Journal of Affective Disorders 175 (2015) 124–132

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Group metacognitive therapy for repetitive negative thinking in primary and non-primary generalized anxiety disorder: An effectiveness trial

Peter M. McEvoy [a,b,*], David M. Erceg-Hurn [a,c], Rebecca A. Anderson [a,b], Bruce N.C. Campbell [a], Amanda Swan [a], Lisa M. Saulsman [a], Mark Summers [a], Paula R. Nathan [a,c]

[a] Centre for Clinical Interventions, Perth, Australia
[b] School of Psychology and Speech Pathology, Curtin University, GPO Box U1987, Perth, Western Australia 6845, Australia
[c] University of Western Australia, Perth, Australia

ARTICLE INFO

Article history:
Received 30 September 2014
Received in revised form
18 December 2014
Accepted 19 December 2014
Available online 29 December 2014

Keywords:
Metacognitive therapy
Repetitive negative thinking
Generalized anxiety disorder
Worry
Effectiveness

ABSTRACT

Background: Generalized anxiety disorder (GAD) is a common and highly comorbid anxiety disorder characterized by repetitive negative thinking (RNT). Treatment trials tend to exclude individuals with non-primary GAD, despite this being a common presentation in real world clinics. RNT is also associated with multiple emotional disorders, suggesting that it should be targeted regardless of the primary disorder. This study evaluated the acceptability and effectiveness of brief group metacognitive therapy (MCT) for primary or non-primary GAD within a community clinic.
Methods: Patients referred to a specialist community clinic attended six, two-hour weekly sessions plus a one-month follow-up ($N=52$). Measures of metacognitive beliefs, RNT, symptoms, positive and negative affect, and quality of life were completed at the first, last, and follow-up sessions.
Results: Attrition was low and large intent-to-treat effects were observed on most outcomes, particularly for negative metacognitive beliefs and RNT. Treatment gains increased further to follow-up. Benchmarking comparisons demonstrated that outcomes compared favorably to longer disorder-specific protocols for primary GAD.
Limitations: No control group or independent assessment of protocol adherence.
Conclusions: Brief metacognitive therapy is an acceptable and powerful treatment for patients with primary or non-primary GAD.

1. Introduction

Generalized anxiety disorder (GAD) is one of the most common and highly comorbid anxiety disorders (Kessler et al., 2005; McEvoy et al., 2011). Comorbidity with major depressive disorder is particularly high, with estimates up to 67% (Judd et al., 1998). Despite comorbidity being the norm rather than the exception in clinical practice (Brown et al., 2001), most trials of evidence-based treatments restrict clinical samples to individuals with a specific primary disorder. One potential obstacle to the dissemination of evidence-based treatments is the perception that real world samples are not reflected within treatment trials (Barlow et al., 1999). Effectiveness research plays a critical role in demonstrating that efficacious treatments evaluated within research settings are transportable to settings with (a) highly complex and comorbid patients who are referred via clinical routes, (b) clinicians with diverse caseloads, and (c) where strict exclusion criteria are not applied and treatments are not closely monitored (Shadish et al., 2000). Meta-analyses investigating the effectiveness of treatments under real world conditions have supported the proposition that efficacious protocols can be highly effective outside of research trials (Stewart and Chambless, 2009). However, recent evidence suggests that more real world effectiveness trials are needed before clinicians are likely to perceive efficacy trials as being useful for guiding their clinical interventions (Gyani et al., 2014). This study contributes to the effectiveness literature by evaluating a brief group intervention targeting repetitive negative thinking (RNT) in primary and non-primary GAD within a community mental health clinic.

RNT can be defined as cognitive perseveration on negative themes, with worry and rumination being the most commonly studied forms within the GAD and depression literatures, respectively. Worry has

* Corresponding author at: School of Psychology and Speech Pathology, Curtin University, GPO Box U1987, Perth, Western Australia 6845, Australia.
Tel.: +61 8 9266 5110; fax: +61 8 9226 2464.
E-mail address: peter.mcevoy@curtin.edu.au (P.M. McEvoy).

http://dx.doi.org/10.1016/j.jad.2014.12.046
0165-0327/

been defined as "a chain of thoughts and images, negatively affect-laden, and relatively uncontrollable" (Borkovec et al., 1983, p. 10), and rumination has been defined as "behavior and thoughts that focus one's attention on one's depressive symptoms and on the implications of the symptoms" (Nolen-Hoeksema, 1991, p. 569). Wells and Matthews' (1996) self-regulatory executive function (S-REF) model is a metacognitive account of emotional disorders, which suggests that positive beliefs about RNT (e.g., RNT is helpful) motivate an individual to engage more fully in RNT. Once RNT is commenced, negative beliefs about RNT (e.g., RNT is dangerous and uncontrollable) then lead to a range of counterproductive cognitive (e.g., suppression, threat monitoring) and behavioral (e.g., avoidance, alcohol use) changes which, in turn, lead to an escalation of RNT. This escalation of RNT strengthens negative beliefs about the uncontrollability and dangerousness of thoughts and, continuing the cycle, leads individuals to abandon functional attempts to reduce their engagement in RNT and instead to use more extreme and dysfunctional overcontrol strategies. Wells (2013) argues that negative beliefs about RNT have the "…most pervasive and powerful influences in psychological disorder…giving rise to a sense of acute danger, hopelessness, and inefficacy (p. 188–189)." Within the S-REF model, RNT, attentional bias toward threat, and problematic behaviors that exacerbate psychological distress are together referred to as the cognitive affective syndrome (CAS). Whereas more traditional cognitive behavior therapy targets the content of negative automatic thoughts, MCT targets positive and negative metacognitive beliefs that maintain the CAS.

Four MCT treatment trials for primary GAD have demonstrated large reductions in metacognitive beliefs and RNT. Two preliminary studies demonstrated promising effects, but small samples (Ns = 10) raise questions about the generalizability of the findings (Wells et al., 2010; Wells and King, 2006). van der Heiden et al. (2012) conducted a randomized controlled trial (RCT, $N = 126$) for primary GAD and found that 14 sessions of individual MCT was superior to intolerance of uncertainty therapy (IUT) and a delayed treatment control (DT). van der Heiden et al. (2013) subsequently evaluated 14 sessions of group MCT for primary GAD ($N = 33$), but found higher dropout (27% vs. 11%) and poorer outcomes than van der Heiden et al's (2012) trial of individual MCT. The authors concluded that group MCT might be less effective and acceptable than individual MCT, possibly due to there being less time to challenge each individual's idiosyncratic metacognitive beliefs. It is notable that van der Heiden et al. (2013) groups were relatively large (10–14 patients/group), which represents a considerable efficiency over individual treatment. However, the large group sizes may have diluted treatment effects and contributed to the high attrition. The only other group MCT trial included just eight adults with obsessive compulsive disorder (Rees and van Koesveld, 2008), suggesting that more research is required to more fully evaluate the utility of group MCT.

An important question that remains to be answered is whether these treatment effects would generalize to clinical samples with primary or non-primary GAD. The S-REF model, from which MCT derives, is a transdiagnostic theory (Wells and Matthews, 1996). MCT should therefore effectively reduce RNT regardless of the specific content of negative thoughts or primary diagnosis. Indeed, theory and accumulating evidence causally implicate RNT in the maintenance of various emotional disorders (Harvey et al., 2004; McEvoy and Brans, 2013; Nolen-Hoeksema and Watkins, 2011), and there is evidence that MCT is effective for a range of primary emotional disorders in addition to GAD, such as depression (Dammen et al., 2015; Papageorgiou and Wells, 2015; Wells et al., 2012), social anxiety disorder (McEvoy et al., 2009), and obsessive compulsive disorder (Rees and van Koesveld, 2008). Interventions targeting RNT may therefore be effective regardless of whether GAD is primary or not. No previous study has evaluated group-based MCT in a sample with primary or non-primary GAD. Given that comorbidity is the norm in clinical practice (Brown et al., 2001), and it may be impractical in many settings to run diagnosis-specific groups based on primary disorders, demonstrating that group MCT is effective in comorbid mixed-diagnosis populations is important for real world practice.

The aim of this study was to evaluate the acceptability and effectiveness of brief MCT targeting RNT for individuals with GAD, regardless of whether or not GAD was their primary disorder. This study met several criteria for an effectiveness trial, including clinically representative patients (various primary disorders, highly comorbid, severe, referred by health practitioners), therapists (broad caseload, various levels of experience), and services (naturalistic community mental health clinic, Stewart and Chambless, 2009). To optimize the feasibility of running group therapy within community clinics, the treatment protocol in this study was shorter than in previous group and individual MCT trials. The shorter duration was expected to minimize attrition rates and clinician time per patient, which are important considerations within public mental health services where resources are scarce.

The first hypothesis was that brief MCT would be acceptable to patients with primary or non-primary GAD in a community clinic, as evidenced by low attrition. The second hypothesis was that group MCT would be associated with significant reductions in positive and negative metacognitive beliefs, as well as diagnosis-specific (i.e., worry, rumination) and transdiagnostic measures of RNT. The frequency of specific negative automatic thoughts was also expected to reduce as a side effect of targeting metacognitive beliefs. The third hypothesis was that MCT would result in significant improvements in symptoms of anxiety, depression, general psychological distress, higher order psychological dimensions of positive and negative affect, and quality of life. The fourth hypothesis was that brief group MCT would compare favorably to previous treatment trials of primary GAD.

2. Method

2.1. Participants

Patients were referred by general practitioners, psychiatrists, or clinical psychologists to a specialist Australian community mental health clinic for psychological treatment of anxiety disorders and/or depression. A structured diagnostic interview (Mini International Diagnostic Interview, Lecrubier et al., 1997; Sheehan et al., 1998) was used to establish the presence of anxiety and/or depressive disorders. Primary diagnoses were those that patients nominated as most debilitating at the time of assessment. Patients were offered a place in the MCT group if they met criteria for GAD, with the exception of patients with primary social anxiety disorder (SAD) who were referred to a SAD-specific group. Patient flow is illustrated in Fig. 1. Data were collected from 11 consecutive groups conducted between September 2010 and July 2013, with between 3 and 7 patients per group (median = 5). Only patients providing informed written consent for their clinical data to be used for research purposes were included in the analyses.

Demographic information for patients attending at least one treatment session is summarized in Table 1. The duration of the current mental disorder episode exceeded a year for most of the sample ($n = 39$, 75%), with a median duration of three years. A significant minority of the sample had self-harmed, attempted suicide, or spent time as an inpatient at a psychiatric hospital. About two-thirds of patients were taking psychiatric medication ($N = 35$, 67%) for an extended period of time (median 1 year; interquartile range 6 months to 4 years) without responding