Cognitive-Behavioral Therapy for Late-Life Generalized Anxiety Disorder: Who Gets Better?

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The authors pooled data from three independently conducted treatment outcome studies to examine predictors of outcome from group-administered cognitive-behavioral therapy (CBT) for older adults with generalized anxiety disorder (GAD). Data were collected from 65 patients with a mean age of 67.7 years (*SD* = 6.6). Average reliable change indices (RCI) based on 3 outcome measures were calculated at posttreatment and at 6-month follow-up. Approximately half of patients achieved a significant RCI at posttreatment and two-thirds achieved a significant RCI at follow-up. Factors associated with better outcomes included better homework adherence, higher baseline GAD severity, and presence of a comorbid psychiatric diagnosis. Results suggest that at-home practice is associated with better and longer-lasting outcomes from CBT in older adults with GAD.

GENERALIZED ANXIETY DISORDER (GAD) may affect three times as many older adults as does major depression (Beekman et al., 1995; Beekman et al., 1998). Among older people, anxiety symptoms and disorders, including GAD, are associated with physical limitations and disability, poorer self-reported health and well-being, and increased use of medical specialists and benzodiazepine medications (De Beurs et al., 1999; Wetherell, Thorp, et al., 2004). Psychotherapeutic treatment, particularly cognitive-behavioral therapy (CBT), has been demonstrated to be effective with younger adults, and several randomized controlled trials have investigated the efficacy of group and individual CBT for late-life GAD (Gorenstein et al., in press; Mohlman et al., 2003; Stanley, Beck, & Glassco, 1996; Stanley, Beck, et al., 2003; Wetherell, Gatz, & Craske, 2003). Although these studies have shown clinically as well as statistically significant reductions in mean levels of anxiety symptoms, most participants remain in the clinical range on measures of psychopathology even after treatment.

Research on psychotherapy for late-life anxiety is important because many older adults report a preference for psychotherapeutic treatment rather than medications (Wetherell, Kaplan, et al., 2004). Furthermore, benzodiazepines continue to be frequently prescribed for late-life anxiety despite associated dangers, supporting the need for empirically tested nonpharmacological interventions (Klap, Unroe, & Unützer, 2003). Investigations of factors predicting outcome from psychotherapy are important in order to suggest mediators or mechanisms of treatment response, which may lead to modifications to enhance the effectiveness of psychotherapy for late-life anxiety.

Demographic variables, clinical variables, baseline symptomatology, and treatment factors have been associated with treatment outcome in younger adults with GAD and similar disorders. In a study of individuals diagnosed with GAD, panic disorder, or dysthymia, for example, poorer prognosis was associated with older age, earlier onset, and the presence of personality disorder or "general neu-

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rotic syndrome" (Seivewright, Tyrer, & Johnson, 1998). In a reanalysis of data from Durham and Turvey (1987), therapeutic outcome was worse for behavior therapy patients with GAD who were taking benzodiazepines, although there was no relationship between drug status and improvement for cognitive therapy patients (Wardle, 1990).

Butler (1993; Butler & Anastasiades, 1988) reported better outcome for less anxious and more depressed patients in behavior therapy and CBT, although these results were not replicated in a subsequent study incorporating a similar patient sample and treatment protocol (Butler, Fennell, Robson, & Gelder, 1991). Butler (1993) also reported an inverse relation between the chronicity of GAD and positive response to psychotherapy, regardless of treatment method. Compared with analytic psychotherapy and anxiety management training, younger adults with GAD may be more responsive to cognitive therapy, particularly if they are married and have no coexisting Axis I psychological disorders (Durham, Allan, & Hackett, 1997). Interestingly, in contrast to the findings of Butler and colleagues (Butler, 1993; Butler & Anastasiades, 1988), these researchers found no relation between treatment outcome and pretreatment severity of anxiety as assessed with the Hamilton Anxiety Rating Scale (Hamilton, 1959). Finally, expectancy for improvement has also been associated with better outcome from CBT for GAD (Borkovec & Costello, 1993). Considering the equivocal findings in the younger adult literature and the absence of analogous research among older cohorts of patients with GAD, further exploration of variables associated with treatment outcome is warranted to identify factors that may predict success for anxious older adults treated with CBT.

The current study represents a pooled analysis of data from three recent trials of CBT for GAD in older people (Stanley et al., 1996; Stanley, Beck, et al., 2003; Wetherell et al., 2003). We examined predictors of outcome immediately after treatment and at 6-month follow-up in 65 adults over the age of 55 who completed 12 to 15 weeks of group-administered CBT. In addition to exploring factors that have demonstrated a positive relation to treatment outcome in younger adults with GAD (e.g., pretreatment anxiety and depression severity, comorbid Axis I disorders, marital status, expectancy, homework adherence), we also investigated variables that might be more specific to understanding treatment outcome in an older adult cohort (e.g., cognitive impairment).

Because this study represents the first investigation of predictors of outcome in a sample of older adults completing psychotherapeutic treatment for anxiety, we included a wide variety of potential predictors in the analyses. To reduce the number of analyses performed, we classified predictors into four groups: demographics, clinical variables, baseline levels of anxiety and depressive symptoms, and treatment variables. Results should be interpreted as exploratory and will require independent replication.

Method

PARTICIPANTS

Participants included 65 older adults with GAD who completed group CBT in independently conducted treatment outcome studies in Houston, Texas (Stanley et al., 1996, $n = 18$; Stanley, Beck, et al., 2003, $n = 29$) and Los Angeles, California (Wetherell et al., 2003, $n = 18$). Participants were recruited through media advertisements, hospital-affiliated health education programs, and community and religious groups (Akkerman et al., 2001; Wetherell & Gatz, 2001). Attrition rates for the CBT condition from the parent treatment studies were 26% for Stanley, Beck, et al. (2003) and 31% for both Stanley et al. (1996) and Wetherell et al. (2003). Eligible participants had a principal or co-principal diagnosis of GAD according to *DSM-III-R* or *DSM-IV* criteria (American Psychiatric Association, 1987, 1994) that was based on administration of the Anxiety Disorders Interview Schedule for DSM-III-R or DSM-IV (ADIS-R; DiNardo & Barlow, 1988; ADIS-IV; DiNardo, Brown, & Barlow, 1994). Reliability of the diagnostic interviews was adequate across all three studies, as assessed by blind review of videotapes (Stanley et al., 1996: kappa = 1.00; Stanley, Beck, et al., 2003: kappa = .78), audiotapes (Wetherell et al., 2003: kappa = .75), and multiple administrations (Stanley, Beck, et al., 2003: kappa = .60).

Exclusion criteria were age under 60 (Stanley, Beck, et al., 2003) or 55 (Stanley et al., 1996, and Wetherell et al., 2003), history of mania or psychosis, cognitive impairment as indicated by a score of less than 23 (Stanley et al., 1996), 24 (Wetherell et al., 2003), or 25 (Stanley, Beck, et al., 2003) on the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975), current participation in psychotherapy, and current alcohol or other substance abuse. With regard to psychotropic medication, in the Texas studies, participants were asked to discontinue antianxiety or antidepressant medication under supervision of the prescribing physician at least 2 weeks prior to the initial diagnostic interview. Exceptions were made for individuals taking occasional sedative-hypnotic medication for sleep problems (e.g., less than four times per week), low levels of psychotropic medication

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