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Remission After Acute Treatment in Children and Adolescents With Anxiety Disorders: Findings From the CAMS

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Abstract

Objective—To report on remission rates in anxious youth who participated in the Child/Adolescent Anxiety Multimodal Study (CAMS). The CAMS, a multisite clinical trial, randomized 488 children and adolescents (ages 7–17 years; 79% Caucasian; 50% female) with separation, social, and/or generalized anxiety disorder to a 12-week treatment of sertraline (SRT), cognitive behavioral therapy (CBT), their combination (COMB), or clinical management with pill placebo (PBO).

Method—The primary definition of remission was loss of all study-entry anxiety disorder diagnoses; additional definitions of remission were used. All outcomes were rated by independent evaluators blind to treatment assignment. Predictors of remission were also examined.

Results—Remission rates after 12 weeks of treatment ranged from 46% to 68% for COMB, 34% to 46% for SRT, 20% to 46% for CBT, and 15% to 27% for PBO. Rates of remission (i.e., achieving a nearly symptom-free state) were significantly lower than rates of response (i.e., achieving a clinically meaningful improvement relative to baseline) for the entire sample. Youth who received COMB had significantly higher rates of remission compared to all other treatment groups. Both monotherapies had higher remission rates compared to PBO, but rates were not different from each other. Predictors of remission were younger age, nonminority status, lower baseline anxiety severity, absence of other internalizing disorders (e.g., anxiety, depression), and absence of social phobia.

Conclusions—For the majority of children, some symptoms of anxiety persisted, even among those showing improvement after 12 weeks of treatment, suggesting a need to augment or extend current treatments for some children.

Keywords

anxiety; children; adolescents; treatment; remission

An index of outcome in randomized controlled trials (RCTs) for pediatric anxiety disorders (ADs) is the response rate. *Response* has been defined as a meaningful improvement in symptoms. An important question for clinicians, patients, and families is, what are the chances of becoming nearly symptom free? That is, what is the chance for remission? Although there is no consensus on an operational definition of remission for childhood ADs, it is defined generally as the absence or near absence of symptoms following treatment for a predetermined period of time (Frank et al., 1991). It is considered a more stringent criterion than response. Identifying remission rates in RCTs is thus an important index of treatment outcome.

Reports of remission rates after acute treatment for pediatric ADs are sparse, though initial studies reveal that remission rates are typically lower than response rates. Hudson et al. (2009) reported that posttreatment response rates (defined as the percentage of children no longer meeting criteria for their principal anxiety diagnosis) were 45% after 10 weeks of

CBT; the remission rate (percentage no longer meeting criteria for any AD) was 33%. Data on remission rates are similarly sparse for pharmacotherapy trials, although they show a similar pattern. Wagner et al. (2004) reported a 78% response rate (defined as a Clinical Global Impression Improvement Scale [CGI-I] score of 1 [*very much improved*] or 2 [*much improved*]) after 16 weeks of paroxetine for youth with social phobia (SOP) and a remission rate (defined as a CGI-I of 1 or a 70% or greater reduction on a social anxiety scale) of 48% and 47%, respectively.

Despite similar patterns of response and remission rates in both pharmacotherapy and cognitive behavioral therapy (CBT) trials for pediatric anxiety, variations in definitions and measurement methods undermine comparisons. The recent Child/Adolescent Anxiety Multimodal Treatment Study (CAMS; Walkup et al., 2008), which compared the efficacy of CBT (Coping Cat; Kendall & Hedtke, 2006), pharmacotherapy (sertraline [SRT]), and their combination (COMB) to pill placebo (PBO) in 488 youth with separation AD (SAD), generalized AD (GAD), and SOP, measured treatment outcome using a variety of methods. Thus, data from this trial are uniquely suited to describe remission rates (i.e., achieving a nearly symptom-free state) conferred by CBT, SRT, and COMB. The initial findings from the CAMS reported only on response rates (Walkup et al., 2008). This study (a) determined multiply defined posttreatment remission rates by treatment condition and (b) assessed predictors of remission.

Method

Participants

The sample was comprised of 488 children and adolescents (ages 7–17 years) who met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) criteria for GAD, SOP, and/or SAD. Detailed demographic and diagnostic characteristics were described in Kendall et al. (2010) and Walkup et al. (2008). Participants were randomized to treatment conditions as follows: COMB (n = 140), SRT (n = 133), CBT (n = 139), and PBO (n = 76). See Figure 1 for CONSORT diagram.

Measures

Outcomes were assessed by an independent evaluator blind to treatment group at the end of 12 weeks of treatment. Measures and definitions of remission were as follows:

1. Loss of all targeted ADs (i.e., GAD, SOP, SAD) as assessed via the Anxiety Disorders Interview Schedule (ADIS-C/P; Silverman & Albano, 1996). The composite diagnosis (i.e., based on child and parent interviews) was used to determine all diagnoses.
2. Clinical Global Impression Severity Scale (CGI-S; Guy, 1976) score of 1 or 2. The CGI-S is a global rating of anxiety severity ranging from 1 (*not at all ill*) to 7 (*extremely ill*). A score of 1 or 2 reflects no to minimal symptoms.
3. CGI-I (Guy, 1976) score of 1. The CGI-I is a 7-point Likert-type scale used to indicate improvement relative to baseline severity. A score of 1 refers to very much improved. In the CAMS, response was defined as a CGI-I score of 1 or 2 (Walkup et al., 2008).

Predictor variables included the following measures—Brief Symptom Inventory (BSI; Derogatis, 1993). The total score of the BSI, a widely used 53-item self-report measure, indexed parents' psychiatric symptomatology.

State-Trait Anxiety Inventory ([STAI] Trait Version; Spielberger, 1983). Parental anxiety was assessed using the total score of the self-report STAI.

Both of these measures were completed primarily (87%) by mothers. The presence of comorbid internalizing (i.e., other anxiety and depressive disorders) and externalizing disorders was assessed using the ADIS-C/P. The CGI-S, study entry AD, and self-reported age, gender, socioeconomic status, and race/ethnicity were also examined as predictors of remission.

Results

Intent-to-treat analyses were conducted including all 488 randomized participants, regardless of study completion and/or compliance. Among them, 439 (90%) had complete Week 12 assessment data. Multiple imputation was used to impute data for the 49 participants who did not provide Week 12 data.

Remission Versus Response Rates

Table 1 presents remission and response rates for each treatment group. McNemar chi-square tests, estimated within a multiple imputation framework, examined whether response and remission rates differed significantly from each other. Results indicated that the sample remission rate was significantly lower than the sample response rate for all definitions of remission, the loss of AD diagnoses ($f = 29.11$, $df = 1$, $ddf = 100$, $p < .0001$), the CGI-S score of 1 or 2 ($f = 19.35$, $df = 1$, $ddf = 77$, $p < .0001$), and the CGI-I score of 1 ($f = 63.43$, $df = 1$, $ddf = 86$, $p < .0001$).

Remission Rates Across Treatment Conditions

To investigate whether remission status varied by treatment condition, we conducted a series of three logistic regression models. Each model also included several covariates: child's age, gender, minority status, socioeconomic status, and treatment site. Six contrasts for each model (comparing each of the four treatment conditions to each other) were conducted. Results for the loss of AD diagnoses indicated that participants in all three active treatments were significantly more likely to remit than participants in the PBO condition (see Table 2). Furthermore, participants in the COMB condition were more likely to remit than participants in the SRT and CBT conditions. SRT and CBT remission rates did not significantly differ from each other.

Results from the models for CGI-S and CGI-I remission revealed only one significant difference (see Tables 3 and 4). Using these definitions for remission, participants in the COMB treatment condition were more likely to remit than participants in the CBT condition. Despite this, neither COMB, CBT, nor SRT participants exhibited significantly different CGI-I or CGI-S remission rates from participants in the PBO condition.

Predictors of Remission

In a second set of analyses, we conducted a series of single-predictor logistic regressions, within a multiple imputation framework, in which each of 10 potential variables was examined as predictors of remission. Four demographic variables (i.e., child's age, gender, minority status, and socioeconomic status), four baseline child clinical variables (i.e., anxiety severity as measured by the CGI-S, primary AD diagnosis, presence of a comorbid internalizing disorder [i.e., anxiety or depressive disorder] other than the primary three [i.e., GAD, SAD, and SOP] treated as part of this study, presence of a comorbid externalizing disorder), and two baseline measures of parental psychopathology (BSI Global scale and

STAI total score) were examined. In a last step, we combined significant predictors together in one model to examine which uniquely contributed to predicting remission rates.

Demographic Variables

Age (measured in year increments) significantly predicted remission status on the ADIS-C/P, $b = -0.007$, $t(464) = -2.65$, $p = .01$, odds ratio (OR) = 0.92, 95% confidence interval (CI) [0.86, 0.98], and CGI-S, $b = -0.006$, $t(443) = -2.11$, $p = .04$, OR = 0.54, 95% CI [0.42, 0.71], such that older children were less likely to enter remission (see Table 5). Minority status also predicted remission on the ADIS-C/P, $b = -0.73$, $t(331) = -2.97$, $p = .003$, OR = 2.07, 95% CI [1.94, 2.21], such that minority children were less likely to enter remission (see Table 6). Neither gender nor socioeconomic status significantly predicted remission status for any definition of remission. None of the demographic variables significantly predicted CGI-I remission status.

Baseline Child Clinical Variables

Higher anxiety on the CGI-S significantly predicted reduced likelihood of remitting for all definitions of remission, loss of AD diagnoses on the ADIS-C/P: $b = -0.61$, $t(437) = -4.51$, $p = .0001$, OR = 0.54, 95% CI [0.42, 0.71]; CGI-S: $b = -0.64$, $t(387) = -4.62$, $p = .0001$, OR = 0.64, 95% CI [0.48, 0.84]; CGI-I: $b = -0.45$, $t(461) = -3.16$, $p = .002$, OR = 0.52, 95% CI [0.40, 0.69].

Diagnoses

Binary variables coded to denote the presence or absence of a diagnosis at baseline for GAD, SAD, and SOP were entered together in models for each definition of remission. There were no significant interactions among diagnoses for any definition of remission; thus, interaction terms were not included in the models. Results revealed that participants with baseline SOP were significantly less likely to achieve remission than those participants without SOP on the ADIS-C/P, $b = -0.91$, $t(473) = -3.65$, $p = .003$, OR = 0.40, 95% CI [0.24, 0.66], and the CGI-S, $b = -0.65$, $t(415) = -2.64$, $p = .01$, OR = 0.52, 95% CI [0.32, 0.85], at Week 12 but not on the CGI-I score of 1, $b = -0.36$, $t(461) = -1.43$, $p = .15$ (see Table 7). No significant differences were found for participants with or without GAD and SAD.

At baseline, 44% of the sample ($n = 215$) met criteria for one or more of the following internalizing disorders, in addition to the child's target diagnosis/diagnoses of GAD, SAD, and/or SOP: selective mutism, obsessive-compulsive disorder, panic disorder, agoraphobia, specific phobia, major depressive disorder, major depressive disorder not otherwise specified, and dysthymic disorder. Eighteen percent ($n = 90$) met criteria for one or more of the following externalizing disorders: attention-deficit/hyperactivity disorder, attention-deficit/hyperactivity disorder not otherwise specified, conduct disorder, and oppositional defiant disorder (see Kendall et al., 2010, for a full description of comorbidities in the CAMS sample). The presence of a comorbid internalizing disorder was associated with a reduced likelihood of achieving remission in Week 12 as assessed by the ADIS-C/P, $b = -0.38$, $t(459) = -2.04$, $p = .04$, but was not statistically associated with the CGI-S, $b = -0.36$, $t(306) = -1.84$, $p = .07$, or CGI-I, $t(437) = -0.89$, $p = .37$, remission status (see Table 8). Comorbid externalizing disorder did not significantly predict remission status for any definition of remission, ADIS-C/P: $t(396) = -0.81$, $p = .42$; CGI-I: $t(322) = 0.04$, $p = .89$; and CGI-S: $t(261) = -0.81$, $p = .42$.

Parental Psychopathology

Parent Global BSI scores did not significantly predict Week 12 remission status on the ADIS-C/P, $t(381) = -0.07$, $p = .94$; the CGI-I, $t(418) = -0.12$, $p = .90$; or the CGI-S, $t(254) = 0.29$, $p = .77$. Similarly, parental trait anxiety did not predict Week 12 remission status, ADIS-C/P: $t(439) = 0.69$, $p = .49$; CGI-I: $t(411) = -0.13$, $p = .90$; and CGI-S: $t(392) = 1.01$, $p = .31$.

Combined Predictors of Remission

In this last step in these analyses, we tested models in which baseline CGI-S score, the presence of SOP, and internalizing comorbidity, together with age and minority status, predicted remission status for each different definition of remission. Results indicated that baseline CGI-S score, $b = -0.53$, $t(432) = -3.80$, $p = .0002$; SOP, $b = -0.77$, $t(467) = -2.93$, $p = .004$; and minority status, $b = -0.68$, $t(321) = -2.69$, $p = .001$, all significantly predicted ADIS-C/P remission status when included in the same model. Internalizing comorbidity, $b = -0.37$, $t(452) = -1.88$, $p = .06$, and age, $b = -0.05$, $t(456) = -1.77$, $p = .08$, were not predictors of ADIS-C/P remission in this model. In contrast, only baseline CGI-S score, $b = -0.64$, $t(384) = -4.20$, $p < .0001$, and SOP, $b = -0.51$, $t(403) = -1.98$, $p = .05$, significantly predicted CGI-S remission status when included, together with comorbid internalizing, age, and minority status, in the same model. Last, only baseline CGI-S significantly predicted CGI-I remission status, $b = -0.42$, $t(460) = -2.87$, $p = .004$, when all significant predictors were included in the same model.

Discussion

Using diagnostic status as a rigorous definition of remission (i.e., no longer meeting criteria for any of the three primary ADs treated in this study), children randomized to the COMB condition had significantly higher remission rates than did children in any of the other treatment conditions. Children treated with either monotherapy had similar remission rates but higher remission rates than those in the PBO treatment. This pattern was similar to that found for response rates in the CAMS (Walkup et al., 2008). Findings also indicated that remission rates for the entire sample were significantly lower than response rates. The pattern and magnitude of remission rates found in the current study were fairly consistent with published CBT and SSRI medication trials for pediatric anxiety (Hudson et al., 2009; Wagner et al., 2004). Importantly, despite the use of varying definitions and measures used to assess remission in published CBT and medication trials, comparable remission rates were found across these definitions and measures used in this study (i.e., the CGI-I has been used most often in medication trials and the loss of AD used most often in CBT trials).

Findings from this study also revealed that remission rates varied based on the definition and measure used. This highlights the importance of developing a consensus definition of remission for ADs, as has been done for depression. Valid measures capturing this definition are also needed. For instance, the use of single-item measures such as the CGI-I, although used in published studies, may not be reliable and reflects a measure of improvement rather than remission.

Several baseline variables predicted remission status. Specifically, out of 10 predictors (four demographic, four child clinical, and two parent), five emerged as significant: younger age, nonminority race/ethnicity, lower severity of anxiety, absence of a comorbid internalizing (i.e., anxiety or depressive) disorder, and absence of SOP. When combined into a single model to assess their relative importance in predicting outcomes, lower baseline anxiety severity, absence of SOP and nonminority status all significantly predicted remission based on the ADIS-C/P. Taken together, each of these variables has been examined in previous

CBT and medication pediatric anxiety trials with respect to treatment response or absence of primary disorder; however, findings across these studies have been inconsistent (e.g., Berman, Weems, Silverman, & Kurtines, 2000). Previous trials examining predictors of response have been hampered by small sample sizes, which may explain the inconsistent findings. Alternatively, predictors of remission may differ from those of response. Given the relatively large sample size of the CAMS, these results help clarify important and clinically relevant predictors of remission. The current findings suggest that the most consistent baseline predictors of remission (i.e., across more than one definition) were younger age, lower anxiety, and the absence of SOP. Taken together, refinements of treatment, augmentation, and/or increased dosage or duration of treatment may be needed for older and non-Caucasian youth and those with higher anxiety severity, SOP (as in Crawley, Beidas, Benjamin, Martin, & Kendall, 2008), and additional comorbid internalizing disorders.

Limitations

Findings from the current study should be interpreted in the context of several limitations. First, although we examined three definitions of remission, alternate definitions may yield different results, and future studies are needed to explore which definition is superior. Second, we examined a limited number of predictors. Future studies may identify additional predictors (as well as moderators or mediators) such as age of onset or duration of illness. Related to this, we did not examine whether the predictors differed for different treatment condition. Third, the sample was comprised of volunteers and excluded youth meeting criteria for major depressive disorder, limiting the representativeness of the sample. Fourth, RCTs such as the CAMS are powered to detect response, not remission, which may explain the absence of consistent statistical differences using the CGI-S and CGI-I remission criteria. Fifth, definitions of response and remission do not explicitly measure the degree to which intervention addresses associated functional impairment, an important index of outcome. Sixth, the current study addressed the end of acute treatment (i.e., 12 weeks of treatment) and not the long-term impact of residual anxiety symptoms. The availability of follow-up data will eventually enable tests to examine whether a particular remission definition possesses greater prognostic significance.

Clinical Implications and Future Directions

Achieving remission, rather than response or symptomatic improvement, is a preferred goal when treating youth with ADs. Although combined treatment had the highest remission rates relative to other treatment arms, clinicians need to be mindful that approximately 30%–50% of youth receiving 12 weeks of high-quality combined treatment will continue to experience some residual symptoms—even among those who show meaningful improvement. Treatments may need to be augmented or prolonged to buttress outcomes by targeting residual symptoms and the specific predictors of poor remission. Universal or unified protocols that target comorbid symptoms, adding social skills training for youth with SOP and enhancing parental involvement, may augment treatment response. Finally, identifying the mechanisms of change in CBT and in SRT and working toward optimizing these change strategies early in treatment may prove fruitful in maximizing the potential for remission. Given that the treatment providers in the CAMS were highly trained and continuously supervised, the need to improve current treatments for anxious youth may be even greater for clinical practice in community settings.

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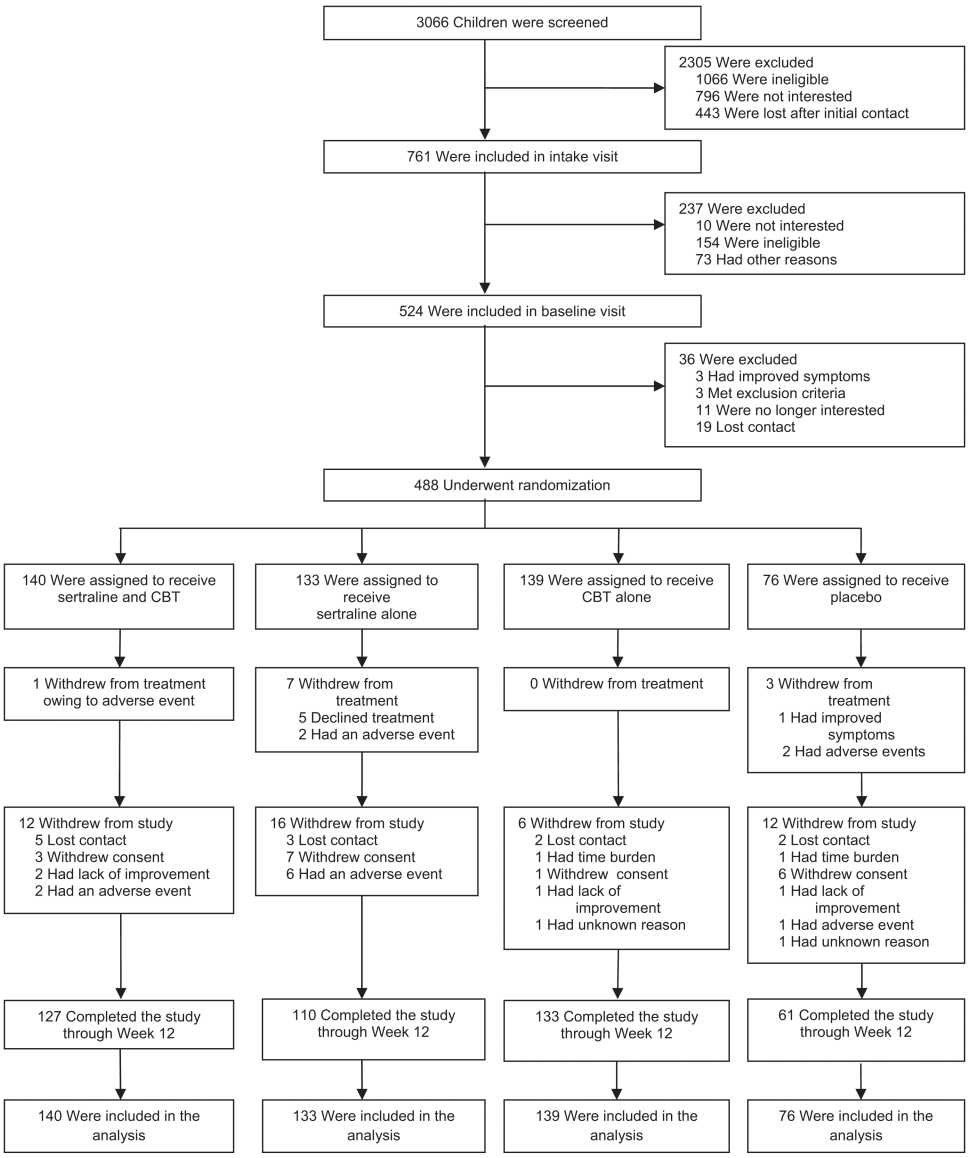

Figure 1.

Flow diagram of Child/Adolescent Anxiety Multimodal Study. Subjects who are shown as having withdrawn from treatment discontinued their assigned therapy but continued to undergo study assessment. Subjects who are shown as having withdrawn from the study discontinued both therapy and assessment. CBT = cognitive behavioral therapy.

Table 1

Response and Remission Rates (With Confidence Intervals in Brackets) of Child/ Adolescent Anxiety Multimodal Study Subjects at Week 12

Treatment	CGI-I response[a]	No AD remission	CGI-S remission	CGI-I remission
COMB (*n* = 140)	80.7	68.3 [58.7, 76.5]	64.9 [54.8, 73.8]	45.6 [36.2, 55.3]
SRT (*n* = 133)	54.9	45.9[b]	46.3 [35.9, 57.1]	33.9 [25.9, 42.9]
CBT (*n* = 139)	59.7	46.2 [37.9, 54.8]	35.9 [28.3, 44.3]	20.4 [14.4, 28.0]
PBO (*n* = 76)	23.7	23.7 [15.5, 34.6]	27.1 [13.0, 48.1]	15.0 [3.4, 46.4]

Note. COMB = combination treatment condition; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo; CGI-I = Clinical Global Impression Improvement Scale; CGI-S = Clinical Global Impression Severity Scale; AD = anxiety disorder.

[a] Response rates reported in Walkup et al. (2008) and presented here for ease of comparison.

[b] No variability in this estimate across imputations, thus confidence interval not applicable.

Table 2

Between-Group Comparisons of Remission Rates Based on Loss of Anxiety Disorder Diagnoses

Comparison	Odds ratio	*SE*	95% confidence interval	*df*	*t* for H_0	*p* value
COMB vs. PBO	7.47	2.63	[2.30, 12.64]	359	2.46	0.01
SRT vs. PBO	2.84	0.93	[1.01, 4.67]	478	1.98	0.05
CBT vs. PBO	2.91	0.96	[1.03, 4.79]	464	1.99	0.05
COMB vs. CBT	2.58	0.75	[1.10, 4.06]	203	2.10	0.04
COMB vs. SRT	2.63	0.74	[1.16, 4.11]	265	2.18	0.03
SRT vs. CBT	0.98	0.25	[0.49, 1.47]	456	−0.09	0.93

Note. COMB = combination treatment condition; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo.

Table 3

Between-Group Comparisons of Remission Rates Based on Clinical Global Impression Severity Scale Score of 1 or 2

Comparison	Odds ratio	*SE*	95% confidence interval	*df*	*t* for H_0	*p* value
COMB vs. PBO	5.59	3.22	[0, 12.07]	43	1.43	0.16
SRT vs. PBO	2.55	1.45	[0, 5.48]	43	1.07	0.29
CBT vs. PBO	1.65	0.94	[0, 3.53]	44	0.69	0.49
COMB vs. CBT	3.39	0.95	[1.51, 5.27]	253	2.51	0.01
COMB vs. SRT	2.22	0.68	[0.86, 3.57]	124	1.77	0.08
SRT vs. CBT	1.56	0.46	[0.64, 2.47]	148	1.20	0.23

Note. COMB = combination treatment condition; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo.

Table 4

Between-Group Comparisons of Remission Rates Based on Clinical Global Impression Improvement Scale Score of 1

Comparison	Odds ratio	*SE*	95% confidence interval	*df*	*t* for H_0	*p* value
COMB vs. PBO	5.97	4.88	[0, 15.82]	43	1.02	0.31
SRT vs. PBO	3.56	2.96	[0, 9.53]	43	0.86	0.39
CBT vs. PBO	1.77	1.49	[0, 4.78]	44	0.52	0.61
COMB vs. CBT	3.42	1.03	[1.39, 5.46]	253	2.34	0.02
COMB vs. SRT	1.71	0.49	[0.74, 2.67]	208	1.45	0.15
SRT vs. CBT	2.01	0.59	[0.86, 3.17]	402	1.72	0.09

Note. COMB = combination treatment; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo.

Table 5

Remission Rates by Age

	% no AD		% CGI-S (1, 2)		% CGI-I (1)	
Treatment	**7–11**	**12–17**	**7–11**	**12–17**	**7–11**	**12–17**
COMB	73.2	58.8	70.4	54.4	48.0	41.0
SRT	51.1	34.9	50.7	37.0	39.6	21.9
CBT	51.7	36.1	37.2	33.6	20.2	20.7
PBO	26.0	19.4	30.0	21.3	15.5	14.1

Note. Percentages reported represent the proportion of participants in that cell (i.e., in that treatment condition and age group) who remitted. COMB = combination treatment; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo; AD = anxiety disorder; CGI-I = Clinical Global Impression Improvement Scale; CGI-S = Clinical Global Impression Severity Scale.

Table 6

Remission Rates by Treatment Condition and Minority Status

	% no AD		% CGI-S (1, 2)		% CGI-I (1)	
Treatment	**Racial minority**	**Caucasian**	**Racial minority**	**Caucasian**	**Racial minority**	**Caucasian**
COMB	45.1	73.0	52.1	67.5	40.1	46.7
SRT	36.7	48.5	41.2	47.8	27.8	35.7
CBT	33.7	50.1	26.0	39.0	21.9	19.9
PBO	18.8	25.1	30.4	26.1	20.7	13.4

Note. Percentages reported represent the proportion of participants in that cell (i.e., in that treatment condition and category with regard to minority status) who remitted. COMB = combination treatment; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo; AD = anxiety disorder; CGI-I = Clinical Global Impression Improvement Scale; CGI-S = Clinical Global Impression Severity Scale.

Table 7

Remission Rates by Treatment Condition for Participants With and Without Social Phobia

	% no AD		% CGI-S (1, 2)		% CGI-I (1)	
Treatment	**No SOP**	**SOP**	**No SOP**	**SOP**	**No SOP**	**SOP**
COMB	88.0	64.0	84.0	60.7	52.0	44.2
SRT	52.0	44.4	47.6	46.0	40.6	32.3
CBT	72.0	40.6	52.0	32.4	28.0	18.7
PBO	46.1	19.1	45.9	23.1	17.3	14.5

Note. Percentages reported represent the proportion of participants in that cell (i.e., in that treatment condition and category with regard to SOP) who remitted. COMB = combination treatment; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo; AD = anxiety disorder; CGI-I = Clinical Global Impression Improvement Scale; CGI-S = Clinical Global Impression Severity Scale; SOP = social phobia.

Table 8

Remission Rates by Treatment Condition for Participants With and Without Additional Internalizing Comorbidity

	% no AD		% CGI-S (1, 2)		% CGI-I (1)	
Treatment	**No AIC**	**AIC**	**No AIC**	**AIC**	**No AIC**	**AIC**
COMB	73.9	62.6	68.6	61.2	52.9	38.3
SRT	52.6	36.4	51.9	38.4	36.5	30.2
CBT	49.1	42.1	40.1	29.8	18.7	22.8
PBO	27.9	18.3	32.8	19.6	15.4	14.3

Note. Percentages reported represent the proportion of participants in that cell (i.e., in that treatment condition and category with regard to AIC) who remitted. COMB = combination treatment; SRT = sertraline; CBT = cognitive behavioral therapy; PBO = placebo; AD = anxiety disorder; CGI-I = Clinical Global Impression Improvement Scale; CGI-S = Clinical Global Impression Severity Scale; AIC = additional internalizing comorbidity.