NKR 43 Angst PICO 2 CBT vs anden psykoterapi

Review information

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What's new

Date / Event	Description

History

Date / Event	Description

Characteristics of studies

Characteristics of included studies

Ginsburg 2012

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention (CBT) ● *Number with primary social phobia (n, %)*: 5, 29.4 % ● *Number with primary generalized anxiety disorder (n, %)*: 6, 35.3 % ● *Number with primary separation anxiety disorder (n, %)*: 4, 23.5% ● *Number with other types of primary anxiety disorders (n, %)*: 2, 11.8% ● *Age in years (mean, SD)*: 11.12 (2.75) ● *Age range and proportion of children and adolescents*: 7-17 (% adolescents not reported) Control ● *Number with primary social phobia (n, %)*: 3, 20% ● *Number with primary generalized anxiety disorder (n, %)*: 8, 53.3 % ● *Number with primary separation anxiety disorder (n, %)*: 4, 26.7% ● *Number with other types of primary anxiety disorders (n, %)*: 0,0 % ● *Age in years (mean, SD)*: 9.33 (2.06) ● *Age range and proportion of children and adolescents*: 7-17 (% adolescents not reported) **Included criteria:** Inclusion criteria for children were: (1)between the ages of 7 and 17, (2) presence of one of the following anxiety disorders:generalized (GAD), social (SOP), separation (SAD), specific (SP), or anxiety not otherwisespecified (ANOS),

	Excluded criteria: exclusion criteria for children were: (3) no medical or psychiatric conditions (e.g., suicidality) contraindicatingstudy intervention and (4) not currently receiving treatment for anxiety reduction.Children were also excluded if they failed a previous trial of CBT for anxiety within theprevious 2 years judged by at least 10 hierarchy-based CBT sessions, including homeworkassignments and exposure exercises. Children were included if they were on stable medicationfor another psychiatric disorder (e.g., Ritalin for attention deficit/hyperactive disorder). **Pretreatment:** T-tests for continuous variables and Chi-square analyses for categorical variables wereused to examine differences on demographic and clinical variables between the twointervention groups at baseline (see Table 1). Children in CBT were significantly olderthan the children in the UC (mean age in years = 11.12 vs. 9.33; p\.05). No groupdifferences were found on any other demographic or clinical variables, including childgender, race, parent marital status, family income, comorbid diagnoses, parent symptomlevel, parenting stress level, child urban hassles level, or primary diagnoses (all ps[.05).
Interventions	**Intervention Characteristics** Intervention (CBT) ● *Description of type of intervention/control*: The CBT used in this study was adapted to a modular format based on empirically supportedanxiety CBT manuals (Kendall 1990; Kendall 1994; Silverman et al. 1999a, b).A modular approach, which has been used in previous studies (Chorpita et al. 2004; Weiszet al. 2011) was selected because it is more clinician-friendly and flexible (i.e., therapistsemphasize modules that are most relevant for each child) than manualized treatments.Thus, it was expected to enhance the utility and adoption of the intervention. The modulesincluded: psychoeducation, exposure, rewards, cognitive restructuring, problem solving,relaxation, and relapse prevention. Parent modules (e.g., psychoeducation, rewards,exposure) were also included. Each therapist was given a therapy box which includedhandouts and other materials to use in the therapy with children. There were a total of eightmodules designed to be delivered over 12 weeks. With the exception of psychoeducationand exposure, module inclusion and sequencing was not predetermined, thereby permittingthe treatment to be tailored to each youth's needs ● *Length of intervention/control (weeks and sessions)*: 12 weeks. Up to 13 sessions ● *Length of follow-up (in months)*: 1 month - i.e., not used in this guideline as too short a timeframe Control ● *Description of type of intervention/control*: This condition focused on providing children therapeutic interventions that did not includeCBT strategies. Therapy represented usual care for that clinician (e.g., art, play, or supportivetherapy). Therapists were provided with instructions about how to avoid includingcomponents of CBT such as directly reinforcing approach behavior via a hierarchy ordirectly challenging fear-evoking cognitions. Therapists were also provided with anattention control manual to use if they desired.

	● *Length of intervention/control (weeks and sessions)*: ● *Length of follow-up (in months)*:
Outcomes	*Remission of primary anxiety diagnosis (EoT)* ● **Outcome type**: DichotomousOutcome ● **Direction**: Higher is better ● **Data value**: Endpoint *Youth reported anxiety symptoms (EoT)* ● **Outcome type**: ContinuousOutcome ● **Scale**: SCARED-R ● **Range**: 0-82 ● **Direction**: Lower is better ● **Data value**: Endpoint *Parent reported anxiety symptoms (EoT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: SCARED-R ● **Range**: 0-82 ● **Unit of measure**: Points ● **Direction**: Lower is better ● **Data value**: Endpoint *Remission of primary anxiety diagnosis (longest FU, at least 3 months)* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Not reported ● **Direction**: Higher is better ● **Data value**: Endpoint ● **Notes**: Only a 1 month follow-up. This guideline requires a follow-up of at least 3 months to be included *Youth reported anxiety symptoms (longest FU, at least 3 months)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Not reported ● **Direction**: Lower is better

- **Data value**: Endpoint
- **Notes**: Only a 1 month follow-up. This guideline requires a follow-up of at least 3 months to be included

Parent reported anxiety symptoms (longest FU, at least 3 months)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Not reported
- **Direction**: Lower is better
- **Data value**: Endpoint
- **Notes**: Only a 1 month follow-up. This guideline requires a follow-up of at least 3 months to be included

Youth reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Not reported
- **Direction**: Higher is better
- **Data value**: Endpoint

Observer reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Fully reported
- **Scale**: CGI-S
- **Range**: 1-7
- **Unit of measure**: Points
- **Direction**: Lower is better
- **Data value**: Endpoint

Combined youth and observer reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Fully reported
- **Scale**: ADIS-C/P
- **Range**: 0-8
- **Unit of measure**: Points
- **Direction**: Lower is better
- **Data value**: Endpoint

Number that discontinued treatment or control (EoT)

- **Outcome type**: DichotomousOutcome

	● **Direction**: Lower is better ● **Data value**: Endpoint
Identification	**Sponsorship source:** This pilot study was supported by a grant from the National Institute of Mental Health(MH90027497) awarded to Golda S. Ginsburg, Ph.D. During the preparation of this manuscript, Dr. Beckerwas supported by the National Institute of Mental Health (T32 MH 18834) **Country:** USA **Setting:** **Comments:** **Authors name:** Ginsburg et al 2012 **Institution:** Division of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences, The Johns Hopkins University School of Medicine **Email:** e-mail: gginsbu@jhmi.edu **Address:** Division of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences,The Johns Hopkins University School of Medicine, 550 North Broadway/Suite 202, Baltimore,MD 21205, USA
Notes	*Nkr 43 Angst* on 02/05/2016 20:22 **Select** Seems relevant:Usual Care (UC)This condition focused on providing children therapeutic interventions that did not includeCBT strategies. Therapy represented usual care for that clinician (e.g., art, play, or supportivetherapy). Therapists were provided with instructions about how to avoid includingcomponents of CBT such as directly reinforcing approach behavior via a hierarchy ordirectly challenging fear-evoking cognitions. Therapists were also provided with anattention control manual to use if they desired. *Nkr 43 Angst* on 06/05/2016 20:50 **Included** This study is partly extracted in James et al 2015. The following data is extracted in the Cochrane review (analysis 3): Remission EoT, child anxiety symp EoT, Lost to follow-up. NOTICE THAT THE FU IN THIS STUDY IS ONLY 1 MONTH, AND SHOULD THUS NOT BE EXTRACTED SINCE OUR GUIDELINE REQUIRES AT LEATS 3 MONTHS FU *Nkr 43 Angst* on 06/05/2016 23:58 **Outcomes** The following data is extracted in the Cochrane review (analysis 3): Remission EoT, child anxiety symp EoT, Lost to follow-up.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Randomization was conducted using the website randomization.com and separate randomization plans were created for each clinician."
Allocation concealment	Unclear risk	Judgement Comment: Not Described
Blinding of participants and personnel	High risk	Judgement Comment: Not blinded
Blinding of outcome assessors	High risk	
Incomplete outcome data	Low risk	Judgement Comment: 3 out of 32 dropped out at post treatment
Selective outcome reporting	Low risk	Judgement Comment: None detected
Other sources of bias	Low risk	Judgement Comment: None detected

Herbert 2009

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group **Open Label:** **Cluster RCT:**
Participants	**Baseline Characteristics** Intervention (CBT) ● *Number with primary social phobia (n, %)*: 23, 100% ● *Number with primary generalized anxiety disorder (n, %)*: 0, 0% ● *Number with primary separation anxiety disorder (n, %)*: 0, 0% ● *Number with other types of primary anxiety disorders (n, %)*: 0, 0% ● *Age in years (mean, SD)*: 14.6 (2.8) ● *Age range and proportion of children and adolescents*: 12-17 (100% adolescents)

	Control ● *Number with primary social phobia (n, %)*: 26, 100% ● *Number with primary generalized anxiety disorder (n, %)*: 0, 0% ● *Number with primary separation anxiety disorder (n, %)*: 0, 0% ● *Number with other types of primary anxiety disorders (n, %)*: 0, 0% ● *Age in years (mean, SD)*: 15.1 (1.4) ● *Age range and proportion of children and adolescents*: 12-17 (100% adolescents) **Included criteria:** Inclusioncriteria included age between 12 and 17, literacy in English, anda DSM-IV diagnosis of primary SAD, generalized subtype. **Excluded criteria:** The exclusion criteria included a history of mentalretardation, pervasive developmental disorder, organic mentaldisorder, bipolar disorder, a psychotic disorder, or borderline orschizotypal personality disorder. Other Axis I disorders such asgeneralized anxiety disorder, major depression, or dysthymia wereacceptable as long as SAD was judged to be clearly primary to andof greater severity than the secondary diagnosis.Additional exclusion criteria were the presence of imminentsuicidal risk (as assessed by the diagnostician using the ADIS-DSMIV:Cand the Beck Depression Inventory), substance abuse ordependence within the past year, or a previous trial of behavior orcognitive behavior therapy for SAD. **Pretreatment:** ANOVAs and post hoc tests revealed no pre-treatment groupdifferences on study measures, age, grade level, or number ofsessions attended (ps > .05) (see Table 1). Chi square analysesrevealed no significant differences between the groups on any ofthe categorical variables, including gender, race/ethnicity, parentalmarriage status
Interventions	**Intervention Characteristics** Intervention (CBT) ● *Description of type of intervention/control*: The G-CBT group met for 2-h sessions each week and were coledby 2 therapists. Groups ranged in size from 4 to 6 patients. Themajor treatment components of G-CBT included psychoeducation,breathing retraining, cognitive restructuring, simulated and in vivoexposure to phobic stimuli, and social skills training. The overallformat of the group and the exposure and cognitive restructuringcomponents were derived largely from the treatment programdeveloped by Heimberg (1991) and Heimberg and Becker (2002)and was similar to the application of Heimberg's protocol toadolescents described by Albano (1995). ● *Length of intervention/control (weeks and sessions)*: 12 weeks and 12 sessions ● *Length of follow-up (in months)*: 6 months Control ● *Description of type of intervention/control*: Psychoeducational-Supportive Therapy (PST)Like those in the G-CBT condition, participants in the PST groupconditions met for 2-h sessions and were co-led by two therapists.PST

	groups were comprised of 4 to 6 participants. The PST programwas based upon the protocol utilized by Heimberg et al. (1990) andHeimberg et al. (1993). The PST program included discussions eachsession around various topics relevant to SAD. Therapists offeredsupport but did not provide specific advice, teach skills, problemsolve,or assign exposure exercises ● *Length of intervention/control (weeks and sessions)*: ● *Length of follow-up (in months)*:
Outcomes	*Remission of primary anxiety diagnosis (EoT)* ● **Outcome type**: DichotomousOutcome *Youth reported anxiety symptoms (EoT)* ● **Outcome type**: ContinuousOutcome *Parent reported anxiety symptoms (EoT)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: SAS-P ● **Range**: 18-90 ● **Unit of measure**: Points ● **Direction**: Lower is better ● **Data value**: Endpoint *Remission of primary anxiety diagnosis (longest FU, at least 3 months)* ● **Outcome type**: DichotomousOutcome ● **Reporting**: Fully reported ● **Direction**: Higher is better ● **Data value**: Endpoint *Youth reported anxiety symptoms (longest FU, at least 3 months)* ● **Outcome type**: ContinuousOutcome ● **Reporting**: Fully reported ● **Scale**: SPAI-C ● **Range**: 0-52 ● **Unit of measure**: Points ● **Direction**: Lower is better

- **Data value**: Endpoint

Parent reported anxiety symptoms (longest FU, at least 3 months)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Fully reported
- **Scale**: SAS-P
- **Range**: 18-90
- **Unit of measure**: Points
- **Direction**: Lower is better
- **Data value**: Endpoint

Youth reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Fully reported
- **Scale**: Self rated performance
- **Range**: 1-5
- **Unit of measure**: Points
- **Direction**: Higher is better
- **Data value**: Endpoint

Observer reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Fully reported
- **Scale**: CGI-S
- **Range**: 1-7
- **Unit of measure**: Points
- **Direction**: Lower is better
- **Data value**: Endpoint

Combined youth and observer reported functioning (EoT)

- **Outcome type**: ContinuousOutcome
- **Reporting**: Not reported

Number that discontinued treatment or control (EoT)

- **Outcome type**: DichotomousOutcome

Identification	**Sponsorship source:** This study was supported by National Institute of Mental Healthgrant R01 MH052232 awarded to Dr. Herbert **Country:** USA **Setting:** **Comments:** **Authors name:** Herbert 2009 **Institution:** **Email:** james.herbert@drexel.edu **Address:** Department of Psychology, Drexel University, MailStop 988, 245 N. 15th Street, Philadelphia, PA 19102-1192, USA.
Notes	*Nkr 43 Angst* on 02/05/2016 20:29 **Select** The comparator is based on at protocol, but I'm uncertain if it can be considered a form of therapy:The PST programwas based upon the protocol utilized by Heimberg et al. (1990) andHeimberg et al. (1993). The PST program included discussions eachsession around various topics relevant to SAD. Therapists offeredsupport but did not provide specific advice, teach skills, problemsolve,or assign exposure exercises *Nkr 43 Angst* on 02/05/2016 20:30 **Select** This study is partly extracted in James et al., 2015. The following data has already been extracted in the Cochrane review (analysis 2): Remission EoT, Child anxiety symp EoT, Lost to follow-up. *Nkr 43 Angst* on 07/05/2016 00:22 **Included** The comparison is between group CBT and group PST *Nkr 43 Angst* on 07/05/2016 00:31 **Outcomes** The following data has already been extracted in the Cochrane review (analysis 2): Remission EoT, Child anxiety symp EoT, Lost to follow-up.

Risk of bias table

Bias	Authors' judgement	Support for judgement
Sequence Generation	Low risk	Quote: "Once individuals were enrolled into the study, they were randomly assigned to one of three treatment conditions (see below for description of conditions) using a block design with block sizes of 6." Judgement Comment: No details but likely ok
Allocation concealment	Unclear risk	Judgement Comment: Not described
Blinding of participants and personnel	High risk	Judgement Comment: Not blinded
Blinding of outcome assessors	Low risk	Quote: "Trained interviewers who conducted the outcome assessments were blind to group assignment and assessment occasion. In addition, observers who provided ratings of various social performance indices derived from the behavioral tasks were likewise blind to group assignment and assessment occasion."
Incomplete outcome data	High risk	Judgement Comment: High attrition rate between 17% to 27%
Selective outcome reporting	Low risk	Judgement Comment: None detected
Other sources of bias	Low risk	Judgement Comment: None detected

Footnotes

Characteristics of excluded studies

Barrington 2005

Reason for exclusion	Wrong patient population

Bogels 2014

Reason for exclusion	Adult population

Cobham 2012

Reason for exclusion	Wrong comparator

Garcia Lopez 2006

Reason for exclusion	Wrong comparator

Ginsburg 2002

Reason for exclusion	Wrong comparator

Hudson 2009

Reason for exclusion	Wrong comparator

Kendall 2008

Reason for exclusion	Wrong comparator

Kendall 2009

Reason for exclusion	Wrong study design

MasiaWarner 2007

Reason for exclusion	Wrong comparator

Muris 2002

Reason for exclusion	Wrong comparator

Reaven 2012

Reason for exclusion	Wrong patient population

Sung 2011

Reason for exclusion	Wrong patient population

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

Summary of findings tables

Additional tables

References to studies

Included studies

Ginsburg 2012

Ginsburg,G. S.; Becker,K. D.; Drazdowski,T. K.; Tein,J. Y.. Treating Anxiety Disorders in Inner City Schools: Results from a Pilot Randomized Controlled Trial Comparing CBT and Usual Care. Child & youth care forum 2012;41(1):1-19. [DOI: 10.1007/s10566-011-9156-4 [doi]]

Herbert 2009

Herbert,J. D.; Gaudiano,B. A.; Rheingold,A. A.; Moitra,E.; Myers,V. H.; Dalrymple,K. L.; Brandsma,L. L.. Cognitive behavior therapy for generalized social anxiety disorder in adolescents: a randomized controlled trial. Journal of anxiety disorders 2009;23(2):167-177. [DOI: 10.1016/j.janxdis.2008.06.004 [doi]]

Excluded studies

Barrington 2005

Barrington,J.; Prior,M.; Richardson,M.; Allen,K.. Effectiveness of CBT versus standard treatment for childhood anxiety disorders in a community clinic setting. Behaviour Change 2005;22(1):29-43. [DOI:]

Bogels 2014

Bogels,S. M.; Wijts,P.; Oort,F. J.; Sallaerts,S. J.. Psychodynamic psychotherapy versus cognitive behavior therapy for social anxiety disorder: an efficacy and partial effectiveness trial. Depression and anxiety 2014;31(5):363-373. [DOI: 10.1002/da.22246 [doi]]

Cobham 2012

Cobham,V. E.. Do anxiety-disordered children need to come into the clinic for efficacious treatment? Journal of consulting and clinical psychology 2012;80(3):465-476. [DOI: 10.1037/a0028205 [doi]]

Garcia Lopez 2006

Garcia-Lopez,L. J.; Olivares,J.; Beidel,D.; Albano,A. M.; Turner,S.; Rosa,A. I.. Efficacy of three treatment protocols for adolescents with social anxiety disorder: a 5-year follow-up assessment. Journal of anxiety disorders 2006;20(2):175-191. [DOI: S0887-6185(05)00025-3 [pii]]

Ginsburg 2002

Ginsburg,G. S.; Drake,K. L.. School-based treatment for anxious african-american adolescents: a controlled pilot study. Journal of the American Academy of Child and Adolescent Psychiatry 2002;41(7):768-775. [DOI: S0890-8567(09)61042-X [pii]]

Hudson 2009

Hudson,J. L.; Rapee,R. M.; Deveney,C.; Schniering,C. A.; Lyneham,H. J.; Bovopoulos,N.. Cognitive-behavioral treatment versus an active control for children and adolescents with anxiety disorders: a randomized trial. Journal of the American Academy of Child and Adolescent Psychiatry 2009;48(5):533-544. [DOI: 10.1097/CHI.0b013e31819c2401 [doi]]

Kendall 2008

Kendall,P. C.; Hudson,J. L.; Gosch,E.; Flannery-Schroeder,E.; Suveg,C.. Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. Journal of consulting and clinical psychology 2008;76(2):282-297. [DOI: 10.1037/0022-006X.76.2.282 [doi]]

Kendall 2009

Kendall,P. C.; Comer,J. S.; Marker,C. D.; Creed,T. A.; Puliafico,A. C.; Hughes,A. A.; Martin,E. D.; Suveg,C.; Hudson,J.. In-session exposure tasks and therapeutic alliance across the treatment of childhood anxiety disorders. Journal of consulting and clinical psychology 2009;77(3):517-525. [DOI: 10.1037/a0013686 [doi]]

MasiaWarner 2007

Masia Warner,C.; Fisher,P. H.; Shrout,P. E.; Rathor,S.; Klein,R. G.. Treating adolescents with social anxiety disorder in school: an attention control trial. Journal of child psychology and psychiatry, and allied disciplines 2007;48(7):676-686. [DOI: JCPP1737 [pii]]

Muris 2002

Muris,P.; Meesters,C.; van Melick,M.. Treatment of childhood anxiety disorders: a preliminary comparison between cognitive-behavioral group therapy and a psychological placebo intervention. Journal of Behavior Therapy and Experimental Psychiatry 2002;33(3-4):143-158. [DOI: S0005791602000253 [pii]]

Reaven 2012

Reaven,J.; Blakeley-Smith,A.; Culhane-Shelburne,K.; Hepburn,S.. Group cognitive behavior therapy for children with high-functioning autism spectrum disorders and anxiety: a randomized trial. Journal of child psychology and psychiatry, and allied disciplines 2012;53(4):410-419. [DOI:]

Sung 2011

Sung,M.; Ooi,Y. P.; Goh,T. J.; Pathy,P.; Fung,D. S.; Ang,R. P.; Chua,A.; Lam,C. M.. Effects of cognitive-behavioral therapy on anxiety in children with autism spectrum disorders: a randomized controlled trial. Child psychiatry and human development 2011;42(6):634-649. [DOI: 10.1007/s10578-011-0238-1 [doi]]

Studies awaiting classification

Ongoing studies

Other references

Additional references

Other published versions of this review

Data and analyses

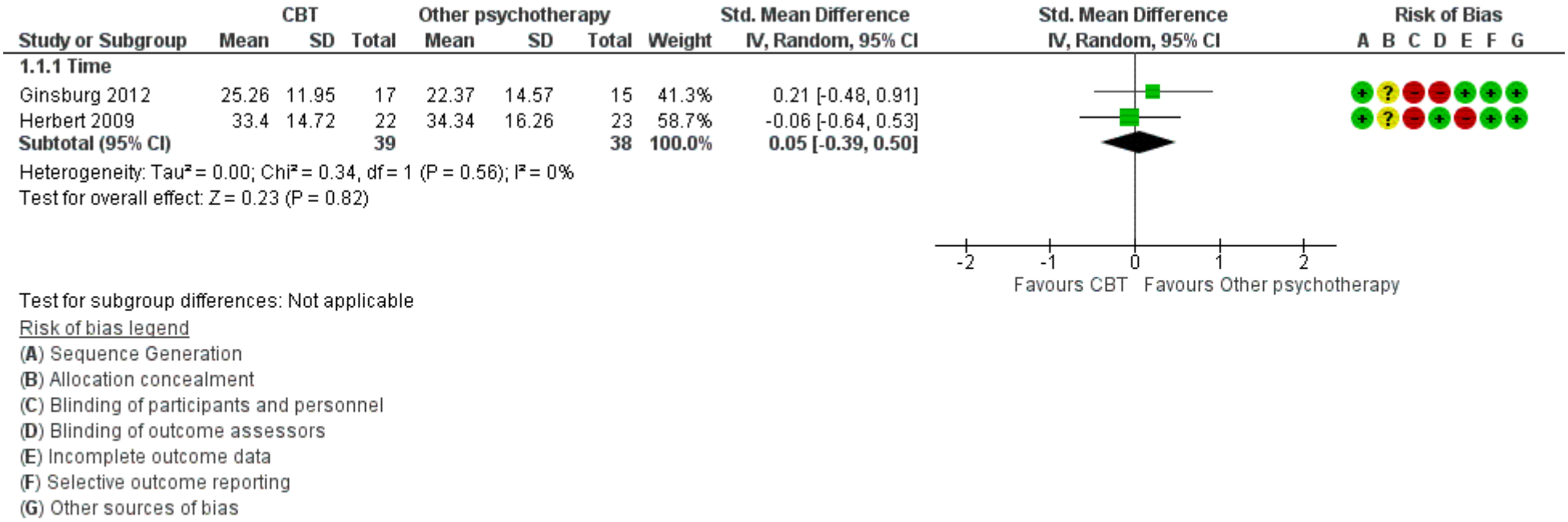
1 CBT vs other forms of psychotherapy

Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Youth reported anxiety symptoms (EoT)	2		Std. Mean Difference (IV, Random, 95% CI)	Subtotals only
1.1.1 Time	2	77	Std. Mean Difference (IV, Random, 95% CI)	0.05 [-0.39, 0.50]
1.2 Parent reported anxiety symptoms (EoT)	2		Std. Mean Difference (IV, Random, 95% CI)	Subtotals only
1.2.1 Time	2	77	Std. Mean Difference (IV, Random, 95% CI)	0.16 [-0.29, 0.61]
1.3 Youth reported anxiety symptoms (longest FU, at least 3 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.3.1 Time	1	45	Mean Difference (IV, Fixed, 95% CI)	-5.55 [-14.80, 3.70]
1.4 Parent reported anxiety symptoms (longest FU, at least 3 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.4.1 Time	1	45	Mean Difference (IV, Fixed, 95% CI)	14.08 [6.16, 22.00]
1.5 Youth reported functioning (EoT)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.5.1 Time	1	45	Mean Difference (IV, Fixed, 95% CI)	0.52 [0.07, 0.97]
1.6 Observer reported functioning (EoT)	2		Mean Difference (IV, Random, 95% CI)	Subtotals only
1.6.1 Time	2	77	Mean Difference (IV, Random, 95% CI)	0.30 [-0.56, 1.16]
1.7 Combined youth and observer reported functioning (EoT)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.7.1 Time	1	32	Mean Difference (IV, Fixed, 95% CI)	0.44 [-0.05, 0.93]

1.8 Remission of primary anxiety diagnosis (EoT)	2		Risk Ratio (IV, Random, 95% CI)	Subtotals only
1.8.1 Time	2	67	Risk Ratio (IV, Random, 95% CI)	0.75 [0.32, 1.76]
1.9 Remission of primary anxiety diagnosis (longest FU, at least 3 months)	1		Risk Ratio (IV, Fixed, 95% CI)	Subtotals only
1.9.1 Time	1	28	Risk Ratio (IV, Fixed, 95% CI)	4.04 [1.01, 16.13]
1.10 Number that discontinued treatment or control (EoT)	2		Risk Ratio (IV, Fixed, 95% CI)	Subtotals only
1.10.1 Time	2	79	Risk Ratio (IV, Fixed, 95% CI)	0.95 [0.39, 2.36]

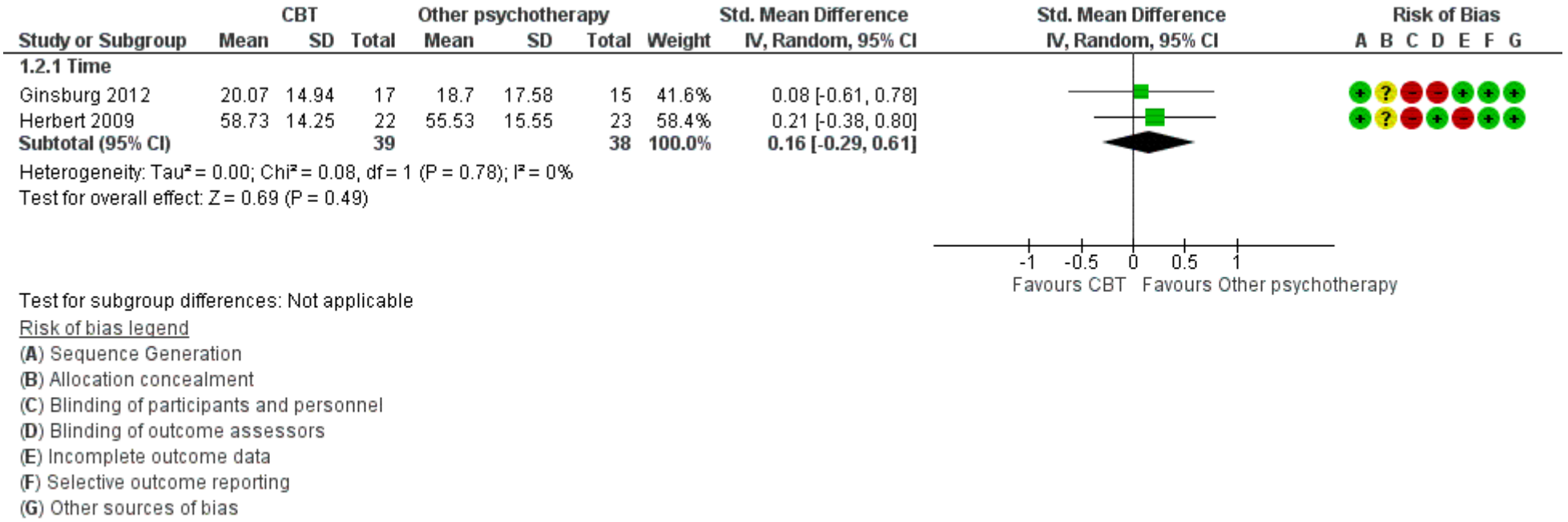
Figures

Figure 1 (Analysis 1.1)



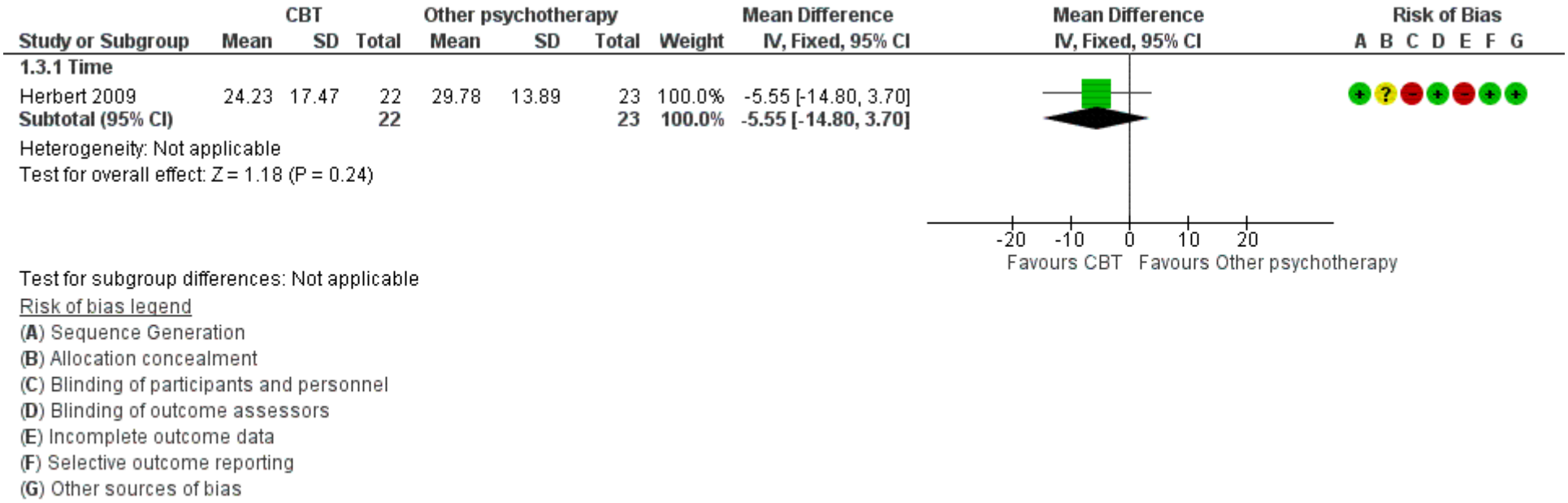
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.1 Youth reported anxiety symptoms (EoT).

Figure 2 (Analysis 1.2)



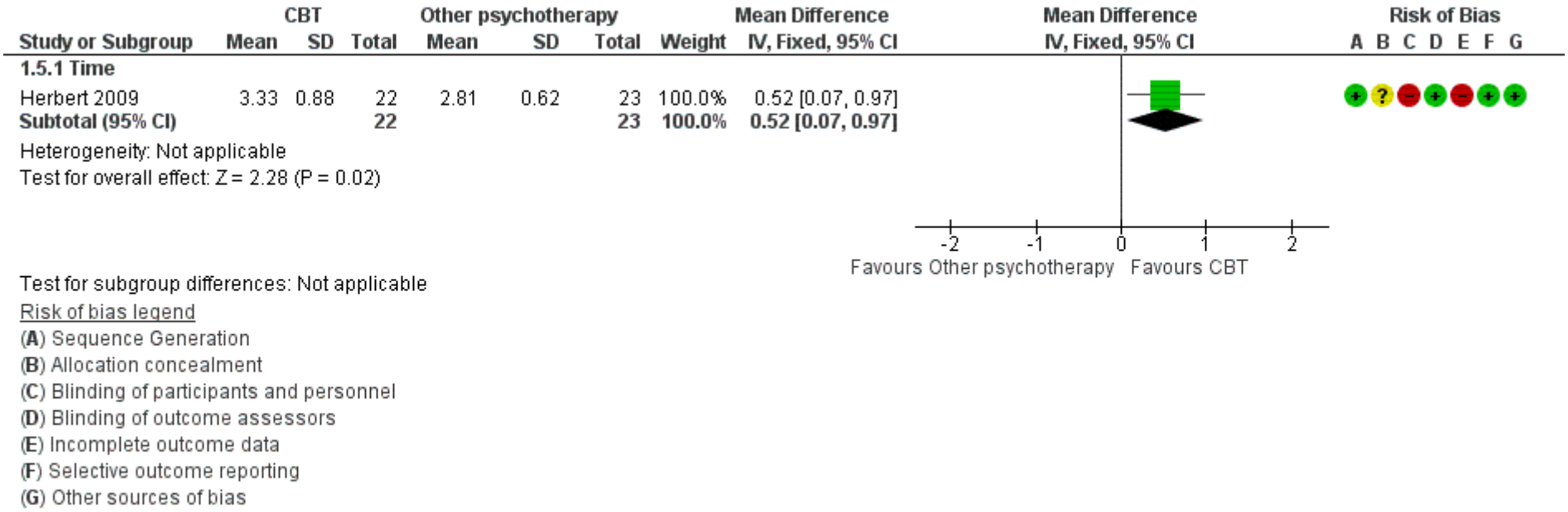
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.2 Parent reported anxiety symptoms (EoT).

Figure 3 (Analysis 1.3)



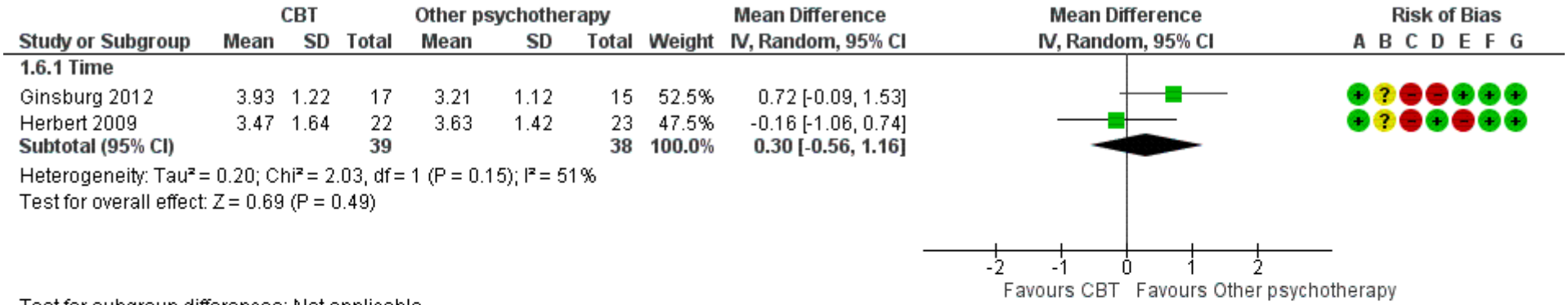
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.3 Youth reported anxiety symptoms (longest FU, at least 3 months).

Figure 4 (Analysis 1.5)



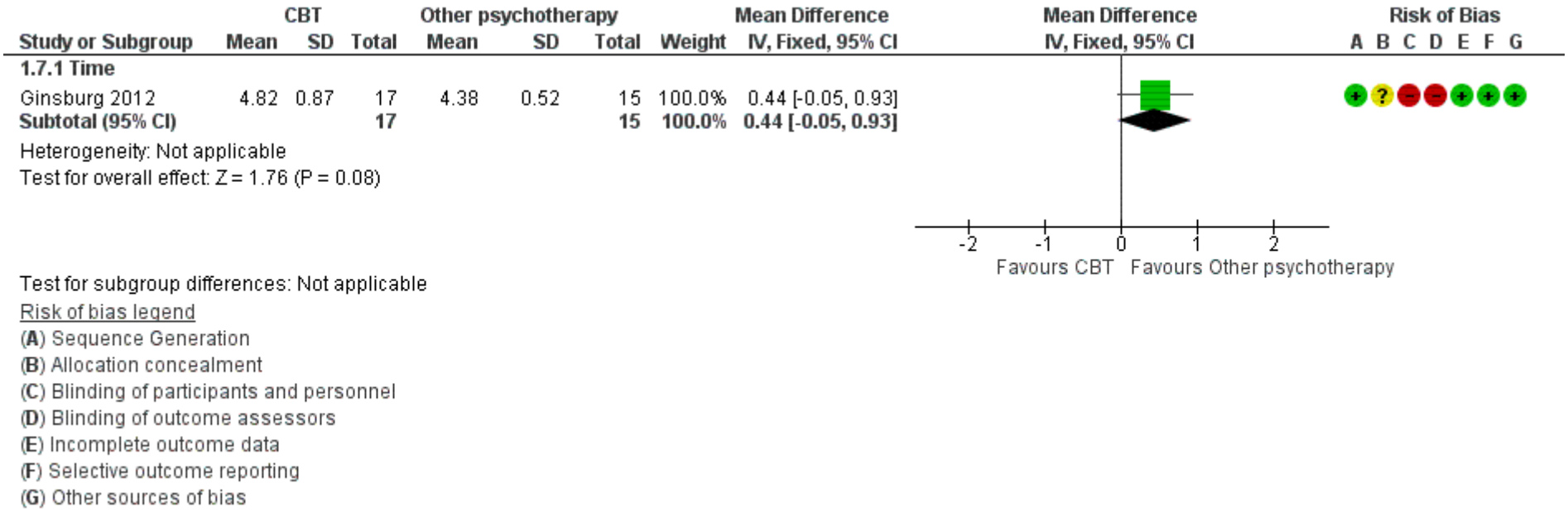
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.5 Youth reported functioning (EoT).

Figure 5 (Analysis 1.6)



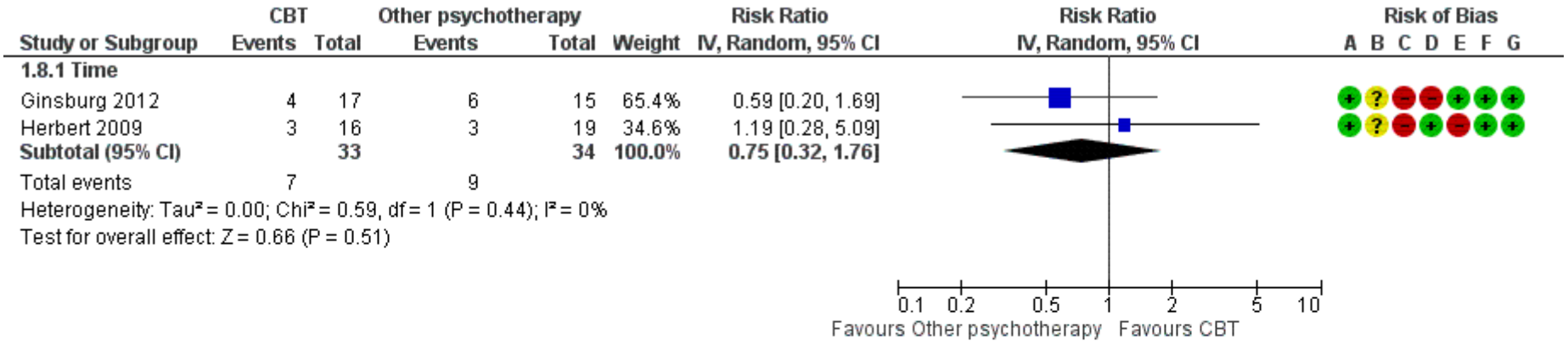
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.6 Observer reported functioning (EoT).

Figure 6 (Analysis 1.7)



Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.7 Combined youth and observer reported functioning (EoT).

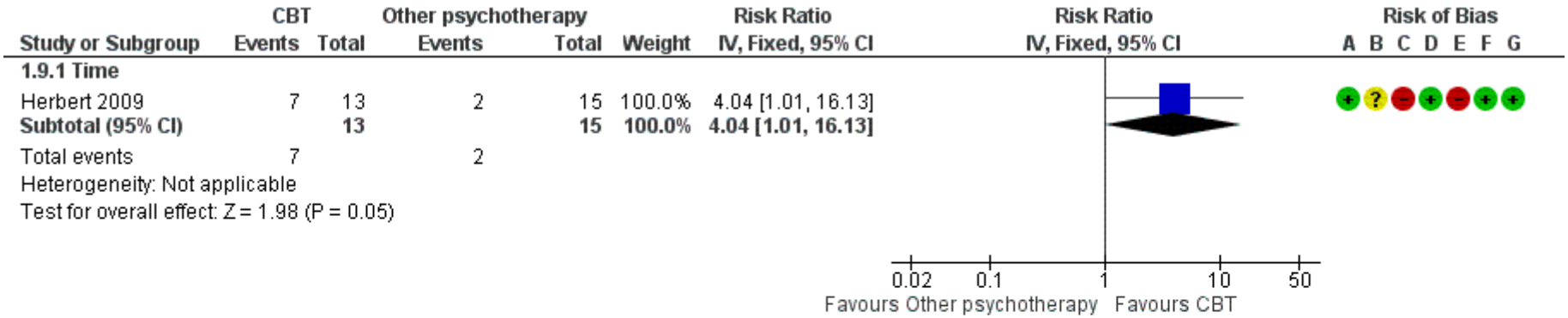
Figure 7 (Analysis 1.8)



Risk of bias legend
(A) Sequence Generation
(B) Allocation concealment
(C) Blinding of participants and personnel
(D) Blinding of outcome assessors
(E) Incomplete outcome data
(F) Selective outcome reporting
(G) Other sources of bias

Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.8 Remission of primary anxiety diagnosis (EoT).

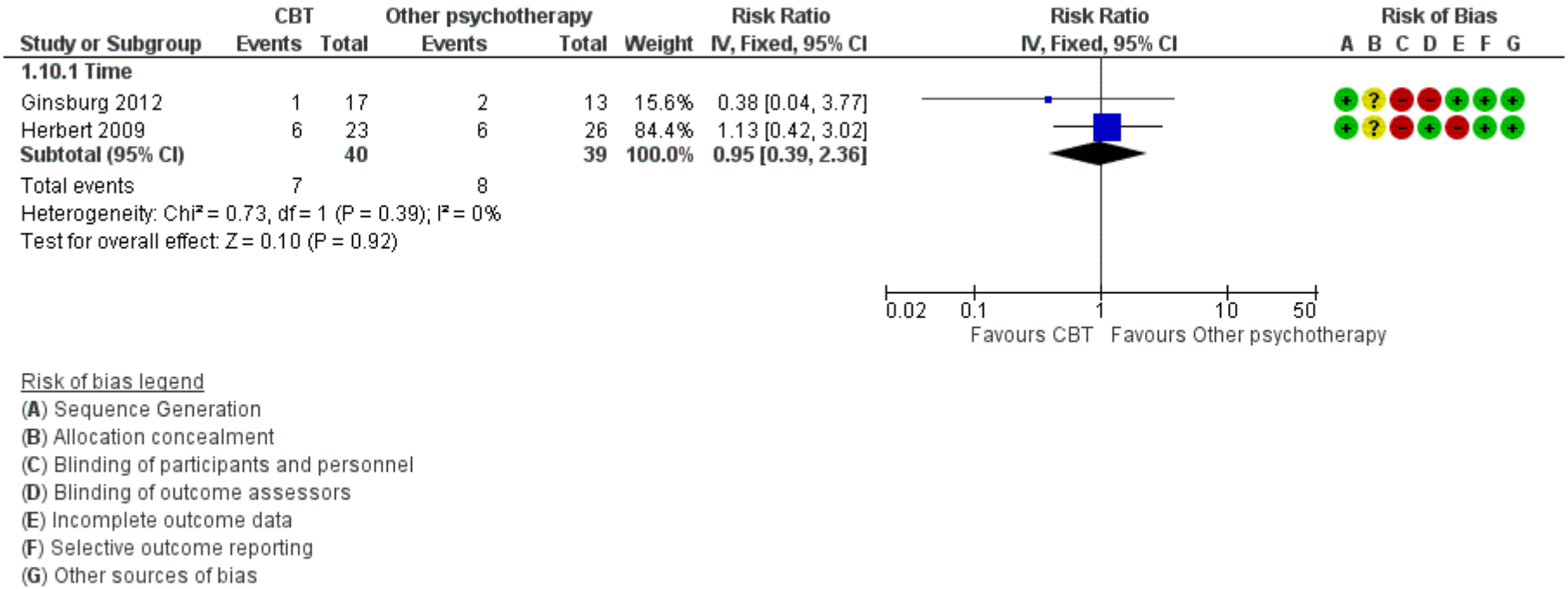
Figure 8 (Analysis 1.9)



Risk of bias legend
(**A**) Sequence Generation
(**B**) Allocation concealment
(**C**) Blinding of participants and personnel
(**D**) Blinding of outcome assessors
(**E**) Incomplete outcome data
(**F**) Selective outcome reporting
(**G**) Other sources of bias

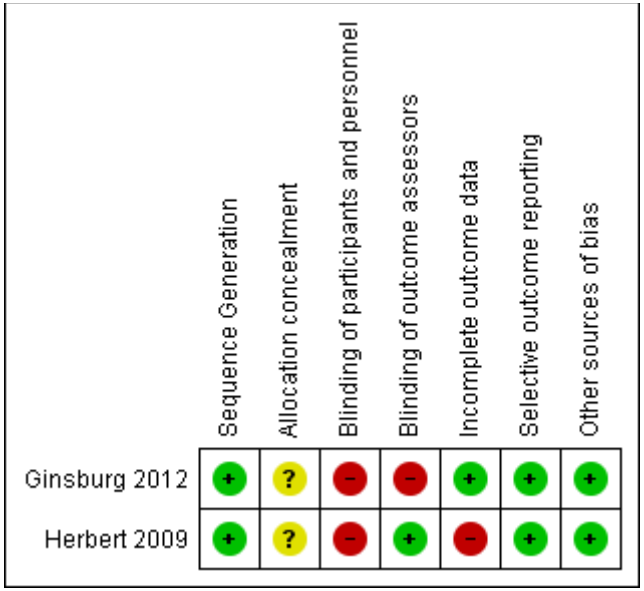
Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.9 Remission of primary anxiety diagnosis (longest FU, at least 3 months).

Figure 9 (Analysis 1.10)



Forest plot of comparison: 1 CBT vs other forms of psychotherapy, outcome: 1.10 Number that discontinued treatment or control (EoT).

Figure 10



Risk of bias summary: review authors' judgements about each risk of bias item for each included study.