

Effective treatment for generalized anxiety disorder



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Introduction

In primary care, as in other fields of medical practice, it is essential that doctors are able to apply the findings of scientific research to the circumstances of individual patients as part of their clinical decision-making process. This is known as evidence based medicine. In this review I have taken an illness which often presents in primary care, namely Generalized Anxiety Disorder (GAD), and by researching possible treatments have developed the skills necessary to search various databases for relevant articles and the ability to assess the validity of the evidence found. In this review I focus specifically on Cognitive-Behavioural Therapy (CBT) as a potential treatment for GAD.

Generalized anxiety disorder is characterized by chronic, uncontrollable worry associated with a wide range of physical symptoms including fatigue, headaches, muscle aches, difficulty swallowing, trembling, twitching, sweating, nausea and shortness of breath. A diagnosis of GAD is made when a person worries excessively about a variety of every day problems for at least 6 months. The disorder is common in later life, with a prevalence of 11.2% in primary care where older adults most often seek treatment and overall is more prevalent than either severe cognitive impairment or depression in the over 65s. Despite this, anxiety disorders in the ageing population have received relatively little research attention. Anxiety in later life has been linked to increased risk of physical disability, memory difficulties, decreased quality of life and inappropriate use of medical services .

There are currently several treatment options available for GAD including drugs such as Benzodiazepines, Selective Serotonin Re-uptake Inhibitors (SSRIs), Azapirones, Barbituates and Pregablin. There are also alternative treatment options such as herbal remedies and psychotherapy such as Cognitive-Behavioural Therapy and Psychodynamic Psychotherapy.

Cognitive-behavioral therapy is a form of psychotherapy which targets problematic emotions and behaviours via a range of approaches and can be used alongside medication or as an alternative to it. When used to treat anxiety disorders the principle methods include education and awareness, motivational interviewing, relaxation training, cognitive restructuring, exposure, problem-solving skills training and behavioural sleep management. Unlike anxiolytics, CBT has no known side effects or risk of physical dependence. Anxiolytics are currently the most common treatment for late-life anxiety and surveys suggest that up to 20% of non-institutionalized elderly persons may be using benzodiazepines. However, the use of these medications as a long term treatment for anxiety disorders is associated with potential risks for elderly patients such as cognitive impairment, falls and hip fractures, drug interactions and toxicity. Also an over-reliance on medication may neglect potentially important psychosocial factors such as social support, coping skills and interpersonal relationships. In light of this it is important that the effectiveness of CBT is assessed as it could prove a useful alternative to long term medication particularly in the ageing population.

Method

I conducted initial research using textbooks and the internet and then used different databases to search for relevant papers and articles. Searches were primarily conducted using MedLine (Medical Literature Analysis and Retrieval System) as it contains information from a wide range of fields including Medicine, Nursing, Pharmacy, Biology and Biochemistry and contains over 18 million records from approximately 5, 000 publications. Web of Knowledge was also used as it encompasses not only MedLine but also other databases such as the Social Sciences Citation Index. I also conducted searches using Scopus and the Cochrane Library but often found that the Cochrane Library yielded few or no results so these searches have been omitted. By beginning with broad search terms it was possible to refine these to yield fewer, more relevant results.

An initial search of the terms “ cognitive-behavioral therapy” and “ generalized anxiety disorder” yielded the following results. The search was also limited to include articles which had both these terms in the title and in the abstract.

Various spellings and abbreviations such as CBT and GAD were used when searching for cognitive-behavioural therapy and generalized anxiety disorder in order to achieve a high number of results and to ensure articles weren't overlooked. After searching through the results, reading abstracts and dismissing articles which weren't relevant to this topic or freely available, 4 articles were chosen to be included in this review. I chose to specifically focus on RCTs as this is the strongest study design for testing cause and effect relationships. When critically appraising the papers included in this <https://assignbuster.com/effective-treatment-for-generalized-anxiety-disorder/>

review, a series of questions primarily derived from the CASP (Critical Appraisal Skills Programme), but also incorporating other sources, were used and articles were judged on how much information they provide and the quality of the evidence. Examples of these questions are as follows.

- Did the trial have a clear objective?
- Is an RCT an appropriate study design to answer this question?
- How were the participants randomized?
- What was the average age of the participants?
- What were the exclusion criteria for participants?
- Were the subjects in each of the groups similar on demographic and baseline clinical variants?
- How did the trial adjust for attrition?
- When/how often was data collected from participants during follow up?
- How were outcomes measured?
- Were details of effect sizes and statistical significance given?
- Did the study have enough participants?
- Does the paper present a clear result?

Results

Discussion

The first study looked at was an RCT published in 1996 entitled “ Treatments of Generalized Anxiety in Older Adults: A Preliminary Comparison of Cognitive-Behavioural and Supportive Approaches”. This trial compared CBT with non directive Supportive Psychotherapy (SP), a form of therapy which involves education, guidance, listening to the patient and encouraging expression of emotions. Results showed significant improvement in all <https://assignbuster.com/effective-treatment-for-generalized-anxiety-disorder/>

measured outcomes for both interventions and generally large effect sizes. However, no significant differences were found between the two groups. The authors gave an extensive list of exclusion criteria, including current involvement in psychotherapy and low MMSE scores, which limits confounding factors and therefore the likelihood of type 1 errors. A major limitation of this study however is the high level of attrition. This study design could possibly be improved if it were to include another control group, which receives no treatment, with which to compare the two interventions with. In this respect the more recent trial "Treatment of generalized anxiety disorder in older adults", which is discussed later, improves on this trial and has a significantly lower attrition rate. However, the authors of this trial argue that by failing to include a waiting-list control group they alleviated the need to withhold treatment from any patients, which could be deemed ethically questionable. This trial had a follow-up assessment period of 6 months which is relatively short compared to the other studies in this review, one of which has a follow-up period of 15 months. It is arguable that this will limit conclusions made in this study regarding the long-term durability of treatment. Unlike other studies this study did not measure the effect of either intervention on the participant's quality of life which is an important factor to consider as GAD has such a profound effect on the sufferers' quality of life.

An RCT published February 2003 entitled "Treatment of generalized anxiety disorder in older adults", compared CBT with a discussion group (DG) and patients receiving no treatment on a waiting list period (WL). The discussion group was organized around worry provoking topics and was designed to be

structurally comparable to CBT. DG consisted of a series of 12 discussions focused on topics known to be worry-provoking for older adults, including memory problems, health concerns, loss of independence and death of friends and family. Both the CBT and DG groups consisted of 4-6 participants and a group leader, one of four advanced doctoral students in clinical psychology. These leaders were spread across the two interventions and each leader chaired at least one CBT group and one DG in order to avoid confounding the effectiveness of the therapist with the effectiveness of the therapeutic model. Participants in both CBT and DG were asked to spend approximately 30 minutes a day on homework exercises. The study gave full details of exclusion criteria including commencement of psychotropic medication within the past 2 months. Patients who had started medication more than 2 months ago were included but were asked not to change their dose or type of medication for the duration of the trial. However, in light of this it is possible to argue that including participants on any form of anxiolytic medication restricts “ conclusions about the impact of CBT without concomitant pharmacological treatment.” The authors included a table detailing demographic information about their study sample in order to support the generalisability of their findings. The table showed that participants came from a range of races, had differing marital and work statuses and suffered from a range of different medical conditions, the most common being osteoarthritis (36%) and hypertension (32%). Compared to the first study, participants not only scored themselves but were also assessed by trained research assistants who were unaware of which group the patient had been assigned to. This adds an element of blinding which is not present in the first study. This was the only study in which patients rated

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their impression of the treatment after the first session. The participants rated the credibility of the intervention, their enjoyment, perceived effectiveness, likelihood of recommending the intervention to a friend, likelihood of participating again in the future and perceived improvement. This is a useful addition to the trial as a patient's satisfaction with a treatment method has a big impact on adherence and possibly symptom improvement. The results showed that participants in both CBT and DG improved compared to the waiting period but there was no significant difference between the two interventions. However, when effect sizes were calculated showed large effects whereas DG showed medium sized effects. Essentially this study shows that CBT is better than no treatment but gives no significant evidence to suggest that it is better than other forms of intervention such as group discussion. This is an interesting point which mirrors the findings of the first trial which compared CBT to SP.

An RCT published in April 2003 entitled "Cognitive- Behavioral Treatment of late-life generalized anxiety disorder" (M A Stanley et al. 2002) evaluated the efficacy of CBT compared to minimal contact control (MCC). The results showed a significant improvement in worry, anxiety, depression and quality of life following CBT compared to MCC. 45% of patients were classed as responding to treatment compared with 8% who received MCC. Importantly these gains were maintained or enhanced over a 1 year follow-up. However, as in the other RCTs in this review, patients did not report a complete return to normal functioning or a complete removal of symptoms. When recruiting participants for this trial the Anxiety Disorders Interview Schedule-IV was used as a diagnostic tool. Patient's underwent two separate diagnostic

interviews conducted by two different evaluators over a period of at least two weeks. These evaluators were unaware of any previous diagnoses made. This shows that all participants in the study had symptoms which were consistent and were not prone to varying over time, which means that any change during follow up assessment was more likely to be due to the intervention than to fluctuations in the severity of their GAD. The study commented on potential variance in results due to gender and explained how they had adjusted for this. Similarly to the last study, this study used not only self-reported scores but also independent clinician rated scores. Unlike previous studies this trial did not include any participants currently receiving medication for their GAD or associated symptoms in order to assess the effectiveness of CBT alone and not in conjunction with medication.

A Randomised Control Trial, conducted by M A Stanley et al. entitled "Cognitive Behaviour Therapy for Generalized Anxiety Disorder Among Older Adults in Primary Care" (2009) compared group CBT conducted in primary care clinics over 3 months with a control of enhanced usual care (EUC). The authors chose to use group CBT rather than individual, one-on-one CBT as they believed that the loss of social support often experienced as a consequence of ageing indicated the potential benefits of group treatment. The results of this trial showed that CBT significantly improved worry severity, depressive symptoms and general mental health but there was no difference in GAD severity between the two groups. The authors clearly set out their objective and gave detailed information on where the study was set, where participants were chosen from, details of the intervention and

main outcome measures at the start of the paper. The fact that the patients were recruited exclusively from a primary care setting and that the intervention was delivered in primary care makes this evidence particularly useful for this review. During recruitment all potential participants were screened using two questions from the Primary Care Evaluation of Mental Disorders, as well as undergoing the Mini-Mental State Examination and a Structured Diagnostic Interview, in order to ensure that all had the same diagnosis and similar GAD severity. Race and ethnicity of participants were identified and the data used to facilitate conclusions about the generalizability of the data. The authors commented on effect sizes and stated that the effect sizes for symptom improvement were comparable to or greater than those in recent primary care studies of younger adults with GAD and older adults with depression. The authors also commented that participants in this trial scored slightly lower mean change in worry severity over time scores in comparison with "Treatment for Generalized Anxiety Disorder in older adults" that was conducted several years earlier. One possible limitation of both this study and the previous study is that patients in the control group received minimal contact with health professionals compared to the intervention group. This may leave patients feeling neglected and as they are aware that they're not receiving any form of treatment, they may not expect to get better and subsequently score themselves lower on assessment than otherwise. In this respect the first two studies are somewhat better designed, as they compare CBT to interventions which involve a similar contact. The second study in particular deals with this issue well by comparing CBT with a discussion group, which requires the

patient to be involved with the intervention, and a waiting list period in which the patient is very much aware that they are receiving no treatment.

Several studies of anxiety in older adults have been conducted using community or senior centre volunteers with self-diagnosed, subjective anxiety symptoms and therefore the findings from these studies may not be applicable to a clinical population. In contrast the four RCTs included in this review were all conducted on patients with diagnosed GAD and CBT and was delivered in a primary care setting. All the studies gave detailed information on how the participants were randomized and how drop-outs were dealt with and had a follow-up period of at least 6 months.

Conclusion

In conclusion, all four studies showed that CBT improves levels of anxiety, as well as other associated symptoms of GAD, when compared to both baseline measures and no treatment. However these studies also showed that when CBT is compared to other forms of therapy, namely Supportive Psychotherapy and discussion groups, there are no significant differences between the two interventions. Although CBT does lead to significant alleviation of symptoms, this evidence does not indicate that CBT is a long lasting cure for GAD and it does not prove CBT to be a better treatment option than other forms of psychotherapy. Therefore it is important to question whether or not the benefits felt by participants receiving CBT, SP or DG are due to a “ placebo” effect compared to participants who are left on a waiting list who may feel they are being neglected and do not expect any improvement in symptoms. This raises the issue of blinding which is a limitation of most conceivable trials including CBT as it is not possible to

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make the participant unaware of what intervention they are receiving when they have to actively participate in treatment.

The dearth of clinical trials, particularly RCT trials, investigating CBT as a treatment for GAD needs to be addressed if an acceptable amount of evidence in favour of CBT is to be established. Suggestions for future trials include RCTs comparing the effectiveness of group CBT compared with individual CBT for older adults and trials comparing CBT with anxiolytic medications such as benzodiazepines. This is a particularly pertinent issue considering the side effects associated with anxiolytics and old age, as previously mentioned. Future trials should aim to recruit a larger number of participants than seen in most of the studies discussed. In theory this should not be difficult if the prevalence of GAD in the elderly population is as alarmingly high as some statistics indicate.