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Applied relaxation vs. cognitive therapy in the treatment of generalized anxiety disorder

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Abstract

The present study investigated the efficacy of a coping-technique, applied relaxation (AR) and cognitive therapy (CT), in the treatment of generalized anxiety disorder. Thirty-six outpatients fulfilling the DSM-III-R criteria for generalized anxiety were assessed with independent assessor ratings and self-report scales before and after treatment and at a 1 yr follow-up. The patients were randomized and treated individually for 12 weekly sessions. The results showed that both treatments yielded large improvements, which were maintained, or furthered at follow-up. There was no difference between AR and CT on any measure. The drop-out rate was 12% for AR and 5% for CT. The proportions of clinically significantly improved patients were 53 and 62% at post-treatment and 67 and 56% at follow-up for AR and CT, respectively. Besides affecting generalized anxiety the treatments also yielded marked and lasting changes on ratings of worry, cognitive and somatic anxiety and depression. The conclusion that can be drawn is that both AR and CT have potential as treatments for generalized anxiety disorder but they have to be developed further in order to increase the efficacy to the level usually seen in panic disorder, 80–85% clinically improved.

1. Introduction

Generalized anxiety disorder (GAD) is one of the most prevalent of the anxiety disorders with a lifetime prevalence of about 5% (Wittchen, Zhao, Kessler & Eaves, 1994). It is, however, a relatively underresearched disorder, both when it comes to psychopathology and treatment. One explanation for this state of affairs is the division of

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the DSM-II (APA, 1968) diagnosis anxiety neurosis into two separate diagnoses in DSM-III (APA, 1980), panic disorder and generalized anxiety disorder. It seems that most of the interest from the research community was focused on the new and more intriguing panic disorder, while relatively little research has been carried out concerning GAD. This may explain why the average proportion of clinically significant improvement for panic disorder is 80–85% (Clark, 1996), while it is only about 50% for GAD (Borkovec & Newman, 1998).

Over the last quarter of a century a number of different behavioral and cognitive behavioral treatment methods have been tested in randomized studies for anxiety neurosis or GAD, e.g. biofeedback, progressive relaxation, applied relaxation, stress inoculation training, anxiety management training and cognitive therapy. Among these methods relaxation training and cognitive therapy/cognitive behavior therapy are the most frequently used (see Durham & Allan, 1993, for a review).

Concerning progressive relaxation (PR) Lehrer, Woolfolk, Rooney, McCann and Carrington (1983) found it to be more effective than a wait-list control condition and also reported better effects for PR than for meditation. LeBoeuf and Lodge (1980) found that PR was equal to electromyography-biofeedback and Raskin, Bali and Peeke (1980) that PR was equal to EMG-biofeedback + PR. Borkovec and Mathews (1988) added PR to cognitive therapy, nondirective therapy and coping desensitization, respectively and reported similar results from these three conditions. Finally, Barlow, Rapee and Brown (1992) found that PR, cognitive therapy and the combination of these two all did better than a wait-list control condition. A development from PR called applied relaxation (AR; Öst, 1987) is a coping technique that has been found effective for panic disorder (Öst, 1988; Öst & Westling, 1995), agoraphobia (Öst, Westling & Hellström, 1993), social phobia (Öst, Jerremalm & Johansson, 1981) and specific phobia (Öst, Johansson & Jerremalm, 1982). In GAD it has only been tested in two studies so far. Tarrier and Main (1986) used a very brief treatment, a single 1 h session and reported that three components of AR did as well as the full treatment and all were better than a wait-list condition. In one of the methodologically best studies in the GAD area Borkovec and Costello (1993) compared AR, CBT (cognitive therapy + AR) and nondirective therapy in a study where 14 sessions were given during a 6-week period. AR and CBT did better than nondirective therapy.

Cognitive therapy (without behavioral components) did as well as a broad spectrum behavior therapy in a study by Durham and Turvey (1987), as well as progressive relaxation in the Barlow et al. (1992) study, as well as behavior therapy and CBT in the White, Keenan and Brooks (1992) study and better than psychodynamic therapy in a study by Durham et al. (1994). Cognitive behavior therapy (a combination of cognitive therapy and various forms of behavioral treatments) was found to be equal to anxiety management training (Lindsey, Gamsu, McLaughlin, Hood & Espie, 1987), equal to applied relaxation (Borkovec & Costello, 1993) and equal to supportive therapy in a geriatric sample (Stanley, Beck & Glassco, 1996). CBT was better than a stripped down form of behavior therapy (Butler, Fennell, Robson & Gelder, 1991) and better than nondirective therapy (Borkovec & Costello, 1993). Two studies have compared CBT with diazepam. Power, Jerrom, Simpson, Mitchell and Swanson (1989) found CBT equal to diazepam, but better than placebo, while diazepam did not differ from placebo. In a larger study Power, Simpson, Swanson and Wallace (1990) found CBT to be