

Best Evidence Summaries of Topics in Mental Healthcare

BEST in MH *clinical question-answering service*

Question

“In older adults with anxiety disorders, how effective is cognitive behaviour therapy (CBT) compared with other forms of psychotherapy or treatment as usual or wait-list control, for improving patient outcomes?”

Clarification of question using PICO structure

Patients: Older adults with anxiety disorders
Intervention: Cognitive behaviour therapy (CBT)
Comparator: Other forms of psychotherapy, treatment as usual or wait-list control
Outcome: Any patient outcomes

Clinical and research implications

Evidence from four systematic reviews, all with significant methodological weaknesses, particularly with respect to evidence synthesis, and one additional small RCT of moderate quality, indicates that CBT may be effective in reducing symptoms of anxiety, worry and depression in older adults with anxiety disorder when compared to a non-active control condition. However, these effects were observed immediately post-treatment and there was no consistent evidence to indicate that effects were sustained in the long-term. Available evidence suggested no consistent differences in effectiveness between CBT and other active treatments (including psychotherapies, supportive therapy or pharmacotherapy). Further research is needed to explore the long term effects of CBT and to provide data on its effectiveness compared to individual alternative treatments.

What does the evidence say?

Number of included studies/reviews (number of participants)

We identified four systematic reviews¹⁻⁴ and one additional randomised controlled trial (RCT)⁵ that reported data relevant to this evidence summary. Two systematic reviews specifically assessed the effectiveness of CBT for the treatment of anxiety in older adults.^{2,4} One systematic review assessed the effectiveness of psychological interventions for the treatment of generalised anxiety disorder (GAD) in adults and included subgroup analyses for older adults; all studies in older adults included in this review assessed the effectiveness of CBT.³ The final review was not clearly reported as a systematic review and did not include any additional results, not reported in the other three.¹ It should be noted that there was a high level of overlap in the studies included in the four systematic reviews (see table below). The RCT compared a telephone CBT intervention to an information only control for the treatment of anxiety in older adults.⁵

Main findings

One systematic review found that CBT was associated with a reduction in post-treatment symptoms of anxiety and depression, compared to a non-active control (effect sizes -0.66 (95% CI: -0.94 to -0.38), 7 studies, and -0.47 (95% CI: -0.90 to -0.05), 6 studies, respectively), however, no follow-up data were available.² A second systematic review reported small pre- to post- treatment improvements in anxiety and depression for CBT (anxiety mean g 1.18 (95% CI: 0.78 to 1.59), depression mean g 0.78 (95% CI: 0.38 to 1.17)), with no comparator.⁴ The third systematic review found that CBT was associated with reductions in anxiety, (SMD -0.73 (95% CI: -1.07 to -0.40)), depression (SMD -0.72 (95% CI: -1.05 to -0.38)) and worry (SMD -1.00 (95% CI: -1.38 to -0.65)) compared to non-active controls.³ These estimates were based on the results of five studies, four of which only reported post-treatment data; the remaining two studies had follow-up periods of 6 and 12 months, but it was not clear which time points were included in the meta-analysis.³ No consistent differences in effect were observed between CBT and active control treatments, including other psychotherapies, supportive therapy or pharmacotherapy.^{2,4} The additional RCT found that a telephone CBT intervention was associated with statistically significant reductions in post-treatment anxiety, worry and insomnia compared to an information only control, however, only the effect on worry was maintained at six months follow-up.⁵

Authors conclusions

Four systematic reviews and one additional RCT, not included in any of the systematic reviews, concluded that psychological therapies/CBT are effective in treating older adults with anxiety disorders.

Reliability of conclusions/Strength of evidence

Four systematic reviews, all with significant methodological weaknesses, particularly with respect to evidence synthesis, and one additional small RCT of moderate quality, all concluded that psychological therapies/CBT are effective in treating older adults with anxiety disorders. However, there was no consistent evidence of a treatment effect beyond the immediate post-treatment measurement and no consistent evidence of a difference in effectiveness between CBT and other active interventions.

What do guidelines say?

Neither National Institute for Health and Care Excellence (NICE) nor Scottish Intercollegiate Guidelines Network (SIGN) guidelines comment upon the use of CBT for treating anxiety disorders specifically in older adults.

Date question received: 24/01/2007
Date searches conducted: 07/11/2014, updated from 06/02/2007
Date answer completed: 01/12/2014

References

1. Ayers CR, Sorrell JT, Thorp SR and Wetherell JL. Evidence-Based Psychological Treatments for Late-Life Anxiety. *Psychology and Aging* (2007);22(1):8-17.
2. Gould RL, Coulson MC and Howard RJ. Efficacy of Cognitive Behavioral Therapy for Anxiety Disorders in Older People: A Meta-Analysis and Meta-Regression of Randomized Controlled Trials. *Journal of the American Geriatrics Society* (2012);60:218-229.
3. Hunot V, Churchill R, Teixeira V, Silva de Lima M. Psychological therapies for generalised anxiety disorder. *The Cochrane Library* 2007, Issue 1.
4. Thorp SR, Ayers CR, Nuevo R, et al. Meta-analysis Comparing Different Behavioral Treatments for Late-Life Anxiety. *Am J Geriatr Psychiatry* (2009);17(2):105-115.
5. Brenes GA, Miller ME, Williamson JD, et al. A Randomized Controlled Trial of Telephone-Delivered Cognitive-Behavioral Therapy for Late-life Anxiety Disorders. *Am J Geriatr Psychiatry* (2012);20(8):707-716.

Results

Systematic reviews

| Author (year) | Search Date | Inclusion criteria | Number of included studies | Summary of results | Risk of bias |
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| Ayers et al. (2007) | 12/2005 | <p><i>Participants:</i> Aged 55 years of age or older; having had subjective complaints of anxiety or a <i>DSM-IV</i> anxiety disorder diagnosis.</p> <p><i>Intervention:</i> Any psychological intervention.</p> <p><i>Comparator:</i> A wait list, minimal contact, usual care, alternative intervention, or attention placebo condition.</p> <p><i>Outcome:</i> At least one objectively evaluated anxiety outcome measure.</p> <p><i>Study design:</i> RCTs</p> | n = 17 studies (9 studies relevant to this evidence summary, all of which were also included in Hunot 2007, Gould 2012 and/or Thorp 2009) | <p>This article reported a review of the geriatric anxiety treatment outcome literature, which incorporated some characteristics of a systematic review.</p> <p>Nine of the seventeen included studies reported data on the effectiveness of CBT in older adults with anxiety. All of these studies were also included in at least one other systematic review in this evidence summary and no additional results were reported in this article.</p> | <p>The article did not clearly report a systematic review and no research objective was reported; inclusion criteria were reported.</p> <p>The Cochrane Database, Medline, and PsycINFO were searched (no search terms reported). Reference lists were reviewed, and experts in the field of geriatric mental health were consulted. Only studies published before December</p> |

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| | | | | | <p>2005 were included.</p> <p>No details of the study selection process were reported.</p> <p>No assessment of methodological quality was reported.</p> <p>Results of individual studies were summarised in a table, but no numerical results were reported.</p> |
| Gould et al. (2012) | 11/2010 | <p><i>Participants:</i> Aged 55 and older; with a diagnosis of panic disorder (PD), generalised anxiety disorder (GAD), agoraphobia, specific phobia, PTSD, OCD, or anxiety disorder not otherwise specified (ADNOS).</p> <p><i>Intervention:</i> CBT that lasted longer than two sessions.</p> <p><i>Comparator:</i> an active control (e.g., pharmacotherapy or a social support or</p> | n = 12 (of which 9 were also included in Thorp 2009, see below) | <p>The review aimed to assess the efficacy of CBT for older people with anxiety disorders, at 3, 6 and 12-month follow-up, and to examine the predictors of efficacy of CBT.</p> <p>The mean age of study participants was 68.2 years and the mean percentage of participants with a co-morbid psychiatric diagnosis was 41.5%. Seven studies included participants with GAD, one study was</p> | <p>The research objective was clearly stated and appropriate inclusion criteria were defined.</p> <p>Four bibliographic databases were searched without</p> |

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| | | <p>attention placebo, supportive psychotherapy counselling, psychoeducation, discussion group, or enhanced treatment as usual) or a Non-active control (e.g., minimal contact treatment-as-usual (TAU) or waiting list).</p> <p><i>Outcome:</i> Evidence-based anxiety outcome measures. Depression outcome measures were also included.</p> <p><i>Study design:</i> Peer-reviewed RCTs.</p> | <p>conducted in people with PD and four studies included participants with a range of anxiety disorders.</p> <p>Nine of the 12 studies delivered CBT in an individual format and the mean number of sessions was 12. The majority of studies included components of cognitive therapy (n = 12), psychoeducation (n = 11), relaxation training (n = 11), and graded exposure (n = 11).</p> <p>CBT vs non-active control: The pooled effect size (Hedges' g) indicated that CBT was associated with statistically significant improvements in both anxiety and depression outcomes, post-treatment, (effect sizes -0.66 (95% CI: -0.94 to -0.38), 7 studies, and -0.47 (95% CI: -0.90 to -0.05), 6 studies, respectively). No follow-up data were available for the non-active comparison.</p> <p>CBT vs active control: CBT was associated with small, non-statistically significant improvements in anxiety symptoms post-treatment and at 3 and 12 months. The reported effect size was statistically significant at 6 months follow-up</p> | <p>language or date restrictions. Key journals and the reference lists of meta-analyses and reviews were hand searched for additional studies. Un-published (not peer reviewed) studies were excluded.</p> <p>The review process included measures to minimise error and/or bias.</p> <p>The methodological quality of included studies was assessed using methods recommended in the Cochrane handbook.</p> <p>Overall effect sizes were calculated</p> |
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| | | | | <p>(-0.29 (95% CI: -0.57 to -0.01), 4 studies). CBT was associated with small, non-statistically significant improvements in depression symptoms post-treatment and at 6 months. The reported effect size was statistically significant at 12 months follow-up (-0.18 (95% CI: -0.82 to -0.46), 3 studies). No data were available for 3 months follow-up.</p> | <p>separately for anxiety and depression measures at each time point (post-treatment, 3, 6 and 12 months) and for active and n-n active control comparisons. However, the active control group included both studies of CBT vs. pharmacotherapy and studied of CBT vs. other psychotherapies; possible differences in effect between different active controls were not investigated.</p> |
| Hunot et al. (2007) | 02/2006 | <p><i>Participants:</i> Aged between 18-75 years with a diagnosis of GAD (according to DSM and ICD criteria), treated in a primary, secondary or community setting. Studies conducted in an in-</p> | n = 23 studies (6 studies relevant to | The review aimed to assess the efficacy and acceptability of psychological therapies for patients with GAD. | The research objective was clearly stated and appropriate |

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| | | <p>patient setting were excluded. Subgroup analyses examined age (adult versus elderly).</p> <p><i>Intervention:</i> Psychological therapies, including CBT (CBT included stand-alone cognitive therapy and behavioural therapy interventions).</p> <p><i>Comparator:</i> Treatment as usual/waiting list.</p> <p><i>Outcome:</i> Primary outcome: change in GAD symptoms according to diagnostic criteria or through validated diagnostic measures such as the Hamilton Anxiety Scale (HAM-A). Secondary outcomes: Reduction in worry/fear; reduction in depressive symptoms; improvement in social functioning, quality of life.</p> <p><i>Study design:</i> RCTS and quasi-RCTS, (e.g. treatment assignment decided through methods such as alternate days of the week). Cross-over trials were eligible for inclusion in the review, using data from the first active treatment stage only.</p> | <p>this evidence summary, of which 5 were also included in both Thorpe 2009 and Gould 2012).</p> | <p>Six of the 23 included studies assessed CBT in elderly patients.</p> <p>Overall summary effect estimates (standard mean difference (SMD)) were calculated separately for anxiety, depression and worry outcomes.</p> <p>Psychological therapies vs. TAU: Subgroup analyses were reported for five studies conducted in elderly people; all of these studies compared CBT to a waiting list control or TAU. Three studies reported outcomes immediately post-treatment, with no follow-up, and the remaining two studies had follow-up times of 6 and 12 months. Summary effect estimates indicated that CBT was associated with small reductions in symptoms of anxiety (SMD-0.73 (95% CI: -1.07 to -0.40)), depression (SMD -0.72 (95% CI: -1.05 to -0.38)) and worry (SMD -1.00 (95% CI: -1.38 to -0.65)).</p> <p>CBT vs. supportive therapy: One study was conducted in elderly people. Results indicated that CBT was associated with a small reduction in symptoms of anxiety at six months follow-up (SMD-0.13</p> | <p>inclusion criteria were defined.</p> <p>Biobibliographic database searches used the Cochrane Collaboration Depression, Anxiety and Neurosis (CCDAN) Collaborative Review Group register. Hand searching of key journals, reference lists of retrieved articles and previous systematic reviews and conference abstracts, and contact with experts in the field were undertaken to identify additional studies. No language, date or publication status restrictions</p> |
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| | | | | <p>(95% CI: -0.64 to -0.37)), but there were no statistically significant differences between the two treatment modalities for depression or worry outcomes.</p> | <p>were reported.</p> <p>The review process included measures to minimise error and/or bias.</p> <p>The methodological quality of included studies was assessed using methods recommended in the Cochrane handbook.</p> <p>Overall effect sizes were calculated separately for anxiety, depression and worry outcomes. However, studies with different follow-up times appear to have been included in the same analysis and possible effects</p> |
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| | | | | | of follow-up time were not investigated. |
| Thorp et al. (2009) | | <p><i>Participants:</i> Studies of participants with anxiety disorders or symptoms and a mean age of 65 years and a minimum lower age limit of 55 years were included.</p> <p><i>Intervention:</i> Behavioural interventions (minimum two sessions), including CBT (e.g. thought monitoring, cognitive restructuring, exposure methods and response prevention, behavioural activation, and problem solving) either alone or with relaxation training (e.g. progressive muscle relaxation (PMR), breathing exercises, meditation, and imagery).</p> <p><i>Comparator:</i> Any control condition. Active control conditions included “supportive counselling or psychotherapy,” “non-formal” training in CBT or relaxation training, group discussion, psychoeducation, time for quiet reflection, and weekly medication management.</p> <p><i>Outcome:</i> Published or cited anxiety or depression measures. Anxiety measures used by included studies were varied widely : trait anxiety; state anxiety; Beck Anxiety Inventory; Hamilton Rating Scale for Anxiety; Penn State Worry Questionnaire;</p> | n = 19 studies | <p>The review aimed to compare the efficacy of cognitive behavioural therapy (CBT), relaxation therapy (RT) and CBT+RT for the treatment of anxiety in older adults.</p> <p>Of the nineteen included studies, two were three arm studies comparing cognitive (CBT), (RT) and active control, two compared RT with active control, one compared CBT with active control, three compared CBT+RT with active control and six compared CBT+RT with wait list control. The remaining five studies were un-controlled (two CBT, two RT and one CBT+RT).</p> <p>The majority of the participants in included studies had generalised anxiety disorder (GAD), or panic disorder (PD). The mean age of participants ranged from 66 to 73 years, where reported.</p> <p>Summary effect sizes were calculated using the standardised mean difference (Hedges’ g). Separate effect sizes were calculated for anxiety and depression measures.</p> <p>Meta-analyses of controlled studies showed no significant difference in anxiety or</p> | <p>Searches were restricted to English language studies, raising the possibility of language bias and potential exclusion of relevant studies.</p> <p>No assessment of the methodological quality of included studies was included. Therefore, the extent to which methodological flaws in the primary studies may have biased the review findings cannot be assessed.</p> <p>The review process was poorly reported and it was not clear whether any measures were</p> |

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| | | <p>Symptom Checklist-90 (phobic anxiety and obsessive compulsive sub-scales); Worry Domain Questionnaire Form for the Elderly; Fear Inventory; Hospital Anxiety and Depression Scale; Generalised Anxiety Questionnaire; Cognitive Anxiety Questionnaire; Worry Scale; Agrophobia Cognitions Questionnaire; Texas Panic-Related Phobia Scale.</p> <p>Depression measures used by included studies were more consistent : Beck Depression Inventory; Self-Rating Depression Scale; Geriatric depression Scale; Hamilton Rating Scale for Depression; Centre for Epidemiological Studies Depression Scale.</p> <p><i>Study design:</i> Prospective studies with at least five participants that reported sufficient data for the calculation of effect sizes. The designs of the included studies were not clearly described; it was unclear whether any of the included studies were RCTs.</p> | <p>depression measures between CBT and active control; mean g 0.00 (95% CI: -0.46 to 0.46) and 0.23 (95% CI: -0.22 to 0.69), respectively (3 studies). Similarly, there was no significant difference in anxiety or depression measures between CBT+RT and active control; mean g 0.33 (95% CI: -0.07 to 0.74) and 0.12 (95%CI: -0.29 to 0.52), respectively (3 studies).</p> <p>Two studies appeared to report three arm comparisons of CBT, RT and active control, but no outcomes data were reported for the CBT vs. RT comparison: De Berry S. The effects of meditation-relaxation on anxiety and depression in a geriatric population. <i>Psychother: Theory, Res Prac</i> 1982;19:512–521. Sallis JF, Lichstein KL, Clarkson AD, et al. Anxiety and depression management for the elderly. <i>Int J Behav Geriatrics</i> 1983;1:3–12.</p> <p>Note: These studies were retrieved and were found to include no additional data.</p> <p>Pooled estimates of effect size (pre- to post-treatment, without comparator) were also reported for each treatment condition. All active treatments had comparable, small positive effects on both anxiety and depression:</p> | <p>taken to minimise error and/or bias, e.g. independent inclusion screening and data extraction by two reviewers.</p> <p>In addition to the comparisons of each intervention with active control, the meta-analyses included the calculation of uncontrolled (pre-versus post-treatment) effect sizes for CBT, RT, CBT+RT, active control and wait list/no treatment. These effect sizes were calculated by pooling data from uncontrolled studies and separate arms of RCTs.</p> <p>Two of the included studies appeared to report direct</p> |
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| | | | | <p>CBT (5 studies) – anxiety mean g 1.18 (95% CI: 0.78 to 1.59), depression mean g 0.78 (95% CI: 0.38 to 1.17)</p> <p>CBT+RT (12 studies): anxiety mean g 0.86 (95% CI:0.63 to 1.08), depression mean g 0.77 (95% CI: 0.55 to 1.00).</p> <p>RT: anxiety (7 studies) mean g 0.91 (95% CI: 0.68 to 1.24), depression (3 studies) mean g 0.77 (95% CI: 0.26 to 1.27).</p> <p>Active control: anxiety (8 studies) mean g 0.50 (95% CI: 0.22 to 0.78), depression (7 studies) mean g 0.53 (95% CI: 0.24 to 0.82).</p> <p>Wait list/no treatment: anxiety (8 studies) mean g 0.05 (95% CI: -0.21 to 0.31), depression (7 studies) mean g 0.20 (95% CI: -0.08 to 0.49).</p> | <p>comparisons of CBT, RT and active control. However, these results were not reported and no meta-analysis of CBT vs. RT was reported.</p> |
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RCTs

| Author (year) | Inclusion criteria | Number of participants | Summary of results | Risk of bias |
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| Brenes et al. (2012) | <p><i>Participants:</i> Aged 60 years and over with a diagnosis of GAD, PD, GAD with PD, or ADNOS, according to DSM-IV criteria.</p> <p><i>Exclusion criteria:</i> current psychotherapy; current alcohol or substance abuse; dementia or global cognitive impairment; psychotic symptoms; active suicidal ideation; or any change in psychotropic medications within the previous 3 months.</p> | n = 60 (intervention 30, control 30) | <p>This study aimed to compare the effects of CBT delivered by telephone (CBTT) with information-only for the treatment of late-life anxiety disorders.</p> <p>The mean age of study participants was approximately 69 years and 83% were female. The only statistically significant difference between groups, at baseline, was mean years in education (14.4±1.6 in the CBT-T group and 13.2±1.6 in the information only group. There were no other differences in</p> | <p>No details of randomisation or allocation concealment procedures were reported.</p> <p>The nature of</p> |

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| | <p><i>Intervention:</i> Telephone CBT (CBT-T), with an 8-chapter workbook. Topics included treatment rationale, cognitive therapy, problem-solving, thought stopping, behavioural activation, in vivo exposure, and relapse prevention. Booster sessions were provided at 2, 4, 8, and 12 weeks post-completion of the workbook.</p> <p><i>Comparator:</i> Information only – participants were provided with written information on anxiety disorders.</p> <p><i>Outcome:</i> Primary outcomes: worry (Penn State Worry Questionnaire; PSWQ); anxiety symptoms (State-Trait Anxiety Inventory-Trait subscale (STAI-T)); Secondary outcomes: fear of anxiety symptoms (Anxiety Sensitivity Index; ASI); depressive symptoms (Beck Depression Inventory; BDI); anxiety symptoms (Hamilton Anxiety Rating Scale; HAMA); insomnia (Insomnia Severity Index; ISI); quality of life (SF-36). Assessments were conducted at baseline, post-intervention and at six months follow-up.</p> | | <p>demographic or clinical characteristics and results did not change when analyses were re-run controlling for education.</p> <p>CBT was associated with statistically significant reductions in post-treatment anxiety: STAI-T effect size 0.71 (p=0.01); ASI effect size 0.85 (p=0.004); HARS 0.81 (p=0.004). These effects were not maintained at six months follow-up.</p> <p>CBT was also associated with statistically significant post-treatment reductions in worry (PSWQ effect size 0.61 (p=0.03)) and insomnia (ISI effect size 0.82 (p=0.005)). Only the effect on worry was maintained at six months follow-up.</p> <p>There were no statistically significant effects on depression or quality of life measures.</p> | <p>the intervention precludes blinding of participants and therapists.</p> <p>Outcomes were assessed by interviewers who were blinded to the treatment condition.</p> <p>Four participants from the CBT-T group and one from information-only group dropped out during the study. An additional two people from</p> |
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| | | | | <p>the CBT-T group and three from information-only group dropped out between the post-treatment and six month follow-up assessments. All analyses were conducted on an intention-to-treat basis.</p> <p>Results were reported for all listed outcomes.</p> |
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Risk of bias:

SRs

| Author (year) | RISK OF BIAS | | | | |
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| | Inclusion criteria | Searches | Review Process | Quality assessment | Synthesis |
| Ayers et al. (2007) |  |  |  |  |  |
| Gould et al. (2012) |  |  |  |  |  |
| Hunot et al. (2007) |  |  |  |  |  |
| Thorp et al. (2009) |  |  |  |  |  |

RCTs

| Study | RISK OF BIAS | | | | | |
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| | Random allocation | Allocation concealment | Blinding of participants and personnel | Blinding of outcome assessment | Incomplete outcome data | Selective Reporting |
| Brenes et al. (2012) |  |  |  |  |  |  |

 Low Risk

 High Risk

 Unclear Risk

Search details

| Source | Search strategy | Number of hits | Relevant evidence identified |
|---------------------------|---|----------------|------------------------------|
| SRs and Guidelines | | | |
| NICE | anxiety older adults cbt | 58 | 0 |
| DARE | (CBT) IN DARE WHERE LPD FROM 06/02/2007 TO 15/09/2014 221 Delete 2 (cognit* ADJ2 therap*) IN DARE WHERE LPD FROM 06/02/2007 TO 15/09/2014 709 Delete 3 MeSH DESCRIPTOR Cognitive Therapy EXPLODE ALL TREES 707 Delete 4 #1 OR #2 OR #3 1028 Delete 5 (anxious OR anxiet*) IN DARE WHERE LPD FROM 06/02/2007 TO 15/09/2014 875 Delete 6 MeSH DESCRIPTOR Anxiety EXPLODE ALL TREES 243 Delete 7 MeSH DESCRIPTOR Anxiety Disorders EXPLODE ALL TREES 434 Delete 8 #5 OR #6 OR #7 1224 Delete 9 (old* OR elder* OR pension* OR retire* OR senior* OR geriatric* OR aged OR ageing OR aging) IN DARE WHERE LPD FROM 06/02/2007 TO 15/09/2014 5806 Delete 10 MeSH DESCRIPTOR Aged, 80 and over EXPLODE ALL TREES 2834 Delete 11 MeSH DESCRIPTOR Frail Elderly EXPLODE ALL TREES 77 Delete 12 MeSH DESCRIPTOR Aged EXPLODE ALL TREES 8315 Delete 13 MeSH DESCRIPTOR Retirement EXPLODE ALL TREES 3 Delete 14 MeSH DESCRIPTOR Geriatric Psychiatry EXPLODE ALL TREES 7 Delete 15 MeSH DESCRIPTOR Health Services for the Aged EXPLODE ALL TREES 145 Delete 16 #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 11835 Delete 17 #8 AND #16 293 Delete 18 #4 AND #17 | 102 | 4 |
| Primary studies | | | |
| CENTRAL | #1 2007 or 2008 or 2009 or 2010 or 2011 or 2012 or 2013 or 2014 or 2015 361148 #2 MeSH descriptor: [Anxiety Disorders] explode all trees 4954 | 10 | 1 |

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| | <p>#3 MeSH descriptor: [Cognitive Therapy] explode all trees 5085</p> <p>#4 "cognitive behav*" 7261</p> <p>#5 CBT 2765</p> <p>#6 #3 or #4 or #5 9423</p> <p>#7 #2 and #6 1260</p> <p>#8 #7 and #1 854</p> <p>#9 "older adult" or elder or geriatric 7139</p> <p>#10 MeSH descriptor: [Geriatric Psychiatry] explode all trees 40</p> <p>#11 #9 or #10 7139</p> <p>#12 #8 and #11 16</p> <p>Central only 10</p> | | |
| PsycINFO | <p>1. PsycINFO; exp ANXIETY DISORDERS/; 62987 results.</p> <p>2. PsycINFO; exp COGNITIVE BEHAVIOR THERAPY/; 12512 results.</p> <p>3. PsycINFO; CBT.ti,ab; 8081 results.</p> <p>4. PsycINFO; "cognitive behav*".ti,ab; 28703 results.</p> <p>5. PsycINFO; 2 OR 3 OR 4; 30972 results.</p> <p>6. PsycINFO; 1 AND 5; 5751 results.</p> <p>11. PsycINFO; CLINICAL TRIALS/; 8066 results.</p> <p>12. PsycINFO; random*.ti,ab; 135095 results.</p> <p>13. PsycINFO; groups.ti,ab; 377354 results.</p> <p>14. PsycINFO; (double adj3 blind).ti,ab; 18245 results.</p> <p>15. PsycINFO; (single adj3 blind).ti,ab; 1458 results.</p> <p>16. PsycINFO; EXPERIMENTAL DESIGN/; 9340 results.</p> <p>17. PsycINFO; controlled.ti,ab; 83711 results.</p> <p>18. PsycINFO; (clinical adj3 study).ti,ab; 8183 results.</p> <p>19. PsycINFO; trial.ti,ab; 71017 results.</p> <p>20. PsycINFO; "treatment outcome clinical trial".md; 28168 results.</p> <p>21. PsycINFO; 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20; 585266 results.</p> <p>22. PsycINFO; 6 AND 21; 2008 results.</p> <p>23. PsycINFO; 22 [Limit to: (Age Groups 380 Aged age 65 yrs and older or 390 Very Old age 85 yrs and</p> | 172 | 0 |

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| | older) and Publication Year 2007-2014]; 172 results. | | |
| Embase | <p>7. EMBASE; exp ANXIETY DISORDERS/; 150765 results.</p> <p>8. EMBASE; exp COGNITIVE BEHAVIOR THERAPY/; 34683 results.</p> <p>9. EMBASE; CBT.ti,ab; 7843 results.</p> <p>10. EMBASE; "cognitive behav*".ti,ab; 22262 results.</p> <p>11. EMBASE; 8 OR 9 OR 10; 44049 results.</p> <p>12. EMBASE; 7 AND 11; 11981 results.</p> <p>13. EMBASE; random*.ti,ab; 907780 results.</p> <p>14. EMBASE; factorial*.ti,ab; 23517 results.</p> <p>15. EMBASE; (crossover* OR cross-over*).ti,ab; 70178 results.</p> <p>16. EMBASE; placebo*.ti,ab; 203202 results.</p> <p>17. EMBASE; (doubl* ADJ blind*).ti,ab; 144123 results.</p> <p>18. EMBASE; (singl* ADJ blind*).ti,ab; 14753 results.</p> <p>19. EMBASE; assign*.ti,ab; 243780 results.</p> <p>20. EMBASE; allocat*.ti,ab; 85946 results.</p> <p>21. EMBASE; volunteer*.ti,ab; 178672 results.</p> <p>22. EMBASE; CROSSOVER PROCEDURE/; 40446 results.</p> <p>23. EMBASE; DOUBLE BLIND PROCEDURE/; 115879 results.</p> <p>24. EMBASE; RANDOMIZED CONTROLLED TRIAL/; 352001 results.</p> <p>25. EMBASE; SINGLE BLIND PROCEDURE/; 18953 results.</p> <p>26. EMBASE; 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25; 1442862 results.</p> <p>27. EMBASE; 12 AND 26; 2790 results.</p> <p>28. EMBASE; 27 [Limit to: Publication Year 2007-2014 and (Human Age Groups Aged 65+ years)]; 222 results.</p> | 222 | 0 |
| Medline | <p>7. MEDLINE; exp ANXIETY DISORDERS/; 71335 results.</p> <p>8. MEDLINE; exp COGNITIVE BEHAVIOR THERAPY/; 17516 results.</p> <p>9. MEDLINE; CBT.ti,ab; 5638 results.</p> <p>10. MEDLINE; "cognitive behav*".ti,ab; 16721 results.</p> | 249 | 0 |

| | | | |
|----------------|---|-----------|--|
| | <p>11. MEDLINE; 8 OR 9 OR 10; 26727 results.</p> <p>12. MEDLINE; 7 AND 11; 5015 results.</p> <p>13. MEDLINE; "randomized controlled trial".pt; 399438 results.</p> <p>14. MEDLINE; "controlled clinical trial".pt; 90638 results.</p> <p>15. MEDLINE; randomized.ab; 318530 results.</p> <p>16. MEDLINE; placebo.ab; 163546 results.</p> <p>17. MEDLINE; "drug therapy".fs; 1782347 results.</p> <p>18. MEDLINE; randomly.ab; 228322 results.</p> <p>19. MEDLINE; trial.ab; 332229 results.</p> <p>20. MEDLINE; groups.ab; 1435618 results.</p> <p>21. MEDLINE; 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20; 3523823 results.</p> <p>22. MEDLINE; 12 AND 21; 2309 results.</p> <p>23. MEDLINE; 22 [Limit to: Publication Year 2007-2014 and (Age Groups All Aged 65 and Over or Aged 80 and Over)]; 249 results.</p> | | |
| Summary | NA | NA | |

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