Evidence-based psychological treatments for late-life anxiety
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CRD summary
The authors concluded that there is evidence supporting relaxation training and cognitive-behaviour therapy, and weaker evidence supporting supportive therapy and cognitive therapy, for anxiety disorders in older adults. The limited number of studies for some interventions, a synthesis focused on positive results and the lack of a quality assessment make the reliability of these conclusions uncertain.

Authors’ objectives
To identify and compare evidence-based psychological treatments for late-life anxiety.

Searching
MEDLINE, PsycINFO and the Cochrane CENTRAL Register were searched for studies published before December 2005; the search terms were not reported. In addition, reference lists were screened and experts in the field were contacted.

Study selection
Study designs of evaluations included in the review
Randomised controlled trials were eligible for inclusion in the review.

Specific interventions included in the review
Studies that compared an evidence-based treatment (EBT) with waiting list, usual care, alternative intervention or placebo intervention were eligible for inclusion. The review only included studies that met EBT criteria. To be classified as an EBT, interventions had to be supported by evidence from at least two published peer-reviewed studies with at least 30 participants randomised to the same treatment, or most studies or most outcomes within studies had to show positive treatment effects. In addition, studies had to have documented evidence of adherence to a specific treatment protocol (see Other Publications of Related Interest).

The included studies evaluated cognitive-behavioural therapy (CBT; defined in the review as including relaxation and cognitive restructuring), cognitive therapy (CT; defined in the review as not including relaxation), relaxation training and supportive therapy (ST). CBT interventions included education, self-monitoring, relaxation training, exposure to situations provoking anxiety, systematic desensitisation and cognitive restructuring; some studies also included other elements. The interventions were provided in group and individual formats.

Participants included in the review
Studies of participants with a mean age of 55 years or over, who had subjective complaints of anxiety or had a diagnosis of anxiety according to the American Psychiatric Association's DSM-IV criteria, were eligible for inclusion. The mean age of the participants in the included studies ranged from 66 to 72 years. Some of the included studies included patients with panic disorder and social phobia.

Outcomes assessed in the review
Studies that reported at least one objective measure of anxiety were eligible for inclusion. The included studies measured anxiety using various means (details of some of these were reported).

How were decisions on the relevance of primary studies made?
Two reviewers selected the studies and any discrepancies were resolved by consensus.

Assessment of study quality
The authors did not state that they assessed validity.

**Data extraction**
Independent reviewers coded the data (see Other Publications of Related Interest). Any disagreements were resolved by discussion among the entire review team and majority consensus was reached.

**Methods of synthesis**
How were the studies combined?
The studies were grouped by type of therapy and combined in a narrative.

How were differences between studies investigated?
Some differences between the studies were described in the text and tables.

**Results of the review**
Seventeen studies (reported in 16 reports) that met EBT criteria were included in the text of the review. The details of 15 studies (reported in 14 reports) that reported positive results were tabulated (n=608). Some studies that reported non-positive outcomes were mentioned briefly in the text, but the number of participants in these studies was not reported.

**CBT.**
Nine of 11 studies provided support for CBT compared with a waiting-list or minimal contact control intervention; the other 2 studies reported no changes associated with CBT.

**CT.**
One of 3 studies evaluating CT found support for CT compared with a waiting-list control. The other 2 studies compared CT with relaxation or pseudorelaxation training and reported that relaxation/pseudorelaxation was more effective than CT.

**Relaxation training.**
Four of 5 studies in patients with subjective symptoms of anxiety provided support for relaxation training compared with waiting list or pseudorelaxation; the other study reported increased anxiety symptoms after relaxation training.

**ST.**
The authors stated that ‘there was some evidence to support the use of supportive therapy but no evidence that supportive therapy was more effective than CBT or relaxation training’. One study reported that CBT was associated with significantly greater reductions in anxiety post-treatment compared with ST. Between-treatment comparisons were not reported for the other 2 studies.

**Authors' conclusions**
There is evidence supporting relaxation training and CBT and weaker evidence supporting ST and CT. Further research is required.

**CRD commentary**
The review addressed a clear question that was defined in terms of the participants, outcomes and study design; although inclusion criteria for the interventions were not explicitly defined, the focus of the review was clear from the text. Several relevant sources were searched, but there were no attempts to minimise publication bias and it was not clear whether any language restrictions had been applied. Methods were used to reduce reviewer errors and bias in the study selection and data extraction processes. Study validity was not assessed, so the results from these studies and any
synthesis may not be reliable.

Between-treatment comparisons were not reported for all studies, which makes it difficult to interpret the results. It is not clear whether all studies reporting non significant results were mentioned in the review, and the focus on studies reporting positive outcomes could have biased the assessment of the evidence. Potential reasons for the lack of significant results in some studies were not discussed. Conclusions about the effectiveness of CT were based on 1 study with 30 participants, while one of the 5 studies evaluating relaxation training showed increased harms from the interventions; thus, conclusions for these therapies appear optimistic. In addition, the lack of an assessment of study quality and the focus on studies reporting positive outcomes make it difficult to confirm the reliability of the authors' other conclusions.

Implications of the review for practice and research
Practice: The authors did not state any implications for practice.

Research: The authors stated that more research into interventions for late-life anxiety is required. They suggested that future research should examine the long-term effects of interventions based on other theories, combinations of psychotherapy and medication, the effects on other types of anxiety disorders (e.g. phobias and post-traumatic stress disorder), and different populations (including medical, psychiatric, cognitively impaired, racially diverse populations and patients in assisted living and residential care). Research into the prevention and detection of anxiety disorders is also needed.

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Other publications of related interest

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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.