

UNIVERSIDADE CATÓLICA DE PELOTAS  
ESCOLAS DE MEDICINA E PSICOLOGIA  
MESTRADO EM SAÚDE E COMPORTAMENTO

A EFICÁCIA DAS PSICOTERAPIAS COMO FORMA DE TRATAMENTO DO  
TRANSTORNO DE ANSIEDADE GENERALIZADA:  
REVISÃO SISTEMÁTICA E METANÁLISE

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*A Deus que jamais abandona  
àqueles que necessitam de sua ajuda.*

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## 1 - INTRODUÇÃO

Contextualizando

A ansiedade é tida, consensualmente, como uma função normal e adaptativa em determinada “quantidade”. Quando patológica, pode ser caracterizada por “um sentimento de temor acompanhado por sinais somáticos de hiperatividade do sistema nervoso autônomo (...)” (Kaplan & Sadock, 1998).

De acordo com os critérios da Classificação de Transtornos Mentais e de Comportamento da CID-10 (Classificação Internacional de Doenças - 10), o transtorno de ansiedade generalizada inclui aqueles que apresentam sintomas e queixas de sentimentos contínuos como nervosismo, tremores, tensão muscular, sudorese, sensação de cabeça leve, palpitações, tonturas e desconforto epigástrico. Além disso, o paciente deve apresentar estes sintomas na maioria dos dias e por pelo menos várias semanas ou meses, envolvendo ainda elementos de apreensão, tensão motora e hiperatividade autonômica.

Os transtornos de ansiedade estão entre os transtornos mais comuns na população e nos serviços de atenção primária. Estes transtornos carregam uma carga substancial de angústia e prejuízos comparados a transtornos crônicos.

Estima-se que cerca de  $\frac{1}{4}$  da população geral já sofreu de algum transtorno de ansiedade (Robins, 1991). Dentre estes, o transtorno de ansiedade generalizada é tido como o mais comum, atingindo ao ano cerca de 3% da população geral (Kessler, 1994).

Na cidade de Pelotas, Rio Grande do Sul, de acordo com estudo transversal realizado por Motta (2000), a prevalência ao ano encontrada para este transtorno chegou a atingir 6,2% da população estudada.

Este transtorno atinge em sua maioria, mulheres. Conforme estudo populacional realizado nos EUA, Kessler (1994) relata que enquanto a prevalência de vida é de 3,6% para o sexo masculino, este índice é de 6,6% para as mulheres.

Sobre os dados de comorbidade, Stein (2001) informa que em settings psiquiátricos cerca de 80 a 90% dos pacientes com TAG têm algum outro diagnóstico em comorbidade. Em contrapartida, alguns estudos conduzidos na comunidade, sugerem que a comorbidade é um preditor de procura dos serviços de saúde e, quando esta taxa apresenta-se muito alta pode ser um reflexo de viés de seleção (Kessler 2000).

Em estudo clínico randomizado com idosos, Stanley (2003) encontrou que 65% dos participantes tinham pelo menos um diagnóstico coexistente. Já entre adultos de 18-65 anos, Durham (1994), encontrou que 80% dos 110 pacientes incluídos em seu estudo clínico apresentavam ao menos um diagnóstico adicional. Neste caso, os diagnósticos em comorbidade mais comuns foram agorafobia, transtorno de pânico, fobia social e distímia (tendo tido cada um destes diagnósticos em média 20% de prevalência).

#### Início e curso da doença

Em revisão sistemática realizada por Kessler (2000), os estudos sobre a idade de instalação da doença sugerem que a maioria das pessoas com TAG têm seus primeiros sintomas do final da adolescência até o começo da terceira década de vida.

O curso costuma ser crônico e recidivante. As taxas de reaparecimento da doença foram iguais a 27% em estudo longitudinal realizado nos Estados Unidos com 167 pacientes portadores de TAG (Yonkers, 2000).

Alguns estudos clínicos randomizados incluíram dados sobre seus pacientes que reportaram o tempo médio de duração da doença. Em UK, Durham (1994) registra que os sujeitos incluídos mencionaram que sofriam de TAG em média há 30 meses (variando de 6-360 meses). Já Ladouceur (2000) encontrou em sua amostra canadense uma média de 15,6 anos de duração da doença. Através destes dados pode-se inferir que o TAG pode incapacitar seus sofredores durante anos.

Yonkers (2000), após cinco anos de estudo, concluiu que a diminuição da probabilidade de melhora do transtorno de ansiedade generalizada estava associada com o baixo nível de satisfação de vida, relações de casal ou de família pobres, um grupo concomitante de transtorno de personalidade, e uma pontuação baixa na avaliação global do paciente. Ainda informa que as probabilidades de remissão completa e parcial em cinco anos foram de 38 e menos de 50% respectivamente.

Kessler (2000) afirma que as implicações da ansiedade generalizada no curso da depressão maior ainda são pouco conhecidas, sendo necessário maiores investigações, já que é sabido que muitos pacientes que sofrem de depressão maior já sofreram, em algum momento de sua vida, de TAG. A identificação e tratamento precoce deste quadro poderiam talvez prevenir a ocorrência de depressão maior.

#### Utilização de Serviços de Saúde

Os resultados encontrados na revisão de Kessler (2000), dão suporte à idéia de que TAG como distúrbio independente, pode ser considerado o maior problema de saúde pública, pois sua magnitude para incapacitar é comparável à encontrada nos casos de depressão maior.

Este quadro ainda é tido como o transtorno mais comum em atenção primária e em pacientes com transtornos médicos crônicos (Stein, 2001). Uma alta taxa de utilização de serviços de saúde está associada com o TAG, sendo que a maioria consulta em serviços de clínica geral. Quando em comorbidade, aproximadamente 68% destes indivíduos procuram tratamento contra 48% daqueles que sofrem exclusivamente de TAG (Lépine 2002).

O longo tempo de duração da doença já citado no item anterior sugere que, quanto mais tempo o sujeito estiver incapacitado por sua ansiedade, maiores serão também os custos para a sociedade.

Ladoucer (2000) descreve que em sua pequena amostra de 26 pacientes com TAG, 20 deles relataram que já haviam buscado um profissional da área de saúde anteriormente. Embora sua amostra fosse pequena, em outro estudo clínico randomizado, Durham (1994) encontrou em sua amostra de 110 participantes, um índice de 51% de pessoas com TAG que já havia procurado ou estava em algum tratamento psiquiátrico.

Além disso, este mesmo estudo informa que 66% dos pacientes estavam tomando alguma medicação psicotrópica (ansiolíticos e/ou antidepressivos). Ainda acrescenta que 31% da amostra relatou o uso regular de álcool como uma forma de aliviar os sintomas de ansiedade.

Estes dados remetem a uma preocupação do quanto este transtorno pode gerar custos para os serviços de saúde, já que se trata de um quadro que em geral vem acompanhado por outras doenças, em que seus sofredores buscam tratamento por diversas vezes e que, ainda pode acarretar no desencadeamento de outros problemas (como abuso de álcool e incapacitação para realização de atividades diversas).

## Tratamento

Várias formas de tratamento têm sido descritas para o tratamento de TAG e, em busca da remissão dos sintomas, as psicoterapias têm sido muito utilizadas.

Roth & Fonagy (1996) estudaram as diversas formas sobre psicoterapias na tentativa de estudá-las. Neste trabalho, é possível observar a dificuldade em definir os diversos tipos de psicoterapias, em avaliar sua eficácia e suas implicações. Entretanto, encontraram em diversos estudos evidências que sugerem que pacientes com transtornos mentais leves a agudos, sem comorbidade, podem ter seus sintomas amenizados através de tratamentos psicoterápicos breves. Sendo assim, as psicoterapias podem ser uma alternativa aos serviços de saúde.

Em revisão sobre tratamentos psicossociais para transtorno de ansiedade generalizada, Barlow (In: Nathan & Gorman, 2002), observa que diferentes condições de tratamento têm sido estudadas sem apontar grandes diferenças entre os índices de melhora e que, já em outros estudos, os tratamentos ativos são superiores às abordagens não-diretivas e uniformemente superiores ao não-tratamento. Ainda informa que alguns trabalhos sugerem que exercícios de relaxamento combinados à terapia cognitiva, com o objetivo de trabalhar o processo de preocupação, apresentam maior êxito nos resultados. Entretanto, esta revisão não relata os métodos ou procedimentos utilizados para seu desenvolvimento.

Gould (1997), ao realizar revisão sobre a terapia cognitivo-compartamental e tratamento farmacológico para o TAG, não encontrou diferenças estatisticamente significativas entre a eficácia da intervenção psicoterápica e farmacológica. Entretanto, este trabalho não relata quais critérios foram considerados para a inclusão dos estudos, ou mesmo se foi utilizado algum método para avaliação da qualidade dos mesmos.

## Levantando dados sobre a eficácia das psicoterapias

Conforme visto, alguns trabalhos têm procurado levantar a eficácia das psicoterapias no tratamento de ansiedade generalizada. Apesar disso, estes estudos não são claros quanto aos métodos utilizados para a realização dos mesmos, diminuindo a confiabilidade de seus dados.

A revisão sistemática tem sido utilizada com êxito em muitas áreas na avaliação de intervenções, tendo inclusive rompido com alguns conceitos sobre a eficácia de determinados tratamentos que já eram usualmente utilizados na prática clínica.

Este método propõe aprimorar e sistematizar a busca dos artigos científicos de uma maneira a diminuir o viés de publicação e a possibilidade de se perder dados. Além disso, envolve todo um processo de avaliação da qualidade metodológica dos estudos a serem incluídos na revisão, restringindo a chance de estudos com vieses serem comparados a outros de qualidade superior.

Os autores ainda devem buscar o contato com aqueles pesquisadores que por um motivo ou outro não tenham apresentado todos os dados necessários para sua avaliação. Este procedimento promove uma maior interação entre diferentes ambientes científicos e também divulga a revisão, o que pode facilitar a aquisição de novos estudos, incluindo aqueles ainda em andamento ou não publicados.

Não obstante, este método permite comparações que exigem uma avaliação prévia sobre a possibilidade delas ocorrerem, já que as diferenças entre os estudos podem confundir os resultados finais. Estas comparações geram então, quando possível, o que se chama de metanálise, processo pelo qual os dados de diversos estudos são cruzados permitindo uma análise com maior poder estatístico.

### 3. ARTIGO CIENTÍFICO

#### **Psychotherapies for Generalized Anxiety Disorder**

Authors: Vanessa Andina Teixeira, Maurício Silva de Lima, Flávio Kapczinski

##### **Abstract**

##### Background

Generalized anxiety is a common mental disorder and has a prevalence of 5,1% for lifetime (Kessler, 1994 and Meltzer, 1995). The comorbidity between GAD and major depression is common and the people with this comorbidity report that GAD has the onset before of depression, predicting the subsequent onset of depressive symptoms and other disorders (Kessler, 2000). An early intervention and treatment of primary GAD would prevent such outcome.

##### Objectives

To conduct a systematic review of RCTs on psychotherapy in the treatment of generalized anxiety disorder and to perform a meta-analytic synthesis of the studies whenever possible.

##### Search strategy

Electronic searches of Cochrane Library, EMBASE, MEDLINE, and LILACS; reference searching; personal communication; conference abstracts; book chapters, were the sources of relevant trials.

##### Selection criteria

The inclusion criteria for all randomized-controlled trials were that they should focus on psychotherapy interventions for treating generalized anxiety disorder.

##### Data collection & analysis

Reviewers extracted the data independently. Relative Risks, weighted mean difference and number needed to treat were estimated, when possible. The

reviewers assumed that people who died or dropped out had no improvement (intention to treat analysis).

### Main results

The evidence from 8 small sample-sized studies suggested that Cognitive-Behaviour Therapy (CBT) was more effective than waiting list groups in almost all continuous outcomes. When CBT was compared to Behavior Therapy the difference was statistically significant only in one continuous outcome. CBT did not show significant differences versus Anxiety Management Training (AMT), as well in comparison with any benzodiazepine. In addition, CBT also did not present statistically significant superiority when compared to the discussion group (DG), both interventions with older adults as participants. However, when CBT was compared to Minimal Contact Group (MCC), with older adults, in three outcomes it was possible to observe statistically significant differences favouring CBT group. The Cognitive Therapy (CT) showed advantage over Anxiety Management Training (AMT), Analytic Psychotherapy (AP) and Waiting List group (WL) in some continuous outcomes. The combined form of Cognitive Restructuring and Progressive Muscle Relaxation (COM) showed superiority only in one outcome when compared to a waiting list group.

### Reviewers' conclusions

In general, a limited number of trials with small sample sizes suggested that the cognitive-behavior treatment and cognitive therapy are the best alternatives for patients suffering of generalized anxiety. However, although CBT intervention has been the mostly studied form of treatment, there is yet doubt about the efficacy of the CBT in front of other interventions, since it did not present the same results when compared to them. Concerning the CT intervention, only two trials assessed this form of treatment, but it was not possible to perform a meta-analysis due the differences between them.

Trials with larger samples and longer follow-up periods are necessary to allow the investigation about the real effectiveness of the interventions. It is also important to consider the duration of treatments and the number of sessions. Furthermore, the

participants should be selected by predicting if the result could be suffering of a confounding bias (like use of medications, sex) and it is also necessary to consider, differences as the duration of the disorder and the presence of comorbid cases. Questions about the interference of these differences on the efficacy of the psychotherapies should be explored further.

## **Backgroud**

Anxiety is consensually considered as a normal and adaptive function to some extent. When pathological, it can be characterized by "a feeling of fear along with somatic symptoms of hyperactivity of the autonomous nerve system (...)" (Kaplan & Sadock, 1998).

According to the Mental and Behavioral Disorders Classification on ICD-10 (International Classification of Diseases-10), the generalized anxiety disorder includes muscular tension, sweating, palpitations, dizziness and epigastric discomfort. Furthermore, the patient must present these symptoms most of the days and for at least several weeks or months, showing yet evidence of apprehension, tension, and autonomic hyperactivity.

On the other hand, authors of the DSM-III included the generalized anxiety disorder in a category which diagnosis is not done when either symptoms such as phobia, panic, obsessive-compulsive disorder or other physical or mental disorders are present, being a residual category. Anxiety disorders are among the most common mental disorders in the population and primary care settings, being estimated that  $\frac{1}{4}$  of the general population has experienced these disorders at some point of their lives (Robins & Regier, 1991). They suffer a significant load of agony disorder when compared to other chronic disorders. Generalized anxiety is the most common among them, having a prevalence of up to 3% in the general population (Kessler, 1994 and Meltzer, 1995).

Based on a systematic review, Kessler (2000), states that even as an independent disorder, the generalized anxiety has a disabling capacity comparable to that of major depression cases, and these findings support the idea that it is the major problem of public health. To better investigate the implications of generalized anxiety on the course of major depression is necessary, because as it is known

that it appears first. Its identification and early treatment might prevent the occurrence of major depression.

Different psychosocial treatments are commonly used as a treatment for GAD, and many of them have proven to be effective when compared to other ways of treatment.

## **Objectives**

(1) To investigate the efficacy and acceptability of psychotherapies in the treatment of generalized anxiety disorder;

(2) To perform a meta-analytic synthesis of the studies whenever possible.

## **Criteria for considering studies for this review**

### Types of studies

All relevant randomized controlled trials which compared psychological treatments to placebo or another active treatment, including other psychotherapy or medications.

### Types of participants

People with any primary diagnosis of anxiety disorders, irrespective of gender, age, race or nationality.

Exclusion criteria: studies where anxiety disorder was secondary to other disorders.

### Types of interventions

1- Any psychological treatment, such as Cognitive therapy; Behavioural therapy; Cognitive behavioural therapies; Psychodynamic therapies\*.

2- Pharmacological treatments

3- Placebo

4- No intervention

5- Another psychotherapy

\* When the psychotherapy was associated to a medication or placebo the study will not be included.

## Types of outcome measures

Primary outcome of interest were:

1) Generalized anxiety changes at the end of trial:

(a) Treatment response as defined in the studies (absence of sufficient symptoms to meet diagnostic criteria for generalized anxiety disorder; score of 'very much improved' or 'much improved' on CGI scale);

(b) Improvement rates in the symptoms of generalized anxiety on any anxiety scale (continuous);

(c) Group mean scores on Hamilton Anxiety Scale (HAM-A).

2) Acceptability of the treatment as measured by:

(a) The number of people dropping out during the trial and post randomisation exclusions;

(b) The number of subjects reporting at least one side-effect during the trial;

(c) Specific side-effects.

3) Relapse.

4) Quality of life measures: average change on any scale at the end of treatment.

## Search strategy for identification of studies

### 1. Electronic databases:

The following electronic databases were searched:

- The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register (CCDANCTR);
- The Cochrane Controlled Clinical Trials Register (CCTR);
- MEDLINE (1966-2002-3);
- LILACS(1982-2002-3).

The Embase and Lilacs searches also act as a quality assessment whereby the comprehensiveness and completeness of the two Cochrane registers were evaluated.

#1 ANXIETY

#2 ANXIETY-DISORDERS\*

#3 ANXIOUS

#4 EXP ANXIETY

#5 EXP ANXIETY DISORDERS

#6 EXP ANXIETY/ OR EXP ANXIETY DISORDERS

#7 EXPLODE "ANXIETY-DISORDERS"

#8 GENERALISED ANXIETY

#9 GENERALIZED ANXIETY

#10 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9

# 11 ALTERNATIVE-THERAPY

#12 BEHAVIOR-THERAPY

#13 BEHAV\* THERAPY

#14 BIOFEEDBACK

#15 COGNITIVE-BEHAVIOR-THERAPY

#16 COGNITIVE-THERAPY

#17 PSYCHOANALYTIC-THERAPY

#18 PSYCHOTHERAPY

#19 PSYCHOTHERAP\*

#20 REHABILITATION

#21 RELAXATION-THERAPY

#22 SOCIAL-INTERVENTION

#23 STRESS-MANAGEMENT

#24 THERAPY

#25 PLACEBO  
 #26 PLACEBO\*  
 #27 PLACEBO\* AND ((EITHER OR ENTWEDER) OR (TREAT\* OR BEHAND\* OR UNTERSUCH\*))  
 #28 PLACEBOS AND CONTROLS  
 #29 SUPPORTIVE-EXPRESSIVE THERAPY  
 #30 THERAPEUTIC COMMUNITY  
 #31 CONFRONTATIONAL INTERVENTIONS  
 #32 GENERAL COUNSELING  
 #33 SOCIAL SKILLS TRAINING  
 #34 COPING SKILLS

#35 #11 or #12 or #13 or #14 or #15 or #16 or #17 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34

#36 ALEATORIS OR CASUAL OR ACASO OR AZAR  
 #37 BLIND\*  
 #38 CLINIC\*  
 #39 CLINICAL TRIAL  
 #40 CLINICAL-ARTICLE  
 #41 CLINICALS AND TRIALS  
 #42 COMPAR\*  
 #43 CONTROL\*  
 #44 CONTROLLED CLINICAL TRIAL  
 #45 EXP CLINICAL ARTICLE  
 #46 EXP CLINICAL TRIALS  
 #47 EXP MAJOR CLINICAL STUDY  
 #48 EXP RANDOMIZED CONTROLLED TRIAL  
 #49 FOLLOW UP STUDIES  
 #50 FOLLOW\* AND UP  
 #51 FOLLOW\* UP  
 #52 MASK\*  
 #53 RANDOM  
 #54 RANDOM ALLOCATION  
 #55 RANDOM\*  
 #56 RANDOM\* AND (ALLOCAT\* OR ASSIGN\*)  
 #57 RANDOMI\*  
 #58 RANDOMIZED CONTROLLED TRIALS  
 #59 RANDOMIZED-CONTROLLED-TRIAL  
 #60 SINGL\*  
 #61 (SINGL\* OR DOUBL\* OR TRIPL\* OR TREBL\*) NEAR (BLIND\* OR MASK\*)  
 #62 (SINGL\*) NEAR (BLIND\* OR MASK\*)  
 #63 SINGLE BLIND METHOD  
 #64 SINGLE-MASKED STUDY  
 #65 STUDY  
 #66 TRIAL\*

#67 #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66

#68 #10 or #35 or #67

2. Handsearching of specialist journals: the main journals have been searched by Cochrane Schizophrenia Group (CSG) and Cochrane Depression, Anxiety and Neurosis Group (CDAN) (see item above).

3. Conference abstracts and book chapters were searched for references.

4. Personal Communication: in order to ensure that as many as possible RCTs and CCTs would be identified, the authors of the included studies were consulted to find out if they know of any published or unpublished RCTs/ CCTs of pharmacological treatment of generalized anxiety disorder, and which were not yet identified. A list of all identified RCTs/ CCTs identified through consulting others sources was sent to the authors.

5. Attempts were made to obtain unpublished trials from pharmaceutical industry.

6. Reference checking of obtained articles.

## **Methods of the review**

### Selection of trials

One reviewer (VAT) screened the abstracts of all publications which were obtained by the search strategy. A distinction was made between:

- 1) Eligible studies, in which psychotherapies were compared to a different type of psychotherapy, placebo, or any active drug;
- 2) Psychotherapeutic treatments without any control element; general treatment studies rather than psychotherapeutic;

For articles that can be possible RCTs the full article was obtained and inspected to assess their relevance to this review based on the criteria for inclusion.

### Quality assessment

In order to ensure that variation was not caused by systematic errors in the design of a study, the methodological quality of the selected trials was assessed by two independent reviewers. The methodological quality was assessed using the criteria described in the Cochrane Handbook (Clarke, 2002). It is based on the evidence of a strong relationship among the potential for bias in the results and the allocation concealment (Schulz 1995) and is defined as below:

- A. Low risk of bias (adequate allocation concealment)
- B. Moderate risk of bias (some doubt about the results)
- C. High risk of bias (inadequate allocation concealment)

### Data Management

Data were independently extracted by two reviewers. Any disagreement was discussed with a third reviewer (MSL), the decisions documented and, where necessary, the authors of the studies contacted for further information. All exclusion/ dropouts were identified. If no information was available (either from the report or the authors) it was assumed that drop out was because of side effects/

treatment failure. The sensitivity of the results was tested to see if the inclusion of this assumption causes any substantial changes.

In case of trials using a crossover design, to exclude the potential additive effect in the second or more stages on these trials only data from the first stage was analysed.

## Analysis

Dichotomous outcomes were analysed by calculating relative risks for each trial with the uncertainty in each result being expressed using confidence intervals. The relative risks from the individual trials were combined through meta-analysis. When overall results were significant, the number needed to treat to produce one outcome was calculated by combining the overall relative risk with an estimate of the prevalence of the event in the control group of the trials.

Data on continuous outcomes are frequently skewed, the mean not being the center of the distribution. The statistics for meta-analysis are thought to be able to cope with some skew, but were formulated for parametric data. To avoid this potential pitfall the following standards were applied to all data before inclusion: i. standard deviations and means were reported or obtained from authors and ii. for data with finite limits, such as endpoint scale data, the standard deviation (SD), when multiplied by 2, was less than the mean. Otherwise the mean is unlikely to be an appropriate measure of the centre of the distribution (Altman 1996). The reviewers reported data that did not meet the first or second standard the 'other data' tables. For change data (endpoint minus baseline), the situation is even more problematic. In the absence of individual patient data it is impossible to know if data is skewed, though this is likely. Where both change and endpoint data were available for the same outcome category only endpoint data are presented. Authors of studies reporting only change data were contacted for endpoint figures. Non-normally distributed data were reported in the 'Other data types' tables. Heterogeneity in the results of the trials was assessed both by inspection of graphical presentations and by calculating a test of heterogeneity. Possible reasons for heterogeneity were pre-specified: 1) that response differs according to

different forms of interventions; 2) that response differs according to duration of the trial; 3) according to the characteristics of patients participating in trials, such as having used benzodiazepine previously. It was assessed by looking at separate subgroups of trials. Tables were used to display characteristics of eligible trials including those that were excluded with the reasons for exclusion. Outcomes were also presented graphically. Review manager software developed by the Cochrane Collaboration was used to organise and process the results.

## **Description of studies**

### Search

The search strategy generated 1406 references, 1347 of which were excluded for not meeting the criteria or not being randomized clinical trials. The remaining 44 were requested, but until now 22 studies have been checked by reading the full paper, with 8 studies included, 12 studies excluded and 2 studies awaiting information from authors (Bowman, 1997; Power, 1990).

Please see 'Included' and 'Excluded' studies tables for substantive descriptions of studies.

### 1. Excluded studies

The majority of excluded studies either did not fulfill the participants' criteria (8). Two studies were not randomized and the participants suffered of any anxiety disorder. One study was not randomized and other one was not a controlled study. Just one chinese paper that had been translated.

### 2. Studies awaiting assessment

Thirty-six studies have been ordered but not yet obtained. Further two studies are still awaiting assessment due to lack of information on the number of subjects included in each intervention and the lack of data about the assessment. Letters were send to the authors.

### 3. Ongoing studies

No ongoing study has been identified.

#### 4. Included studies

Eight randomized controlled studies fulfilled inclusion criteria. Three trials were conducted in the United States of America, four in United Kingdom and one in Canada.

Although no restrictions were made in terms of languages of original reports, none of the included studies was published in a language other than english.

##### 4.1 Duration of trials

Duration of included trials:

- Ranging from 4 to 24-week treatment (8 to 20 sessions)
- Ranging from 4 weeks to 12-month follow-up

##### 4.2 Design

All included trials were conducted in a 'parallel groups' design.

##### 4.3 Participants

This review included 489 subjects in 8 randomized trials assessing the efficacy of psychotherapy interventions for treating generalized anxiety disorder (GAD).

The mean age of participants was 37.4 years old, ranging from 18 to 65 in the studies with adults. In studies with older adults the average was 66.6 years old (minimum of 55 years old). Most subjects (73,7%) were female. Only in one paper the majority was male (56%) (Barlow, 1992).

In four studies the patients were suffering of other mental disorders. The most of them had diagnosis of other anxiety disorders and/or depression. Three studies reported parallel use of psychotropics.

Concerning the diagnosis of GAD, three studies used the DSM-III-R criteria, three used DSM-IV criteria and the other two studies used different scales (like Hamilton Anxiety Rating Scale and Zung Anxiety Scale).

#### 4.4 Setting

Five studies included subjects in outpatient programs and two included subjects from general population. One study included both of them (Wetherell, 2003).

The trials were conducted in: USA (3), UK (4) and Canada (1).

#### 4.5 Sample size

Sample size ranged from 26 to 110 participants.

#### 4.6 Types of Interventions

##### 4.6.1. Cognitive-Behavioral Therapy (CBT)

Consists in helping the patients to recognize the automatic and erroneous thoughts, to minimize their worries and gradually learn new skills and practice other alternatives.

Six studies used this form of psychotherapy. However, they were based in different models, which are described below:

Butler, 1991: based on Beck et al., the rationale for this treatment was that learning to recognize anxious thoughts can control anxiety.

Ladouceur, 2000: the treatment consisted in training patients to develop strategies when facing uncertain situations. Through five steps, the patients recognize that the uncertainty is a source of worry and anxiety, note their worries, correct their erroneous beliefs, learn to focus their problems trying to resolve them and, finally they were helped to change the meaning that was given to threatening future events through a cognitive exposure.

Lindsay, 1987: based on Beck & Emery's approach. The treatment focused on anxiety-related self-statements and the sessions included challenges to the automatic cognitions and reviews about errors in thinking, homework, etc. The patients also received a relaxation tape.

Power, 1989: based on Beck and Emery's approach. Consisted in the elicitation and modification of automatic thoughts. In addition the patients were also trained in a progressive relaxation.

Stanley, 2003: based on Borkovec and Costello and Craske, Barlow, and O'Leary and adapted to the elderly. The treatment consisted in education and awareness training (to help the patients to identify the symptoms), muscle relaxation, cognitive therapy (helping them to use new coping skills) and graduated exposure.

Wetherell, 2003: based on Craske, Barlow and O'Leary with minor modifications to the elderly. Included relaxation training, cognitive restructuring and worry exposure.

#### 4.6.1.1. Cognitive Therapy (CT)

Focus on identifying erroneous cognitions and learning to change thoughts and reactions in front of stressful situations. Two studies described this form of psychotherapy. They are:

Barlow, 1992: this author used the term: "Cognitive Restructuring" to designe this approach, however this intervention is based in Beck and Emery's cognitive therapy approach. It involved two phases: - exploration of the role thoughts and their importance for the patients' anxiety reactions and, - the cognitive skills (they were gradually applied to anxiety-provoking situations).

Durham, 1994: based on the Beck and Emery's approach. It consisted of identifying anxious cognitions and learning to switch more helpful thoughts, reactions and unpleasant bodily sensations. With some patients the therapy yet involved the exploration and modification of dysfunctional attitudes and beliefs.

#### 4.6.1.2. Behavioral Treatment (BT)

This therapy was used only at the Butler's study (1992). The rationale was that anxiety can be controlled through relaxation, by reducing avoidance through exposure and building confidence through reengagement with pleasurable activities.

#### 4.6.2. Analytic Psychotherapy

Only Durham (1994) used this form of intervention. This approach involved the exploration and understanding of the presenting symptom into the patient's

relationship and developmental context, transference and resistance aspects of the therapeutic relationship.

#### 4.6.3. Anxiety Management Training

Two studies described this form of therapy, but they were based on different models.

Durham, 1994: based on Clark's model. Consisted in education about anxiety and acquisition of more adaptive coping strategies, through individual sessions with homework tasks and learning coping skills.

Lindsay, 1987: based on Suinn & Richardson. Focused on relaxation exercises (in addition the patients received a tape to practice between the sessions); on records of the situations in which the subjects experienced anxiety (through diaries) - they were encouraged to use relaxation on these situations; and on explanations about the symptoms of anxiety, emphasizing on physical symptoms.

#### 4.6.4. Discussion Group

Only Wetherell (2003) used this form of therapy. This treatment consisted on discussions focusing on topics known to be worry-provoking (in this case, for older adults, they included memory problems, health concerns, loss of independence, death...). The patients were encouraged to participate and to share information. The leaders did not teach skills or reinforce coping strategies and they were provided validation and supportive listening.

### 4.7 Outcomes

Most analyzed outcomes were continuous.

Many trials presented some results in graphics. Wherever possible, the data were elicited. The use of the scoring data is in several cases precluded by the lack of standard deviation figures, and in other cases by skewed data distribution.

#### 4.7.1. Scales

The majority of the scales evaluated the changes in the symptoms and severity of GAD. The scales included in the analyses were:

- ADIS-R and ADIS-IV
- Beck Anxiety Inventory (BAI)
- Cognitive Anxiety Questionnaire (CAQ, which was not a valid scale in the date of the original Lindsay, 1987)
- Cognitive-Somatic Anxiety Questionnaire (Cognitive/Somatic)
- Dysfunctional Attitude Scale (DAS)
- Eysenck Personality Inventory (EPI)
- Fear Questionnaire
- GAD Severity Ratings
- General Health Questionnaire (GHQ)
- Global Scale (psychologist assessor)
- Hamilton Anxiety Scale (HARS)
- Kellner and Sheffield Rating Scale
- Leeds Scales for the Self-Assessment of Anxiety and Depression
- Life Satisfaction Index-Z
- Penn State Worry Questionnaire (PSWQ)
- Quality of Life Inventory (QOLI)
- Role and Social Functioning and Energy/Vitality
- Self-Esteem Scale
- Significant Other Rating Scale (SORS - which were developed for the Ladouceur, 2000)
- Social Adjustment Scale (SAS)
- State Trait Anxiety Inventory (STAI)
- Worry and Anxiety Questionnaire
- Zung Self-rating Anxiety Scale

## **Methodological quality of included studies**

### **Randomization**

All trials were randomized, but most of them were not clear about the randomization procedure. Only one study informed by mail how the allocation concealment was performed, Stanley (2003), the procedure being "A" conformed criteria described in the Cochrane Handbook (Clarke, 2002). The other studies were rated "B" because information on allocation concealment was not available in the report.

### **Blinding**

In all studies it was adopted a single-blind procedure. Except in Power (1989) the medication groups were double blind and the psychotherapy arm was single blind. No information on blinding procedures was provided in Lindsay's report (1987).

### **Outcome reporting**

Many outcomes could not be summarized because they were presented as graphs, as percentiles, or only as statistical tests and p-values. Other outcomes were presented only in some assessments, specially in the "waiting list" groups cause they passed from this condition to a treatment condition before the end of follow-up.

## Results

The studies included in this review examined a range of comparisons, which could not be pooled or summarized together. Twenty-five comparisons are described below. The results showed in the last comparison are very similar to the 24th comparison. However, this comparison was necessary to assess if there was some interference in the results because of differences between the studies.

### Comparison 1: Cognitive Behaviour Therapy versus Placebo

No statistically significant differences were observed among the dichotomous variables.

Power (1989) found a significant difference in favour to CBT group in the outcome 4 (means Of Hamilton Anxiety Rating Scale after six-week treatment). The difference was statistically significant (WMD  $-8.20$ ; 95% CI  $-12.94, -3.46$ ), and in the outcome 5 (Means of Kellner and Sheffield Rating Scale after six-week treatment) the difference was  $-12.80$  (95% CI  $-25.15, -0.45$ ).

### Comparison 2: Cognitive Behaviour Therapy versus Waiting List

This comparison found statistically significant differences between the groups, with those being favourable to CBT group. In the outcomes 1 to 4, Butler's study (1991) presented data of subjects with comorbid cases, with significant differences in three of them. At the Beck Anxiety Inventory (BAI), it is possible to see a large difference, being the WMD equal to  $-14.00$  (95% CI  $-22.84, -5.16$ ). At the Leeds Scales (outcome 4), the difference was equal to  $-3.40$  (95% CI  $-6.33, -0.47$ ). Lindsay, 1987 found in the outcomes 5, 7 and 8, statistically significant differences again favouring CBT group. In the items of anxiety, the General Health Questionnaire (GHQ) showed a difference of  $3.70$  (95% CI  $-6.15, -1.25$ ). However, at the GHQ – items of general health -, the WMD was equal to  $-2.80$  (95% CI  $-4.74, -0.86$ ). The largest difference was in the outcome 7 (means of Zung Self-Rating Anxiety Scale), where the WMD was  $-19.10$  (95% CI  $-34.17, -4.03$ ).

When the outcomes were dichotomous, the analysis showed a statistically significant difference only at the outcome 11, which referred to the subjects with

meaningful change after treatment, according to GHQ instrument. The observed WMD 2.96 (95% CI 1.12 – 7.85) was favourable to the CBT group. The other outcomes did not show significant differences, even when both studies were analysed together.

#### Comparison 3: Cognitive-Behavioral Treatment versus Waiting List

The included study (Ladouceur, 2000) had a sample with a few patients who were simultaneously using psychotropic medications. Considering the means of the Penn State Worry Questionnaire (PSWQ), the WMD was equal to –18.94 (95% CI –25.95, -11.93). When the outcome was based on means of BAI, the difference after the treatment was equal to –5.16 (95% CI –10.00, -0.32). One (outcome 1 – ADIS-IV) of the three other comparisons showed a statistically significant difference favouring CBT group (WMD –3,03; 95% CI –4.15, -1.91).

#### Comparison 4: Cognitive Behaviour Therapy versus Behavior Therapy – Comorbid Cases

The only study included was Butler, 1991. In the outcome 1, when the measure was based on the means of Hamilton Anxiety Rating Scale (HARS), the difference between the groups was statistically significant (WMD –4.80; 95% CI –8.50, -1.10). The other continuous measures did not show statistically significant results. In the dichotomous outcome 09 (dropouts) no statistically significant difference was observed.

#### Comparison 5: Cognitive-Behaviour Therapy versus Anxiety Management Training

Both continuous and dichotomous outcomes did not show statistically significant differences between the groups. The only study included was Lindsay, 1987.

#### Comparison 6: Cognitive Behaviour Therapy versus Diazepam

Power, 1989, found no statistically significant differences between the groups in both continuous and dichotomous outcomes.

Comparison 7: Cognitive-Behaviour Therapy versus Lorazepam/Ativan

Both continuous and dichotomous outcomes did not show statistically significant differences between the groups. The study included was Lindsay, 1987.

Comparison 8: All Cognitive-Behavior Therapy versus No intervention - Adulthood

The only analysed outcome was dropouts and no statistically significant differences were found.

Comparison 9: All Cognitive-Behavior Therapy versus any Benzodiazepine - Adulthood

The only analysed outcome was dropouts and no statistically significant differences were found.

Comparison 10: Behavior Therapy versus Waiting List

Butler, 1991 (this study included patients with comorbid cases) found no statistically significant differences between the groups.

Comparison 11: Cognitive-Behavioral versus Minimal Contact Control – Older Adults with comorbid cases

Stanley, 2003 found statistically significant differences in outcomes 1, 2 and 3 favouring CBT group. The largest difference among the continuous outcomes was shown in the means of PSWQ, where the WMD was equal to  $-10.20$  (95% Conf. Int.  $-14.88, -5.52$ ). The outcome 7 that measured Life Satisfaction, showed a WMD equal to  $4.20$  (95% CI  $0.99, 7.41$ ). None of the other comparisons showed statistically significant results.

Comparison 12: Cognitive-Behavioral Therapy versus Waiting List – Older Adults with comorbid cases a few patients who were simultaneously using psychotropic medications

In outcomes 1, 2 and 4, Wetherell, 2003, found statistically significant differences between the groups favouring CBT group. The largest difference was observed in

outcome 2 (% of day worried), where the WMD was equal to  $-19.90$  (95% CI  $-35.15, -4.65$ ). The other six outcomes did not show significant differences.

Comparison 13: Cognitive-Behavioral Therapy versus Discussion Group – Older adults with comorbid cases a few patients who were simultaneously using psychotropic medications

None of the 18 outcomes showed statistically significant differences between the groups. The only study included was Wetherell, 2003.

Comparison 14: Discussion Group versus Waiting List – Older adults with comorbid cases a few patients who were simultaneously using psychotropic medications

Wetherell, 2003 found no statistically significant differences between the groups.

Comparison 15: Cognitive Therapy versus Analytic Psychotherapy

Durham, 1994 found statistically significant differences in the outcomes 4 (HARS), 7 (BAI) and 8 (BAI), favouring CT group. All of these are continuous variables and the largest difference was in the outcome where the cognitive therapy had a low contact level (WMD  $-12.20$ ; 95% CI  $-20.73, -3.67$ ). None of the other fourteen outcomes showed statistically significant differences.

Comparison 16: Cognitive Therapy versus Anxiety Management Training – a few patients who were simultaneously using psychotropic medications

Durham, 1994 found a difference in outcome 5 (means of Dysfunctional Attitude Scale), being the WMD equal to  $33.40$  (95% CI  $6.56, 60.24$ ), favouring CT group. However, none of other 9 outcomes showed statistically significant differences.

Comparison 17: Anxiety Management Training versus Analytic Psychotherapy – a few patients who were simultaneously using psychotropic medications

Durham, 1994 found no statistically significant differences between the groups.

#### Comparison 18: Anxiety Management Training versus Lorazepam/Ativan

None of the eight outcomes showed statistically significant differences. The study included was Lindsay, 1987.

#### Comparison 19: Cognitive Restructuring (COG) versus Waiting List - a few patients who were simultaneously using psychotropic medications

Barlow, 1992 found a number of statistically significant differences favouring the COG group, including:

- Means of ADIS-R Clinical Severity (WMD -2.40; 95% CI -3.51, -1.29);
- Means of HARS (WMD -10.30; 95% CI -14.61, -5.99);
- Means of Cognitive-Somatic Anxiety Questionnaire (CSAQ) – Cognitive (WMD -6.10; 95% CI -9.87, -2.33);
- Means of CSAQ-Somatic (WMD -4.30; 95% CI -6.52, -2.08);
- Means of Eysenck Personality Inventory (EPI)-Extraversion (WMD 2.90; 95% CI 1.18, 4.62);
- Means of EPI-Neuroticism (WMD 6.70; 95% CI 2.98, 10.42).

The remaining 9 outcomes did not show statistically significant differences.

#### Comparison 20: Cognitive Restructuring versus Progressive Muscle Relaxation (REL) - a few patients who were simultaneously using psychotropic medications

None of the 15 outcomes showed statistically significant differences between the groups. The study included was Barlow, 1992.

#### Comparison 21: Cognitive Restructuring versus Combination of Progressive Muscle Relaxation plus Cognitive Restructuring (COM) - a few patients who were simultaneously using psychotropic medications

Barlow, 1992 found no statistically significant differences between the groups over the fifteen outcomes.

Comparison 22: COM versus Waiting List - a few patients who were simultaneously using psychotropic medications

Of the fifteen outcomes, only one showed a statistically significant difference between the groups. Barlow, 1992 found through the means of HARS a WMD equal to  $-5.30$  (95% CI  $-13.61, -3.59$ ).

Comparison 23: COM versus Progressive Muscle Relaxation

In the Barlow's study (1992), no statistically significant differences were found in the 15 analysed outcomes.

Comparison 24: All CBT versus No intervention – According to age

This comparison showed statistically significant differences in the continuous outcomes. CBT was superior in the means of HARS (WMD  $-6.17$ ; 95% CI  $-7.93, -4.42$ ), BAI (WMD  $-7.40$ ; 95% CI  $-12.00, -2.80$ ) and PSWQ (WMD  $-12.17$ ; 95% CI  $-18.33, -6.02$ ).

Comparison 25: All CBT versus No intervention

Although this comparison showed similar results to the previous, it was necessary to analyse this data to exclude differences' possible interference among the studies. Again, the results were favourable to CBT group. In the outcome with means of BAI the WMD was equal to  $-7.40$  (95% CI  $-12.00, -2.80$ ). When the outcome was based on means of PSWQ, the WMD was equal to  $-12.17$  (95% CI  $-18.33, -6.02$ ). In this comparison it was not possible to analyse the dropouts.

## Discussion

Discussing a synthesis of the findings

It was possible to perform a meta-analysis only for a limited number of outcomes reported in the included studies. This reflects an essential feature of this review, i.e., the heterogeneity of intervention and clinical assessments in the studies.

The most studied intervention was the Cognitive-Behavioral approach (CBT). When compared to no interventions, CBT showed superiority in continuous outcomes, like in Beck Anxiety Inventory (WMD  $-7.40$ ; 95% CI  $-12.00, -2.80$ ) and Hamilton Anxiety Rating Scale (WMD  $-6.17$ ; 95% CI  $-7.93, -4.42$ ), at the comparison 24 (all CBT versus no intervention – according to age).

When CBT was compared to Behavioral Treatment (BT), only one outcome it demonstrated a statistically significant difference (in the outcome 1, based on means of HARS, WMD  $-4.80$ ; 95% CI  $-8.50, -1.10$ ). CBT did not show significant differences versus Anxiety Management Training (AMT), as in the comparison with any benzodiazepine. In addition, CBT also did not present statistically significant superiority when compared to the discussion group (DG), with older adults as participants.

The only study that included DG (Wetherell, 2003) did not present important differences when compared to other interventions.

The Cognitive Therapy (CT) showed advantage in some outcomes when compared to AMT and Analytic Psychotherapy (AP). As in all comparisons, these results were possible to be seen just in the continuous measures (see the results section).

Barlow, 1992 named the intervention he used Cognitive Restructuring (COG), but the model was based on a cognitive therapy. Therefore, this intervention continued showing superiority once compared to waiting list group. The best results could be

observed in outcomes based on means of HARS (WMD  $-10.30$ ; 95% CI  $-14.61$ ,  $-1.29$ ) and means of EPI-Neuroticism (WMD  $6.70$ ; 95% CI  $2.98$ ,  $10.42$ ). However, the CT intervention did not show the same performance when compared to the Progressive Muscle Relaxation (REL) and combined form of REL+COG (COM). No statistically significant differences were found in these cases.

The COM group showed advantage only in one outcome when compared to a waiting list group (found through means of HARS, WMD  $-5.30$ ; 95% CI  $-13.61$ ,  $-3.59$ ). This intervention was not superior when compared to other groups.

None of the outcomes showed statistically significant differences favouring AMT. In addition, this intervention reveals to be less effective than CT in some outcomes.

#### General considerations

This review included 8 RCTs that assessed the efficacy of psychotherapy treatments for generalized anxiety disorder. However, these studies compared different groups, with distinct therapeutic approaches, using singular scales and, in general, with few participants in the samples. All these differences implicated in a difficulty to work with the data and compare them.

Through these problems, was possible to realize that the differences are a reproduction of reality, where the health services have difficulty to choose a psychological treatment for use in the general practice. Psychotherapies have many models and few of them have been evaluated. Maybe because of that is much easier to find studies comparing medications than psychotherapies.

In other cases, the differences are just a singular way to name the interventions, as in the paper of Barlow, 1992, where the author called a cognitive therapy by Cognitive Restructuring.

Regarding the scales used by the authors, we found some unknown instruments or that had not yet been validated by the time papers were published.

In addition, the comparisons were also impaired by the differences among participants. The authors used diverse criteria to include the patients and the majority of the participants were female, spite this difference has not been interfered between the groups, according to them.

Another important consideration is the lack of half of papers due to the difficulty to acquire them.

In general, the results suggest that cognitive-behavior treatment and cognitive therapy are the efficient alternatives for patients suffering of generalized anxiety disorder. However, although CBT intervention has been the mostly studied form of treatment, there is yet doubt about the efficacy of the CBT in front of other interventions, since it did not present the same results when compared to them. Regarding the CT intervention, only two trials assessed this form of treatment, but it was not possible to perform a meta-analysis due the differences between them.

## **Reviewers' conclusions**

### Implications for practice

The psychotherapies are effective to treat generalized anxiety disorder when compared to no intervention. The mean duration of the interventions was equal to thirteen weeks (ranging from 4-24 weeks). The treatments varied from 8 to 20 sessions.

These results suggested that the brief interventions are efficient to reduce the symptoms of GAD. Cognitive-behavior therapy presented the better results when compared to no intervention, even though it has been the mostly studied form of treatment, it did not demonstrate the same results in front of the other interventions.

A cost-benefit analysis is needed to evaluate if psychotherapies are less costly than pharmacological treatment, since there was no differences in the change of symptoms were demonstrated between these interventions.

It is important to be cautious about the results and necessary to consider the limitations of this review.

## Implications for research

Randomized trials with larger group samples are still need to additional exploration of current available evidence for psychotherapies treating generalized anxiety disorder. Although some interventions show potential, the efficacy of some interventions has to explore further its practical applicability, analysing the possibilities and cost-effectiveness of each one.

The trials should be conducted with larger samples and longer follow-up periods to allow the investigation about the real effectiveness of the interventions. It is also important to consider the duration of treatments and the number of sessions.

Furthermore, the participants should be selected by predicting if the result could be suffering of a confounding bias. In this review, some studies included subjects that were taking medication parallel to the study, which could interfere in the final result. It is also necessary to considering, differences like the duration of the disorder and the presence of comorbid cases.

The techniques used for randomization, blindness and allocation concealment should be described clearly in the presentation of a study. In addition, the authors should present all outcomes in tables in the clearest possible so that readers can analyse the data.

A good number of trials in this review failed to report data about dropouts, not conducting intent-to-treat analysis.

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Potential conflict of interest

None.

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## **4. ANEXOS**

## Estratégia de Pesquisa

Em função das diversas dificuldades em “rodar” a estratégia de busca proposta inicialmente, optou-se por favorecer uma busca mais sensível que específica.

As buscas foram realizadas através da internet e incluíram os seguintes termos:

### COCHRANE LIBRARY:

(#30 = BEHAVIOR-THERAPY or #30 = BIOFEEDBACK or #30 = CASE-MANAGEMENT or #30 = COGNITIVE-ANALYTIC-THERAPY or #30 = COGNITIVE-BEHAVIOR-THERAPY or #30 = COGNITIVE-THERAPY or #30 = COUNSELLING or #30 = CRISIS-INTERVENTION or #30 = FAMILY-THERAPY or #30 = MARITAL-THERAPY or #30 = PSYCHOANALYTIC-THERAPY or #30 = PSYCHOTHERAPY or #30 = RELAXATION-THERAPY or #30 = SOCIAL-INTERVENTION) AND (#45 = anxiety or #45 = "anxiety disorder")

### MEDLINE:

CONTROLLED+ GENERALIZED + ANXIETY

### LILACS:

- 1) GENERALIZED + ANXIETY
- 2) ANSIEDADE GENERALIZADA

### PUBMED:

CONTROLLED + GENERALIZED + ANXIETY

### Characteristics of included studies

Study ID	Methods	Participants	Interventions	Outcomes	Notes	Allocation Concealment
Barlow, 1992	<ul style="list-style-type: none"> <li>- RCT: no information about allocation concealment.</li> <li>- Design: four parallel groups. Progressive Muscle Relaxation (REL); Cognitive Resctructuring (COG); Combination of relaxation and cognitive restructuring (COM); Waiting List (WL).</li> <li>- Setting: outpatients</li> <li>- Blindness: the interviewrs were blind to subject's treatment condition.</li> <li>- Analysis: ITT</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: principal diagnostic of Generalized Anxiety Disorder according to DSM-II-R.</li> <li>- N=65</li> <li>- Age: 18-65, mean= 40,65 years.</li> <li>- Sex: 44% women, 56% men</li> <li># There was no significant diferences between the groups.</li> </ul>	<ul style="list-style-type: none"> <li>- COG Group: Based on Beck and Emery's cognitive therapy approach. One hour a session, over 15 sessions. n=17</li> <li>- REL Group: based on procedures outlined by Bernstein and Borkovec. The patients were required to do home practice twice per day. Total: 60 sessions. n=16</li> <li>- COM Group: involved training in both relaxation and cognitive restructuring. n=12</li> <li>- WL Group: during 15 weeks the subjects were required to self-monitor. n=20</li> <li># The treatments groups received the interventions during fifteen weeks.</li> </ul>	<ul style="list-style-type: none"> <li>- State Trait Anxiety Inventory (STAI); Cognitive-Somatic Anxiety Questionnaire (CSAQ); Fear Questionnaire (FQ); Beck Depression Inventory (BDI); Eysenck Personality Inventory (EPI); Subjective Symptoms Scale (SSS) - wich contains 9-point rating scales(0-8) indicating the degree of interference that anxiety produced in five areas.</li> </ul>	<ul style="list-style-type: none"> <li>- State Trait Anxiety Inventory (STAI); Cognitive-Somatic Anxiety Questionnaire (CSAQ); Fear Questionnaire (FQ); Beck Depression Inventory (BDI); Eysenck Personality Inventory (EPI); Subjective Symptoms Scale (SSS) - wich contains 9-point rating scales(0-8) indicating the degree of interference that anxiety produced in five areas.</li> </ul>	B - Unclear
Butler, 1991	<ul style="list-style-type: none"> <li>- RCT: no information about allocation concealment .</li> <li>- Design: three parallel groups: Behavioral Therapy (BT); Cognitive Behavior Therapy (CBT) or Waiting List (WL)</li> <li>- Blindness: the assessments were made by an independent assessor who was "blind" of the results of random</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Generalized Anxiety Disorder. DSM-III-R diagnostic criteria.</li> <li>- N=57</li> <li>- Age: range: 18-65; mean=35 years</li> <li>- Sex: of the 57 patients, there was only 8 men.</li> </ul>	<ol style="list-style-type: none"> <li>1. BT Group: n=19. Twelve sessions and three booster sessions after treatment.</li> <li>2. CBT Group: n=19. 12 sessions and three booster sessions after treatment.</li> <li>3. WL Group: n= 19. Patients entered treatment after three months.</li> </ol> <p># Before begining the</p>	<ul style="list-style-type: none"> <li>- Ratings of mood: Hamiltons Anxiety Scale, Leeds Scale, STAI-Trait scale, Beck Anxiety Inventory, Beck Depression Inventory.</li> <li>- Measures of cognition: Dyscfunctional Attitude Scale, Cognition Checklist, Fear of Negative Evaluation Scale, Subjective Probalities Questionnaire.</li> <li>- Expectations: a 0-8 scale</li> </ul>	<ul style="list-style-type: none"> <li>- Non ITT</li> <li>- Allocation concealment unclear</li> <li>- Comorbid cases</li> </ul>	B - Unclear

	<p>allocation to group or to therapist.</p> <ul style="list-style-type: none"> <li>- Setting: outpatients</li> <li>- Duration: six month follow-up. 12 individual sessions</li> <li>- Analysis: non ITT.</li> </ul>		<p>treatment, patients were sent a booklet describing treatment and asked to read before their first session.</p>	<p>to patients perceived suitability before and after treatment.</p> <ul style="list-style-type: none"> <li>- Background and descriptive data: a 0-3 scale about the severity and degree of interference with the patient's lives.</li> </ul>		
Durham, 19994	<ul style="list-style-type: none"> <li>- RCT: no information about allocation concealment.</li> <li>- Design: 3 parallel groups. Cognitive Therapy (CT), Analytic Psychotherapy (AP), Anxiety Management Training (AMT).</li> <li>- Blindness: the evaluator assessments was blind to the patient's therapist and treatment conditions.</li> <li>- Setting: outpatients.</li> <li>- Duration: 6-month treatment and follow-up.</li> <li>- Analysis: ITT to BSI and STAI-T.</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Generalized Anxiety Disorder according to DSM-II-R.</li> <li>- N=110</li> <li>- Age: mean=39 (18-65 years)</li> <li>- Sex: 32% men, 67% women.</li> </ul>	<ul style="list-style-type: none"> <li>- CT Group: n=40. Based on Beck and Emery's model.</li> <li>- AT Group: n=45.</li> <li>- AMT: n=25. Clark's Model. Low contact.</li> <li># Contact Level: Low contact = 8-10 sessions, High contact = 16-20 sessions. Both over six month period.</li> </ul>	<p>Assessor Ratings:</p> <ul style="list-style-type: none"> <li>-Hamilton Rating Scale for Anxiety (HRSA)</li> <li>- Social Adjustment Scale (SAS)</li> <li>- 0-8 point rating of overall severity</li> <li>- 0-8 point rating of the overall degree of improvement</li> </ul> <p>Patient ratings:</p> <ul style="list-style-type: none"> <li>- Brief Symptom Inventory (BSI)</li> <li>- State-Trait Anxiety Inventory (STAI-T)</li> <li>- Beck Anxiety Inventory (BAI)</li> <li>- Beck depression Inventory (BDI)</li> <li>- Self-Esteem Scale (SES)</li> <li>- Dysfunctional Attitude Scale (DAS)</li> </ul>	<ul style="list-style-type: none"> <li>- There was a significant bias in the sample towards lower socio-economic status (<math>p&lt;0,05</math>).</li> <li>- Of the 110 patients, 99 attended for an initial interview, 19 dropped out.</li> <li>- Patients in CT had significantly higher expectations than those in AP (<math>p&lt;0,01</math>).</li> <li>- Patients in CT and AMT had significantly higher perceptions of treatment suitability than those in AP (<math>p&lt;0,001</math>).</li> <li>- 66% were taking some psychotropic medication.</li> <li>- 51% received psychiatric treatment (23% inpatient, 28% outpatients).</li> </ul>	B - Unclear

Ladouceur, 2000	<ul style="list-style-type: none"> <li>- RCT: no information about the allocation concealment.</li> <li>- Design: 2 parallel groups. Cognitive-Behavioral therapy (CBT) versus Waiting List (WL).</li> <li>- Setting: general population.</li> <li>- Duration: 16-week treatment, 6-month follow-up.</li> <li>- Blindness: an independent clinician assessed the measures.</li> <li>- Analysis: there was no dropouts. ITT.</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: primary diagnosis of Generalized Anxiety Disorder, according to DSM-IV.</li> <li>- N=26</li> <li>- Age: mean=39,7 (SD=10,8).</li> <li>- Sex: 20 women and 6 men.</li> </ul>	<ul style="list-style-type: none"> <li>- CBT Group: n=14. 16 one-hour therapy sessions conducted weekly.</li> <li>- WL Group: n=12. Once a month the participants were telephoned to monitor their state.</li> <li># Total: 16-week treatment.</li> </ul>	<ul style="list-style-type: none"> <li>- Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV); Penn State Worry Questionnaire (PSWQ); Worry and Anxiety Questionnaire (WAQ); Beck Anxiety Inventory (BAI); Beck Depression Inventory (BDI); Significant Other rating Scale (SORS); Intolerance of Uncertainty Scale (IUS); Therapist Rating Scale; Credibility and Expectancy Scale; Nijmegen Motivation List.</li> </ul>	<ul style="list-style-type: none"> <li>- 9 patients were taking medication (4- both anxiolytics and antidepressants and 5 were taking only anxiolytics).</li> <li>- The mean number of additional diagnosis at intake was 1,62.</li> <li>- 20 of 26 participants reported having already consulted a mental health professional.</li> </ul>	B – Unclear
Lindsay, 1987	<ul style="list-style-type: none"> <li>- RCT: no information about allocation concealment.</li> <li>- Design: 4 parallel groups: Cognitive Behavior Therapy (CBT), Anxiety Management Training (AMT), Benzodiazepine (BZ), Waiting List (WL). #The patients that were used some medication had to be off anti-anxiety drugs for six weeks prior to treatment. The patients at the control group that had to be 10 weeks without any therapy were not asked to wait a further three months until follow-up and were offered a psychological treatment of choice.</li> <li>- Blindness: no</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Generalized Anxiety Disorder. Was used the General Health Questionnaire, Fear Survey Schedule and the Zung Anxiety Scale.</li> <li>- N=40</li> <li>- Age: mean=36 years (20-62)</li> <li>- Sex: 16 men, 24 women, equally represented at the groups.</li> </ul>	<ol style="list-style-type: none"> <li>1. CBT Group: n=10. Based on Beck &amp; Emery and Beck, Rush, Shaw and Emery and Meichenbaum's approach.</li> <li>2. AMT Group: n=10. Based on the work of Suinn &amp; Richardson.</li> <li>3. BZ Group: n=10. The patients were prescribed Lorazepam 1mg t.i.d. for ten days, 1 mg b.d. for a further ten days and 1 mg notice for the final ten days.</li> <li>4. WL Group: n=10.</li> </ol> <p># The CBT and AMT sessions were arranged twice a week over four weeks.</p>	<p>Change after the treatment:</p> <ul style="list-style-type: none"> <li>- General Health Questionnaire</li> <li>- Zung Sel-rating Anxiety Scale</li> <li>- Modified Autonomic Perception Questionnaire</li> <li>- Cognitive Anxiety Questionnaire</li> </ul> <p># The assessments were administered pre-, post and follow-up treatment.</p>	<ul style="list-style-type: none"> <li>- ITT unclear</li> <li>- Allocation concealment unclear</li> </ul>	B – Unclear

	<p>information.</p> <ul style="list-style-type: none"> <li>- Setting: outpatients.</li> <li>- Duration: 4 treatment weeks, 3 month follow-up.</li> <li>- Analysis: ITT unclear.</li> </ul>					
Power, 1989	<ul style="list-style-type: none"> <li>- RCT: no information about allocation concealment .</li> <li>- Design: three parallel groups: Cognitive Behaviour Treatment (CBT); Diazepam Group (DZ) an Placebo Group (PL).</li> <li>- Blindness: single-blind to psychotherapy group. Double-blind to medications groups preceded by a one-week single-blind placebo wash-in period for diazepam and placebo groups. The assessments were conducted by a psychologist not officially informed of the subject's group allocation. However, the assessor would have been able to conclude that a patient was at the CBT group if the subject informed that didn't use medication.</li> <li>- Setting: outpatients.</li> <li>- Duration: 6 week period. 12-month follow-up.</li> <li>- Analysis: ITT unclear.</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Primary Generalized Anxiety Disorder according to "Present State Examination" , "Research Diagnostic Criteria", a minimum score of 15 on the "Hamilton Rating Scale for Anxiety" and others judgements like duration of the symptoms.</li> <li>- Patients with minor secondary phobic or depressive features were included.</li> <li>- N=31</li> <li>- Age: mean = 34 years</li> <li>- Sex: 27 women and 4 men equally represented at the groups.</li> </ul>	<ol style="list-style-type: none"> <li>1. CBT Group: n=10. Four sessions based on Beck and Emery's approach plus a taped relaxation training instructions - using a procedure adapted from Jacobson.</li> <li>2. Diazepam Group: n=10. 5 mg three times daily</li> <li>3. Placebo Group: n=11. Three times daily.</li> </ol> <p># All groups received the interventions during six weeks.</p>	<ul style="list-style-type: none"> <li>- Global outcome rating through a 7-point scale of symptom change</li> <li>- Kellner and Sheffield Rating Scale for Distress</li> <li>- Hamilton Scale for Anxiety</li> <li># All assesments were collected at baseline pre-treatment (day 0); 1 month following baseline (day 28) and at the end of active treatment (day 42)</li> <li>- There's a table that indicated post-study psychotropic prescription and/or psychological treatment at 12 month follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>- ITT unclear</li> <li>- Allocation concealment unclear</li> <li>- Comorbid cases</li> </ul>	B – Unclear
Stanley, 2003	<ul style="list-style-type: none"> <li>- RCT: adequate allocation concealment</li> <li>- Design: 2 parallel groups. Cognitive-</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Generalized Anxiety Disorder according to DSM-IV (diagnostic</li> </ul>	<ul style="list-style-type: none"> <li>- CBT Group: n=39. Based on Borkovec and Costello, Craske, Bralow and O'Leary - adapted for</li> </ul>	<ul style="list-style-type: none"> <li>- Worry: Penn State Worry Questionnaire (PSWQ), Worry Scale (WS), Global measure severity (0-8).</li> </ul>	<ul style="list-style-type: none"> <li>- Elderly patients.</li> <li>- The groups differed to gender (<math>p &lt; 0,01</math>), with more</li> </ul>	B – Unclear

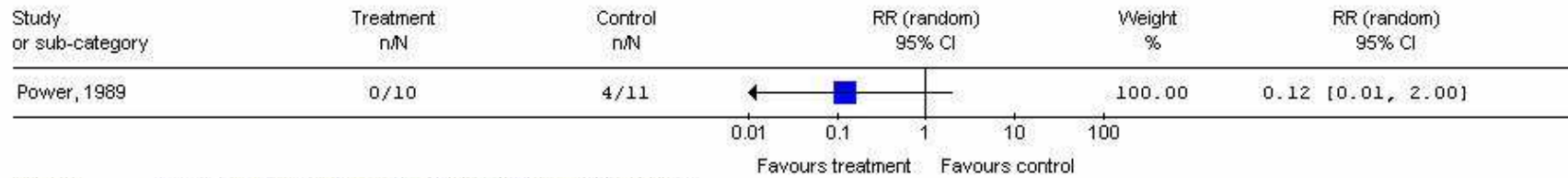
	<p>Behavioral Group (CBT) and Minimal Contact Control (MCC).</p> <ul style="list-style-type: none"> <li>- Setting: general population</li> <li>- Duration: 15 treatment weeks, 12-month follow-up.</li> <li>-Blindness: Independent evaluators assessed the rating of outcomes measures.</li> <li>- Analysis: ITT to PSQW and BDI questionnaires.</li> </ul>	<p>principal n=64, or co-principal n=21).</p> <ul style="list-style-type: none"> <li>- N=85</li> <li>- Age: mean=66,2; SD=5,21</li> <li>- Sex: 64 women(75%), 21 men (25%).</li> </ul>	<p>the elderly. Total 15 sessions.</p> <ul style="list-style-type: none"> <li>- MCC Group: n=41. Involved only weekly telephone calls to assess symptom severity.</li> </ul>	<ul style="list-style-type: none"> <li>- Anxiety: State-Trait Anxiety Inventory (STAI), Hamilton Anxiety Rating Scale (HAMA).</li> <li>- Depressive symptoms: Beck Depression Inventory (BDI), Geriatric Depression Scale (GDS), Hamilton Depression scale (HAMD).</li> <li>- Quality of life: Quality of Life Inventory (QOLI), Life Satisfaction Index-Z (LSI-Z).</li> </ul>	<p>men and fewer women assigned to MMC. The author considered that gender was not expected to have relationship with treatment outcome.</p> <ul style="list-style-type: none"> <li>- 14 dropouts until posttreatment assessment and 2 during the follow-up (total=16).</li> <li>- Comorbid cases</li> </ul>	
Wetherell, 2003	<ul style="list-style-type: none"> <li>- Design: 3 parallel groups. Cognitive-Behavioral Therapy (CBT), Discussion Group (DG) and Wait List (WL). Twelve-week treatment and 6-month follow-up.</li> <li>- Setting: outpatients and general population.</li> <li>- Duration: 12 sessions, 12-month follow-up.</li> <li>- Blindness: trained research assistants who were not aware of the allocation performed the assessments interviews.</li> <li>- Analysis: non ITT</li> </ul>	<ul style="list-style-type: none"> <li>- Diagnostic: Principal diagnosis of Generalized Anxiety Disorder, according to DSM-IV criteria.</li> <li>- N=75</li> <li>-Age: &gt;55 years, mean=67,1; SD=8,2</li> <li>-Sex: 60 women (80%), 15 men (20%)</li> </ul>	<ul style="list-style-type: none"> <li>- CBT Group: n=26. Based on Craske, Barlow and O'Leary with minor modifications to older adults. Total: 12 sessions.</li> <li>- DG: n=26. Focused on topics for older adults and homeworks of similar duration of CBT Group. Total: 12 sessions.</li> <li>- WL Group: n=23.</li> </ul>	<ul style="list-style-type: none"> <li>- Anxiety Disorders Interview Schedule for DSM-IV (ADIS IV): the disorder is rated on 0 (none) to 8 (very severe) scale of severity / disablement.</li> <li>- Penn State Worry Questionnaire (PSWQ): 16-item self report instrument, measured pathological worry.</li> <li>- Hamilton Anxiety Rating Scale (HARS): 14-item interviewer-rated.</li> <li>- Beck Anxiety Inventory (BAI): 21-item self report questionnaire.</li> <li>- Hamilton Depression Rating Scale (HDRS).</li> <li>- Beck Depression Inventory (BDI).</li> <li>- Quality of Life: the Medical Outcomes Study short form self-report health survey.</li> </ul>	<ul style="list-style-type: none"> <li>- 52% of comorbid cases</li> <li>- 29% of participants use psychotropic medication</li> </ul>	B - Unclear

### Characteristics of excluded studies

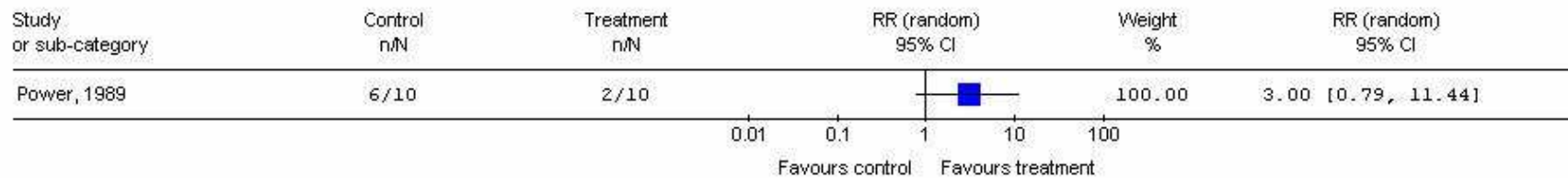
Study ID	Reason for exclusion
Arean, 1993	Not randomized, no controlled study. No available data.
Borkovec, 1993	Allocation: "random assignment to conditions took place within wave of 3 clients" Participants: patients with generalized anxiety disorder Interventions: nondirective versus applied relaxation versus cognitive behavioral
Cobham, 1998	Allocation: randomized Participants: children with any anxiety disorders Interventions: child-focused cognitive-behavioral therapy (CBT) versus child-focused CBT plus prenatal anxiety management (CBT+PAM)
Guizhen, 1998	Allocation: randomized Participants: patients with anxiety neuroses Interventions: acupuncture only versus behavioral desensitization only versus combined acupuncture with behavioral desensitization
Harvey, 1998	Allocation: randomized Participants: patients with diverse mental health problems Interventions: generic counselling vs usual general practice care
Jannoun, 1982	Allocation: randomized Participants: all complained of a moderate to severe generalized anxiety disorder and panic attacks Interventions: anxiety management training versus no intervention Outcomes: no data available
Razali, 1998	Allocation: randomized

	<p>Participants: cases of anxiety and depression</p> <p>Inteventions: standard treatment for their respective illness versus standard treatment plus religious-sociocultural psychotherapy</p>
Svartberg, 1998	<p>Allocation: randomized</p> <p>Participants: patients with diverse mental disorders</p> <p>Interventions: short-term anxiety-provoking psychotherapy (STAPP) versus nondirective psychotherapy (NDP)</p>
White, 1995	<p>Allocation: "were allocated", no further details</p> <p>Participants: those with generalized anxiety disorder</p> <p>Interventions: cognitive therapy (CT) versus behaviour therapy (BT) versus cognitive-behaviour therapy (CBT) versus subconscious retraining (SCR)</p>
White, 1998	<p>Allocation: randomized</p> <p>Participants: patients with any anxiety disorder</p> <p>Interventions: stresspac versus advice only versus no intervention</p>
Zhang, 2000	<p>Allocation: randomized</p> <p>Participants: patients with diverse anxiety disorders</p>

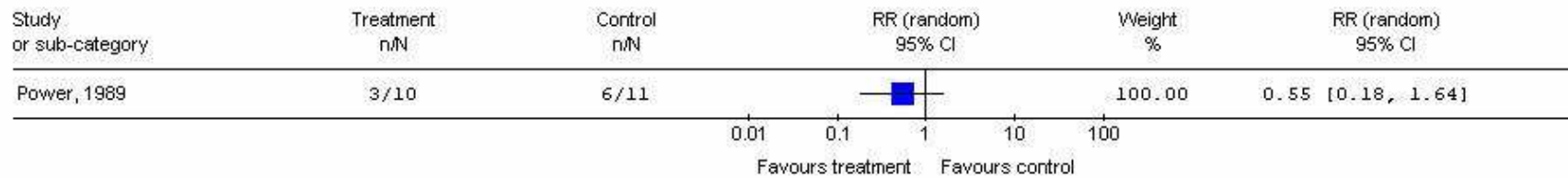
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 01 Cognitive Behaviour Therapy versus Placebo  
 Outcome: 01 No change in anxiety symptoms or worse - Global Scale (psychologist assessor)



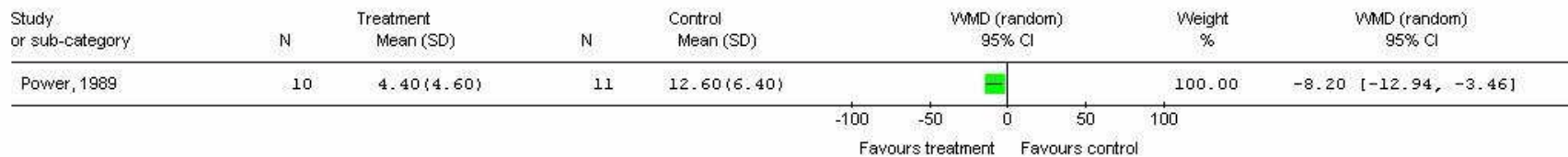
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 01 Cognitive Behaviour Therapy versus Placebo  
 Outcome: 02 Very much improved - Global Scale (psychologist assessor)



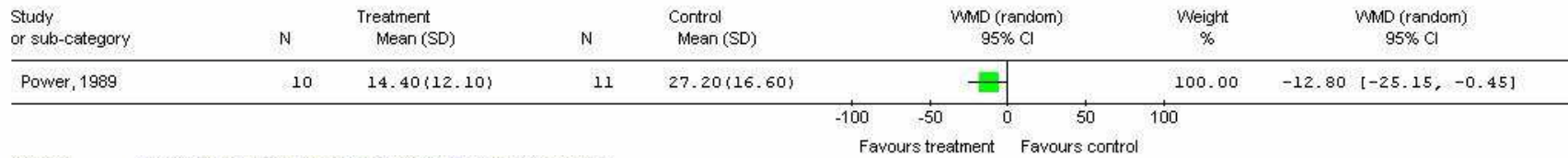
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 01 Cognitive Behaviour Therapy versus Placebo  
 Outcome: 03 Subsequent psychological and/or psychotropic treatment at twelve-month follow-up



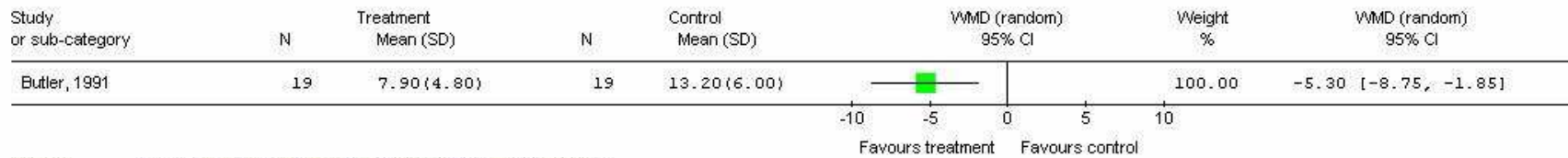
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 01 Cognitive Behaviour Therapy versus Placebo  
 Outcome: 04 Means of Hamilton Rating Scale after 6-week treatment



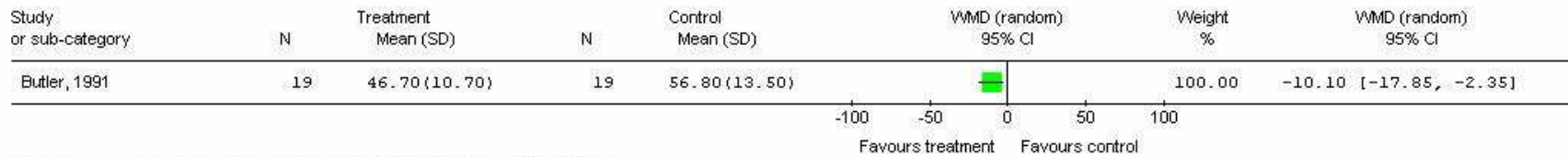
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 01 Cognitive Behaviour Therapy versus Placebo  
 Outcome: 05 Means of Kellner and Sheffield Rating Scale after 6-week treatment



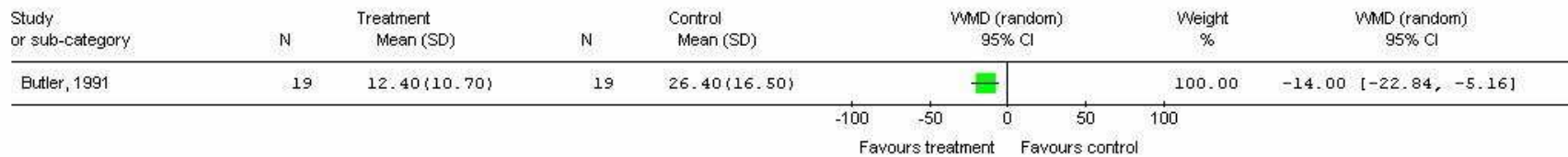
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 01 Means of Hamilton Anxiety Scale after 3-month treatment / COMORBID CASES



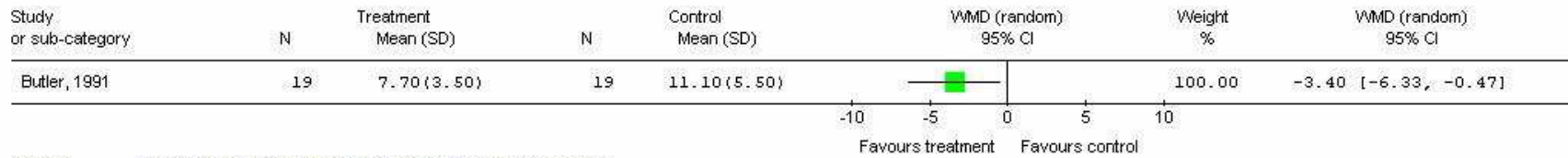
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 02 Means of State Trait Anxiety Inventory after 3-month treatment / COMORBID CASES



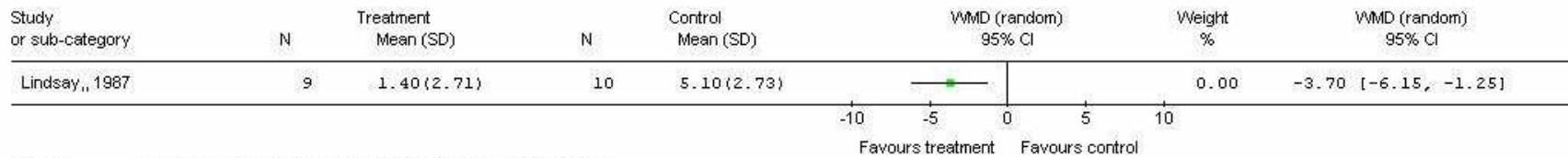
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 03 Means of Beck Anxiety Inventory after 3-month treatment / COMORBID CASES



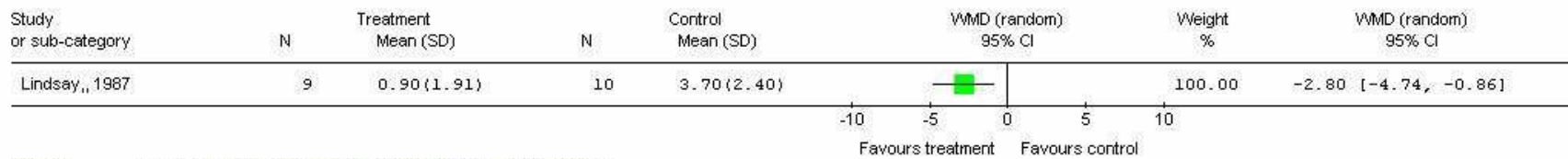
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 04 Means of Leeds Scales for the Self-Assessment of Anxiety and Depression after 3-month treatment / COM CASES



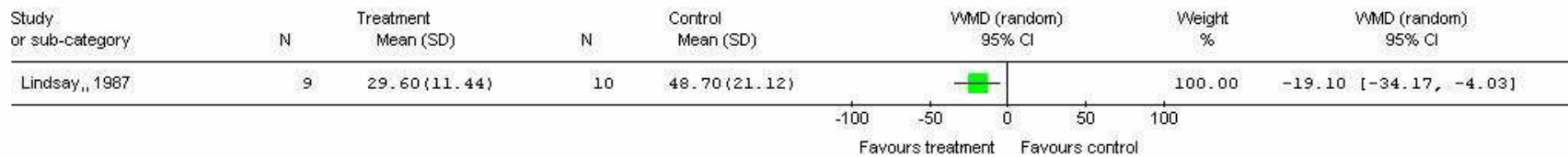
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 05 Means of General Health Questionnaire, anxiety - after 4-week treatment



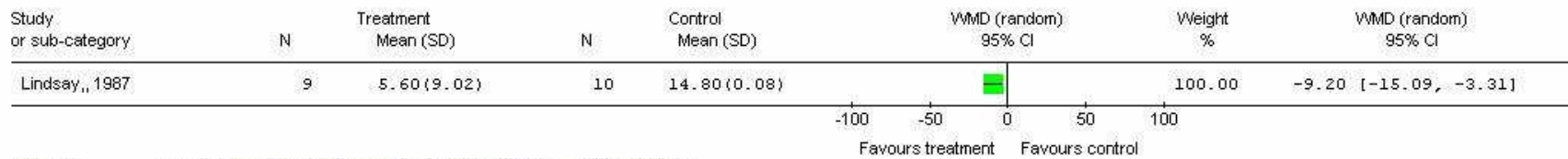
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 06 Means of General Health Questionnaire - general health, after 4-week treatment



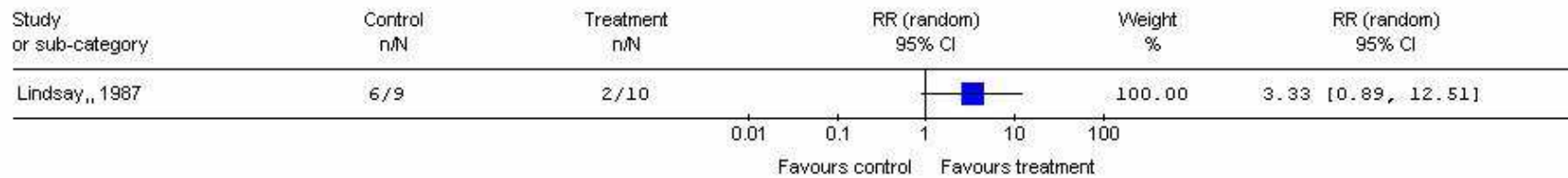
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 07 Means of Zung Self-rating Anxiety Scale after 4-week treatment



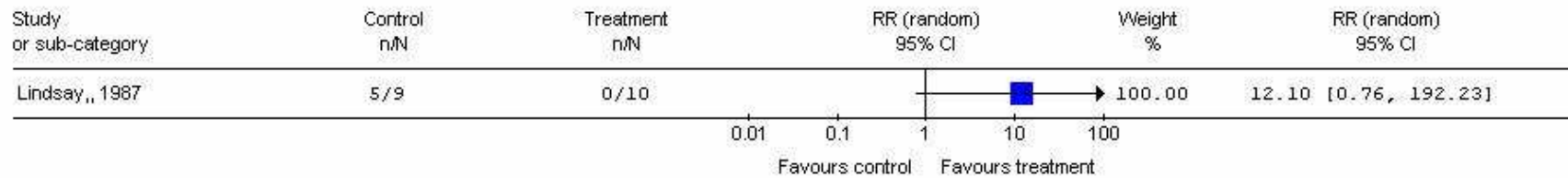
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 08 Means of Cognitive Anxiety Questionnaire - after 4-week treatment



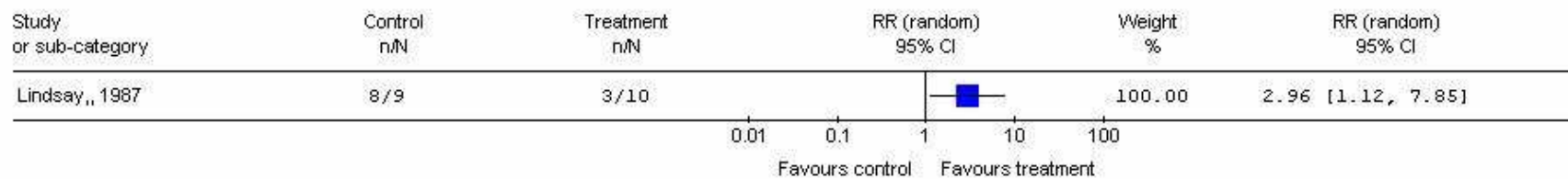
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 09 Subjects that showed clinically meaningful change after treatment - Zung



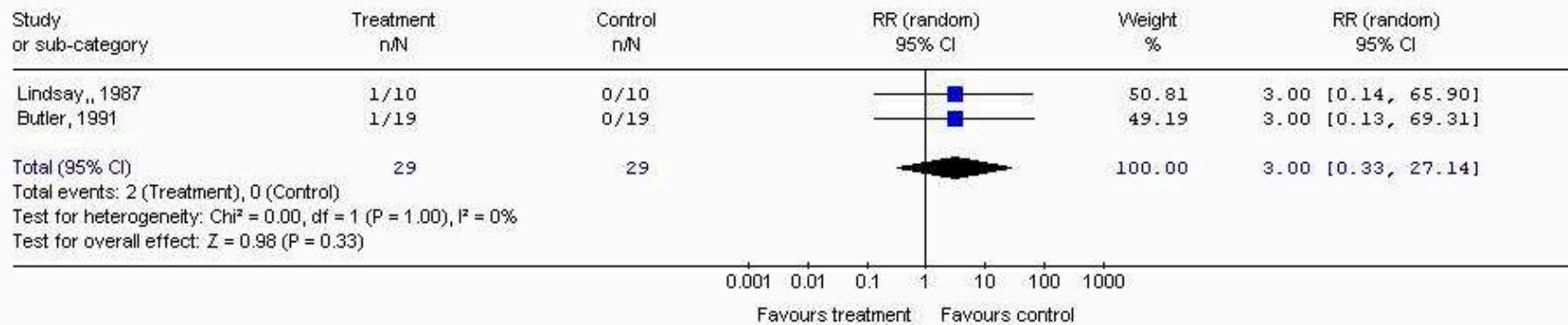
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 10 Subjects that showed clinically meaningful change after treatment - CAQ



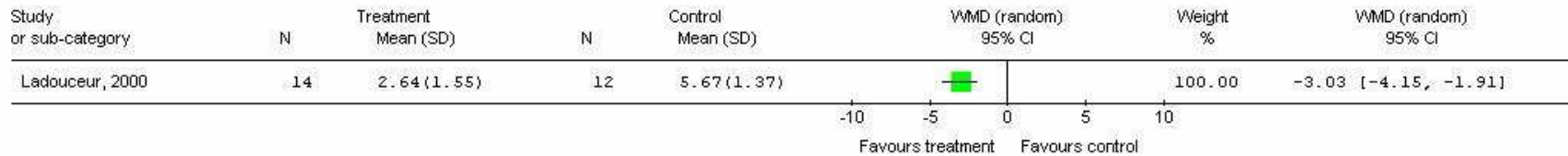
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 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 11 Subjects that showed clinically meaningful change after treatment - GHQ-anxiety



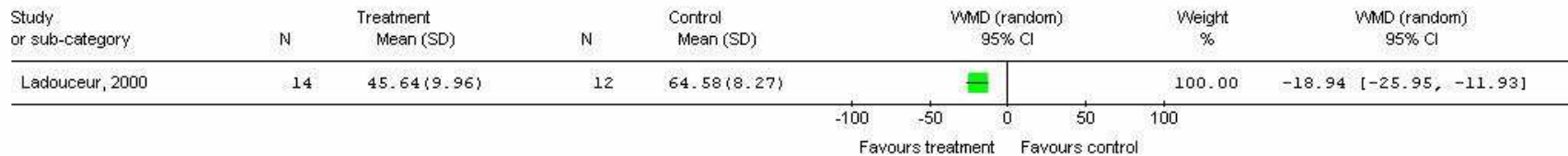
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 02 Cognitive Behavior Therapy versus Waiting List  
 Outcome: 12 Dropouts



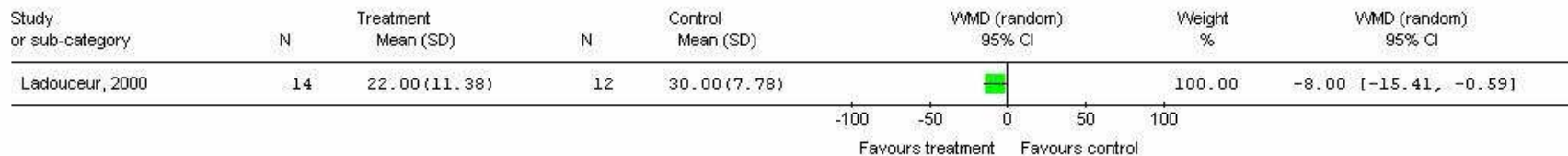
Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 03 Cognitive-Behavioral Treatment versus Waiting List - (some patients were simultaneously using med)  
 Outcome: 01 Means of ADIS-IV (Symptom Severity Scale) - after treatment



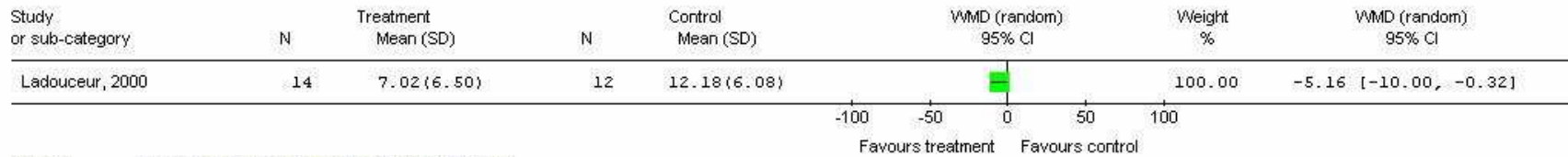
Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 03 Cognitive-Behavioral Treatment versus Waiting List - (some patients were simultaneously using med)  
 Outcome: 02 Means of Penn State Worry Questionnaire - after treatment



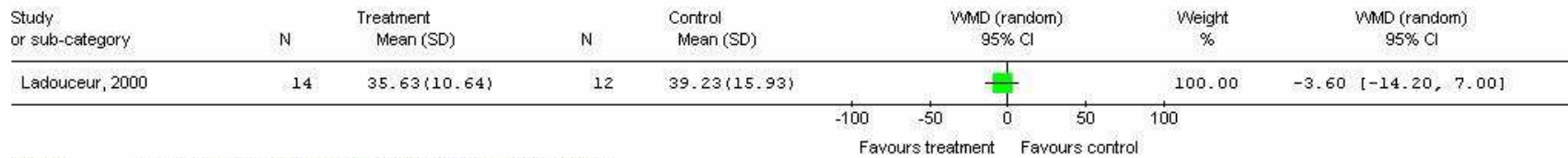
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 Comparison: 03 Cognitive-Behavioral Treatment versus Waiting List - (some patients were simultaneously using med)  
 Outcome: 03 Means of Worry and Anxiety Questionnaire (Somatic scale) - after treatment



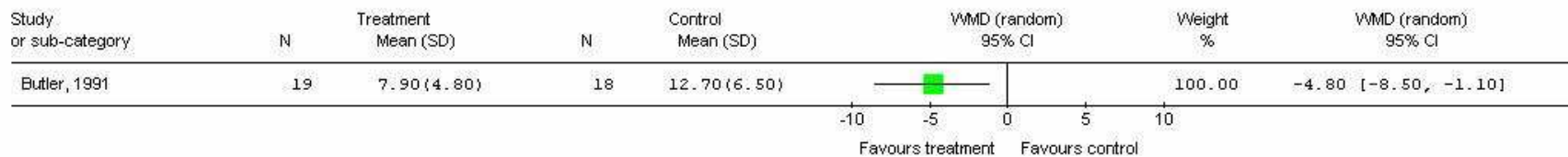
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 Comparison: 03 Cognitive-Behavioral Treatment versus Waiting List - (some patients were simultaneously using med)  
 Outcome: 04 Means of Beck Anxiety Inventory - after treatment



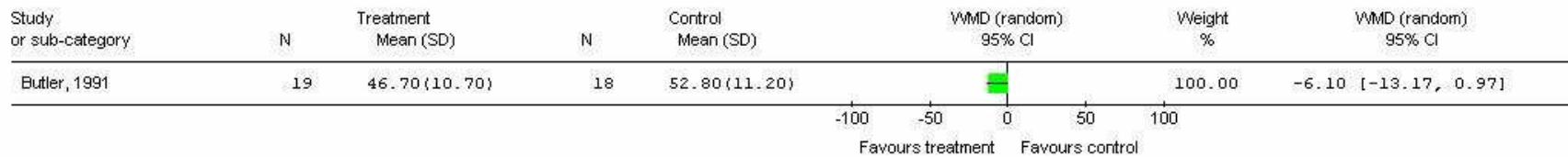
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 Comparison: 03 Cognitive-Behavioral Treatment versus Waiting List - (some patients were simultaneously using med)  
 Outcome: 05 Means of Significant Other Rating Scale - after treatment



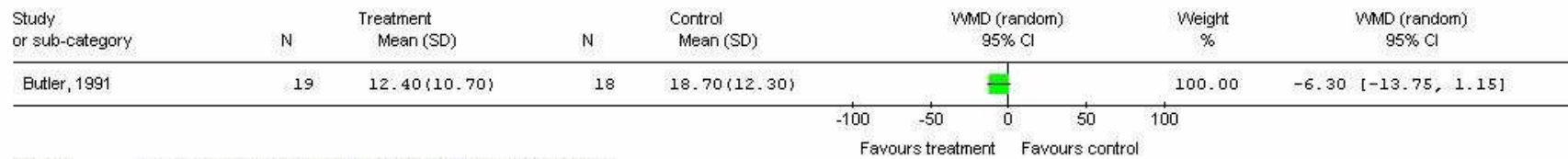
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 04 Cognitive Behavior Therapy versus Behavior Therapy / COMORBID CASES  
 Outcome: 01 Means of Hamilton Anxiety Scale after 3-month treatment



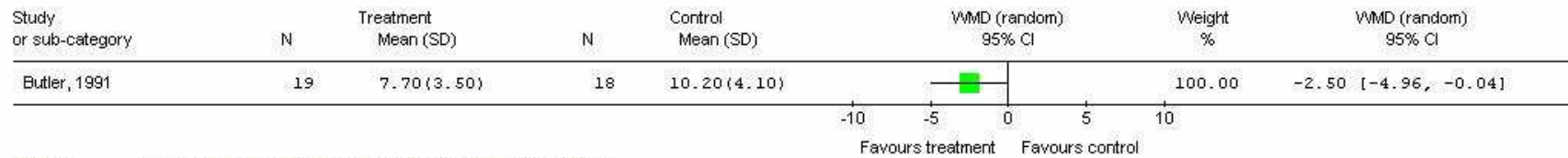
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 Comparison: 04 Cognitive Behavior Therapy versus Behavior Therapy / COMORBID CASES  
 Outcome: 02 Means of State Trait Anxiety Inventory after 3-month treatment



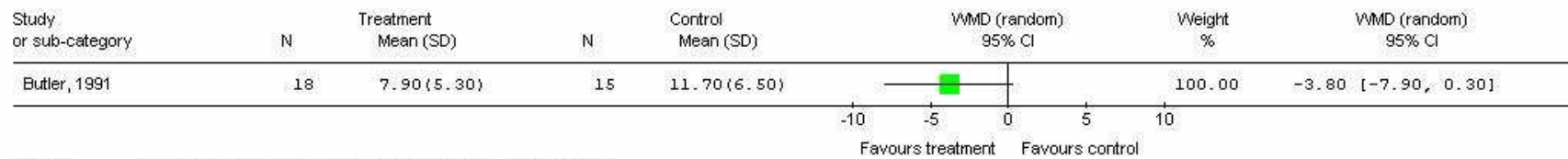
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 Outcome: 03 Means of Beck Anxiety Inventory after 3-month treatment



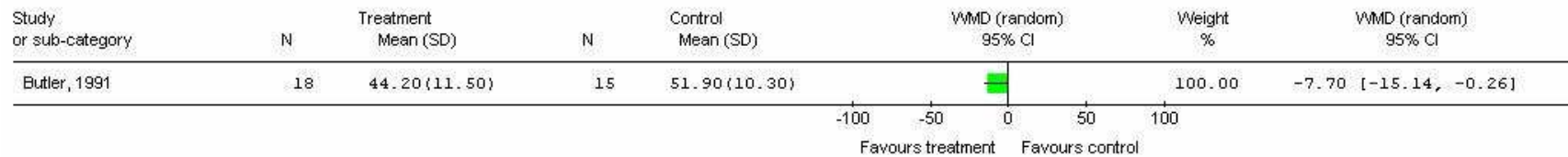
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 04 Cognitive Behavior Therapy versus Behavior Therapy / COMORBID CASES  
 Outcome: 04 Means of Leeds Scales for the Self-Assessment of Anxiety and Depression after 3-month treatment



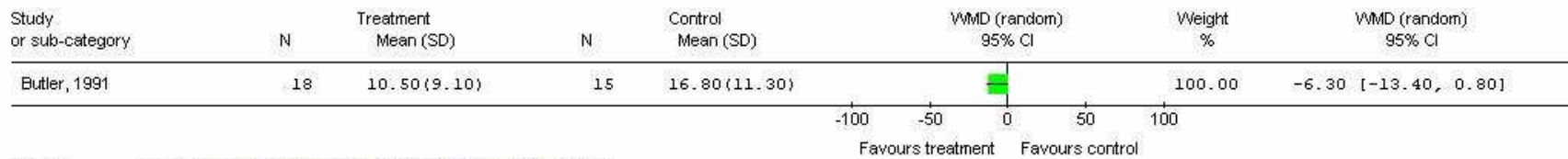
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 04 Cognitive Behavior Therapy versus Behavior Therapy / COMORBID CASES  
 Outcome: 05 Means of Hamilton Anxiety Scale after 6-month follow-up



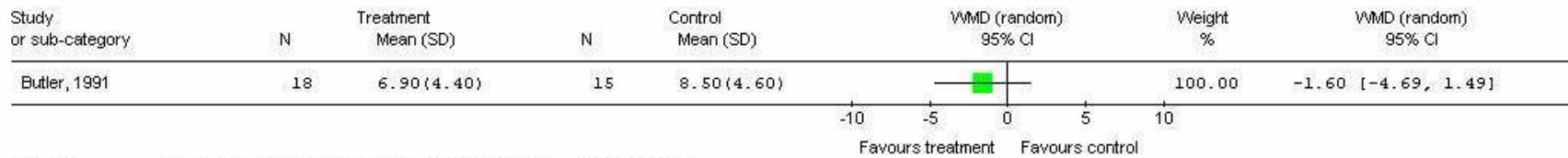
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 Outcome: 06 Means of State Trait Anxiety Inventory after 6-month follow-up



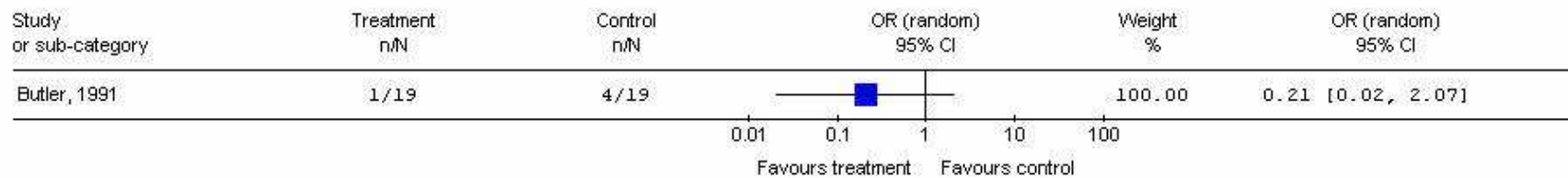
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 Outcome: 07 Means of Beck Anxiety Inventory after 6-month follow-up



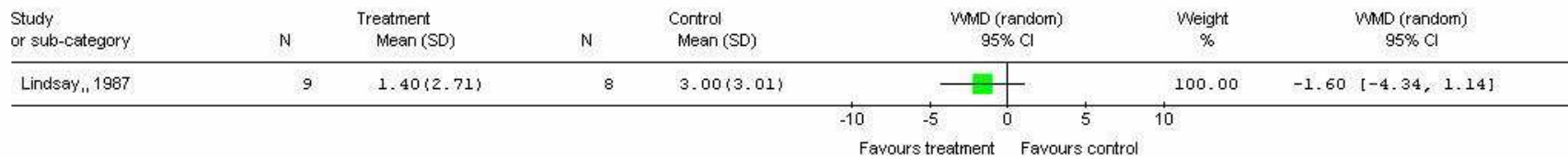
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 Outcome: 08 Means of Leeds Scales for the Self-Assessment of Anxiety and Depression after 6-month follow-up



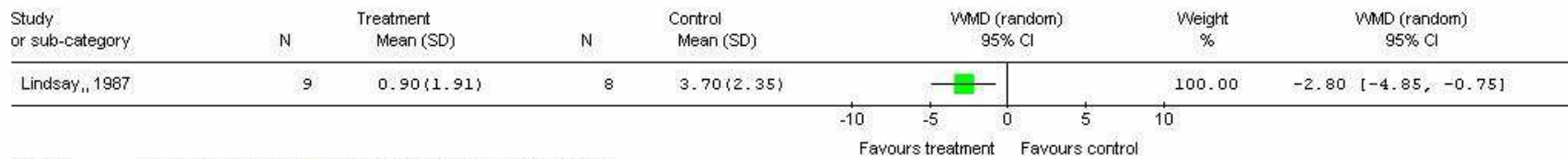
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 Comparison: 04 Cognitive Behavior Therapy versus Behavior Therapy / COMORBID CASES  
 Outcome: 09 Dropouts after 6-month follow-up



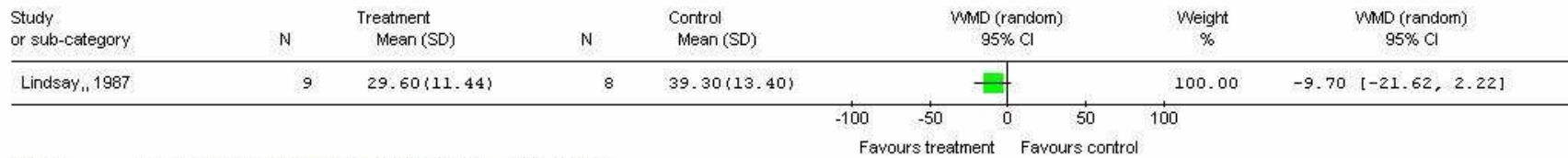
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 01 Means of General Health Questionnaire - anxiety, after 4-week treatment



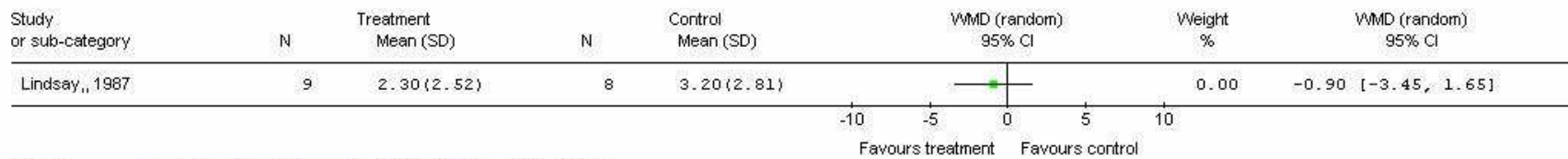
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 02 Means of General Health Questionnaire - general health, after 4-week treatment



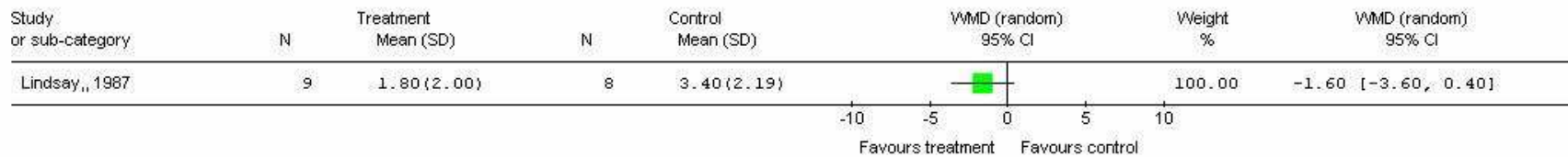
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 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 03 Means of Zung Self-rating Anxiety Scale after 4-week treatment



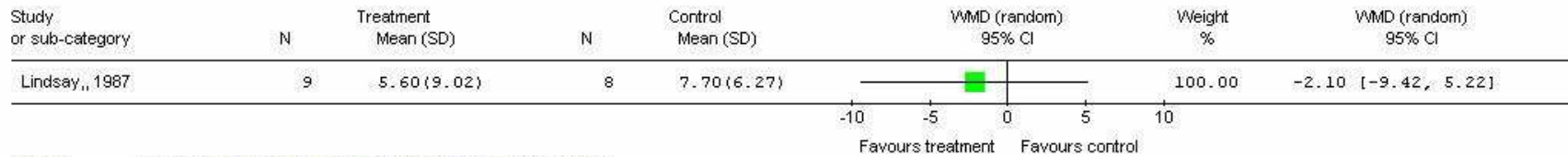
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 Outcome: 04 Means of General Health Questionnaire - anxiety, after 3-month follow-up



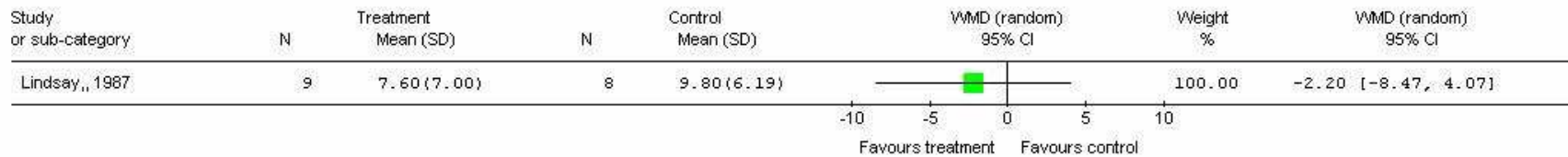
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 Outcome: 05 Means of General Health Questionnaire - general health, after 3-month follow-up



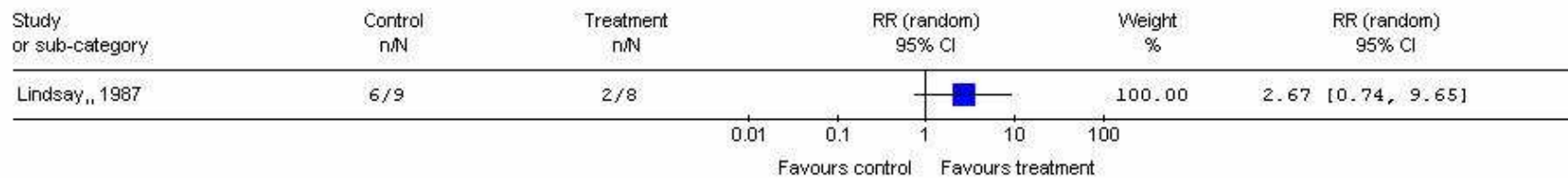
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 Outcome: 06 Means of Cognitive Anxiety Questionnaire - after 4-week treatment



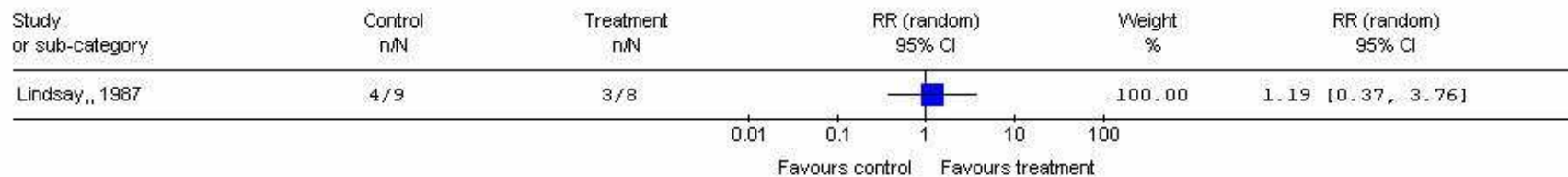
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 Outcome: 07 Means of Cognitive Anxiety Questionnaire after 3-month follow-up



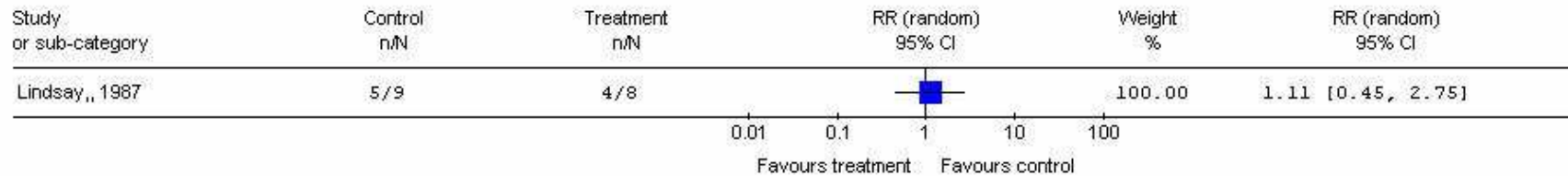
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 08 Subjects that showed clinically meaningful change after treatment - Zung



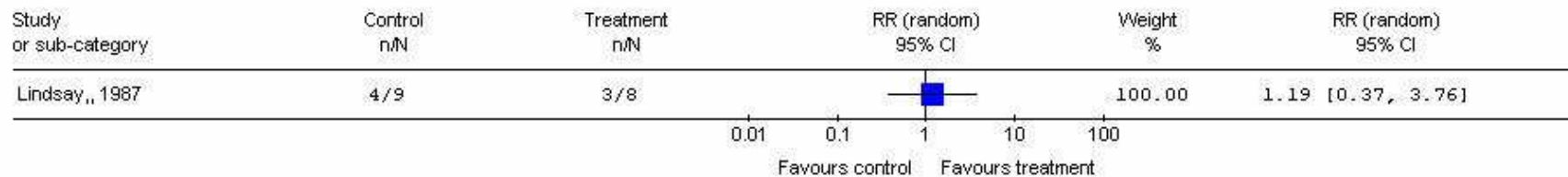
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 Outcome: 09 Subjects that showed clinically meaningful change after 3-month follow-up - Zung



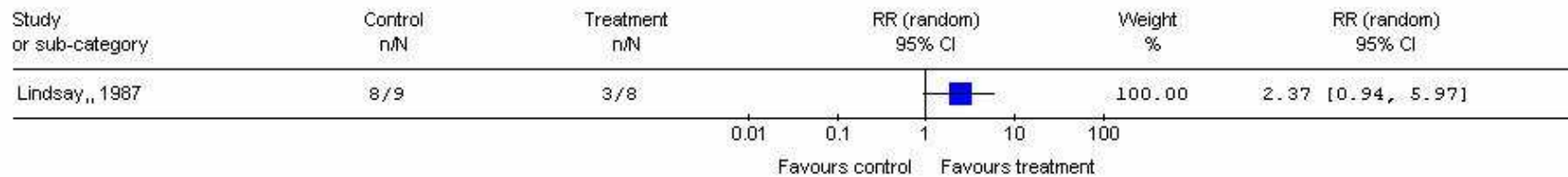
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 10 Subjects that showed clinically meaningful change after treatment - CAQ



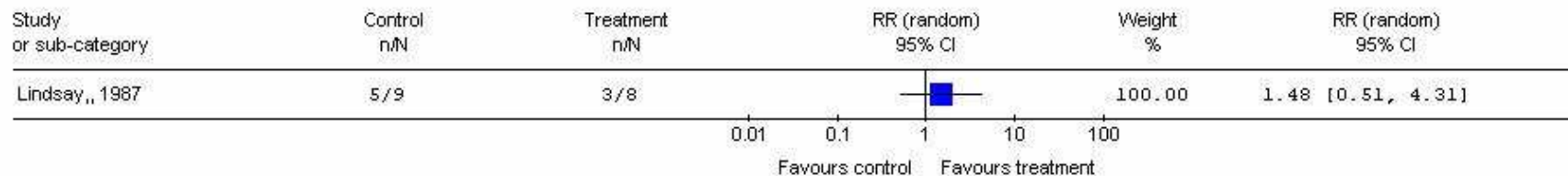
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 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 11 Subjects that showed clinically meaningful change after 3-month follow-up - CAQ



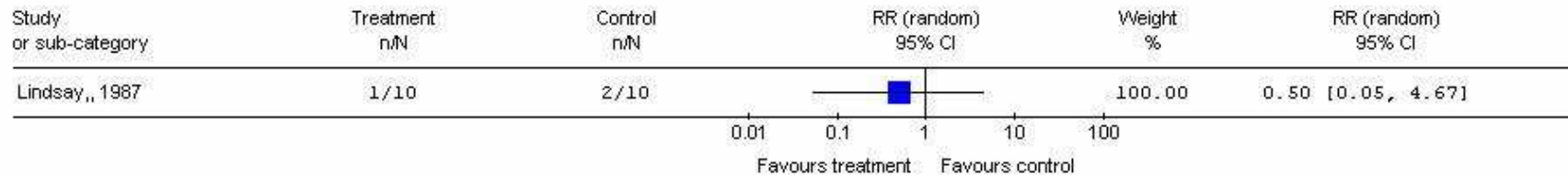
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 12 Subjects that showed clinically meaningful change after treatment - GHQ-anxiety



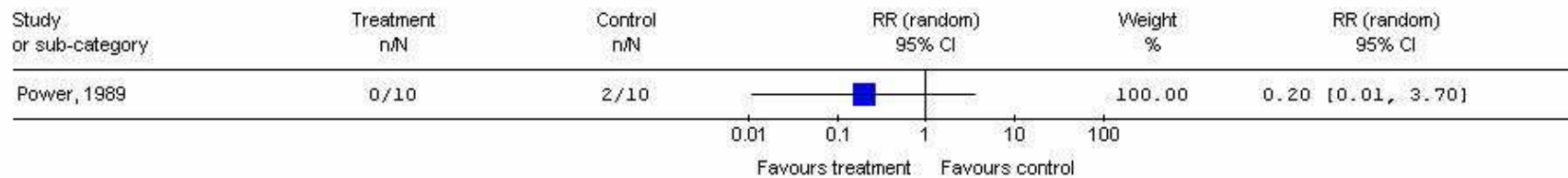
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 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 13 Subjects that showed clinically meaningful change after 3-month follow-up - GHQ-anxiety



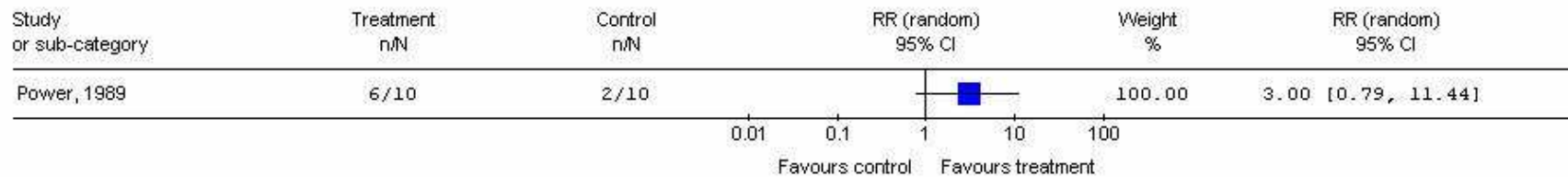
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 Comparison: 05 Cognitive-Behaviour Therapy versus Anxiety Management Training  
 Outcome: 14 Dropouts



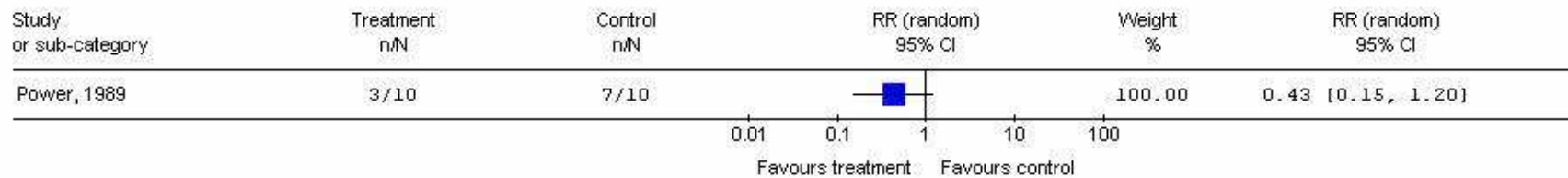
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 06 Cognitive Behaviour Therapy versus Diazepam  
 Outcome: 01 No change in anxiety symptoms or worse - Global Scale (psychologist assessor)



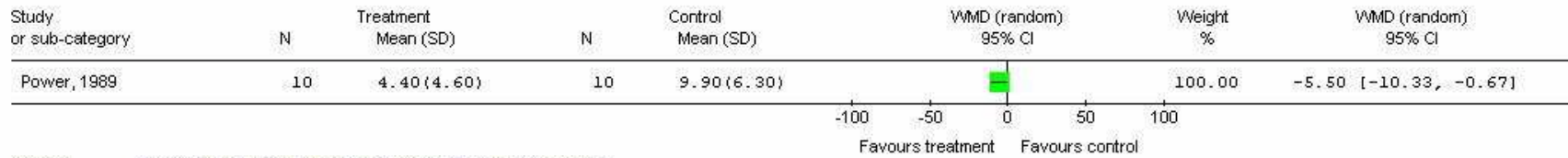
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 06 Cognitive Behaviour Therapy versus Diazepam  
 Outcome: 02 Very much improved - Global Scale (psychologist assessor)



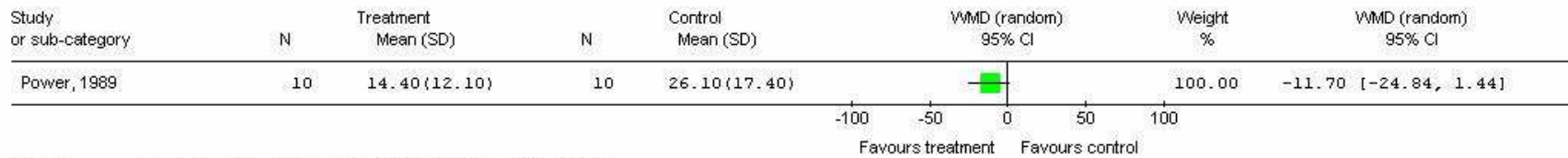
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 Comparison: 06 Cognitive Behaviour Therapy versus Diazepam  
 Outcome: 03 Subsequent psychological and/or psychotropic treatment at twelve-month follow-up



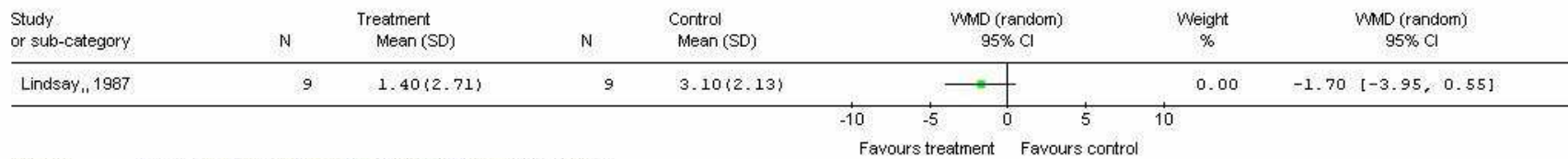
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 06 Cognitive Behaviour Therapy versus Diazepam  
 Outcome: 04 Means of Hamilton Rating Scale after 6-week treatment



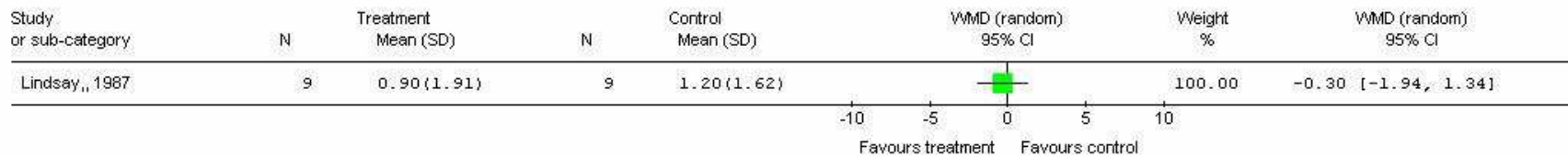
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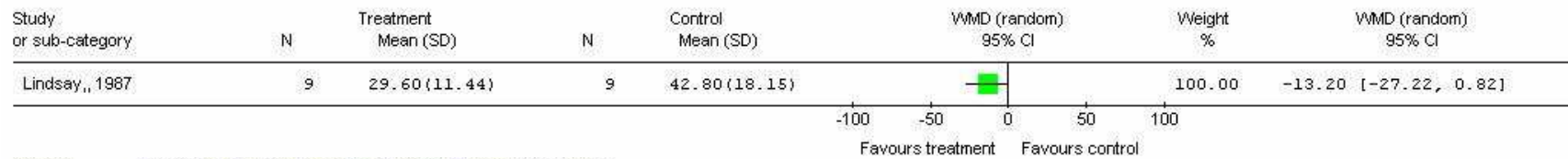
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 07 Cognitive-Behaviour Therapy versus Lorazepam/Ativan  
 Outcome: 01 Means of General Health Questionnaire - anxiety, after 4-week treatment



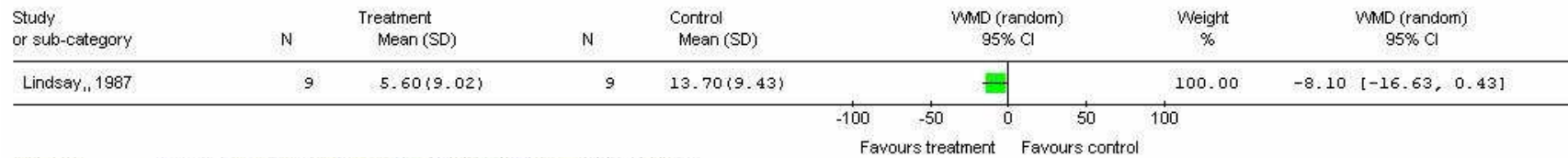
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 Outcome: 02 Means of General Health Questionnaire - general health, after 4-week treatment



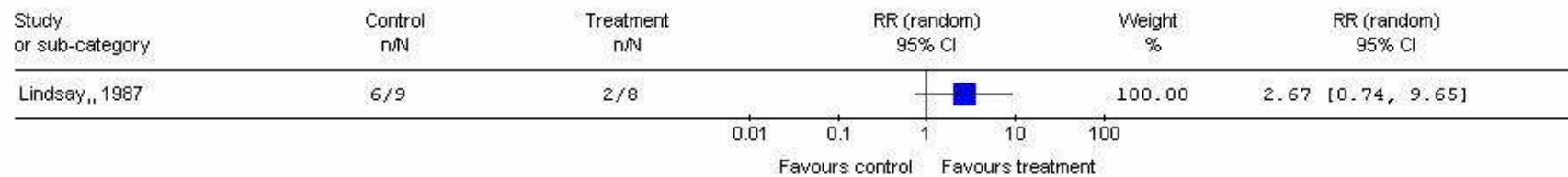
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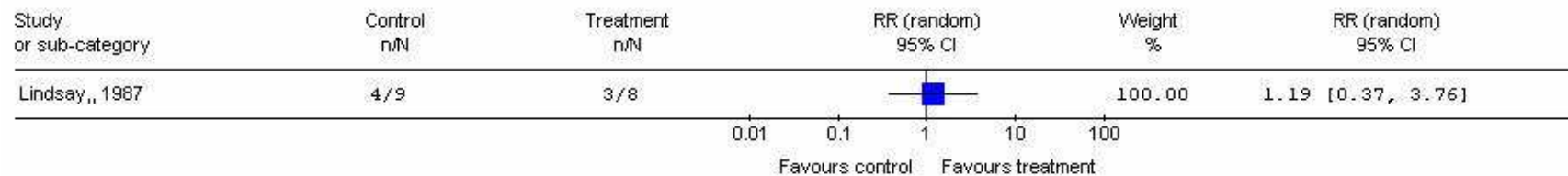
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 Outcome: 04 Means of Cognitive Anxiety Questionnaire after 4-week treatment



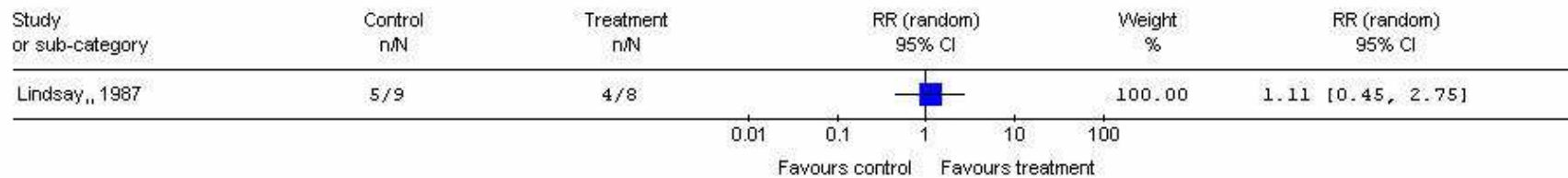
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 Comparison: 07 Cognitive-Behaviour Therapy versus Lorazepam/Ativan  
 Outcome: 05 Subjects that showed clinically meaningful change after treatment - Zung



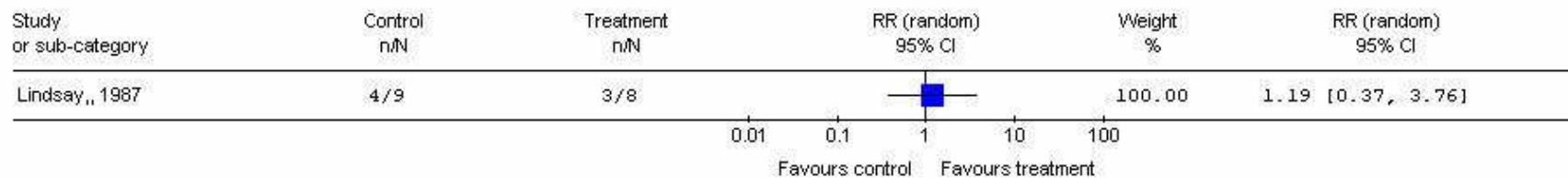
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 Comparison: 07 Cognitive-Behaviour Therapy versus Lorazepam/Ativan  
 Outcome: 06 Subjects that showed clinically meaningful change after 3-month follow-up - Zung



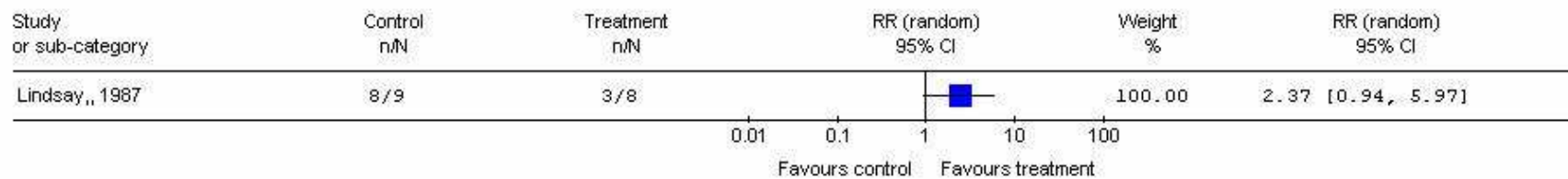
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 Outcome: 07 Subjects that showed clinically meaningful change after treatment - CAQ



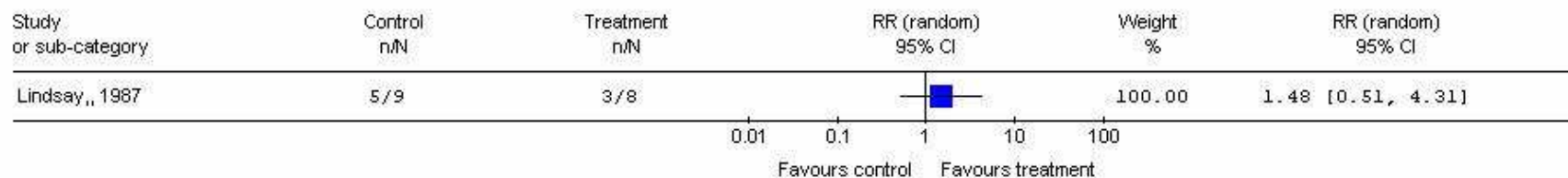
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 Comparison: 07 Cognitive-Behaviour Therapy versus Lorazepam/Ativan  
 Outcome: 08 Subjects that showed clinically meaningful change after 3-month follow-up - CAQ



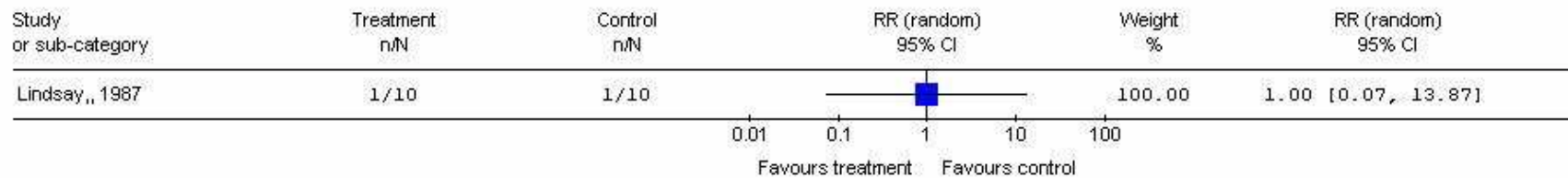
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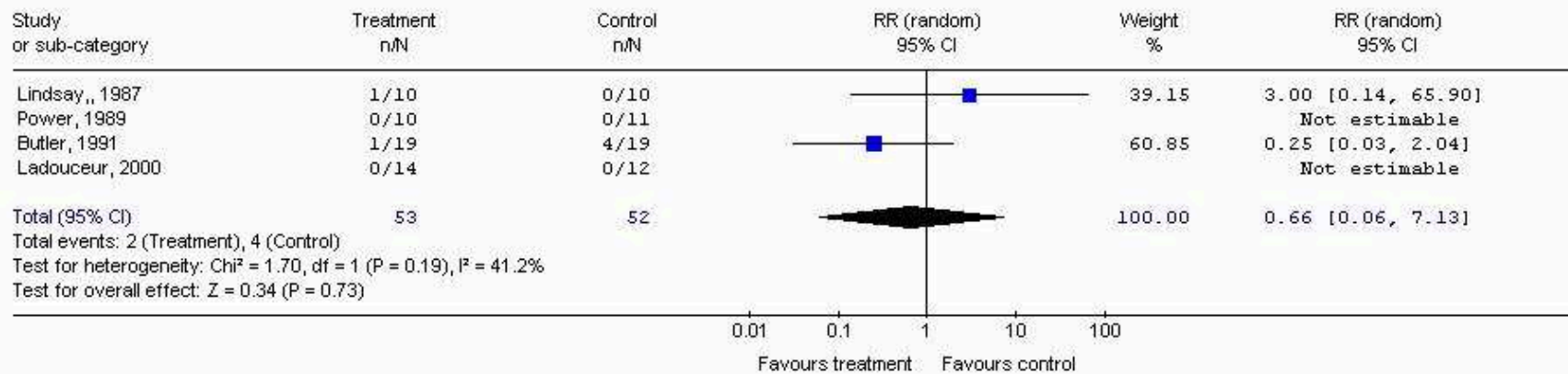
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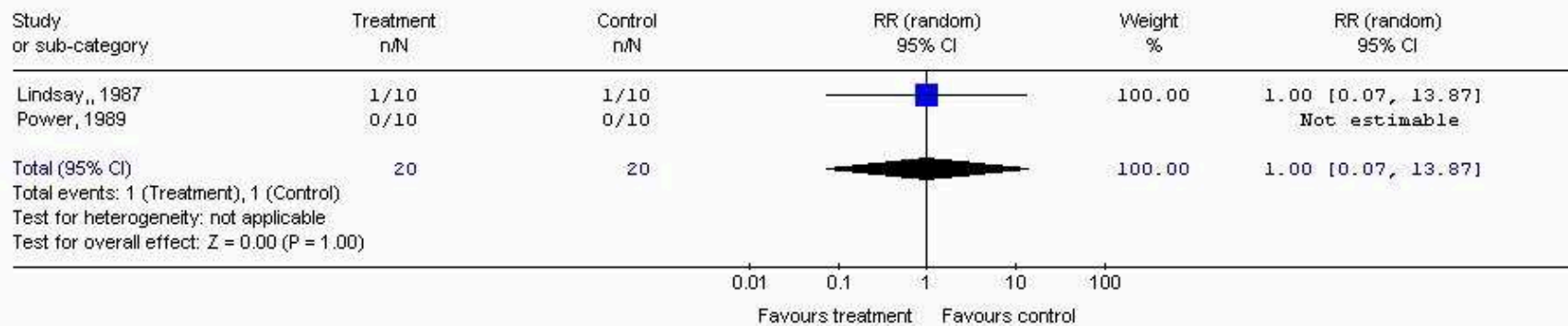
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 Comparison: 07 Cognitive-Behaviour Therapy versus Lorazepam/Ativan  
 Outcome: 11 Dropouts



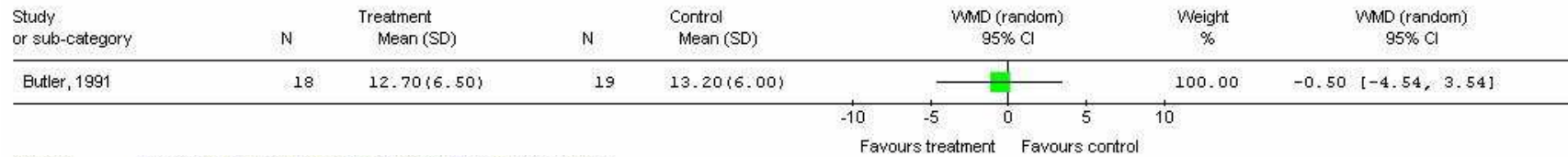
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 Comparison: 08 All Cognitive-Behavior Therapy versus No intervention - ADULTHOOD  
 Outcome: 01 Dropouts



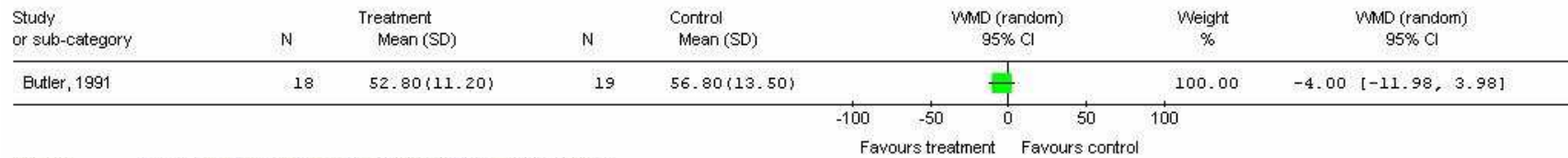
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 Comparison: 09 All Cognitive Behavior Therapy versus any Benzodiazepine - ADULTHOOD  
 Outcome: 01 Dropouts



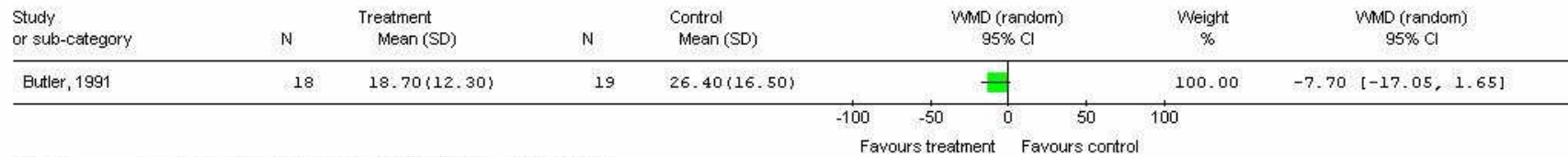
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 Comparison: 10 Behavior Therapy versus Waiting List / COMORBID CASES  
 Outcome: 01 Means of Hamilton Anxiety Scale after 3-month treatment



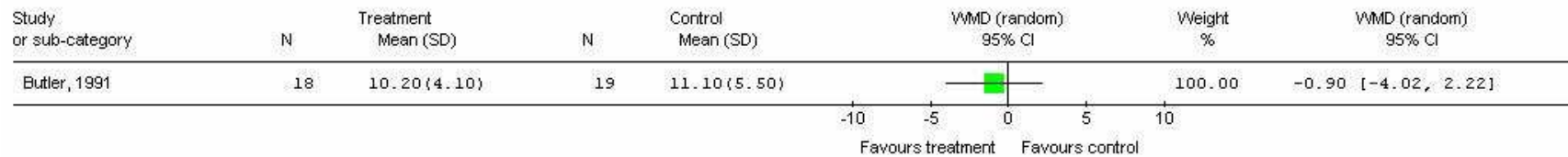
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 Comparison: 10 Behavior Therapy versus Waiting List / COMORBID CASES  
 Outcome: 02 Means of State Trait Anxiety Inventory after 3-month treatment



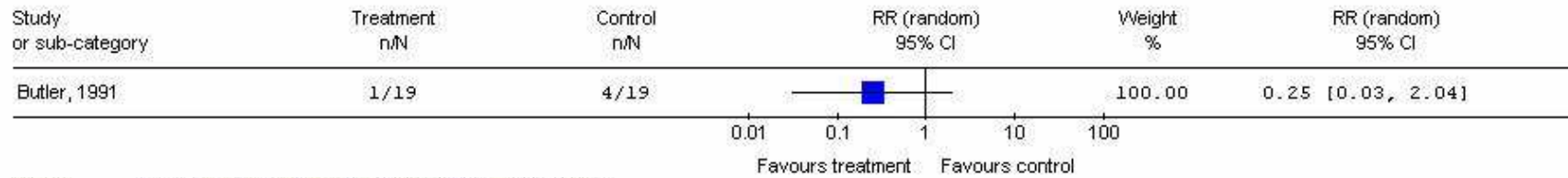
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 Comparison: 10 Behavior Therapy versus Waiting List / COMORBID CASES  
 Outcome: 03 Means of Beck Anxiety Inventory after 3-month treatment



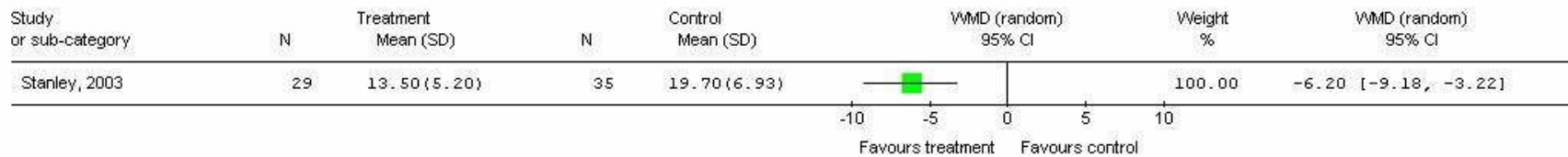
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 Outcome: 04 Means of Leeds Scales for the Self-Assessment of Anxiety and Depression after 3-month treatment



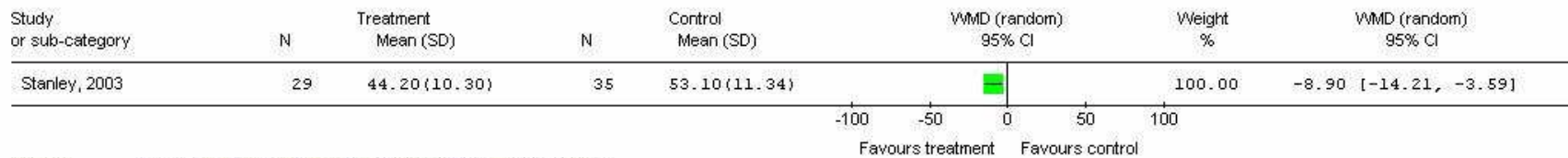
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 Comparison: 10 Behavior Therapy versus Waiting List / COMORBID CASES  
 Outcome: 05 Dropouts



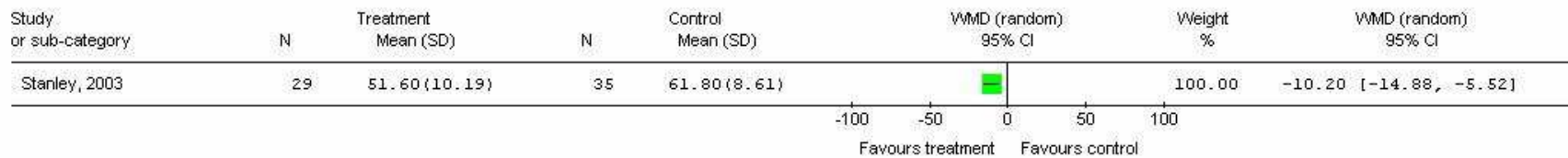
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 01 Means of Hamilton Rating Scale for Anxiety - after 15 weeks treatment



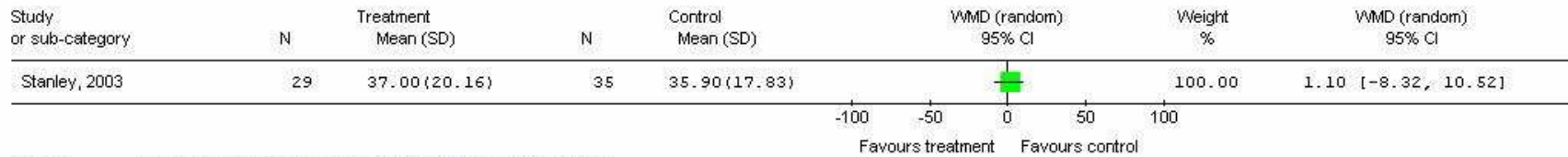
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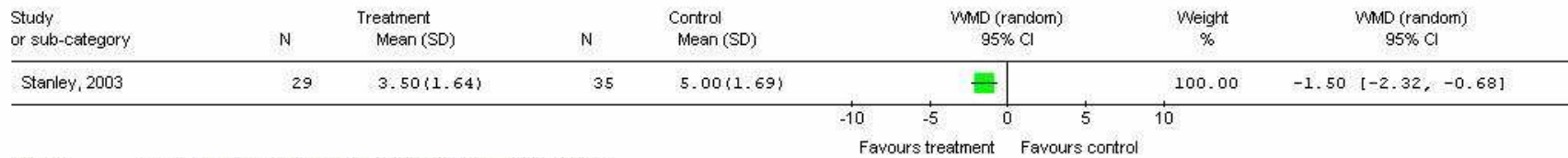
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 Outcome: 03 Means of Penn State Worry Questionnaire - after 15 weeks treatment



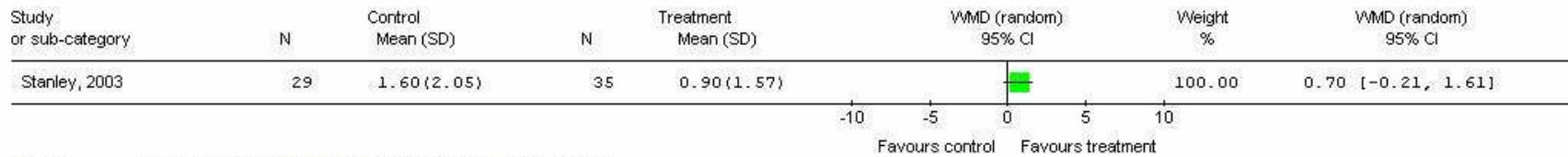
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 04 Means of Worry Scale - after 15 weeks treatment



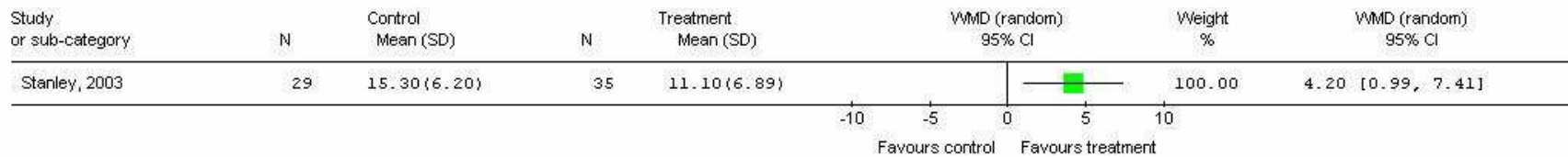
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 05 Means of GAD severity (clinician-rated global measure) - after 15 weeks treatment



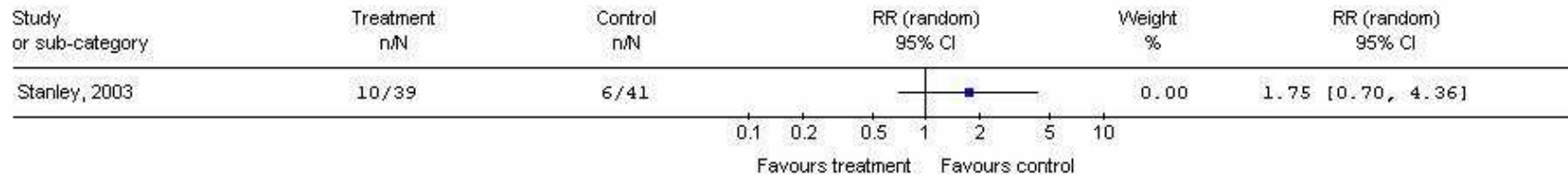
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 06 Means of Quality of Life Inventory - after 15 weeks treatment



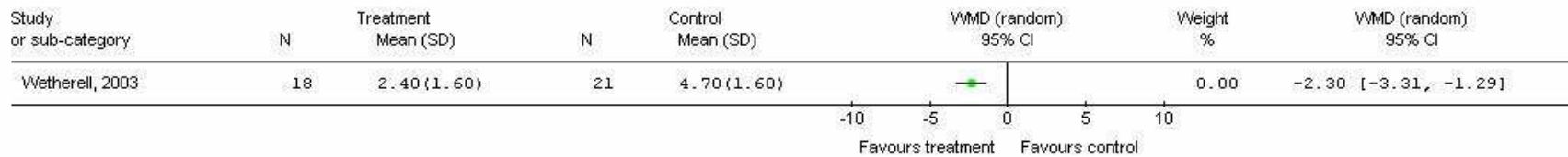
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 07 Means of Life Satisfaction Index-Z - after 15 weeks treatment



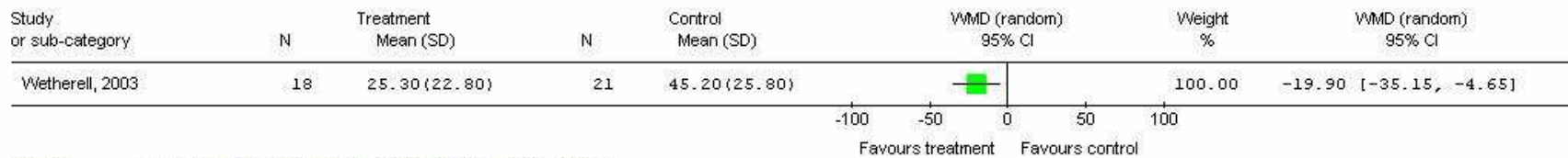
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 11 Cognitive-Behavioral Therapy versus Minimal Contact Control - OLDER ADULTS / Comorbid cases  
 Outcome: 08 Dropouts



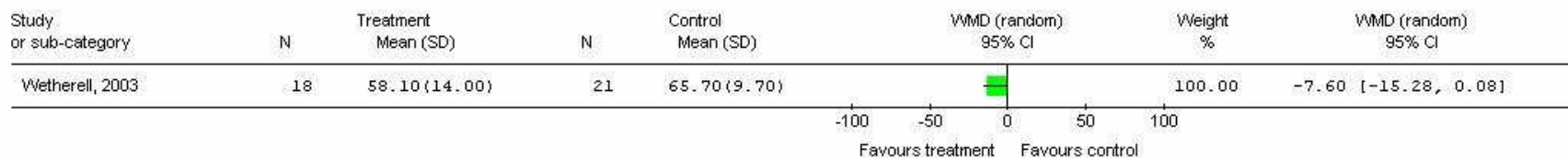
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 01 GAD Severity Ratings after 12-week treatment



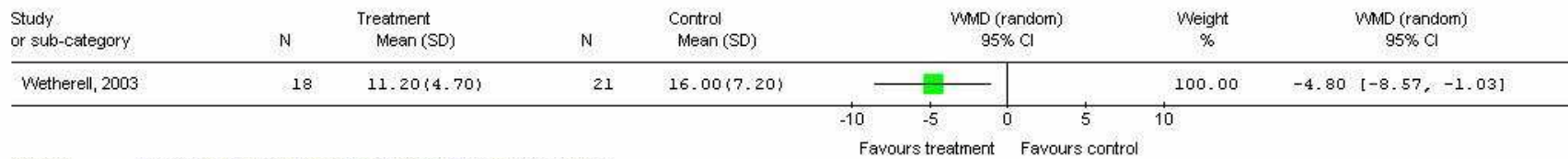
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 02 Means of % of day worried after 12-week treatment



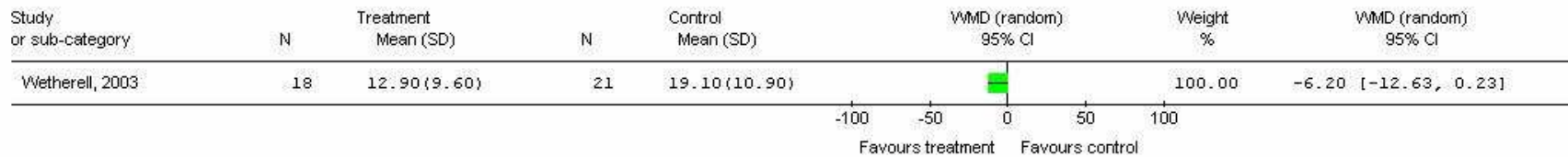
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 03 Means of Penn State Worry Questionnaire after 12-week treatment



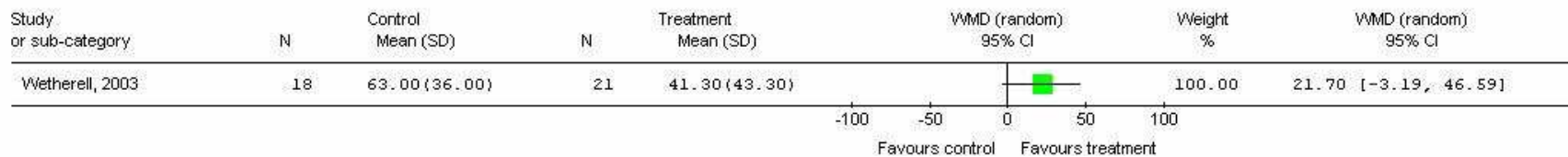
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 04 Means of Hamilton Anxiety Rating Scale after 12-week treatment



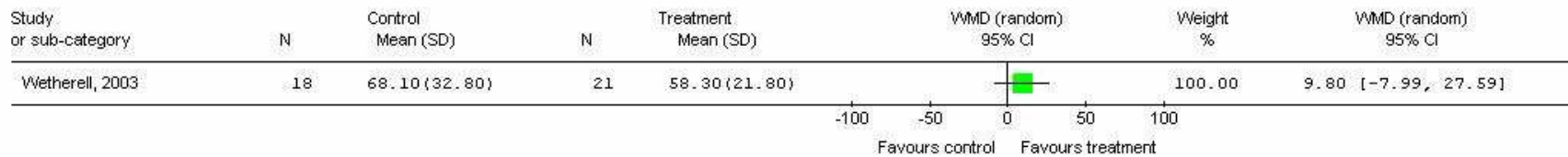
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 05 Means of Beck Anxiety Inventory after 12-week treatment



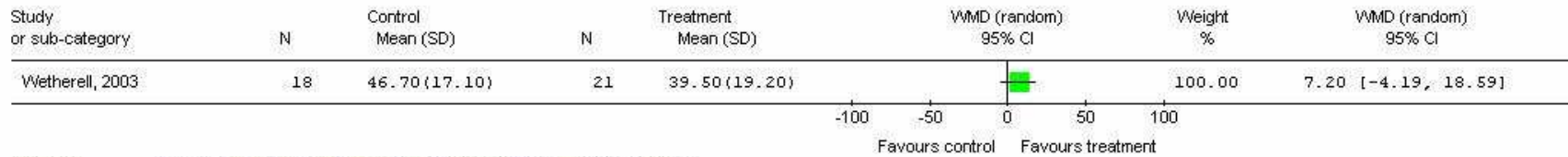
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 06 Means of Role Functioning after 12-week treatment



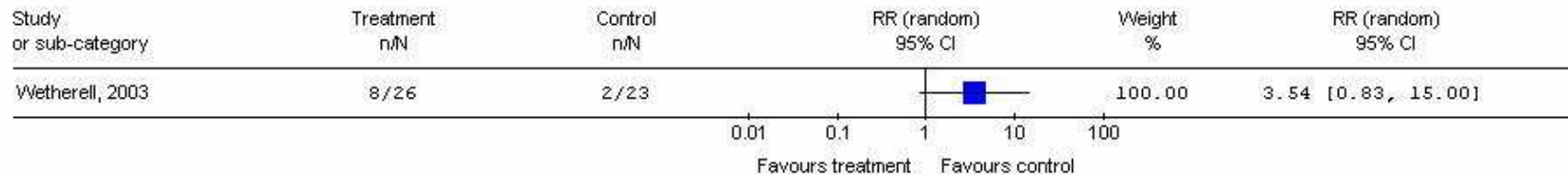
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 07 Means of Social Functioning after 12-week treatment



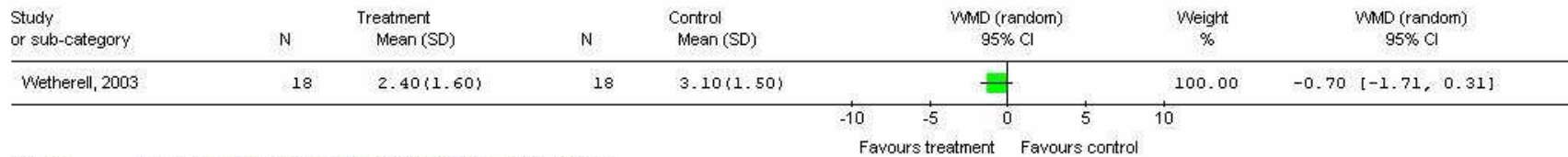
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 08 Means of Energy/Vitality after 12-week treatment



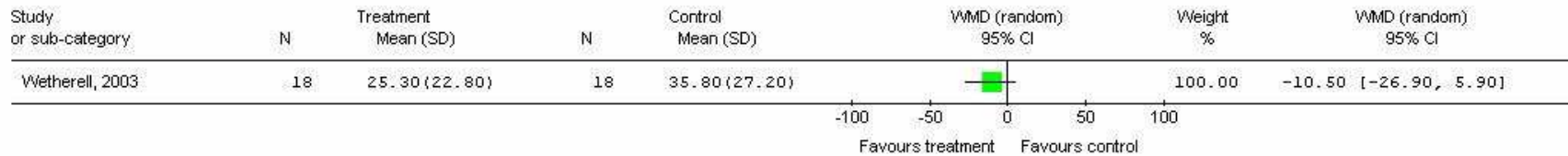
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 12 Cognitive-Behavioral Therapy versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 09 Dropouts after 12-week treatment



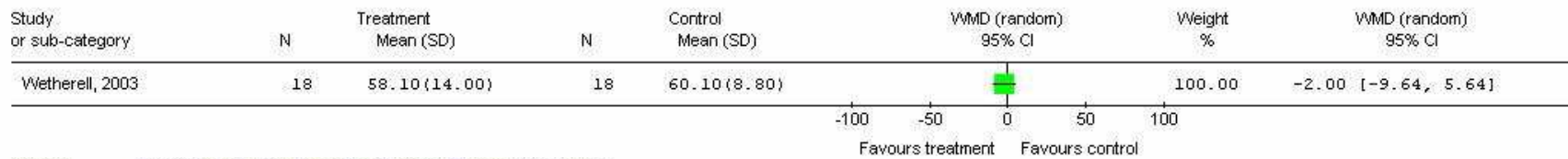
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me)  
 Outcome: 01 Means of GAD Severity Rating after 12-week treatment



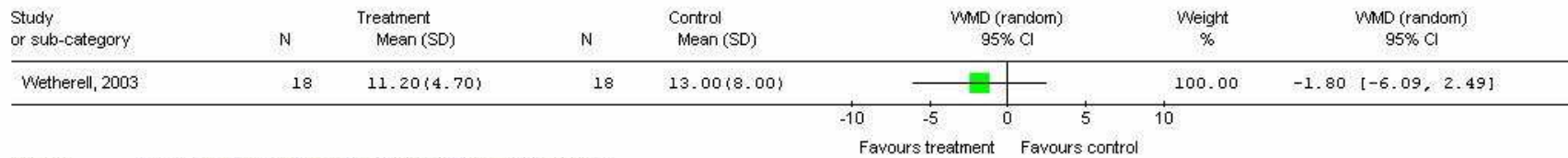
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me)  
 Outcome: 02 Means of % of day worried after 12-week treatment



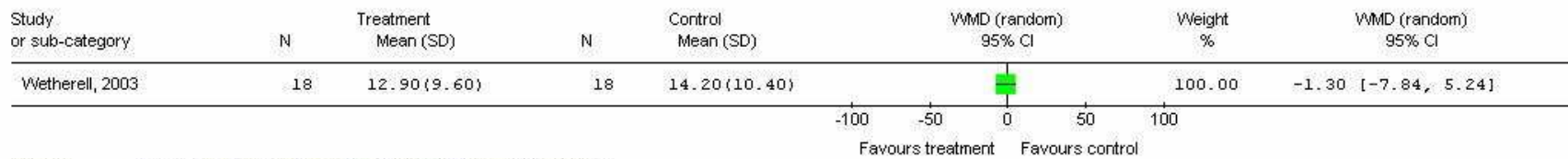
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 03 Means of Penn State Worry Questionnaire after 12-week treatment



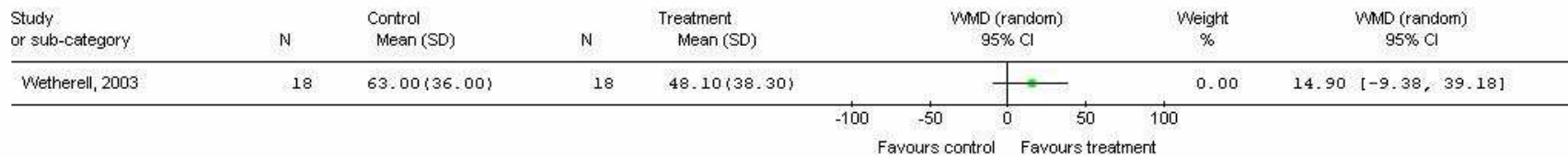
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 04 Means of Hamilton Anxiety Rating Scale after 12-week treatment



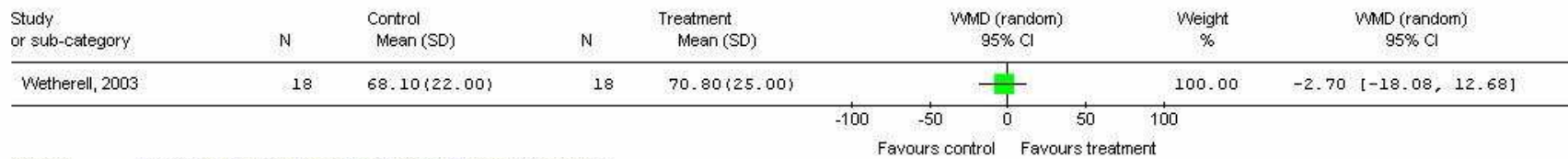
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 05 Means of Beck Anxiety Inventory after 12-week treatment



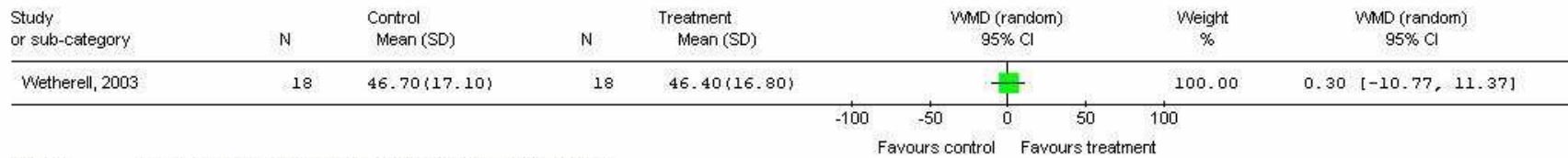
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 06 Means of Role Functioning after 12-week treatment



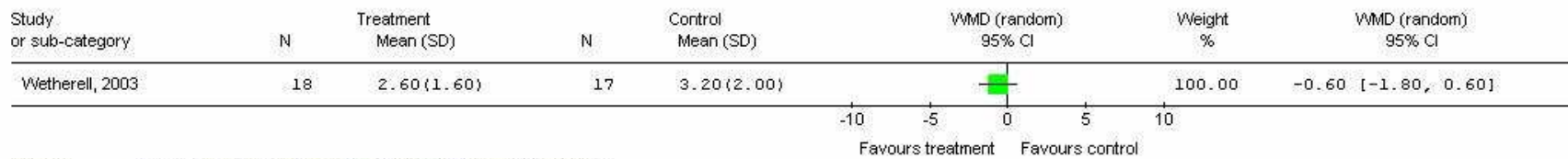
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 07 Means of Social Functioning after 12-week treatment



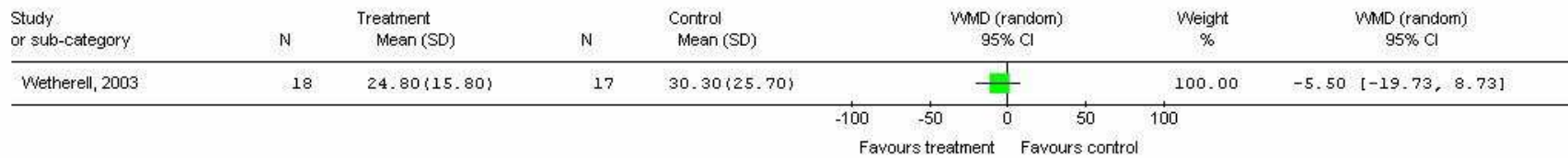
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 08 Means of Energy/Vitality after 12-week treatment



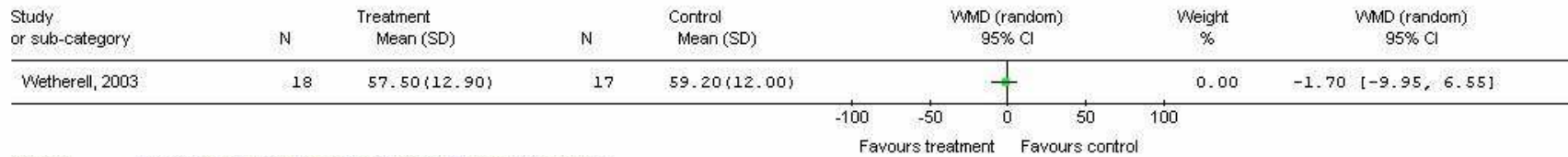
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 09 Means of GAD Severity Rating after 6-month follow-up



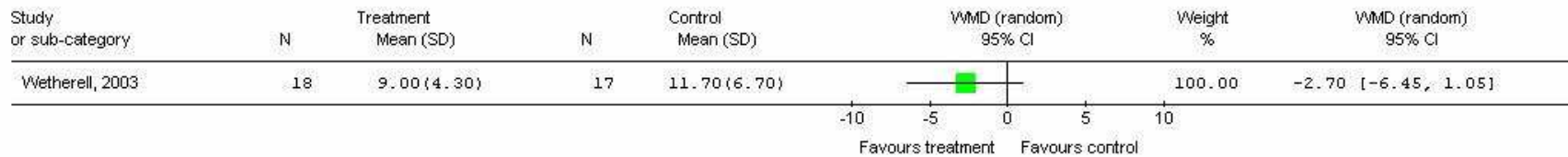
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 10 Means of % day worried after 6-month follow-up



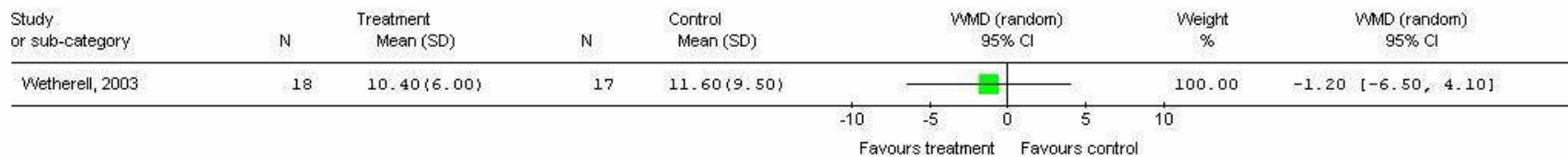
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
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 Outcome: 11 Means of Penn State Worry Questionnaire after 6-month follow-up



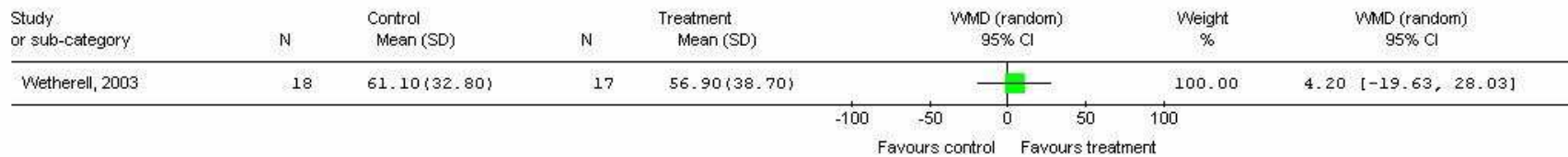
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 12 Means of Hamilton Anxiety Rating Scale after 6-month follow-up



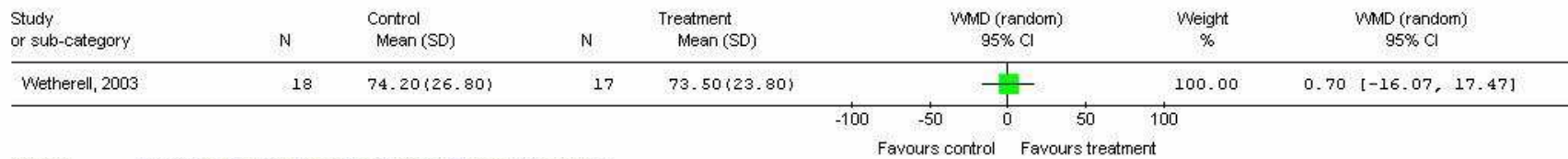
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 13 Means of Beck Anxiety Inventory after 6-month follow-up



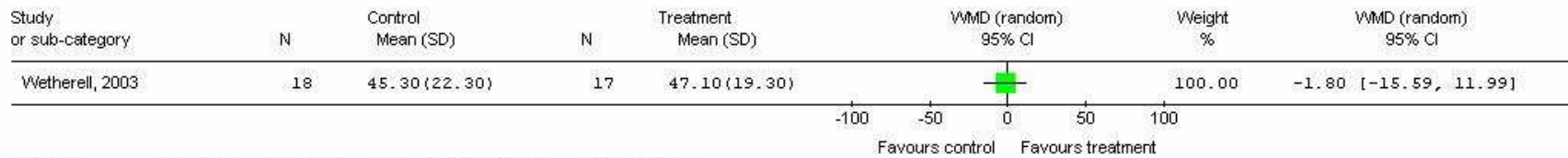
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 14 Means of Role of Functioning after 6-month follow-up



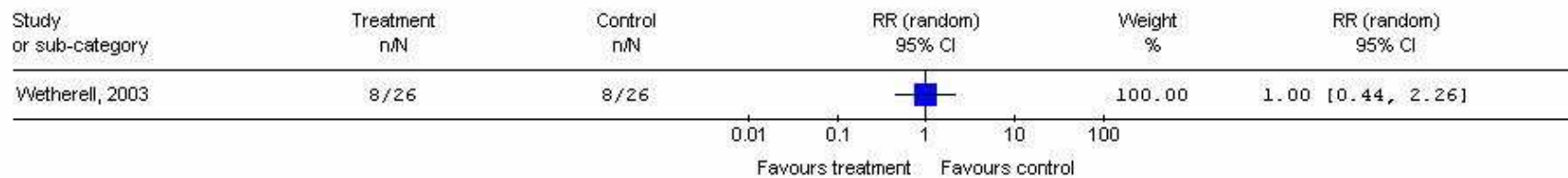
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 15 Means of Social Functioning after 6-month follow-up



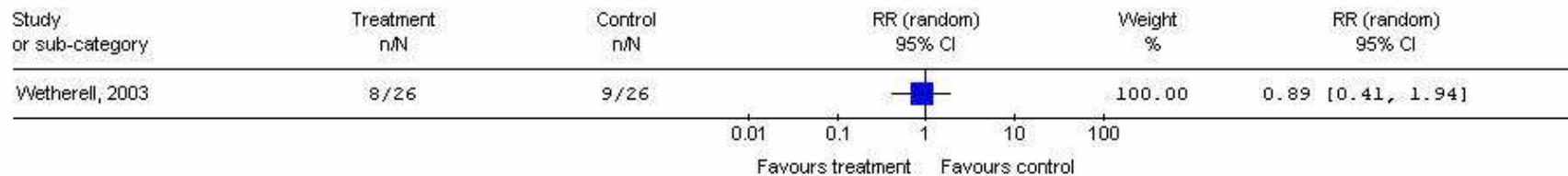
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 16 Means of Energy/Vitality after 6-month follow-up



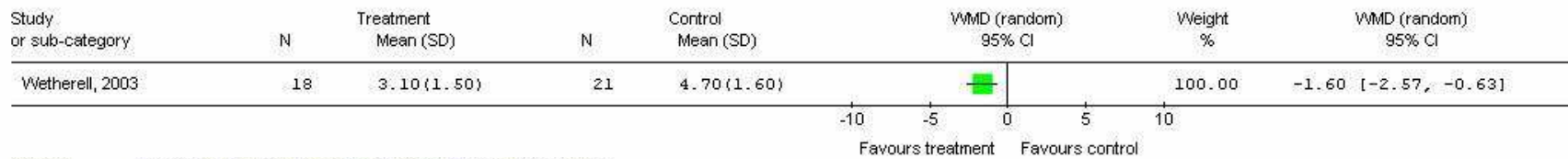
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 17 Dropouts after 12-week treatment



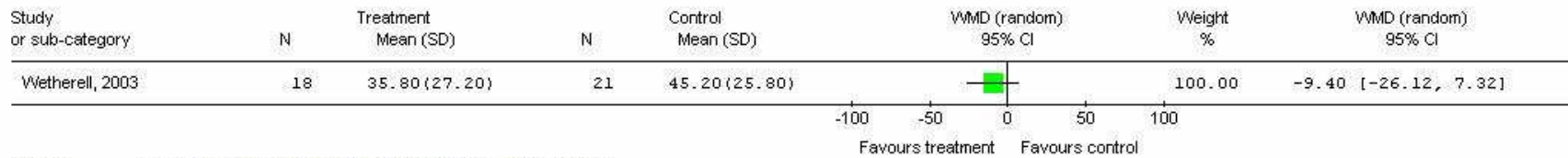
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 13 Cognitive-Behavioral Therapy versus Discussion Group - OLDER ADULTS / Comorbid cases(some patients using me  
 Outcome: 18 Dropouts after 6-month follow-up



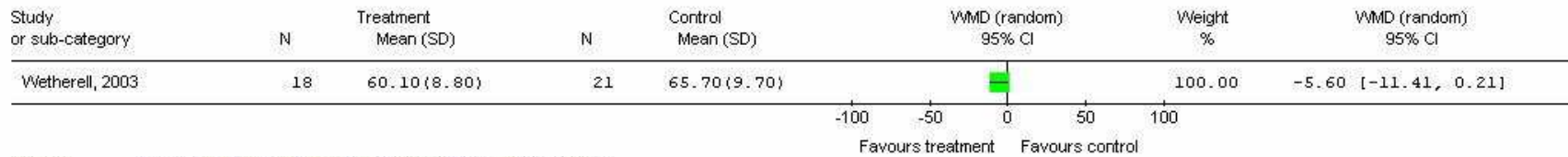
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 01 Means of GAD Severity Rating after 12-week treatment



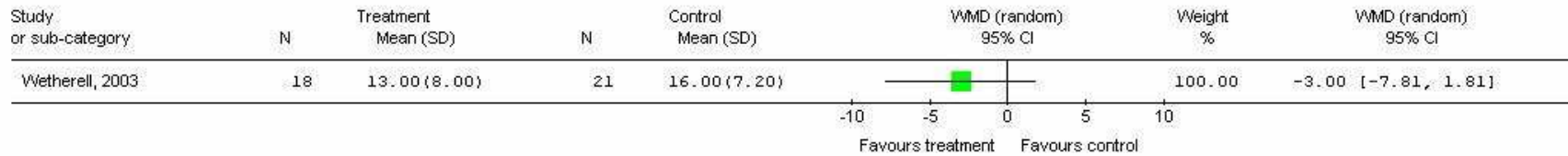
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 02 Means of % of day worried after 12-week treatment



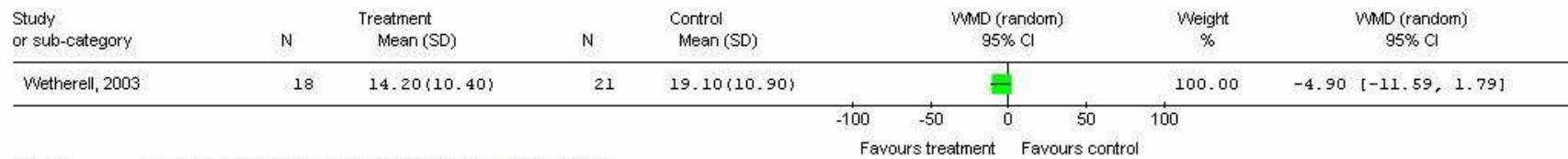
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 03 Means of Penn State Worry Questionnaire after 12-week treatment



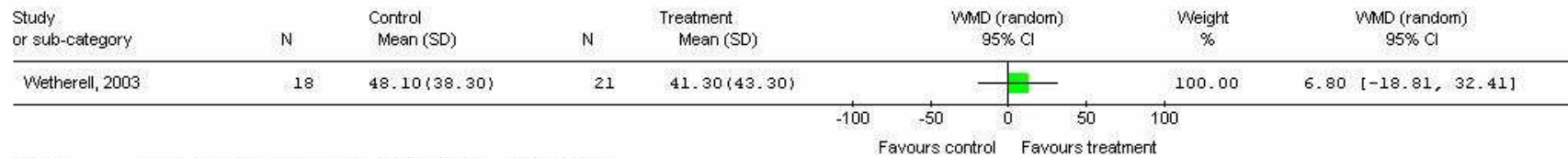
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 04 Means of Hamilton Anxiety Rating Scale after 12-week treatment



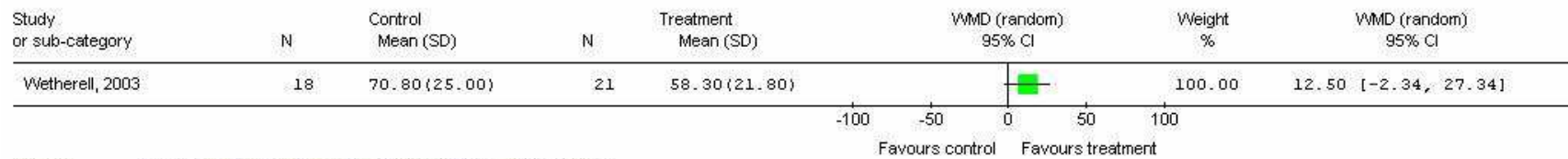
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 05 Means of Beck Anxiety Inventory after 12-week treatment



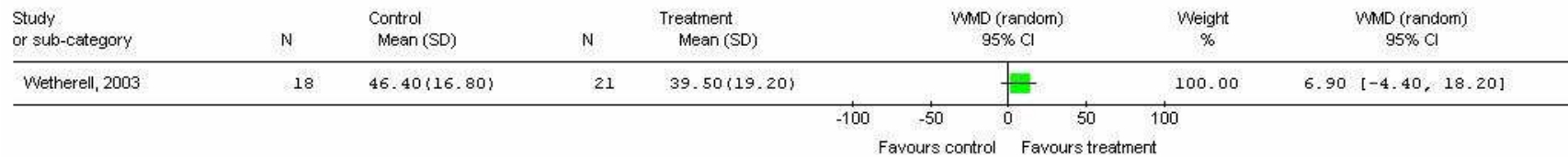
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 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 06 Means of Role Functioning after 12-week treatment



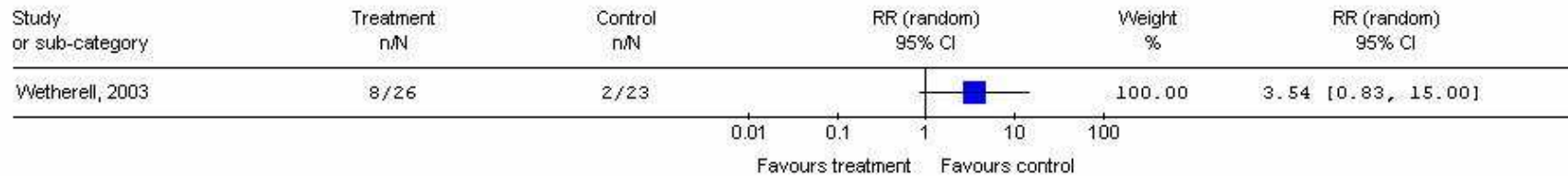
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 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 07 Means of Social Functioning after 12-week treatment



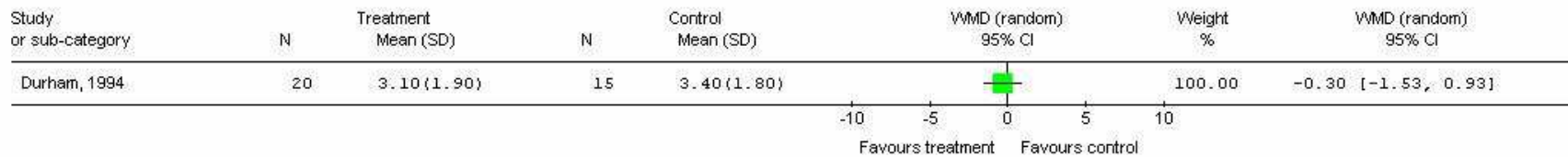
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 08 Means of Energy/Vitality after 12-week treatment



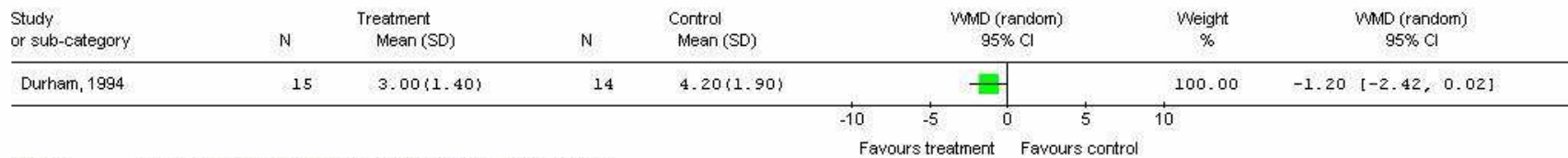
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 14 Discussion Group versus Waiting List - OLDER ADULTS / Comorbid cases(some patients using med)  
 Outcome: 09 Dropouts after 12-week treatment



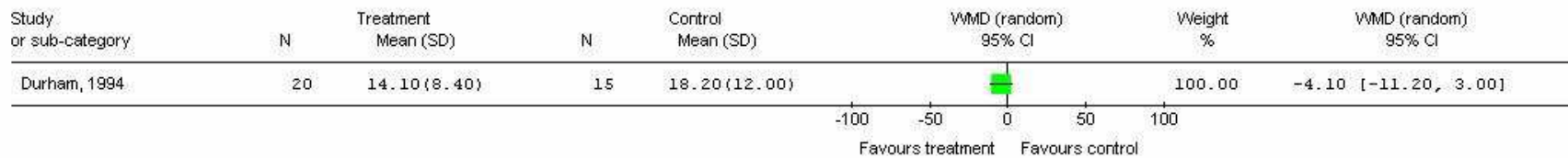
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 01 Means of 0-8 point rating of overall severity - After treatment - LOW contact



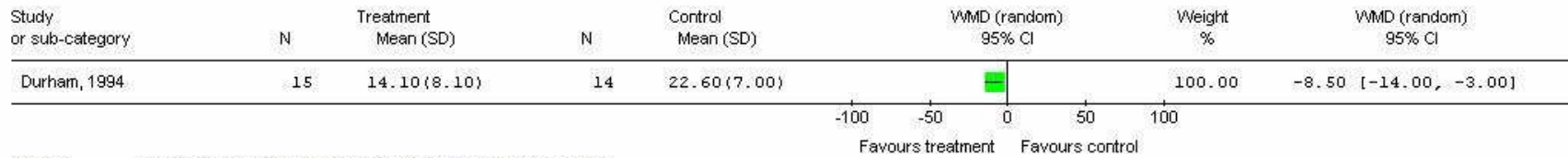
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 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 02 Means of 0-8 point rating of overall severity - After treatment - HIGH contact



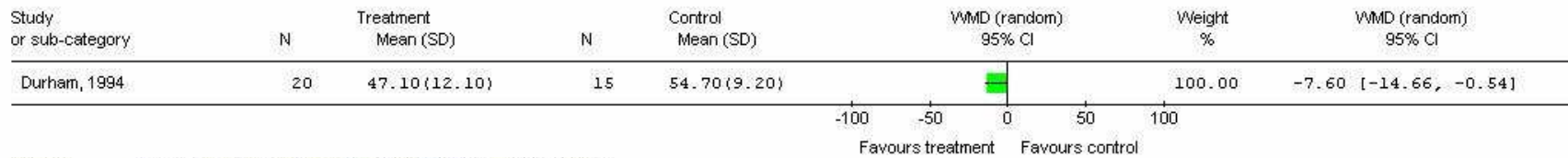
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 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 03 Means of Hamilton Rating Scale for Anxiety - After treatment - LOW contact



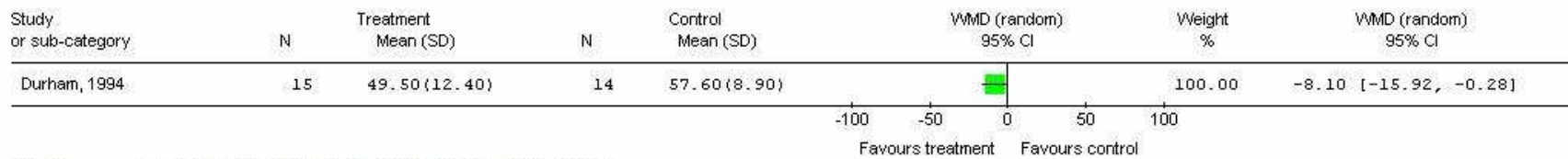
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 Outcome: 04 Means of Hamilton Rating Scale for Anxiety - After treatment - HIGH contact



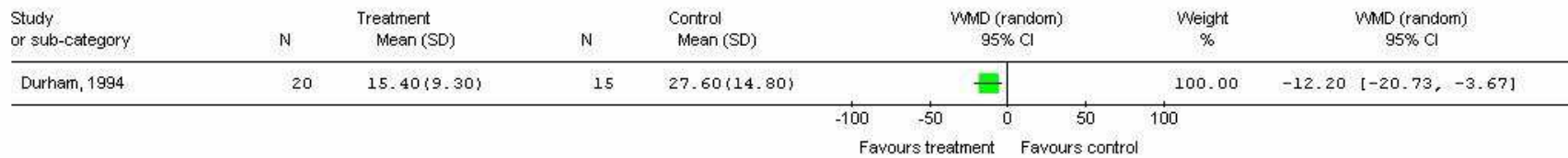
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 05 Means of State-Trait Anxiety Inventory - After treatment - LOW contact



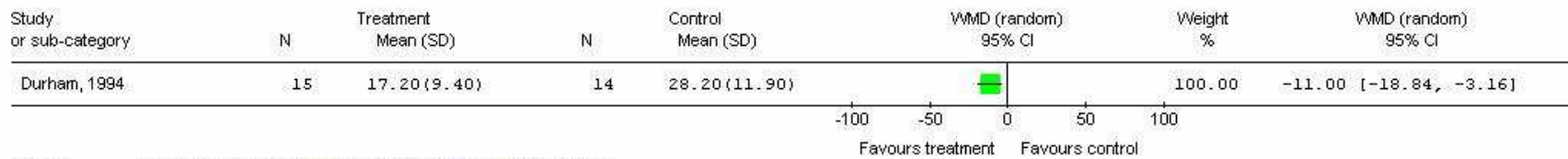
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 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 06 Means of State-Trait Anxiety Inventory - After treatment - HIGH contact



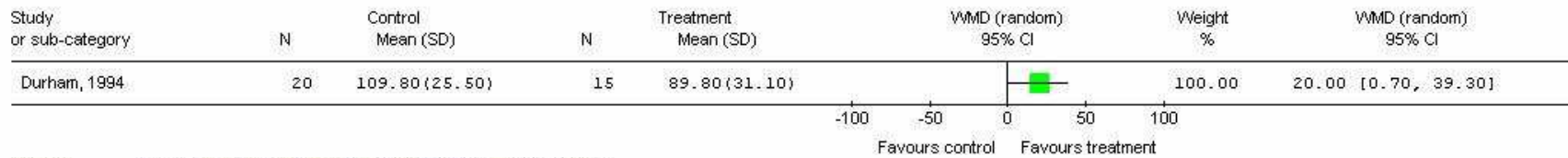
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 07 Means of Beck Anxiety Inventory - After treatment - LOW contact



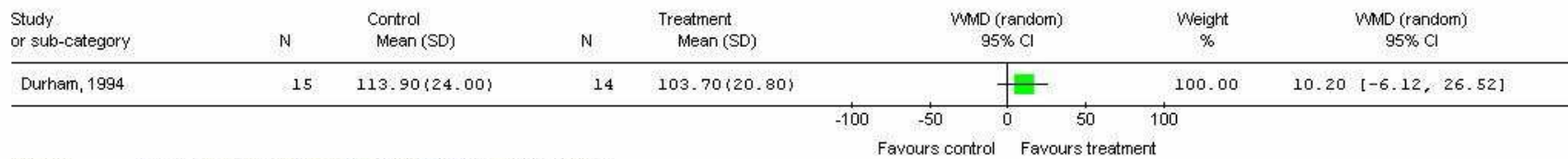
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 08 Means of Beck Anxiety Inventory - After treatment - HIGH contact



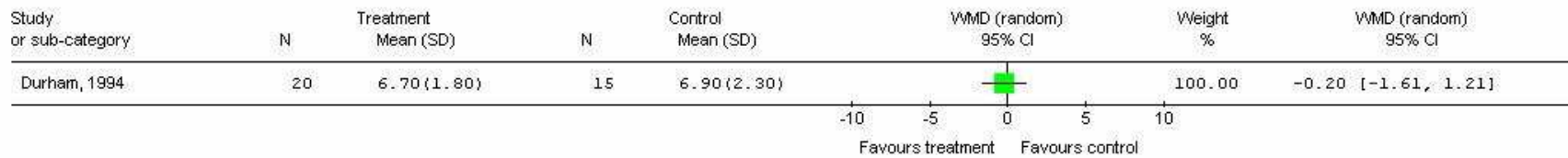
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 09 Means of Dysfunctional Attitude Scale - After treatment - LOW contact



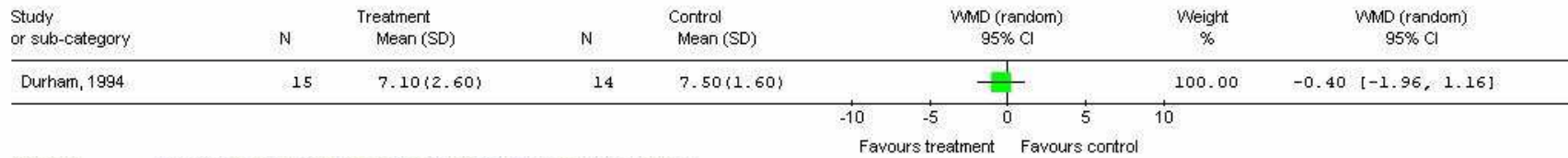
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 10 Means of Dysfunctional Attitude Scale - After treatment - HIGH contact



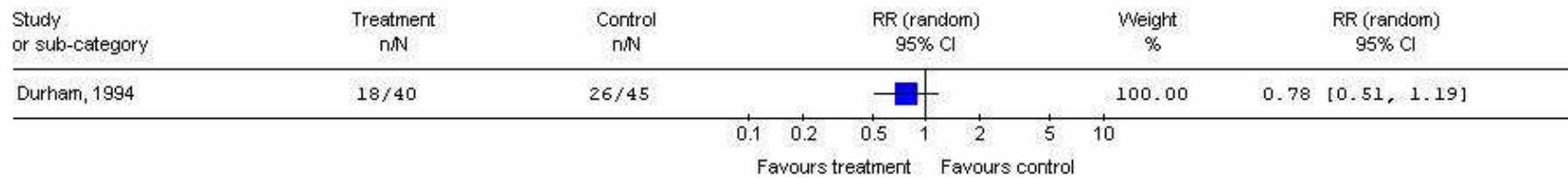
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 11 Means of Social Adjustment Scale - After treatment - LOW contact



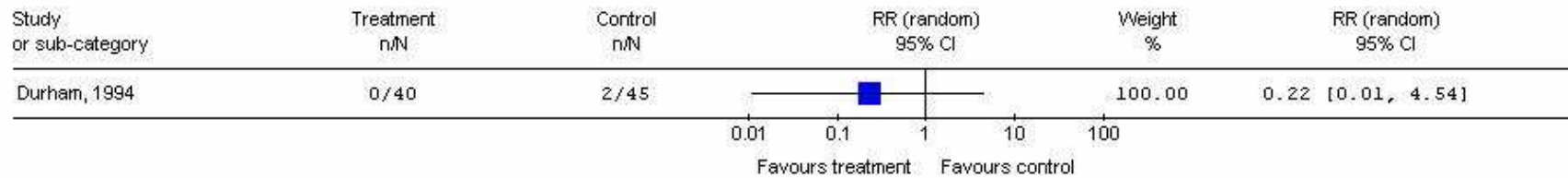
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 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 12 Means of Social Adjustment Scale - After treatment - HIGH contact



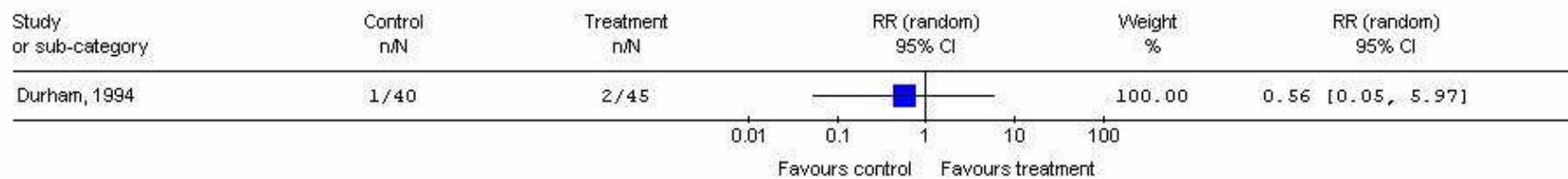
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 13 Dropouts after treatment



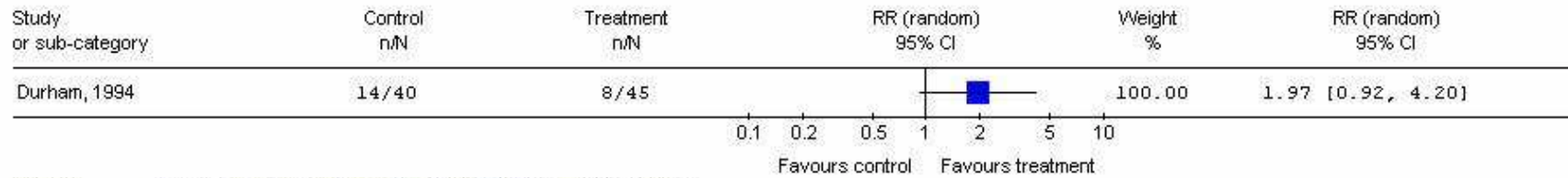
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 14 No change or worse after treatment (patients ratings)



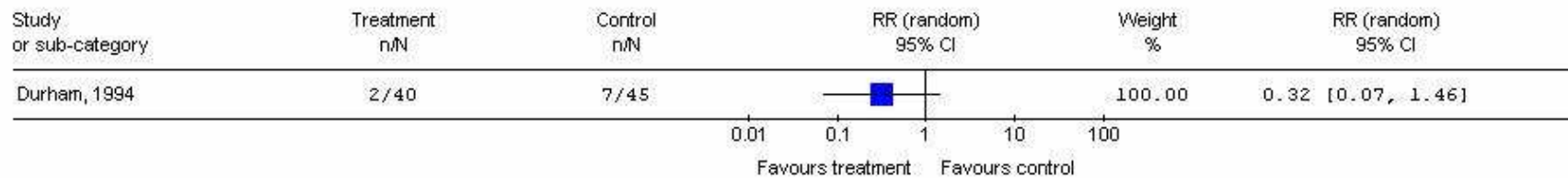
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 15 Better after treatment (patients ratings)



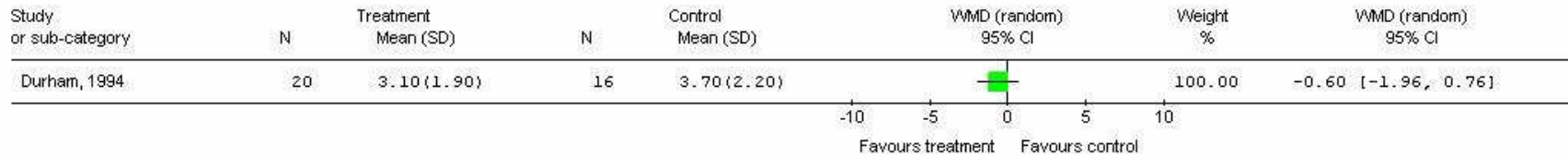
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 16 Change very considerable or better - after treatment (patients ratings)



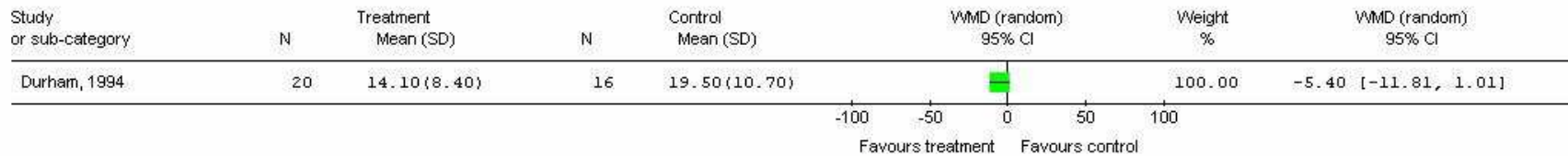
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 15 Cognitive Therapy versus Analytic Psychotherapy (some patients using med)  
 Outcome: 17 No change or worse after six month follow-up (patients ratings)



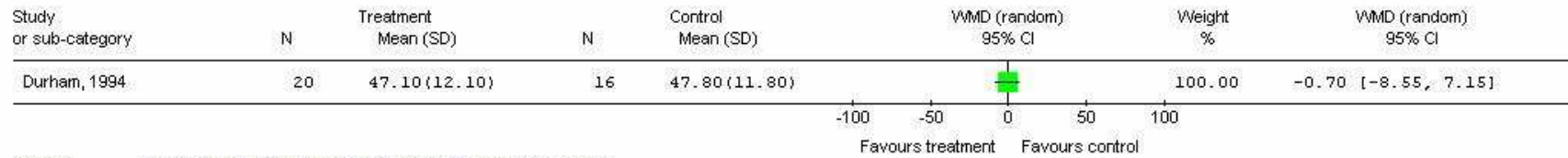
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 01 Means of 0-8 point rating of overall severity - After treatment - LOW contact



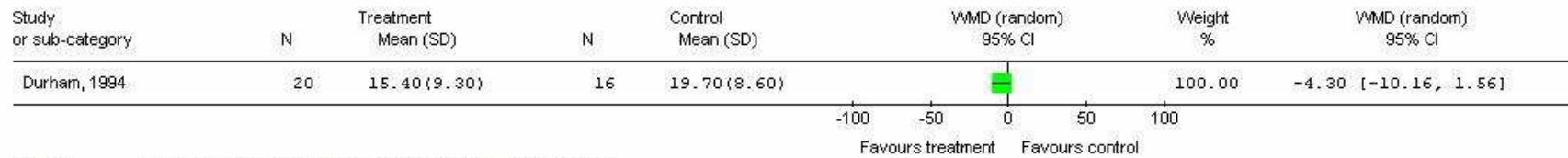
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 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 02 Means of Hamilton Rating Scale for Anxiety - After treatment - LOW contact



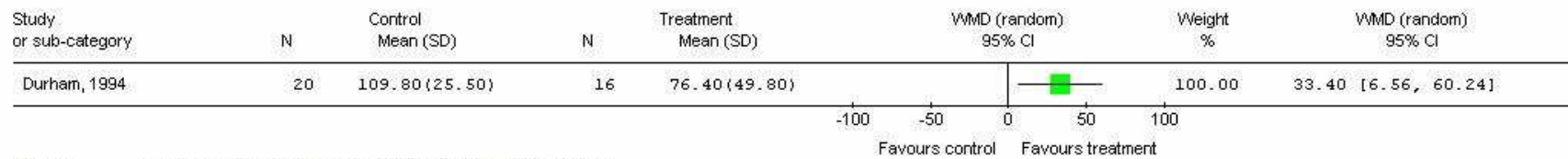
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 03 Means of State-Trait Anxiety Inventory - After treatment - LOW contact



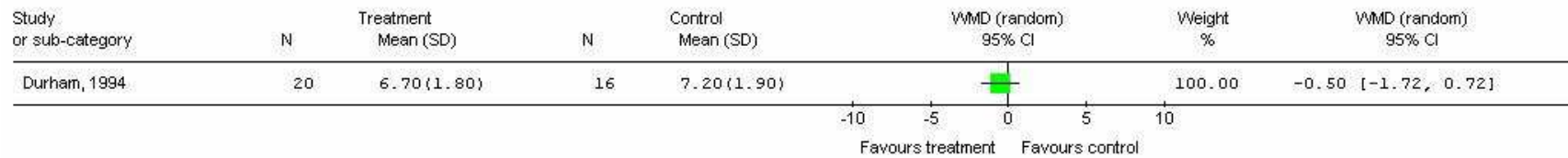
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 Outcome: 04 Means of Beck Anxiety Inventory - After treatment - LOW contact



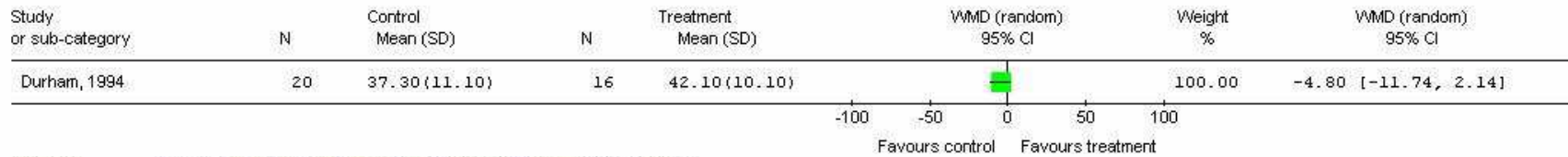
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 05 Means of Dysfunctional Attitude Scale - After treatment - LOW contact



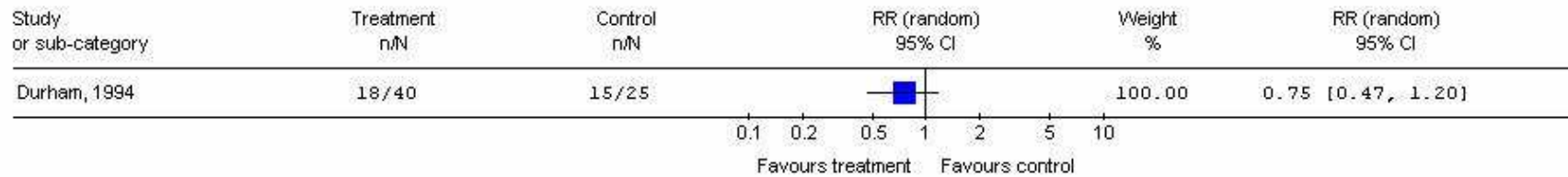
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 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 06 Means of Social Adjustment Scale - After treatment - LOW contact



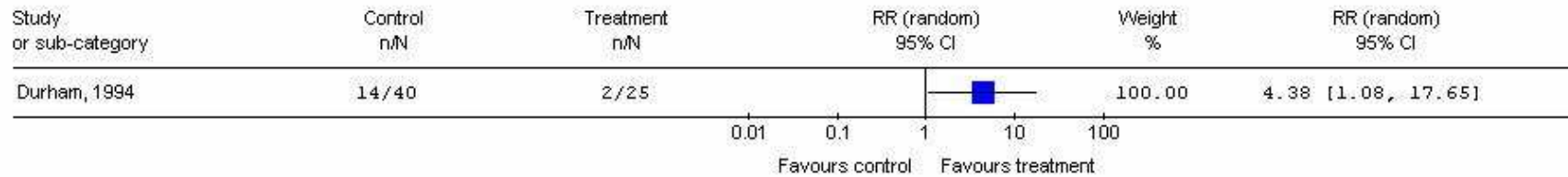
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 Outcome: 07 Means of Self-Esteem Scale - after treatment - LOW contact



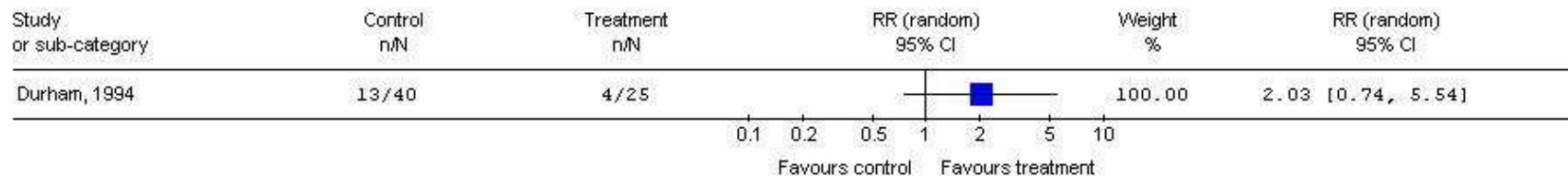
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 08 Dropouts after treatment



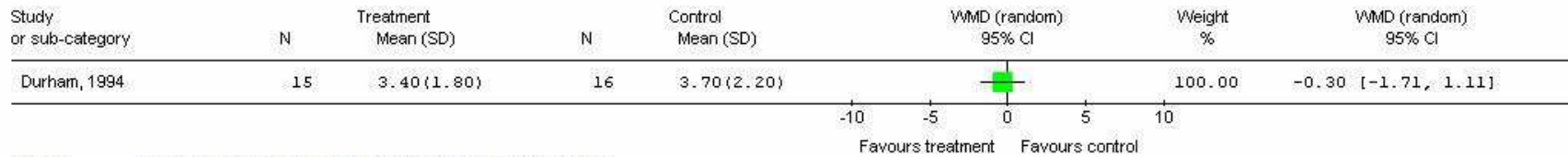
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 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 09 Change very considerable or better - after treatment (patients ratings)



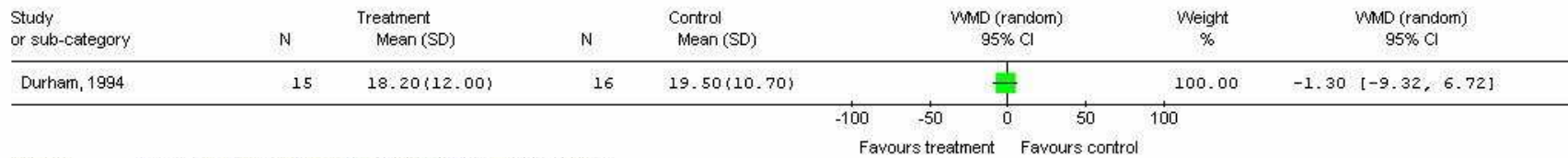
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 Comparison: 16 Cognitive Therapy versus Anxiety Management Training (some patients using med)  
 Outcome: 10 Change very considerable or better - after six month follow-up (patients ratings)



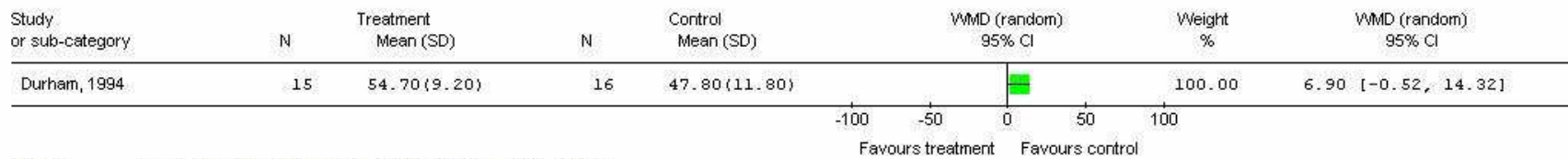
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 Outcome: 01 Means of 0-8 point rating of overall severity - After treatment - LOW contact



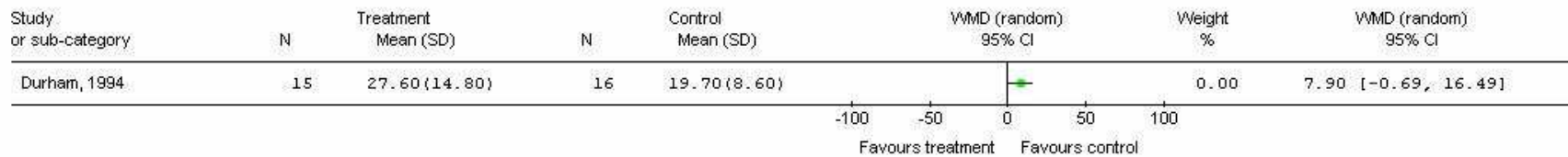
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 Outcome: 02 Means of Hamilton Rating Scale for Anxiety - After treatment - LOW contact



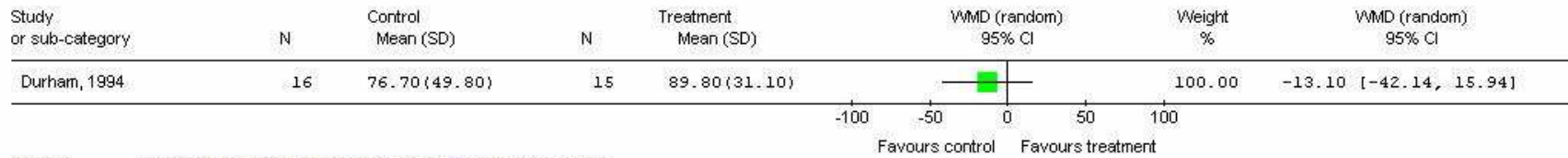
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 Outcome: 03 Means of State-Trait Anxiety Inventory - After treatment - LOW contact



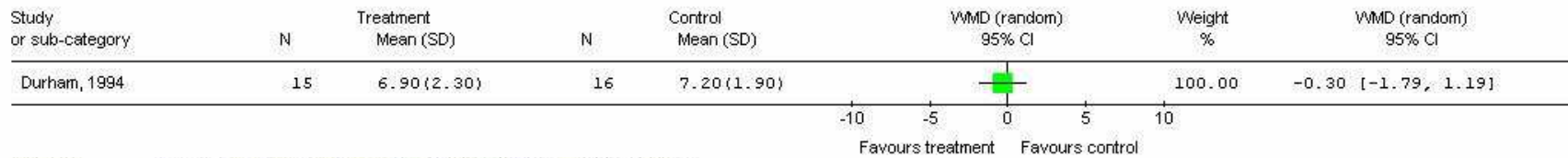
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 Outcome: 04 Means of Beck Anxiety Inventory - After treatment - LOW contact



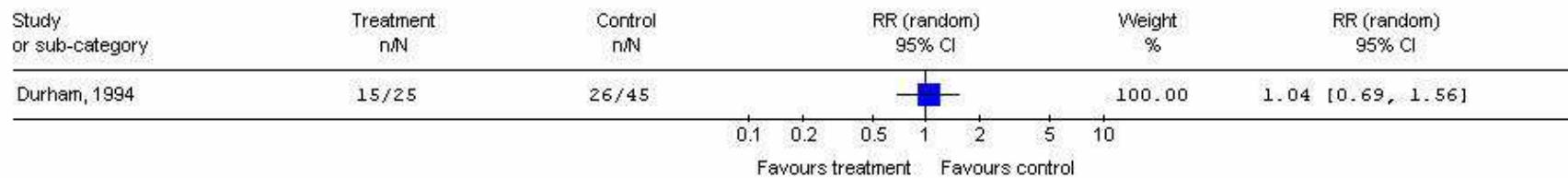
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 Outcome: 05 Means of Dysfunctional Attitude Scale - After treatment - LOW contact



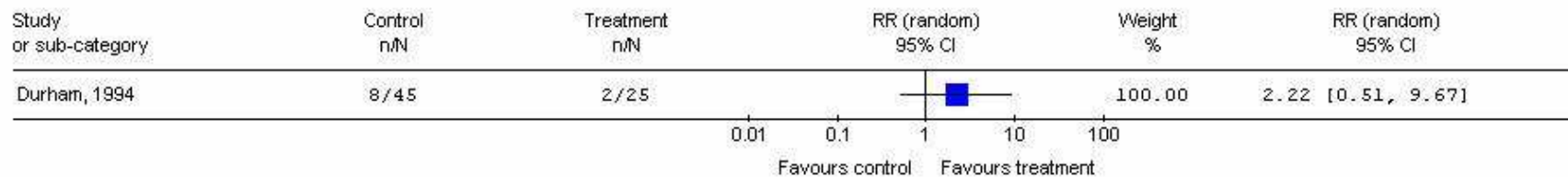
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 Outcome: 06 Means of Social Adjustment Scale - After treatment - LOW contact



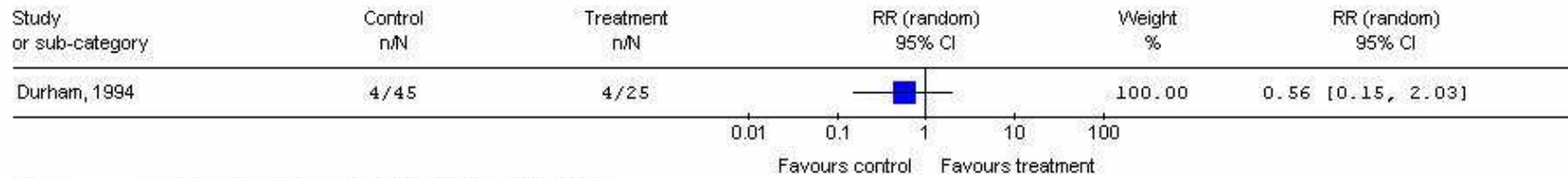
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 Comparison: 17 Anxiety Management Training versus Analytic Psychotherapy (some patients using med)  
 Outcome: 07 Dropouts after treatment



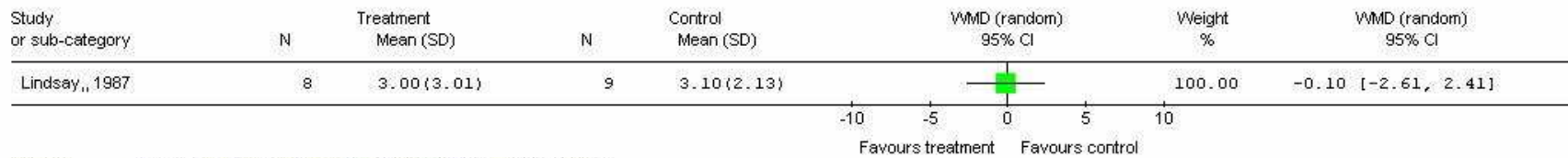
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 Comparison: 17 Anxiety Management Training versus Analytic Psychotherapy (some patients using med)  
 Outcome: 08 Change very considerable or better - after treatment (patients ratings)



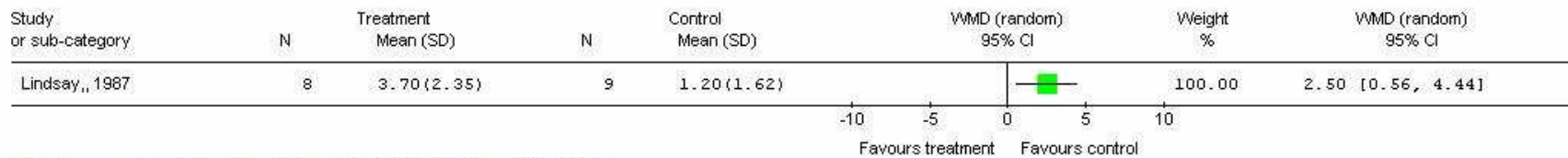
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 Comparison: 17 Anxiety Management Training versus Analytic Psychotherapy (some patients using med)  
 Outcome: 09 Change very considerable or better - after six month follow-up (patients ratings)



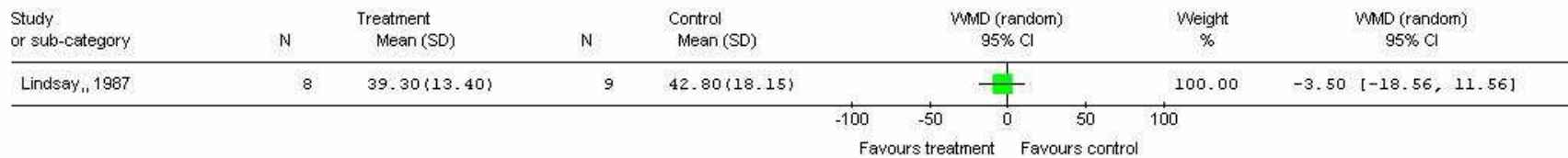
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 18 Anxiety Management Training versus Lorazepam/Ativan  
 Outcome: 01 Means of General Health Questionnaire - anxiety, after 4-week treatment



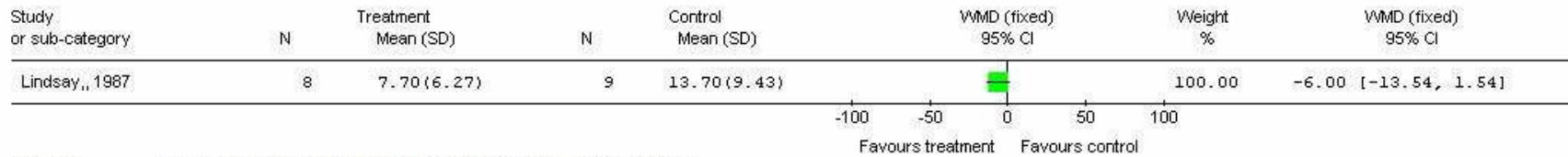
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 Comparison: 18 Anxiety Management Training versus Lorazepam/Ativan  
 Outcome: 02 Means of General Health Questionnaire - general health, after 4-week treatment



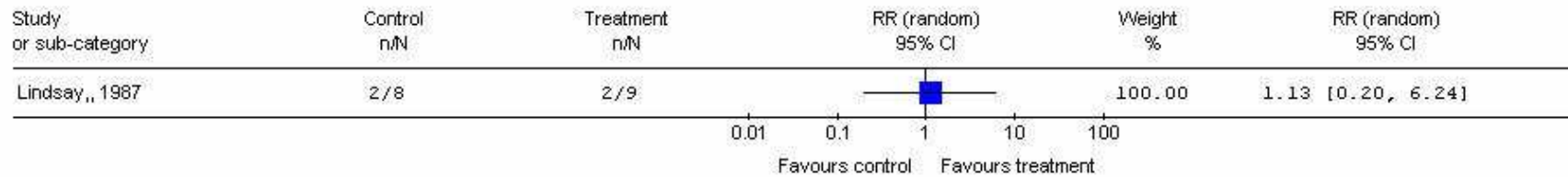
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 Outcome: 03 Means of Zung Self-rating Anxiety Scale after 4-week treatment



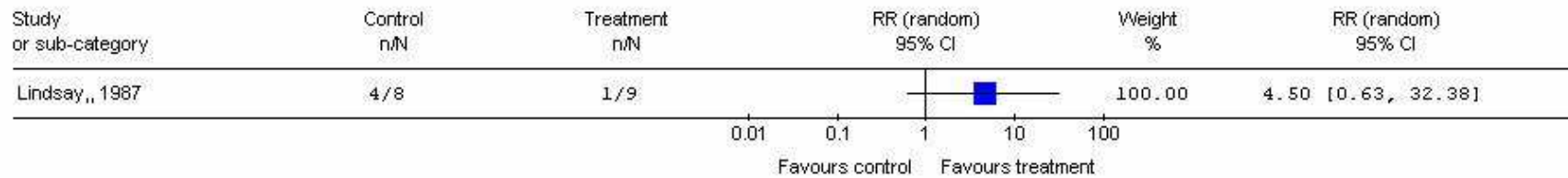
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 Outcome: 04 Means of Cognitive Anxiety Questionnaire after 4-week treatment



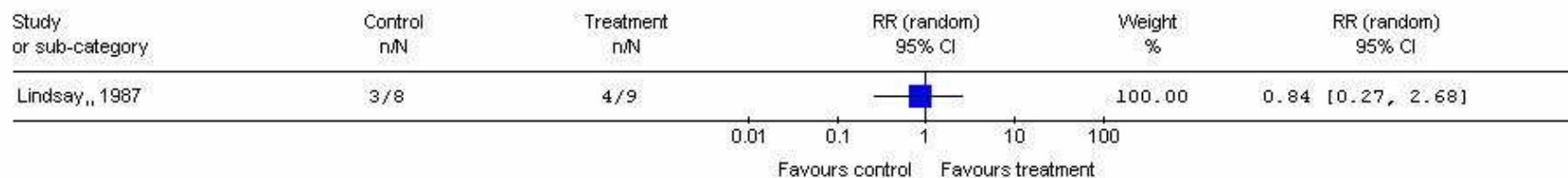
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 Comparison: 18 Anxiety Management Training versus Lorazepam/Ativan  
 Outcome: 05 Subjects that showed clinically meaningful change after treatment - Zung



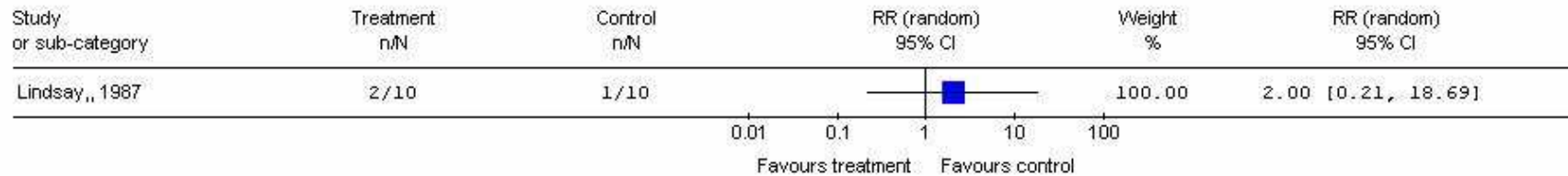
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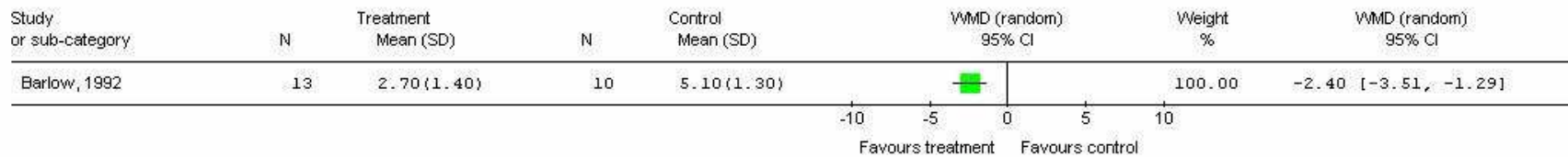
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 Outcome: 07 Subjects that showed clinically meaningful change after treatment - GHQ-anxiety



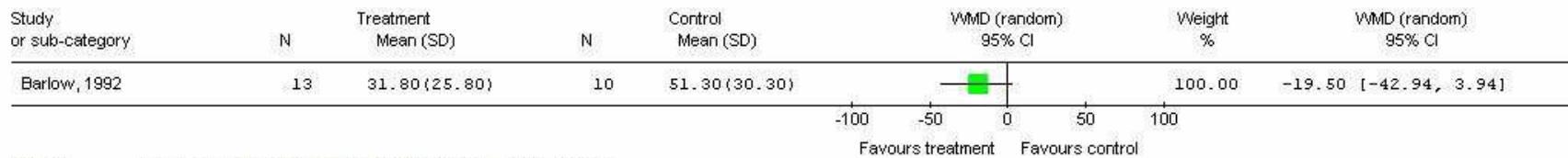
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 18 Anxiety Management Training versus Lorazepam/Ativan  
 Outcome: 08 Dropouts



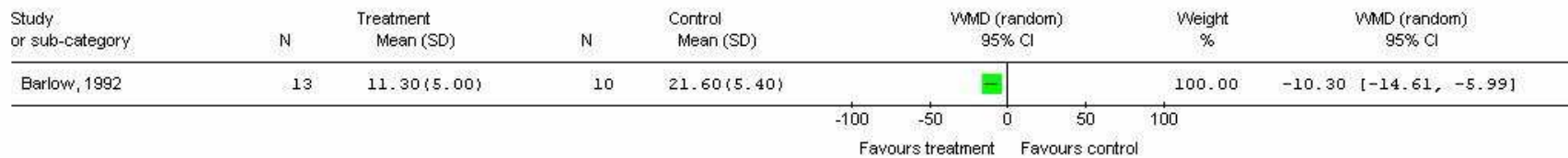
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 19 Cognitive Restructuring versus Waiting List (some patients using med)  
 Outcome: 01 Means of ADIS-R Clinical Severity at post-treatment



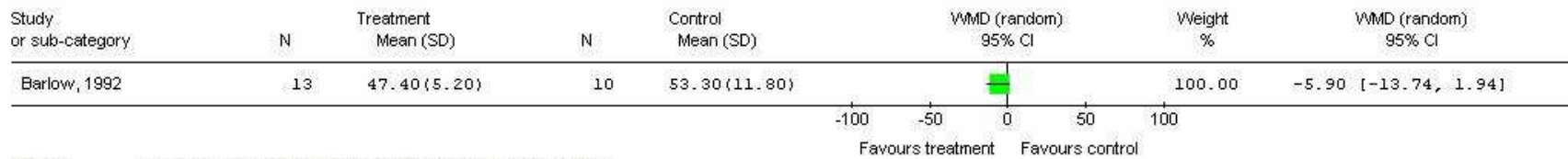
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 Comparison: 19 Cognitive Restructuring versus Waiting List (some patients using med)  
 Outcome: 02 Means of % of day worry at post-treatment



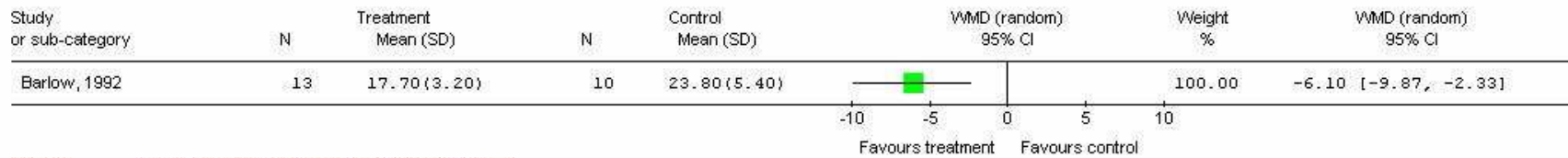
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 Comparison: 19 Cognitive Restructuring versus Waiting List (some patients using med)  
 Outcome: 03 Means of Hamilton Anxiety Rating Scale at post-treatment



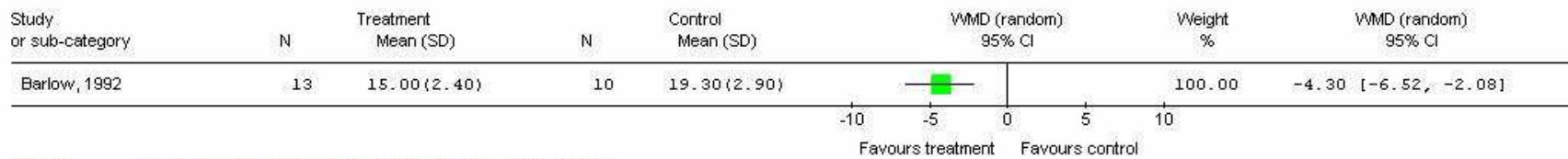
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 Comparison: 19 Cognitive Restructuring versus Waiting List (some patients using med)  
 Outcome: 04 Means of State Trait Anxiety Inventory at post-treatment



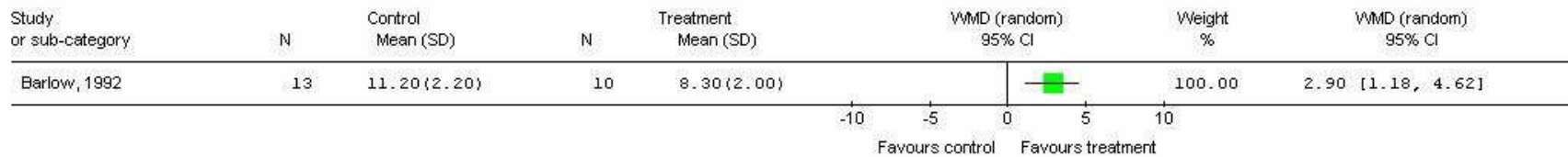
Review: Psychotherapies for Generalized Anxiety Disorder (Version 02)  
 Comparison: 19 Cognitive Restructuring versus Waiting List (some patients using med)  
 Outcome: 05 Means of Cognitive-Somatic Anxiety Questionnaire-Cognitive at post-treatment



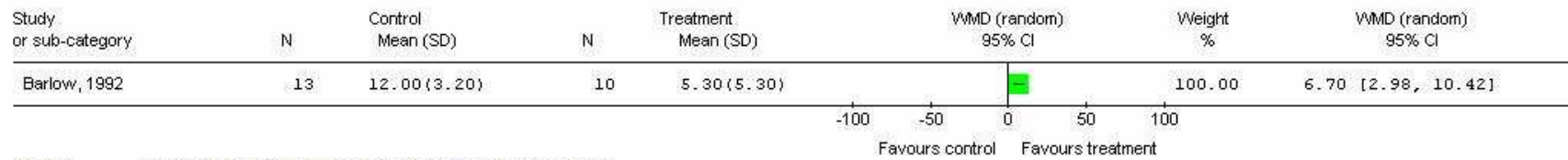
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 Outcome: 06 Means of CSAQ-Somatic at post-treatment



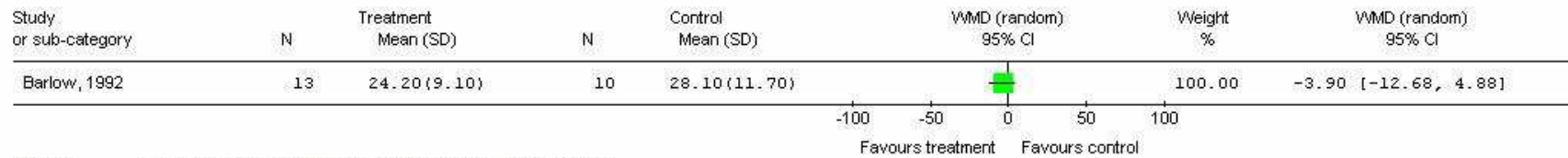
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 Outcome: 07 Means of Eysenck Personality Inventory-Extraversion at post-treatment



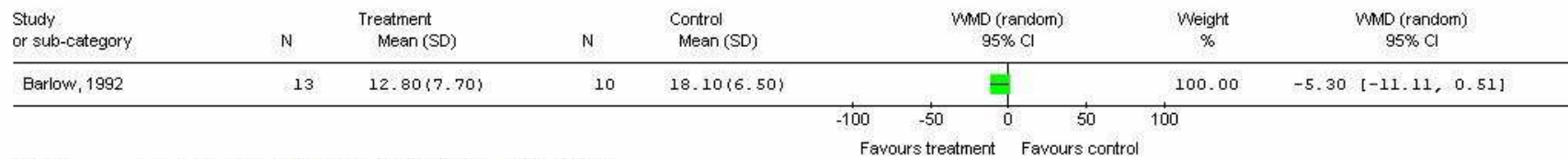
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 Outcome: 08 Means of EPI-Neuroticism at post-treatment



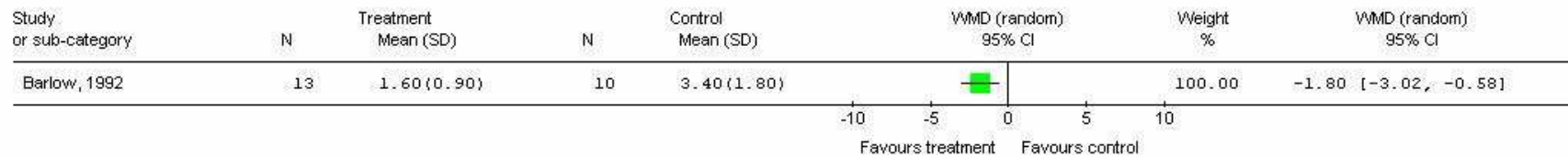
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 Outcome: 09 Means of Fear Questionnaire-Total at post-treatment



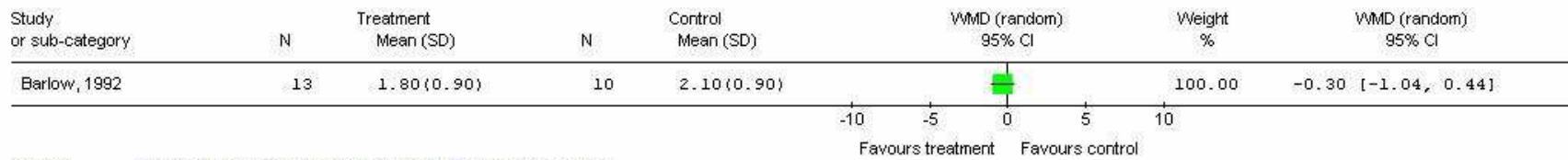
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 Outcome: 10 Means of FQ - Anxiety/Depression at post-treatment



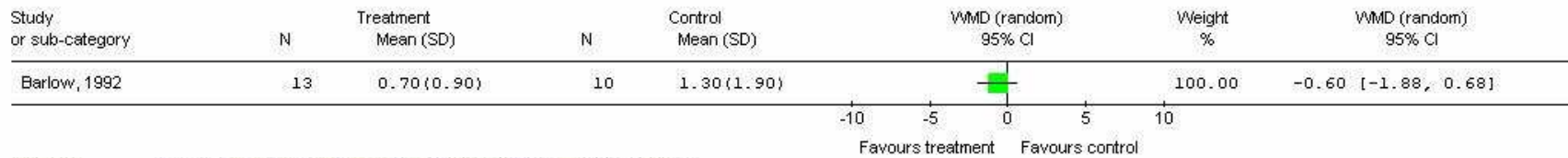
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 Outcome: 11 Means of Subject Symptoms Scales at post-treatment



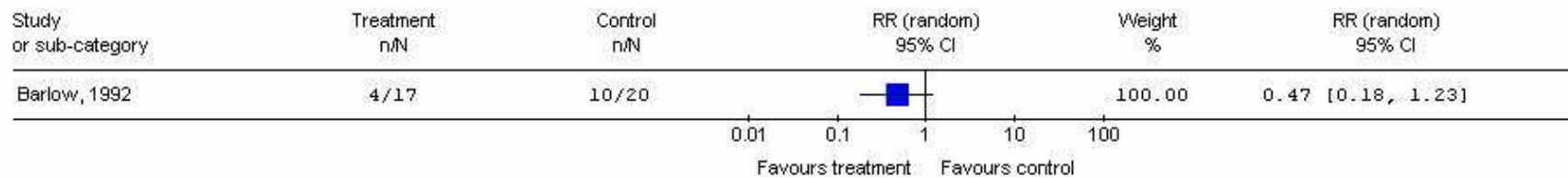
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 Outcome: 12 Means of Average Daily Anxiety at post-treatment



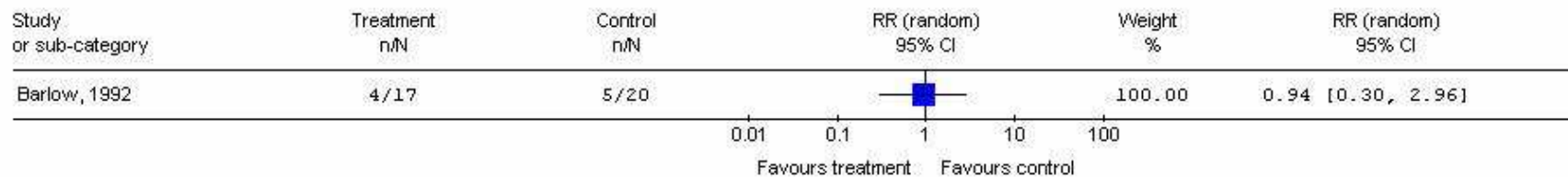
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 Outcome: 13 Means of Intense Anxiety Episodes (per week) at post-treatment



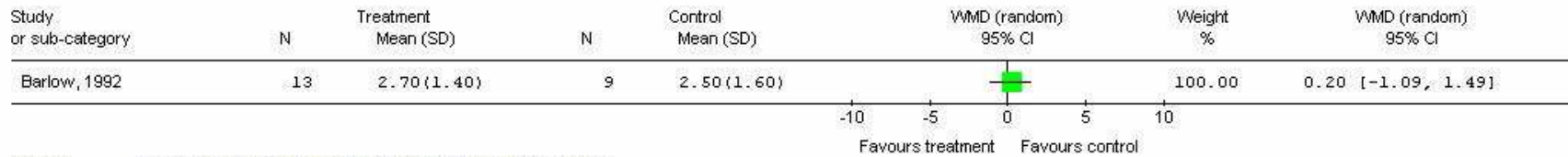
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 Outcome: 14 Dropouts



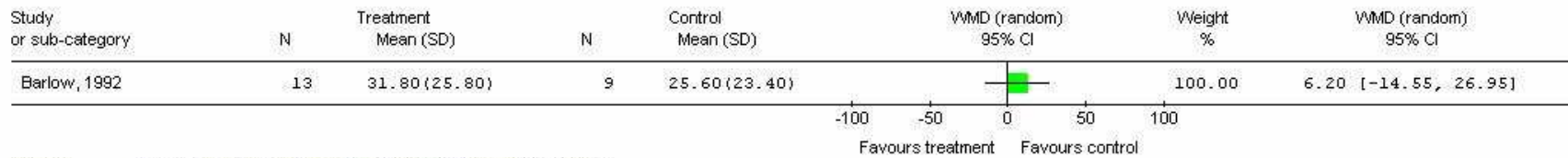
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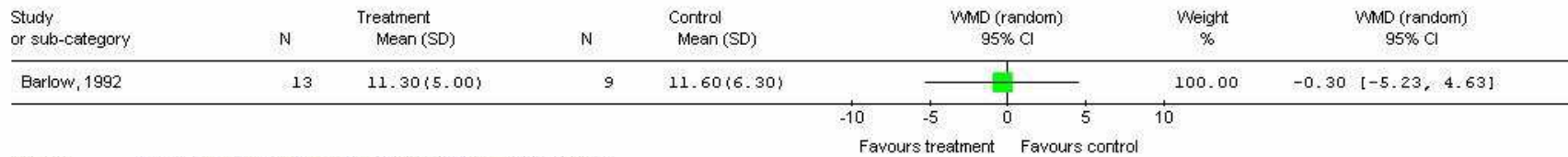
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 Comparison: 20 Cognitive Restructuring versus Progressive Muscle Relaxation (some patients using med)  
 Outcome: 01 Means of ADIS-R Clinical Severity at post-treatment



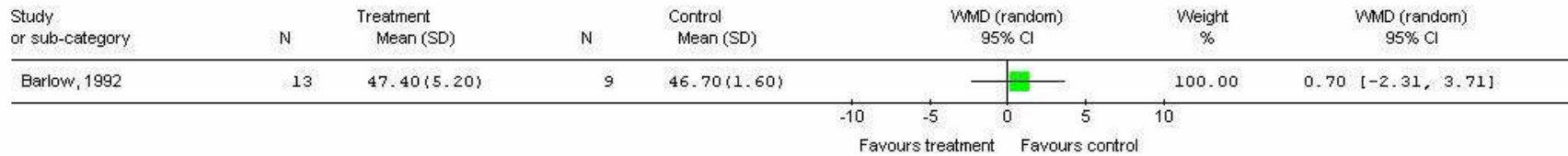
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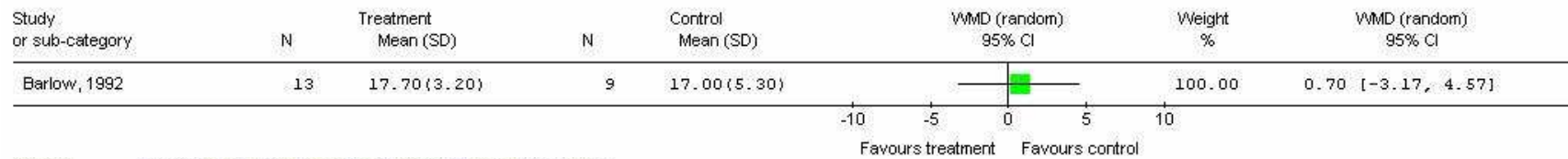
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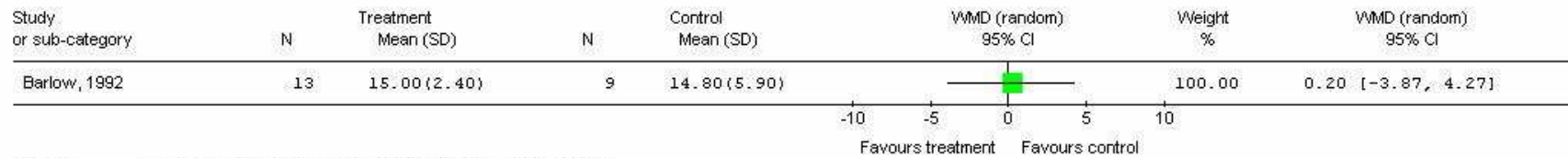
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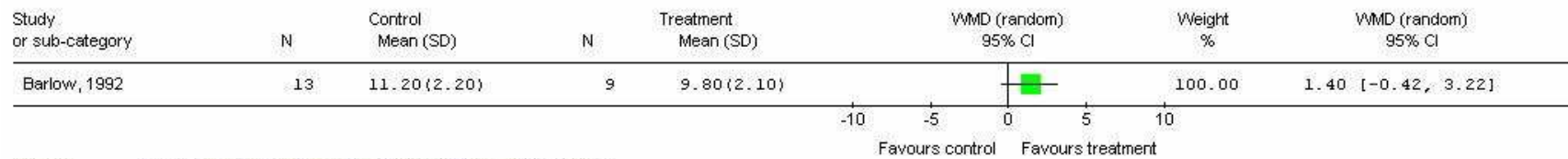
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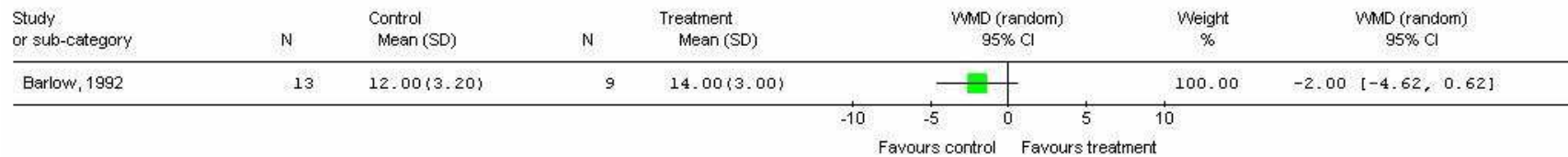
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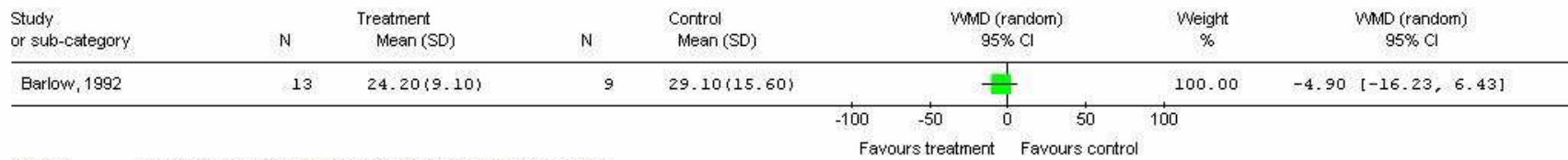
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 Outcome: 07 Means of Eysenck Personality Inventory-Extraversion at post-treatment



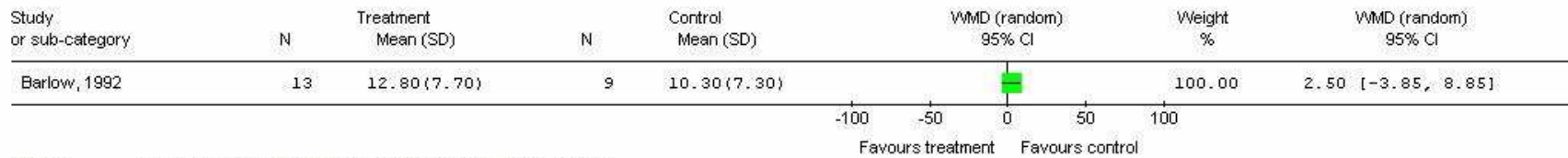
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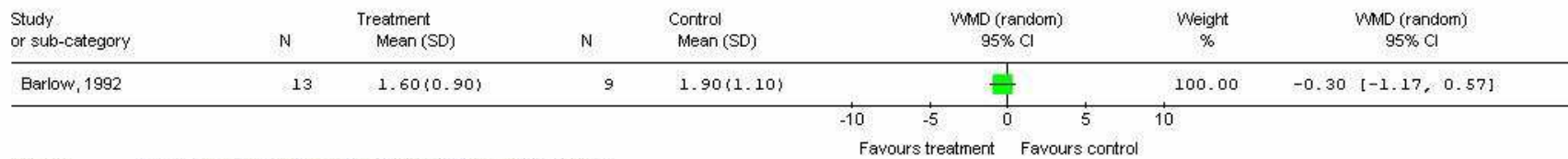
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 Outcome: 09 Means of Fear Questionnaire-Total at post-treatment



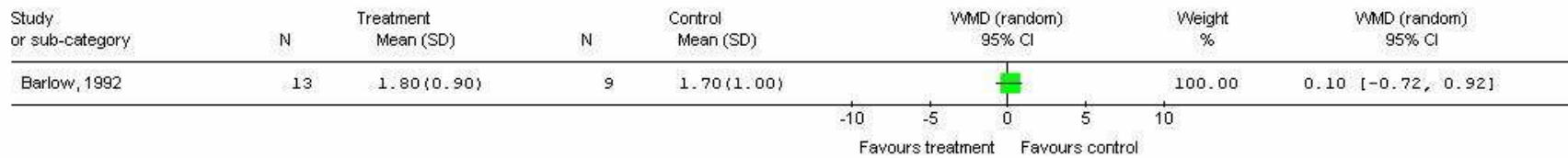
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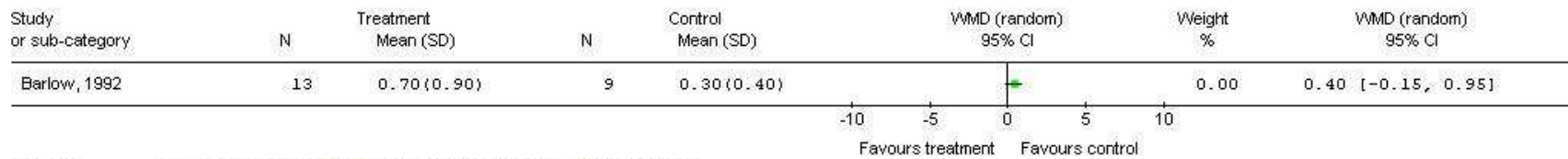
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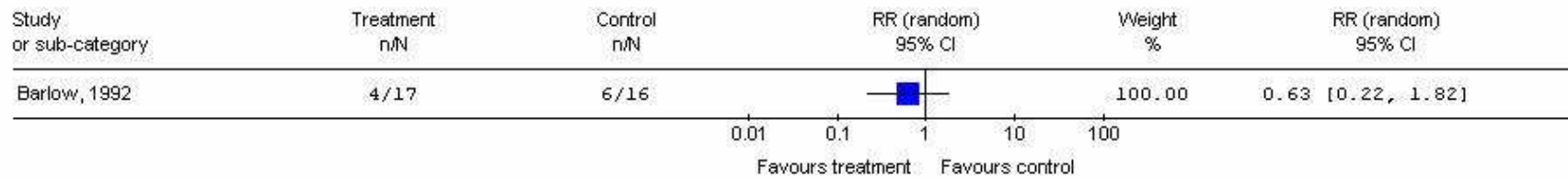
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 Comparison: 20 Cognitive Restructuring versus Progressive Muscle Relaxation (some patients using med)  
 Outcome: 12 Means of Average Daily Anxiety at post-treatment



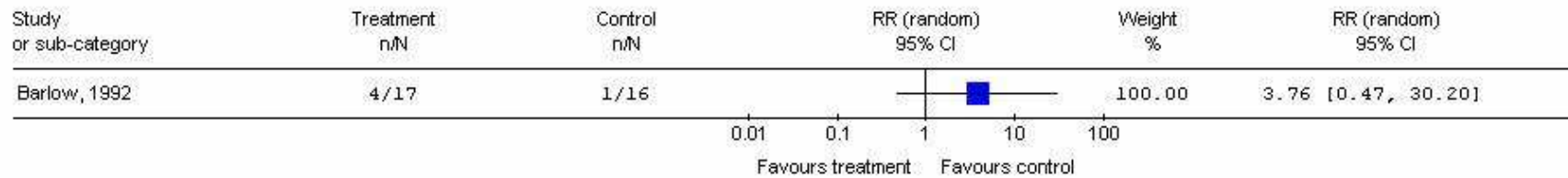
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 Outcome: 13 Means of Intense Anxiety Episodes (per week) at post-treatment



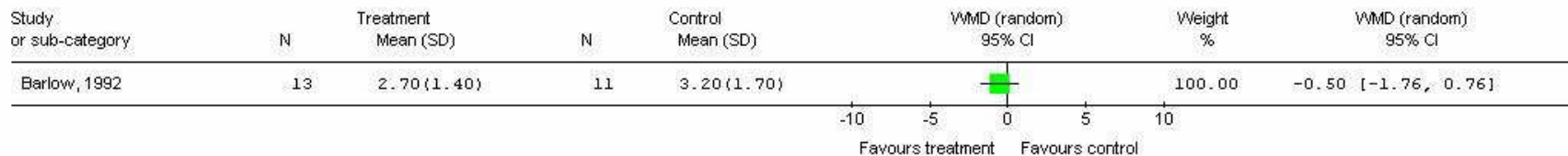
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 Outcome: 14 Dropouts



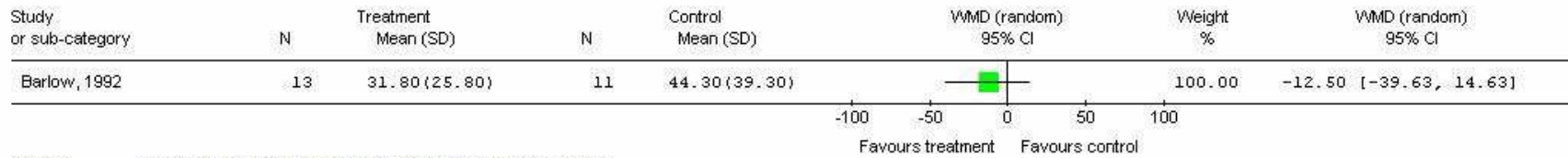
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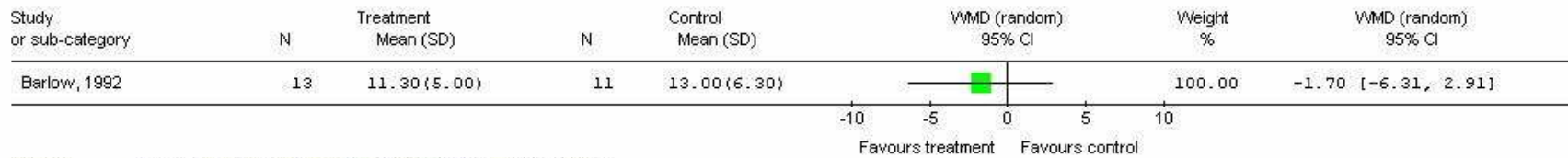
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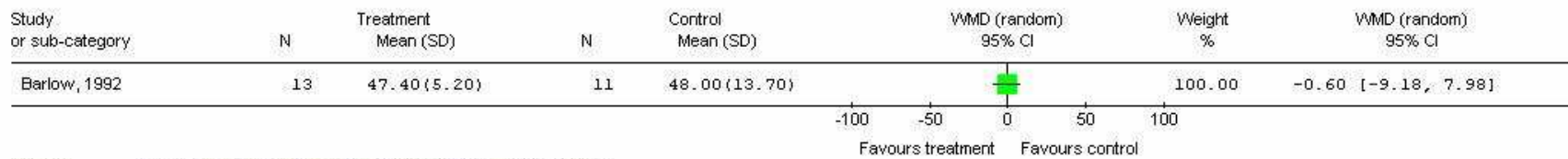
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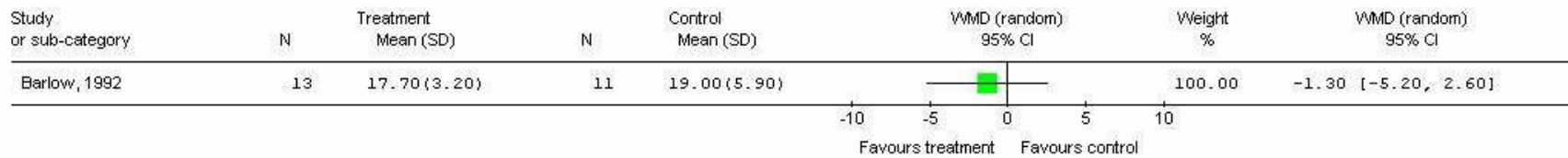
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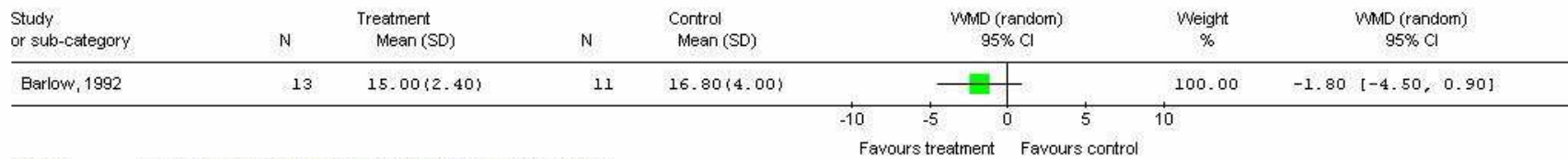
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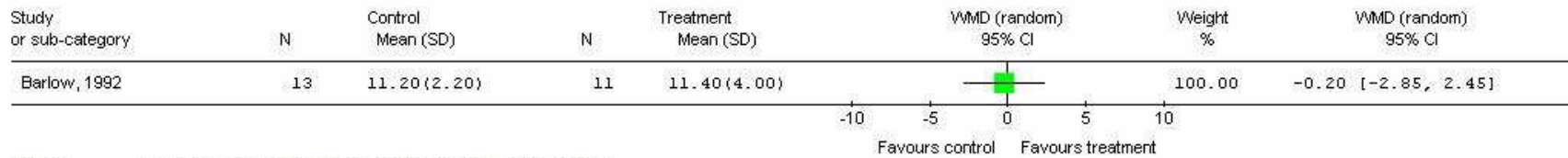
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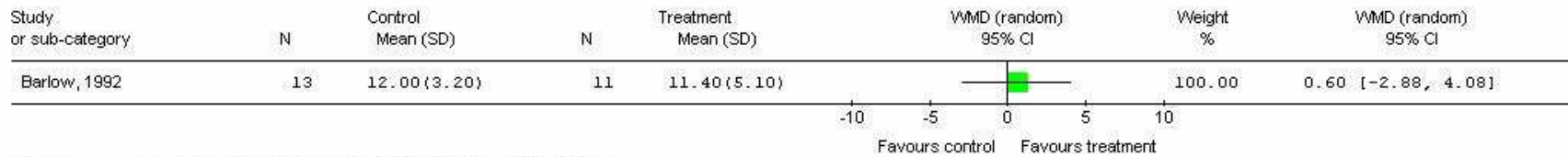
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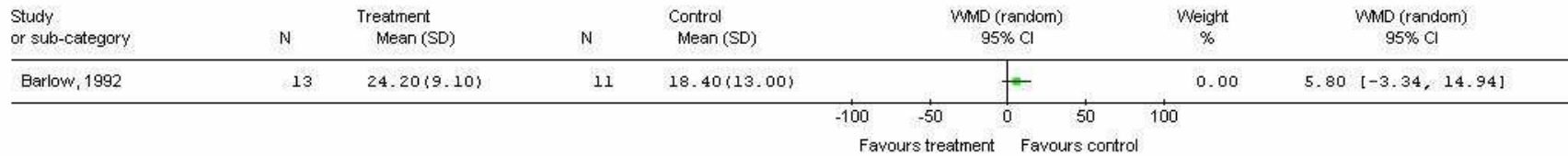
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 Outcome: 07 Means of Eysenck Personality Inventory-Extraversion at post-treatment



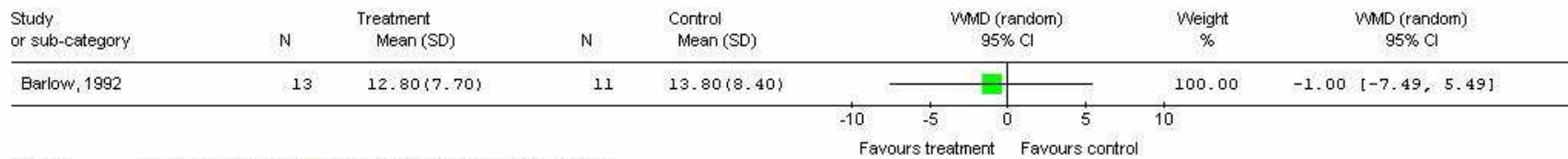
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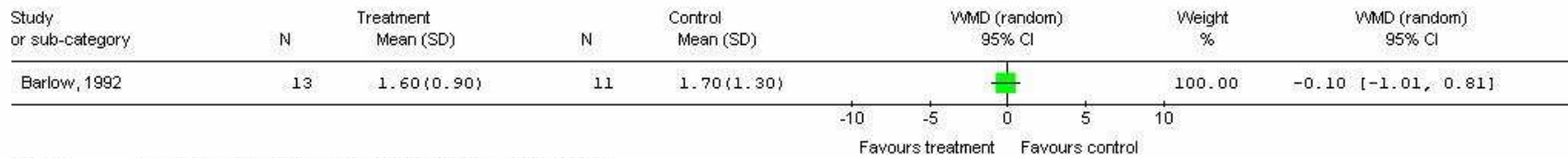
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 Outcome: 09 Means of Fear Questionnaire-Total at post-treatment



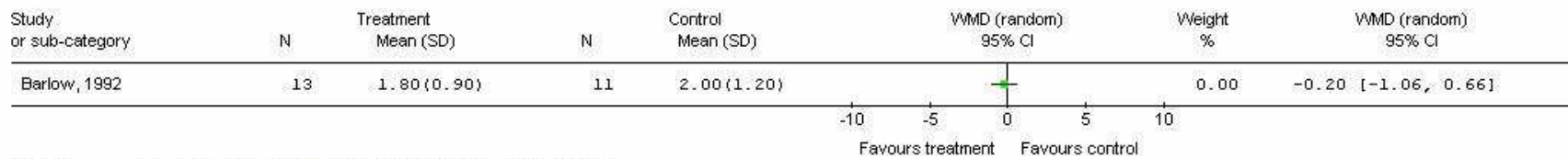
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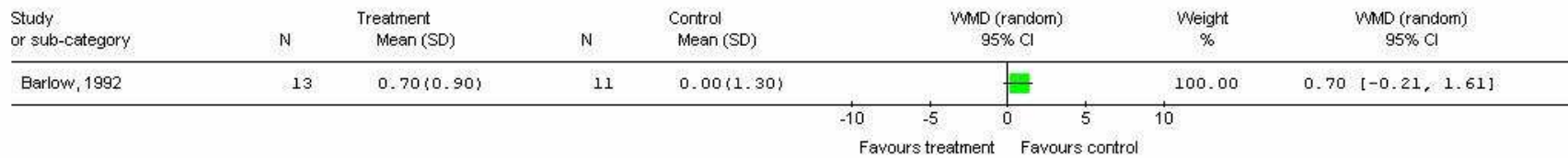
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 Outcome: 11 Means of Subject Symptoms Scales at post-treatment



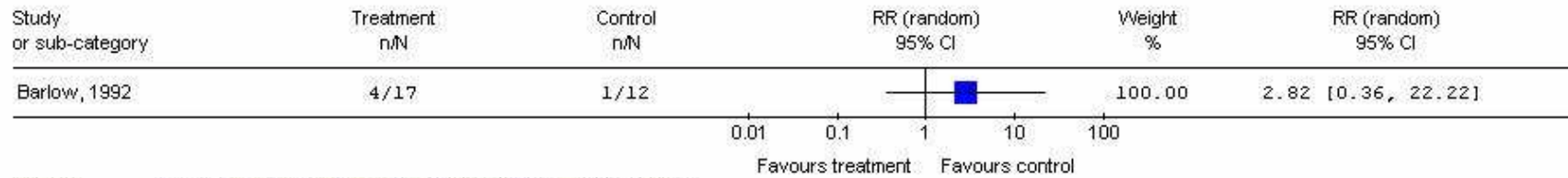
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 Outcome: 12 Means of Average Daily Anxiety at post-treatment



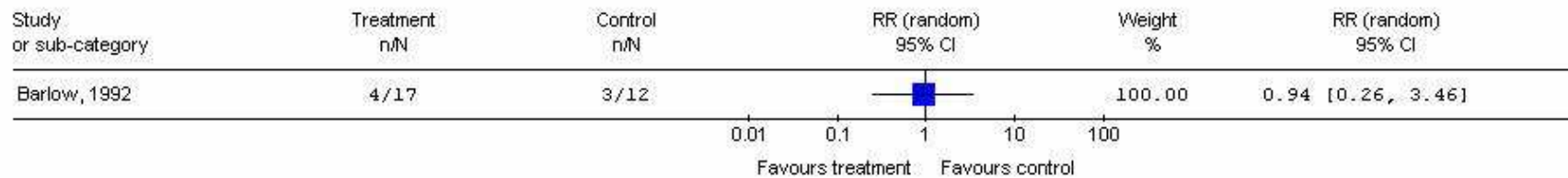
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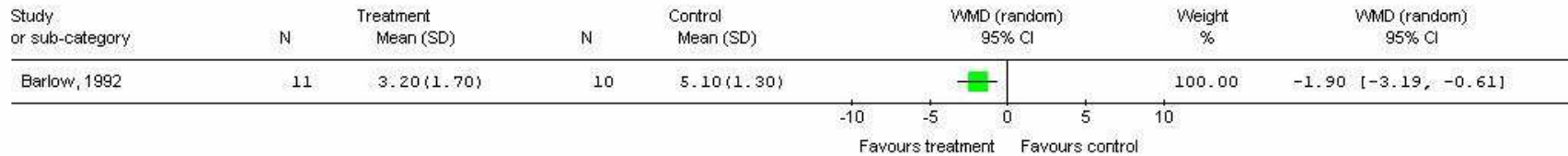
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 Comparison: 21 Cognitive Restructuring versus Combination of Rel+Cog (COM) (some patients using med)  
 Outcome: 14 Dropouts



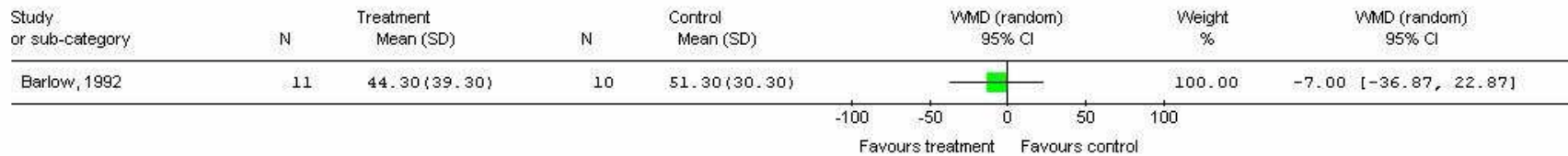
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 Outcome: 15 Subjects reported psychotropic medication at post-treatment



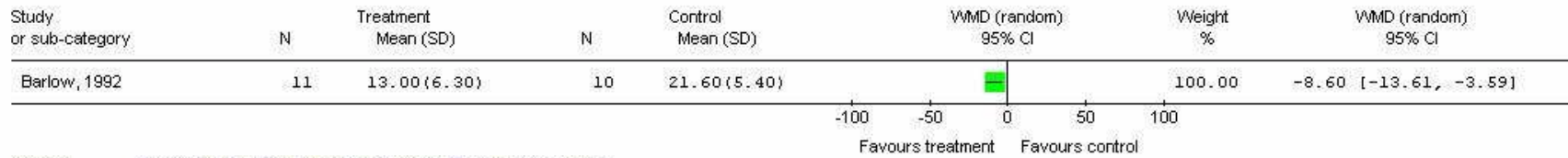
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 Outcome: 01 Means of ADIS-R Clinical Severity at post-treatment



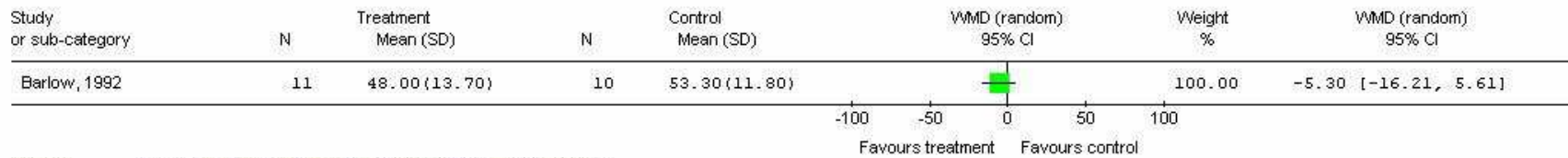
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 Comparison: 22 COM versus Waiting List (some patients using med)  
 Outcome: 02 Means of % of day worry at post-treatment



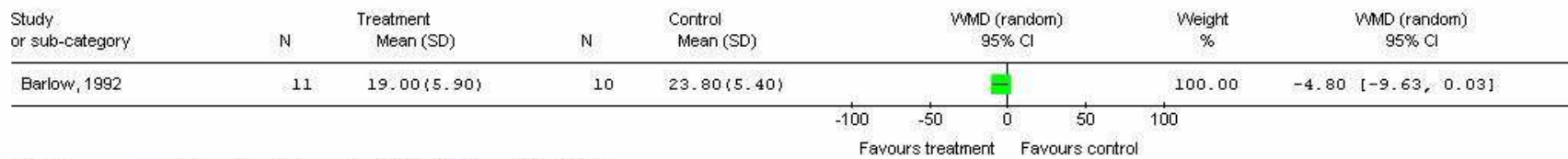
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 Outcome: 03 Means of Hamilton Anxiety Rating Scale at post-treatment



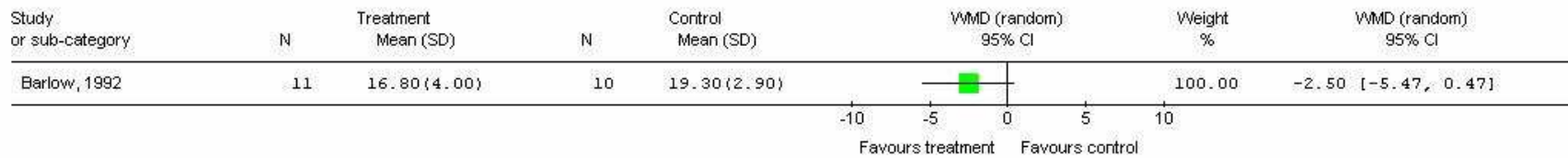
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 Outcome: 04 Means of State Trait Anxiety Inventory at post-treatment



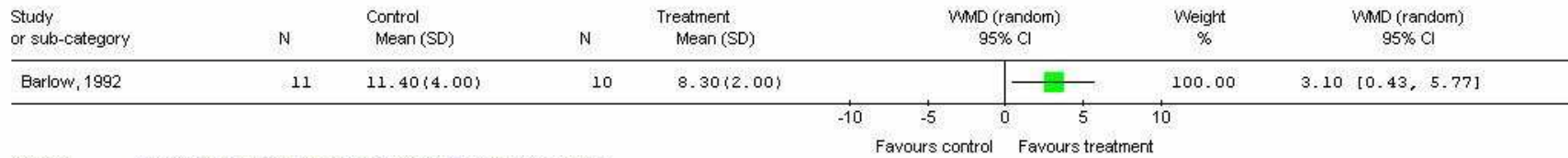
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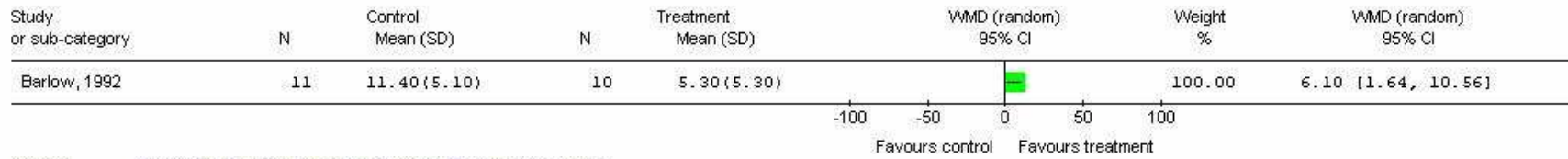
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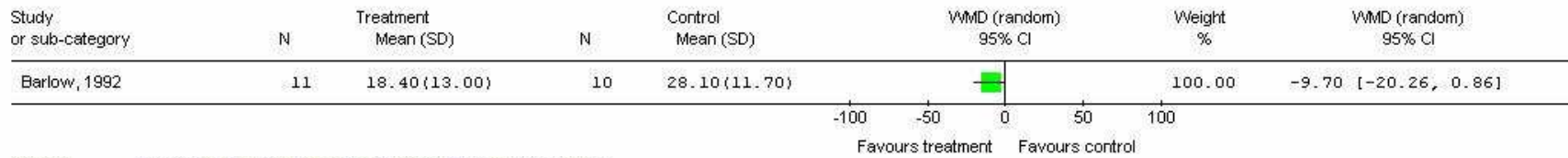
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 Comparison: 22 COM versus Waiting List (some patients using med)  
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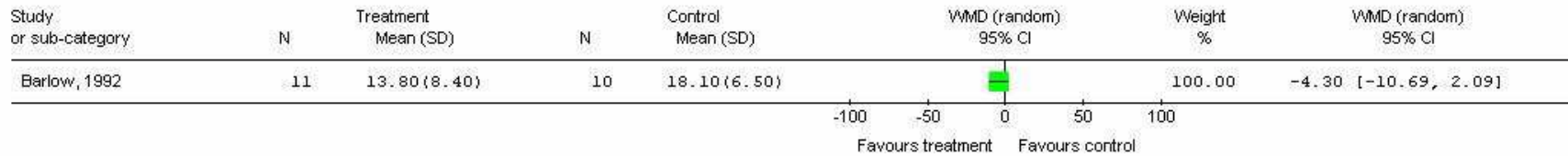
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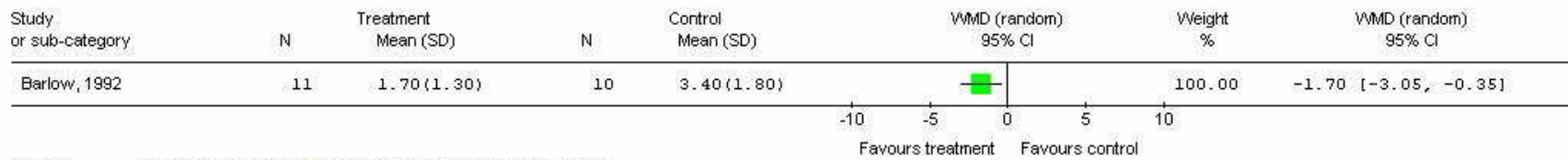
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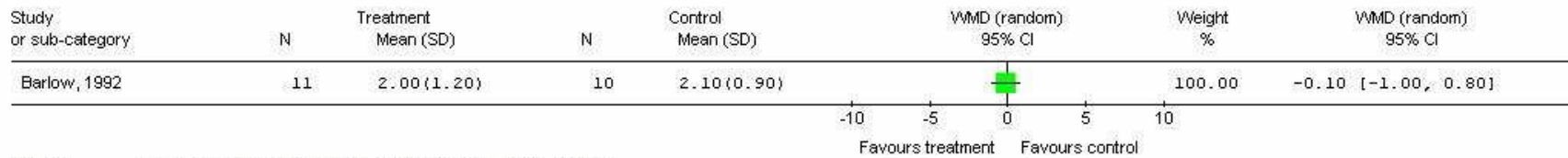
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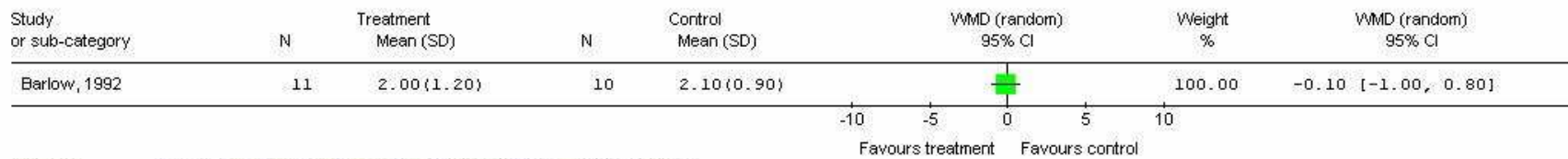
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 Outcome: 11 Means of Subject Symptoms Scales at post-treatment



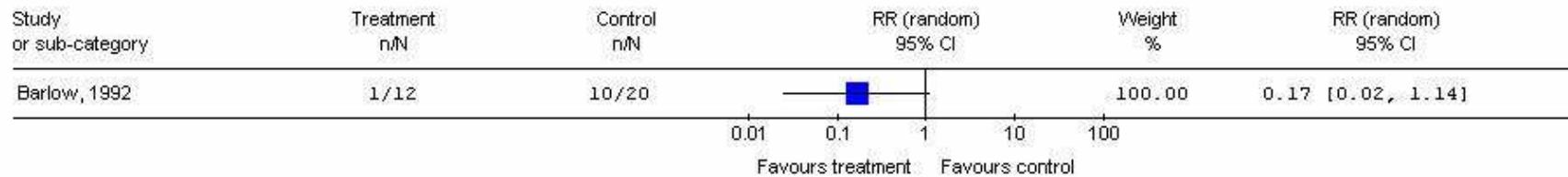
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 Outcome: 12 Means of Average Daily Anxiety at post-treatment



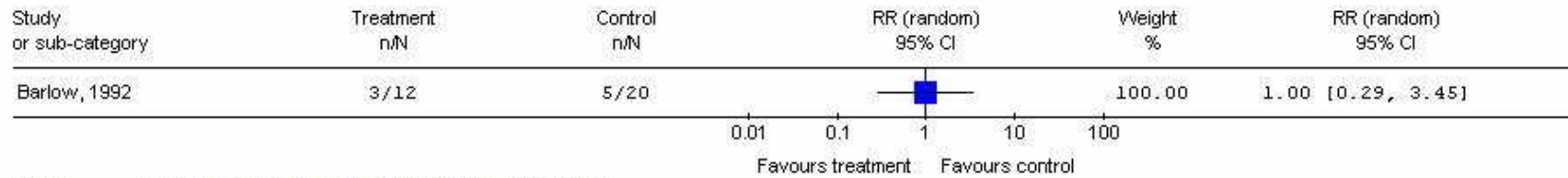
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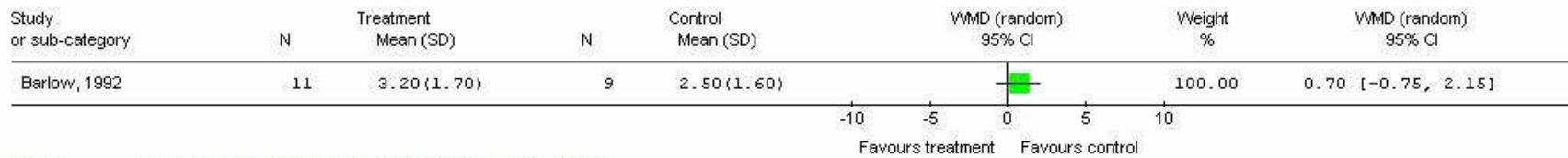
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 Comparison: 22 COM versus Waiting List (some patients using med)  
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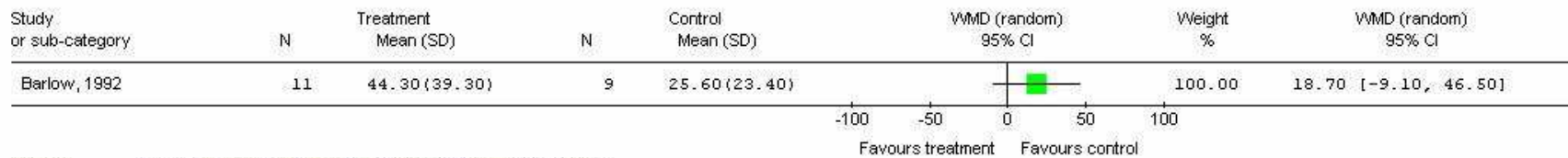
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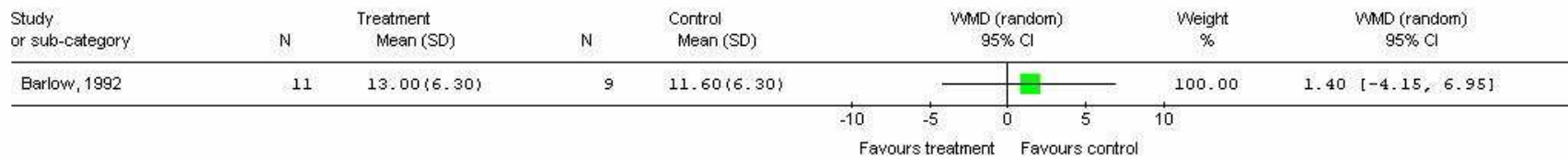
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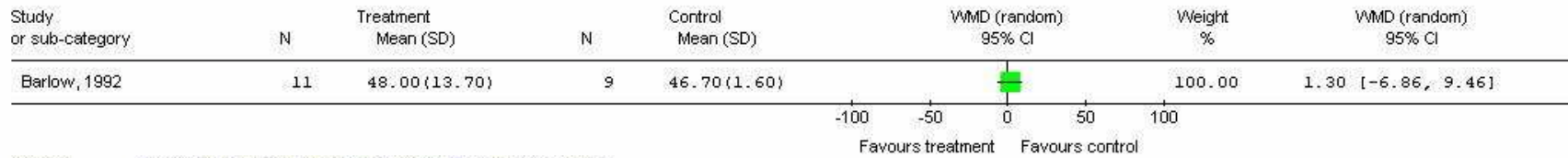
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 Outcome: 02 Means of % of day worry at post-treatment



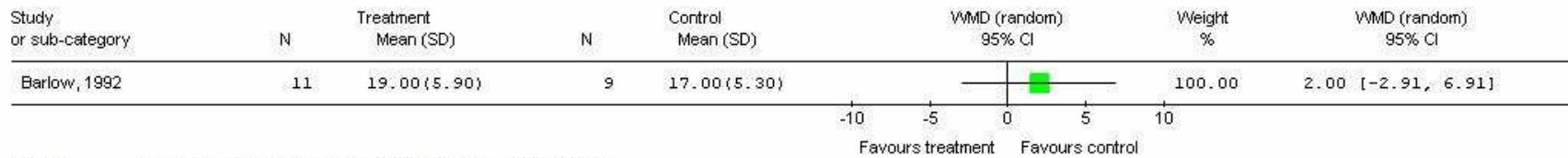
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 Outcome: 03 Means of Hamilton Anxiety Rating Scale at post-treatment



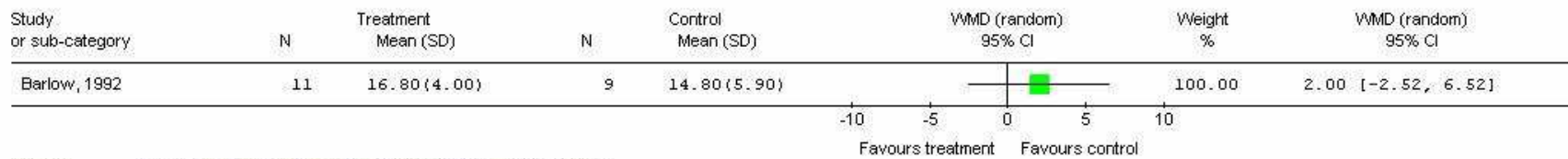
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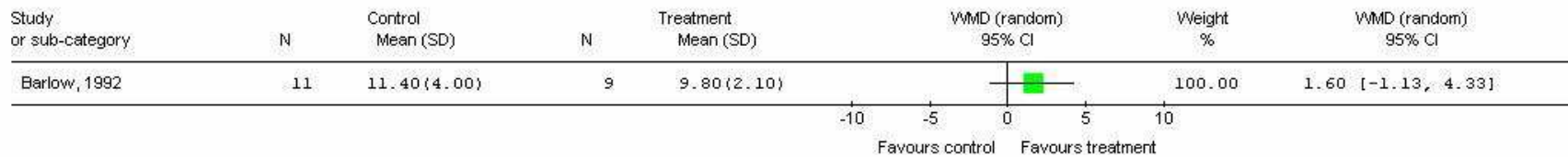
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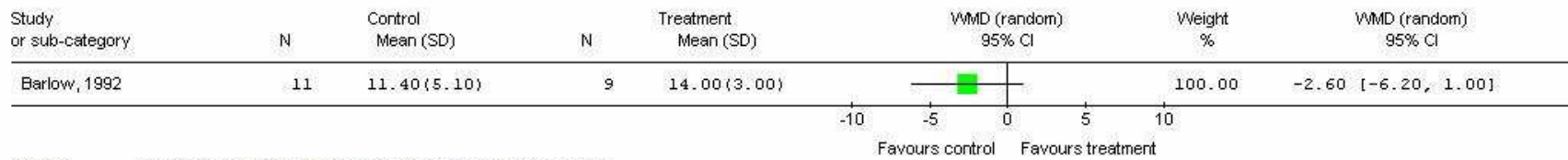
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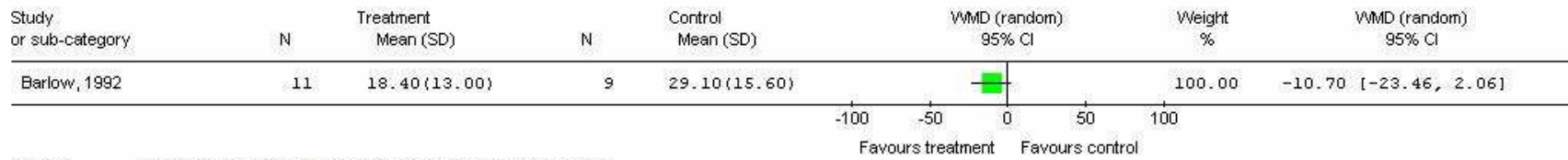
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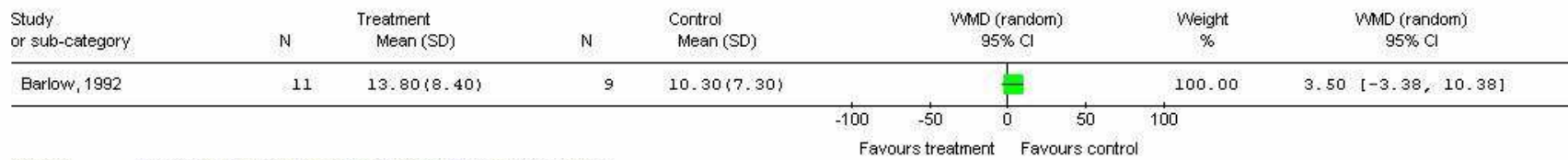
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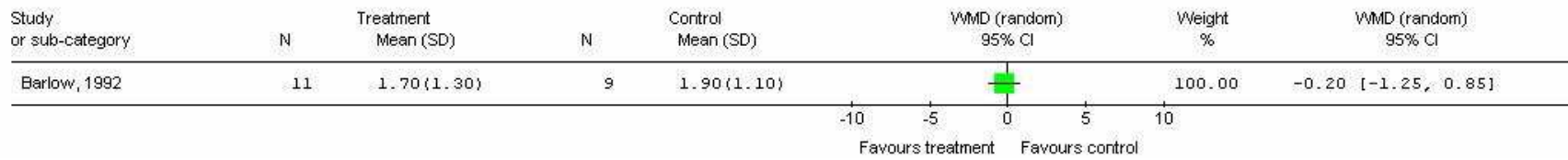
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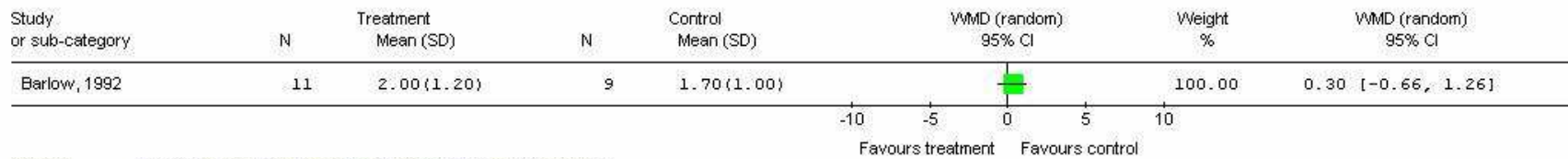
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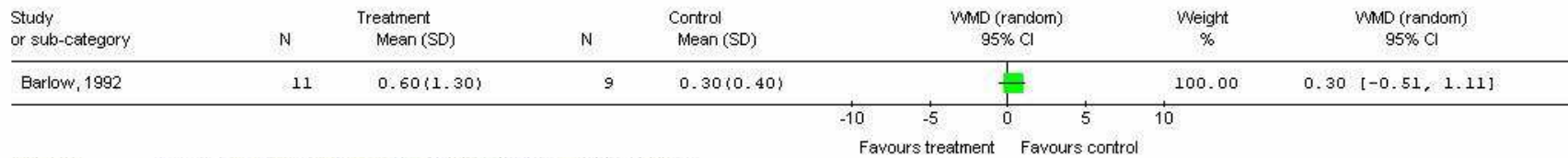
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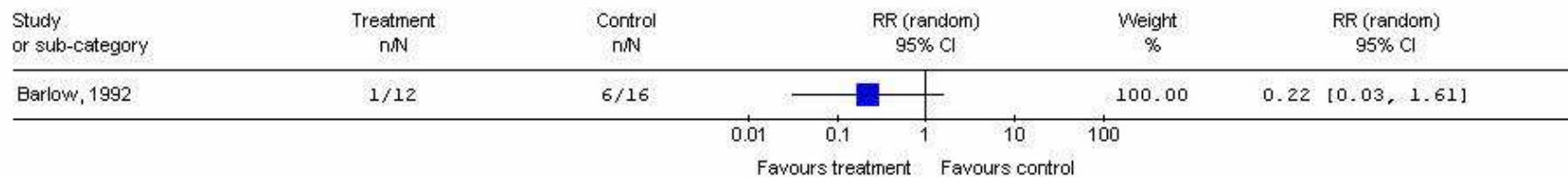
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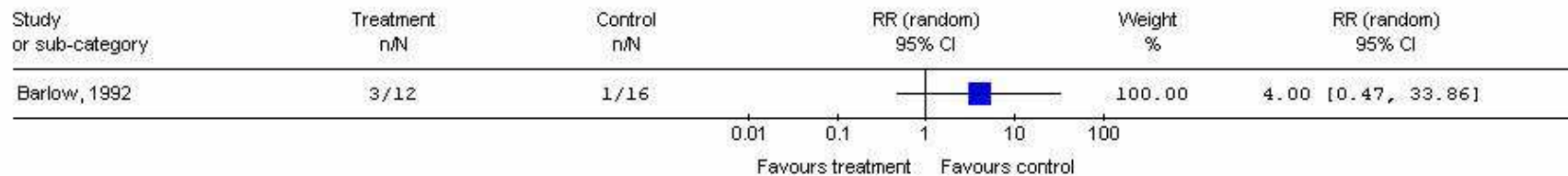
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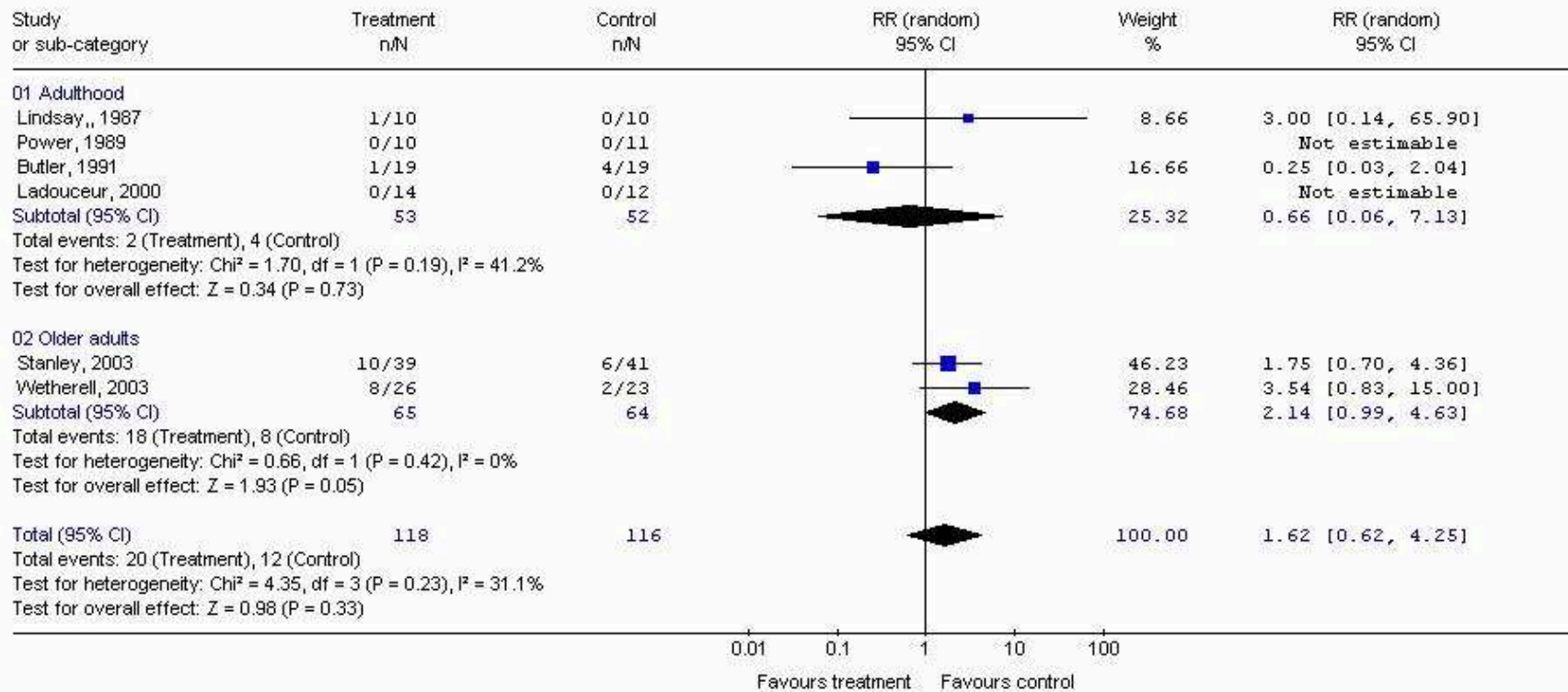
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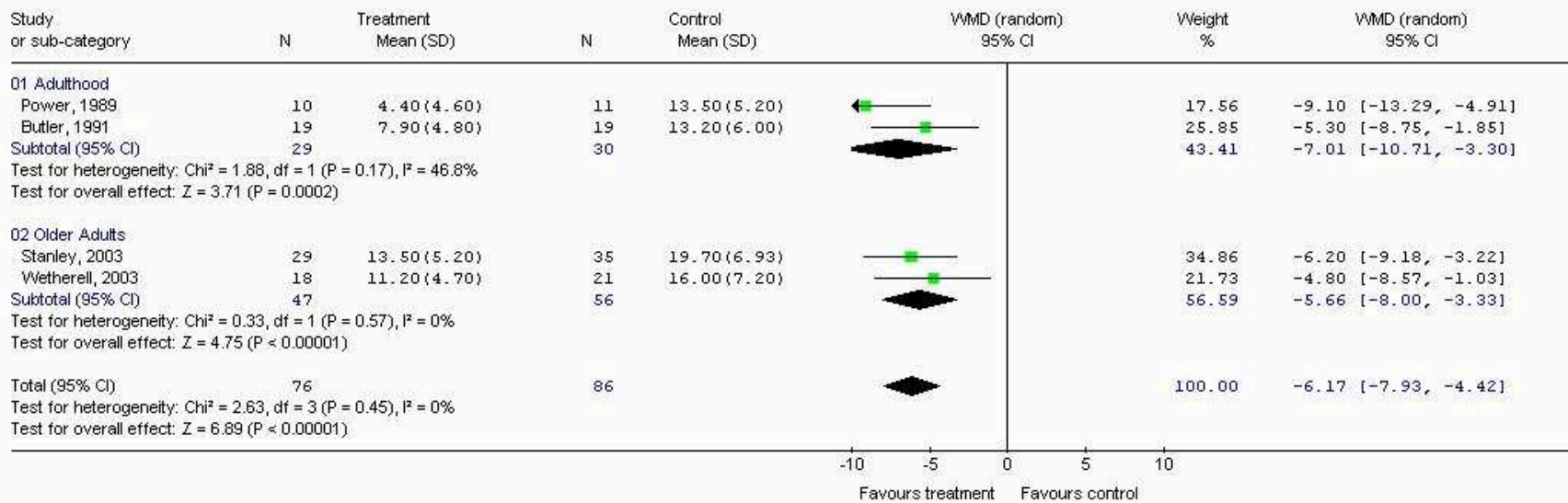
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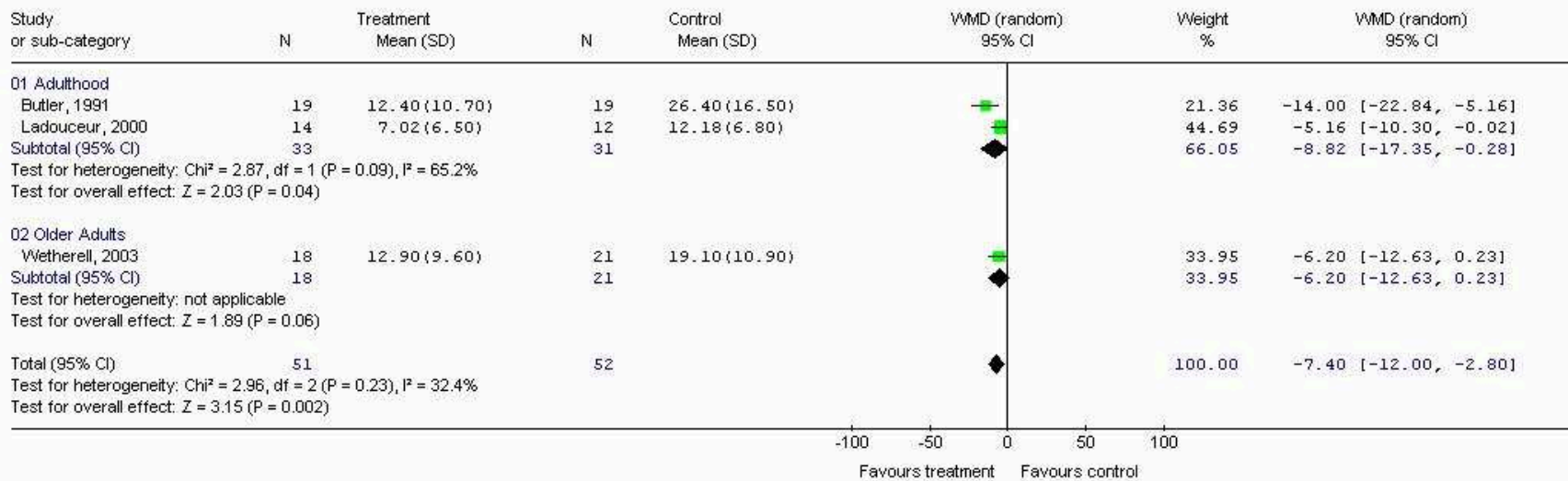
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 Comparison: 24 All CBT versus No intervention - According to age  
 Outcome: 01 Dropouts



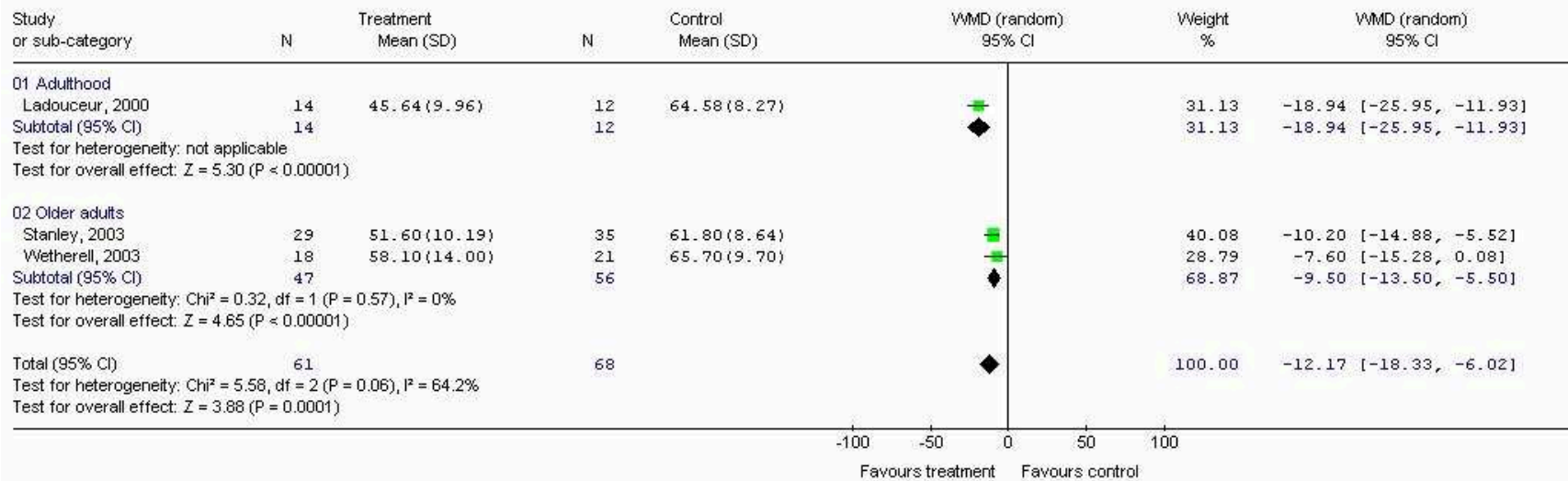
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 Outcome: 02 Means of Hamilton Anxiety Rating Scale



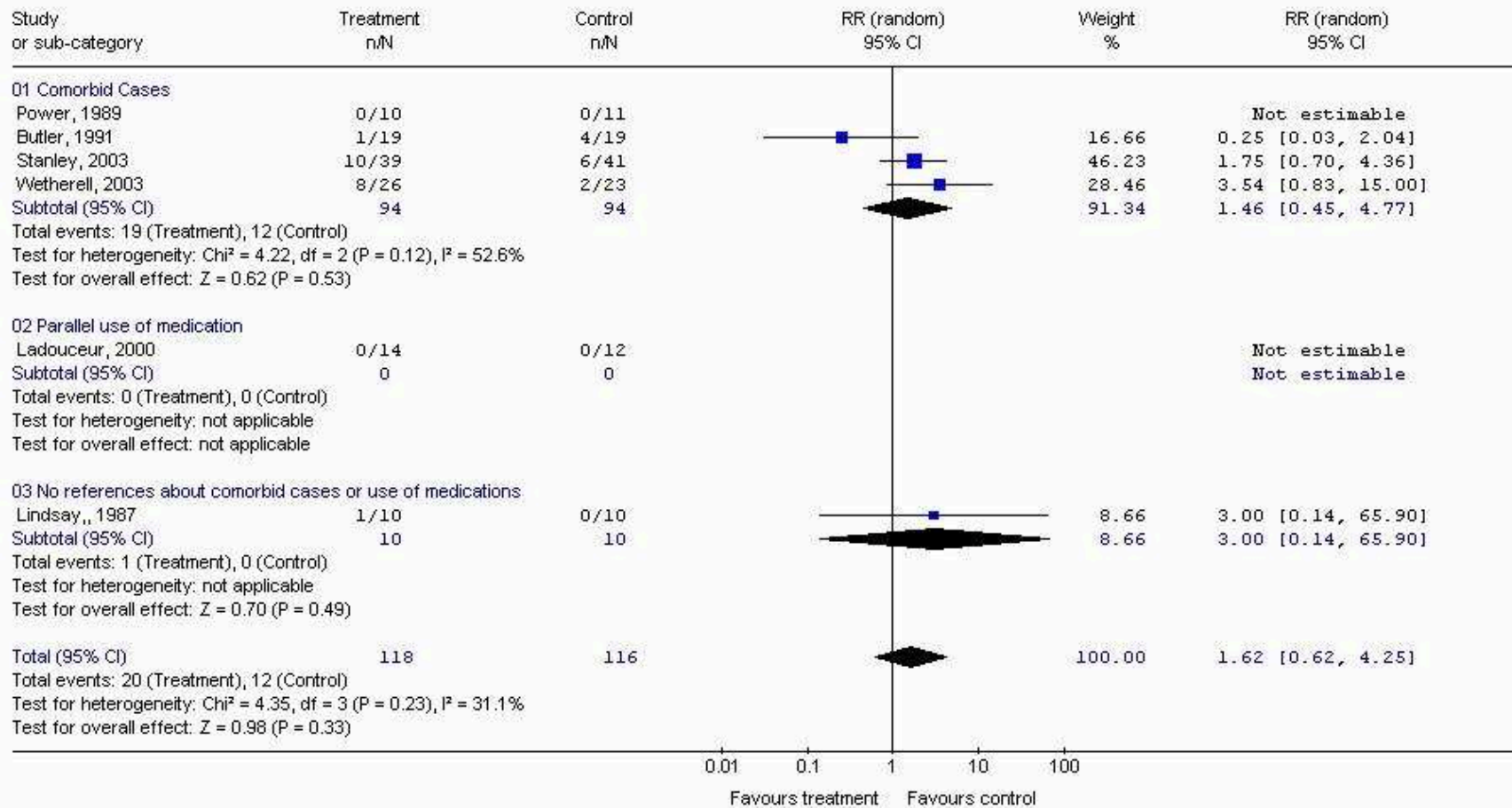
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 Outcome: 03 Means of Beck Anxiety Inventory



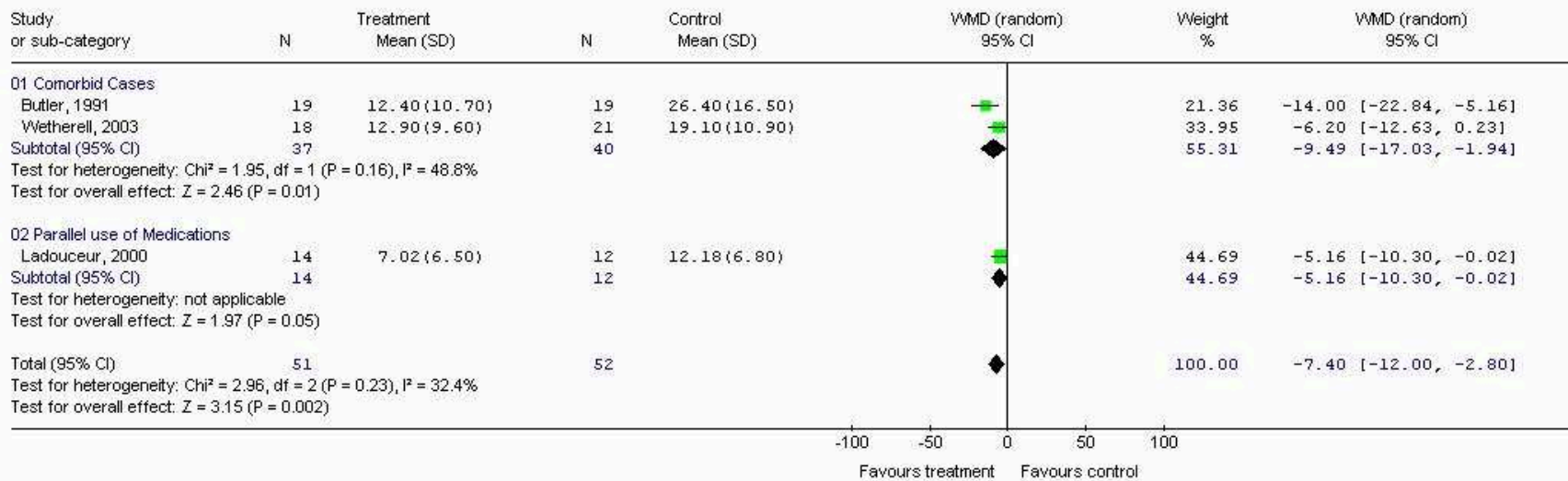
Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 24 All CBT versus No intervention - According to age  
 Outcome: 04 Means of Penn State Worry Questionnaire



Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 25 All CBT versus No intervention  
 Outcome: 01 Dropouts



Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 25 All CBT versus No intervention  
 Outcome: 02 Means of Beck Anxiety Inventory



Review: Psychotherapies for Generalized Anxiety Disorder  
 Comparison: 25 All CBT versus No intervention  
 Outcome: 03 Means of Penn State Worry Questionnaire

