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A Preliminary Investigation of the Long-Term Outcome of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders

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Abstract

Objective—To conduct a preliminary examination of long-term outcomes on a broad range of affective disorder symptoms treated with a newly developed intervention: The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP).

Method—Maintenance of treatment gains at long-term follow-up (LTFU) were explored in patients (*n* = 15, mean age = 32.27; 60% female) who completed a clinical trial of the UP.

Results—Treatment gains observed at 6-month follow-up (6MFU) on measures of clinical severity, general symptoms of depression and anxiety, and a measure of symptom interference in daily functioning were largely maintained 12 months later (at an average of 18 months posttreatment), and any significant changes from 6MFU to LTFU reflected small increases in symptoms that remained, on average, in the subclinical range.

Conclusions—These findings provide the first initial support for the durability of broad treatment gains following transdiagnostic treatment.

Keywords

anxiety disorders; treatment outcome; cognitive-behavioral treatment; transdiagnostic; unified protocol

1. Introduction

The past three decades have seen significant advances in the development and further refinement of psychological treatments for anxiety disorders. There is now sufficient evidence to support the efficacy of cognitive behavior therapy (CBT) for the treatment of

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anxiety disorders in adults, with meta-analyses of randomized controlled clinical trials demonstrating moderate to strong effect sizes for CBT when compared to both wait-list and placebo controls [1–3]. However, the majority of efficacy trials fail to adequately assess the maintenance of treatment gains by rarely extending follow-up assessments beyond 6 months posttreatment [4]. One possible explanation for the relative absence of long-term CBT outcomes (i.e., > 12 months) for anxiety disorders is that CBT is proposed to facilitate symptom reduction through the induction of new skills and behaviors that should be applicable across situations, whereas it is often expected that the therapeutic benefit of pharmacological interventions will dissipate upon discontinuation. Therefore, it could be argued that a positive response to CBT at posttreatment reflects sufficient mastery of treatment principles or skills, and that treatment gains should continue to persist, perhaps even indefinitely, following treatment termination.

This presumption is unfortunate, as the long-term outcome studies that do exist demonstrate the importance of continued follow-up assessments beyond 6 or 12 months. For example, Durham et al. [5] reported that CBT yielded more favorable long-term outcomes (2–14 years posttreatment) for anxiety disorders than non-CBT therapies and pharmacotherapy in terms of overall functional impairment, but not with regard to diagnostic status, likelihood of recovery, or patients' subjective report of overall improvement. When the maintenance of remission status following a course of CBT is assessed beyond a 2-year follow-up, studies suggest that approximately 1 out of 4 patients with an anxiety disorder will experience a reoccurrence of symptoms [6–8]. It is important to emphasize that these studies do not reflect a continuation of a poor initial response to CBT, but rather, an erosion of the positive treatment effects observed at acute outcome. Anxiety disorders tend to follow a chronic course, with many individuals experiencing episodic symptoms in addition to periods of full symptom remission [9,10]. Naturalistic, longitudinal studies of the long-term course of anxiety disorders suggest that anxiety disorders are best characterized by low rates of remission and moderate rates of relapse or symptom recurrence following remission, with relapse likely to occur within the first 2 years of follow-up [11–13]. Although the long-term efficacy of CBT for anxiety disorders requires further systematic evaluation, the existing data suggest that a positive response at post-treatment or even at 6-month follow-up is not reliably related to long-term efficacy.

We recently evaluated the efficacy of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) [14,15]. The UP is a transdiagnostic treatment designed to target a full range of emotional problems by distilling and integrating empirically supported therapeutic principles common to psychological treatments for anxiety and depressive disorders. Results from an open clinical trial [16] and a randomized controlled trial (RCT) comparing the UP to a delayed treatment condition [17] indicated that treatment with the UP significantly reduced both symptom severity and symptom interference across all anxiety and comorbid depressive disorders, and resulted in significant gains in general symptoms of anxiety and depression that were maintained up to 6 months posttreatment [17]. Although these studies support the short-term efficacy of the UP as a transdiagnostic treatment for anxiety and comorbid depressive disorders, the examination of the sustainability of treatment gains achieved with transdiagnostic protocols is of critical importance since there is no guarantee that results will be similar to more focused CBT approaches.

The aim of the present study was to conduct an initial examination of the sustainability of the UP by assessing long-term treatment outcome in a sample of patients who completed a full course of treatment with the UP during the previous RCT of this protocol, as described above. Because existing efficacy studies of therapist-delivered transdiagnostic treatments either include acute outcome only or do not evaluate patients beyond a 6-month follow-up assessment, the present study is the first to present any data on the maintenance of treatment gains over an extended follow-up period. Based on the UP's status as a newly developed treatment, an overall scarcity of long-term outcomes reported for CBT, and a lack of any long-term outcomes for transdiagnostic treatment protocols, the current study was exploratory in nature. However, given the waxing and waning nature of anxiety disorders and previous studies demonstrating an erosion of treatment gains over extended follow-up periods, we hypothesized that some patients would likely evidence some symptom reoccurrence during the follow-up period.

2. Materials and method

2.1. Procedure

Data for this study were derived from two sources: 1) the aforementioned RCT of the UP [17], and 2) routine clinical assessments conducted at our Center for Anxiety and Related Disorders (CARD) at intake, 12-months, and 24-months. All participants in the UP RCT were recruited based on the diagnoses assigned at intake, and then further assessed for UP study eligibility during a study-specific baseline assessment. Participants enrolled in the RCT were then randomized to either immediate treatment with the UP or a 16-week delayed treatment condition. Treatment initiators from both conditions were evaluated at posttreatment and then again at 6 months posttreatment, which concluded participation in the UP RCT. However, participants were also contacted for routine clinical follow-ups at 12 and 24 months from the initial intake. All procedures were approved by the university's institutional review board and all participants signed a written voluntary informed consent form.

For the present study, assessments from the UP RCT at posttreatment and 6-months posttreatment were integrated with the initial diagnostic assessment, as well as a 24-month follow-up assessment. For participants in the RCT, the 24-month routine clinical assessment occurred at approximately 18 months posttreatment (mean = 18.80 months, *SD* = 1.59, range = 16.53 to 21.27); the length of time from the UP posttreatment assessment to the 24-month follow-up assessment was comparable for participants randomized to immediate treatment (mean = 18.17 months, *SD* = 1.35) and those randomized to delayed treatment (mean = 20.38 months, *SD* = .91).

The follow-up assessments conducted in the UP RCT were identical to routine clinical assessments administered at intake and follow-up with one exception: two of the diagnosis-specific symptom measures administered during routine diagnostic assessments at intake and 24-month follow-up differ from those administered during the UP RCT at posttreatment and 6-months posttreatment. Figure 1 summarizes participant enrollment and flow through as it pertains to the present study; however, since data were also collected from routine clinical follow-up assessments, these numbers do not reflect attrition rates for the UP RCT.

Participants were compensated for completion of assessments. All follow-up assessments took place between May of 2010 and August of 2011.

2.2 Participants

Eligibility criteria for the RCT included a principal (i.e., most severe and/or interfering) diagnosis of an anxiety disorder, an age requirement of 18 years or older, fluency in English, and the ability to provide informed consent. Exclusion criteria included the presence of any clinical conditions requiring immediate or simultaneous treatment (e.g., current *DSM-IV* diagnosis of bipolar disorder, schizophrenia, schizoaffective disorder, or organic mental disorder, clear and current suicidal risk, or current or recent history of substance abuse or drug dependence). We also excluded any individual who had already received a minimum of 8 sessions of CBT within the past 5 years. For additional details on recruitment and exclusion criteria for the RCT, see Farchione et al. [17].

Of the 37 patients who consented to treatment and were randomized to receive either immediate or delayed treatment, 32 were identified as treatment completers (i.e., received a minimum of 8 treatment sessions), with 28 also completing a follow-up assessment at 6 months posttreatment. Fifteen of these participants completed the additional 24-month assessment (i.e., approximately 18-months posttreatment) as part of routine clinical assessment study at CARD. The remaining 17 treatment completers were unable to be reached by phone or mail (n = 13), declined to participate (n = 3), or failed to attend their scheduled assessment for reasons unknown (n = 1).

Thus, the sample for the present study consisted of 15 treatment completers with additional follow-up data available. During the RCT, 11 of these participants received immediate treatment with the UP and the remaining four received treatment with the UP following a 16-week delay. The sample included nine females and six males (mean age = 32.27 years, *SD* = 10.42, range = 20 to 52) and all participants identified as Caucasian. Principal diagnoses represented included generalized anxiety disorder (GAD; n = 3), social anxiety disorder (SOC; n = 2), panic disorder with agoraphobia (PDA; n = 5), and obsessive-compulsive disorder (OCD; n = 5). One participant had a co-principal diagnosis (i.e., two diagnoses of equal severity) of OCD and PDA. At the initial intake assessment, participants had an average of 2.47 diagnoses (*SD* = 1.51 diagnoses, range = 1 to 5). Comorbid anxiety disorders included SOC (n = 3), OCD (n = 1), GAD (n = 5), PDA (n = 2), and posttraumatic stress disorder (n = 1). Approximately half (n = 7) of participants also met diagnostic criteria for a current depressive disorder at intake. Five participants indicated that they had received additional talk therapy since completing the RCT; the reasons stated for doing so included marital stress (n = 2), life stress (n = 1), depression (n = 1), and panic (n = 1).

2.3. Treatment

Treatment during the RCT consisted of a maximum of 18, one-hour individual therapy sessions. Participants included in the current study completed between 11 and 18 treatment sessions (mean number = 16.47, *SD* = 2.56); average number of sessions completed for current sample was comparable to treatment initiators from the RCT (mean number = 15.26 sessions; *SD* = 4.60). The UP is comprised of five core modules designed to target various

aspects of emotional processing and the regulation of emotional experiences, including: a) emotional awareness training, b) understanding how thoughts can influence emotional experiences, c) learning how to identify behaviors associated with the avoidance of emotional responses, d) increasing awareness and tolerance of physical sensations, and e) confronting strong emotions through interoceptive and situation-based emotion-focused exposures. These five core modules are preceded by an introductory module focused on educating the patient about the functional, adaptive nature of emotions and constructing a framework for understanding their emotional experiences, as well as a module that targets motivation enhancement and treatment engagement. The final module is dedicated to reviewing the participant's progress and developing relapse prevention strategies. All treatment completers received all treatment modules. For further information on treatment development and delivery, see Ellard et al. [16].

2.4. Assessment

Assessments were administered at pretreatment, posttreatment, 6-month follow-up (6MFU), and long-term follow-up (LTFU), unless otherwise noted. As stated previously, the clinician-administered measures were identical across all time points and self-report measures were nearly identical across assessments, with one minor exception noted below.

Intake diagnoses were established using the Anxiety Disorders Interview Schedule for DSM-IV-Lifetime Version (ADIS-IV-L) [18]. The ADIS-IV-L focuses on the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* [19] diagnoses of anxiety and mood disorders, somatoform disorders, and substance and alcohol use disorders. Diagnoses are assigned a clinical severity rating (CSR) on a scale ranging 0 (*no symptoms*) to 8 (*extremely severe symptoms*), with a score of 4 (*definitely disturbing/disabling*) as the clinical threshold for *DSM-IV* diagnostic criteria. In the event two diagnoses are determined to be equally interfering, they are assigned as co-principal diagnoses. The full ADIS-IV-L was administered at intake, while an abbreviated version that focuses only on current symptomology (ADIS-IV) [20] was administered at pretreatment, posttreatment, and at 6MFU for the RCT. The additional follow-up assessments that occurred 12 and 24 months after patients originally presented to CARD for treatment were also conducted using the ADIS-IV. Diagnosticians included clinical psychologists and advanced clinical doctoral students who were required to undergo rigorous training on all measures to meet strict certification criteria [21].

Self-reported general symptoms of depression and anxiety were assessed with the Beck Depression Inventory (BDI-II) [22] and the Beck Anxiety Inventory (BAI) [23,24]. A self-report measure of positive and negative affect, the Positive and Negative Affect Schedule (PANAS) [25] was also administered. Additional measures were included to assess diagnosis-specific symptoms, including the Social Interaction Anxiety Inventory (SIAS) [26] to assess current symptoms of SOC and the Penn State Worry Questionnaire (PSWQ) [27] to assess symptoms of GAD. Current symptoms of OCD were assessed using the Obsessive-Compulsive Inventory-Revised version (OCI-R) [28]. Current symptoms related to panic were assessed using the Albany Panic and Phobia Questionnaire (APPQ) [29]. The OCI-R and APPQ were not administered as part of the RCT, so data from these measures

are limited to baseline and LTFU. Lastly, a five-item measure, the Work and Social Adjustment Scale (WSAS) [30,31] was clinician-administered (WSAS-C) and completed as a self-report measure (WSAS-SR) to capture the degree to which symptoms were currently interfering in the domains of work, home management, private leisure, social leisure, and family relationships.

2.5. Data analysis

First chi-square analyses were conducted to determine a) whether participants who agreed to complete the 24-month routine clinical follow-up assessment differed significantly from those who declined to participate or were unable to be reached, and b) whether participants who sought additional treatment between 6MFU and LTFU differed in any meaningful ways from participants who did not seek additional treatment.

A series of repeated measures univariate analyses of variance (ANOVAs) were conducted to determine the long-term outcome of treatment with the UP. Mean differences in outcome were used to calculate standardized effect size estimates for pretreatment and LTFU scores. To facilitate comparison with outcomes reported in the RCT of the UP (Farchione et al., 2012), Hedges' *g* (a variation of Cohen's *d* effect size that corrects for biases due to small sample sizes) was utilized to calculate effect size estimates. Effect size estimates were interpreted conservatively, with 0.2, 0.5, 0.8 reflecting small, medium, and large effects, respectively [32].

To determine the clinical significance of the effects of the UP at LTFU, we utilized a similar approach to determining the proportion of participants that achieved treatment responder status and high end-state functioning (HESF) as previous evaluations of the UP [16,17]. Participants were considered to meet responder status if they achieved a 30% or greater reduction on two of the following three measures: diagnostic clinical severity (ADIS-IV CSR), clinician-assessed functional impairment (WSAS-C), or the diagnosis specific measure for the principal diagnosis (SIAS, PSWQ, OCI-R, APPQ). Participants were considered to have achieved HESF if they no longer met diagnostic criteria for their principal diagnosis (i.e., ADIS-IV CSR < 4), and if their score on either the clinician-rated measure of impairment or the diagnosis-specific measure for the principal diagnosis fell in the subclinical range. Finally, maintenance of treatment gains was explored using within-treatment effect size estimates (standardized gains, ES*sg*) for the primary outcome variables for posttreatment, 6MFU, and LTFU. We also calculated the percentage of participants who retained responder or HESF statuses across each time point.

3. Results

3.1. Group comparisons

For the first comparison (a), there were no significant differences between groups in randomization status (randomization to immediate treatment or to delayed treatment; $p < .98$), principal diagnosis ($p < .12$), or clinical severity rating of principal diagnosis at posttreatment ($p < .84$) or six months later ($p < .25$). The second comparison (b) also indicated no differences between the participants who did and those who did not seek further

treatment during the extended follow-up period in diagnostic group ($p < .94$), or CSR for principal diagnosis at either 6MFU ($p < .40$) or LTFU ($p < .77$).

3.2. Efficacy and clinical significance

Treatment with the UP yielded a very strong effect on diagnostic severity for principal diagnoses (ADIS-IV CSRs) from pretreatment to LTFU ($F_{1, 14} = 22.67$, $p < .001$, Hedges's g = 1.83), as well as on the number of clinical diagnoses ($F_{1, 14} = 22.78$, $p < .001$, Hedges's g = 1.17). Analysis of treatment effects on both self-reported (WSAS-SR; $F_{1, 12} = 8.75$, $p < .05$, Hedges's g = 1.29) and clinician-assessed impairment (WSAS-C; $F_{1, 14} = 7.71$, $p < .05$, Hedges's g = .69) in work, home management, social life, and family relationships revealed moderate to large effects of time. A strong effect was observed on general anxiety symptoms (BAI) that nearly achieved statistical significance ($F_{1, 12} = 4.71$, $p = .051$, Hedges's g = .92). There was also a trend toward significant reductions in symptoms of depression (BDI; $F_{1, 12} = 3.08$, $p < .11$, Hedges's g = .36) and increases in positive affect (PANAS-PA; $F_{1, 12} = 3.40$, $p < .10$, Hedges's g = − .40). Descriptive statistics and effect size estimates at pretreatment and LTFU are presented in Table 1.

Using the clinical significance algorithm described earlier, two thirds of participants ($n = 10$) met criteria for treatment responder status at LTFU and 90% of treatment responders (or 60% of the total sample) met criteria for HESF. With regard to the effect of the UP on comorbid depressive disorders, only one of the seven participants who were diagnosed with a depressive disorder at pre-treatment still met criteria for one at LTFU; there were no new cases of depression.

3.3. Maintenance of treatment gains

Effect size estimates suggest that there were only negligible changes in clinical severity of principal diagnoses (ADIS-IV CSRs), the number of clinical diagnoses, self-reported impairment (WSAS-SR), and positive affect (PANAS-PA) from 6MFU to LTFU (see Table 2). Symptoms of depression (BDI; ES*sg* = −0.50) and anxiety (BAI; ES*sg* = −.19) evidenced moderate and small increases, respectively, from 6MFU to LTFU. However, average BDI scores at LTFU were reflective of normal to very minimal levels of depression based on clinical severity ranges [22], and average BAI scores remained below the suggested clinical cutoff of 14 [24]. Clinician-assessed scores for functional impairment (WSAS-C; ES*sg* = −.58) demonstrated moderate increases from 6MFU to LTFU, although average scores at LTFU (mean = 11.00, *SD* = 7.67) were only slightly above the suggested cutoff (i.e., <10) [31]. Negative affectivity (PANAS-NA) evidenced moderate increases from 6MFU to LTFU (ES*sg* = −0.50). Among the participants who met criteria for treatment responder status ($n = 8$) and HESF ($n = 7$) at post-treatment, 86% and 75% maintained their treatment responder and HESF status, respectively, at 6MFU. Of the participants who met criteria for treatment responder status or HESF at 6MFU, 100% maintained their respective statuses at LTFU.

3.3. Impact of seeking additional treatment

Chi-square analyses were performed to evaluate whether receiving additional treatment was related to clinical significance statuses at LTFU. Neither responder status ($p < .10$) nor HESF ($p < .10$) at LTFU were related to receiving additional treatment. Maintenance of

responder status ($p < .10$) or HESF ($p < .10$) from 6MFU to LTFU was also unrelated to receiving additional treatment. Although these *p* values might be interpreted as marginally significant in our small sample size, review of the cross tabulation tables revealed that the direction of the relationship between additional treatment and clinical significance was such that participants who achieved responder status or HESF were actually less likely to have received additional treatment than participants who did not achieve responder or HESF status; the same relationship was observed for maintenance of responder status and HESF (i.e., there was a trend where participants who maintained responder or HESF statuses over the extended follow-up period did not pursue additional treatment).

4. Discussion

The aim of the current study was to further explore the utility of the UP as a transdiagnostic treatment for anxiety disorders by evaluating, in a preliminary manner, long-term outcome and maintenance of treatment gains during an extended follow-up period. Results suggest that treatment with the UP results in significant reductions in symptom severity for both principal and comorbid diagnoses across a range of anxiety and related disorders at approximately 18 months following treatment among those evaluated. Although effect sizes at 6MFU were generally larger than those observed at LTFU, 100% of participants who qualified as either a responder or as HESF at 6MFU retained this status for another year (i.e., at LTFU).

In previous trials of the UP [16,17], continued treatment gains were observed from posttreatment to 6MFU. For example, more participants in the RCT met criteria for responder status and HESF at 6MFU (71% and 64%, respectively) than at posttreatment (59% and 52%, respectively). Results from the current study indicated that participants did not evidence further symptom reduction or change in diagnostic status for their principal diagnosis beyond the 6-month assessment point. Overall, treatment gains at 6MFU remained fairly stable up to approximately 18 months posttreatment. Participants did demonstrate some increases in general depression symptoms, negative affect, and clinician-rated interference across life domains from 6MFU to LTFU, but average scores on these measures still remained in the non-clinical to mild range.

These findings (i.e., plateau of symptom improvement and/or marginal worsening between 6MFU and LTFU) are consistent with other long-term outcome studies. As noted by Gloster et al. [33], without further assessment, we are unable to conclude whether these small increases in symptomatology indicate the onset of a gradual deterioration process, or whether scores would stabilize at these slightly elevated, but non-clinical, levels. However, previous studies have shown that past episodes of anxiety disorders and subthreshold symptoms each independently predict subsequent episodes of anxiety and depressive disorders [34], which suggests that these small increases in symptoms may represent a prodromal period of sorts, where some regression is evident but full disorder reoccurrence has yet to occur. It is also possible though that transdiagnostic treatments developed to target shared mechanisms will result in superior maintenance of treatment gains compared to more focused CBT interventions.

The major limitation of the current study was the small sample size, which precluded analyzing differences in long-term treatment efficacy or maintenance of treatment gains across diagnostic categories. Only approximately half of treatment completers from the UP RCT had follow-up data available to analyze for the present study, and so it is possible that this sample is not fully representative of the original sample of participants. However, thorough analysis of a wide range of possible variables, including posttreatment severity, revealed no meaningful differences between the participants who agreed to participate in the routine clinical follow-up assessment 2 years after their initial evaluation and those who declined or were unable to be reached. Additionally, all participants in the current study identified as Caucasian, which may impact the generalizability of our findings to minority populations.

Another limitation is the lack of overlap among the measures used to assess symptoms related to PDA and OCD in the RCT and those used in ongoing clinical assessment at CARD. Although we were able to use pretreatment and LTFU data to calculate symptom change on the OCI-R and APPQ to quantify clinical significance (i.e., treatment responder and HESF statuses), these outcomes may reflect slightly different profiles of symptom changes for PDA and OCD than in the RCT due to measurement variability. For example, the PDA measure used in the UP RCT (PDSS) [35] assesses frequency of panic attacks, associated distress, and anticipatory anxiety, in addition to agoraphobic avoidance, whereas the APPQ reflects anticipatory anxiety of interoceptive, agoraphobic, and social situations. Symptom improvement on diagnosis-specific measures was only one of three outcomes used to determine treatment responder and HESF statuses, however, which likely helped to minimize the effect of any such variability.

Despite these limitations, the present study provides some useful, albeit preliminary, support for the long-term efficacy and durability of the UP as a transdiagnostic treatment. Within a diagnostically heterogeneous clinical sample of patients with significant comorbidity (i.e., mean = 2.57 diagnoses, range = 1 to 5), over half of participants (53%) did not meet diagnostic criteria for any clinical diagnosis at LTFU. A more idiographic review of treatment effects on comorbidity during follow-up revealed some interesting patterns for the remaining 47% of participants. For one thing, five of the seven participants with a clinical diagnosis at LTFU were non-responders at posttreatment and retained a non-responder status throughout follow-up. One participant had achieved HESF at posttreatment, but then experienced deterioration in status over time. Another participant with significant comorbidity (i.e., five clinical diagnoses at pretreatment) was classified as a responder at posttreatment and maintained this responder status throughout follow-up, but still met criteria for two clinical diagnoses at LTFU, indicating significant treatment gains that were maintained in conjunction with the persistence of some psychopathology.

Given the chronic, waxing and waning nature of anxiety disorders, it is imperative that we continue to monitor treatment outcomes over longer periods of time. Only through continued assessment can we begin to identify possible methods to maximize the cost-effectiveness of psychological treatments, particularly more efficient transdiagnostic treatments. For example, patients determined to be at risk of relapse may benefit greatly from a small number of booster sessions focused on sustainment of skills learned in treatment,

particularly if these sessions were delivered before full symptom reoccurrence. Spending more time on relapse prevention strategies may also serve to further enhance current CBT protocols.

Identifying predictors of long-term outcome will be particularly important, as research suggests that predictors of short-term outcome, such as positive response at posttreatment, are not necessarily predictive of long-term treatment outcomes [5]. It is also possible that a shift will be necessary in how both clinicians and patients conceptualize treatment for anxiety disorders, such that ongoing assessment and further treatment at some point in the future are expected. Indeed, there is preliminary evidence to suggest that maintenance CBT aimed at reinforcing acute treatment gains may help to reduce relapse over time [36]. Acute symptom reduction is an important outcome, but for the significant number of individuals who continue to struggle with symptoms of anxiety and depression, these gains are only as meaningful as they are sustainable.

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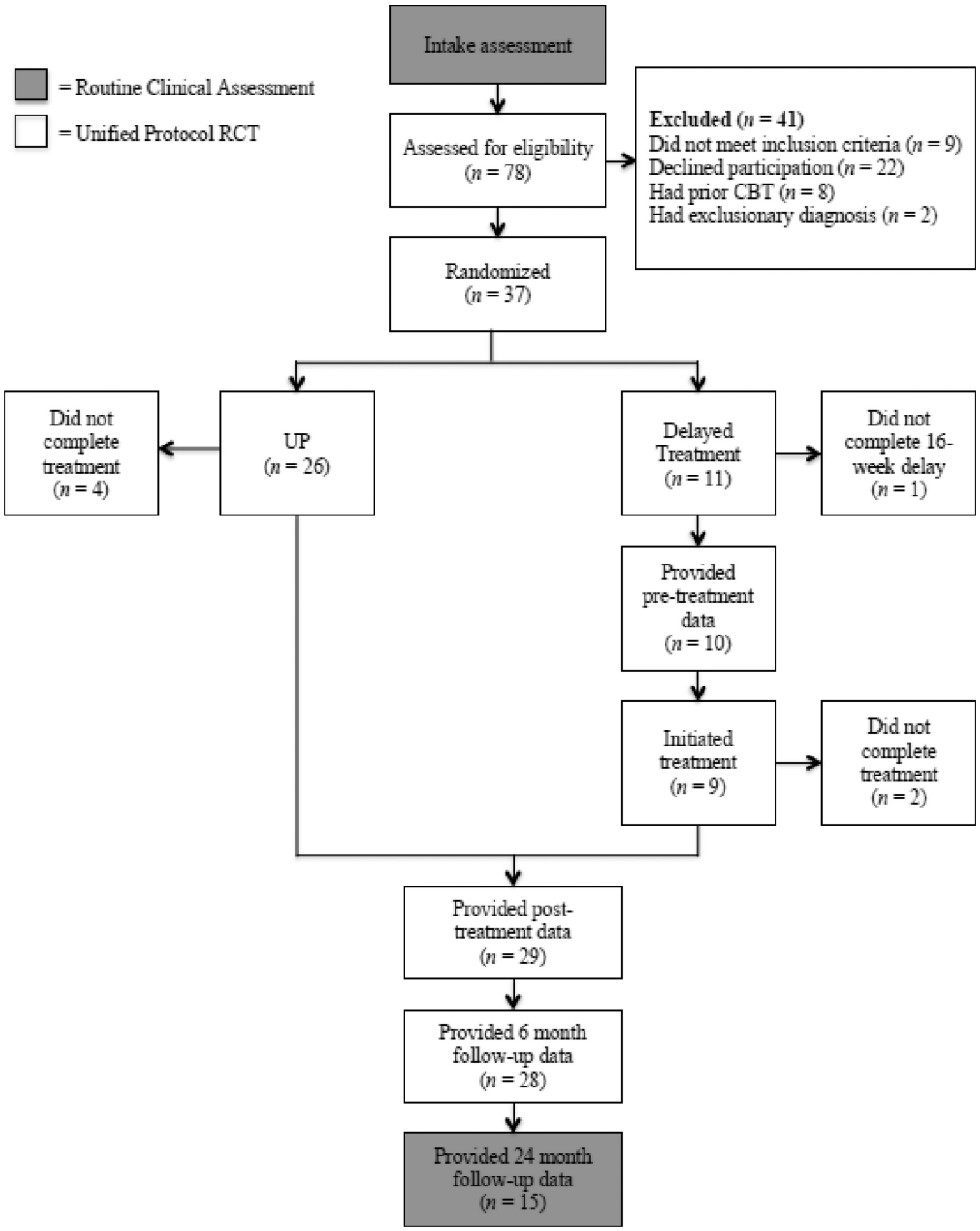

Figure 1.

Participant flow from initial intake to enrollment in the Unified Protocol RCT and participation in 24-month routine clinical follow-up assessment.

Note: RCT = randomized controlled trial; CBT = cognitive-behavioral therapy; UP = Unified Protocol.

Table 1

Descriptive Statistics and Effect Size Estimates for Outcome Variables at Long-Term Follow-up (N = 15)

	Pre	LTFU		
Measure	**Mean (*SD*)**	**Mean (*SD*)**	***F***	**Hedges's *g***
ADIS (Co-) Principal Dx CSR	5.27 (1.03)	2.23 (2.04)	22.67**	1.83
Number of Clinical Dx	2.47 (1.51)	0.87 (1.13)	22.78**	1.17
BDI-II	15.67 (8.64)	12.00 (10.86)	3.08	0.36
BAI	20.00 (7.58)	11.46 (10.21)	4.71	0.92
WSAS-SR	18.27 (7.03)	8.54 (7.61)	8.75*	1.29
WSAS-C	15.53 (4.79)	11.00 (7.67)	7.71*	0.69
PANAS-NA	25.47 (4.57)	23.38 (9.04)	0.63	0.28
PANAS-PA	27.87 (6.31)	30.69 (7.39)	3.40	−0.40

* $p<.05$,

** $p<.001$

Note Pre = pre-treatment; LTFU = long-term follow-up; ADIS = Anxiety Disorders Interview Schedule; Dx = diagnosis; CSR = clinical severity rating; BDI-II = Beck Depression Inventory; BAI = Beck Anxiety Inventory; WSAS-SR = Work and Social Adjustment Scale - Self-Report; WSAS-C = Work and Social Adjustment Scale - Clinician-Assessed; PANAS-NA = Positive and Negative Affect Schedule - Negative Affectivity; PANAS-PA = Positive and Negative Affect Schedule - Positive Affectivity. Positive effect sizes denote a decrease in scores, negative effect sizes denote an increase.

Table 2

Descriptive Statistics and Effect Sizes for Outcome Variables During Follow-Up (N = 15)

	Pre	Post	6MFU	LTFU	Pre-6MFU	Pre-LTFU	Post-6MFU	6MFU-LTFU
Measure	**Mean *(SD)***	**Mean *(SD)***	**Mean *(SD)***	**Mean *(SD)***	**ES*sg***	**ES*sg***	**ES*sg***	**ES*sg***
ADIS (Co-) Principal Dx CSR	5.27 (1.03)	2.90 (1.69)	2.30 (1.69)	2.23 (2.04)	2.12	1.88	0.36	0.04
Number of Clinical Dx	2.47 (1.51)	1.29 (1.27)	0.79 (1.22)	0.87 (1.13)	1.22	1.20	0.40	−0.07
BDI-II	15.67 (8.64)	6.50 (6.76)	6.93 (9.23)	12.00 (10.86)	0.98	0.37	−0.05	−0.50
BAI	20.00 (7.58)	8.36 (5.92)	9.79 (7.65)	11.46 (10.21)	1.34	0.95	−0.21	−0.19
WSAS-SR	18.27 (7.03)	6.50 (5.79)	8.93 (9.19)	8.54 (7.61)	1.14	1.33	−0.32	0.05
WSAS-C	15.53 (4.79)	8.50 (7.27)	7.07 (5.72)	11.00 (7.67)	1.60	0.71	0.22	−0.58
PANAS-NA	25.47 (4.57)	20.57 (5.23)	19.21 (7.61)	23.38 (9.04)	1.00	0.29	0.21	−0.50
PANAS-PA	27.87 (6.31)	30.29 (6.16)	30.71 (4.20)	30.69 (7.39)	−0.53	−0.41	−0.08	0.00

Note: Pre = pre-treatment; Post = posttreatment; 6MFU = 6-month follow-up; LTFU = long-term follow-up; ADIS = Anxiety Disorders Interview Schedule; Dx = diagnosis; CSR = clinical severity rating; BDI-II = Beck Depression Inventory; BAI = Beck Anxiety Inventory; WSAS-SR = Work and Social Adjustment Scale - Self-Report; WSAS-C = Work and Social Adjustment Scale - Clinician-Assessed; PANAS-NA = Positive and Negative Affect Schedule - Negative Affectivity; PANAS-PA = Positive and Negative Affect Schedule - Positive Affectivity. Positive effect sizes denote a decrease in scores, negative effect sizes denote an increase.