Mindfulness-based cognitive therapy for generalised anxiety disorder and health service utilisation among Chinese patients in primary care: a randomised, controlled trial

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KEY MESSAGES

1. Both mindfulness-based cognitive therapy and psycho-education appear to reduce anxiety symptoms in patients with generalised anxiety disorder.
2. Psycho-education may be a better intervention, especially for depressive symptoms and mental health–related quality of life.

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Generalised anxiety disorder (GAD) is one of the most common mental health problems in the primary care or community setting.[1] Medication or cognitive behavioural therapy is the first-line treatment for GAD, but medication is associated with side-effects and costs, and individual cognitive behavioural therapy is expensive and time-consuming. Mindfulness-based cognitive therapy (MBCT) is useful to reduce anxiety symptoms by training present-moment mindful awareness.[2] This study was conducted to compare the effectiveness of MBCT with psycho-education (based on cognitive behavioural therapy principles) and usual care in patients with GAD.[3]

A total of 182 participants aged 21 to 65 years with a principal diagnosis of GAD were randomised to receive 8 weeks of MBCT (n=61), psycho-education (n=61), or usual care (n=60). The MBCT and psycho-education groups were comparable in terms of the course structure and the therapist's contact time and attention. Participants who received usual care had unrestricted access to medical services; they were on a waiting list for MBCT and did not receive any intervention until the end of their study period (3 months after intervention). Validated scales were used to assess psychological symptoms including anxiety, worry, and depressive symptoms, and quality of care at baseline, end of intervention, and 3 months after the intervention. Participants in the MBCT and psycho-education groups were further assessed at 6 and 9 months after intervention.

At baseline, the three groups were comparable in terms of demographic and socio-economic factors as well as outcome measures. Immediately and 3 months after intervention, both MBCT and psycho-education groups demonstrated a significant reduction in anxiety score, compared with the usual care group. Anxiety score in the MBCT and psycho-education groups was comparable at any follow-up. For worry score, significant relative change was noted between the psycho-education and usual care groups at 3 months after intervention only. Significant improvement over time was noted in the psycho-education group for depressive symptoms and mental components of the health-related quality of life scale, compared with the usual care group. Nonetheless, there was no significant difference between the MBCT and usual care groups or between the MBCT and psycho-education groups. At 6 and 9 months after intervention, both MBCT and psycho-education groups showed significant improvement in outcome measures, but the two groups did not differ significantly.

Both MBCT and psycho-education were better than usual care in terms of reduced anxiety symptoms among patients with GAD. Psycho-education may have additional beneficial effects of improving worry, depressive symptoms, and mental health–related quality of life. Further studies are needed to explore whether any patient characteristics or populations are more suitable for MBCT or psycho-education. Studies of patients with recurrent depression show that those with ≥3 episodes of depression benefit most from MBCT.

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