

# A Randomized Clinical Trial of Transdiagnostic Cognitive-Behavioral Treatments for Anxiety Disorder by Comparison to Relaxation Training

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Transdiagnostic cognitive-behavioral treatments (CBT) for anxiety disorders have been gaining increased attention and empirical study in recent years. Despite this, all of the research on transdiagnostic anxiety treatments to date have either not used a control condition, or have relied on no-treatment or delayed-treatment controls, thus limiting inferences about comparative efficacy. The current study was a randomized clinical trial examining the efficacy of a 12-week transdiagnostic cognitive-behavioral group treatment in comparison to a 12-week comprehensive relaxation training program. Results from 87 treatment initiators suggested significant and statistically equivalent/noninferior outcomes across conditions, although relaxation was associated with a greater rate of dropout despite no differences in treatment credibility. No evidence was found for any differential effects of transdiagnostic CBT for any primary or comorbid diagnoses.

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THE RELEASE OF DSM-III in 1980 (American Psychiatric Association, 1980) with its increased diagnostic classification yielded a new era of increasingly focused psychosocial and pharmacological treatment models designed to specifically target the individual

diagnoses. This has been particularly notable within the domain of anxiety disorders, as DSM-III expanded the classification structure from three anxiety-related neuroses to nine distinct diagnoses. Subsequent revisions (American Psychiatric Association, 1987, 1994) have revised and expanded the specificity of the diagnostic system such that there are 12 anxiety disorder diagnoses and over 25 subtypes and specified categories. Treatments designed specifically for these diagnoses (e.g., Andrews, Crino, Hunt, Lampe, & Page, 1994; Craske, Antony, & Barlow, 1997; Craske & Barlow, 2006; Craske, Barlow, & Zinbarg, 1992; Foa & Kozak, 1997; Hope, Heimberg, Juster, & Turk, 2000; Resick & Schnicke, 1993), particularly cognitive-behavioral treatments (CBTs), arose quickly and are currently seen as the most efficacious and effective interventions for these diagnoses (Hofmann & Smits, 2008; Norton & Price, 2007).

Although the efficacy of these diagnosis-specific anxiety treatments is very well established (e.g., Norton & Price, 2007), concerns have been raised about whether the increase in anxiety disorder diagnoses has led to more efficacious treatments tailored or delivered to specific diagnoses. Indeed, Tyrer et al. (1988) critiqued the diagnostic system by showing that identical pharmacological and CBTs did not differentially impact patients with varied DSM-III anxiety disorder diagnoses. Subsequently, several researchers and teams have generated an impressive body of genetic (Jang, 2005), etiological (Chorpita & Barlow, 1998; Clark & Watson, 1991), comorbidity (Brown, Campbell, Lehman, Grisham, & Mancill, 2001), and treatment (Borkovec, Abel, & Newman, 1995; Brown, Antony, & Barlow, 1995) evidence suggesting that anxiety disorders either share a common underlying

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element or are superficially different manifestations of the same pathology; that is, fears of contamination and arachnids are both simply fears, and their corresponding behavioral manifestations (washing vs. escape) are stimulus-appropriate approaches to minimize or negate the perceived threat (for reviews, see [Moses & Barlow, 2006](#); [Norton, 2006](#)).

From this conceptualization, several independent laboratories have begun to develop transdiagnostic, unified, or broad-spectrum interventions designed to tailor treatment to the alleged core pathology underlying anxiety disorder while dismissing the necessity of specific diagnostic categories (e.g., [Erickson, 2003](#); [Erickson, Janeck, & Tallman, 2007](#); [Norton, 2008](#); [Norton, Hayes, & Hope, 2004](#); [Norton & Hope, 2005](#); [Lumpkin, Silverman, Weems, Markham, & Kurtines, 2002](#); [Schmidt, Buckner, Pusser, Woolaway-Bickel, & Preston, 2012-this issue](#)). While similar to diagnosis-specific CBT for anxiety disorders in content and presumed mechanism of action, transdiagnostic CBT programs differ from diagnosis-specific CBT in their delivery; that is, CBT protocols that can be delivered to individuals or groups experiencing a range of anxiety presentations. Indeed, within the child anxiety literature, CBT protocols that are not bound to specific diagnoses have been commonplace for decades (e.g., [Kendall, 1990](#)). Among the most empirically evaluated of the adult transdiagnostic CBT protocols was developed by [Norton and Hope \(2002\)](#). [Norton and Hope \(2005\)](#) published the first randomized controlled trial of a 12-week transdiagnostic group treatment and found that, compared to wait-list controls ( $n=11$ ), clients receiving treatment ( $n=12$ ) improved significantly. Roughly 67% of those receiving treatment, as compared to none of the wait-list controls, showed a reduction in diagnostic severity to subclinical levels, and significant improvement was also noted on several indices of anxiety. Unfortunately, the small sample size of this study ( $n=23$ ) precluded analyses of outcome by diagnosis. In a secondary analysis of the treatment data, [Norton et al. \(2004\)](#) also noted significant decreases in depressive symptoms and the diagnostic severity of depressive disorders among those receiving treatment. Recently, [Norton \(2008\)](#) reported the results of an open trial of the transdiagnostic group CBT using mixed-effects regression modeling of session-by-session anxiety data from 52 participants with an anxiety disorder (predominantly panic disorder [42.3%] and social phobia [48.1%]). Results indicated that participants tended to improve over treatment, with no differential outcome for any primary or comorbid diagnoses. Effect sizes were very high ( $d=1.68$ ) and comparable to average treatment effects reported in meta-analyses of diagnosis-

specific CBT for the anxiety diagnoses (see [Hofmann & Smits, 2008](#); [Norton & Price, 2007](#)).

In addition, other research centers have begun to develop and empirically evaluate the efficacy of independent group and individual transdiagnostic treatments. [Erickson \(2003\)](#), for example, reported the results of an uncontrolled trial of a transdiagnostic group CBT program for 70 individuals with an anxiety disorder diagnosis. His results suggested significant decreases in self-reported anxiety and depression among clients completing the 11-week treatment. Further, 6-month follow-up data from 16 participants suggested maintenance of treatment gains. No analyses of outcome by diagnosis were conducted. [Erickson et al. \(2007\)](#) then randomized 152 patients to either an 11-week group CBT program or a delayed treatment control condition. The immediate treatment group improved more than the delayed treatment controls. When diagnostic categories were examined separately, however, only patients with primary panic disorder showed greater improvement than controls, possibly due to the reduced sample sizes of these subgroup analyses. [Lumpkin et al. \(2002\)](#) reported similar treatment effects following a 12-week transdiagnostic individual treatment with anxious youths. Multiple baseline results suggested notable reductions on measures of anxiety occurring during treatment after stable baseline periods. As well, treatment gains were maintained at 6 and 12 months. Again, no analyses by diagnosis were conducted.

In the outcome trial using the highest standard of comparison to date, [McEvoy and Nathan \(2007\)](#) utilized a benchmarking strategy—comparing observed effect sizes to those obtained from methodologically similar studies—to compare the efficacy of their transdiagnostic CBT intervention for anxiety and depression to similar published efficacy trials. Data from 143 participants attending at least three sessions (30 with anxiety disorders, 38 with depressive disorders, 75 with comorbid anxiety and depressive disorders) indicated treatment effect sizes, reliable change indices, and clinically significant change indices that were highly similar to those obtained in methodologically similar diagnosis-specific treatment studies for major depressive disorder or specific anxiety disorder diagnoses.

Overall, the published and unpublished data reported thus far converge on the conclusion that participants undertaking transdiagnostic treatment programs for anxiety disorders show significant improvement, and that such change is greater than that experienced by control participants not receiving treatment (see [McEvoy, Nathan, & Norton, 2009](#)). Indeed, [Norton and Philipp \(2008\)](#) reported a meta-analysis on the efficacy of transdiagnostic

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