NKR 58 PICO 5b metakognitiv terapi for generaliseret angst

Review information

Authors

Sundhedsstyrelsen[1]

[1][Empty affiliation]

Citation example: S. NKR 58 PICO 5b metakognitiv terapi for generaliseret angst. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Nordahl 2018

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Intervention ● *mean age in years (SD)*: 36.96 (14.02) ● *Number of females %*: 19/28 (68%) Control ● *mean age in years (SD)*: 38.61 (10.9) ● *Number of females %*: 24/34 (75%) **Included criteria:** The eligibility and inclusion criteria were a diagnosis of GAD,giving written consent before entry in the study and aged 18 years or older. Patients not willing to withdraw psychotropic medication for a period of 3 weeks before entry to the trial were not included but received treatment outside of the trial. **Excluded criteria:** known somatic diseases, psychosis, recent suicidal attempts and/or current intent, primary post-traumatic stress disorder, cluster A or cluster B personality disorder, substance dependence or unwilling-ness to accept random allocation.
Interventions	**Intervention Characteristics** Intervention ● *Description*: Metacognitive therapy (MCT). In MCT, the patients' metacognitive beliefs were targeted. Metacognitive beliefs refer to beliefs about thinking, such as the belief that worry is uncontrollable or overthinking is harmful.The metacognitive beliefs were challenged by verbal means and by behavioural experiments with a main emphasis on negative beliefs about worry, specifically its uncontrollability and dangerousness. In MCT the goal is elimination of negative metacognitive beliefs and the introduction of an alternative set of strategies so that the patient is better able to regulate worry and step backfrom triggering thoughts. MCT for GAD consists of five modules:case formulation and socialisation (sessions one and two), modifying beliefs about uncontrollability and danger of worry (sessions three to six), challenging positive beliefs about the utility and advantages of worry (sessions seven and eight), implementation of alternative coping strategies (sessions nine and ten) and relapse prevention

	(sessions 11–12). The rationale given to patients is that worrying can be controlled by disengaging from trigger thoughtsand postponing further conceptual processing; mental events do not matter, only responses to them do; worrying is harmless and there are no advantages to worrying. ● *Dose* : Treatments were applied for a maximum of 12 weekly sessions of 60 min duration. ● *Duration*: 12 weeks Control ● *Description*: Cognitive behavoiral therapy (CBT). CBT treatment consisted of four modules:detecting early cues of anxiety and worry, applied relaxation asa response to these cues, imaginal rehearsal of coping methodswith self-control desensitisation and CBT on catastrophic beliefs and worry. Patients receiving CBT were informed in the rationale of the treatment that imaginal rehearsal of coping methods would facilitate fear and worry reduction and development of new coping responses, cognitive therapy would reduce anxiety-maintaining thoughts and beliefs and use of cognitive therapy during imaginal rehearsal would provide cognitive coping along with relaxation skills. We used detection of anxiety cues and applied relaxation in the first three sessions. Self-control desensitisation began in session four, cognitive therapy began in session five and both were conducted in every session thereafter. During desensitisation, after the client was deeply relaxed, external and internal worry cues were presented until the client signalled the presence of anxiety.The client then continued imagining the external situation while imaging that he or she was using relaxation skills in that situation. At the elimination of anxious feelings, he or she imagined continued use of these skills for 20 seconds and then turned off all imagery and focused only on relaxation for 20 seconds. The scenes were repeated until the client could no longer generate anxiety or was able to eliminate it rapidly (5–10 seconds). Cognitive therapy was used up to 15 min per session. The primary goal was to produce cognitive copingres ponses (both self-statements and perspective shifts) for use during desensitisation; if time or client readiness allowed, we placed emphasis on applying cognitive therapy skills more generally. The cognitive therapy included thought and belief identification, logical analysis with probability, and evidence searching to develop alternative thoughts. ● *Dose* : Treatments were applied for a maximum of 12 weekly sessions of 60 min duration. ● *Duration*: 12 weeks
Outcomes	*Grad af angst, Beck Anxiety Inventory (BAI)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Beck Anxiety Inventory (BAI) ● **Range**: 0-63 ● **Direction**: Lower is better ● **Data value**: Endpoint *Funktion, Penn State Worry Questionnaire (PSWQ)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: Penn State Worry Questionnaire (PSWQ) ● **Range**: 0-80 ● **Direction**: Lower is better ● **Data value**: Endpoint *Frafald, alle årsager* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Direction**: Lower is better

	● **Data value**: Endpoint *Bedring, recovered or reliably improved on PSWQ* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Scale**: Penn State worry Questionnaire ● **Direction**: Higher is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** This trial was funded by the Norwegian University of Science and Technology (SAK: PI-4-215-06,SAK: PI-13-114-08) **Country:** Norway **Setting:** Outpatient clinic **Authors name:** Hans M. Nordahl **Institution:** Department of Mental Health, Norwegian University of Science and Technology and Research Director, St Olavs Hospital, Nidaros DPS,Norway **Email:** Hans.nordahl@nt.nu **Address:** Professor Hans M. Nordahl, Department of Mental Health, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, PO Box8905, N-7006 Trondheim, Norway.
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "Trial participants were randomly assigned to one of three conditions, using the IBM random number generator program. Randomisation was stratified by gender and by DSM-IV 22 major depressive disorder,"
Allocation concealment (selection bias)	Unclear risk	Quote: "randomisation sequence was prepared by the trial statistician, who was independent of patient recruitment." Judgement Comment: Insufficient information on allocation concealment.
Blinding of participants and personnel (performance bias)	High risk	Judgement Comment: No information of blinding of participants and personnnels. Blinding not feasible.
Blinding of outcome assessment (detection bias)	High risk	Judgement Comment: No information of blinding of outcome assessors. Outcomes were measured with self-reported questionnaires and participants were not blinded.
Incomplete outcome data (attrition bias)	Low risk	Judgement Comment: Few participants were lost to follow up and losses to follow-up were balanced in the groups and for reasons not related to outcome. ITT analyses performed.
Selective reporting (reporting bias)	High risk	Judgement Comment: Registered at ClinicaTrials.gov. Only the two outcomes PSWQ and STAI are stated in the protocol. STAI stated as a primary outcome in the protocol but as a secondary outcome in the report. One or more primary outcomes were not pre-specified in study protocol
Other bias	High risk	Judgement Comment: There are to publications on this Study. Nordahl. et all and Kvistedal. Kvistedal is a preliminary analysis of the trial. This means that the blinding of the randomization was broken before the inclusion were completed.

Footnotes

Characteristics of excluded studies

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

References to studies

Included studies

Nordahl 2018

Nordahl, Hans M.; Borkovec, Thomas D.; Hagen, Roger; Kennair, Leif E. O.; Hjemdal, Odin; Solem, Stian; Hansen, Bjarne; Haseth, Svein; Wells, Adrian. Metacognitive therapy versus cognitive-behavioural therapy in adults with generalised anxiety disorder. BJPsych Open 2018;4(5):393-400. [DOI:]

Excluded studies

Data and analyses

1 Meta-kognitiv terapi vs kognitiv adfærdsterapi

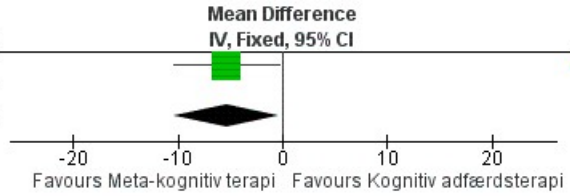
Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Grad af angst (severity of anxiety)	1	60	Mean Difference (IV, Fixed, 95% CI)	-5.36 [-10.48, -0.24]
1.2 Funktion (function)	1	60	Mean Difference (IV, Fixed, 95% CI)	-11.74 [-18.55, -4.93]
1.3 Frafald, alle årsager, dropouts all causes	1	60	Risk Ratio (M-H, Fixed, 95% CI)	0.88 [0.13, 5.81]
1.4 Bedring (response)	1	57	Risk Ratio (M-H, Fixed, 95% CI)	1.10 [0.83, 1.48]

Figures

Figure 1 (Analysis 1.1)

Study or Subgroup	Meta-kognitiv terapi Mean	SD	Total	Kognitiv adfærdsterapi Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Nordahl 2018 (1)	5.06	5.57	32	10.42	12.8	28	100.0%	-5.36 [-10.48, -0.24]
Total (95% CI)			**32**			**28**	**100.0%**	**-5.36 [-10.48, -0.24]**

Heterogeneity: Not applicable
Test for overall effect: Z = 2.05 (P = 0.04)



Footnotes
(1) Grad af angst målt med Beck Anxiety Inventory (BAI) range 0-63, lower is better

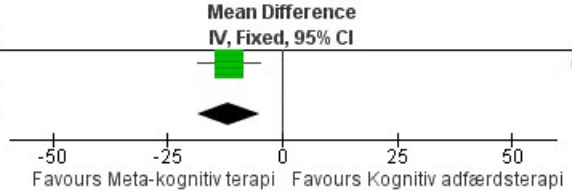
Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

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

Figure 2 (Analysis 1.2)

Study or Subgroup	Meta-kognitiv terapi Mean	SD	Total	Kognitiv adfærdsterapi Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Nordahl 2018 (1)	42.93	14.09	32	54.67	12.8	28	100.0%	-11.74 [-18.55, -4.93]
Total (95% CI)			**32**			**28**	**100.0%**	**-11.74 [-18.55, -4.93]**

Heterogeneity: Not applicable
Test for overall effect: Z = 3.38 (P = 0.0007)



Footnotes
(1) Funktion er målt med Penn State Worry Questionnaire (PSWQ), Range 0-80, lower is better

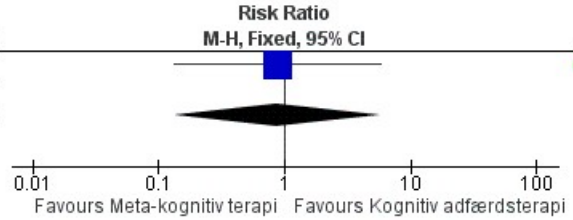
Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

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

Figure 3 (Analysis 1.3)

Study or Subgroup	Meta-kognitiv terapi Events	Total	Kognitiv adfærdsterapi Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Nordahl 2018	2	32	2	28	100.0%	0.88 [0.13, 5.81]
Total (95% CI)		**32**		**28**	**100.0%**	**0.88 [0.13, 5.81]**
Total events	2		2			

Heterogeneity: Not applicable
Test for overall effect: Z = 0.14 (P = 0.89)



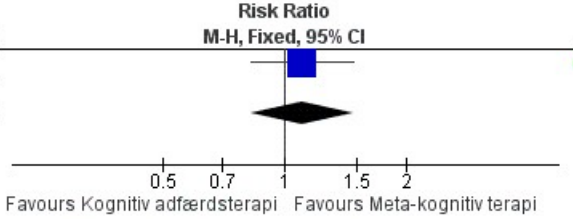
Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

Forest plot of comparison: 1 Meta-kognitiv terapi vs kognitiv adfærdsterapi, outcome: 1.3 Frafald, alle årsager, dropouts all causes.

Figure 4 (Analysis 1.4)

Study or Subgroup	Meta-kognitiv terapi Events	Total	Kognitiv adfærdsterapi Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Nordahl 2018 (1)	25	31	19	26	100.0%	1.10 [0.83, 1.48]
Total (95% CI)		**31**		**26**	**100.0%**	**1.10 [0.83, 1.48]**
Total events	25		19			

Heterogeneity: Not applicable
Test for overall effect: Z = 0.67 (P = 0.51)



Footnotes
(1) Bedring er defineret som recovered or reliably improved on Penn State Worry Questionnaire (PSWQ)

Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

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