NKK 58 PICO 5a acceptance-commitment terapi ved generaliseret angst

Review information

Authors

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Citation example: S. NKK 58 PICO 5a acceptance-commitment terapi ved generaliseret angst. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Stefan 2019

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Intervention ● *Age in years, mean (SD)*: 25.86 (6.7) ● *Number of females, %*: 22/24 (91.6%) Control ● *Age in years, mean (SD)*: 28.08 (8.17) ● *Number of females, %*: 17/23 (74%) **Included criteria:** Inclusion criterion was primary diagnosis of generalized anxiety disorder (GAD). **Excluded criteria:** Exclusion criteria were:severe major depression, bipolar disorder, panic disorder, substance use/abuse/dependence, psychotic disorders,suicidal or homicidal ideation, organic brain syndrome, disabling medical conditions, mental retardation, recent concurrent treatment with psychotropic drug (less than 3 months), and/or psychotherapy outside study. Patients with comorbid anxiety disorder diagnoses (e.g., social phobia, specific phobia) were recruited in the trial provided their primary diagnosis was GAD, but we excluded patients with panic disorder because the focus of treatment for this condition is substantially different. **Pretreatment:** No significant differences between the groups.
Interventions	**Intervention Characteristics** Intervention ● *Description*: Acceptance and commitment therapy (ACT/ABBT). The ACT/ABBT protocol was derived from the principles and techniques proposed by Eifert and Forsyth (2005) and Roemer and Orsillo (2005). From this perspective, GAD is maintained by dysfunctional reactions to internal experiences (i.e., emotions, thoughts, bodily sensations), experiential avoidance, and behavioral restriction, so the treatment aims to address all of these problems. The structure of the ACT/ABBT session parallels the one of theCT/BTP and REBT protocols. From the ACT/ABBT point of view, it is not the worry or the negative emotions that are problematic, but the rigid unwillingness to have these internal experiences (Hayes et al., 2010).

<table>
<tr><td></td><td>Therefore, the treatment protocol aims to help the patients accept their thoughts and feelings, while acting according to their values, and not to change the content of thoughts, like in the CT/BTP and REBT approaches. In this sense, ACT/ABBT includes three major treatment goals: (a) education about the nature of anxiety, worry, and the role of experiential avoidance; (b) practicing mindfulness and acceptance skills when dealing with disturbing internal experiences; and (c) identifying values and following valued action paths when facing obstacles. The techniques include mindfulness exercises, cognitive diffusion techniques, acceptance and value identification exercises, and behavioral prescriptions for committing to valued action.

Dose: 20 individual 50-min sessions for all groups. The first 8 sessions were delivered twice a week, whereas sessions 9–20 were conducted on a weekly basis.
Duration: 16 weeks.

Control

Description: Cognitive Therapy (CT/BTP) The CT/BTP protocol was derived from Borkovec and Costello's (1993) therapeutic approach, relying on principles of CT for anxiety (Beck & Emery, 1985) and including applied relaxation. CT/BTP sessions were highly structured, containing the following elements (see also Beck, 1995): (a) mood check and bridging from previous sessions; (b) setting an agenda; (c) reviewing homework; (d) discussing the issues on the agenda and setting new homework; and (e) summarizing and feedback. The CT/BTP protocol included several directions as primary goals in therapy: providing a cognitive conceptualization of the problem, identifying and restructuring automatic thoughts, intermediate and core beliefs through cognitive (e.g., changing automatic thoughts using a collaborative empiricisms approach, teaching the patient to search for evidence and form alternative ways of thinking), and behavioral techniques (i.e., behavioral experiments), enhancing adaptive behavior (i.e., activity scheduling, dealing with avoidance behavior, social skills training), and using applied relaxation as a coping strategy.
Dose: 20 individual 50-min sessions for all groups. The first 8 sessions were delivered twice a week, whereas sessions 9–20 were conducted on a weekly basis.
Duration: 16 weeks.
</td></tr>
<tr><td>Outcomes</td><td>Grad af angst, Generalized Anxiety Disorder Questionnaire IV (GAD-Q-IV) , mean SD

Outcome type: Continuous Outcome
Reporting: Fully reported
Scale: Generalized Anxiety Disorder Questionnaire IV
Range: 0-12
Direction: Lower is better
Data value: Endpoint

Funktion, Penn State Worry Questionnaire (PSWQ)

Outcome type: Continuous Outcome
Reporting: Fully reported
Scale: Penn State Worry Questionnaire (PSWQ)
Range: 0-80
Direction: Lower is better
Data value: Endpoint

Bedring, GAD -Q-IV minimum 9 points lower

Outcome type: Dichotomous Outcome
Reporting: Fully reported
Scale: GAD-Q-IV
</td></tr>
</table>

	● **Direction**: Higher is better ● **Data value**: Endpoint *Frafald, alle årsager* ● **Outcome type**: Dichotomous Outcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** Funding information: Albert Ellis Institute; International Institutef or the Advanced Studies of Psychotherapy and Applied Mental Health **Country:** Romania **Setting:** Outpatient clinic **Authors name:** Simona Stefan **Institution:** Department of Clinical Psychology andPsychotherapy, Babeş-Bolyai University,Cluj-Napoca, Romania **Email:** Email: daniel.david@ubbcluj.ro **Address:** Daniel David, Department of Clinical Psychology and Psychotherapy/InternationalInstitute for the Advanced Study of Psychotherapy and Applied Mental Health, Babeş-Bolyai University, No 37 Republicii Street, 400015 Cluj-Napoca, Romania
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "Eligible participants were randomly allocated by use of a random number generator to CT/BTP, REBT, and ACT/ ABBT."
Allocation concealment (selection bias)	Unclear risk	Judgement Comment: No information of allocation concealment
Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: No information of blinding of participant and personnel, blinding not feasible.
Blinding of outcome assessment (detection bias)	High risk	Judgement Comment: No information of blinding of outcome assessors, outcome measures were self-reported and patients were not blinded.
Incomplete outcome data (attrition bias)	Low risk	Quote: "Analyses were conducting using an intention-to-treat (ITT) approach, using a last observation carried forward principle" Judgement Comment: Low numbers of dropouts Only 2 in the ACT group and 1 in the CT group.
Selective reporting (reporting bias)	High risk	Judgement Comment: Protocol available at clinicaltrials.goc. Definition of treatment respons not specified in the protocol.
Other bias	Low risk	Judgement Comment: The study appears to be free from other sources of bias

Wetherell 2011

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** ● No information, but stated that the groups were equivalent on all variables at the point of randomization. Overall ● *Mean age, years (SD)*: 70.8 (6.5) **Included criteria:** Participants were 21 adults at least 60 years of age with a principal (i.e., most severe) diagnosis of GAD according to the Diagnostic and Statistical Manual of Mental Disorders criteria as assessed with the Anxiety Disorders Interview Schedule. **Excluded criteria:** The 15 patients interviewed but not enrolled were excluded because they did not meet criteria for GAD (n=12), met criteria for substance abuse in the past 6 months(n=2), or had serious medical conditionst hat could compromise study participation (n=1).
Interventions	**Intervention Characteristics** Intervention ● *Description*: Acceptance and Commitment Therapy ACT). The ACT protocol focused on the limitations of control-oriented strategies and introduced the concepts of willingness and nonjudgmental observation of worry and other aversive internal experiences. Patients also completed exercises to help them identify core values and developed goals and actionsteps in the service of those values. Each session included a mindfulness exercise, and other metaphors and experiential exercises (e.g., finger trap,"tug of war with a monster,""passengers on the bus") were drawn from existing ACT protocols (Hayes, Strosahl, & Wilson, 1999). Patients completed daily written homework assignments (e.g.,listing previously tried strategies to control worry), which were reviewed with the therapist every session. ● *Dose*: 12 weekly hour-long individual sessions of ACT. ● *Duration*: 12 weeks. Control ● *Description*: Cognitive Behavoiral Therapy (CBT)The CBT protocol was based on components developed and tested with older GAD patients and was therefore slightly different from protocols used with younger people (Wetherell et al., 2009). It included psychoeducation, symptom monitoring,relaxation and attention training, thought-stopping and scheduled worry (elements reported particularly helpful by participants in our team's previous research), development and implementation of coping thoughts, problem-solving skills training, imaginal andin vivo rehearsal of coping strategies, and relapse prevention. As with ACT, patients completed daily homework assignments (e.g., relaxation exercises, thought records). Manuals for both conditions are available from the first author upon request. ● *Dose*: 12 weekly hour-long individual sessions of CBT. ● *Duration*: 12 weeks.
Outcomes	*Grad af angst,* Hamilton Anxiety Rating Scale (*HAM-A)* ● **Outcome type**: Continuous Outcome ● **Reporting**: Fully reported ● **Scale**: *HAM-A* ● **Range**: 0-56 ● **Direction**: Lower is better ● **Data value**: Endpoint

	Funktion, Penn State Worry Questionnaire (PSWQ) ● **Outcome type**: Continuous Outcome ● **Reporting**: Fully reported ● **Scale**: Penn State Worry Questionnaire (PSWQ) ● **Range**: 0-80 ● **Direction**: Lower is better ● **Data value**: Endpoint *Livskvalitet,* Self-Report Health Survey (SF-36) ● **Outcome type**: Continuous Outcome ● **Reporting**: Fully reported ● **Scale**: Self-Report Health Survey (SF-36) ● **Range**: 0-100 ● **Direction**: higher is better ● **Data value**: Endpoint *Bedring, antal personer med mindst 50% reduktion på HAM-A* ● **Outcome type**: Dichotomous Outcome ● **Reporting**: Fully reported ● **Scale**: HAM-A ● **Direction**: Higher is better ● **Data value**: Endpoint *Frafald, alle årsager* ● **Outcome type**: Dichotomous Outcome ● **Reporting**: Fully reported ● **Direction**: Lower is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** Research supported by NIMH K23 MH067643. **Country:** USA **Setting:** Outpatient clinic **Authors name:** Julie Loebach Wetherell **Institution:** UCSD Department of Psychiatry, **Email:** jwetherell@ucsd.edu **Address:** Julie Wetherell, Ph.D., UCSD Department of Psychiatry, 9500 Gilman Drive, Dept. 9111N-1, La Jolla, CA92093-9111;
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Judgement Comment: No information of how the allocation sequence was generated.
Allocation concealment (selection bias)	Unclear risk	Judgement Comment: No information of allocation concealment.
Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: No blinding of participants and personnel. Blinding of particiapants and personel not feasible.
Blinding of outcome assessment (detection bias)	Low risk	Quote: "Assessments were conducted by two research assistants blind to treatment condition." Judgement Comment: Blinding of outcome assessors. Presume that HAM-A and PSWQ were clinician rated. SF 36 were self-reported.
Incomplete outcome data (attrition bias)	High risk	Quote: "Five participants withdrew from the study during the waiting period (due to time constraints, improvement in anxiety symptoms, or loss of contact). We present data from the 16 participants who attended at least one session of psychotherapy (n = 7 ACT, n = 9 CBT)." Judgement Comment: 21 participants were randomly assigned to receive either 12 weekly hour-long individual sessions of ACT (n = 11) or CBT (n = 10).endpoint data available on 7/11 in the ACT group and 7/10. in the CBT group. 5 withdrew before treatment start, 4 from the ACT group and 1 from the CBT group. 2 were lost to follow-up both from CBT group.
Selective reporting (reporting bias)	Low risk	Judgement Comment: No protocol available. the trial reports on all the outcomes stated in the methods section.
Other bias	Low risk	Judgement Comment: The study appears to be free of other sources of bias.

Footnotes

Characteristics of excluded studies

Afshar 2018

Reason for exclusion	På arabisk

Arch 2017

Reason for exclusion	Wrong patient population

Dahlin 2016

Reason for exclusion	Wrong study design

Dalrymple 2007

Reason for exclusion	Wrong patient population

Hayes 1999

Reason for exclusion	Wrong study design

Hayes 2010

Reason for exclusion	Wrong intervention

Hayes Skelton 2013

Reason for exclusion	Wrong intervention

Niles 2017

Reason for exclusion	Wrong patient population

Roemer 2002

Reason for exclusion	Wrong study design

Roemer 2005

Reason for exclusion	Wrong study design

Roemer 2007

Reason for exclusion	Wrong intervention

Roemer 2008

Reason for exclusion	Wrong intervention

Treanor 2011

Reason for exclusion	Wrong intervention

Zargar 2012

Reason for exclusion	Wrong intervention

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

References to studies

Included studies

Stefan 2019

Stefan, Simona; Cristea, Ioana A.; Szentagotai Tatar, Aurora; David, Daniel. Cognitive-behavioral therapy (CBT) for generalized anxiety disorder: Contrasting various CBT approaches in a randomized clinical trial.. Journal of clinical psychology 2019;75(7):1188-1202. [DOI:]

Wetherell 2011

Wetherell, J. L.; Afari, N.; Ayers, C. R.; Stoddard, J. A.; Ruberg, J.; Sorrell, J. T.; Liu, L.; Petkus, A. J.; Thorp, S. R.; Kraft, A.; Patterson, T. L.. Acceptance and Commitment Therapy for generalized anxiety disorder in older adults: a preliminary report. Behavior therapy 2011;42(1):127-134. [DOI: 10.1016/j.beth.2010.07.002 [doi]]

Excluded studies

Afshar 2018

Afshar, Hossein keshavarz; Rafei, Zahra; Mirzae, Abbas. The effectiveness of Acceptance and Commitment Therapy (ACT) on general anxiety. Payesh Health Monitor 2018;17(3):11-18. [DOI:]

Arch 2017

Arch, Joanna J.; Eifert, Georg H.; Davies, Carolyn; Vilardaga, Jennifer C. Plumb; Rose, Raphael D.; Craske, Michelle G.. Chapter: Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders.. Mindfulness: Clinical applications of mindfulness and acceptance: Specific interventions for psychiatric, behavioural, and physical health conditions., Vol. III 2017;(Journal Article):49-82. [DOI:]

Dahlin 2016

Dahlin, M.; Ryberg, M.; Vernmark, K.; Annas, N.; Carlbring, P.; Andersson, G.. Internet-delivered acceptance-based behavior therapy for generalized anxiety disorder: A pilot study. Internet interventions 2016;6(Journal Article):16-21. [DOI: 10.1016/j.invent.2016.08.004 [doi]]

Dalrymple 2007

Dalrymple, K. L.; Herbert, J. D.. Acceptance and commitment therapy for generalized social anxiety disorder: a pilot study. Behavior modification 2007;31(5):543-568. [DOI: 31/5/543 [pii]]

Hayes 1999

Hayes, Steven C.; Strosahl, Kirk D.; Wilson, Kelly G.. Acceptance and commitment therapy : an experiential approach to behavior change. 1999;(Book, Whole). [DOI:]

Hayes 2010

Hayes, S. A.; Orsillo, S. M.; Roemer, L.. Changes in proposed mechanisms of action during an acceptance-based behavior therapy for generalized anxiety disorder. Behaviour research and therapy 2010;48(3):238-245. [DOI: 10.1016/j.brat.2009.11.006 [doi]]

Hayes Skelton 2013

Hayes-Skelton, S. A.; Roemer, L.; Orsillo, S. M.. A randomized clinical trial comparing an acceptance-based behavior therapy to applied relaxation for generalized anxiety disorder. Journal of consulting and clinical psychology 2013;81(5):761-773. [DOI: 10.1037/a0032871 [doi]]

Niles 2017

Niles, Andrea N.; Wolitzky-Taylor, Kate B.; Arch, Joanna J.; Craske, Michelle G.. Applying a novel statistical method to advance the personalized treatment of anxiety disorders: A composite moderator of comparative drop-out from CBT and ACT.. Behaviour Research & Therapy 2017;91(Journal Article):13-23. [DOI:]

Roemer 2002

Roemer, Lizabeth; Orsillo, Susan M.. Expanding Our Conceptualization of and Treatment for Generalized Anxiety Disorder: Integrating Mindfulness/Acceptance-Based Approaches With Existing Cognitive-Behavioral Models. Clinical Psychology: Science and Practice 2002;9(1):54-68. [DOI: 10.1093/clipsy.9.1.54]

Roemer 2005

Roemer, Lizabeth; Salters, Kristalyn; Raffa, Susan D.; Orsillo, Susan M.. Fear and Avoidance of Internal Experiences in GAD: Preliminary Tests of a Conceptual Model. Cognitive Therapy and Research 2005;29(1):71-88. [DOI: 10.1007/s10608-005-1650-2]

Roemer 2007

Roemer, L.; Orsillo, S. M.. An open trial of an acceptance-based behavior therapy for generalized anxiety disorder. Behavior therapy 2007;38(1):72-85. [DOI: S0005-7894(06)00070-0 [pii]]

Roemer 2008

Roemer, L.; Orsillo, S. M.; Salters-Pedneault, K.. Efficacy of an acceptance-based behavior therapy for generalized anxiety disorder: evaluation in a randomized controlled trial. Journal of consulting and clinical psychology 2008;76(6):1083-1089. [DOI: 10.1037/a0012720 [doi]]

Treanor 2011

Treanor, M.; Erisman, S. M.; Salters-Pedneault, K.; Roemer, L.; Orsillo, S. M.. Acceptance-based behavioral therapy for GAD: effects on outcomes from three theoretical models. Depression and anxiety 2011;28(2):127-136. [DOI: 10.1002/da.20766 [doi]]

Zargar 2012

Zargar, F.; Asgharnejad Farid, A. A.; Atef-Vahid, M. K.; Afshar, H.; Maroofi, M.; Omranifard, V.. Effect of acceptance-based behavior therapy on severity of symptoms, worry and quality of life in women with generalized anxiety disorder. Iranian journal of psychiatry and behavioral sciences 2012;6(2):23-32. [DOI:]

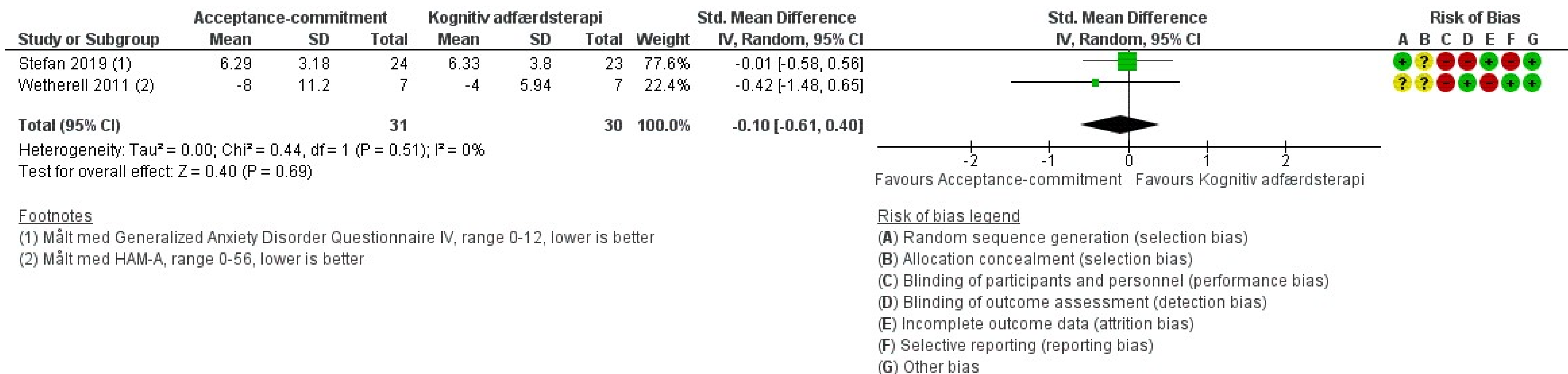
Data and analyses

1 Acceptance-commitment terapi vs kognitiv adfærdsterapi

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Grad af angst (severity of anxiety)	2	61	Std. Mean Difference (IV, Random, 95% CI)	-0.10 [-0.61, 0.40]
1.2 Funktion (function)	2	63	Mean Difference (IV, Random, 95% CI)	1.55 [-4.47, 7.56]
1.3 Livskvalitet (qualilty of life)	1	16	Mean Difference (IV, Fixed, 95% CI)	7.00 [-7.54, 21.54]
1.4 Bedring (response)	2	61	Risk Ratio (M-H, Random, 95% CI)	1.18 [0.85, 1.64]
1.5 Frafald, alle årsager (dropouts all causes)	2	68	Risk Ratio (M-H, Random, 95% CI)	0.88 [0.51, 1.53]

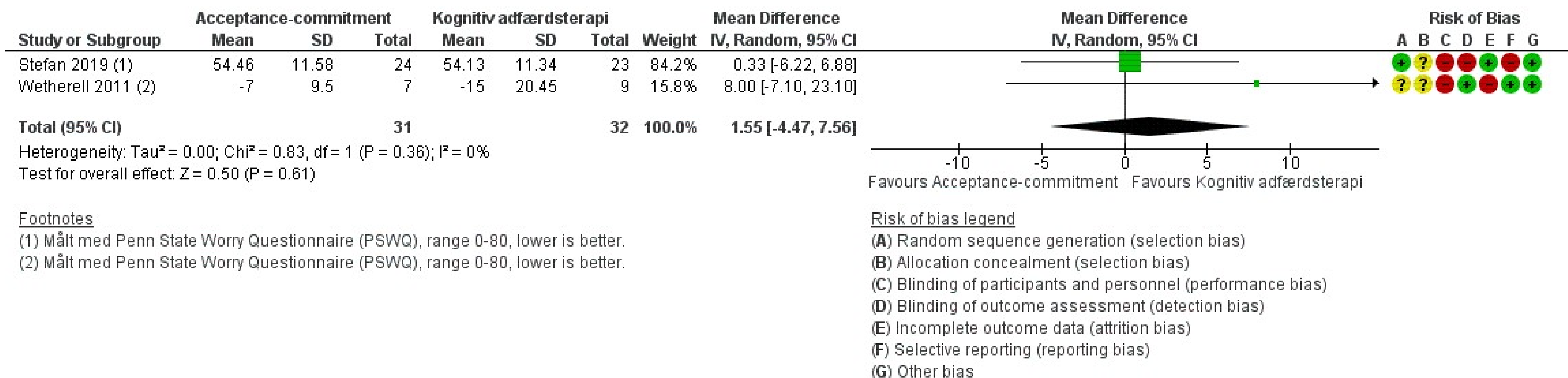
Figures

Figure 1 (Analysis 1.1)



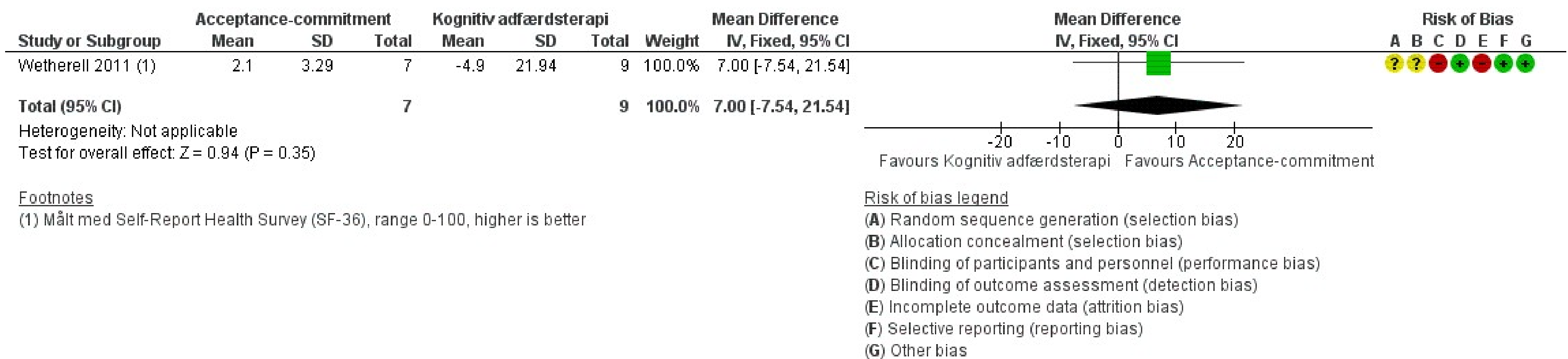
Forest plot of comparison: 1 Acceptance-commitment terapi vs kognitiv adfærdsterapi vs Control, outcome: 1.1 Grad af angst (severity of anxiety).

Figure 2 (Analysis 1.2)



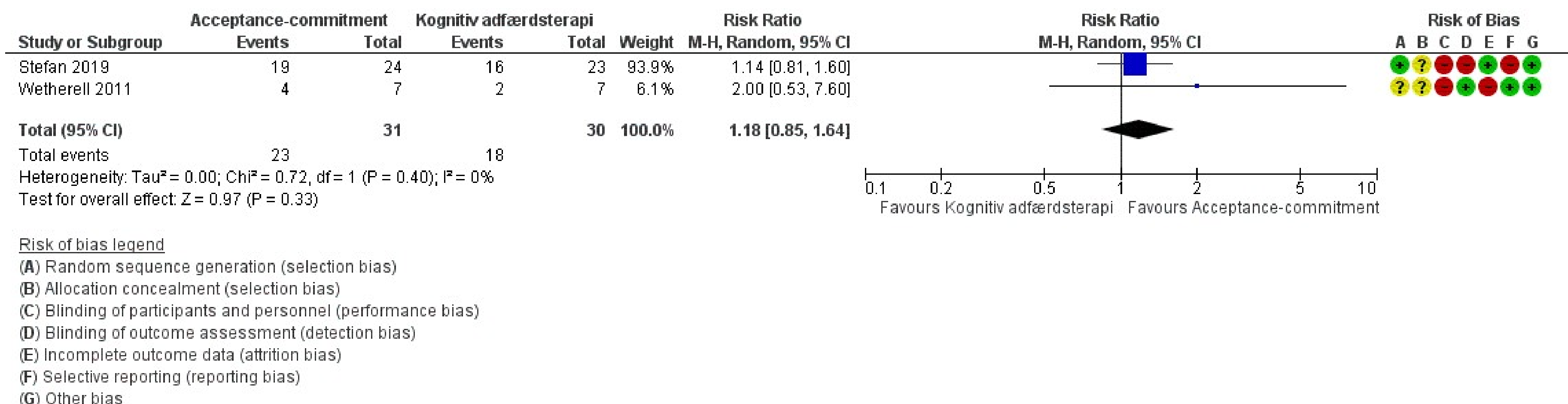
Forest plot of comparison: 1 Acceptance-commitment terapi vs kognitiv adfærdsterapi vs Control, outcome: 1.2 Funktion (function).

Figure 3 (Analysis 1.3)



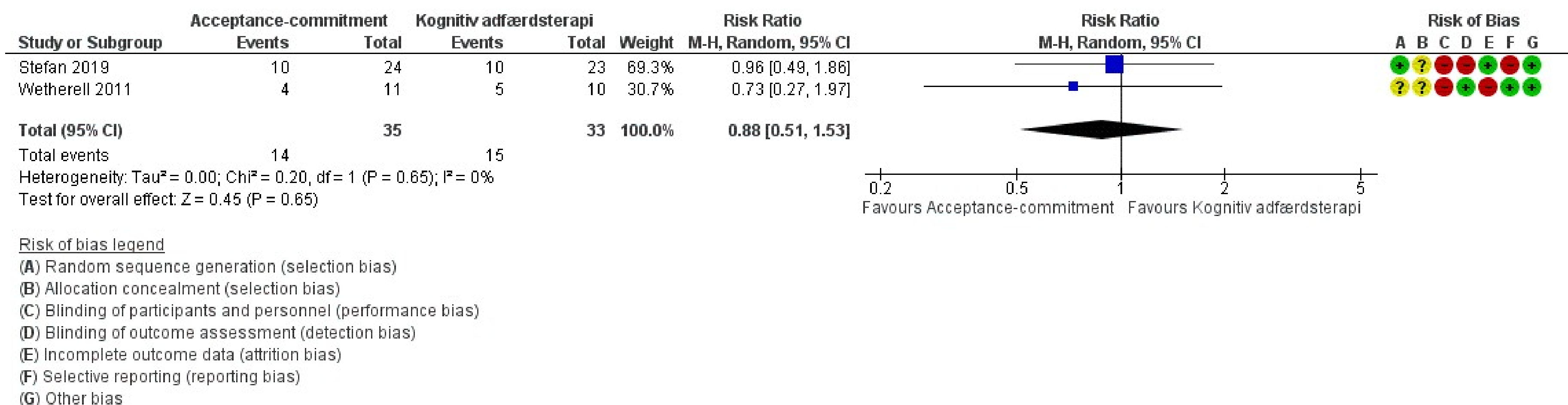
Forest plot of comparison: 1 Acceptance-commitment terapi vs kognitiv adfærdsterapi vs Control, outcome: 1.3 Livskvalitet (qualilty of life).

Figure 4 (Analysis 1.4)



Forest plot of comparison: 1 Acceptance-commitment terapi vs kognitiv adfærdsterapi vs Control, outcome: 1.4 Bedring (response).

Figure 5 (Analysis 1.5)



Forest plot of comparison: 1 Acceptance-commitment terapi vs kognitiv adfærdsterapi vs Control, outcome: 1.5 Frafald, alle årsager (dropouts all causes).