The efficacy of group metacognitive therapy for children (MCT-c) with generalized anxiety disorder: An open trial

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ARTICLE INFO

Keywords:
Generalized anxiety
Metacognitive therapy
Children
Disorder-specific treatment
Efficacy

ABSTRACT

Metacognitive therapy is an effective treatment for anxiety disorders in adults. Studies have demonstrated that the underlying theoretical model is also supported in children. It has therefore been suggested that metacognitive therapy for children may be effective. Our study is an open trial of metacognitive therapy for children with generalized anxiety as their primary disorder. Therapy was provided in groups. Families were interviewed with the Anxiety Disorders Interview Schedule — child/parent versions. They reported on the child’s anxiety levels using the Revised Childrens Anxiety and Depression Scale — child/parent versions. Children reported on metacognitive beliefs using the Metacognitions Questionnaire for Children — 30 item version. Forty-four children aged 7–13 years (50% girls) were enrolled, and one family dropped out during treatment. Fifty percent of the children had received counseling or psychological treatment for their anxiety disorder previously. Following treatment, 86.4% of the children were free of their primary disorder and 72.7% were free of all anxiety disorders, the corresponding figures were 75% and 65.9% at 6-months follow-up. The effect sizes were large for all measures and clinically significant improvements were obtained for 70% of the children at posttest and 77% at follow-up. Our study suggests that metacognitive therapy for children with generalized anxiety disorder may be a highly promising treatment approach.

1. Introduction

Two decades ago, Wells (1995) developed metacognitive therapy (MCT) based on a corresponding metacognitive model (MCM) of psychological disorder. The metacognitive model states that what causes disorders it not the negative content of thoughts, but rather the metacognitive beliefs held by the client. In the case of generalized anxiety disorder (GAD), anxiety is maintained by the client’s positive metacognitive beliefs that engaging in worry may help the client be prepared for negative events in the future and by negative metacognitive beliefs that worry is uncontrollable and dangerous. Furthermore, unhelpful attentional deployment, coping strategies such as worry and thought suppression, and behaviours such as avoidance and reassurance seeking together constitute a cognitive attentional syndrome which maintains the metacognitive beliefs and thereby the anxiety (Wells, 2009). As the effect of the traditional cognitive behavioral therapies (CBT) has shown to be only modest when treating GAD (Wells & Carter, 2001), researchers have begun to investigate the effects of MCT in the treatment of anxiety disorders in adults. The adult literature has shown substantial support for the metacognitive model (for a review see: Wells, 2009) and therapy in treating anxiety disorders (e.g., Kvistedal, 2011; Rees & van Koenveld, 2008; van der Heiden, Muris, & van der Molen, 2012; Wells & Colbear, 2012). Although further studies are warranted before firm conclusions can be drawn, a recent meta-analysis suggested that the effect of MCT may be larger than that of CBT in treating these disorders (between-group Hedges’ g = 0.97; Normann, van Emmerik, & Morina, 2014).

As more than one third of anxious adults aged 32 years report that they had had an anxiety disorder before the age of 15 years (Gregory et al., 2007), it is pivotal that treatments are developed and adapted for the use with children. The need for effective treatments in childhood populations is supported by the fact that anxiety disorders are one of the most common psychiatric disorders in childhood with 12% of 9–11-year olds having fulfilled criteria for an anxiety disorder. This percentage increases to 23% in young adulthood (Copeland, Angold, Shanahan, & Costello, 2014).

The most commonly investigated treatment for childhood anxiety disorders is CBT. CBT is an overall term for different treatments applying standard CBT techniques with a focus on working with the reciprocity of emotions, the content of thoughts and behaviours. The aim
of CBT is to identify the patient’s cognitive distortions in order to reality test them, thus, leading the patient to obtain new skills and challenge irrational thoughts and beliefs by using rational thinking (James, James, Cowdrey, Soler, & Choke, 2013). CBT is well-established for use with children and adolescents. The treatment is generally well-accepted by the children and their families and dropout rates are low. For instance, the Child/Adolescent Anxiety Multimodal Study (CAMS) reported a dropout rate of 4.3% in the CBT alone condition compared to 17.3% in the sertraline alone condition (Piacentini et al., 2014). CBT also has a solid empirical evidence base for the effectiveness of the intervention; a Cochrane review reported that 59% of children who were enrolled in a minimum of 8 weeks of treatment were free of all anxiety disorders following CBT (James et al., 2013). A meta-analysis revealed that the mean effect size of different types of CBT on self-reported anxiety symptoms was 0.74 with a 95% confidence interval of 0.60-0.82 (Ishikawa, Okajima, Matsuoka, & Sakano, 2007). As approximately 40% of the children continue to meet diagnostic criteria for one or more anxiety disorders, there is room for improvement. MCT has proven promising in treatment of adult anxiety, and we suggest further investigation of this treatment in children with anxiety disorders. In this paper, we will focus on MCT for children with GAD. We do this for two reasons. One is that disorder-specific treatment models may be one pathway for gaining larger treatment effects. Another is that MCT for GAD in adults so far is the treatment protocol that has been most thoroughly tested and thus has the strongest evidence base. Furthermore, MCT for GAD has been included in the NHS NICE guidelines for GAD (NICE, 2012).

1.1. The metacognitive model for generalized anxiety disorder

MCT is based on a substantive theory of psychological disorder. The metacognitive model suggests that psychopathology is caused by unhelpful metacognitive beliefs that control the patient’s attention, cognitions and behaviours. Research has shown that patients suffering from GAD hold both positive and negative metacognitive beliefs about worry (e.g., Ruscio & Borkovec, 2004; Wells & Carter, 2001). Positive metacognitive beliefs about worry consist of beliefs that worry may be beneficial and keep the patient from future harm. Believing that worry is beneficial has been found to increase the likelihood that worry will be applied as a coping strategy (Wells, 2009). Although findings are ambiguous, the literature suggests that all adults hold positive metacognitive beliefs to some extent (Cartwright-Hatton & Wells, 1997; Wells & Carter, 2001). However, according to theory, it is the negative metacognitive beliefs that distinguish normal from pathological worry. As such, patients with GAD hold negative metacognitive beliefs about worry as uncontrollable and that worry may be dangerous (Barahmand, 2009; Cartwright-Hatton & Wells, 1997; Wells & Carter, 2001). This association has also been found in community studies (Davis & Valentin, 2000; Spada et al., 2012; Spada, Mohiyeddini, & Wells, 2008). These beliefs play a key role in maintaining the disorder (Wells, 2009) and are core features in the diagnostic criteria of GAD accompanied with at least one physiological symptom as seen in the DSM-5 (American Psychiatric Association, 2013).

1.2. Metacognitive therapy

Therapeutically, MCT for adults targets these core metacognitive beliefs using verbal and behavioral techniques and experiments. These are thoroughly explained in Wells (2009). One very important technique in MCT for GAD is detached mindfulness, which teaches the patient to engage in his/her experiences in a metacognitive mode. Here the patient may notice a negative thought that would normally trigger a worry process, but by using detached mindfulness, the patient does not pay attention to it, but rather continues with his or her business, leaving the thought to itself. In traditional CBT, the patient would learn to identify the negative thoughts and evaluate the probability of these, leading to a cognitive restructuring of the thoughts from catastrophizing to more realistic. MCT differs from CBT by engaging the client in a metacognitive mode of thinking, where negative thoughts are dealt with by choosing not to engage with them rather than starting to analyze them (Wells, 2009). Applying detached mindfulness is one way to challenge the person’s negative metacognitive beliefs about the uncontrollability of worry, as it creates counter-evidence, thus leading the way for the person to develop more adaptive beliefs about worry (Wells, 2009).

1.3. Metacognitions in children

The first step in applying treatment components and techniques as those described above in childhood samples, is to examine if children are capable of performing the cognitive tasks required to engage in the described theory and treatment. Childhood researchers have found support for applying the metacognitive model in children (for a review, see Ellis & Hudson, 2010). Research suggest that the metacognitive development begins in middle childhood and continues through adolescence and into adulthood (Flavell, 1979; Flavell, Green, & Flavell, 2006; Pillow, 2008). Children as early as 3–4 years of age begin to develop an understanding of the possible influence of previous knowledge, emotions, attention focus, beliefs and desires on the mental state (Pillow, 2008). Further, a series of studies found that 6–7 year old children were more likely to comprehend that a person waiting quietly is able to have thoughts and ideas contrary to being empty of thoughts and ideas (Flavell, 1979; Pillow, 2008). This indicates the understanding of thoughts as a stream of consciousness in which children are able to have thoughts about their thoughts. Thus, findings from the developmental literature suggest that children from the age of 6 or 7 years are able to understand and operate at a metacognitive level. Furthermore, several studies of clinical samples of children and adolescents with anxiety disorders have also found overall support for the MCM (Cartwright-Hatton et al., 2004; Esbjørn, Lanfeldt et al., 2015; Smith & Hudson, 2013), although some researchers report ambiguous findings not fully supporting the application of the MCM to children and adolescents (Bacow, May, Brody, & Pincus, 2009).

Overall, the literature suggests that MCT may be feasible with children. None-the-less, only two studies exist that have examined MCT in childhood samples (Esbjørn, Normann, & Reinholdt-Dunne, 2015; Simons, Schneider, & Herpertz-Dahlmann, 2006). The first study to be published, examined the effect of MCT for pediatric OCD (Simons et al., 2006). The authors compared a traditional CBT method, exposure and response prevention, to MCT with five cases in each group and draw the preliminary conclusion that MCT may be a promising alternative to traditional CBT methods. The second study examined an adaptation of MCT from adults to children and provided suggestions for a manual for group based metacognitive therapy for children with GAD (MCT-c; Esbjørn, Normann, & Reinholdt-Dunne., 2015). The study reported results on four children aged 11–12 years. No children dropped out of therapy, and the reliable change index scores indicated clinically significant improvements in three out of the four children. Overall, the results suggest that the adaptation of MCT-c from adults to children was successful. Although previous studies suggested that MCT for children may be a promising supplement to CBT, the evidence does not yet warrant firm conclusions.

The purpose of the present study was therefore to extend previous findings and explore the efficacy of the MCT-c manual (Esbjørn, Normann, & Reinholdt-Dunne, 2015) by conducting an open trial for children with GAD in a larger clinical sample. Based on the adult literature on MCT, and the mentioned case study on MCT-c, we hypothesized that MCT-c would be effective in treating GAD in children.
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