36 cbt & psychotherapy relevant abstracts august '16 newsletter

(Richards, Ekers et al. ; Pereira 2015; Armitage, Rahim et al. 2016; Beard, Hsu et al. 2016; Brewin and Andrews 2016; Buntrock, Ebert et al. 2016; Chowdhary, Anand et al. 2016; Christensen, Batterham et al. 2016; Clarke, DeBar et al. 2016; Delgadillo, Moreea et al. 2016; Eckerd, Barnett et al. 2016; Fornaro, Orsolini et al. 2016; Gershoff and Grogan-Kaylor 2016; Goracci, Rucci et al. 2016; Hallford and Mellor 2016; Haslam, Cruwys et al. 2016; Hawton, Witt et al. 2016; Janse, Wiborg et al. 2016; Jarrett, Minhajuddin et al. 2016; Keefe, Webb et al. 2016; Larsson, Hooper et al. 2016; Louzon, Bossarte et al. 2016; Luong, Wrzus et al. 2016; Magruder, Goldberg et al. 2016; McLeod, Horwood et al. 2016; Melo, Daher et al. 2016; O'Toole, Solomon et al. 2016; Park, Ayduk et al. 2016; Passos, Mwangi et al. 2016; Pompoli, Furukawa et al. 2016; Qaseem, Kansagara et al. 2016; Sin and Spain 2016; Skapinakis, Caldwell et al. 2016; Vaillancourt-Morel, Godbout et al. 2016; Veale, Lim et al. 2016; Wisco, Baker et al. 2016)

Armitage, C. J., W. A. Rahim, et al. (2016). ***"An exploratory randomised trial of a simple, brief psychological intervention to reduce subsequent suicidal ideation and behaviour in patients admitted to hospital for self-harm."*** The British Journal of Psychiatry 208(5): 470-476. http://bjp.rcpsych.org/content/bjprcpsych/208/5/470.full.pdf

Background Implementation intentions link triggers for self-harm with coping skills and appear to create an automatic tendency to invoke coping responses when faced with a triggering situation. Aims To test the effectiveness of implementation intentions in reducing suicidal ideation and behaviour in a high-risk group. Method Two hundred and twenty-six patients who had self-harmed were randomised to: (a) forming implementation intentions with a 'volitional help sheet'; (b) self-generating implementation intentions without help; or (c) thinking about triggers and coping, but not forming implementation intentions. We measured self-reported suicidal ideation and behaviour, threats of suicide and likelihood of future suicide attempt at baseline and then again at the 3-month follow-up. Results All suicide-related outcome measures were significantly lower at follow-up among patients forming implementation intentions compared with those in the control condition (ds > 0.35). The volitional help sheet resulted in fewer suicide threats (d = 0.59) and lowered the likelihood of future suicide attempts (d = 0.29) compared with patients who self-generated implementation intentions. Conclusions Implementation intention-based interventions, particularly when supported by a volitional help sheet, show promise in reducing future suicidal ideation and behaviour.

Beard, C., K. J. Hsu, et al. (2016). ***"Validation of the phq-9 in a psychiatric sample."*** Journal of Affective Disorders 193: 267-273. http://www.sciencedirect.com/science/article/pii/S0165032715310272

Background The PHQ-9 was originally developed as a screener for depression in primary care and is commonly used in medical settings. However, surprisingly little is known about its psychometric properties and utility as a severity measure in psychiatric populations. We examined the full range of psychometric properties of the PHQ-9 in patients with a range of psychiatric disorders (i.e., mood, anxiety, personality, psychotic). Methods Patients (n=1023) completed the PHQ-9 upon admission and discharge from a partial hospital, as well as other self-report measures of depression, anxiety, well-being, and a structured diagnostic interview. Results Internal consistency was good (α=.87). The PHQ-9 demonstrated a strong correlation with a well-established measure of depression, moderate correlations with related constructs, a weak correlation with a theoretically unrelated construct (i.e., disgust sensitivity), and good sensitivity to change, with a large pre- to post-treatment effect size. Using a cut-off of ≥13, the PHQ-9 demonstrated good sensitivity (.83) and specificity (.72). A split-half exploratory factor analysis/confirmatory factor analysis suggested a two-factor solution with one factor capturing cognitive and affective symptoms and a second factor reflecting somatic symptoms. Psychometric properties did not differ between male and female participants. Limitations No clinician-rated measure of improvement, and the sample lacked ethnoracial diversity. Conclusions This first comprehensive validation of the PHQ-9 in a large, psychiatric sample supported its use as a severity measure and as a measure of treatment outcome. It also performed well as a screener for a current depressive episode using a higher cut-off than previously recommended for primary care samples.

Brewin, C. R. and B. Andrews (2016). ***"Creating memories for false autobiographical events in childhood: A systematic review."*** Applied Cognitive Psychology: n/a-n/a. http://dx.doi.org/10.1002/acp.3220

(Available in free full text) Using a framework that distinguishes autobiographical belief, recollective experience, and confidence in memory, we review three major paradigms used to suggest false childhood events to adults: imagination inflation, false feedback and memory implantation. Imagination inflation and false feedback studies increase the belief that a suggested event occurred by a small amount such that events are still thought unlikely to have happened. In memory implantation studies, some recollective experience for the suggested events is induced on average in 47% of participants, but only in 15% are these experiences likely to be rated as full memories. We conclude that susceptibility to false memories of childhood events appears more limited than has been suggested. The data emphasise the complex judgements involved in distinguishing real from imaginary recollections and caution against accepting investigator-based ratings as necessarily corresponding to participants' self-reports. Recommendations are made for presenting the results of these studies in courtroom settings.

Buntrock, C., D. Ebert, et al. (2016). ***"Effect of a web-based guided self-help intervention for prevention of major depression in adults with subthreshold depression: A randomized clinical trial."*** JAMA 315(17): 1854-1863. http://dx.doi.org/10.1001/jama.2016.4326

Importance Evidence-based treatments for major depressive disorder (MDD) are not very successful in improving functional and health outcomes. Attention has increasingly been focused on the prevention of MDD. Objective To evaluate the effectiveness of a web-based guided self-help intervention for the prevention of MDD. Design, Setting, and Participants Two-group randomized clinical trial conducted between March 1, 2013, and March 4, 2015. Participants were recruited in Germany from the general population via a large statutory health insurance company (ie, insurance funded by joint employer-employee contributions). Participants included 406 self-selected adults with subthreshold depression (Centre for Epidemiologic Studies Depression Scale score ≥16, no current MDD according to Diagnostic and Statistical Manual of Mental Disorders [Fourth Edition, Text Revision] criteria).Interventions All participants had unrestricted access to usual care (visits to the primary care clinician) and were randomized to either a web-based guided self-help intervention (cognitive-behavioral and problem-solving therapy supported by an online trainer; n = 202) or a web-based psychoeducation program (n = 204). Main Outcomes and Measures The primary outcome was time to onset of MDD in the intervention group relative to the control group over a 12-month follow-up period as assessed by blinded diagnostic raters using the telephone-administered Structured Clinical Interview for DSM-IV Axis Disorders at 6- and 12-month follow-up, covering the period to the previous assessment. Results Among 406 randomized patients (mean age, 45 years; 73.9% women), 335 (82%) completed the telephone follow-up at 12 months. Fifty-five participants (27%) in the intervention group experienced MDD compared with 84 participants (41%) in the control group. Cox

regression analyses controlling for baseline depressive symptom severity revealed a hazard ratio of 0.59 (95% CI, 0.42-0.82; P = .002) at 12-month follow-up. The number needed to treat to avoid 1 new case of MDD was 5.9 (95% CI, 3.9-14.6). Conclusions and Relevance Among patients with subthreshold depression, the use of a web-based guided self-help intervention compared with enhanced usual care reduced the incidence of MDD over 12 months. Further research is needed to understand whether the effects are generalizable to both first onset of depression and depression recurrence as well as efficacy without the use of an online trainer.

Chowdhary, N., A. Anand, et al. (2016). ***"The healthy activity program lay counsellor delivered treatment for severe depression in india: Systematic development and randomised evaluation."*** The British Journal of Psychiatry 208(4): 381-388. http://bjp.rcpsych.org/content/bjprcpsych/208/4/381.full.pdf

(Available in free full text) Background Reducing the global treatment gap for mental disorders requires treatments that are economical, effective and culturally appropriate. Aims To describe a systematic approach to the development of a brief psychological treatment for patients with severe depression delivered by lay counsellors in primary healthcare. Method The treatment was developed in three stages using a variety of methods: (a) identifying potential strategies; (b) developing a theoretical framework; and (c) evaluating the acceptability, feasibility and effectiveness of the psychological treatment. Results The Healthy Activity Program (HAP) is delivered over 6–8 sessions and consists of behavioral activation as the core psychological framework with added emphasis on strategies such as problem-solving and activation of social networks. Key elements to improve acceptability and feasibility are also included. In an intention-to-treat analysis of a pilot randomised controlled trial (55 participants), the prevalence of depression (Beck Depression Inventory II ⩾19) after 2 months was lower in the HAP than the control arm (adjusted risk ratio = 0.55, 95% CI 0.32–0.94, P = 0.01). Conclusions Our systematic approach to the development of psychological treatments could be extended to other mental disorders. HAP is an acceptable and effective brief psychological treatment for severe depression delivered by lay counsellors in primary care.

Christensen, H., P. J. Batterham, et al. (2016). ***"Effectiveness of an online insomnia program (shuti) for prevention of depressive episodes (the goodnight study): A randomised controlled trial."*** The Lancet Psychiatry 3(4): 333-341. http://www.sciencedirect.com/science/article/pii/S2215036615005362

Summary Background In view of the high co-occurrence of depression and insomnia, a novel way to reduce the risk of escalating depression might be to offer an insomnia intervention. We aimed to assess whether an online self-help insomnia program could reduce depression symptoms. Methods We did this randomised controlled trial at the Australian National University in Canberra, Australia. Internet users (aged 18–64 years) with insomnia and depression symptoms, but who did not meet criteria for major depressive disorder, were randomly assigned (1:1), via computer-generated randomisation, to receive SHUTi, a 6 week, modular, online insomnia program based on cognitive behavioural therapy for insomnia, or HealthWatch, an interactive, attention-matched, internet-based placebo control program. Randomisation was stratified by age and sex. Telephone-based interviewers, statisticians, and chief investigators were masked to group allocation. The primary outcome was depression symptoms at 6 months, as measured with the Patient Health Questionnaire (PHQ-9). The primary analysis was by intention to treat. This trial is registered with the Australian New Zealand Clinical Trials Registry, number ACTRN12611000121965. Findings Between April 30, 2013, and June 9, 2014, we randomly assigned 1149 participants to receive SHUTi (n=574) or HealthWatch (n=575), of whom 581 (51%) participants completed the study program assessments at 6 weeks and 504 (44%) participants completed 6 months' follow-up. SHUTi significantly lowered depression symptoms on the PHQ-9 at 6 weeks and 6 months compared with HealthWatch (F[degrees of freedom 2,640·1]=37·2, p<0·0001). Major depressive disorder was diagnosed in 22 (4%) participants at 6 months (n=9 in the SHUTi group and n=13 in the HealthWatch group), with no superior effect of SHUTi versus HealthWatch (Fisher's exact test=0·52; p=0·32). No adverse events were reported. Interpretation Online cognitive behaviour therapy for insomnia treatment is a practical and effective way to reduce depression symptoms and could be capable of reducing depression at the population level by use of a fully automatised system with the potential for wide dissemination. Funding Australian National Health and Medical Research Council.

Clarke, G., L. L. DeBar, et al. (2016). ***"Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial."*** Pediatrics 137(5). http://pediatrics.aappublications.org/content/pediatrics/137/5/e20151851.full.pdf

BACKGROUND AND OBJECTIVE: Health care providers have few alternatives for youth depression other than antidepressants. We examined whether brief cognitive behavioral therapy (CBT) is a viable alternative in primary care. METHODS: A total of 212 adolescents aged 12 to 18 with major depression who had recently declined or quickly discontinued new antidepressant treatment were randomized to self-selected treatment as usual (TAU) control condition or TAU plus brief individual CBT. Blinded evaluators followed youth for 2 years. The primary outcome was time to major depression diagnostic recovery. RESULTS: CBT was superior to the control condition on the primary outcome of time to diagnostic recovery from major depression, with number needed to treat from 4 to 10 across follow-up. A similar CBT advantage was found for time to depression diagnosis response, with number needed to treat of 5 to 50 across time points. We observed a significant advantage for CBT on many secondary outcomes over the first year of follow-up but not the second year. Cohen's d effect sizes for significant continuous measures ranged from 0.28 to 0.44, in the small to medium effect range. Most TAU health care services did not differ across conditions, except for psychiatric hospitalizations, which occurred at a significantly higher rate in the control condition through the first year of follow-up. CONCLUSIONS: Observed results were consistent with recent meta-analyses of CBT for youth depression. The initial year of CBT superiority imparted an important clinical benefit and may reduce the risk of future recurrent depression episodes.

Delgadillo, J., O. Moreea, et al. (2016). ***"Different people respond differently to therapy: A demonstration using patient profiling and risk stratification."*** Behaviour Research and Therapy 79: 15-22. http://www.sciencedirect.com/science/article/pii/S0005796716300249

Background This study aimed to identify patient characteristics associated with poor outcomes in psychological therapy, and to develop a patient profiling method. Method Clinical assessment data for 1347 outpatients was analysed. Final treatment outcome was based on reliable and clinically significant improvement (RCSI) in depression (PHQ-9) and anxiety (GAD-7) measures. Thirteen patient characteristics were explored as potential outcome predictors using logistic regression in a cross-validation design. Results Disability, employment status, age, functional impairment, baseline depression and outcome expectancy predicted post-treatment RCSI. Regression coefficients for these factors were used to derive a weighting scheme called Leeds Risk Index (LRI), used to assign risk scores to individual cases. After stratifying cases into three levels of LRI scores, we found significant differences in RCSI and treatment completion rates. Furthermore, LRI scores were significantly correlated with the proportion of treatment sessions classified as 'not on track'. Conclusions The LRI tool can identify cases at risk of poor progress to inform personalized treatment recommendations for low and high intensity psychological interventions.

Eckerd, L. M., J. E. Barnett, et al. (2016). ***"Grief following pet and human loss: Closeness is key."*** Death Stud 40(5): 275-282

The authors compared grief severity and its predictors in two equivalent college student samples who had experienced the death of a pet (n = 211) or a person (n = 146) within the past 2 years. The human death sample reported higher grief severity, p < .01, but effect sizes were small (ds = .28–.30). For both samples, closeness to the deceased was overwhelmingly the strongest predictor of grief severity; other predictors generally dropped out with closeness added to the model. Results highlight the importance of including closeness to deceased in grief research, and its centrality in understanding grief counseling clients.

Fornaro, M., L. Orsolini, et al. (2016). ***"The prevalence and predictors of bipolar and borderline personality disorders comorbidity: Systematic review and meta-analysis."*** Journal of Affective Disorders 195: 105-118. http://www.sciencedirect.com/science/article/pii/S016503271531291X

AbstractI ntroduction Data about the prevalence of borderline personality (BPD) and bipolar (BD) disorders comorbidity are scarce and the boundaries remain controversial. We conducted a systematic review and meta-analysis investigating the prevalence of BPD in BD and BD in people with BPD. Methods Two independent authors searched MEDLINE, Embase, PsycINFO and the Cochrane Library from inception till November 4, 2015. Articles reporting the prevalence of BPD and BD were included. A random effects meta-analysis and meta-regression were conducted. Results Overall, 42 papers were included: 28 considering BPD in BD and 14 considering BD in BPD. The trim and fill adjusted analysis demonstrated the prevalence of BPD among 5273 people with BD (39.94±11.78 years, 44% males) was 21.6% (95% CI 17.0–27.1). Higher comorbid BPD in BD were noted in BD II participants (37.7%, 95% CI 21.9–56.6, studies=6) and North American studies (26.2%, 95% CI 18.7–35.3, studies=11). Meta regression established that a higher percentage of males and higher mean age significantly (p<0.05) predicted a lower prevalence of comorbid BPD in BD participants. The trim and fill adjusted prevalence of BD among 1814 people with BPD (32.22±7.35 years, 21.5% male) was 18.5% (95% CI 12.7–26.1). Limitations Paucity of longitudinal/control group studies and accurate treatment records. Conclusions BPD-BD comorbidity is common, with approximately one in five people experiencing a comorbid diagnosis. Based on current diagnostic constructs, and a critical interpretation of results, both qualitative and quantitative syntheses of the evidence prompt out the relevance of differences rather similarities between BD and BPD.

Gershoff, E. T. and A. Grogan-Kaylor (2016). ***"Spanking and child outcomes: Old controversies and new meta-analyses."*** J Fam Psychol 30(4): 453-469. http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/fam0000191

Whether spanking is helpful or harmful to children continues to be the source of considerable debate among both researchers and the public. This article addresses 2 persistent issues, namely whether effect sizes for spanking are distinct from those for physical abuse, and whether effect sizes for spanking are robust to study design differences. Meta-analyses focused specifically on spanking were conducted on a total of 111 unique effect sizes representing 160,927 children. Thirteen of 17 mean effect sizes were significantly different from zero and all indicated a link between spanking and increased risk for detrimental child outcomes. Effect sizes did not substantially differ between spanking and physical abuse or by study design characteristics.

Goracci, A., P. Rucci, et al. (2016). ***"Development, acceptability and efficacy of a standardized healthy lifestyle intervention in recurrent depression."*** Journal of Affective Disorders 196: 20-31. http://www.sciencedirect.com/science/article/pii/S0165032715308715

Abstract Background Research evidence on the effects of integrated multifaceted lifestyle interventions for depression is scanty. The aim of the present study is to report on the development, acceptability and efficacy of a standardized healthy lifestyle intervention, including exercise, eating habits, sleep hygiene and smoking cessation in preventing relapses. Methods One hundred-sixty outpatients with recurrent unipolar depression or bipolar disorder were recruited after achieving full remission or recovery from the most recent depressive episode. Patients were randomized to 3-months of usual care or to an intervention aimed at promoting a healthy lifestyle (HLI), as an augmentation of pharmacological maintenance treatment. Usual care consisted of clinical management visits. At the end of the intervention, follow-up visits were scheduled at 3,6,9 and 12 months. Results During the intervention phase, 1 relapse occurred in the HLI group and 4 in the control group. Over the 12 months of follow-up, relapses were 5 in the HLI group and 16 in control group. Using an intent-to-treat approach, the overall percentage of relapses was 6/81 (7.4%) in the HLI group vs. 20/79 (25.3%) in the control group. In a Kaplan-Meier survival analysis the risk of relapse was significantly lower in patients receiving the HLI intervention (log-rank test, p=0.003) over the 60 weeks of observation. The majority of patients assigned to HLI adhered to the program, and were highly motivated throughout the intervention. Limitations The retention rate was low because patients were recruited during the maintenance phase and the 1-year follow-up was relatively short to detect a long-term effect of HLI. Conclusions The HLI program proved to be efficacious in preventing relapses. Given the absence of contraindications and its cost-effectiveness in routine practice, the use of HLI should be encouraged to promote the well-being of patients with recurrent depression.

Hallford, D. J. and D. Mellor (2016). ***"Autobiographical memory and depression: Identity-continuity and problem-solving functions indirectly predict symptoms over time through psychological well-being."*** Applied Cognitive Psychology 30(2): 152-159. http://dx.doi.org/10.1002/acp.3169

The aim of this study was to assess the longitudinal associations between adaptive autobiographical memory functions and depressive symptoms. Consistent with the proposed mechanisms of change underpinning cognitive-reminiscence therapy (CRT), it was hypothesised that more frequent adaptive reminiscence would lead to increases in psychological resources over time and indirectly affect depressive symptoms through this pathway. A sample of 171 young adults (mean age = 25.9 years, SD = 3.5) completed measures of how frequently they utilised autobiographical memory for identity-continuity and problem-solving purposes, depressive symptoms and personal resources (self-esteem, self-efficacy, meaning in life and optimism) at two time-points. The results of structural equation modelling supported the model of indirect influence between reminiscence functions and depression through these psychological resources. These findings clarify the effects of adaptive autobiographical memory on depressive symptoms in young adults and indicate potential benefits of interventions such as CRT.

Haslam, C., T. Cruwys, et al. (2016). ***"Groups 4 health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health."*** Journal of Affective Disorders 194: 188-195. http://www.sciencedirect.com/science/article/pii/S0165032715312180

Background Social isolation and disconnection have profound negative effects on mental health, but there are few, if any, theoretically-derived interventions that directly target this problem. We evaluate a new intervention, Groups 4 Health (G4H), a manualized 5-module psychological intervention that targets the development and maintenance of social group relationships to treat psychological distress arising from social isolation. Methods G4H was tested using a non-randomized control design. The program was delivered to young adults presenting with social isolation and affective disturbance. Primary outcome measures assessed mental health (depression, general anxiety, social anxiety, and stress), well-being (life satisfaction, self-esteem) and social connectedness (loneliness, social functioning). Our secondary goal was to assess whether mechanisms of

social identification were responsible for changes in outcomes. Results G4H was found to significantly improve mental health, well-being, and social connectedness on all measures, both on program completion and 6-month follow-up. In line with social identity theorizing, analysis also showed that improvements in depression, anxiety, stress, loneliness, and life satisfaction were underpinned by participants' increased identification both with their G4H group and with multiple groups. Limitations This study provides preliminary evidence of the potential value of G4H and its underlying mechanisms, but further examination is required in other populations to address issues of generalizability, and in randomized controlled trials to address its wider efficacy. Conclusions Results of this pilot study confirm that G4H has the potential to reduce the negative health-related consequences of social disconnection. Future research will determine its utility in wider community contexts.

Hawton, K., K. G. Witt, et al. (2016). ***"Psychosocial interventions for self-harm in adults. ."*** Cochrane Database Syst Rev. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD012189/full

Background Self-harm (SH; intentional self-poisoning or self-injury) is common, often repeated, and associated with suicide. This is an update of a broader Cochrane review first published in 1998, previously updated in 1999, and now split into three separate reviews. This review focuses on psychosocial interventions in adults who engage in self-harm. Objectives To assess the effects of specific psychosocial treatments versus treatment as usual, enhanced usual care or other forms of psychological therapy, in adults following SH. Search methods The Cochrane Depression, Anxiety and Neurosis Group (CCDAN) trials coordinator searched the CCDAN Clinical Trials Register (to 29 April 2015). This register includes relevant randomised controlled trials (RCTs) from: the Cochrane Library (all years), MEDLINE (1950 to date), EMBASE (1974 to date), and PsycINFO (1967 to date). Selection criteria We included RCTs comparing psychosocial treatments with treatment as usual (TAU), enhanced usual care (EUC) or alternative treatments in adults with a recent (within six months) episode of SH resulting in presentation to clinical services. Data collection and analysis We used Cochrane's standard methodological procedures. Main results We included 55 trials, with a total of 17,699 participants. Eighteen trials investigated cognitive-behavioural-based psychotherapy (CBT-based psychotherapy; comprising cognitive-behavioural, problem-solving therapy or both). Nine investigated interventions for multiple repetition of SH/probable personality disorder, comprising emotion-regulation group-based psychotherapy, mentalisation, and dialectical behaviour therapy (DBT). Four investigated case management, and 11 examined remote contact interventions (postcards, emergency cards, telephone contact). Most other interventions were evaluated in only single small trials of moderate to very low quality. There was a significant treatment effect for CBT-based psychotherapy compared to TAU at final follow-up in terms of fewer participants repeating SH (odds ratio (OR) 0.70, 95% confidence interval (CI) 0.55 to 0.88; number of studies k = 17; N = 2665; GRADE: low quality evidence), but with no reduction in frequency of SH (mean difference (MD) -0.21, 95% CI -0.68 to 0.26; k = 6; N = 594; GRADE: low quality). For interventions typically delivered to individuals with a history of multiple episodes of SH/probable personality disorder, group-based emotion-regulation psychotherapy and mentalisation were associated with significantly reduced repetition when compared to TAU: group-based emotion-regulation psychotherapy (OR 0.34, 95% CI 0.13 to 0.88; k = 2; N = 83; GRADE: low quality), mentalisation (OR 0.35, 95% CI 0.17 to 0.73; k = 1; N = 134; GRADE: moderate quality). Compared with TAU, dialectical behaviour therapy (DBT) showed a significant reduction in frequency of SH at final follow-up (MD -18.82, 95% CI -36.68 to -0.95; k = 3; N = 292; GRADE: low quality) but not in the proportion of individuals repeating SH (OR 0.57, 95% CI 0.21 to 1.59, k = 3; N = 247; GRADE: low quality). Compared with an alternative form of psychological therapy, DBT-oriented therapy was also associated with a significant treatment effect for repetition of SH at final follow-up (OR 0.05, 95% CI 0.00 to 0.49; k = 1; N = 24; GRADE: low quality). However, neither DBT vs 'treatment by expert' (OR 1.18, 95% CI 0.35 to 3.95; k = 1; N = 97; GRADE: very low quality) nor prolonged exposure DBT vs standard exposure DBT (OR 0.67, 95% CI 0.08 to 5.68; k = 1; N =18; GRADE: low quality) were associated with a significant reduction in repetition of SH. Case management was not associated with a significant reduction in repetition of SH at post intervention compared to either TAU or enhanced usual care (OR 0.78, 95% CI 0.47 to 1.30; k = 4; N = 1608; GRADE: moderate quality). Continuity of care by the same therapist vs a different therapist was also not associated with a significant treatment effect for repetition (OR 0.28, 95% CI 0.07 to 1.10; k = 1; N = 136; GRADE: very low quality). None of the following remote contact interventions were associated with fewer participants repeating SH compared with TAU: adherence enhancement (OR 0.57, 95% CI 0.32 to 1.02; k = 1; N = 391; GRADE: low quality), mixed multimodal interventions (comprising psychological therapy and remote contact-based interventions) (OR 0.98, 95% CI 0.68 to 1.43; k = 1 study; N = 684; GRADE: low quality), including a culturally adapted form of this intervention (OR 0.83, 95% CI 0.44 to 1.55; k = 1; N = 167; GRADE: low quality), postcards (OR 0.87, 95% CI 0.62 to 1.23; k = 4; N = 3277; GRADE: very low quality), emergency cards (OR 0.82, 95% CI 0.31 to 2.14; k = 2; N = 1039; GRADE: low quality), general practitioner's letter (OR 1.15, 95% CI 0.93 to 1.44; k = 1; N = 1932; GRADE: moderate quality), telephone contact (OR 0.74, 95% CI 0.42 to 1.32; k = 3; N = 840; GRADE: very low quality), and mobile telephone-based psychological therapy (OR not estimable due to zero cell counts; GRADE: low quality). None of the following mixed interventions were associated with reduced repetition of SH compared to either alternative forms of psychological therapy: interpersonal problem-solving skills training, behaviour therapy, home-based problem-solving therapy, long-term psychotherapy; or to TAU: provision of information and support, treatment for alcohol misuse, intensive inpatient and community treatment, general hospital admission, or intensive outpatient treatment. We had only limited evidence on whether the intervention had different effects in men and women. Data on adverse effects, other than planned outcomes relating to suicidal behaviour, were not reported. Authors' conclusions CBT-based psychological therapy can result in fewer individuals repeating SH; however, the quality of this evidence, assessed using GRADE criteria, ranged between moderate and low. Dialectical behaviour therapy for people with multiple episodes of SH/probable personality disorder may lead to a reduction in frequency of SH, but this finding is based on low quality evidence. Case management and remote contact interventions did not appear to have any benefits in terms of reducing repetition of SH. Other therapeutic approaches were mostly evaluated in single trials of moderate to very low quality such that the evidence relating to these interventions is inconclusive.

Janse, A., J. F. Wiborg, et al. (2016). ***"The efficacy of guided self-instruction for patients with idiopathic chronic fatigue: A randomized controlled trial."*** J Consult Clin Psychol 84(5): 377-388. http://www.ncbi.nlm.nih.gov/pubmed/26950098

OBJECTIVE: To determine the efficacy of a cognitive-behavioral intervention for patients meeting U.S. Centers for Disease Control and Prevention (CDC) criteria for idiopathic chronic fatigue (ICF). ICF is thought to be a less severe disorder than chronic fatigue syndrome (CFS). The intervention consisted of a booklet with self-instructions combined with e-mail contact with a therapist. METHOD: Randomized controlled trial conducted at an outpatient facility. All patients suffered from severe and persistent fatigue with moderate impairment levels or fewer than 4 additional symptoms. Patients were randomly allocated to either guided self-instruction or a wait-list control group. Primary outcome measures were fatigue severity assessed with the Checklist Individual Strength and level of overall impairment assessed with the Sickness Impact Profile. Outcome measures were assessed prior to randomization and following treatment or wait-list control group. RESULTS: One hundred patients were randomly allocated to the intervention or a wait-list control group and 95 completed second assessment. An intention-to-treat analysis showed significant treatment effects for fatigue severity (-8.98, 95% confidence interval [CI] [-13.99, -3.97], Cohen's d = 0.68, p < .001) and for overall impairment (-317.19, 95% CI [-481.70, -152.68], Cohen's d = 0.53, p < .01) in favor of the

intervention. The number of additional symptoms and overall impairment at baseline did not moderate posttreatment fatigue severity. Baseline overall impairment moderated posttreatment impairment. CONCLUSIONS: Patients with ICF can be treated effectively with a minimal intervention. This is relevant as ICF is more prevalent than CFS and treatment capacity is limited.

Jarrett, R. B., A. Minhajuddin, et al. (2016). ***"Quantifying and qualifying the preventive effects of acute-phase cognitive therapy: Pathways to personalizing care."*** J Consult Clin Psychol 84(4): 365-376. http://psycnet.apa.org/journals/ccp/84/4/365/

OBJECTIVE: To determine the extent to which prospectively identified responders to cognitive therapy (CT) for recurrent major depressive disorder (MDD) hypothesized to be lower risk show significantly less relapse or recurrence than treated higher risk counterparts across 32 months. METHOD: Outpatients (N = 523), aged 18-70, with recurrent MDD received 12-14 weeks of CT. The last 7 consecutive scores from the Hamilton Rating Scale for Depression (HRSD-17) were used to stratify or define responders (n = 290) into lower (7 HRSD-17 scores of less than or equal to 6; n = 49; 17%) and higher risk (n = 241; 83%). The lower risk patients entered the 32-month follow-up. Higher risk patients were randomized to 8 months of continuation-phase CT or clinical management plus double-blind fluoxetine or pill placebo, with a 24-month follow-up. RESULTS: Lower risk patients were significantly less likely to relapse over the first 8 months compared to higher risk patients (Kaplan-Meier [KM] estimates; i.e., 4.9% = lower risk; 22.1% = higher risk; log-rank chi2 = 6.83, p = .009). This increased risk was attenuated, but not completely neutralized, by active continuation-phase therapy. Over the subsequent 24 months, the lower and higher risk groups did not differ in relapse or recurrence risk. CONCLUSIONS: Rapid and sustained acute-phase CT remission identifies responders who do not require continuation-phase treatment to prevent relapse (i.e., return of an index episode). To prevent recurrence (i.e., new episodes), however, strategic allocation and more frequent "dosing" of CT and/or targeted maintenance-phase treatments may be required. Longitudinal follow-up is recommended.

Keefe, J. R., C. A. Webb, et al. (2016). ***"In cognitive therapy for depression, early focus on maladaptive beliefs may be especially efficacious for patients with personality disorders."*** J Consult Clin Psychol 84(4): 353-364. http://www.ncbi.nlm.nih.gov/pubmed/26727410

OBJECTIVE: Patients with major depressive disorder (MDD) and a comorbid personality disorder (PD) have been found to exhibit relatively poor outcomes in cognitive therapy (CT) and other treatments. Adaptations of CT focusing heavily on patients' core beliefs have yielded promising findings in the treatment of PD. However, there have been no investigations that have specifically tested whether increased focus on maladaptive beliefs contributes to CT's efficacy for these patients. METHOD: CT technique use from an early CT session was assessed for 59 patients (33 without PD, 26 with PD-predominantly Cluster C) who participated in a randomized controlled trial for moderate to severe MDD. Scores were calculated for directive CT techniques (CT-Concrete) and a set of belief-focused items (CT-Belief) as rated by the Collaborative Study Process Rating Scale. Robust regressions were conducted to estimate relations between scores on each of these measures and change in depressive and PD symptoms. A PD status by CT-Belief use interaction tested the hypothesis that therapist use of CT-Belief techniques would exhibit a stronger association with symptom change in the PD group relative to the non-PD group. RESULTS: As hypothesized, a significant interaction between PD status and use of CT-Belief techniques emerged in the prediction of depressive and PD symptom change. Among PD patients, higher early CT-Belief interventions were found to predict significantly greater improvement. CT-Belief use did not predict greater symptom change among those without PD. CONCLUSIONS: Early focus on CT-Belief interventions may facilitate changes in depression and PD symptoms for patients with MDD-PD comorbidity.

Larsson, A., N. Hooper, et al. (2016). ***"Using brief cognitive restructuring and cognitive defusion techniques to cope with negative thoughts."*** Behavior Modification 40(3): 452-482. http://bmo.sagepub.com/content/40/3/452.abstract

Negative thoughts, experienced by 80% to 99% of the non-clinical population, have been linked to the development of psychopathology. The current study aimed to compare a cognitive restructuring and cognitive defusion technique for coping with a personally relevant negative thought. Over a 5-day period, participants used either a restructuring, defusion, or control strategy to manage a negative thought. Pre- and post-intervention participants reported (a) believability of the thought, (b) discomfort associated with the thought, (c) negativity associated with the thought, and (d) willingness to experience the thought. Daily online questionnaires assessing the total frequency of negative thought intrusions and their level of willingness to experience the negative thought were also used. Also, 10 positive and negative self-statements were rated on the same scales, and self-report measures of mood and psychological flexibility were completed. Findings indicated that defusion lowered believability, increased comfort and willingness to have the target thought, and increased positive affect significantly more than the control and cognitive restructuring. Within groups, cognitive restructuring also made significant gains in target thought discomfort, negativity, and "willingness to have" in the same direction as defusion but the no-instruction control did not. Negative thought frequency was reduced in the defusion group, maintained in the restructuring group, and increased in the no-instruction control group. Similar trends emerged from the secondary outcome measures, that is, the effects of the strategies on the positive and negative self-statements. The current findings support the efficacy of using defusion as a strategy for managing negative thoughts.

Louzon, S. A., R. Bossarte, et al. (2016). ***"Does suicidal ideation as measured by the phq-9 predict suicide among va patients?"*** Psychiatric Services 67(5): 517-522. http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201500149

Objective: Frequency of suicidal ideation in the past two weeks, assessed by item 9 of the nine-item Patient Health Questionnaire (PHQ-9), has been positively associated with suicide mortality among patients in a setting other than the Veterans Health Administration (VHA). To inform suicide prevention activities at the VHA, it is important to evaluate whether item 9 is associated with suicide risk among patients in the VHA system. Methods: PHQ-9 assessments (N=447,245) conducted by the VHA between October 1, 2009, and September 30, 2010, were collected. National Death Index data were used to ascertain suicide mortality from the date of PHQ-9 assessment through September 30, 2011. Multivariable proportional hazards regressions were used to evaluate associations between responses to item 9 and suicide mortality. Results: After the analyses adjusted for covariates, a response of "several days" for item 9 was associated with a 75% increased risk of suicide (hazard ratio [HR]=1.75, 95% confidence interval [CI]=1.24–2.46), a response of "more than half the days" was associated with a 115% increased risk of suicide (HR=2.15, CI=1.32–3.51), and a response of "nearly every day" was associated with a 185% increased risk of suicide (HR=2.85, CI=1.81–4.47), compared with a response of "not at all." However, 71.6% of suicides during the study period occurred among patients who responded "not at all" to item 9 from their most recent PHQ-9. Conclusions: Higher levels of suicidal ideation, indicated by item 9 of the PHQ-9, were associated with increased risk of suicide among patients in the VHA system.

Luong, G., C. Wrzus, et al. (2016). ***"When bad moods may not be so bad: Valuing negative affect is associated with weakened affect-health links."*** Emotion 16(3): 387-401. http://www.ncbi.nlm.nih.gov/pubmed/26571077

Bad moods are considered "bad" not only because they may be aversive experiences in and of themselves, but also because they are associated with poorer psychosocial functioning and health. We propose that people differ in their negative

affect valuation (NAV; the extent to which negative affective states are valued as pleasant, useful/helpful, appropriate, and meaningful experiences) and that affect-health links are moderated by NAV. These predictions were tested in a life span sample of 365 participants ranging from 14-88 years of age using reports of momentary negative affect and physical well-being (via experience sampling) and assessments of NAV and psychosocial and physical functioning (via computer-assisted personal interviews and behavioral measures of hand grip strength). Our study demonstrated that the more individuals valued negative affect, the less pronounced (and sometimes even nonexistent) were the associations between everyday experiences of negative affect and a variety of indicators of poorer psychosocial functioning (i.e., emotional health problems, social integration) and physical health (i.e., number of health conditions, health complaints, hand grip strength, momentary physical well-being). Exploratory analyses revealed that valuing positive affect was not associated with the analogous moderating effects as NAV. These findings suggest that it may be particularly important to consider NAV in models of affect-health links.

Magruder, K. M., J. Goldberg, et al. (2016). ***"Long-term trajectories of ptsd in vietnam-era veterans: The course and consequences of ptsd in twins."*** Journal of Traumatic Stress 29(1): 5-16. http://dx.doi.org/10.1002/jts.22075

(Available in free full text) We estimated the temporal course of posttraumatic stress disorder (PTSD) in Vietnam-era veterans using a national sample of male twins with a 20-year follow-up. The complete sample included those twins with a PTSD diagnostic assessment in 1992 and who completed a DSM-IV PTSD diagnostic assessment and a self-report PTSD checklist in 2012 (n = 4,138). Using PTSD diagnostic data, we classified veterans into 5 mutually exclusive groups, including those who never had PTSD, and 4 PTSD trajectory groups: (a) early recovery, (b) late recovery, (c) late onset, and (d) chronic. The majority of veterans remained unaffected by PTSD throughout their lives (79.05% of those with theater service, 90.85% of those with nontheater service); however, an important minority (10.50% of theater veterans, 4.45% of nontheater veterans) in 2012 had current PTSD that was either late onset (6.55% theater, 3.29% nontheater) or chronic (3.95% theater, 1.16% nontheater). The distribution of trajectories was significantly different by theater service ($p < .001$). PTSD remains a prominent issue for many Vietnam-era veterans, especially for those who served in Vietnam.

McLeod, G. F. H., L. J. Horwood, et al. (2016). ***"Adolescent depression, adult mental health and psychosocial outcomes at 30 and 35 years."*** Psychological Medicine 46(07): 1401-1412. http://dx.doi.org/10.1017/S0033291715002950

Background There is limited information on long-term outcomes of adolescent depression. This study examines the associations between severity of depression in adolescence and a broad array of adult functional outcomes. Method Data were gathered as part of the Christchurch Health and Development Study, a 35-year longitudinal study of a birth cohort of 1265 children born in Christchurch, New Zealand in 1977. Severity of depression at age 14–16 years was classified into three levels according to DSM symptom criteria for major depression (no depression/sub-threshold symptoms/major depression). This classification was related to adult functional outcomes assessed at ages 30 and 35 years using a generalized estimating equation modeling approach. Outcome measures spanned domains of mental disorder, education/economic circumstances, family circumstances and partner relationships. Results There were modest but statistically significant bivariate associations between adolescent depression severity and most outcomes. After covariate adjustment there remained weak but significant ($p < 0.05$) associations with rates of major depression, anxiety disorder, illicit substance abuse/dependence, any mental health problem and intimate partner violence (IPV) victimization. Estimates of attributable risk for these outcomes ranged from 3.8% to 7.8%. For two outcomes there were significant ($p < 0.006$) gender interactions such that depression severity was significantly related to increased rates of unplanned pregnancy and IPV victimization for females but not for males. Conclusions The findings reinforce the importance of the individual/family context in which adolescent depression occurs. When contextual factors and probable maturational effects are taken into account the direct effects of adolescent depression on functioning in mature adulthood appear to be very modest.

Melo, M. C. A., E. D. F. Daher, et al. (2016). ***"Exercise in bipolar patients: A systematic review."*** Journal of Affective Disorders 198: 32-38. http://www.sciencedirect.com/science/article/pii/S0165032715314063

Abstract Background Sedentary lifestyle is frequent in psychiatric disorders, however the directions of this association and benefits of physical activity are unclear. This is a systematic review about exercise in patients with bipolar disorder. Methods We performed a systematic literature search of studies published in English (1995 Jan to 2016 Jan) in PubMed, and Cochrane Library combining the medical terms 'physical activity' or 'sedentary' or 'physical exercise' with 'bipolar disorder' or 'mania' or 'bipolar depression'. Results Thirty-one studies were selected and included 15,587 patients with bipolar disorder. Sedentary lifestyle varied from 40% to 64.9%. Physical activity was associated with less depressive symptoms, better quality of life and increased functioning. Some evidence indicates a relationship between vigorous exercises and mania. Three prospective cohorts were reported; and no prospective randomized controlled trial was identified. Three studies focused on biomarkers in bipolar patients; and one reported the relationship between exercise and sleep in this group. Two assessed physical exercise in adolescents. Limitations (1) Differences between studies preventing a unified analysis; (2) most studies were cross-sectional; (3) motivation for exercising is a selection bias in most studies; (4) no intervention study assessing only physical exercise; (5) lack of studies comparing exercise across mood states. Conclusion Generally, exercise was associated with improved health measures including depressive symptoms, functioning and quality of life. Evidence was insufficient to establish a cause-effect relationship between mood and physical exercise. Future research including randomized trials is needed to clarify the role of physical activity in bipolar patients.

O'Toole, S. K., S. L. Solomon, et al. (2016). ***"A meta-analysis of hypnotherapeutic techniques in the treatment of ptsd symptoms."*** Journal of Traumatic Stress 29(1): 97-100. http://dx.doi.org/10.1002/jts.22077

(Available in free full text) The efficacy of hypnotherapeutic techniques as treatment for symptoms of posttraumatic stress disorder (PTSD) was explored through meta-analytic methods. Studies were selected through a search of 29 databases. Altogether, 81 studies discussing hypnotherapy and PTSD were reviewed for inclusion criteria. The outcomes of 6 studies representing 391participants were analyzed using meta-analysis. Evaluation of effect sizes related to avoidance and intrusion, in addition to overall PTSD symptoms after hypnotherapy treatment, revealed that all studies showed that hypnotherapy had a positive effect on PTSD symptoms. The overall Cohen's d was large (−1.18) and statistically significant ($p < .001$). Effect sizes varied based on study quality; however, they were large and statistically significant. Using the classic fail-safe N to assess for publication bias, it was determined it would take 290 nonsignificant studies to nullify these findings.

Park, J., O. Ayduk, et al. (2016). ***"Stepping back to move forward: Expressive writing promotes self-distancing."*** Emotion 16(3): 349-364. http://www.ncbi.nlm.nih.gov/pubmed/26461252

Prior research indicates that expressive writing enhances well-being by leading people to construct meaningful narratives that explain distressing life experiences. But how does expressive writing facilitate meaning-making? We addressed this issue in 2 longitudinal studies by examining whether and how expressive writing promotes self-distancing, a process that facilitates meaning-making. At baseline in both studies, participants reflected on a distressing life experience. In Study 1 participants were then randomly assigned to write about their distressing experience or a non-emotional topic for 15 min on 3

consecutive days; in Study 2 participants were randomly assigned to write or think about their distressing experience or write about a non-emotional topic for the same amount of time. One day following the intervention, expressive writing participants in both studies self-distanced more when they reflected over their distressing experience compared with participants in the other conditions, which in turn led them to experience less emotional reactivity 1 month (Studies 1 and 2) and 6 months (Study 2) after the intervention. Analyses using data from both studies indicated that expressive writing reduced physical symptoms indirectly through its effects on self-distancing and emotional reactivity [that is, expressive writing group (vs. comparison groups) --> greater self-distancing --> less emotional reactivity --> fewer physical symptoms]. Finally, linguistic analyses using essays from both studies indicated that increased use of causation words and decreased use of negative emotion words and first-person singular pronouns predicted increases in self-distancing over time. These findings demonstrate that expressive writing promotes self-distancing and illustrate how it does so.

Passos, I. C., B. Mwangi, et al. (2016). ***"Identifying a clinical signature of suicidality among patients with mood disorders: A pilot study using a machine learning approach."*** Journal of Affective Disorders 193: 109-116. http://www.sciencedirect.com/science/article/pii/S0165032715310922

Objective A growing body of evidence has put forward clinical risk factors associated with patients with mood disorders that attempt suicide. However, what is not known is how to integrate clinical variables into a clinically useful tool in order to estimate the probability of an individual patient attempting suicide. Method A total of 144 patients with mood disorders were included. Clinical variables associated with suicide attempts among patients with mood disorders and demographic variables were used to 'train' a machine learning algorithm. The resulting algorithm was utilized in identifying novel or 'unseen' individual subjects as either suicide attempters or non-attempters. Three machine learning algorithms were implemented and evaluated. Results All algorithms distinguished individual suicide attempters from non-attempters with prediction accuracy ranging between 65% and 72% ($p < 0.05$). In particular, the relevance vector machine (RVM) algorithm correctly predicted 103 out of 144 subjects translating into 72% accuracy (72.1% sensitivity and 71.3% specificity) and an area under the curve of 0.77 ($p < 0.0001$). The most relevant predictor variables in distinguishing attempters from non-attempters included previous hospitalizations for depression, a history of psychosis, cocaine dependence and post-traumatic stress disorder (PTSD) comorbidity. Conclusion Risk for suicide attempt among patients with mood disorders can be estimated at an individual subject level by incorporating both demographic and clinical variables. Future studies should examine the performance of this model in other populations and its subsequent utility in facilitating selection of interventions to prevent suicide.

Pereira, J.-A. (2015). ***The effective practitioner: The role and contribution of therapist effects in the delivery of psychological therapies***. Department of Psychology, University of Sheffield. Doctor of Philosophy**:** 1-373.

Background: Variability in human performance is a naturally occurring phenomenon and applies to practitioners. Mainstream psychotherapy research has focused on treatments rather than practitioners and has viewed variability as error within the dominant paradigm of the randomised controlled trial. Aims: To investigate variability via the role of practitioner personal qualities and their association with differential patient outcomes, their contribution to effective practice, and the extent these qualities vary with patient severity. Method: A practice-based paradigm was adopted and sampled practitioners and data within a single Improving Access to Psychological Therapies (IAPT) service. The full sample comprised 42 practitioners – psychological wellbeing practitioners, counsellors, and cognitive-behaviour therapists – who completed measures of resilience, empathy, and mindfulness as well as provided qualitative accounts of their practice. A series of seven sequential studies utilised subsamples of the responses from these 42 practitioners, which were analysed prior to yoking with their patient outcome data to determine associations with more and less effective practice. Studies comprised mixed and integrated quantitative and qualitative analyses comparing benchmarking and multilevel modelling research methods (N=37) and thematic analysis (N=6). Results: Significant variability in practitioner effectiveness was found. Practitioners' personal aspects were associated with patient outcomes and were influenced by their professional roles, level of treatment intensity provided, and their theoretical orientation. Practitioners' mindfulness and combined resilience and mindfulness were associated with better patient outcomes and this role increased as patient severity increased. In contrast, empathy did not differ between more and less effective practitioners, with more effective practitioners showing marginally lower levels of empathy. Conclusion: Findings suggest that more effective practitioners do differ from less effective practitioners in the personal aspects they bring to their professional practice. Findings have implications for practitioner training and routine practice. The findings are limited in their generalisability and may only apply to IAPT services.

Pompoli, A., T. A. Furukawa, et al. (2016). ***"Psychological therapies for panic disorder with or without agoraphobia in adults: A network meta-analysis."*** Cochrane Database of Systematic Reviews(4). http://dx.doi.org/10.1002/14651858.CD011004.pub2

Background: Panic disorder is characterised by the presence of recurrent unexpected panic attacks, discrete periods of fear or anxiety that have a rapid onset and include symptoms such as racing heart, chest pain, sweating and shaking. Panic disorder is common in the general population, with a lifetime prevalence of 1% to 4%. A previous Cochrane meta-analysis suggested that psychological therapy (either alone or combined with pharmacotherapy) can be chosen as a first-line treatment for panic disorder with or without agoraphobia. However, it is not yet clear whether certain psychological therapies can be considered superior to others. In order to answer this question, in this review we performed a network meta-analysis (NMA), in which we compared eight different forms of psychological therapy and three forms of a control condition. Objectives: To assess the comparative efficacy and acceptability of different psychological therapies and different control conditions for panic disorder, with or without agoraphobia, in adults. Search methods: We conducted the main searches in the CCDANCTR electronic databases (studies and references registers), all years to 16 March 2015. We conducted complementary searches in PubMed and trials registries. Supplementary searches included reference lists of included studies, citation indexes, personal communication to the authors of all included studies and grey literature searches in OpenSIGLE. We applied no restrictions on date, language or publication status. Selection criteria: We included all relevant randomised controlled trials (RCTs) focusing on adults with a formal diagnosis of panic disorder with or without agoraphobia. We considered the following psychological therapies: psychoeducation (PE), supportive psychotherapy (SP), physiological therapies (PT), behaviour therapy (BT), cognitive therapy (CT), cognitive behaviour therapy (CBT), third-wave CBT (3W) and psychodynamic therapies (PD). We included both individual and group formats. Therapies had to be administered face-to-face. The comparator interventions considered for this review were: no treatment (NT), wait list (WL) and attention/psychological placebo (APP). For this review we considered four short-term (ST) outcomes (ST-remission, ST-response, ST-dropouts, ST-improvement on a continuous scale) and one long-term (LT) outcome (LT-remission/response). Data collection and analysis: As a first step, we conducted a systematic search of all relevant papers according to the inclusion criteria. For each outcome, we then constructed a treatment network in order to clarify the extent to which each type of therapy and each comparison had been investigated in the available literature. Then, for each available comparison, we conducted a random-effects meta-analysis. Subsequently, we performed a network meta-analysis in order to synthesise the available direct evidence with indirect evidence, and to obtain an overall effect size estimate for each possible pair of therapies in the network. Finally, we calculated a probabilistic ranking of the different psychological therapies

and control conditions for each outcome. Main results: We identified 1432 references; after screening, we included 60 studies in the final qualitative analyses. Among these, 54 (including 3021 patients) were also included in the quantitative analyses. With respect to the analyses for the first of our primary outcomes, (short-term remission), the most studied of the included psychological therapies was CBT (32 studies), followed by BT (12 studies), PT (10 studies), CT (three studies), SP (three studies) and PD (two studies). The quality of the evidence for the entire network was found to be low for all outcomes. The quality of the evidence for CBT vs NT, CBT vs SP and CBT vs PD was low to very low, depending on the outcome. The majority of the included studies were at unclear risk of bias with regard to the randomisation process. We found almost half of the included studies to be at high risk of attrition bias and detection bias. We also found selective outcome reporting bias to be present and we strongly suspected publication bias. Finally, we found almost half of the included studies to be at high risk of researcher allegiance bias. Overall the networks appeared to be well connected, but were generally underpowered to detect any important disagreement between direct and indirect evidence. The results showed the superiority of psychological therapies over the WL condition, although this finding was amplified by evident small study effects (SSE). The NMAs for ST-remission, ST-response and ST-improvement on a continuous scale showed well-replicated evidence in favour of CBT, as well as some sparse but relevant evidence in favour of PD and SP, over other therapies. In terms of ST-dropouts, PD and 3W showed better tolerability over other psychological therapies in the short term. In the long term, CBT and PD showed the highest level of remission/response, suggesting that the effects of these two treatments may be more stable with respect to other psychological therapies. However, all the mentioned differences among active treatments must be interpreted while taking into account that in most cases the effect sizes were small and/or results were imprecise. Authors' conclusions: There is no high-quality, unequivocal evidence to support one psychological therapy over the others for the treatment of panic disorder with or without agoraphobia in adults. However, the results show that CBT - the most extensively studied among the included psychological therapies - was often superior to other therapies, although the effect size was small and the level of precision was often insufficient or clinically irrelevant. In the only two studies available that explored PD, this treatment showed promising results, although further research is needed in order to better explore the relative efficacy of PD with respect to CBT. Furthermore, PD appeared to be the best tolerated (in terms of ST-dropouts) among psychological treatments. Unexpectedly, we found some evidence in support of the possible viability of non-specific supportive psychotherapy for the treatment of panic disorder; however, the results concerning SP should be interpreted cautiously because of the sparsity of evidence regarding this treatment and, as in the case of PD, further research is needed to explore this issue. Behaviour therapy did not appear to be a valid alternative to CBT as a first-line treatment for patients with panic disorder with or without agoraphobia.

Qaseem, A., D. Kansagara, et al. (2016). ***"Management of chronic insomnia disorder in adults: A clinical practice guideline from the american college of physicians."*** Annals of Internal Medicine 165(2): 125-133. http://dx.doi.org/10.7326/M15-2175

(Available in free full text) Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on the management of chronic insomnia disorder in adults.Methods: This guideline is based on a systematic review of randomized, controlled trials published in English from 2004 through September 2015. Evaluated outcomes included global outcomes assessed by questionnaires, patient-reported sleep outcomes, and harms. The target audience for this guideline includes all clinicians, and the target patient population includes adults with chronic insomnia disorder. This guideline grades the evidence and recommendations by using the ACP grading system, which is based on the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach.Recommendation 1: ACP recommends that all adult patients receive cognitive behavioral therapy for insomnia (CBT-I) as the initial treatment for chronic insomnia disorder. (Grade: strong recommendation, moderate-quality evidence)Recommendation 2: ACP recommends that clinicians use a shared decision-making approach, including a discussion of the benefits, harms, and costs of short-term use of medications, to decide whether to add pharmacological therapy in adults with chronic insomnia disorder in whom cognitive behavioral therapy for insomnia (CBT-I) alone was unsuccessful. (Grade: weak recommendation, low-quality evidence).

Richards, D. A., D. Ekers, et al. ***"Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (cobra): A randomised, controlled, non-inferiority trial."*** The Lancet. http://dx.doi.org/10.1016/S0140-6736(16)31140-0

(Available in free full text) Background Depression is a common, debilitating, and costly disorder. Many patients request psychological therapy, but the best-evidenced therapy—cognitive behavioural therapy (CBT)—is complex and costly. A simpler therapy—behavioural activation (BA)—might be as effective and cheaper than is CBT. We aimed to establish the clinical efficacy and cost-effectiveness of BA compared with CBT for adults with depression. Methods In this randomised, controlled, non-inferiority trial, we recruited adults aged 18 years or older meeting Diagnostic and Statistical Manual of Mental Disorders IV criteria for major depressive disorder from primary care and psychological therapy services in Devon, Durham, and Leeds (UK). We excluded people who were receiving psychological therapy, were alcohol or drug dependent, were acutely suicidal or had attempted suicide in the previous 2 months, or were cognitively impaired, or who had bipolar disorder or psychosis or psychotic symptoms. We randomly assigned participants (1:1) remotely using computer-generated allocation (minimisation used; stratified by depression severity [Patient Health Questionnaire 9 (PHQ-9) score of <19 vs ≥19], antidepressant use, and recruitment site) to BA from junior mental health workers or CBT from psychological therapists. Randomisation done at the Peninsula Clinical Trials Unit was concealed from investigators. Treatment was given open label, but outcome assessors were masked. The primary outcome was depression symptoms according to the PHQ-9 at 12 months. We analysed all those who were randomly allocated and had complete data (modified intention to treat [mITT]) and also all those who were randomly allocated, had complete data, and received at least eight treatment sessions (per protocol [PP]). We analysed safety in the mITT population. The non-inferiority margin was 1·9 PHQ-9 points. This trial is registered with the ISCRTN registry, number ISRCTN27473954. Findings Between Sept 26, 2012, and April 3, 2014, we randomly allocated 221 (50%) participants to BA and 219 (50%) to CBT. 175 (79%) participants were assessable for the primary outcome in the mITT population in the BA group compared with 189 (86%) in the CBT group, whereas 135 (61%) were assessable in the PP population in the BA group compared with 151 (69%) in the CBT group. BA was non-inferior to CBT (mITT: CBT 8·4 PHQ-9 points [SD 7·5], BA 8·4 PHQ-9 points [7·0], mean difference 0·1 PHQ-9 points [95% CI −1·3 to 1·5], p=0·89; PP: CBT 7·9 PHQ-9 points [7·3]; BA 7·8 [6·5], mean difference 0·0 PHQ-9 points [−1·5 to 1·6], p=0·99). Two (1%) non-trial-related deaths (one [1%] multidrug toxicity in the BA group and one [1%] cancer in the CBT group) and 15 depression-related, but not treatment-related, serious adverse events (three in the BA group and 12 in the CBT group) occurred in three [2%] participants in the BA group (two [1%] patients who overdosed and one [1%] who self-harmed) and eight (4%) participants in the CBT group (seven [4%] who overdosed and one [1%] who self-harmed). Interpretation We found that BA, a simpler psychological treatment than CBT, can be delivered by junior mental health workers with less intensive and costly training, with no lesser effect than CBT. Effective psychological therapy for depression can be delivered without the need for costly and highly trained professionals.

Sin, J. and D. Spain (2016). ***"Psychological interventions for trauma in individuals who have psychosis: A systematic review and meta-analysis."*** Psychosis: Psychological, Social and Integrative Approaches

Background: Psychological interventions, in particular those derived from cognitive-behavioural therapy frameworks, and eye movement desensitisation and reprocessing, are effective for reducing post-traumatic stress disorder and associated distress. To date, studies have tended to exclude individuals who have psychosis; a clinical population who are known to be at risk of experiencing trauma. Whether people with psychosis also benefit from trauma-focussed psychological therapies (TFPT) warrants further investigation. Method: A systematic search for randomised controlled trials was undertaken. Data were synthesised using narrative and meta-analytic approaches. Results: Five studies met the review inclusion criteria. Study findings overall indicate that TFPT are effective for reducing intrusive thoughts and images, negative beliefs associated with traumatic memories, hypervigilance, and avoidance. Limited data were available about the utility of interventions for improving mood, anxiety and quality of life. Attrition rates were comparable for participants offered active and control condition. Conclusion: Findings are consistent with those reported for the non-psychosis population. Future studies should establish which interventions are more acceptable and glean more favourable outcomes for this clinical population.

Skapinakis, P., D. Caldwell, et al. (2016). ***"A systematic review of the clinical effectiveness and cost-effectiveness of pharmacological and psychological interventions for the management of obsessive-compulsive disorder in children/adolescents and adults."*** Health Technol Assess 20(43). http://journalslibrary.nihr.ac.uk/hta/hta20430

Background Obsessive–compulsive disorder (OCD) is a relatively common and disabling condition. Objectives To determine the clinical effectiveness, acceptability and cost-effectiveness of pharmacological and psychological interventions for the treatment of OCD in children, adolescents and adults. Data sources We searched the Cochrane Collaboration Depression, Anxiety and Neurosis Trials Registers, which includes trials from routine searches of all the major databases. Searches were conducted from inception to 31 December 2014. Review methods We undertook a systematic review and network meta-analysis (NMA) of the clinical effectiveness and acceptability of available treatments. Outcomes for effectiveness included mean differences in the total scores of the Yale–Brown Obsessive–Compulsive Scale or its children's version and total dropouts for acceptability. For the cost-effectiveness analysis, we developed a probabilistic model informed by the results of the NMA. All analyses were performed using OpenBUGS version 3.2.3 (members of OpenBUGS Project Management Group; see http://www.openbugs.net). Results We included 86 randomised controlled trials (RCTs) in our systematic review. In the NMA we included 71 RCTs (54 in adults and 17 in children and adolescents) for effectiveness and 71 for acceptability (53 in adults and 18 in children and adolescents), comprising 7643 and 7942 randomised patients available for analysis, respectively. In general, the studies were of medium quality. The results of the NMA showed that in adults all selective serotonin reuptake inhibitors (SSRIs) and clomipramine had greater effects than drug placebo. There were no differences between SSRIs, and a trend for clomipramine to be more effective did not reach statistical significance. All active psychological therapies had greater effects than drug placebo. Behavioural therapy (BT) and cognitive therapy (CT) had greater effects than psychological placebo, but cognitive–behavioural therapy (CBT) did not. BT and CT, but not CBT, had greater effects than medications, but there are considerable uncertainty and methodological limitations that should be taken into account. In children and adolescents, CBT and BT had greater effects than drug placebo, but differences compared with psychological placebo did not reach statistical significance. SSRIs as a class showed a trend for superiority over drug placebo, but the difference did not reach statistical significance. However, the superiority of some individual drugs (fluoxetine, sertraline) was marginally statistically significant. Regarding acceptability, all interventions except clomipramine had good tolerability. In adults, CT and BT had the highest probability of being most cost-effective at conventional National Institute for Health and Care Excellence thresholds. In children and adolescents, CBT or CBT combined with a SSRI were more likely to be cost-effective. The results are uncertain and sensitive to assumptions about treatment effect and the exclusion of trials at high risk of bias. Limitations The majority of psychological trials included patients who were taking medications. There were few studies in children and adolescents. Conclusions In adults, psychological interventions, clomipramine, SSRIs or combinations of these are all effective, whereas in children and adolescents, psychological interventions, either as monotherapy or combined with specific SSRIs, were more likely to be effective. Future RCTs should improve their design, in particular for psychotherapy or combined interventions.

Vaillancourt-Morel, M.-P., N. Godbout, et al. (2016). ***"Adult sexual outcomes of child sexual abuse vary according to relationship status."*** Journal of Marital and Family Therapy 42(2): 341-356. http://dx.doi.org/10.1111/jmft.12154

This study tested a moderation model in which the association between child sexual abuse severity and negative sexual outcomes (i.e., sexual avoidance and compulsivity) differed as a function of relationships status (i.e., single, cohabiting, and married individuals). A sample of 1,033 adults completed self-report questionnaires online, and 21.5% reported childhood sexual abuse. Path analyses indicated that child sexual abuse severity was associated with higher sexual compulsivity in single individuals, both higher sexual avoidance and compulsivity in cohabiting individuals, and higher sexual avoidance in married individuals. The moderation model was invariant across men and women. These results suggest that the time course of negative sexual outcomes associated with child sexual abuse may follow distinct patterns of expression according to relationship status.

Veale, D., L. F. Lim, et al. (2016). ***"Sensitivity to change in the obsessive compulsive inventory: Comparing the standard and revised versions in two cohorts of different severity."*** Journal of Obsessive-Compulsive and Related Disorders 9: 16-23. http://www.sciencedirect.com/science/article/pii/S2211364916300045

The Obsessive Compulsive Inventory (OCI) is often used as a screening instrument for symptoms of Obsessive–Compulsive disorder (OCD) and as an outcome measure for treatment. Three versions of the OCI are available: the original 42-item version, the revised 18-item version (OCI-R) and a shorter version that focuses on the highest subscale (OCI-R Main). Our aim was to determine sensitivity to change and evaluate cut-off scores for caseness in each version of the OCI using the same dataset. Method: We compared the effect size and the number of patients who achieved reliable and clinically significant change after cognitive behavior therapy in two samples of out-patients with OCD. One sample (n=63) had OCD of minor to moderate severity and a second sample (n=73) had severe, treatment refractory OCD. Results: The OCI-R is a valid self-report outcome measure for measuring change and is less burdensome for patients to complete than the OCI. Questions remain about whether the OCI or OCI-R is sufficiently sensitive to change for a service evaluation. We would recommend a slightly higher cut-off score of ≥17 on the OCI-R for the definition of caseness. Discussion: In both samples, the OCI and OCI-R had very similar treatment effect sizes and to a lesser extent in the percentage who achieved reliable improvement and clinically significant change. The OCI-R Main was more sensitive to change than the OCI or OCI-R in both samples. All versions of the OCI were less sensitive to change compared with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS).

Wisco, B. E., A. S. Baker, et al. (2016). ***"Mechanisms of change in written exposure treatment of posttraumatic stress disorder."*** Behavior Therapy 47(1): 66-74. http://www.sciencedirect.com/science/article/pii/S0005789415000945

(Available in free full text) Although the effectiveness of exposure therapy for PTSD is recognized, treatment mechanisms are not well understood. Emotional processing theory (EPT) posits that fear reduction within and between sessions creates new learning, but evidence is limited by self-report assessments and inclusion of treatment components other than exposure. We examined trajectories of physiological arousal and their relation to PTSD treatment outcome in a randomized controlled trial of written exposure treatment, a protocol focused on exposure to trauma memories. Hierarchical linear modeling

was used to model reduction in Clinician Administered PTSD Scale score as a predictor of initial activation and within- and between-session change in physiological arousal. Treatment gains were significantly associated with initial physiological activation, but not with within- or between-session changes in physiological arousal. Treatment gains were associated with larger between-session reductions in self-reported arousal. These findings highlight the importance of multimethod arousal assessment and add to a growing literature suggesting refinements of EPT.