36 cbt & psychotherapy relevant abstracts may ’16 newsletter

(Anderson, Crowley et al. 2015; Clark and Egan 2015; Owen, Drinane et al. 2015; Aas, Henry et al. 2016; Anderson, McClintock et al. 2016; Berry and Danquah 2016; Caslini, Bartoli et al. 2016; Cassiello-Robbins and Barlow 2016; Crawford, Thana et al. 2016; Edmondson, Brennan et al. 2016; Enander, Andersson et al. 2016; Fleischman and Shorey 2016; Girme, Overall et al. 2016; Guidi, Tomba et al. 2016; Haug, Nordgreen et al. 2016; Hovenkamp-Hermelink, Riese et al. 2016; Infurna, Reichl et al. 2016; Kuipers, Onwumere et al. 2016; Le Grange 2016; Lemmens, DeRubeis et al. 2016; Levita, Salas Duhne et al. 2016; Levitt, Minami et al. 2016; Levitt, Pomerville et al. 2016; Lutz, Schiefele et al. 2016; Moyers, Houck et al. 2016; Oud, Mayo-Wilson et al. 2016; Owen, Wampold et al. 2016; Richards, Bower et al. 2016; Rousmaniere, Swift et al. 2016; Schöttke, Flückiger et al. 2016; Scott and Young 2016; Spinhoven, Elzinga et al. 2016; Tyrer, Eilenberg et al. 2016; Uher and Pavlova 2016; Westra, Constantino et al. 2016; Williams, Farquharson et al. 2016)

Aas, M., C. Henry, et al. (2016). ***"The role of childhood trauma in bipolar disorders."*** International Journal of Bipolar Disorders 4(1): 1-10. http://dx.doi.org/10.1186/s40345-015-0042-0

(Available in free full text) This review will discuss the role of childhood trauma in bipolar disorders. Relevant studies were identified via Medline (PubMed) and PsycINFO databases published up to and including July 2015. This review contributes to a new understanding of the negative consequences of early life stress, as well as setting childhood trauma in a biological context of susceptibility and discussing novel long-term pathophysiological consequences in bipolar disorders. Childhood traumatic events are risk factors for developing bipolar disorders, in addition to a more severe clinical presentation over time (primarily an earlier age at onset and an increased risk of suicide attempt and substance misuse). Childhood trauma leads to alterations of affect regulation, impulse control, and cognitive functioning that might decrease the ability to cope with later stressors. Childhood trauma interacts with several genes belonging to several different biological pathways [Hypothalamic–pituitary–adrenal (HPA) axis, serotonergic transmission, neuroplasticity, immunity, calcium signaling, and circadian rhythms] to decrease the age at the onset of the disorder or increase the risk of suicide. Epigenetic factors may also be involved in the neurobiological consequences of childhood trauma in bipolar disorder. Biological sequelae such as chronic inflammation, sleep disturbance, or telomere shortening are potential mediators of the negative effects of childhood trauma in bipolar disorders, in particular with regard to physical health. The main clinical implication is to systematically assess childhood trauma in patients with bipolar disorders, or at least in those with a severe or instable course. The challenge for the next years will be to fill the gap between clinical and fundamental research and routine practice, since recommendations for managing this specific population are lacking. In particular, little is known on which psychotherapies should be provided or which targets therapists should focus on, as well as how childhood trauma could explain the resistance to mood stabilizers.

Anderson, T., M. E. J. Crowley, et al. (2015). ***"Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome."*** Psychother Res. http://www.tandfonline.com/doi/full/10.1080/10503307.2015.1049671

Objectives: Therapist effects, independent of the treatment provided, have emerged as a contributor to psychotherapy outcomes. However, past research largely has not identified which therapist factors might be contributing to these effects, though research on psychotherapy implicates relational characteristics. The present Randomized Clinical Trial tested the efficacy of therapists who were selected by their facilitative interpersonal skills (FIS) and training status. Method: Sixty-five clients were selected from 2713 undergraduates using a screening and clinical interview procedure. Twenty-three therapists met with 2 clients for 7 sessions and 20 participants served in a no-treatment control group. Results: Outcome and alliance differences for Training Status were negligible. High FIS therapists had greater pre–post client outcome, and higher rates of change across sessions, than low FIS therapists. All clients treated by therapists improved more than the silent control, but effects were greater with high FIS than low FIS therapists. From the first session, high FIS therapists also had higher alliances than low FIS therapists as well as significant improvements on client-rated alliance. Conclusions: Results were consistent with the hypothesis that therapists’ common relational skills are independent contributors to therapeutic alliance and outcome.

Anderson, T., A. S. McClintock, et al. (2016). ***"A prospective study of therapist facilitative interpersonal skills as a predictor of treatment outcome."*** J Consult Clin Psychol 84(1): 57-66. http://www.ncbi.nlm.nih.gov/pubmed/26594945

OBJECTIVE: This study examined whether therapists' facilitative interpersonal skills (FIS) would prospectively predict the outcomes of therapies that occurred more than one year later. METHOD: Therapists were 44 clinical psychology trainees who completed the FIS performance task and a self-reported measure of social skills in the initial weeks of their training. In the FIS task, prospective therapists were presented with a standard set of videos portraying clients in therapy. Verbal responses to these therapeutic simulations were recorded and then rated by trained coders. More than one year later, the therapists began providing psychotherapy to clients in a psychology clinic. Clients completed a symptom measure before each therapy session. RESULTS: Using multilevel modeling, it was found that therapist FIS significantly predicted client symptom change. That is, higher FIS therapists were more effective than lower FIS therapists. However, subsequent analyses showed that this FIS effect was not uniform across all therapy durations; specifically, higher FIS therapists were more effective than lower FIS therapists over shorter durations (e.g., </=8 sessions) but did not differ from lower FIS therapists in effectiveness for the small percentage of therapies that were longer-term (e.g., >16 sessions). CONCLUSIONS: Therapists' interpersonal characteristics may influence client progress in therapy.

Berry, K. and A. Danquah (2016). ***"Attachment-informed therapy for adults: Towards a unifying perspective on practice."*** Psychology and Psychotherapy: Theory, Research and Practice 89(1): 15-32. http://dx.doi.org/10.1111/papt.12063

(Available in free full text) Purpose We aimed to provide an integrated overview of the key goals and strategies of an attachment-informed psychotherapy by summarizing the literature describing the clinical implications of attachment theory for psychological therapy for adults. Method We carried out a narrative thematic review of 58 texts from a diverse range of therapeutic schools, until we agreed that we had reached a saturation of themes. Results We identified six key themes: Changing internal working models; the therapeutic relationship and creating a secure base; formulating and processing relationship experiences; countertransference; separation, termination and boundary issues; and working with different attachment styles or patterns. We discuss empirical evidence in relation to each theme and highlight areas for research. Conclusions Attachment theory provides a useful framework to inform psychological therapy with adults, but there is a pressing need for further research to empirically demonstrate the ‘added value’ of an attachment perspective. Practitioner points * Attachment theory should be used to inform individual psychological therapy in adulthood. * From the outset of their careers, therapists should receive training and supervision to enhance their awareness of their own and their clients' attachment

experiences and how these play out during therapy. * There is a need for greater empirical research to investigate whether the degree to which therapists formulate and meet clients' attachment needs influences outcomes.

Caslini, M., F. Bartoli, et al. (2016). ***"Disentangling the association between child abuse and eating disorders: A systematic review and meta-analysis."*** Psychosomatic Medicine 78(1): 79-90. http://journals.lww.com/psychosomaticmedicine/Fulltext/2016/01000/Disentangling_the_Association_Between_Child_Abuse.10.aspx

Objectives: The aim of this systematic review and meta-analysis was to estimate the association between distinct types of child abuse—sexual (CSA), physical (CPA), and emotional (CEA)—and different eating disorders (EDs). Methods: Electronic databases were searched through January 2014. Studies reporting rates of CSA, CPA, and CEA in people with anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), as compared with individuals without EDs, were included. Pooled analyses were based on odds ratios (ORs), with relevant 95% confidence intervals (CIs), weighting each study with inverse variance models with random effects. Risk of publication bias was estimated. Results: Thirty-two of 1714 studies assessed for eligibility met the inclusion criteria, involving more than 14,000 individuals. The association between EDs and any child abuse showed a random-effects pooled OR of 3.21 (95% CI = 2.29–4.51, p < .001) with moderate heterogeneity (I2 = 57.2%, p = .005), whereas for CSA, this was 1.92 (95% CI = 1.13–3.28, p = .017), 2.73 (95% CI = 1.96–3.79, p < .001), and 2.31 (95% CI = 1.66–3.20, p < .001), for AN, BN, and BED, respectively. However, adjusting for publication bias, the estimate for CSA and AN was not significant (OR = 1.06, 95% CI = 0.59–1.88, p = .85). Although CPA was associated with AN, BN, and BED, CEA was associated just with BN and BED. Conclusions: BN and BED are associated with childhood abuse, whereas AN shows mixed results. Individuals with similar trauma should be monitored for early recognition of EDs.

Cassiello-Robbins, C. and D. H. Barlow (2016). ***"Anger: The unrecognized emotion in emotional disorders."*** Clinical Psychology: Science and Practice 23(1): 66-85. http://dx.doi.org/10.1111/cpsp.12139

Anger plays a prominent definitional role in some psychological disorders currently widely scattered across DSM-5 categories (e.g., intermittent explosive disorder, borderline personality disorder). But the presence and consequences of anger in the emotional disorders (e.g., anxiety disorders, depressive disorders) remain sparsely examined. In this review, we examine the presence of anger in the emotional disorders and find that anger is elevated across these disorders and, when it is present, is associated with negative consequences, including greater symptom severity and worse treatment response. Based on this evidence, anger appears to be an important and understudied emotion in the development, maintenance, and treatment of emotional disorders.

Clark, G. I. and S. J. Egan (2015). ***"The Socratic method in cognitive behavioural therapy: A narrative review."*** Cognitive Therapy and Research 39(6): 863-879. http://dx.doi.org/10.1007/s10608-015-9707-3

The Socratic Method has been described as an important component of CBT interventions yet an empirical case for its use has not been made. The objective of this paper is to review the role of the Socratic Method in CBT in four stages. First, a review of the literature describes how the Socratic Method is applied and defined within CBT, with assumptions regarding its proposed benefits identified. Second, a review of empirical literature demonstrates that multiple challenges to the evaluation of the Socratic Method exist and that no direct evidence supports the premise that it is beneficial in CBT. Evidence is examined which may suggest why the Socratic Method could be beneficial in therapy. Finally, the hypothesised function of the Socratic Method within therapy is discussed in reference to the Interacting Cognitive Subsystems framework. A number of avenues for future research are proposed in order to determine whether this potentially valuable therapeutic component contributes to the efficacy of CBT.

Crawford, M. J., L. Thana, et al. (2016). ***"Patient experience of negative effects of psychological treatment: Results of a national survey."*** The British Journal of Psychiatry 208(3): 260-265. http://bjp.rcpsych.org/content/bjprcpsych/208/3/260.full.pdf

Background To make informed choices, patients need information about negative as well as positive effects of treatments. There is little information about negative effects of psychological interventions.AimsTo determine the prevalence of and risk factors for perceived negative effects of psychological treatment for common mental disorders. Method Cross-sectional survey of people receiving psychological treatment from 184 services in England and Wales. Respondents were asked whether they had experienced lasting bad effects from the treatment they received.ResultsOf 14 587 respondents, 763 (5.2%) reported experiencing lasting bad effects. People aged over 65 were less likely to report such effects and sexual and ethnic minorities were more likely to report them. People who were unsure what type of therapy they received were more likely to report negative effects (odds ratio (OR) = 1.51, 95% CI 1.22–1.87), and those that stated that they were given enough information about therapy before it started were less likely to report them (OR = 0.65, 95% CI 0.54–0.79). Conclusions One in 20 people responding to this survey reported lasting bad effects from psychological treatment. Clinicians should discuss the potential for both the positive and negative effects of therapy before it starts. [Note too the Supporting Safe Therapy information resource at http://www.supportingsafetherapy.org].

Edmondson, A. J., C. A. Brennan, et al. (2016). ***"Non-suicidal reasons for self-harm: A systematic review of self-reported accounts."*** Journal of Affective Disorders 191: 109-117. http://www.sciencedirect.com/science/article/pii/S0165032715307485

(Available in free full text) Background Self-harm is a major public health problem yet current healthcare provision is widely regarded as inadequate. One of the barriers to effective healthcare is the lack of a clear understanding of the functions self-harm may serve for the individual. The aim of this review is to identify first-hand accounts of the reasons for self-harm from the individual's perspective. Method A systematic review of the literature reporting first-hand accounts of the reasons for self-harm other than intent to die. A thematic analysis and 'best fit' framework synthesis was undertaken to classify the responses. Results The most widely researched non-suicidal reasons for self-harm were dealing with distress and exerting interpersonal influence. However, many first-hand accounts included reasons such as self-validation, and self-harm to achieve a personal sense of mastery, which suggests individuals thought there were positive or adaptive functions of the act not based only on its social effects. Limitations Associations with different sub-population characteristics or with the method of harm were not available from most studies included in the analysis. Conclusions Our review identified a number of themes that are relatively neglected in discussions about self-harm, which we summarised as self-harm as a positive experience and defining the self. These self-reported "positive" reasons may be important in understanding and responding especially to repeated acts of self-harm.

Enander, J., E. Andersson, et al. (2016). ***"Therapist guided internet based cognitive behavioural therapy for body dysmorphic disorder: Single blind randomised controlled trial."*** BMJ 352. http://www.bmj.com/content/bmj/352/bmj.i241.full.pdf

(Available in free full text) Objectives To evaluate the efficacy of therapist guided internet based cognitive behavioural therapy (CBT) programme for body dysmorphic disorder (BDD-NET) compared with online supportive therapy. Design A 12 week single blind parallel group randomised controlled trial.Setting Academic medical centre. Participants 94 self referred adult outpatients with a diagnosis of body dysmorphic disorder and a modified Yale-Brown obsessive compulsive scale (BDD-YBOCS) score of ≥20. Concurrent psychotropic drug treatment was permitted if the dose had been stable for at least two months before enrolment and remained unchanged during the trial.Interventions Participants received either BDD-NET (n=47) or supportive therapy (n=47) delivered via the internet for 12 weeks.Main outcome measures The primary outcome was the BDD-YBOCS score after treatment and follow-up (three and six months from baseline) as evaluated by a masked assessor. Responder status was defined as a ≥30% reduction in symptoms on the scale. Secondary outcomes were measures of depression (MADRS-S), global functioning (GAF), clinical global improvement (CGI-I), and quality of life (EQ5D). The six month follow-up time and all outcomes other than BDD-YBOCS and MADRS-S at 3 months were not pre-specified in the registration at clinicaltrials.gov because of an administrative error but were included in the original trial protocol approved by the regional ethics committee before the start of the trial. Results BDD-NET was superior to supportive therapy and was associated with significant improvements in severity of symptoms of body dysmorphic disorder (BDD-YBOCS group difference −7.1 points, 95% confidence interval −9.8 to −4.4), depression (MADRS-S group difference −4.5 points, −7.5 to −1.4), and other secondary measures. At follow-up, 56% of those receiving BDD-NET were classed as responders, compared with 13% receiving supportive therapy. The number needed to treat was 2.34 (1.71 to 4.35). Self reported satisfaction was high. Conclusions CBT can be delivered safely via the internet to patients with body dysmorphic disorder. BDD-NET has the potential to increase access to evidence based psychiatric care for this mental disorder, in line with NICE priority recommendations. It could be particularly useful in a stepped care approach, in which general practitioner or other mental health professionals can offer treatment to people with mild to moderate symptoms at low risk of suicide.

Fleischman, S. and H. S. Shorey (2016). ***"The relationships between adult attachment, theoretical orientation, and therapist-reported alliance quality among licensed psychologists."*** Psychotherapy Research 26(1): 95-105. http://www.tandfonline.com/doi/full/10.1080/10503307.2014.947390

Objective: Attachment anxiety has been depicted as an undesirable therapist characteristic based on findings that preoccupied therapists, relative to those with other attachment styles, report more ruptures in the therapeutic alliance. What has not been considered, however, is the extent to which attachment dynamics are related to theoretical orientations and how attachment styles and theoretical orientations combine to predict therapists' perceptions of the quality of their alliances. Method: The present surveyed 290 licensed psychologists nationally. Results: Results revealed that even within a sample of primarily secure psychologists, higher 15 levels of attachment anxiety correlated positively with the endorsement of psychodynamic orientations, and negatively with the endorsement of cognitive-behavioral orientations and self-reported alliance quality. Endorsement of cognitive-behavioral orientations, in turn, correlated positively with therapist-reported alliance quality. Conclusion: The results are discussed in terms of the extent to which attachment dimensions should be considered in therapists' understandings of their therapeutic alliances.

Girme, Y. U., N. C. Overall, et al. (2016). ***"Happily single: The link between relationship status and well-being depends on avoidance and approach social goals."*** Social Psychological and Personality Science 7(2): 122-130. http://spp.sagepub.com/content/7/2/122.abstract

Although prior research suggests that single people experience lower well-being than those involved in romantic relationships, the effect of relationship status is small. Moreover, relationships can be a source of hurt and conflict, which single people can avoid. The current research examined for whom being involved in a relationship versus being single enhances versus undermines well-being by testing whether social goals moderated the link between relationship status and (1) daily life satisfaction (Study 1, N = 187, undergraduate sample) and (2) life satisfaction/well-being across time (Study 2, N = 4,024, nationally representative sample). In both studies, single people high in avoidance goals who strive to prevent relationship conflict and disagreements were just as happy as people involved in a relationship. In addition, individuals high in approach goals who strive to enhance relationship closeness experienced greater life satisfaction/well-being but particularly when they were involved in a relationship (Study 2).

Guidi, J., E. Tomba, et al. (2016). ***"The sequential integration of pharmacotherapy and psychotherapy in the treatment of major depressive disorder: A meta-analysis of the sequential model and a critical review of the literature."*** American Journal of Psychiatry 173(2): 128-137. http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2015.15040476

A number of randomized controlled trials in major depressive disorder have employed a sequential model, which consists of the use of pharmacotherapy in the acute phase and of psychotherapy in its residual phase. The aim of this review was to provide an updated meta-analysis of the efficacy of this approach in reducing the risk of relapse in major depressive disorder and to place these findings in the larger context of treatment selection. Method: Keyword searches were conducted in MEDLINE, EMBASE, PsycINFO, and Cochrane Library from inception of each database through October 2014. Randomized controlled trials examining the efficacy of the administration of psychotherapy after successful response to acute-phase pharmacotherapy in the treatment of adults with major depressive disorder were considered for inclusion in the meta-analysis. Results: Thirteen high-quality studies with 728 patients in a sequential treatment arm and 682 in a control treatment arm were included. All studies involved cognitive-behavioral therapy (CBT). The pooled risk ratio for relapse/recurrence was 0.781 (95% confidence interval [CI]=0.671–0.909; number needed to treat=8), according to the random-effects model, suggesting a relative advantage in preventing relapse/recurrence compared with control conditions. A significant effect of CBT during continuation of antidepressant drugs compared with antidepressants alone or treatment as usual (risk ratio: 0.811; 95% CI=0.685–0.961; number needed to treat=10) was found. Patients randomly assigned to CBT who had antidepressants tapered and discontinued were significantly less likely to experience relapse/recurrence compared with those assigned to either clinical management or continuation of antidepressant medication (risk ratio: 0.674; 95% CI=0.482–0.943; number needed to treat=5). Conclusions: The sequential integration of CBT and pharmacotherapy is a viable strategy for preventing relapse in major depressive disorder. The current indications for the application of psychotherapy in major depressive disorder are discussed, with special reference to its integration with pharmacotherapy.

Haug, T., T. Nordgreen, et al. (2016). ***"Working alliance and competence as predictors of outcome in cognitive behavioral therapy for social anxiety and panic disorder in adults."*** Behaviour Research and Therapy 77: 40-51. http://www.sciencedirect.com/science/article/pii/S000579671530067X

Objective The research on the association between the working alliance and therapist competence/adherence and outcome from cognitive behavioral therapy (CBT) is limited and characterized by inconclusive findings. This study investigates the working alliance and competence/adherence as predictors of outcome of CBT for social anxiety disorder (SAD) and panic disorder (PD). Method Eighty-two clinically referred patients (58.5% female; age: M = 33.6 years, SD = 10.3) with PD (n = 31) or SAD (n = 51) were treated with 12 sessions of manualized CBT by 22 clinicians with limited CBT experience in a randomized

controlled effectiveness trial. Independent assessors rated the CBT competence/adherence of the therapists using a revised version of the Cognitive Therapy Adherence and Competence Scale, and the patients rated the quality of the working alliance using the Working Alliance Inventory-short form in therapy sessions 3 and 8. The outcome was assessed by independent assessors as well as by patients self-report. A total of 20.7% of the patients (27.5% SAD, 9.7% PD) dropped out during treatment. The association between the alliance, competence/adherence, outcome and dropout was investigated using multiple regression analyses. Results Higher therapist' competence/adherence early in the therapy was associated with a better outcome among PD patients, lower competence/adherence was associated with dropout among SAD patients. Higher rating of the alliance late in the therapy was associated with a better outcome, whereas lower alliance rating late in the therapy was associated with dropout. Conclusion The findings indicate that the therapist competence/adherence and the working alliance have independent contributions to the outcome from CBT for anxiety disorders, but in different phases of the treatment.

Hovenkamp-Hermelink, J. H. M., H. Riese, et al. (2016). ***"Low stability of diagnostic classifications of anxiety disorders over time: A six-year follow-up of the NESDA study."*** Journal of Affective Disorders 190: 310-315. http://www.sciencedirect.com/science/article/pii/S0165032715306169

Background Stability of diagnosis was listed as an important predictive validator for maintaining separate diagnostic classifications in DSM-5. The aim of this study is to examine the longitudinal stability of anxiety disorder diagnoses, and the difference in stability between subjects with a chronic versus a non-chronic course. Methods Longitudinal data of 447 subjects with a current pure anxiety disorder diagnosis at baseline from the Netherlands Study of Depression and Anxiety were used. At baseline, 2-, 4-, and 6-year follow-up mental disorders were assessed and numbers (and percentages) of transitions from one anxiety disorder diagnosis to another were determined for each anxiety disorder diagnosis separately and for subjects with a chronic (i.e. one or more anxiety disorder at every follow-up assessment) and a non-chronic course. Results Transition percentages were high in all anxiety disorder diagnoses, ranging from 21.1% for social anxiety disorder to 46.3% for panic disorder with agoraphobia at six years of follow-up. Transition numbers were higher in the chronic than in the non-chronic course group (p=0.01). Limitations Due to the 2 year sample frequency, the number of subjects with a chronic course may have been overestimated as intermittent recovery periods may have been missed. Conclusions These data indicate that anxiety disorder diagnoses are not stable over time. The validity of the different anxiety disorder categories is not supported by these longitudinal patterns, which may be interpreted as support for a more pronounced dimensional approach to the classification of anxiety disorders.

Infurna, M. R., C. Reichl, et al. (2016). ***"Associations between depression and specific childhood experiences of abuse and neglect: A meta-analysis."*** Journal of Affective Disorders 190: 47-55. http://www.sciencedirect.com/science/article/pii/S0165032715305309

Background Research documents a strong relationship between childhood maltreatment and depression. However, only few studies have examined the specific effects of various types of childhood abuse/neglect on depression. This meta-analysis estimated the associations between depression and different types of childhood maltreatment (antipathy, neglect, physical abuse, sexual abuse, and psychological abuse) assessed with the same measure, the Childhood Experience of Care and Abuse (CECA) interview. Method A systematic search in scientific databases included use of CECA interview and strict clinical assessment for major depression as criteria. Our meta-analysis utilized Cohen's d and relied on a random-effects model. Results The literature search yielded 12 primary studies (reduced from 44), with a total of 4372 participants and 34 coefficients. Separate meta-analyses for each type of maltreatment revealed that psychological abuse and neglect were most strongly associated with the outcome of depression. Sexual abuse, although significant, was less strongly related. Furthermore, the effects of specific types of childhood maltreatment differed across adult and adolescent samples. Limitations Our strict criteria for selecting the primary studies resulted in a small numbers of available studies. It restricted the analyses for various potential moderators. Conclusion This meta-analysis addressed the differential effects of type of childhood maltreatment on major depression, partially explaining between-study variance. The findings clearly highlight the potential impact of the more "silent" types of childhood maltreatment (other than physical and sexual abuse) on the development of depression.

Kuipers, E., J. Onwumere, et al. (2016). ***"Psychological therapies for psychosis: A view from the hills."*** The Lancet Psychiatry 3(1): 9-10. http://www.sciencedirect.com/science/article/pii/S2215036615005702

(Available in free full text) Cognitive behavioural therapy for psychosis and family interventions for psychosis are two of the therapies that show the most convincing evidence of achieving meaningful outcomes for individuals with psychosis and their informal carers. 2015 saw several interesting publications describing applications of these therapies in a variety of contexts ... Taking service users' problems at face value, and demonstrating that people with psychosis—and their carers—can and should be offered the full range of treatments for their distress, is part of the continuing revolution in our understanding of how to improve outcomes for the wide range of difficulties people with psychosis can face.

Le Grange, D. (2016). ***"Elusive etiology of anorexia nervosa: Finding answers in an integrative biopsychosocial approach."*** Journal of the American Academy of Child & Adolescent Psychiatry 55(1): 12-13. http://www.sciencedirect.com/science/article/pii/S0890856715006851

(Free full text available) Elucidating etiology is essential for targeted prevention and efficacious treatment. Anorexia nervosa (AN), one of the more pernicious and deadly psychiatric disorders, requires such an understanding of the core links between cause of illness and intervention, yet the etiology of AN continues to elude us. In consequence, efficacious treatment remains a quagmire, and favorable outcomes for adolescents and especially adults remain a profound challenge. Our lack of etiologic clarity belies the immense effort many scholars in our field have devoted to uncovering pathways to find answers to better understand the cause(s) of AN. Most variables examined as possible etiology candidates, and using Kraemer et al.'s criteria, 1 typically qualify as "correlates," with few emerging as potential risk factors (variable or causal). Over the years, biological, psychological, and sociocultural models have been preeminent, each enjoying its time in the sun, and often to the exclusion of the others. With such discernable variations in etiologic models, related treatment strategies have been equally variable.2 However, current evidence is increasingly pointing to a closer interplay among these 3 parts of the etiology puzzle.3 and 4 For instance, a cultural environment that relentlessly amplifies a slender ideal, especially (albeit not exclusively) for its young female members, often has been put forward as the prime candidate in the etiology debate. However, we now know that AN—and personality traits such as perfectionism and neurocognitive processes such as inhibitory control—is heritable, and that a unique interaction among environment, genetics, and personality could be at the focal point of a better understanding of the etiology of AN ... The field is making significant strides in rendering the elusive nature of the etiology of eating disorders somewhat less elusive. Work such as Sundquist et al.'s study highlights the complexity of this task but also underscores that the answer is not a straightforward one. So, what do this study and the collective work of the "etiology searchers" in our field teach us at this time? The answers are probably to be found in an integrative biopsychosocial approach, in which researchers might want to heed the call, whenever possible, to use family studies and other genetically informative designs to tease these factors apart. That said, what we have learned so far is that individual differences, whether these are perfectionism, scholastic

achievement, or neural mechanisms, are strongly influenced by genetic and environmental factors that are probably working together, rather than independently. Moreover, we have learned that environmental experiences and developmental changes interact with, and influence, the expression of genetic risk. It goes without saying that many pieces of the etiology puzzle will continue to elude us for years to come, but collectively we are making great strides despite considerable headwinds.

Lemmens, L. H. J. M., R. J. DeRubeis, et al. (2016). ***"Sudden gains in cognitive therapy and interpersonal psychotherapy for adult depression."*** Behaviour Research and Therapy 77: 170-176. http://www.sciencedirect.com/science/article/pii/S0005796715300784

AbstractObjective We examined the rates, baseline predictors and clinical impact of sudden gains in a randomized comparison of individual Cognitive Therapy (CT) and Interpersonal Psychotherapy (IPT) for adult depression. Method 117 depressed outpatients received 16–20 sessions of either CT or IPT. Session-by-session symptom severity was assessed using the BDI-II. Sudden gains were examined using the original criteria as defined by Tang and DeRubeis (1999b). Furthermore, we examined whether the duration of the between-session interval at which sudden gains were recorded affected the results. Results There were significantly more patients with sudden gains in CT (42.2%) as compared to IPT (24.5%). The difference appeared to be driven by the criterion representing the stability of the gain. No between-group differences were found with regard to the magnitude, timing and predictors of the gains. Those with sudden gains were less depressed at post-treatment and follow-up. After controlling for the duration of the between-session interval, the difference in rates between the two conditions became a non-significant trend. Other sudden gains characteristics were similar to those observed when allowing for longer intervals as well. Conclusions The current study indicates differences in occurrence of sudden gains in two treatment modalities that overall showed similar results, which might reflect different mechanisms of change.

Levita, L., P. G. Salas Duhne, et al. (2016). ***"Facets of clinicians' anxiety and the delivery of cognitive behavioral therapy."*** Behaviour Research and Therapy 77: 157-161. http://www.sciencedirect.com/science/article/pii/S0005796715300796

Psychological therapists commonly fail to adhere to treatment protocols in everyday clinical practice. In part, this pattern of drift is attributable to anxious therapists being less likely to undertake some elements of evidence-based therapies – particularly the exposure-based elements. This study considers what facets of anxiety (cognitive, behavioral, physiological) are related to junior clinicians' reported use of cognitive-behavioral therapy techniques. Thirty-two clinicians (mean age = 28.9 years; mean length of CBT experience = 1.5 years; 23 female, nine male) who offered CBT were assessed for their cognitive, behavioral and physiological characteristics (Intolerance of Uncertainty scale; risk taking; skin conductance response and heart rate variability). While the three different facets of anxiety were relatively poorly associated with each other, as is usual in this literature, each facet was linked differently to the reported delivery of CBT techniques (P < .05). Overall, higher anxiety levels were associated with a poorer use of exposure methods or with a greater use of other behavioral or cognitive methods. Of the three facets of anxiety, only physiological reactivity showed an association with the clinicians' temporal characteristics, with more experienced therapists being more likely to have greater skin conductance responses to positive and negative outcomes. These findings suggest that clinicians who are more anxious are less likely to deliver the full evidence-based form of CBT and to focus instead on less challenging elements of the therapy. Potential ways of overcoming this limitation are discussed.

Levitt, H. M., T. Minami, et al. (2016). ***"How therapist self-disclosure relates to alliance and outcomes: A naturalistic study."*** Counselling Psychology Quarterly 29(1): 7-28. http://www.tandfonline.com/doi/full/10.1080/09515070.2015.1090396

This study examined therapists' self-disclosure within early sessions of a naturalistic database of 52 therapy dyads collected at a university counseling center. Therapist orientations and client issues varied. We identified both types and functions of therapist self-disclosure in order to explore how self-disclosures related to therapy alliance and outcomes. Findings indicated that the number of disclosures was not significantly correlated with outcome or alliance scores. Central findings regarding the function of self-disclosures included that disclosures that acted to humanize the therapist were associated with fewer clinical symptoms post-session than disclosures expressing appreciation or encouragement. Also, disclosures that conveyed similarity between the therapist and client were associated with fewer post-session clinical symptoms and interpersonal problems when compared to disclosures that conveyed neither similarity nor dissimilarity. As well, neutral therapist self-disclosures were associated with better client functioning than disclosures that relayed negative or positive information about the therapist. Suggestions are provided for clinical practice and future research.

Levitt, H. M., A. Pomerville, et al. (2016). ***"A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda."*** Psychol Bull. http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2016-21269-001

This article argues that psychotherapy practitioners and researchers should be informed by the substantive body of qualitative evidence that has been gathered to represent clients' own experiences of therapy. The current meta-analysis examined qualitative research studies analyzing clients' experiences within adult individual psychotherapy that appeared in English-language journals. This omnibus review integrates research from across psychotherapy approaches and qualitative methods, focusing on the cross-cutting question of how clients experience therapy. It utilized an innovative method in which 67 studies were subjected to a grounded theory meta-analysis in order to develop a hierarchy of data and then 42 additional studies were added into this hierarchy using a content meta-analytic method-summing to 109 studies in total. Findings highlight the critical psychotherapy experiences for clients, based upon robust findings across these research studies. Process-focused principles for practice are generated that can enrich therapists' understanding of their clients in key clinical decision-making moments. Based upon these findings, an agenda is suggested in which research is directed toward heightening therapists' understanding of clients and recognizing them as agents of change within sessions, supporting the client as self-healer paradigm. This research aims to improve therapists' sensitivity to clients' experiences and thus can expand therapists' attunement and intentionality in shaping interventions in accordance with whichever theoretical orientation is in use. The article advocates for the full integration of the qualitative literature in psychotherapy research in which variables are conceptualized in reference to an understanding of clients' experiences in sessions.

Lutz, W., A. K. Schiefele, et al. (2016). ***"Clinical effectiveness of cognitive behavioral therapy for depression in routine care: A propensity score based comparison between randomized controlled trials and clinical practice."*** J Affect Disord 189: 150-158. http://www.ncbi.nlm.nih.gov/pubmed/26433763

BACKGROUND: The efficacy of cognitive behavioral therapy (CBT) for the treatment of depressive disorders has been demonstrated in many randomized controlled trials (RCTs). This study investigated whether for CBT similar effects can be expected under routine care conditions when the patients are comparable to those examined in RCTs. METHOD: N=574 CBT patients from an outpatient clinic were stepwise matched to the patients undergoing CBT in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP). First, the exclusion criteria of the RCT were applied to the naturalistic sample of the outpatient clinic. Second, propensity score matching (PSM) was used to adjust the remaining naturalistic sample on the basis of baseline covariate distributions. Matched samples were then compared regarding treatment

effects using effect sizes, average treatment effect on the treated (ATT) and recovery rates. RESULTS: CBT in the adjusted naturalistic subsample was as effective as in the RCT. However, treatments lasted significantly longer under routine care conditions. LIMITATIONS: The samples included only a limited amount of common predictor variables and stemmed from different countries. There might be additional covariates, which could potentially further improve the matching between the samples. CONCLUSIONS: CBT for depression in clinical practice might be equally effective as manual-based treatments in RCTs when they are applied to comparable patients. The fact that similar effects under routine conditions were reached with more sessions, however, points to the potential to optimize treatments in clinical practice with respect to their efficiency.

Moyers, T. B., J. Houck, et al. (2016). ***"Therapist empathy, combined behavioral intervention, and alcohol outcomes in the combine research project."*** Journal of Consulting and Clinical Psychology 84(3): 221-229 http://psycnet.apa.org/journals/ccp/84/3/221/

Objective: Common factors such as therapist empathy play an important role in treatment for addictive behaviors. The present study was a secondary analysis designed to evaluate the relation between therapist empathy and alcohol treatment outcomes in data from a large, multisite, randomized controlled trial. Method: Audio-recorded psychotherapy sessions for 38 therapists and 700 clients had been randomly selected for fidelity coding from the combined behavioral intervention condition of Project COMBINE. Sessions were evaluated by objective raters for both specific content (coping with craving, building social skills, and managing negative mood) and relational components (empathy level of the therapist). Multilevel modeling with clients nested within therapists evaluated drinks per week at the end of treatment. Results: Approximately 11% of the variance in drinking was accounted for by therapists. A within-therapist effect of empathy was detected (B = −0.381, SE = 0.103, p < .001); more empathy than usual was associated with subsequent decreased drinking. The Social and Recreational Counseling module (B = −0.412, SE = 0.124, p < .001), Coping with Cravings and Urges module (B = −0.362, SE = 0.134, p < .01), and the Mood Management module (B = −0.403, SE = 0.138, p < .01) were also associated with decreased drinking. No between-therapist effect was detected, and the Empathy × Module Content interactions were not significant. Conclusions: The results of the study appear consistent with the hypothesis that skills building and therapist empathy are independent contributions to the overall benefit derived from the combined behavioral intervention.

Oud, M., E. Mayo-Wilson, et al. (2016). ***"Psychological interventions for adults with bipolar disorder: Systematic review and meta-analysis."*** The British Journal of Psychiatry 208(3): 213-222. http://bjp.rcpsych.org/content/bjprcpsych/208/3/213.full.pdf

Psychological interventions may be beneficial in bipolar disorder. Aims To evaluate the efficacy of psychological interventions for adults with bipolar disorder. Method A systematic review of randomised controlled trials was conducted. Outcomes were meta-analysed using RevMan and confidence assessed using the GRADE method. Results We included 55 trials with 6010 participants. Moderate-quality evidence associated individual psychological interventions with reduced relapses at post-treatment (risk ratio (RR) = 0.66, 95% CI 0.48–0.92) and follow-up (RR = 0.74, 95% CI 0.63–0.87), and collaborative care with a reduction in hospital admissions (RR = 0.68, 95% CI 0.49–0.94). Low-quality evidence associated group interventions with fewer depression relapses at post-treatment and follow-up, and family psychoeducation with reduced symptoms of depression and mania. Conclusions There is evidence that psychological interventions are effective for people with bipolar disorder. Much of the evidence was of low or very low quality thereby limiting our conclusions. Further research should identify the most effective (and cost-effective) interventions for each phase of this disorder.

Owen, J., J. M. Drinane, et al. (2015). ***"Psychotherapist effects in meta-analyses: How accurate are treatment effects?"*** Psychotherapy (Chic) 52(3): 321-328. http://www.ncbi.nlm.nih.gov/pubmed/26301423

Psychotherapists are known to vary in their effectiveness with their clients, in randomized clinical trials as well as naturally occurring treatment settings. The fact that therapists matter has 2 effects in psychotherapy studies. First, if therapists are not randomly assigned to modalities (which is rare) this may bias the estimation of the treatment effects, as the modalities may have therapists of differing skill. In addition, if the data are analyzed at the client level (which is virtually always the case) then the standard errors for the effect sizes will be biased due to a violation of the assumption of independence. Thus, the conclusions of many meta-analyses may not reflect true estimates of treatment differences. We reexamined 20 treatment effects selected from 17 meta-analyses. We focused on meta-analyses that found statistically significant differences between treatments for a variety of disorders by correcting the treatment effects according to the variability in outcomes known to be associated with psychotherapists. The results demonstrated that after adjusting the results based on most small estimates of therapist effects, approximately 80% of the reported treatment effects would still be statistically significant. However, at larger estimates, only 20% of the treatment effects would still be statistically significant after controlling for therapist effects. Although some meta-analyses were consistent in their estimates for treatment differences, the degree of certainty in the results was considerably reduced after considering therapist effects. Practice implications for understanding treatment effects, namely, therapist effects, in meta-analyses and original studies are provided.

Owen, J., B. E. Wampold, et al. (2016). ***"As good as it gets? Therapy outcomes of trainees over time."*** J Couns Psychol 63(1): 12-19. http://www.ncbi.nlm.nih.gov/pubmed/26751153

There is a paucity of empirical studies that demonstrate psychotherapy trainees improve at assisting their clients' therapy outcomes over time. We examined whether trainees (i.e., practicum, predoctoral interns, and postdoctoral fellows) improved in their clients' therapy outcomes over time. We examined 114 trainees (i.e., who were trainees for the first client in the database) and had over 12 months of client outcome data (M = 45.31 months). At the start of their time in our database, about half of the participants (48.2%) were predoctoral interns, 42.1% were practicum students, and 9.6% were postdoctoral fellows. Collectively, they treated 2,991 clients (M = 26 clients per trainee). Clients completed the Behavioral Health Measure, which assesses general psychological functioning (i.e., well-being, symptom distress, and life functioning), as a measure of therapy outcomes. Trainees demonstrated small-sized growth in their clients' outcomes over time (d = 0.04 per year); however, this growth was moderated by client severity. That is, trainees demonstrated growth over time in working with clients who were less distressed (d = -0.13 to 0.10 over time), but there was no change over time for trainees when working with more distressed clients (d = 0.67 to .65 over time). The results were consistent across trainee level (i.e., practicum, predoctoral intern, postdoctoral fellow), yet trainees varied in their patterns of growth. Psychotherapy training has a small, but positive, effect on trainees' ability to foster positive outcomes with their clients over time.

Richards, D. A., P. Bower, et al. (2016). ***"Clinical effectiveness and cost-effectiveness of collaborative care for depression in UK primary care (CADET): A cluster randomised controlled trial."*** Health Technol Assess 20(14): 1-192. http://www.ncbi.nlm.nih.gov/pubmed/26910256

(Free full text available) BACKGROUND: Collaborative care is effective for depression management in the USA. There is little UK evidence on its clinical effectiveness and cost-effectiveness. OBJECTIVE: To determine the clinical effectiveness and cost-effectiveness of collaborative care compared with usual care in the management of patients with moderate to severe

depression. DESIGN: Cluster randomised controlled trial. SETTING: UK primary care practices (n = 51) in three UK primary care districts. PARTICIPANTS: A total of 581 adults aged >/= 18 years in general practice with a current International Classification of Diseases, Tenth Edition depressive episode, excluding acutely suicidal people, those with psychosis, bipolar disorder or low mood associated with bereavement, those whose primary presentation was substance abuse and those receiving psychological treatment. INTERVENTIONS: Collaborative care: 14 weeks of 6-12 telephone contacts by care managers; mental health specialist supervision, including depression education, medication management, behavioural activation, relapse prevention and primary care liaison. Usual care was general practitioner standard practice. MAIN OUTCOME MEASURES: Blinded researchers collected depression [Patient Health Questionnaire-9 (PHQ-9)], anxiety (General Anxiety Disorder-7) and quality of life (European Quality of Life-5 Dimensions three-level version), Short Form questionnaire-36 items) outcomes at 4, 12 and 36 months, satisfaction (Client Satisfaction Questionnaire-8) outcomes at 4 months and treatment and service use costs at 12 months. RESULTS: In total, 276 and 305 participants were randomised to collaborative care and usual care respectively. Collaborative care participants had a mean depression score that was 1.33 PHQ-9 points lower [n = 230; 95% confidence interval (CI) 0.35 to 2.31; p = 0.009] than that of participants in usual care at 4 months and 1.36 PHQ-9 points lower (n = 275; 95% CI 0.07 to 2.64; p = 0.04) at 12 months after adjustment for baseline depression (effect size 0.28, 95% CI 0.01 to 0.52; odds ratio for recovery 1.88, 95% CI 1.28 to 2.75; number needed to treat 6.5). Quality of mental health but not physical health was significantly better for collaborative care at 4 months but not at 12 months. There was no difference for anxiety. Participants receiving collaborative care were significantly more satisfied with treatment. Differences between groups had disappeared at 36 months. Collaborative care had a mean cost of pound272.50 per participant with similar health and social care service use between collaborative care and usual care. Collaborative care offered a mean incremental gain of 0.02 (95% CI -0.02 to 0.06) quality-adjusted life-years (QALYs) over 12 months at a mean incremental cost of pound270.72 (95% CI -pound202.98 to pound886.04) and had an estimated mean cost per QALY of pound14,248, which is below current UK willingness-to-pay thresholds. Sensitivity analyses including informal care costs indicated that collaborative care is expected to be less costly and more effective. The amount of participant behavioural activation was the only effect mediator. CONCLUSIONS: Collaborative care improves depression up to 12 months after initiation of the intervention, is preferred by patients over usual care, offers health gains at a relatively low cost, is cost-effective compared with usual care and is mediated by patient activation. Supervision was by expert clinicians and of short duration and more intensive therapy may have improved outcomes. In addition, one participant requiring inpatient treatment incurred very significant costs and substantially inflated our cost per QALY estimate. Future work should test enhanced intervention content not collaborative care per se.

Rousmaniere, T. G., J. K. Swift, et al. (2016). ***"Supervisor variance in psychotherapy outcome in routine practice."*** Psychother Res 26(2): 196-205. http://www.ncbi.nlm.nih.gov/pubmed/25274037

OBJECTIVE: Although supervision has long been considered as a means for helping trainees develop competencies in their clinical work, little empirical research has been conducted examining the influence of supervision on client treatment outcomes. Specifically, one might ask whether differences in supervisors can predict/explain whether clients will make a positive or negative change through psychotherapy. METHOD: In this naturalistic study, we used a large (6521 clients seen by 175 trainee therapists who were supervised by 23 supervisors) 5-year archival data-set of psychotherapy outcomes from a private nonprofit mental health center to test whether client treatment outcomes (as measured by the OQ-45.2) differed depending on who was providing the supervision. Hierarchical linear modeling was used with clients (Level 1) nested within therapists (Level 2) who were nested within supervisors (Level 3). RESULTS: In the main analysis, supervisors explained less than 1% of the variance in client psychotherapy outcomes. CONCLUSIONS: Possible reasons for the lack of variability between supervisors are discussed.

Schöttke, H., C. Flückiger, et al. (2016). ***"Predicting psychotherapy outcome based on therapist interpersonal skills: A five-year longitudinal study of a therapist assessment protocol."*** Psychother Res. http://www.tandfonline.com/doi/abs/10.1080/10503307.2015.1125546?src=recsys

Objective: In the past decade, variation in outcomes between therapists (i.e., therapist effects) have become increasingly recognized as an important factor in psychotherapy. Less is known, however, about what accounts for differences between therapists. The present study investigates the possibility that therapists' basic therapy-related interpersonal skills may impact outcomes. Method: To examine this, psychotherapy postgraduate trainees completed both an observer- and an expert-rated behavioral assessment: the Therapy-Related Interpersonal Behaviors (TRIB). TRIB scores were used to predict trainees' outcomes over the course of the subsequent five years. Results: Results indicate that trainees' with more positively rated interpersonal behaviors assessed in the observer-rated group format but not in a single expert-rated format showed superior outcomes over the five-year period. This effect remained controlling for therapist characteristics (therapist gender, theoretical orientation [cognitive behavioral or psychodynamic], amount of supervision, patient's order within therapist's caseload), and patient characteristics (patient age, gender, number of comorbid diagnoses, global severity, and personality disorder diagnosis). Conclusions: These findings underscore the importance of therapists' interpersonal skills as a predictor of outcome and source of therapist effects. The potential utility of assessing therapists' and therapists-in-training interpersonal skills are discussed.

Scott, J. and A. H. Young (2016). ***"Psychotherapies should be assessed for both benefit and harm."*** The British Journal of Psychiatry 208(3): 208-209. http://bjp.rcpsych.org/content/bjprcpsych/208/3/208.full.pdf

The past four decades have witnessed a transformation in research on the benefits of psychological therapies. However, even though therapists highlight that negative and adverse effects are seen in day-to-day practice, research on the negative effects of psychotherapy is insufficient. Given the unrelenting popularity of therapies, the argument for examining the adverse effects of psychotherapy would seem to be compelling. Such a strategy would extend beyond supervision of individual therapists to the introduction of monitoring systems that allow for a more systematic examination of failed psychotherapy interventions (such as exist for medication prescribing). The starting point could be the development of a consensus on how to define, classify and assess psychotherapy side-effects, unwanted events, adverse reactions, etc. This would provide a conceptual framework for communication, monitoring and research. This approach should not be viewed as an attack on therapies: every branch of medicine learns from mistakes, the same must surely be true for psychological treatments.

Spinhoven, P., B. M. Elzinga, et al. (2016). ***"Childhood maltreatment, maladaptive personality types and level and course of psychological distress: A six-year longitudinal study."*** Journal of Affective Disorders 191: 100-108. http://www.sciencedirect.com/science/article/pii/S0165032715304572

Background Childhood maltreatment and maladaptive personality are both cross-sectionally associated with psychological distress. It is unknown whether childhood maltreatment affects the level and longitudinal course of psychological distress in adults and to what extent this effect is mediated by maladaptive personality. Methods A sample of 2947 adults aged 18–65, consisting of healthy controls, persons with a prior history or current episode of depressive and/or anxiety disorders according to the Composite Interview Diagnostic Instrument were assessed in six waves at baseline (T0) and 1 (T1), 2 (T2), 4 (T4) and 6 years (T6) later. At each wave psychological distress was measured with the Inventory of Depressive

Symptomatology, Beck Anxiety Inventory, and Fear Questionnaire. At T0 childhood maltreatment types were measured with a semi-structured interview (Childhood Trauma Interview) and personality traits with the NEO-Five Factor Inventory. Results Using latent variable analyses, we found that severity of childhood maltreatment (emotional neglect and abuse in particular) predicted higher initial levels of psychological distress and that this effect was mediated by maladaptive personality types. Differences in trajectories of distress between persons with varying levels of childhood maltreatment remained significant and stable over time. Limitations Childhood maltreatment was assessed retrospectively and maladaptive personality types and level of psychological distress at study entry were assessed concurrently. Conclusions Routine assessment of maladaptive personality types and possible childhood emotional maltreatment in persons with severe and prolonged psychological distress seems warranted to identify persons who may need a different or more intensive treatment.

Tyrer, P., T. Eilenberg, et al. (2016). ***"Health anxiety: The silent, disabling epidemic."*** BMJ 353. http://www.bmj.com/content/bmj/353/bmj.i2250.full.pdf

(BMJ editorial) We are glad to say, Mr Jones, that all your test results are normal and you have nothing to fear." Mr Jones has received this message many times after being examined for many severe diseases such as cancer, multiple sclerosis, and heart disease, which over the years he has been convinced he must have. Yet, this is the core of his problem—despite how much he would like to, he cannot do what the doctor says: stop worrying. He used to attend his general practitioner frequently to be reassured that nothing was wrong with him, but the reassurance was only short lived and then the worrying started all over again. After many years of distress, Mr Jones is embarrassed that he cannot control his health worries and preoccupation and has lately avoided contact with his GP, knowing it does not help him very much. Mr Jones is not alone. He joins many others with health anxiety. This diagnosis is a relatively recent one that will be unfamiliar to many readers of this journal. It overlaps with hypochondriasis and the new "illness anxiety disorder" in the American classification DSM-5, but it differs in several important respects. Illness anxiety disorder is narrowly defined; it includes only patients who do not display somatic symptoms, and this limits its use in clinical practice. The diagnosis of health anxiety is empirically based and defined by cognitive and emotional symptoms that allow it to coexist with other diseases. Both health anxiety and illness anxiety are primarily anxiety disorders and are unsatisfactorily lumped with somatic ones. Despite anxiety being the core component, people with health anxiety are rarely seen by psychiatrists; most attend primary care or secondary hospital clinics. Here, sadly, the pathology often goes unrecognised and is treated inappropriately by reassurance and investigations that invariably have negative results. Neither the patient nor the physician doubts that anxiety is present; what fails to be noticed is that, unlike people who want relief from somatic symptoms alone, people with health anxiety do not ask for such relief, only freedom from worry about disease. Research has also shown that a key component of health anxiety is rumination, so that patients cannot stop thinking about a disease once the thought has come into their mind. Health anxiety is remarkably common, persistent, and a generator of long term morbidity and increased sick leave. It is often found in conjunction with other disorders, including physical ones. Formerly, hypochondriasis could be diagnosed only in the absence of physical disease, but this can be present, and often is, in health anxiety. There are other people with health anxiety who are so concerned that they might have a feared diagnosis that they avoid consultation altogether. Not surprisingly, it is difficult to know the size of this group. What is now abundantly clear is that people with health anxiety do not get better without the right intervention and experience great distress from their symptoms. Health anxiety is reaching epidemic proportions. In 2007 the Australian National survey found that 3.4% of people in the community met the diagnostic criteria.8 Much higher levels are found in secondary care. In a study carried out in 2006 in north Nottinghamshire with patients attending cardiology, respiratory medicine, gastroenterology, and endocrinology clinics, 12% had excessive health anxiety, but four years later in the same clinics this had risen to 20%. What is the explanation for this big rise? Methodological differences and change in diagnostic criteria may have a role. But a more likely explanation is the increased pathologisation of our society combined with internet browsing, appropriately called cyberchondria. Although the internet is of great value for those seeking the cause of medical symptoms, it is a menace for those with health anxiety. People with health anxiety pay selective attention to the most serious explanation of symptoms, even though these may be very uncommon. So to say to people with health anxiety that their chances of having a particular disease is only 1 in 1000 is of little benefit. This knowledge often just convinces them that they are indeed that one person. Because many doctors are not familiar with diagnosing health anxiety, and because those affected are presenting to clinics where there is limited psychological knowledge, the right treatment is seldom given. Several highly effective psychological treatments are now available, ranging from traditional cognitive therapy to group based mindfulness and acceptance and commitment therapy. An additional bonus is that the benefit from these treatments tends to be long lasting. This is relevant to referral practice; GPs are more likely to ask for help for people with panic and generalised anxiety symptoms, even though these symptoms commonly return after initial benefit. For people who recognise that they have health anxiety, treatment over the internet has also been found to be both cost effective and long lasting. There is also good evidence that some of these treatments can be given successfully by trained general nurses, whom patients may be more willing to accept as therapists than psychologists. So what is needed now? Physicians in primary and secondary care need to be more aware of this important diagnosis and not to regard their tasks as being restricted to excluding disease in their particular specialty. The diagnosis is in most cases easy to establish using research criteria, and, contrary to what many believe, it is well accepted by patients if explained respectfully. All patients with health anxiety should now be offered the many established, effective, evidence based treatments.

Uher, R. and B. Pavlova (2016). ***"Long-term effects of depression treatment."*** The Lancet Psychiatry 3(2): 95-96. http://www.sciencedirect.com/science/article/pii/S2215036615005787

(Available in free full text) In most cases, depression is a recurrent or chronic condition that affects individuals over the course of their lifetime.1 The realisation that depression needs long-term treatment2 has not been matched by adequate evidence of the long-term effects of specific treatments, leaving a major gap in evidence for the clinical practice of psychiatry. The most commonly used long-term treatment is maintenance antidepressants. However, for most antidepressant drugs, the efficacy of treatment lasting more than 1 year is unknown. The absence of evidence of the long-term therapeutic effects of antidepressant drugs leaves uncertainty and invites controversy. In The Lancet Psychiatry, the Article by Nicola Wiles and colleagues 3 brings perhaps the most substantial body of evidence of the long-term effects of a treatment of major depressive disorder: a comprehensive report of the effectiveness and cost-effectiveness of adjunctive cognitive behavioural therapy (CBT) in a 3·5 year follow-up of the CoBalT trial. In the CoBalT trial, 469 primary care patients with depressive symptoms of at least moderate severity despite adherence to antidepressant treatment were randomly allocated to be offered a course of 12 to 18 sessions of individual CBT or to continue their usual care that included antidepressants. Most participants had chronic and severe depression with comorbid anxiety disorders. Those who were offered the adjunctive CBT had fewer depressive symptoms and were more likely to fulfil criteria for response at 6 and 12 month follow-up.4 In the present study, Wiles and colleagues report the results of a 46 months follow-up. Outcomes were available from roughly 60% of participants. They showed that the benefits of CBT were fully maintained. More than 3 years after the end of treatment, participants who were allocated to CBT continued to do better on several self-reported outcomes and the effect sizes were similar to those at 6 and 12 months. Participants who received CBT scored roughly four points lower on the Beck Depression Inventory (mean score of 19·2 with CBT vs 23·4 without CBT), two points lower on the Patient Health Questionnaire, had fewer anxiety symptoms, and were twice as likely to meet

criteria for response or remission. These differences in outcomes were maintained for more than 3 years whereas four-fifths of participants in both groups continued to take antidepressant drugs. An accompanying health economic analysis shows that add-on individual CBT provides exceptionally good value for money.

Westra, H. A., M. J. Constantino, et al. (2016). ***"Integrating motivational interviewing with cognitive-behavioral therapy for severe generalized anxiety disorder: An allegiance-controlled randomized clinical trial."*** J Consult Clin Psychol. http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/ccp0000098

OBJECTIVE: Although integrating motivational interviewing (MI) and cognitive-behavioral therapy (CBT) has been recommended for treating anxiety, few well-controlled tests of such integration exist. METHOD: In the present randomized trial for severe generalized anxiety disorder (GAD), we compared the efficacy of 15 sessions of CBT alone (N = 43) versus 4 MI sessions followed by 11 CBT sessions integrated with MI to address client resistance/ambivalence (N = 42). Clients were adults, predominantly female and Caucasian, with a high rate of diagnostic comorbidity. To control for allegiance, therapists were nested within treatment group and supervised separately by experts in the respective treatments. RESULTS: Piecewise multilevel models revealed no between-groups differences in outcomes from pre- to posttreatment; however, there were treatment effects over the follow-up period with MI-CBT clients demonstrating a steeper rate of worry decline (gamma = -0.13, p = .03) and general distress reduction (gamma = -0.12, p = .01) than CBT alone clients. Also, the odds of no longer meeting GAD diagnostic criteria were approximately 5 times higher at 12-months for clients receiving MI-CBT compared with CBT alone. There were also twice as many dropouts in CBT alone compared with MI-CBT (23% vs. 10%); a difference that approached significance (p = .09). The treatments were competently delivered, and intraclass correlations revealed negligible between-therapist effects on the outcomes. CONCLUSIONS: The findings support the integration of MI with CBT for severe GAD and point to the importance of training therapists in appropriate responsivity to in-session markers of resistance and ambivalence. (PsycINFO Database Record

Williams, R., L. Farquharson, et al. (2016). ***"Patient preference in psychological treatment and associations with self-reported outcome: National cross-sectional survey in England and Wales."*** BMC Psychiatry 16(1): 1-8. http://dx.doi.org/10.1186/s12888-015-0702-8

(Available in free full text) Background Providers of psychological therapies are encouraged to offer patients choice about their treatment, but there is very little information about what preferences people have or the impact that meeting these has on treatment outcomes. Method Cross-sectional survey of people receiving psychological treatment from 184 NHS services in England and Wales. 14,587 respondents were asked about treatment preferences and the extent to which these were met by their service. They were also asked to rate the extent to which therapy helped them cope with their difficulties. Results Most patients (12,549–86.0 %, 95 % CI: 85.5–86.6) expressed a preference for at least one aspect of their treatment. Of these, 4,600 (36.7 %, 95 % CI: 35.8–37.5) had at least one preference that was not met. While most patients reported that their preference for appointment times, venue and type of treatment were met, only 1,769 (40.5 %) of the 4,253 that had a preference for gender had it met. People who expressed a preference that was not met reported poorer outcomes than those with a preference that was met (Odds Ratios: appointment times = 0.29, venue = 0.32, treatment type = 0.16, therapist gender = 0.32, language in which treatment was delivered = 0.40). Conclusions Most patients who took part in this survey had preferences about their treatment. People who reported preferences that were not met were less likely to state that treatment had helped them with their problems. Routinely assessing and meeting patient preferences may improve the outcomes of psychological treatment.