

Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* **MH** *clinical question-answering service*

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Question: In adults with anxiety disorders in acute psychiatric inpatient settings, how effective is CBT?

Clarification of question: Patients = adults with a primary diagnosis of any anxiety disorder; Intervention = CBT, cognitive behaviour therapy, group or individual; Comparison = any, Outcome = any.

What does the evidence say?

One evidence based guideline and 7 reasonable to well-conducted systematic reviews in a range of anxiety disorders found good evidence that CBT was effective in the condition studied (e.g. GAD, panic, OCD, PTSD). One systematic review in panic found a lack of evidence of the long term effectiveness of CBT (3 trials). No trials in inpatients were identified by any of the authors.

This answer is a brief summary of the available evidence, if there is anything else you would like to know, please contact me on: contact@bestinmh.org.uk. This answer will shortly be posted on our website: www.bestinmh.org.uk.

This question was received on 12.09.2007; the answer was completed by Elizabeth Barley PhD CPsychol on 20.09.2006.

METHODS

Search date: 19.09.2007

Source of Evidence	Search Terms	Search Results	Evidence Identified
NLH guideline finder	Anxiety	19	1 (GAD and panic) (1)
CDSR	Anxiety AND CBT OR cognitive	194	2 SRs (OCD (2) search date 2006, PTSD (3) search date unknown, published 2007,)
DARE		139	2 SRs (GAD search date 2002 (4), panic (5) search date unknown, published 2003)
Clinical Evidence	Mental health section search for anxiety disorders	Sections on anxiety disorders (GAD, panic, OCD, PTSD) searched	4SRs (GAD (6), Panic (7), OCD (8), PTSD (9) search dates all 2006)
PsiTri	Anxiety (health condition) AND cognitive (intervention)	131 – scanned for trials published after 2002	none

(SR = systematic review, GAD – generalised anxiety disorder, OCD- obsessive compulsive disorder, PTSD – post traumatic stress disorder)

EVIDENCE SUMMARY

I found one evidence based guideline (1) and 8 good or reasonably-well conducted recent SRs (2-9) in a range of anxiety disorders (GAD, panic, OCD, PTSD). All found that CBT based interventions were effective for the conditions studied, except one (5) which considered only long term effectiveness in panic and which found insufficient evidence. Only one author (4) considered treatment setting separately, but did not identify any trials in inpatients. None of the included trials in the other SRs appeared to be in inpatients.

EVIDENCE DETAILS

Systematic reviews:

author, date	source, type	search date	no. of trials	main findings/author conclusions and comment
Gava, 2007 (2)	Cochrane	2006	8 RCTs (OCD)	“The findings of this review suggest that psychological treatments derived from cognitive behavioural models are an effective treatment for adult patients with obsessive compulsive disorder.”
Bisson, 2007 (3)	Cochrane	n/k	33 RCTs (PTSD)	“There was evidence individual TFCBT Trauma-focused cognitive behavioural therapy/exposure therapy, EMDR eye movement desensitisation and reprocessing, stress management and group TFCBT are effective in the treatment of PTSD.”
Haby, 2006 (4)	DARE prov. record	2002	19 RCTs (panic), 3 (GAD)	CBT beneficial. Heterogeneity explained by treatment, duration of therapy, inclusion of severe patients in the trial, year of study, country of study, control group, language and number of dropouts from the control group.
Nadiga, 2003 (5)	DARE	n/k	3 RCTs (only those with long term outcomes)	CRD commentary: “The authors concluded that more data are required before definitive conclusions can be drawn about the long-term effectiveness of CBT. These conclusions are likely to be reliable.”
Gale, 2007 (6)	Clinical Evidence	2006	2SRs and 4 RCTs	2 SRs 4 RCTs found CBT (using a combination of interventions, such as exposure, relaxation, and cognitive restructuring) improved anxiety and depression over 4–12 weeks compared with WLC, anxiety management alone, relaxation alone, or non-directive psychotherapy. 2 RCTs found no significant difference in symptoms at 13 weeks and 6 months between CT and applied relaxation. 1 RCT found no significant difference in anxiety and depression at 24 months between CT (with a behavioural component), CT (without a behavioural component), and applied relaxation with visualisation.
Kumar, 2007 (7)			5 RCTs	CBT improved symptoms compared with both a pharmacological placebo and a waiting list control at 6 months or longer. One of the reviews found no significant difference between CBT and pharmacotherapy in direct

			comparison studies but found that pooled effect sizes were greater for CBT versus control compared with pharmacotherapy versus control. One of the reviews found high quality evidence of benefit from CBT in panic disorder with or without mild to moderate agoraphobia, but no good evidence of benefit in severe agoraphobia.
Mustafa Soomro, 2007 (8)		1SR, 6 RCTs	2 RCTs found that CBT improved symptoms compared with no treatment or waiting list control after 6–12 weeks. One SR and 4 subsequent RCTs found no consistent evidence of a difference in symptoms between BT and CT or CBT.
Bisson, 2007 (9)		3 RCTs	Two small RCTs in people with acute stress disorder after a traumatic event (road traffic accident or non-sexual assault) found that 5 sessions of CBT reduced the proportion of people with PTSD after 6 months compared with supportive counselling. One RCT in people with acute stress disorder found that CBT alone and CBT plus hypnosis reduced rates of PTSD compared with supportive counselling. However, the differences between groups were not significant.

(WLC – wait list control, BT – behavioural therapy, CT – cognitive therapy)

References

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