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Cognitive therapy versus applied relaxation as treatment of generalized anxiety disorder

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Abstract

Cognitive therapy (CT) and applied relaxation (AR) as treatments of generalized anxiety disorder (GAD) were compared in a sample of 45 patients of a community mental health center, randomly allocated to condition. Patients were assessed before and after a 12-session treatment, and at one and six months follow-ups. There was a 20% drop out from CT and 15% from AR (NS), with some drop outs being considerably improved. Both completers and intention-to-treat analyses revealed that both treatments were effective (ESs of composite and specific measures ranging from 0.53 to 1.14). At one-month follow-up AR tended to do better than CT, with CT catching up with AR at six months. Recovery rates and proportions of patients showing reliable change were comparable to other studies on AR and CT, with 55% of CT and 53.3% of AR patients recovered on the STAI-trait at six-month follow-up. These results confirm that both CT and AR are effective treatments for GAD, and also that there is still room for improvement.

1. Introduction

Although a very common and chronic problem in the general population (lifetime prevalence 4.1–6.6%, Blazer, Hughes, George, Swartz, & Boyer, 1991; Kessler et al., 1994), generalized anxiety disorder (GAD) is not so frequently seen in mental health centers (e.g. approx. 4.3% of the patients from our center have GAD as a first diagnosis). Despite a relatively low prevalence of GAD at our center, we decided thirteen years ago to start a clinical trial, comparing what then seemed to be two of the most promising treatments for GAD, applied relaxation (AR) and cogni-

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tive therapy (CT). In the meantime, much more has become clear about the effects of various treatments for GAD.

Several studies have compared CT and cognitive-behavior therapy (CBT), based on the work of Beck and Emery (1985) with behavior therapy (BT) approaches (such as anxiety management training). In general, C(B)T was more effective than BT, especially in the long run (Butler, Fennell, Robson, & Gelder, 1991; Durham & Turvey, 1987; Durham, Murphy, Allan, Richard, Treliving, & Fenton, 1994). CBT has also been compared to benzodiazepines, and proved to be more effective both in the short and in the long term (Power, Jerrom, Simpson, Mitchell, & Swanson, 1989; Power, Simpson, Swanson, & Wallace, 1990). A recently developed CBT package specifically focussing at worrying was only compared to a waitlist condition (Ladouceur et al., 2000). AR, a treatment approach developed by several workers (Bernstein & Borkovec, 1973; Öst, 1987) also fared well in various clinical trials (Barlow, Rapee, & Brown, 1992; Borkovec & Costello, 1993), and has often been part of CBT programs (e.g. Borkovec & Costello, 1993; Power et al., 1990). According to DeRubeis and Crits-Cristoph (1998), only C(B)T has proved to be effective and specific, whereas AR has been proved to be effective. Only three studies directly compared these two approaches. One found no statistically significant differences, but had low statistical power (Barlow et al., 1992). The second found no significant differences immediately after treatment, but at 12-months follow-up CT seemed superior to AR (Borkovec & Costello, 1993). The third found the two approaches equally effective (Öst & Breitholtz, 2000).

In a recent overview of six controlled trials, Fisher and Durham (1999), using the STAI-trait as common measure, compared seven psychological treatments of GAD. Individual AR and individual C(B)T were found to be the most effective, and the most consistent in their positive effects, with about 63% recovered immediately after AR, and 48% after C(B)T. At a half year follow-up, 60% of the AR, and 51% of the C(B)T patients were recovered. Non-directive therapy, group C(B)T and group BT were moderately effective (31–38% recovery at half year follow-up), and individual BT (11%) and analytical psychotherapy the least (4% recovery). Thus, the present study is helpful as an independent test of whether the good results of AR and C(B)T achieved in other centers can be replicated, and as a much needed direct comparison of CT and AR.

A threat to external validity is the recruitment of subjects through media releases, and other ‘unnatural’ ways, as has been done in the typical GAD treatment study (e.g. recently by Ladouceur et al., 2000; Öst & Breitholtz, 2000). Two of the three previous studies directly comparing AR and CT for GAD used advertisements to recruit subjects (Borkovec & Costello, 1993; Öst & Breitholtz, 2000). By contrast, the GAD patients in the present study were not especially recruited for the study, but came from the regular population referred to a community mental health center. A second threat to external validity is the use of stringent exclusion criteria. In the present study most comorbid diagnoses were allowed, and many patients indeed had comorbid diagnoses. A third threat to validity is the investigation of a treatment developed by the researchers. The finding that researchers-alliance is related to stronger effects of the pertinent treatment, also called the “allegiance-effect”, is not uncommon (McNally, 1996). Independent replication is the best safeguard against this bias (in general, independent replication is the most essential, but sometimes undervalued, verification tool in science). A relevant example are three studies each comparing Clark and Salkovskis’ CT for panic disorder with Öst’s AR package in the treatment of panic disorder. Clark and coworkers found CT to be superior to AR (Clark et al., 1994), whereas Öst’s group found AR and CT equally effective (Öst & Westling, 1995). An independent replication