

A Randomized Clinical Trial of Cognitive-Behavioral Therapy and Applied Relaxation for Adults With Generalized Anxiety Disorder

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This randomized clinical trial compared cognitive-behavioral therapy (CBT), applied relaxation (AR), and wait-list control (WL) in a sample of 65 adults with a primary diagnosis of generalized anxiety disorder (GAD). The CBT condition was based on the intolerance of uncertainty model of GAD, whereas the AR condition was based on general

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theories of anxiety. Both manualized treatments were administered over 12 weekly 1-hour sessions. Standardized clinician ratings and self-report questionnaires were used to assess GAD and related symptoms at pretest, posttest, and at 6-, 12-, and 24-month follow-ups. At posttest, CBT was clearly superior to WL, AR was marginally superior to WL, and CBT was marginally superior to AR. Over follow-up, CBT and AR were equivalent, but only CBT led to continued improvement. Thus, direct comparisons of CBT and AR indicated that the treatments were comparable; however, comparisons of each treatment with another point of reference (either waiting list or no change over follow-up) provided greater support for the efficacy of CBT than AR.

THE DIAGNOSTIC FEATURES OF generalized anxiety disorder (GAD) have undergone extensive change over the past 20 years. Once thought of as a mild condition characterized by an expansive set of

anxious symptoms (*DSM-III*; American Psychiatric Association [APA], 1980), GAD is now recognized as a disabling disorder typified by excessive and uncontrollable worry (*DSM-IV-TR*; APA, 2000). Accordingly, psychological treatments for GAD have evolved from those based on a general understanding of anxiety (e.g., Suinn & Richardson, 1971) to those based on a specific conceptualization of pathological worry (e.g., Roemer & Orsillo, 2007). Although it is sometimes assumed that the recently developed interventions lead to better outcomes than the earlier treatments, the data thus far have not been convincing.

Of all general anxiety-reduction strategies, applied relaxation (AR) has received the most empirical support in the treatment of GAD. In fact, AR has been identified as one of the few empirically supported treatments for GAD (see Chambless et al., 1998; Chambless & Ollendick, 2001). Given its long history and demonstrated efficacy, AR has often been compared to other anxiety-reduction strategies (see Arntz, 2003; Barlow, Rapee, & Brown, 1992; Öst & Breitholz, 2000). Taken together, the extant data clearly support the efficacy of AR for the treatment of GAD in terms of diagnostic severity, worry, anxiety, depression, and general psychopathology.

Recently developed treatments for GAD differ from earlier ones (such as AR) in that they specifically target the cognitive, behavioral, and emotional processes thought to underlie pathological worry. To our knowledge, Borkovec and Costello (1993) are the only researchers who have compared a GAD-specific form of cognitive-behavioral therapy or CBT (based on the avoidance model of worry) to AR alone. Although other trials have included GAD-specific forms of CBT and AR (e.g., Borkovec, Newman, Pincus, & Lytle, 2002), these trials have combined AR with other treatment strategies such as self-control desensitization. Thus, only the Borkovec and Costello study allows for a direct comparison of GAD-specific CBT and AR. Overall, the results show that CBT and AR were equivalent at posttreatment and that both conditions led to the maintenance of treatment gains, with some evidence of further gains in CBT.

Like Borkovec and others (e.g., Roemer & Orsillo, 2007; Wells, 2006), our group has developed a treatment for GAD that is based on a conceptualization of pathological worry. Namely, our cognitive model posits that intolerance of uncertainty (a dispositional characteristic resulting from negative beliefs about uncertainty and its implications) plays a central role in the etiology of GAD by leading to biased cognitive processing. The model also underscores the role of positive beliefs

about worry, negative problem orientation, and cognitive avoidance (see Dugas & Koerner, 2005, for a review). Accordingly, our treatment targets the aforementioned cognitive factors and ultimately attempts to aid individuals with GAD to develop beliefs about uncertainty that are less negative, rigid, and pervasive. To date, the treatment has been tested in three randomized clinical trials. The first study (Ladouceur et al., 2000) revealed that the CBT protocol was superior to a wait-list control condition on all outcomes. More importantly, the short- and long-term outcomes were at least as good as the best outcomes reported in the treatment literature for GAD (for reviews, see Covin, Ouimet, Seeds, & Dozois, 2008; Gould, Safren, O'Neill, & Otto, 2004). The second study (Dugas et al., 2003) compared the treatment delivered in a group format to wait-list control. Although the findings were similar to those obtained in the first trial, one important difference emerged: not only were treatment gains maintained over the follow-up period, level of worry *decreased* from posttreatment to 24-month follow-up. Finally, the third study (Gosselin, Ladouceur, Morin, Dugas, & Baillargeon, 2006) contrasted the treatment to nondirective therapy in terms of their impact on medication discontinuation in long-term benzodiazepine users. Overall, the treatment was more effective than nondirective therapy in helping patients discontinue their use of benzodiazepines. In addition, relative to nondirective therapy, the treatment led to greater gains in terms of diagnostic remission and symptomatic improvement.

Although the findings presented above are encouraging, the treatment has yet to be compared to a directive and active treatment. Consequently, the main goal of this study was to compare the CBT protocol to AR in terms of its short- and long-term benefits and to replicate the superiority of both treatments to a wait-list control condition. Given that AR (a) is an empirically supported treatment for GAD (Chambless et al., 1998; Chambless & Ollendick, 2001); (b) is one of the most commonly administered nonpharmacological interventions for GAD (Turner, Beidel, Spaulding, & Brown, 1995); and (c) does not include components that overlap with those of our CBT protocol (Dugas & Robichaud, 2007), it was chosen as the comparison treatment condition for the current study. To address the study's main goal, we used three experimental conditions: cognitive-behavioral therapy (CBT), applied relaxation (AR), and wait-list control (WL). The hypotheses were as follows:

1. Both active treatments would be superior to wait-list at posttest.

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