, Barbara discovered that in her compliant role, she avoided thinking about what she wanted and instead got others to tell her what to do, which she in turn resented.

By the end of her therapy, Barbara understood how her anxiety was often "self-imposed" and that weakening her compliant role also lowered her anxiety. While she noticed gains in managing anxiety, she also reported feeling apprehensive about no longer having the therapy available to her. This may account for some inconsistency in her post-treatment scores.

Barbara's STAI-T had not decreased by the end of treatment, remaining at 52, but had done so when measured one year later, shifting to 35 (54th percentile). However, at post-treatment her BAI score had fallen to 5, considered minimal, and 9, in the low end of the mild range, at the one-year follow-up. She scored 15 on the BAI at the 6-month follow-up, suggesting that she continued to experience some struggle with anxiety. Barbara's OQ-45 score had fallen below clinical significance at post-treatment (40) and even lower (25) at the 12 month follow-up. This change exceeded the RCI of 14. Importantly, Barbara no longer met the criteria for GAD on the SCID one week post-treatment and the assessor described her as significantly brighter and more spontaneous at the follow-up session.

### Case C

Carla (pseudonym) was a 33 year-old Caucasian female, divorced, with a 10 year-old daughter living at home. She had functioned as the primary parent with her daughter since separating from her husband when her daughter was three. Carla held an advanced degree and worked in her field. She began having symptoms of anxiety and depression 15 years earlier during her divorce when she feared she would not get custody of her daughter. She had no history of psychiatric care and was not on medication. She reported that her current anxiety focused on her work and the responsibilities associated with supporting her daughter. She reported insomnia, preoccupation, fluctuating mood, and allergies that she linked to stress. She occasionally took prescription and non-prescription allergy medication. Her social life was limited mostly to seeing her daughter and boyfriend of three years. Her affect was very flat.

At baseline, Carla's STAI-T scores (44, 41, 41) were in the 83rd percentile range. The scores for her BAI (10, 7, 7) however, were not elevated, unusual in light of her DSM-IV diagnosis. Closer examination of her BAI scores showed she did not endorse the physical symptoms of anxiety (sweating, flushing, heart palpitations) that the BAI taps heavily. Her

OQ-45 for the three baseline assessments (60, 44, 61) was slightly below clinical significance (62).

In the first session, the therapist worked with the patient to identify the primary source of her anxiety and its impact on her. The patient recognized that her thoughts made her anxious and interfered with her doing more of what she wanted to do with her life, and kept her in a cautious role that limited her freedom. She also recognized that her tendency toward negative predictions was common both in her family and her culture. Carla had grown up in a Nordic culture where her family, especially her mother, was always thinking the worst would happen.

The therapist helped Carla discriminate her anxious role from her role at work where she was self-confident and felt freer. In this, the therapist worked with Carla to notice and to identify the actual experience she has when she is anxious. It was apparent early in the work that Carla largely relied on her thoughts when she was in her anxious role and had much less familiarity with the sensations in her body or the emotions and feelings that linked to the sensations, so the work early on linked her to her body. The therapist framed it as learning new ways of thinking, and introduced the fork-in-the-road between thinking and feeling as an important one for Carla. The therapist also introduced her to centering and then contrasting it with the posture she takes when she is anxious (where Carla discovered she collapses and constricts herself with tension). Carla discovered how her relationship with herself changed as she changed her posture.

In the fourth session, the therapist said to Carla: “You have a way of explaining reality, which makes you anxious and that makes you less able to deal with reality, . . . moving away from the reality into doomsday thinking, running away from feelings to feeling anxious.” Carla explored this habit and the roots it has in her family and culture and her own reluctance, in effect, to move away from the anxiety-generating thoughts into feelings about the realities. She recognized that her work was to make the commitment to choose differently each time she recognized her anxiety and the anxiety-provoking thoughts that were generating it.

In the next sessions, the therapist worked with Carla’s tendency to “sit” on her feelings, and to turn anger back on herself. This laid the foundation for working with the role that she assumed with the therapist—at times “sitting on herself” when frustrated with the therapist. They discovered she literally sat on her hands momentarily when the role was triggered.

After weakening her compliant role with the therapist, Carla was able to work more freely in the session. The therapist introduced the idea that the role is an earlier survival solution that now functions as a way to avoid an experience or conflict. Carla first explored her anxiety role where she

set herself up with her thoughts and used magical thinking to avoid disappointment. Carla then worked with her “apathetic withdrawal” role in which she forces herself to do tasks she doesn’t want to do and then feels “blah.” This work enabled Carla to access the feeling of “not wanting to do it,” and her impulse to have a tantrum. Carla discovered that exploring her impulse to have a tantrum was actually very energizing for her. She contrasted this to the role where she felt “blah,” worried, and often criticized herself for not wanting to do something. Carla understood that the role took her away from exploring her conflicts (both the part of her who wants to do the task and the part of her who doesn’t). When she was in her “blah,” “have to” role of victim, she was unable to make a reality decision with her full energy; instead from the old role she dragged herself into doing the work, and ended up anxious and worried. Carla realized that when she found herself thinking something was wrong with her that this was a sign she had turned anger against herself.

Carla no longer met the criteria for GAD when the SCID was re-administered, one week post-treatment. Her post-treatment STAI-T score fell to the 54th percentile and at the 12 month follow-up to the 9th percentile. Similarly, her OQ-45 scores decreased to 29 post-treatment and to 19 at the 12 month follow-up; exceeding the RCI of 14. Her BAI dropped to 0 at follow-up though as mentioned above both her baseline and treatment scores were low.

#### Rater observations

Over the three rated sessions, the frequency of the therapist weakening social communications, educating about anxiety, and using specific SCT techniques for reducing anxiety decreased. This gradual decrease of skill building interventions is consistent with the SCT approach of actively intervening to modify defenses (anxiety, tension, depression) early in treatment in order to develop the skills the patient can then utilize later in treatment. Later in treatment relationship oriented interventions occupied a larger percentage of total interventions, while the number of such interventions remained relatively constant throughout the three coded sessions. In practice the therapist role shifted emphasis from skill development to exploring the present previously obscured by the defenses.

#### Discussion

This article has provided an overview of systems-centered therapy, and its application to GAD. In each of three patients, clinically diagnosed with GAD, treatment was associated with remission of the generalized anxiety disorder diagnosis

and maintenance of gains as measured by self-report inventories at a one-year follow-up.

The findings from this study offer preliminary support for further exploration of SCT as a viable alternate treatment for GAD that may increase the efficacy and power of treatment of GAD. To this end, several limitations of the present study need to be addressed. Replicating these findings with a larger number of subjects is one important next step. In addition, expanding the recruitment of subjects to include a wider variety of socio-economic and educational backgrounds will be important as well as adding instruments that measure more of the intrapsychic and interpersonal dimensions related to role. It will also be important to use interviewers for the outcome assessment who are blind to the treatment condition. In addition, it will be essential to investigate the effectiveness of this treatment as administered by clinicians with less experience than the present therapists and to include a measure of the client-therapist relationship. It is also important to examine this treatment using a more traditional therapy format (e.g., weekly sessions). Ultimately, a randomized controlled study with a comparison group is needed for more definitive conclusions.

It will also be particularly important in advancing research on SCT to test the hypothesis suggested by this study that addressing the role system is important in the treatment of GAD. In SCT, a role system is an implicit organization which has an identifiable way of perceiving, feeling, and relating to one's self and others. This idea is similar to the argument Westen and Morrison (2001) make for the importance of ascertaining whether a change in state is accompanied by changes in the Aimplicit networks@ (Acognitive, affective and motivational@) that encode the anxiety states (p. 887–8). The role system can be understood as a stabilizing system that organizes emotional processing and adaptive learning. If a role maintains the status quo by resisting the integration of new information, it is implicated in maladaptive functioning. If modifying the role system improves the maintenance of treatment gains, then support will be garnered for the SCT hypothesis that GAD symptoms are outputs of a role system.

The SCT hierarchy of intervention strategies first targets the symptoms (which for GAD patients are also adequately treated by CBT and relaxation therapies). Secondly, SCT addresses the role constellation that maintains the system functioning of which the GAD symptoms are an output. We are also hypothesizing that it is also the role system that prevents the adaptive learning that comes from the emotional processing that GAD patients lack (Borkovec & Newman, 1999). Thus, this study has led us to hypothesize that intervening to the role system as a mediating variable will increase the power of GAD treatment.

Finally, this paper puts forth a first step in researching SCT as an alternative method with GAD patients and to-

ward the goal of developing the empirical validation that any alternative therapy must require of itself.

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