Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review

THIRD EDITION

The Australian Psychological Society Ltd

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This document presents a comprehensive review of the best available evidence up to January 2010, examining the efficacy of a broad range of psychological interventions across the mental disorders affecting adults, adolescents and children. Evidence published after this date has not been reviewed. While every reasonable effort has been made to ensure the accuracy of the information, no guarantee can be given that the information is free from error or omission. The APS, its employees and agents shall accept no liability for any act or omission occurring from reliance on the information provided, or for any consequences of any such act or omission. The APS does not accept any liability for any injury, loss or damage incurred by use of or reliance on the information. Such damages include, without limitation, direct, indirect, special, incidental or consequential.

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Table of Contents

EXAMINATION OF THE EVIDENCE BASE FOR PSYCHOLOGICAL INTERVENTIONS IN THE TREATMENT OF MENTAL DISORDERS 1

REVIEW METHODOLOGY 4

DESCRIPTION OF INTERVENTIONS 6

PRESENTATION AND REPORTING 9

ABBREVIATIONS 10

CATEGORISATION OF LEVEL OF EVIDENCE SUMMARY TABLE 10

MENTAL DISORDERS: ADULT 13

MENTAL DISORDERS: ADOLESCENTS AND CHILDREN 132

Examination of the evidence base for psychological interventions in the treatment of mental disorders

BACKGROUND

An update of the 2006 systematic review of the literature examining the efficacy of a broad range of psychological interventions for the ICD-10 mental disorders has been undertaken to support the delivery of psychological services under government mental health initiatives. Delivery of evidence-based psychological interventions by appropriately trained mental health professionals is seen as best practice for Australian psychological service delivery. Therefore, keeping abreast of new developments in the treatment of mental disorders is crucial to best practice.

Many psychological interventions have not yet been empirically investigated because they do not lend themselves to study under existing research paradigms. The body of evidence-based research will continue to expand over time as the barriers to conducting systematic evaluations of the effectiveness of various interventions are identified and new research methodologies are developed. This review reflects the current state of research knowledge.

This review builds on the earlier literature review by expanding the list of mental disorders to include posttraumatic stress disorder, social anxiety, and somatoform disorders. Borderline personality disorder has also been included in this review. The complete list of disorders reviewed in this document is outlined below.

DISORDERS INCLUDED IN REVIEW

Mood disorders
> Depression
> Bipolar disorder

Anxiety disorders
> Generalised anxiety disorder
> Panic disorder
> Specific phobia
> Social anxiety disorder
> Obsessive compulsive disorder
> Posttraumatic stress disorder

Substance use disorders

Eating disorders
> Anorexia nervosa
> Bulimia nervosa
> Binge eating disorder

Adjustment disorder

Sleep disorders

Sexual disorders

Somatoform disorders
> Pain disorder
> Chronic fatigue syndrome
> Somatisation disorder
> Hypochondriasis
> Body dysmorphic disorder

Borderline personality disorder

Psychotic disorders

Dissociative disorders

Childhood disorders
> Attention deficit hyperactivity disorder
> Conduct disorder
> Enuresis

EVIDENCE-BASED PRACTICE IN AUSTRALIAN HEALTHCARE

Evidence-based practice has become a central issue in the delivery of health care in Australia and internationally. Best practice is based on a thorough evaluation of evidence from published research studies that identifies interventions to maximise the chance of benefit, minimise the risk of harm and deliver treatment at an acceptable cost. Government-sponsored health programs quite reasonably require the use of treatment interventions that are considered to be evidence-based as a means of discerning the allocation of funding. It is appropriate that these are interventions that have been shown to be effective according to the best available research evidence.

NHMRC guidelines for evaluating evidence

The National Health and Medical Research Council (NHMRC) has published a clear and accessible guide for evaluating evidence and developing clinical practice guidelines[1]. The NHMRC guide informs public health policy in Australia and has been adopted as protocol for evidence reports by the Australian Psychological Society.

Using the best available evidence

The evidence on which a treatment recommendation is based is graded by the NHMRC according to the criteria of level, quality, relevance and strength. The 'level' and 'quality' of evidence refers to the study design and methods used to eliminate bias. Level 1, the highest level, is given to a systematic review of high quality randomised clinical trials – those trials that eliminate bias through the random allocation of subjects to either a treatment or control group. The NHMRC has developed a rating scale to designate the level of evidence of clinical studies.

LEVEL	Evidence source
I	Systematic review of all relevant randomised controlled trials
II	At least one properly designed randomised controlled trial
III-1	Well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III-2	Comparative studies with concurrent controls and allocation not randomised (cohort studies) or interrupted time series with a control group
III-3	Comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group
IV	Case series, either post-test, or pre-test and post-test

Source: NHMRC, 1999

According to the NHMRC, the 'relevance' of evidence refers to the extent to which the findings from a study can be applied to other clinical settings and different groups of people. This should also include consideration of relevant outcomes from the consumer's perspective, such as improved quality of life. Finally, the 'strength' of evidence relates to the size of the treatment effect seen in clinical studies. Strong treatment effects are less likely than weak effects to be the result of bias in research studies and are more likely to be clinically important.

Using evidence to make recommendations for treatment

According to the NHMRC, evidence is necessary but not sufficient in making recommendations for treatment. Assessing the evidence according to the criteria of level, quality, relevance and strength, and then turning it into clinically useful recommendations depends on the judgement and experience the expert clinicians whose task it is to develop treatment guidelines.

There is debate about what defines 'evidence-based' practice. Some clinicians believe that only psychological interventions that have demonstrated treatment efficacy by the 'gold standard' of clinical trials – randomised controlled trials (RCTs) – should be endorsed.
Others contend that psychological research evidence

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[1] National Health and Medical Research Council (1999). *A guide to the development, implementation and evaluation of clinical practice guidelines*. Canberra: Author.

should be gathered from broader methodologies and that, for instance, the psychotherapeutic experience cannot be captured in RCTs. This debate has also contributed to the momentum for broadening this latest review of the literature to a more comprehensive range of psychological interventions for various mental disorders than in previous APS reviews. In addition, although RCTs are identified as providing the strongest evidence, a range of other methodologies for investigating the efficacy of interventions have been adopted. Further, the importance of therapist and client variables as contributors to treatment outcomes is acknowledged, and a summary of the implications of non-intervention factors to clinical outcomes is provided.

A criticism of the use of the RCT as a necessary measure of the success of an intervention has been that in the real world the treatment setting is never as controlled as in RCT conditions. This has led to the debate between studies of treatment efficacy (controlled studies) and studies of treatment effectiveness (studies in a naturalistic setting). It can be argued that both are important and that effectiveness studies complement RCTs by demonstrating efficacy in actual treatment settings and identifying factors in the real life setting that impact on treatment efficacy.[2]

RELEVANCE OF THERAPIST AND CLIENT CHARACTERISTICS

The NHMRC states that in order to provide quality health outcomes, clients' preferences and values, clinicians' experience, and the availability of resources also need to be considered in addition to research evidence. Effective evidence-based psychological practice requires more than a mechanistic adherence to well-researched intervention strategies. Psychological practice also relies on clinical expertise in applying empirically supported principles to develop a diagnostic formulation, form a therapeutic alliance, and collaboratively plan treatment within a client's socio-cultural context. The best-researched treatments will not work unless clinicians apply them effectively and clients accept them. A Policy Statement on Evidence-Based Practice in Psychology by the American Psychological Association (APA) explicitly enshrines the role of clinical expertise and client values – alongside the application of best available research evidence – in its definition of evidence-based practice, "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences".[3]

According to the APA, therapist interpersonal skills that manifest in the form of the therapeutic relationship and therapist competencies in assessment and treatment processes are central to positive treatment outcomes. In addition, some of the client characteristics that can impact on treatment outcomes include cultural and family factors, level of social support, environmental context and personal preferences and values.

Increasingly researchers are adopting the view that as well as investigating the efficacy of specific interventions, there is a need to better understand the factors in the real world treatment setting, some of which have been briefly outlined here, that contribute to outcomes. A better understanding of these factors will assist practitioners to provide best practice interventions along with best therapeutic process in care settings.

USING EVIDENCE-BASED PSYCHOLOGICAL INTERVENTIONS IN PRACTICE

Using evidence-based psychological interventions in practice requires a complex combination of relational and technical skills, with attention to both clinical and research sources of evidence to identify treatment efficacy. This requires the use of empirical principles and systematic observation to accurately assess mental disorders and develop a diagnostic formulation, select a treatment strategy, and to collaboratively set goals of treatment with consideration of a client's unique presentation and within the limits of available resources. The choice of treatment strategies requires knowledge of interventions and the research supporting their effectiveness, in addition to skills that address different psychosocio-cultural circumstances in any given individual situation. For comprehensive evidence-based health care, the scientific method remains the best tool for systematic observation and for identifying which interventions are effective for whom under what circumstances.

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[2] Summerfelt, W. T., & Herbert, Y. M. (1998). Efficacy vs effectiveness in psychiatric research. *Psychiatric Services, 49*, 834.

[3] American Psychological Association. (2005). *Policy statement on evidence-based practice in psychology.* 2005 Presidential Task Force on Evidence-Based Practice. Author.

Review methodology

AIM OF REVIEW

The purpose of this literature review was to assess evidence for the effectiveness or efficacy of specific psychological interventions for each of the ICD-10 disorders listed on page 1.

ARTICLE SELECTION

Articles were included in the review if they:

> Were published after 2004, except where no post-2004 studies investigating the specific intervention were found or if the study provided additional information that related to a specific population (e.g., older adults) or a specific context (e.g., inpatient setting)

> Investigated interventions for a specific mental disorder

> Were published in a scientific journal or practice guideline. No unpublished studies, other grey literature[4], or studies captured in a post-2004 systematic review (or meta-analysis) were included

STUDIES ASSESSING INTERVENTIONS

The types of studies included in this review are listed below.

Systematic reviews and meta-analyses

A *systematic review* is a literature review, focused on a particular question, which attempts to identify, evaluate, select and synthesise all relevant high quality research. The quality of studies to be incorporated into a review is carefully considered, using predefined criteria. In most cases only RCTs are included; however, other types of evidence may also be taken into account. If the data collected in a systematic review is of sufficient quality and similar enough, it can be quantitatively synthesised in a *meta-analysis*. This process generally provides a better overall estimate of a clinical effect than do the results from individual studies. A meta-analysis also allows for a more detailed exploration of specific components of a treatment, for example, the effect of treatment on a particular sub-group.

Randomised controlled trial

An *experimental study* (or controlled trial) is a statistical investigation that involves gathering empirical and measurable evidence. Unlike research conducted in a naturalistic setting, in experimental studies it is possible to control for potential compounding factors. The most robust form of experimental study is the RCT. In RCTs participants are allocated at random (using random number generators) to either treatment or control groups to receive or not receive one or more interventions that are being compared. The primary purpose of randomisation is to create groups as similar as possible, with the intervention being the differentiating factor.

Some studies may mimic RCTs but the treatment and control groups are not as similar as those produced through pure randomisation methods. These types of studies are called *pseudo-randomised controlled trials* because group allocation is conducted in a non-random way using methods such as alternate allocation, allocation by day of week, or odd-even study numbers.

Non-randomised controlled trial

Sometimes randomisation to groups is not possible or practical. Studies without randomisation, but with all other characteristics of an RCT, are referred to as *non-randomised controlled trials*.

Comparative studies

A statistical investigation that includes neither randomisation to groups nor a control group, but has at least two groups (or conditions) that are being compared, is referred to as a *comparative study*.

[4] The term 'grey literature' refers to research that is either unpublished or has been published in either non-peer reviewed journals or has been published for commercial purposes.

Case series

In these studies, all participants receive the intervention and its effectiveness is calculated by comparing measures taken at baseline (the beginning of treatment) and comparing them to measures taken at the end of treatment.

DATABASES USED IN SEARCH FOR RELEVANT STUDIES

The literature review was conducted using searches of three databases:

> the Cochrane Library – evidence-based healthcare database of the Cochrane Collaboration (www.cochrane.org)

> PsycINFO – database of psychological literature (www.apa.org/psycinfo)

> MEDLINE – database from the US National Library of Medicine (www.nlm.nih.gov/)

Information on research studies was also gathered from clinical experts in various areas of specialty within psychology. In addition, the literature review comprised information sourced from clinical practice guidelines of the following reputable institutions:

> National Institute for Clinical Excellence (NICE) (www.nice.org.uk)

> British Psychological Society (www.bps.org.uk)

> National Guideline Clearinghouse (www.guideline.gov)

> American Psychiatric Association (www.psych.org)

> Royal Australian and New Zealand College of Psychiatry (www.ranzcp.org)

SELECTION OF PSYCHOLOGICAL INTERVENTIONS

Increasingly there is a demand for psychologists in the primary sector to deliver effective, short-term therapies, as the most 'cost-effective' approach to psychological intervention. A broad range of psychological interventions was thus selected. The following interventions were selected through direction from government and identification of interventions with a large or increasing evidence base:

> Cognitive behaviour therapy (CBT)

> Interpersonal psychotherapy (IPT)

> Narrative therapy

> Family therapy and family-based interventions

> Mindfulness-based cognitive therapy (MBCT)

> Acceptance and commitment therapy (ACT)

> Solution-focused brief therapy (SFBT)

> Dialectical behaviour therapy (DBT)

> Schema-focused therapy

> Psychodynamic psychotherapy

> Emotion-focused therapy

> Hypnotherapy

> Self help

> Psychoeducation

It is anticipated that future revisions of this document may include reviews of additional interventions.

Description of Interventions

COGNITIVE BEHAVIOUR THERAPY (CBT)

Cognitive behaviour therapy is a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. The therapist helps individuals identify unhelpful thoughts, emotions and behaviours. CBT has two aspects: behaviour therapy and cognitive therapy. Behaviour therapy is based on the theory that behaviour is learned and therefore can be changed. Examples of behavioural techniques include exposure, activity scheduling, relaxation, and behaviour modification. Cognitive therapy is based on the theory that distressing emotions and maladaptive behaviours are the result of faulty patterns of thinking. Therefore, therapeutic interventions, such as cognitive restructuring and self-instructional training are aimed at replacing such dysfunctional thoughts with more helpful cognitions, which leads to an alleviation of problem thoughts, emotions and behaviour. Skills training (e.g., stress management, social skills training, parent training, and anger management), is another important component of CBT.[5]

Motivational interviewing (MI)

Often provided as an adjunct to CBT, motivational interviewing is a directive, person-centred counselling style that aims to enhance motivation for change in individuals who are either ambivalent about, or reluctant to, change. The examination and resolution of ambivalence is its central purpose, and discrepancies between the person's current behaviour and their goals are highlighted as a vehicle to trigger behaviour change. Through therapy using MI techniques, individuals are helped to identify their intrinsic motivation to support change.[6]

INTERPERSONAL PSYCHOTHERAPY (IPT)

Interpersonal psychotherapy is a brief, structured approach that addresses interpersonal issues. The underlying assumption of IPT is that mental health problems and interpersonal problems are interrelated. The goal of IPT is to help clients understand how these problems, operating in their current life situation, lead them to become distressed, and put them at risk of mental health problems. Specific interpersonal problems, as conceptualised in IPT, include interpersonal disputes, role transitions, grief, and interpersonal deficits. IPT explores individuals' perceptions and expectations of relationships, and aims to improve communication and interpersonal skills.[7]

NARRATIVE THERAPY

Narrative therapy has been identified as a mode of working of particular value to Aboriginal and Torres Strait Islander people, as it builds on the story telling that is a central part of their culture. Narrative therapy is based on understanding the 'stories' that people use to describe their lives. The therapist listens to how people describe their problems as stories and helps them consider how the stories may restrict them from overcoming their present difficulties. This therapy regards problems as being separate from people and assists individuals to recognise the range of skills, beliefs and abilities that they already have and have successfully used (but may not recognise), and that they can apply to the problems in their lives. Narrative therapy reframes the 'stories' people tell about their lives and puts a major emphasis on identifying people's strengths, particularly those that they have used successfully in the past.[8]

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

Family therapy may be defined as any psychotherapeutic endeavour that explicitly focuses on altering interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family. There are several family-oriented treatment traditions including psychoeducational, behavioural, object relations (psychodynamic), systemic, structural, post-Milan, solution-focused, and narrative therapies.[9]

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[5] Australian Psychological Society. (2007). *Better access to mental health initiative: Orientation manual for clinical psychologists, psychologists, social workers and occupational therapists*. Melbourne: Author.
[6] *Ibid.*, p.40.
[7] *Ibid.*, p.39.
[8] *Ibid.*, p.39.
[9] Henken, T., et al. (2009). Family therapy for depression. *Cochrane Database of Systematic Reviews 2007.* Issue 3. DOI: 10.1002/14651858.CD006728.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

Mindfulness-based cognitive therapy is a group treatment that emphasises mindfulness meditation as the primary therapeutic technique. MBCT was developed to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT, the emphasis is on changing the relationship to thoughts, rather than challenging them. Decentered thoughts are viewed as mental events that pass transiently through one's consciousness, which may allow depressed individuals to decrease rumination and negative thinking.[10]

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

ACT is based in a contextual theory of language and cognition known as relational frame theory and makes use of a number of therapeutic strategies, many of which are borrowed from other approaches. ACT helps individuals increase their acceptance of the full range of subjective experiences, including distressing thoughts, beliefs, sensations, and feelings, in an effort to promote desired behaviour change that will lead to improved quality of life. A key principle is that attempts to control unwanted subjective experiences (e.g., anxiety) are often only ineffective but even counterproductive, in that they can result in a net increase in distress, result in significant psychological costs, or both. Consequently, individuals are encouraged to contact their experiences fully and without defence while moving toward valued goals. ACT also helps individuals indentify their values and translate them into specific behavioural goals.[11]

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

Solution-focused brief therapy is a brief resource-oriented and goal-focused therapeutic approach that helps individuals change by constructing solutions. The technique includes the search for pre-session change, miracle and scaling questions, and exploration of exceptions.[12]

DIALECTICAL BEHAVIOUR THERAPY (DBT)

Dialectical behaviour therapy is designed to serve five functions: enhance capabilities, increase motivation, enhance generalisation to the natural environment, structure the environment, and enhance therapist capabilities and motivation to treat effectively. The overall goal is the reduction of ineffective action tendencies linked with deregulated emotions. It is delivered in four modes of therapy. The first mode involves a traditional didactic relationship with the therapist. The second mode is skills training, which involves teaching the four basic DBT skills of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Skills generalisation is the third mode of therapy in which the focus is on helping the individual integrate the skills learnt into real-life situations. The fourth mode of therapy employed is team consultation, which is designed to support therapists working with difficult clients.[13]

SCHEMA-FOCUSED THERAPY

Schema-focused therapy focuses on identifying and changing maladaptive schemas and their associated ineffective coping strategies. Schemas are psychological constructs that include beliefs that we have about ourselves, the world and other people, which are the product of how our basic childhood needs were dealt with. Schema change requires both cognitive and experiential work. Cognitive schema-change work employs basic cognitive-behavioural techniques to identify and change automatic thoughts, identify cognitive distortions, and conduct empirical tests of individuals' maladaptive rules about how to survive in the world that have been developed from schemas. Experiential work includes work with visual imagery, gestalt techniques, creative work to symbolise positive experiences, limited re-parenting and the healing experiences of a validating clinician.[14]

PSYCHODYNAMIC PSYCHOTHERAPY

Short-term psychodynamic psychotherapy is a brief, focal, transference-based therapeutic approach that helps individuals by exploring and working through specific intra-psychic and interpersonal conflicts. It is characterised by the exploration of a focus that can be identified by both the therapist and the individual. This consists of material from current and past interpersonal and intra-psychic conflicts and interpretation in a process in which the therapist is active in creating the alliance and ensuring the time-limited focus.

In contrast, *long-term* psychodynamic psychotherapy is open-ended and intensive and is characterised by a framework in which the central elements are exploration of unconscious conflicts, developmental deficits, and distortion of intra-psychic structures. Confrontation,

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[10] Eisendrath, S. J., Delucci, K., Bitner, R., Feinmore, P., Smit, M., & McLane, M. (2008). Mindfulness-based cognitive therapy for treatment-resistant depression: A pilot study. *Psychotherapy and Psychosomatics, 77*, 319-320.

[11] Forman, E., et al. (2007). A Randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification, 31*, 772-799.

[12] Knekt, P., et al. (2007). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine, 38*, 689-703.

[13] Lynch, T. R., Trost, W. T., Salsman, N., & Linehan, M. M. (2007). Dialectical behaviour therapy for borderline personality disorder. *Annual Review of Clinical Psychology, 3*, 181-205.

[14] Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behaviour Therapy and Experimental Psychiatry, 40*, 317-328.

clarification and interpretation are major elements, as well as the therapist's actions in ensuring the alliance and working through in the therapeutic relationship to attain conflict resolution and greater self-awareness.[15]

EMOTION-FOCUSED THERAPY (EFT)

Emotion-focused therapy combines a client-centred therapeutic approach with process-directive, marker-guided interventions derived from experiential and gestalt therapies applied at in-session intrapsychic and/or interpersonal targets. These targets are thought to play prominent roles in the development and exacerbation of disorders such as depression. The major interventions used in EFT (e.g., empty-chair and two-chair dialogues, focusing on an unclear bodily-felt sense) facilitate creation of new meaning from bodily felt referents, letting go of anger and hurt in relation to another person, increased acceptance and compassion for oneself, and development of a new view and understanding of oneself.[16]

HYPNOTHERAPY

Hypnotherapy involves the use of hypnosis, a procedure during which the therapist suggests that the individual experiences changes in sensations, perceptions, thoughts or behaviour. The hypnotic context is generally established by an induction procedure. Traditionally, hypnotherapy involves: education about hypnosis and discussion of common misconceptions; an induction procedure, such as eye fixation; deepening techniques, such as progressive muscle relaxation; therapeutic suggestion, such as guided imagery, anchoring techniques and ego-strengthening; and an alerting phase that involves orienting the individual to the surroundings.[17]

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

Self-help therapy (also known as bibliotherapy) is used as both an adjunct to traditional therapy or as a standalone treatment. Most self-help programs are based on CBT principles and typically combine psychoeducation with skills training, including homework tasks. In self-help programs individuals read books or use computer programs to help them overcome psychosocial problems. Some self-help programs include brief contact with a therapist (guided self-help) whereas others do not (pure self-help).

PSYCHOEDUCATION

Psychoeducation is not a type of therapy but rather, a specific form of education. Psychoeducation involves the provision and explanation of information to clients about what is widely known about characteristics of their diagnosis. Individuals often require specific information about their diagnosis, such as the meaning of specific symptoms and what is known about the causes, effects, and implications of the problem. Information is also provided about medications, prognosis, and alleviating and aggravating factors. Information is also provided about early signs of relapse and how they can be actively monitored and effectively managed. Individuals are helped to understand their disorder to enhance their therapy and assist them to live more productive and fulfilled lives. Psychoeducation can be provided in an individual or group format.[18]

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[15] Knekt, P., et al. (2007). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. *Psychological Medicine, 38*, 689-703.

[16] Ellison, J. A., Greenberg, L. S., Goldman, R. N., & Angus, L. (2009). Maintenance of gains following experiential therapies for depression. *Journal of Consulting and Clinical Psychology, 77*, 103-112.

[17] Izquierdo de Santiago, A., & Khan, M. (2009). Hypnosis for schizophrenia. *Cochrane Database of Systematic Reviews 2007.* Issue 4. DOI: 10.1002/14651858.CD004160.pub3.

[18] Australian Psychological Society. (2007). *Better access to mental health initiative: Orientation manual for clinical psychologists, psychologists, social workers and occupational therapists* (p.40). Melbourne: Author.

Presentation and reporting

DISORDERS AND INTERVENTIONS

Under each of the disorder section headings, for example, 'Depression', an intervention was included only if studies or guidelines were found that met the search criteria outlined on page 2. For low prevalence disorders, where little formal research has been conducted and published, there may be as few as one, or at times, no intervention listed.

STRUCTURE AND LAYOUT

To increase the useability of the review, the research evidence has been grouped according to client type and presented in two separate sections. The first section presents the evidence for *adults* (including older adults) and the second presents the evidence for *adolescents* and *children*. In these sections, studies focusing on individual therapy appear before those focusing on group therapy. In some meta-analyses and systematic reviews, client type was not differentiated. In these instances, the study is labelled 'Combined' and is repeated in each section at the end of the relevant intervention.

In addition, some of the disorders included in this review comprise multiple diagnostic categories. For example, 'Eating disorders' is made up of anorexia nervosa, bulimia nervosa and binge eating disorder. As effective treatments for these subcategories differ, findings have been reported under the relevant diagnostic label.

Finally, a 'Summary of evidence' appears at the beginning of each section and provides an overview of the findings for each disorder without the methodological detail. The 'Categorisation of level of evidence summary table' provides a designation of the level of evidence for each intervention using the NHMRC categories. Where studies found no support for the intervention, the term 'Insufficient evidence' is used.

REPORTING OF STUDY INFORMATION

The specific information reported from the selected studies includes:

> bibliographic information

> design of the study (e.g., meta-analysis)

> number of participants

> details of intervention/s

> details of comparison groups

> methodology (including randomisation procedure)

> treatment outcomes

INTERPRETING THE EVIDENCE

When interpreting the information presented in this review, readers should remain aware of the limitations affecting the conclusions that can be drawn. These limitations include small sample size; inconsistent or unclear descriptions of comparison groups; and limited reporting on the methodology used, including limited descriptions of sample characteristics. In addition, it is important to note that the review provides only a brief synopsis of the research studies and outcomes. Further information about individual studies should be sought from the original research papers.

Abbreviations

TAU	Treatment as usual
RCT	Randomised controlled trial
CCT	Clinical controlled trial
EDNOS	Eating disorder not otherwise specified
NOS	Not otherwise specified
AOD	Alcohol and other drugs
CBT	Cognitive behaviour therapy
MI	Motivational interviewing
IPT	Interpersonal psychotherapy
MBCT	Mindfulness-based cognitive therapy
ACT	Acceptance and commitment therapy
SFBT	Solution-focused brief therapy
DBT	Dialectical behaviour therapy
EFT	Emotion-focused therapy

Categorisation of level of evidence summary tables

When weighing the evidence, the highest level of evidence for each intervention category for a given disorder was identified. This strategy has the advantage of generating transparent rankings, but does not equate to a comprehensive systematic review, or critical appraisal of the relevant scientific literature. As noted by the NHMRC, a single hierarchy of evidence as used in this review does not capture all meaningful information on intervention effectiveness.

The following tables are a summary of the level of evidence for the interventions reviewed for mental disorders affecting adults (table 1) and adolescents and children (table 2).

CATEGORISATION OF LEVEL OF EVIDENCE SUMMARY TABLE: **ADULT INTERVENTIONS**

	CBT	IPT	NARRATIVE	FAMILY	MBCT	ACT	SFBT	DBT	SCHEMA-FOCUSED	PSYCHO-DYNAMIC	EMOTION-FOCUSED	HYPNOSIS	SELF-HELP	PSYCHO-EDUCATION
Mood disorders														
Depression	Level I	Level I	IE	IE	Level III-2	Level III-1	Level II	Level II	IE	Level I	Level II	IE	Level I	Level II
Bipolar	Level II*	Level II*	IE	Level II*	Level II*	IE	IE	IE	IE	IE	IE	IE	IE	Level II*
Anxiety disorders														
Generalised anxiety	Level I	IE	IE	IE	Level IV	IE	IE	IE	IE	Level II	IE	IE	Level IV	IE
Panic	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level II	Level II
Specific phobia	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level II	IE
Social anxiety	Level I	Level III-1	IE	IE	IE	Level IV	IE	IE	IE	Level II*	IE	IE	Level II	IE
Obsessive compulsive	Level I	IE	IE	IE	IE	Level IV	IE	IE	IE	IE	IE	IE	Level II	IE
Posttraumatic stress [19]	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Substance use disorders	Level I	Level IV	IE	IE	IE	Level IV	Level II	Level II	IE	Level III-1	IE	IE	Level II	IE
Eating disorders														
Anorexia nervosa	Level III-2	IE	IE	Level II	IE	IE	IE	IE	IE	Level II	IE	IE	IE	IE
Bulumia nervosa	Level I	Level III-3	IE	IE	IE	IE	IE	Level II	IE	IE	IE	IE	Level II	IE
Binge eating	Level I	IE	IE	IE	IE	IE	IE	Level II	IE	IE	IE	IE	Level I	IE
Adjustment disorder	Level III-1	IE	IE	IE	Level IV	IE	IE	IE	IE	IE	IE	IE	IE	IE
Sleep disorders	Level I	IE	IE	IE	Level IV	IE	IE	IE	IE	IE	IE	IE	Level I	IE
Sexual disorders	Level II	Level II	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level I	IE
Somatoform disorders														
Pain	Level II	IE	IE	IE	IE	Level III-3	IE	IE	IE	IE	IE	IE	Level II	IE
Chronic fatigue	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level II	Level II
Somatisation	Level I	IE	IE	Level II	IE	IE	IE	IE	IE	Level II	IE	IE	IE	IE
Hypochondriasis	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level III-2	Level I
Body dysmorphic	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Borderline personality disorder	IE	IE	IE	IE	IE	IE	IE	Level I	Level II	Level II	IE	IE	IE	IE
Psychotic disorders	Level I	IE	IE	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Dissociative disorders	Level IV	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Attention deficit & hyperactivity	Level II	IE	IE	IE	Level IV	IE	IE	Level III-1	IE	IE	IE	IE	IE	IE

* as adjunt to medication
IE - Insufficient evidence; NS - No studies found
CBT, cognitive behaviour therapy; IPT, interpersonal psychotherapy; MCBT, minfulness-based cognitive therapy; ACT, acceptance and commitment therapy; SFBT, solution-focused brief therapy; DBT, dialectical behaviour therapy

[19] *there is Level I evidence supporting the efficacy of eye movement desensitization and reprocessing (EMDR), an intervention not included in this review.*

CATEGORISATION OF LEVEL OF EVIDENCE SUMMARY TABLE: **ADOLESCENT & CHILD INTERVENTIONS**

	CBT	IPT	NARRATIVE	FAMILY	MBCT	ACT	SFBT	DBT	SCHEMA-FOCUSED	PSYCHO-DYNAMIC	EMOTION-FOCUSED	HYPNOSIS	SELF-HELP	PSYCHO-EDUCATION
Mood disorders														
Depression	Level I	Level I (A)	IE	Level I	IE	IE	IE	IE	IE	IE	IE	IE	Level II (A)	IE
Bipolar	Level IV*	IE	IE	Level II (A)*	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Anxiety disorders														
Generalised anxiety	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Panic	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Specific phobia	Level II	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Social anxiety	Level II	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Obsessive compulsive	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Posttraumatic stress [20]	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Substance use disorders	Level I (A)	IE	IE	Level I (A)	IE	IE	IE	IE	IE	IE	IE	IE	Level II (A)	IE
Eating disorders														
Anorexia nervosa	IE	IE	IE	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Bulumia nervosa	IE	IE	IE	Level II (A)	IE	IE	IE	IE	IE	IE	IE	IE	Level II (A)	IE
Binge eating	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Adjustment disorder	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Sleep disorders	Level II	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Somatoform disorders														
Pain	Level IV	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Chronic fatigue	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Somatisation	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Hypochondriasis	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Body dysmorphic	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Psychotic disorders	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Dissociative disorders	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Childhood disorders														
Attention deficit & hyperactivity	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE
Conduct & Oppositional defiant	Level I	IE	IE	Level I	IE	IE	IE	Level IV (A)	IE	IE	IE	IE	IE	IE
Enuresis	Level I	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	IE	Level II	IE

* as adjunt to medication
IE - Insufficient evidence; NS - No studies found
CBT, cognitive behaviour therapy; IPT, interpersonal psychotherapy; MCBT, minfulness-based cognitive therapy; ACT, acceptance and commitment therapy; SFBT, solution-focused brief therapy; DBT, dialectical behaviour therapy

[20] *there is Level I evidence supporting the efficacy of eye movement desensitization and reprocessing (EMDR), an intervention not included in this review.*

Depression

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy, interpersonal psychotherapy, brief psychodynamic psychotherapy, and self-help (primarily CBT-based) in the treatment of depression in adults. There is Level II evidence for solution-focused brief therapy, dialectical behaviour therapy, emotion-focused therapy, and psychoeducation. A small number of studies providing Level III evidence or below for mindfulness-based cognitive therapy and acceptance and commitment therapy were found. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Depression: The treatment and management of depression in adults (NICE clinical guideline 90)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (46 studies)
PARTICIPANTS	Adults diagnosed with depression or depressive symptoms as indicated by depression scale score for subthreshold and other groups
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, TAU, placebo), other therapies (including IPT and psychodynamic psychotherapy), pharmacotherapy
PROCEDURE	Review of RCTs published between 1979 and 2009 in peer-reviewed journals investigating the effectiveness of a range of high- and low- intensity psychological interventions.
FINDINGS	Individual CBT is more effective than a waitlist control in reducing depression. However, the results of studies investigating group CBT compared with a waitlist control or TAU were inconclusive. When individual CBT was compared to a placebo plus clinical management and to general practitioner care no differences in effectiveness were found. When CBT was compared to other active psychological therapies (IPT and short-term psychodynamic psychotherapy), no clinically significant differences were found. Results of trials comparing CBT with antidepressant medication immediately posttreatment suggest broad equalivalence in effectiveness. However, after 12 months CBT appears to be more effective, with less likelihood of relapse compared to medication.

TITLE OF PAPER	***A randomized controlled trial of cognitive behavioural therapy as an adjunct to pharmacotherapy in primary care based patients with treatment resistant depression: A pilot study***
AUTHORS AND JOURNAL	Wiles, N. J., Hollinghurst, S., Mason, V., & Musa, M. (2008). *Behavioural and Cognitive Psychotherapy, 36,* 21-33.
DESIGN	RCT pilot study (2 groups) including 4-month follow up
PARTICIPANTS	25 adults diagnosed with depression who were taking antidepressant medication and had received that medication for at least 6 weeks at the recommended dose
INTERVENTIONS	CBT (plus pharmacotherapy)
COMPARISON GROUPS	TAU (any other treatment plus pharmacotherapy)
PROCEDURE	Participants were randomised to either receive 12-20 sessions of CBT plus pharmacotherapy or to continue with TAU.
FINDINGS	Eight out of 14 patients experienced at least a 50% reduction in depressive symptoms (4 months compared to baseline); however these results were not replicated in the control group. There was no difference in quality of life at the 4-month follow up for those in the CBT group compared to TAU.

TITLE OF PAPER	***Therapist-delivered internet psychotherapy for depression in primary care: A randomised controlled trial***
AUTHORS AND JOURNAL	Kessler, D., Lewis, G., Wiles, N., King, M., Weich, S., Sharp, D. J., et al. (2009). *The Lancet, 374,* 628-634.
DESIGN	RCT (2 groups) including 4- and 8-month follow up
PARTICIPANTS	297 adults with depression across 55 general practices
INTERVENTIONS	CBT plus TAU (from general practitioner while on waitlist for CBT)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomly assigned to internet-based CBT plus TAU or to the control group. Group allocation was stratified by centre. The CBT intervention delivered online in real time, comprised up to 10 sessions lasting up to 55 minutes and was to be completed within 16 weeks of randomisation. At least 5 sessions were expected to be completed by 4-month follow up.
FINDINGS	Participants in the CBT group were more likely to have recovered from depression at 4 months than those in the control group. Therapeutic gains at 4 months were maintained at 8 months.

TITLE OF PAPER	***Telephone-administered psychotherapy for depression***
AUTHORS AND JOURNAL	Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Homos-Webb, L., Vella, L., et al. (2005). *Archives of General Psychiatry, 62,* 1007-1014.
DESIGN	RCT (2 groups) including 12-month follow up
PARTICIPANTS	127 adults with depression and functional impairment due to multiple sclerosis
INTERVENTIONS	CBT
COMPARISON GROUPS	Emotion-focused therapy (EFT)
PROCEDURE	Participants randomised to receive a weekly 50-minute session of telephone-administered CBT or telephone-administered supportive EFT for 16 weeks. Telephone EFT was adapted from the manual developed for process-experiential psychotherapy. Randomisation was stratified based on whether participants were currently diagnosed with MDD and were taking antidepressant medication.
FINDINGS	Treatment gains were significant for both treatment groups, with improvements over the 16 weeks greater for those in the telephone CBT group. Treatment gains were maintained at the 12-month follow up, but the differences between the groups were no longer significant.

TITLE OF PAPER	***Six-year outcome of cognitive behavior therapy for prevention of recurrent depression***
AUTHORS AND JOURNAL	Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). *American Journal of Psychiatry, 161,* 1872 –1876.
DESIGN	RCT (2 groups) including 6-year follow up
PARTICIPANTS	40 adults with recurrent major depression who had been successfully treated with antidepressant medication
INTERVENTIONS	CBT plus pharmacotherapy
COMPARISON GROUPS	Clinical management plus pharmacotherapy
PROCEDURE	Participants were randomly allocated to either ten 30-minute sessions of CBT (cognitive behaviour treatment of residual symptoms supplemented by lifestyle modification and well-being therapy) or clinical management. Antidepressant medication was tapered every second week and eventually withdrawn. Participants were then followed up over a 6-year period.
FINDINGS	CBT was found to be significantly more effective than clinical management in reducing relapse over a 6-year period following cessation of pharmacotherapy for depression.

GROUP

TITLE OF PAPER	***The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders***
AUTHORS AND JOURNAL	Oei, T. P. S., & Dingle, G. (2008). *Journal of Affective Disorders, 107,* 5-21.
DESIGN	Meta-analysis (34 studies included)
PARTICIPANTS	2134 adults with depression
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, TAU, minimal contact, placebo), bona fide interventions (e.g., group IPT, group behaviour therapy) and non-bona fide interventions (e.g., support groups and medications).
PROCEDURE	Two separate analyses were conducted – one on studies with control groups and one on those without (effect sizes were calculated on pre- to post-treatment changes).
FINDINGS	The review demonstrated that group CBT is one of the most effective treatment alternatives for depression and compares well with drug treatment and other forms of psychological therapy, including individual CBT.

GROUP

TITLE OF PAPER	***A nonrandomized effectiveness comparison of broad-spectrum group CBT to individual CBT for depressed outpatients in a community mental health setting***
AUTHORS AND JOURNAL	Craigie, M. A., & Nathan, P. (2009). *Behavior Therapy, 40,* 302-314.
DESIGN	Comparative study
PARTICIPANTS	234 adult outpatients diagnosed with major depression
INTERVENTIONS	CBT
COMPARISON GROUPS	Individual vs group format
PROCEDURE	Participants were referred to either group or individual CBT. Group CBT consisted of 10 weekly 2-hour sessions, with a 1-month follow up. Individual CBT was implemented in a more flexible manner, based on a case formulation developed for each client.
FINDINGS	Individual and group CBT were both effective even in the presence of high levels of comorbidity. Although individual CBT was generally superior to group CBT in reducing depression and anxiety symptoms, both treatment modes were associated with equivalent improvements on a measure of quality of life.

COMBINED ADULTS, ADOLESCENTS & CHILDREN

TITLE OF PAPER	***The empirical status of cognitive-behavioral therapy***
AUTHORS AND JOURNAL	Butler, A. C., Chapman, J. E., Forman, E. M., & Beck. A. T. (2006). *Clinical Psychology Review, 26,* 17-31.
DESIGN	Review of meta-analyses (16 studies)
PARTICIPANTS	9995 adults, adolescents and children with depression in 32 studies across 16 disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, TAU, placebo, no treatment), other therapies (relaxation, supportive therapy, stress management), and pre-post comparisons
PROCEDURE	Review of meta-analyses with effect sizes that contrast CBT with outcomes from various control groups.
FINDINGS	Large effect sizes in favour of CBT were found for adult and adolescent unipolar depression, and for childhood depressive disorders. The effects of CBT were also maintained for substantial periods beyond the cessation of treatment, with relapse rates half those of pharmacotherapy.

OLDER ADULTS

TITLE OF PAPER	***A randomised controlled trial of cognitive behaviour therapy vs treatment as usual in the treatment of mild to moderate late life depression***
AUTHORS AND JOURNAL	Laidlaw, K., Davidson, K., Toner, H., Jackson, G., Clark, S., Law, J., et al. (2008). *International Journal of Geriatric Psychiatry, 23,* 843-850.
DESIGN	RCT (2 groups) including 3- and 6-month follow up
PARTICIPANTS	40 older adults who met criteria for major depressive disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (general practitioner managed physical treatment for depression, e.g., pharmacotherapy, physical review, or no treatment if deemed appropriate)
PROCEDURE	Participants were randomised to receive either CBT for late life depression or TAU. CBT for late life depression is a structured problem-solving approach with symptom reduction as the primary aim. On average, participants received 8 sessions of CBT.
FINDINGS	Participants in both treatment conditions experienced a decrease in depressive symptoms at treatment end (18 weeks) and at the 6-month follow up. After adjusting for differences between groups at baseline, the CBT participants achieved statistically significantly better Beck Hopelessness Scale scores at the 6-month follow up. Fewer participants in the CBT group met the Research Diagnostic Categorisation status for depression at treatment end, and at the 3-month follow-up.

OLDER ADULTS – GROUP

TITLE OF PAPER	***A pilot randomised controlled trial of a brief cognitive-behavioural group intervention to reduce recurrence rates in late life depression***
AUTHORS AND JOURNAL	Wilkinson, P., Alder, N., Juszcak, E., Matthews, H., Merritt, C., Montgomery, H., et al. (2009). *International Journal of Geriatric Psychiatry, 24,* 68-75.
DESIGN	RCT pilot study (2 groups)
PARTICIPANTS	45 older adults who had experienced an episode of major depression within the last year that had remitted for at least 2 months on antidepressant medication
INTERVENTIONS	CBT plus pharmacotherapy
COMPARISON GROUPS	TAU (pharmacotherapy and monitoring by a GP)
PROCEDURE	Participants were allocated to brief group CBT plus TAU or TAU alone. The group CBT intervention was manualised and was designed to be delivered in eight 90-minute sessions.
FINDINGS	There was greater symptom reduction at 6 and 12 months (as measured on the Montgomery Asberg Rating Scale) for those receiving group CBT than for those in TAU; however, the difference was not statistically significant. Results on the secondary outcome (the Beck Depression Inventory) were contradictory. Overall scores increased in participants receiving group CBT plus pharmacotherapy; however, the differences were not clinically significant.

OLDER ADULTS – GROUP

TITLE OF PAPER	***Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care***
AUTHORS AND JOURNAL	Hyer, L. Yeager, C. A., Hilton, N., Sacks, A. (2009). *American Journal of Alzheimer's Disease & Other Dementias, 23,* 528-539.
DESIGN	RCT (2 groups, 2 trials)
PARTICIPANTS	25 older adults with depression in long-term care
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (usual nursing facility activities)
PROCEDURE	In the first trial, participants were randomly allocated to a CBT program called GIST comprising group, individual, and staff therapy or to TAU. In the second trial, the GIST group remained for an additional course and the TAU group crossed over to GIST. GIST consists of 13 weekly 75-90 minute sessions delivered in an open, repeated-session group format. Individual-based and staff/peer interventions complemented the group sessions.
FINDINGS	There were significant differences between GIST and TAU in favour of GIST on measures of depression and life satisfaction, and the differences were maintained over another 14 sessions. After crossover to GIST, TAU participants showed significant improvement from baseline.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***Depression: The treatment and management of depression in adults (NICE clinical guideline 90)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (15 studies)
PARTICIPANTS	Adults diagnosed with depression or depressive symptoms as indicated by depression scale score for subthreshold and other groups
INTERVENTIONS	IPT
COMPARISON GROUPS	Control (waitlist, TAU), CBT, pharmacotherapy
PROCEDURE	Review of RCTs published between 1979 and 2009 in peer-reviewed journals investigating the effectiveness of a range of high- and low- intensity psychological interventions.
FINDINGS	When IPT was compared to usual general practitioner care and placebo, clinically significant differences in favour of IPT were found. However, no clinically significant differences were found between IPT and CBT and between IPT and antidepressant medication alone.

TITLE OF PAPER	***Brief interpersonal psychotherapy for depressed mothers whose children are receiving psychiatric treatment***
AUTHORS AND JOURNAL	Swartz, H. A., Frank, E., Zuckoff, A., Cyranowski, J. M., Houck, P. R., & Cheng, Y., et al. (2008). *American Journal of Psychiatry, 165,* 1155-1162.
DESIGN	RCT (2 groups) including 3- and 9-month follow up
PARTICIPANTS	47 mothers with major depression whose children were receiving psychiatric treatment
INTERVENTIONS	IPT
COMPARISON GROUPS	TAU (diagnosis, psychoeducation and treatment referral)
PROCEDURE	Participants were randomised to either a brief IPT intervention called IPT-MOMS or to TAU. *IPT-MOMS* consisted of 9 sessions based on IPT for depression with additional modifications designed to help depressed mothers engage in treatment and address relationship difficulties that arise in the context of parenting an ill child.
FINDINGS	At the 3- and 9-month follow ups, mothers treated with IPT-MOMS had significantly better maternal symptom and functioning scores compared with the comparison group, with the exception of Beck Anxiety Inventory scores at the 9-month follow up.

TITLE OF PAPER	***Telephone-delivered, interpersonal psychotherapy for HIV-infected rural persons with depression: A pilot trial***
AUTHORS AND JOURNAL	Ransom, D., Heckman, T. G., Anderson, T., Garske, J., Holroyd, K., & Basta, T. (2008). *Psychiatric Services, 59,* 871-877.
DESIGN	RCT pilot study (2 groups)
PARTICIPANTS	79 adults with AIDS and a diagnosed depression-spectrum disorder
INTERVENTIONS	IPT
COMPARISON GROUPS	TAU (usual access to services provided by AIDS service organisations)
PROCEDURE	Participants were randomly assigned to either telephone-delivered IPT plus TAU or TAU alone. Telephone IPT consisted of six 50-minute sessions of standard IPT delivered via telephone.
FINDINGS	The treatment group reported significantly greater improvement in depressive symptoms when compared to the control group, and nearly a third of the treatment group also reported clinically meaningful reductions in psychiatric distress from pre- to post-intervention.

GROUP

TITLE OF PAPER	***Group interpersonal psychotherapy for postnatal depression: A pilot study***
AUTHORS AND JOURNAL	Reay, R., Fisher, Y., Robertson, M., Adams, E., & Owen, C. (2006). *Archive of Women's Mental Health, 9,* 31-39.
DESIGN	Case series including 3-month follow up
PARTICIPANTS	18 mothers with infants 12 months or younger, who met a diagnosis of major depression
INTERVENTIONS	IPT
COMPARISON GROUPS	None
PROCEDURE	The group IPT intervention consisted of two individual sessions and 8 two-hour group sessions of IPT, plus a 2-hour psychoeducation session for partners.
FINDINGS	Symptom severity significantly decreased from pre- to post-treatment and this decrease was maintained at 3 months.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders***
AUTHORS AND JOURNAL	Feijo de Mello, M., de Jesus Mari, J., Bacaltchuk, J., Verdeil, H., & Neugebauer, R. (2005). *European Archives of Psychiatry and Clinical Neuroscience, 255,* 75 – 82.
DESIGN	Systematic review and meta-analysis (13 studies and 4 meta-analyses)
PARTICIPANTS	2199 adults and adolescents diagnosed with depression
INTERVENTIONS	IPT
COMPARISON GROUPS	Pharmacotherapy, placebo, CBT
PROCEDURE	Review and meta-analysis of RCTs published between 1974 and 2002 investigating IPT for depression.
FINDINGS	IPT was superior to placebo (9 studies) and more effective than CBT in reducing depressive symptoms (3 studies). No differences were found between IPT and medication in treating depression, and the combination of IPT and medication was not superior to medication alone.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

GROUP

TITLE OF PAPER	***Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research***
AUTHORS AND JOURNAL	Coelho, H. F., Canter, P. H., & Ernst, E. (2007). *Journal of Consulting and Clinical Psychology, 75,* 1000-1005.
DESIGN	Systematic review (4 studies)
PARTICIPANTS	284 adults with depression
INTERVENTIONS	MBCT
COMPARISON GROUPS	TAU (not defined)
PROCEDURE	Four studies met the inclusion criteria (2 RCTs, 1 study based on a subset of one of the RCTs, and 1 non-randomised trial) and all compared MBCT plus TAU with TAU alone.
FINDINGS	Few MBCT trials were available for analysis. Two of the trials indicated that MBCT may have an additive benefit to TAU for preventing relapse or recurrence in patients with 3 or more previous episodes of major depression. None of the trials compared MBCT alone to TAU.

GROUP

TITLE OF PAPER	***Mindfulness-based cognitive therapy for residual depressive symptoms***
AUTHORS AND JOURNAL	Kingston, T., Dooley, B., Bates, A., Lawlor, E., & Malone, K. (2007). *Psychology and Psychotherapy: Theory, Research and Practice, 80,* 193-203.
DESIGN	Non-randomised study (2 groups) including 1-month follow up
PARTICIPANTS	19 adults with a diagnosis of recurrent major depressive disorder (3+ previous episodes) with residual depressive symptoms
INTERVENTIONS	MBCT
COMPARISON GROUPS	TAU (regular outpatient visits to psychiatric clinics and pharmacotherapy)
PROCEDURE	Participants who were assigned to TAU also participated in a second MBCT group (TAU acted as a waitlist control). Due to insufficient referral numbers at study commencement, randomisation was not possible. First referrals were assigned to the MBCT group. MBCT was delivered in the standard curriculum and format (eight, 2-hour weekly sessions).
FINDINGS	In comparison to TAU and across time, participants experienced a significant reduction in depressive symptoms following MBCT.

GROUP

TITLE OF PAPER	***Mindfulness-based cognitive therapy for treatment resistant depression: A pilot study***
AUTHORS AND JOURNAL	Eisendrath, S. J., Delucchi, K., Bitner, R., Fenimore, P., Smit, M., & McLane, M. (2008). *Psychotherapy and Psychosomatics, 77,* 319-320.
DESIGN	Case series
PARTICIPANTS	51 adult outpatients whose diagnosed depression had failed to remit with at least two antidepressant medication treatments
INTERVENTIONS	MBCT
COMPARISON GROUPS	None
PROCEDURE	Six MBCT groups containing 7-12 participants were run. Standard MBCT was modified for an actively depressed population but delivered in the usual format (eight, 2-hour weekly sessions).
FINDINGS	Participants who completed MBCT experienced a significant decrease in levels of depression, anxiety and rumination.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF PAPER	***A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression***
AUTHORS AND JOURNAL	Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). *Behavior Modification, 31,* 772-799.
DESIGN	Pseudo-randomised controlled trial (2 groups)
PARTICIPANTS	101 university students with a mixture of anxiety and mood disturbance
INTERVENTIONS	ACT
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomly assigned based on symptom level to either ACT or CBT condition, and treatment length was determined by the participant (sometimes in consultation with the therapist). The mean number of sessions was 15 for both groups.
FINDINGS	Most participants demonstrated clinically significant improvements; however, there were no significant differences between the treatment groups.

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

TITLE OF PAPER	***Randomized trial on the differences of long and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up***
AUTHORS AND JOURNAL	Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Marttunen, M., et al. (2006). *Psychological Medicine, 38,* 689-703.
DESIGN	RCT (3 groups) including a 3-year follow up
PARTICIPANTS	326 adult outpatients with a diagnosed mood or anxiety disorder
INTERVENTIONS	SFBT
COMPARISON GROUPS	Psychodynamic psychotherapy
PROCEDURE	Participants were randomly assigned to one of three groups: long-term psychodynamic psychotherapy (2-3 sessions per week, up to 3 years duration); short-term psychodynamic psychotherapy (20 weekly sessions over 5-6 months); or solution-focused therapy (12 sessions over a maximum of 8 months).
FINDINGS	Participants in all three treatment groups showed significant reductions in their depressive symptoms. In the first year of follow-ups, the short-term therapies were significantly more effective than the long-term therapy; however, these differences were not significant after 2 years. After 3 years, long-term psychodynamic psychotherapy was significantly more effective than either of the short-term therapies. There were no significant differences between the two short-term therapy groups.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

OLDER ADULTS

TITLE OF PAPER	***Dialectical behavior therapy for depressed older adults***
AUTHORS AND JOURNAL	Lynch, T.R., Morse, J.Q., Mendelson, T., & Robins, C.J. (2003). *International Journal of Geriatric Psychiatry, 22,* 131-143.
DESIGN	RCT (2 groups)
PARTICIPANTS	34 older adults with depression
INTERVENTIONS	DBT plus clinical management and pharmacotherapy
COMPARISON GROUPS	Clinical management and pharmacotherapy
PROCEDURE	Participants were randomly assigned to one of two treatment groups: 28 weeks of pharmacotherapy and clinical management either alone or with DBT and telephone coaching. DBT included psychoeducation, teaching core mindfulness concepts and practices, distress tolerance training, emotional regulation and interpersonal effectiveness skills. This program was then offered a second time so that each topic was covered twice (28 weeks).
FINDINGS	While both groups showed a reduction in depressive symptoms, only the DBT group reported lower levels of self-rated depressive symptoms. At 6-month follow up there was a significant difference between the two groups in remission of symptoms favouring the DBT group.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis***
AUTHORS AND JOURNAL	Driessen, E., Cuijpers, P., de Maat, S., C. M., Abbass, A. A., de Jonghe, F., & Dekker, J. J. M. (2009). *Clinical Psychology Review,* doi: 10.1016/j.cpr.2009.08.010.
DESIGN	Meta-analysis (23 studies)
PARTICIPANTS	1365 adults with depression
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	Control (waitlist, TAU), other therapies
PROCEDURE	Systematic review of RCTs, non-random controlled studies and open studies.Meta-analyses were conducted assessing pre- to post-treatment change, posttreatment to follow-up change in the short-term psychodynamic psychotherapy conditions and comparison of short-term psychodynamic psychotherapy with control conditions or alternative treatments at posttreatment and follow up.
FINDINGS	Short-term psychodynamic psychotherapy was found to be significantly more effective than control conditions at posttreatment. Pretreatment to posttreatment changes in depression in the intervention group were large, and changes were maintained until 1-year follow up. When short-term psychodynamic psychotherapy was compared to other psychotherapies, a small but significant effect size was found in favour of the other therapies; however these differences disappeared at the 3-month follow up, but a non-significant trend indicated possible superiority of the other psychotherapies at 1-year follow up. Effect sizes were smaller for group short-term psychodynamic psychotherapy than for individual therapy. Supportive and expressive modes were equally efficacious.

TITLE OF PAPER	***Depression: The treatment and management of depression in adults (NICE clinical guideline 90)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (10 studies)
PARTICIPANTS	Adults diagnosed with depression or depressive symptoms as indicated by depression scale score for subthreshold and other groups
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	Waitlist control, CBT, pharmacotherapy
PROCEDURE	Review of RCTs published between 1979 and 2009 in peer-reviewed journals investigating the effectiveness of a range of high- and low- intensity psychological interventions.
FINDINGS	When psychodynamic psychotherapy was compared to antidepressant medication, one study found no significant differences whereas another found medication to be superior. In studies comparing short-term psychodynamic psychotherapy with CBT, no clinically significant differences were found. Problems with unextractable data and multiple different comparators limited the analyses possible for the review and a number of findings were contradictory or difficult to interpret. Therefore results must be interpreted with caution.

TITLE OF PAPER	***Randomized trial on the differences of long and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up***
AUTHORS AND JOURNAL	Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Marttunen, M., et al. (2006). *Psychological Medicine, 38,* 689-703.
DESIGN	RCT (3 groups) including a 3-year follow up
PARTICIPANTS	326 adult outpatients with a diagnosed mood or anxiety disorder
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	SFBT
PROCEDURE	Participants were randomly assigned to one of three groups: long-term psychodynamic psychotherapy (2-3 sessions per week, up to 3 years duration); short-term psychodynamic psychotherapy (20 weekly sessions over 5-6 months); or solution-focused therapy (12 sessions over a maximum of 8 months).
FINDINGS	Participants in all three treatment groups showed significant reductions in their depressive symptoms. In the first year of follow-ups, the short-term therapies were significantly more effective than the long-term therapy; however, these differences were not significant after 2 years. After 3 years, long-term psychodynamic psychotherapy was significantly more effective than either of the short-term therapies. There were no significant differences between the two short-term therapies.

TITLE OF PAPER	***Brief dynamic therapy combined with pharmacotherapy in the treatment of major depressive disorder: Long-term results***
AUTHORS AND JOURNAL	Maina, G., Rosso, G., & Bogetto, F. (2009). *Journal of Affective Disorders, 114,* 200-207.
DESIGN	RCT (2 groups) including a 6-month continuation treatment trial and 48-month naturalistic follow up
PARTICIPANTS	92 adult outpatients who met criteria for remission at the end of a 6-month acute phase for MDD, single episode and who had been treated with a combination of brief dynamic therapy and medication or medication alone
INTERVENTIONS	Psychodynamic psychotherapy plus pharmacotherapy
COMPARISON GROUPS	Pharmacotherapy (pharmacotherapy and clinical management, including psychoeducation)
PROCEDURE	Participants were randomised to receive 15 to 30 weekly, 45-minute sessions of brief dynamic therapy plus pharmacotherapy or pharmacotherapy alone.
FINDINGS	At the 48-month follow up, the combined treatment was associated with a significantly higher proportion of patients with sustained remission.

EMOTION-FOCUSED THERAPY (EFT)

TITLE OF PAPER	***Telephone-administered psychotherapy for depression***
AUTHORS AND JOURNAL	Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Homos-Webb, L., Vella, L., et al. (2005). *Archives of General Psychiatry, 62,* 1007-1014.
DESIGN	RCT (2 groups) including 12-month follow up
PARTICIPANTS	127 adults with depression and functional impairment due to multiple sclerosis
INTERVENTIONS	EFT
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomised to receive a weekly 50-minute session of telephone-administered CBT or telephone-administered supportive EFT for 16 weeks. Telephone supportive EFT was adapted from the manual developed for process-experiential psychotherapy. Randomisation was stratified based on whether or not participants were currently diagnosed with MDD and were taking antidepressant medication.
FINDINGS	Treatment gains were significant for both treatment groups, with improvements over the 16 weeks greater for those in the telephone CBT group. Treatment gains were maintained at the 12-month follow up, but the differences between the groups were no longer significant.

TITLE OF PAPER	***Maintenance of gains following experiential therapies for depression***
AUTHORS AND JOURNAL	Ellison, J. A., Greenberg, L. S., Goldman, R. N., & Angus, L. (2009). *Journal of Consulting and Clinical Psychology, 77,* 103-112.
DESIGN	Analysis of 18-month follow-up data, post RCT
PARTICIPANTS	43 adults who had been randomly assigned and had responded to short-term client-centered and emotion-focused therapies
INTERVENTIONS	EFT
COMPARISON GROUPS	Client-centred therapy
PROCEDURE	In the RCT, participants were randomised to receive 16-20 sessions of either supportive EFT or client-centred therapy. Follow-up interviews were conducted at 6-, 12- and 18-months.
FINDINGS	At the 6-month follow up, the two treatment groups did not differ significantly on self-reported symptomology. However, at 18 months, supportive EFT demonstrated superior effects in terms of less depressive relapse and a greater number of asymptomatic or minimally symptomatic weeks.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Depression: The treatment and management of depression in adults (NICE clinical guideline 90)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (23 studies)
PARTICIPANTS	Adults diagnosed with depression or depressive symptoms as indicated by depression scale score for subthreshold and other groups
INTERVENTIONS	Pure self-help and self-help with minimal therapist contact
COMPARISON GROUPS	Control (waitlist, TAU, information, discussion), other therapies (including CBT and psychoeducation)
PROCEDURE	Review of RCTs published between 1979 and 2009 in peer-reviewed journals investigating the effectiveness of a range of high and low intensity psychological interventions.
FINDINGS	In studies that compared *pure self-help* with non-active controls, pure self-help was shown to be an effective treatment for those with ranging depressive symptom severity. However, the effectiveness of pure self-help at 12-month follow up is less clear. When pure self-help was compared with other therapies (psychoeducation and group CBT) no clinically significant differences were found. There is some evidence that guided self-help has a beneficial effect in those with largely subclinical depression. This evidence is derived mainly from studies comparing guided self-help to a waitlist control.

TITLE OF PAPER	***Computerised cognitive-behavioural therapy for depression: Systematic review***
AUTHORS AND JOURNAL	Kaltenthaler, E., Parry, G., Beverley, C., & Ferriter, M. (2008). *British Journal of Psychiatry, 193,* 181-184.
DESIGN	Systematic review (4 studies included)
PARTICIPANTS	Adults with mild to moderate depression, with or without anxiety
INTERVENTIONS	Pure self-help and self-help with minimal therapist contact
COMPARISON GROUPS	TAU (not defined), BluePages (web-based information program), attention placebo
PROCEDURE	Review of 3 computerised CBT programs delivered alone or as part of a package of care via a computer interface or over the telephone with a computer response: **1** *Beating the Blues* – a 15-minute introductory video and eight, 1 hour interactive computer sessions using CBT strategies. Sessions are usually weekly and completed in the routine care setting. **2** *MoodGYM* – a web-based CBT program for depression. It consists of five interactive modules, available sequentially on a week-by-week basis, with revision in the sixth week. **3** *Overcoming depression on the internet (ODIN)* – a US-based program that uses cognitive restructuring techniques delivered via the internet in the form of self-guided interactive tutorials.
FINDINGS	Three of the four RCTs reviewed showed evidence of effectiveness. There is some evidence that *Beating the Blues* is more effective than TAU. Both *MoodGYM* and its study comparator (BluePages) were more effective in reducing depressive symptoms than the control group. Two ODIN studies were reviewed. One reported no treatment effect and one reported greater reduction in depressive symptoms in the ODIN group compared to the control.

TITLE OF PAPER	***Clinician-assisted internet-based treatment is effective for depression: Randomized controlled trial***
AUTHORS AND JOURNAL	Perini, S., Titov, N., & Andrews, G. (2009). *Australian and New Zealand Journal of Psychiatry, 43,* 571-578.
DESIGN	RCT (2 groups)
PARTICIPANTS	45 adults with depression
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either the *Sadness* program (internet CBT-based program) or a waitlist control group. The *Sadness* program consisted of four components: six online lessons, homework assignments, participation in an online forum, and regular email contact with a clinician.
FINDINGS	*Sadness* program participants reported significantly reduced symptoms of depression compared with controls. There were no differences between the groups on the measures assessing level of psychosocial disability.

TITLE OF PAPER	***Effectiveness of bibliotherapy self-help for depression with varying levels of telephone support***
AUTHORS AND JOURNAL	Bilich, L. L., Deane, F. P., Phipps, A. B., Barisic, M., & Gould, G. (2008). *Clinical Psychology and Psychotherapy, 15,* 61-74.
DESIGN	RCT (3 groups) including a 1-month follow up
PARTICIPANTS	84 adults with mild to moderate depression
INTERVENTIONS	Self-help with minimal therapist contact (2 forms)
COMPARISON GROUPS	Waitlist control
PROCEDURE	A self-help workbook called *The Good Mood Guide – A Self-Help Guide for Depression* (GMG) was developed for the study using cognitive behavioural principles. The GMG contained 8 units to be completed over a week. An additional weekly telephone contact of up to 30 minutes was included in the intervention. Participants were randomly assigned to either assisted self-help, minimal contact, or to a waitlist control. Those in the assisted self-help group received more intensive assistance in completing the workbook than those in the minimal contact group.
FINDINGS	Both treatment groups had significant reductions in depressive symptoms compared to the control group and treatment gains were maintained at the 1-month follow up.

TITLE OF PAPER	***The clinical effectiveness of guided self-help versus waiting-list control in the management of anxiety and depression: A randomised controlled trial***
AUTHORS AND JOURNAL	Mead, N., MacDonald, W., Bower, P., Lovell, K., Richards, D., Roberts, C., et al. (2005). *Psychological Medicine, 35,* 1633-1643.
DESIGN	RCT (2 groups) including 3-month follow up
PARTICIPANTS	114 adults with significant symptoms of depression and anxiety
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomised to either guided self-help or a waitlist control. The guided self-help group received a maximum of 4 brief (15-30 minute) sessions with a therapist in addition to the purposely written psychoeducation self-help manual. Those in the waitlist control received routine care from primary-care professionals (e.g., general support, pharmacotherapy).
FINDINGS	Although adherence to the guided self-help intervention was acceptable, no statistically significant differences between the groups in depressive symptoms were found at 3-month follow up.

TITLE OF PAPER	***A randomised controlled trial of the use of self-help materials in addition to standard general practice treatment of depression compared to standard treatment alone***
AUTHORS AND JOURNAL	Salkovskis, P., Rimes, K., Stephenson, D., Sacks, G., & Scott, J. (2005). *Psychological Medicine, 36,* 325-333.
DESIGN	RCT (2 groups)
PARTICIPANTS	96 adults diagnosed with major depressive disorder who were prescribed antidepressant medication
INTERVENTIONS	Pure self-help plus TAU (pharmacotherapy and any other intervention deemed appropriate by the primary care team)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomised to either 26 weeks of self-help (bibliotherapy) plus TAU or TAU alone. The individualised self-help package was designed to improve treatment adherence, decrease treatment drop-out, and teach simple self-help strategies. It was administered by a third-party data management organisation.
FINDINGS	Participants in both conditions improved significantly over time, however there were no significant differences between the groups on any of the outcomes measures.

PSYCHOEDUCATION

GROUP

TITLE OF PAPER	***Patient education and group counselling to improve the treatment of depression in primary care: A randomized control trial***
AUTHORS AND JOURNAL	Hansson, M., Bodlund, O., & Chotai, J. (2008). *Journal of Affective Disorders, 105,* 235-240.
DESIGN	RCT (2 groups)
PARTICIPANTS	319 adults diagnosed with depression
INTERVENTIONS	Psychoeducation plus TAU (pharmacotherapy and/or supportive follow up)
COMPARISON GROUPS	TAU
PROCEDURE	Forty six participating health care centres were randomly allocated to group psychoeducation (n = 205) or to the control group (n = 115). The group psychoeducation program, Contactus, comprised 6 weekly lectures on topics such as diagnosing and treating depression and non-pharmacological alternatives to treatment, followed by post-lecture group discussions (8-10 patients per group).
FINDINGS	At treatment completion, those completing *Contactus* showed significantly greater symptom improvement than those in the control group.

TITLE OF PAPER	***A randomized controlled trial of a psychoeducational group program for unipolar depression in adults in Norway***
AUTHORS AND JOURNAL	Dalgard, O. D. (2006). *Clinical Practice and Epidemiology in Mental Health, 2:*15.
DESIGN	RCT (2 groups) including 6- and 12-month follow up
PARTICIPANTS	155 adults diagnosed with unipolar depression
INTERVENTIONS	Psychoeducation
COMPARISON GROUPS	TAU (medication, psychotherapy or both)
PROCEDURE	The first wave of the study was an RCT and the second wave was offered to the control group. In wave 1, participants were randomly allocated to either the *Coping with Depression* course plus TAU or to TAU. The intervention aimed to promote positive thinking, pleasant activities, social skills and social support. It consisted of 8 weekly, 2.5 hour sessions, and booster sessions 1, 2, and 4 months post-program.
FINDINGS	Both groups demonstrated improvements in their depression, however, at the 6-month follow up the difference between the groups was significant and favoured the intervention group. Treatment gains were maintained at 12-months, but the difference was no longer significant.

Bipolar

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy, interpersonal psychotherapy, family therapy, mindfulness-based cognitive therapy and psychoeducation, as adjuncts to pharmacotherapy, in the treatment of bipolar disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Clinical practice recommendations for bipolar disorder***
AUTHORS AND JOURNAL	Mahli, G. S., Adams, D., Lampe, L., Paton, M., O'Connor, N., Newton, L. A., et al. (2009). *Acta Psychiatrica Scandinavia, 119 (s439),* 27-46.
DESIGN	Systematic review in development of clinical guidelines
PARTICIPANTS	Not stated
INTERVENTIONS	CBT, interpersonal and social rhythm therapy, family therapy, psychoeducation
COMPARISON GROUPS	Brief psychoeducation
PROCEDURE	Review of psychosocial treatments for bipolar disorder
FINDINGS	There are no definitive studies of psychotherapies as standalone interventions in bipolar disorder and they should only be used as an adjunct to pharmacotherapy and are most effective during the maintenance phase. Psychosocial interventions appear to have the greatest benefit in reducing risk of relapse and improving functioning during the maintenance phase. A number of intensive psychosocial interventions have shown superior clinical outcomes compared to brief psychoeducation: CBT (5 studies with level II evidence), group psychoeducation (2 studies with level II evidence), interpersonal and social rhythm therapy (2 studies with level II evidence), and family therapy (2 studies with level II evidence).

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***Clinical practice recommendations for bipolar disorder***
AUTHORS AND JOURNAL	Mahli, G. S., Adams, D., Lampe, L., Paton, M., O'Connor, N., Newton, L. A., et al. (2009). *Acta Psychiatrica Scandinavia, 119 (s439),* 27-46.
DESIGN	Systematic review in development of clinical guidelines
PARTICIPANTS	Not stated
INTERVENTIONS	Interpersonal and social rhythm therapy, CBT, family therapy, psychoeducation
COMPARISON GROUPS	Brief psychoeducation
PROCEDURE	Review of psychosocial treatments for bipolar disorder
FINDINGS	There are no definitive studies of psychotherapies as standalone interventions in bipolar disorder – they should only be used as an adjunct to pharmacotherapy and are most effective during the maintenance phase. Psychosocial interventions appear to have the greatest benefit in reducing risk of relapse and improving functioning during the maintenance phase. A number of intensive psychosocial interventions have shown superior clinical outcomes compared to brief psychoeducation: CBT (5 studies), group psychoeducation (2 studies), interpersonal and social rhythm therapy (2 studies), and family therapy (2 studies).

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

TITLE OF PAPER	***Clinical practice recommendations for bipolar disorder***
AUTHORS AND JOURNAL	Mahli, G. S., Adams, D., Lampe, L., Paton, M., O'Connor, N., Newton, L. A., et al. (2009). *Acta Psychiatrica Scandinavia, 119 (s439),* 27-46.
DESIGN	Systematic review in development of clinical guidelines
PARTICIPANTS	Not stated
INTERVENTIONS	Family therapy, CBT, interpersonal and social rhythm therapy, psychoeducation
COMPARISON GROUPS	Brief psychoeducation
PROCEDURE	Review of psychosocial treatments for bipolar disorder
FINDINGS	There are no definitive studies of psychotherapies as standalone interventions in bipolar disorder – they should only be used as an adjunct to pharmacotherapy and are most effective during the maintenance phase. Psychosocial interventions appear to have the greatest benefit in reducing risk of relapse and improving functioning during the maintenance phase. A number of intensive psychosocial interventions have shown superior clinical outcomes compared to brief psychoeducation: CBT (5 studies), group psychoeducation (2 studies), interpersonal and social rhythm therapy (2 studies), and family therapy (2 studies).

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF PAPER	***Mindfulness-based cognitive therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning***
AUTHORS AND JOURNAL	Williams, J. M. G., Alatiq, Y., Crane, C., Barnhofer, T., Fennell, M. J. V., Duggan, D. S., et al. (2007). *Journal of Affective Disorders, 107,* 275-279.
DESIGN	RCT pilot study (2 groups)
PARTICIPANTS	68 adults with bipolar or unipolar depression
INTERVENTIONS	MBCT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to the MBCT or waitlist condition. Those in the MBCT group met weekly for two hours over 8 weeks.
FINDINGS	Participants who received MBCT had significantly lower anxiety scores posttreatment compared to waitlist controls. The effect of MBCT in reducing depression was observed among all participants attending MBCT.

PSYCHOEDUCATION

GROUP

TITLE OF PAPER	***Clinical practice recommendations for bipolar disorder***
AUTHORS AND JOURNAL	Mahli, G. S., Adams, D., Lampe, L., Paton, M., O'Connor, N., Newton, L. A., et al. (2009). *Acta Psychiatrica Scandinavia, 119 (s439),* 27-46.
DESIGN	Systematic review in development of clinical guidelines
PARTICIPANTS	Not stated
INTERVENTIONS	Psychoeducation, CBT, interpersonal and social rhythm therapy, family therapy
COMPARISON GROUPS	Brief psychoeducation
PROCEDURE	Review of psychosocial treatments for bipolar disorder
FINDINGS	There are no definitive studies of psychotherapies as standalone interventions in bipolar disorder – they should only be used as an adjunct to pharmacotherapy and are most effective during the maintenance phase. Psychosocial interventions appear to have the greatest benefit in reducing risk of relapse and improving functioning during the maintenance phase. A number of intensive psychosocial interventions have shown superior clinical outcomes compared to brief psychoeducation: CBT (5 studies), group psychoeducation (2 studies), interpersonal and social rhythm therapy (2 studies), and family therapy (2 studies).

GROUP

TITLE OF PAPER	***Group psychoeducation for stabilised bipolar disorders: 5-year outcome of a randomised clinical trial***
AUTHORS AND JOURNAL	Colom, F., Vieta, E., Sanchez-Moreno, J., Palomino-Otiniano, R., Reinares, M., Goikolea, J. M., et al. (2009). *British Journal of Psychiatry, 194,* 260-265.
DESIGN	RCT (2 groups) including a 5-year naturalistic follow up
PARTICIPANTS	120 adults diagnosed with bipolar disorder
INTERVENTIONS	Psychoeducation plus pharmacotherapy
COMPARISON GROUPS	Control (group meeting plus pharmacotherapy)
PROCEDURE	Participants were randomised to receive 21 sessions of a manualised group psychoeducation program over 6 months or to join an unstructured support group.
FINDINGS	At the 5-year follow up, time to any illness recurrence was longer for the psychoeducation group. Group participants also had fewer recurrences of any type, spent less time acutely ill, and spent less time in hospital.

GROUP

TITLE OF PAPER	***Psychoeducation for bipolar II disorder: An exploratory, 5-year outcome subanalysis***
AUTHORS AND JOURNAL	Colom, F., Vieta, E., Sanchez-Moreno, J., Goikolea, J. M., Popova, E., Bonnin, C. M., et al. (2009). *Journal of Affective Disorders, 112,* 30-35.
DESIGN	Post-hoc analysis of data obtained from an RCT
PARTICIPANTS	20 adults diagnosed with bipolar disorder II
INTERVENTIONS	Psychoeducation plus pharmacotherapy
COMPARISON GROUPS	Control (group meeting plus pharmacotherapy)
PROCEDURE	Post-hoc analyses were conducted on a subset of 20 (out of 120) participants with bipolar II who were randomised to receive either 21 sessions of a manualised group psychoeducation program over 6 months, or to join an unstructured support group.
FINDINGS	Over the 5-year naturalistic follow up, those in the treatment group had a lower mean number of episodes (hypomanic and depressive), spent fewer days in mood episodes, and had higher mean levels of functioning.

Generalised anxiety

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for psychodynamic psychotherapy in the treatment of generalised anxiety disorder (GAD) in adults. Three studies with small sample sizes provided Level IV evidence for mindfulness-based cognitive therapy and self-help (primarily CBT-based). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***A meta-analysis of CBT for pathological worry among clients with GAD***
AUTHORS AND JOURNAL	Covin, R., Ouimet, A. J., Seeds, P. M., & Dozois, D. J. A. (2008). *Journal of Anxiety Disorders, 22,* 108-116.
DESIGN	Meta-analysis (10 studies)
PARTICIPANTS	Adults diagnosed with GAD
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (no treatment, psychological placebo)
PROCEDURE	Systematic review and meta-analysis of peer-reviewed outcomes studies (up to 2006) of CBT for GAD.
FINDINGS	CBT for GAD is effective for reducing pathological worry, however, effectiveness was moderated by age. Younger adults responded more favourably to CBT interventions than did older adults. Despite this difference, when compared to control groups, the mean effect size of CBT for older adults was still higher. Therapeutic effects of CBT were maintained at 6- and 12-month follow-up.

TITLE OF PAPER	***Short-term psychodynamic psychotherapy and cognitive-behavioural therapy in generalised anxiety disorder: A randomised, controlled trial***
AUTHORS AND JOURNAL	Leichsenring, F., Salzer, S., Jaeger, U., Krieske, R., Ruger, F., Winkelbach, C., et al. (2009). *American Journal of Psychiatry, 166,* 875-881.
DESIGN	RCT (2 groups)
PARTICIPANTS	57 adults with a primary diagnosis of GAD
INTERVENTIONS	CBT
COMPARISON GROUPS	Psychodynamic psychotherapy
PROCEDURE	Participants were randomly allocated to either CBT or short-term psychodynamic psychotherapy. Participants in both groups received up to 30 weekly 50-minute sessions carried out according to treatment manuals.
FINDINGS	Both therapeutic interventions resulted in significant, large, and stable improvements in symptoms of anxiety and depression. CBT resulted in greater improvements on measures of trait anxiety, worry and depression.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

GROUP

TITLE OF PAPER	***Mindfulness-based cognitive therapy for generalised anxiety disorder: A preliminary evaluation***
AUTHORS AND JOURNAL	Craigie, M. A., Rees, C. S., & Marsh, A. (2008). *Behavioural and Cognitive Psychotherapy, 36,* 553-568.
DESIGN	Case series including 3- and 6-month follow up
PARTICIPANTS	23 adults with a primary diagnosis of GAD
INTERVENTIONS	MBCT
COMPARISON GROUPS	None
PROCEDURE	The intervention was delivered in 9 weekly 2-hour group sessions. A total of 4 MBCT groups were conducted, with sizes ranging from 5 to 7 participants.
FINDINGS	There was significant improvement in pathological worry and several GAD related symptoms at posttreatment. Treatment gains were maintained at follow up. When standardised recovery criteria to pathological worry were applied, the rate of recovery at posttreatment was very small, although it improved at follow up.

GROUP

TITLE OF PAPER	***Mindfulness-based cognitive therapy for generalized anxiety disorder***
AUTHORS AND JOURNAL	Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, D. (2008). *Journal of Anxiety Disorders, 22,* 716-721.
DESIGN	Case series
PARTICIPANTS	11 adults diagnosed with GAD
INTERVENTIONS	MBCT
COMPARISON GROUPS	None
PROCEDURE	Participants met for 8 consecutive weeks for 2 hours in a group format. Each session followed an agenda and focused on specific formal and informal mindfulness-based stress reduction techniques (e.g. meditation, yoga).
FINDINGS	At posttreatment, participants experienced a significant reduction in anxiety, tension, worry, and depressive symptoms. Furthermore, those whose baseline symptoms were in the clinical range experienced a reduction in their symptoms comparable to those of a non-clinical population.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***Short-term psychodynamic psychotherapy and cognitive-behavioural therapy in generalised anxiety disorder: A randomised, controlled trial***
AUTHORS AND JOURNAL	Leichsenring, F., Salzer, S., Jaeger, U., Kachele, H., Leweke, F., Ruger, U., et al. (2009). *American Journal of Psychiatry, 166,* 875-881.
DESIGN	RCT (2 groups)
PARTICIPANTS	57 adults with a primary diagnosis of GAD
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomly allocated to either CBT or short-term psychodynamic psychotherapy. Participants in both groups received up to 30 weekly 50-minute sessions carried out according to treatment manuals.
FINDINGS	Both therapeutic interventions resulted in significant, large, and stable improvements in symptoms of anxiety and depression. CBT resulted in greater improvements on measures of trait anxiety, worry and depression.

TITLE OF PAPER	***A 12-month comparison of brief psychodynamic psychotherapy and pharmacotherapy treatment in subjects with generalised anxiety disorders in a community setting***
AUTHORS AND JOURNAL	Ferrero, A., Piero, A., Fassina, S., Massola, T., Lanteri, A., Abbate Daga, G., et al. (2007). *European Psychiatry, 22,* 530-539.
DESIGN	Non-randomised controlled trial (3 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	87 adults diagnosed with GAD
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	Participants were allocated to one of three groups based on clinical need: pharmacotherapy, brief Adlerian psychodynamic psychotherapy therapy, or a combination of both. The main elements of the brief Adlerian treatment were encouraging relationships, identifying the focus, and determining areas of possible change within the focus therapy. Participants received 10-15 individual sessions of 45-minute duration.
FINDINGS	Comparisons between the 3 groups revealed overall and progressive improvement in symptoms and resulted in long-term therapeutic benefits. No significant differences in outcome were observed between the groups.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Internet-based self-management of generalised anxiety disorder: A preliminary study***
AUTHORS AND JOURNAL	Draper, M., Rees, C. S., & Nathan, P. R. (2008). *Behaviour Change, 25,* 229-244.
DESIGN	Case series (pilot study)
PARTICIPANTS	3 adults diagnosed with GAD
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	None
PROCEDURE	Participants completed *What? Me Worry!?!*, an internet-based intervention that combines elements of CBT with techniques that target intolerance of uncertainty, metacognitive beliefs, and acceptance and mindfulness. The participants were granted access to the website and instructed to complete each of the 11 modules on a weekly basis. They were also asked to fill out three self-report questionnaires each week to monitor their progress.
FINDINGS	Participants achieved clinically significant improvements on measures of worry, GAD symptomology and metacognitions. At treatment end none of the participants met diagnostic criteria for GAD.

Panic

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self-help (primarily CBT-based) and psychoeducation in the treatment of panic disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***A meta-analysis of the efficacy of psycho- and pharmacotherapy in panic disorder with and without agoraphobia***
AUTHORS AND JOURNAL	Mitte, K. (2005). *Journal of Affective Disorders, 88,* 27-45.
DESIGN	Meta-analysis (124 studies)
PARTICIPANTS	Adults with a diagnosis of panic disorder with and without agoraphobia
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, pill, therapy placebo), pharmacotherapy
PROCEDURE	Review and meta-analysis of published and unpublished studies investigating the effectiveness of CBT alone, pharmacotherapy alone and in combination.
FINDINGS	Both CBT and pharmacotherapy were found to be more effective than no treatment or placebo in treating panic disorder. In studies directly comparing CBT to pharmacotherapy, no significant differences between the two treatments were found. The combination of CBT and pharmacotherapy was slightly more effective than CBT alone for all symptom categories, with the exception of quality of life.

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	CBT, IPT, psychodynamic psychotherapy, solution-focused brief therapy (SFBT), hypnotherapy, self-help
COMPARISON GROUPS	Pharmacotherapy (imipramine), other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	CBT with or without exposure is effective in the treatment of panic disorder. There is some evidence to support the use of CBT-based *self-help* delivered via computer. Applied relaxation is more effective than a waitlist placebo. There is a lack of evidence supporting the use of *IPT, psychodynamic psychotherapy*, *SFBT*, and *hypnotherapy* in treating panic disorder. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclic antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine.

TITLE OF PAPER	***Is a combined therapy more effective than either CBT or pharmacotherapy (SSRI) alone? Results of a multicentre trial on panic disorder with or without agoraphobia.***
AUTHORS AND JOURNAL	Van Apeldoorn, F.J., van Hout, W.J.P.J., Mersch, P.P.A., Huisman, M., Slaap, B.R., Hale, W.W., et al. (2008). *Acta Psychiatrica Scandinavica, 117,* 260-270.
DESIGN	RCT (3 groups)
PARTICIPANTS	150 participants with panic disorder (with or without agoraphobia).
INTERVENTIONS	CBT
COMPARISON GROUPS	Pharmacotherapy (SSRI)
PROCEDURE	Patients received one of the three conditions over nine months: CBT alone, CBT plus an SSRI, or SSRI alone. CBT consisted of up to 18, 50-minute sessions. The frequency of sessions was tapered towards the end of the treatment period.
FINDINGS	CBT and SSRI were effective treatments on their own; however, CBT in combination with SSRI was superior to CBT alone.

TITLE OF PAPER	***Reducing therapist contact in cognitive behaviour therapy for panic disorder and agoraphobia in primary care: Global measures of outcome in a randomised controlled trial***
AUTHORS AND JOURNAL	Sharp, D. M., Power, K. G., & Swanson, V. (2000). *British Journal of General Practice, 50,* 963-968.
DESIGN	RCT (3 groups)
PARTICIPANTS	104 adults diagnosed with panic disorder (with or without agoraphobia)
INTERVENTIONS	CBT
COMPARISON GROUPS	Pure self-help and self-help with minimal therapist contact
PROCEDURE	Participants were randomly allocated to one of three conditions: standard face-to-face CBT (6 contact hours), minimum contact (2 contact hours), or pure self-help (initial assessment only). All participants received the same CBT-based treatment manual and were seen by the same therapist. The treatment period was 12 weeks.
FINDINGS	The standard therapist contact group showed the strongest and most comprehensive treatment response, followed by the minimum contact group, and then the pure self-help group.

GROUP

TITLE OF PAPER	***Treatment of panic disorder with agoraphobia: Randomised placebo-controlled trial of four psychosocial treatments combined with imipramine or placebo.***
AUTHORS AND JOURNAL	Marchand, A., Coutu, M., Dupuis, G., Fleet, R., Borgeat, F., Todorov, C., et al. (2008). *Cognitive Behavioural Therapy, 37,* 146-159.
DESIGN	RCT (8 groups) including 12-month follow up
PARTICIPANTS	137 adults diagnosed with panic disorder (with moderate to severe agoraphobia)
INTERVENTIONS	CBT plus pharmacotherapy
COMPARISON GROUPS	Supportive therapy plus pharmacotherapy
PROCEDURE	Participants were randomised to one of four psychosocial treatments: cognitive therapy and graded in vivo exposure, graded in vivo exposure, cognitive therapy, and supportive therapy. Each treatment was combined with either imipramine or placebo, resulting in 8 treatment conditions. All treatments were conducted in small groups, that met for 14 three hour sessions over 18 weeks.
FINDINGS	All treatment modalities were effective in terms of reducing self-reported panic-agoraphobia symptoms at treatment completion and at the 12-month follow-up. There were no significant differences between the imipramine and placebo conditions.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	IPT, CBT, psychodynamic psychotherapy, SFBT, hypnotherapy, self-help
COMPARISON GROUPS	Pharmacotherapy, other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	There is a lack of evidence supporting the use of *IPT, psychodynamic psychotherapy*, *SFBT*, and *hypnotherapy* in treating panic disorder. *CBT* with or without exposure is effective in the treatment of panic disorder. There is some evidence to support the use of CBT-based *self-help* delivered via computer. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclics antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine. Applied relaxation is more effective than a waitlist placebo.

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	SFBT, CBT, IPT, psychodynamic psychotherapy, hypnotherapy, self-help
COMPARISON GROUPS	Pharmacotherapy, other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	There is a lack of evidence supporting the use of *SFBT*, *IPT*, *psychodynamic psychotherapy*, and *hypnotherapy* in treating panic disorder. *CBT* with or without exposure is effective in the treatment of panic disorder. There is some evidence to support the use of CBT-based *self-help* delivered via computer. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclics antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine. Applied relaxation is more effective than a waitlist placebo.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***Practice guideline for the treatment of patients with panic disorder: Second edition***
AUTHORS AND JOURNAL	American Psychiatric Association (2009). Arlington, VA: Author.
DESIGN	Systematic review
PARTICIPANTS	Not stated
INTERVENTIONS	Psychodynamic psychotherapy, CBT
COMPARISON GROUPS	Pharmacotherapy, control (placebo, waitlist, no-treatment), other therapies (e.g. relaxation)
PROCEDURE	Review of controlled trials.
FINDINGS	There is more support for the efficacy of CBT in treating panic disorder than for psychodynamic psychotherapy. Support for psychodynamic psychotherapy comes mostly from case studies and uncontrolled trials, whereas the support for CBT comes mostly from RCTs. Evidence also suggests that individual and group CBT are equally effective.

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	Psychodynamic psychotherapy, CBT, IPT, SFBT, hypnotherapy, self-help
COMPARISON GROUPS	Pharmacotherapy, other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	There is a lack of evidence supporting the use of *psychodynamic psychotherapy*, *IPT*, *SFBT*, and *hypnotherapy* in treating panic disorder. *CBT* with or without exposure is effective in the treatment of panic disorder. There is some evidence to support the use of CBT-based *self-help* delivered via computer. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclics antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine. Applied relaxation is more effective than a waitlist placebo.

TITLE OF PAPER	***A randomised controlled clinical trial of psychoanalytic psychotherapy for panic disorder***
AUTHORS AND JOURNAL	Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., et al. (2007). *American Journal of Psychiatry, 164,* 2.
DESIGN	RCT (2 groups)
PARTICIPANTS	49 adults diagnosed with panic disorder
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	Applied relaxation training
PROCEDURE	Participants were randomly allocated to bi-weekly sessions over 12 weeks of either psychodynamic psychotherapy or applied relaxation training.
FINDINGS	Those in the psychodynamic psychotherapy group had significantly greater reduction in the severity of panic symptoms and significantly greater improvement in psychosocial functioning compared to the control group.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	Self-help, CBT, IPT, psychodynamic psychotherapy, SFBT, hypnotherapy
COMPARISON GROUPS	Pharmacotherapy, other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	There is some evidence to support the use of CBT-based *self-help* delivered via computer. *CBT* with or without exposure is effective in the treatment of panic disorder. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclics antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine. Applied relaxation is more effective than a waitlist placebo. There is a lack of evidence supporting the use of *IPT*, *psychodynamic psychotherapy*, *SFBT*, and *hypnotherapy* in treating panic disorder.

TITLE OF PAPER	***Reducing therapist contact in cognitive behaviour therapy for panic disorder and agoraphobia in primary care: Global measures of outcome in a randomised controlled trial***
AUTHORS AND JOURNAL	Sharp, D. M., Power, K. G., & Swanson, V. (2000). *British Journal of General Practice, 50,* 963-968.
DESIGN	RCT (3 groups)
PARTICIPANTS	104 adults diagnosed with panic disorder (with or without agoraphobia)
INTERVENTIONS	Pure self-help and self-help with minimal therapist contact
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomly allocated to one of three conditions: standard face-to-face CBT (6 contact hours), minimum contact (2 contact hours), or pure self-help (initial assessment only). All participants received the same CBT-based treatment manual and were seen by the same therapist. The treatment period was 12 weeks.
FINDINGS	The standard therapist contact group showed the strongest and most comprehensive treatment response, followed by the minimum contact group, and then the pure self-help group.

GROUP

TITLE OF PAPER	***A bibliotherapy approach to relapse prevention in individuals with panic attacks***
AUTHORS AND JOURNAL	Wright, J., Clum, G. A., Roodman, A., & Febbraro, G. A. M. (2000). *Journal of Anxiety Disorders, 14,* 483-499.
DESIGN	RCT (2 groups)
PARTICIPANTS	36 adults with a diagnosis of panic disorder or who have experienced at least one panic attack
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either self-help for relapse prevention or to a waitlist control. The self-help group received a relapse prevention treatment manual and brief phone calls aimed at bolstering program compliance.
FINDINGS	The treatment group demonstrated significantly greater reductions in anxiety, avoidance, depression, panic cognition and panic attacks than the control group.

HYPNOTHERAPY

TITLE OF PAPER	***Clinical guidelines for the management of anxiety: Panic disorder (with or without agoraphobia) and generalised anxiety disorder***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2004). London: Author.
DESIGN	Systematic review
PARTICIPANTS	Not defined
INTERVENTIONS	Hypnotherapy, psychodynamic psychotherapy, CBT, IPT, SFBT, self-help
COMPARISON GROUPS	Pharmacotherapy, other therapies (e.g. applied relaxation)
PROCEDURE	Review of all clinical guidelines, systematic reviews, meta-analyses and RCTs published between 1979 and 2003 investigating the effectiveness of psychological and pharmacological interventions for the treatment of panic disorder.
FINDINGS	There is a lack of evidence supporting the use of *hypnotherapy psychodynamic psychotherapy*, *IPT*, and *SFBT* in treating panic disorder. *CBT* with or without exposure is effective in the treatment of panic disorder. There is some evidence to support the use of CBT-based *self-help* delivered via computer. In studies comparing/combining CBT and pharmacotherapy, CBT was found to be superior to tricyclics antidepressants but no differences were found between CBT with imipramine and CBT with placebo in the acute phase of the illness; however, 3 months posttreatment, CBT with placebo was more effective than CBT with imipramine. Applied relaxation is more effective than a waitlist placebo.

Specific phobia

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self-help (primarily CBT-based) in the treatment of specific phobia in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Psychological approaches in the treatment of specific phobias: A meta-analysis***
AUTHORS AND JOURNAL	Wolizky-Taylor, K. B., Horowitz, J.D., Powers, M. B., & Telch, M. J. (2008). *Clinical Psychology Review, 28,* 1021-1037.
DESIGN	Meta-analysis (33 studies)
PARTICIPANTS	1193 adults with specific phobias
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, placebo), other active treatments (e.g. EMDR, relaxation)
PROCEDURE	Meta-analysis of RCTs published between 1977 and 2007 investigating psychosocial treatments for specific phobia. Effect sizes were calculated for each of the treatment comparisons.
FINDINGS	Exposure-based CBT outperformed control and other treatment groups, including CBT without exposure. Exposure treatments involving physical contact with the phobic target were more effective than other forms of exposure (e.g. imaginal). Placebo treatments were significantly more effective than no treatment.

TITLE OF PAPER — ***Internet-based self-help versus one-session exposure in the treatment of spider phobia: A randomized controlled trial***

AUTHORS AND JOURNAL — Andersson, G., Waara, J., Jonsson, U., Malmaeus, F., Calrbing, P., & Ost, L. (2009). *Cognitive Behavior Therapy, 38,* 114-120.

DESIGN — RCT (2 groups) including 12-month follow up

PARTICIPANTS — 30 adults diagnosed with specific phobia, spider type

INTERVENTIONS — CBT

COMPARISON GROUPS — Self-help with minimal therapist contact

PROCEDURE — Participants were randomly allocated to either guided internet-based self-help or one session of live exposure. The self-help treatment consisted of 5 weekly text modules presented as downloadable PDF files, a 20-minute video in which exposure was modelled, and internet-based support (25-minutes per client). The live exposure treatment was delivered in a single, 3-hour session following a brief orientation session.

FINDINGS — Both treatment conditions were effective. At posttreatment and at the 12-month follow up there was no significant difference between the two groups with the exception of the proportion showing clinically significant improvement on the primary measure, the behavioural approach test.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER — ***Internet-based self-help versus one-session exposure in the treatment of spider phobia: A randomized controlled trial***

AUTHORS AND JOURNAL — Andersson, G., Waara, J., Jonsson, U., Malmaeus, F., Calrbing, P., & Ost, L. (2009). *Cognitive Behavior Therapy, 38,* 114-120.

DESIGN — RCT (2 groups) including 12-month follow up

PARTICIPANTS — 30 adults diagnosed with specific phobia, spider type

INTERVENTIONS — Self-help with minimal therapist contact

COMPARISON GROUPS — CBT

PROCEDURE — Participants were randomly allocated to either guided internet-based self-help or one session of live exposure. The self-help treatment consisted of 5 weekly text modules presented as downloadable PDF files, a 20-minute video in which exposure was modelled, and internet-based support (25-minutes per client). The live exposure treatment was delivered in a single, 3-hour session following a brief orientation session.

FINDINGS — Both treatment conditions were effective. At posttreatment and at the 12-month follow up there was no significant difference between the two groups. However, the results also showed that the live exposure treatment is more effective posttreatment for those who showed clinically significant improvement on the primary measure, the behavioural approach test.

Social anxiety

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self-help (primarily CBT-based) and psychodynamic psychotherapy (with pharmacotherapy) in the treatment of social anxiety in adults. Three studies provided Level III evidence or below for interpersonal psychotherapy and acceptance and commitment therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***A meta-analytic review of psychological treatments for social anxiety disorder***
AUTHORS AND JOURNAL	Powers, M., Sigmarsson, S. R., & Emmelkemp, P. M. G. (2009). *International Journal of Cognitive Therapy, 1,* 94-113.
DESIGN	Meta-analysis (32 studies)
PARTICIPANTS	1479 adults with social anxiety
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, pill-placebo, psychological placebo), other active therapy (social skills training, relaxation)
PROCEDURE	Systematic review and meta analysis of high quality RCTs, including follow up from all studies reporting pretreatment and follow-up comparison data.
FINDINGS	CBT (cognitive therapy and exposure) outperformed waitlist and placebo conditions across outcome domains and at follow up. No significant differences were found between combined treatment (exposure with cognitive therapy) and exposure or cognitive interventions alone. While not significantly different, exposure produced the largest controlled effect size relative to cognitive or combined therapy. No significant differences between individual or group formats were found.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***A randomized trial of interpersonal psychotherapy versus supportive therapy for social anxiety disorder***
AUTHORS AND JOURNAL	Lipsitz, J. D., Gur, M., Vermes, D., Petkova, E., Cheng, J., Miller, N., et al. (2008). *Depression and Anxiety, 25,* 542-553.
DESIGN	Pseudo-randomised controlled trial (2 groups)
PARTICIPANTS	70 adults diagnosed with SAD
INTERVENTIONS	IPT
COMPARISON GROUPS	Supportive therapy
PROCEDURE	Participants were randomly allocated to 14 weekly sessions of either IPT or supportive therapy.
FINDINGS	Participants in both groups improved significantly; however there was no significant difference between the two groups.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF PAPER	***Acceptance and commitment therapy for generalized social anxiety disorder***
AUTHORS AND JOURNAL	Dalrymple, K. L., & Herbert, J. D. (2007). *Behavior Modification, 31,* 543-568.
DESIGN	Case series
PARTICIPANTS	19 adults diagnosed with SAD (generalised subtype)
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	All participants received 12 weekly 1-hour sessions of manualised ACT.
FINDINGS	Significant improvements occurred in social anxiety symptoms and quality of life from pretreatment to follow up. Earlier changes in experiential avoidance predicted later changes in symptom severity.

GROUP

TITLE OF PAPER	***Mindfulness and acceptance-based group therapy for social anxiety disorder: An open trial***
AUTHORS AND JOURNAL	Kocovski, N. L., Fleming, J. E., & Rector, N. A. (2009). *Cognitive and Behavioral Practice, 16,* 276-289.
DESIGN	Case series including 3-month follow up
PARTICIPANTS	42 adult outpatients with SAD (generalised subtype)
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	Participants attended twelve 2-hour group sessions of ACT enhanced with MBCT, and 1 follow-up session 3 months posttreatment.
FINDINGS	There were significant reductions in social anxiety, depression, and rumination as well as significant increases in mindfulness and acceptance. All gains were maintained at follow up.

PSYCHODYNAMIC PSYCHOTHERAPY

GROUP

TITLE OF PAPER	***A pilot study of clonazepam versus psychodynamic group therapy plus clonazepam in the treatment of generalized social anxiety disorder***
AUTHORS AND JOURNAL	Knijnik, D. Z., Blanco, C., Salum Abrahao, G., Moraes, C. U., Mombach, C., Almeida, E., et al. (2008). *European Psychiatry, 23,* 567-574.
DESIGN	RCT (two groups)
PARTICIPANTS	58 adult outpatients with a diagnosis of generalised SAD
INTERVENTIONS	Psychodynamic psychotherapy plus pharmacotherapy
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	Participants were randomly allocated to receive group psychodynamic psychotherapy plus clonazepam or clonazepam alone. The group therapy consisted of 12 weekly 90-minute sessions using a focused, short-term, psychodynamic approach.
FINDINGS	Those in the psychodynamic psychotherapy plus clonazepam group showed significantly greater improvement in social anxiety symptoms than those receiving clonazepam only. There were no significant differences between the groups on secondary measures of broader psychosocial functioning.

SELF HELP – PURE SELF HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Shyness 2: Treating social phobia online: Replication and extension***
AUTHORS AND JOURNAL	Titov, N., Andrews, G., & Schwencke, G. (2008). *Australian and New Zealand Journal of Psychiatry, 42,* 595-605.
DESIGN	RCT (2 groups)
PARTICIPANTS	88 adults with social phobia
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either a clinician-assisted computerised CBT program or to a waitlist control group. Those in the treatment group completed 6 online lessons, CBT-based homework assignments and participated in an online discussion forum. The therapist sent regular email reminders.
FINDINGS	The treatment group experienced significantly reduced symptoms of social phobia at posttreatment compared with controls.

TITLE OF PAPER	***Self-help cognitive-behavioral therapy with minimal therapist contact for social phobia: A controlled trial***
AUTHORS AND JOURNAL	Abramowitz, J. S., Moore, E. L., Braddock, A. E., & Harrington, D. L. (2009). *Journal of Behavior Therapy and Experimental Psychiatry, 40,* 98-105.
DESIGN	RCT (two groups) including 3-month follow up
PARTICIPANTS	21 adults with social phobia
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either immediate treatment or to a waitlist control. Those in the immediate treatment group received a copy of the *Shyness and Social Anxiety workbook*, a CBT-based self-help resource. The 11 chapters were divided into 5 sections to be read over 8 weeks. At weeks 1, 2, 3, 6 and 8, a brief meeting with the therapist (about 30 minutes) was held to review the chapters assigned that week.
FINDINGS	Results revealed that the self-help program was superior to waitlist on most outcome measures. Across the entire sample, reductions in social anxiety, global severity, general anxiety, and depression were observed at posttest and at 3-month follow up.

TITLE OF PAPER	***Treatment of social phobia: A randomised trial of internet-delivered cognitive-behavioral therapy with telephone support***
AUTHORS AND JOURNAL	Carlbring, P., Gunnarsdottir, M., Hedensjo, L., Andersson, G., Ekselius, L., & Furmark, T. (2007). *British Journal of Psychiatry, 190,* 123-128.
DESIGN	RCT (2 groups) including 3-month follow up
PARTICIPANTS	60 adults with social phobia
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to receive either the 9-week treatment program or to a waitlist control. The 186-page treatment text was taken from an existing CBT-based self-help resource. It was divided into 9 modules and adapted for the internet. Treatment group participants received feedback on their homework assignments and brief weekly phone calls (about 10 minutes) from the therapists.
FINDINGS	Treatment participants experienced greater reductions on measures of general and social anxiety, avoidance and depression compared to the control group.

Obsessive compulsive

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self-help (primarily CBT-based) in the treatment of obsessive compulsive disorder (OCD) in adults. One study with a small sample size provided Level IV evidence for acceptance and commitment therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Psychological treatments versus treatment as usual for obsessive compulsive disorder (OCD)***
AUTHORS AND JOURNAL	Gava, I., Barbui, C., Aguglia, E., Carlino, D., Churchill, R., De Vanna, M., & McGuire, H. *Cochrane Database of Systematic Reviews 2007 (2)*. DOI: 10.1002/14651858. CD005333.pub2.
DESIGN	Meta-analysis (8 studies)
PARTICIPANTS	Adults diagnosed with OCD
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (no treatment, waitlist, usual care/management)
PROCEDURE	Systematic review (8 trials with 11 comparisons) and meta-analysis (7 trials with 10 comparisons) of published and unpublished RCTs of psychological treatments of OCD in comparison with TAU.
FINDINGS	Results of the meta-analysis suggested that those receiving CBT exhibited significantly fewer obsessive compulsive symptoms posttreatment than those receiving TAU. No differences were found between individual and group CBT in reducing OCD symptoms.

TITLE OF PAPER	***Satiation therapy and exposure response prevention in the treatment of obsessive compulsive disorder***
AUTHORS AND JOURNAL	Khodarahimi, S. (2009). *Journal of Contemporary Psychotherapy, 39,* 203-207.
DESIGN	RCT (2 groups) including 3- and 6-month follow up
PARTICIPANTS	60 self-referred adult outpatients diagnosed with OCD
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to one of three groups: satiation therapy, ERP, or a waitlist control. Those in the treatment groups attended sessions twice a week for 90 minutes.
FINDINGS	At posttreatment and at the two follow ups, the therapeutic groups showed significantly more improvement than the control group. Satiation therapy and ERP were similarly effective in reducing obsessive-compulsive symptoms.

TITLE OF PAPER	***A randomized controlled trial of cognitive-behavioral therapy for augmenting pharmacotherapy in obsessive-compulsive disorder***
AUTHORS AND JOURNAL	Simpson, H. B., Foa, E. B., Liebowitz, M. R., Ledley, D. R., Huppert, J. D., Cahill, S., et al. (2008). *American Journal of Psychiatry, 165,* 621-630.
DESIGN	RCT (2 groups)
PARTICIPANTS	108 adult outpatients who reported minimal symptom improvement from an adequate trial of SSRI medication
INTERVENTIONS	CBT
COMPARISON GROUPS	Stress management
PROCEDURE	Participants continuing SSRI treatment were randomly assigned to 17 twice-weekly sessions (90-120 minutes) of exposure and response prevention (ERP) or stress management.
FINDINGS	The group receiving ERP experienced significantly greater symptom reduction than the group receiving stress management. In addition, significantly more participants in the ERP group were treatment responders and achieved minimal symptoms.

TITLE OF PAPER	***Group and individual treatment of obsessive-compulsive disorder using cognitive therapy and exposure plus response prevention: A 2-year follow-up of two randomized trials***
AUTHORS AND JOURNAL	Whittal, M. L., Robichaud, M., Thordarson, D. S., & McLean, P. D. (2008). *Journal of Consulting and Clinical Psychology, 76,* 1003-1014.
DESIGN	Two-year follow up of two separate RCTs
PARTICIPANTS	86 adults with OCD who completed a trial of individual or group ERP or individual or group cognitive therapy
INTERVENTIONS	CBT
COMPARISON GROUPS	Individual vs group
PROCEDURE	Using samples from two RCTs, the durability of CBT conducted in a group vs individual format was examined and the differential efficacy of cognitive and behavioural modalities assessed.
FINDINGS	For completers, treatment gains achieved during group and individual therapy were maintained at the 2-year follow up. Recovery and relapse rates were equivalent for group and individual treatment. Among individual treatment participants, cognitive therapy and ERP were equally beneficial. However, for participants treated in groups, those receiving ERP reported fewer OCD symptoms than those in group cognitive therapy.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF PAPER	***Increasing willingness to experience obsessions: Acceptance and commitment therapy as a treatment for obsessive compulsive disorder***
AUTHORS AND JOURNAL	Twohig, M. P., Hayes, S. C., & Masuda, A. (2006). *Behavior Therapy, 37,* 3-13.
DESIGN	Case series
PARTICIPANTS	4 adults who met criteria for OCD
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	A non-concurrent, multiple baseline, across participants experimental design was used. All participants received eight weekly, 1-hour sessions of ACT.
FINDINGS	None of the participants showed decreases in self-reported compulsions during a 1- to 7-week baseline. All showed large reductions in compulsions during treatment and retention of most or all the gains at treatment completion.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Computerised cognitive behaviour therapy for obsessive-compulsive disorder: A systematic review***
AUTHORS AND JOURNAL	Tumur, I., Kaltenthaler, E., Ferriter, M., & Beverley, C. (2007). *Psychotherapy and Psychosomatics, 76,* 196-202.
DESIGN	Systematic review (4 studies)
PARTICIPANTS	325 adults diagnosed with OCD
INTERVENTIONS	Pure self-help
COMPARISON GROUPS	Relaxation, CBT (telephone), none
PROCEDURE	Systematic review of published evidence (2 RCTs and 2 non-RCTs) assessing the effectiveness of computer-based CBT in the treatment of OCD. All four studies used the software program, *BTSteps*, a telephone interactive voice response system and workbook. The program comprises nine CBT-based 'steps'.
FINDINGS	Computer-based CBT was superior to relaxation, but not as effective as telephone-based CBT in reducing OCD symptoms. However, computer-based CBT was as effective as telephone CBT in reducing symptom severity, time spent in rituals and obsessions, and work and social disability caused by OCD.

Posttraumatic stress

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy in the treatment of posttraumatic stress disorder (PTSD) in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. It should be noted however, that there is Level I evidence supporting the efficacy of eye movement desensitization and reprocessing (EMDR), an intervention that was not included in this review.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder***
AUTHORS AND JOURNAL	Australian Centre for Posttraumatic Mental Health. (2007). Melbourne: Author.
DESIGN	Systematic review (8 studies) and review of existing PTSD guidelines
PARTICIPANTS	Adults exposed to trauma, including the acute distress disorder subgroup
INTERVENTIONS	CBT, psychoeducation, hypnotherapy
COMPARISON GROUPS	Five therapy groupings (trauma-focused CBT, eye movement desensitisation and reprocessing, stress management, group CBT, and other therapies including hypnotherapy and psychodynamic psychotherapy)
PROCEDURE	Systematic review of RCTs published between 2004 and 2005 of the same five therapy groupings used in the NICE review published 2005. The NICE review compared the five groupings against waitlist or TAU control or against another psychological treatment.
FINDINGS	*Trauma-focused CBT* was found to be effective in the treatment of PTSD symptoms and comorbid anxiety and depression, as well as in achieving improvements in broader quality of life. There is some evidence that group CBT is more effective than a waitlist control and that non-trauma focused CBT and trauma-focused CBT are equally effective. *Psychoeducation*, when delivered as a 'stand alone' intervention, was found to be inferior to trauma-focused exposure interventions. *Hypnotherapy* was not found to be an effective 'stand alone' intervention when compared to trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR). The evidence is inconclusive as to whether 'other psychological therapies' are more effective than a waitlist.

TITLE OF PAPER	***A systematic review on the effectiveness of cognitive behavioral therapy for posttraumatic stress disorder***
AUTHORS AND JOURNAL	Mendes, D. D., Mello, M. F., Ventura, P., de Medeiros Passarela, C., & de Jesus Mari, J. (2008). *International Journal of Psychiatry in Medicine, 38,* 241-259.
DESIGN	Meta-analysis (23 studies)
PARTICIPANTS	1923 adults with PTSD
INTERVENTIONS	CBT
COMPARISON GROUPS	EMDR, supportive therapy, waitlist control, cognitive therapy, exposure therapy
PROCEDURE	Systematic review and meta-analysis of the efficacy of CBT in comparison to studies that used other psychotherapy techniques.
FINDINGS	CBT had better remission rates than EMDR or supportive therapy and was comparable to exposure therapy and cognitive therapy in terms of efficacy and compliance.

TITLE OF PAPER	***Treatment of acute stress disorders***
AUTHORS AND JOURNAL	Bryant, R. A., Mastrodomenico, J., Felmingham, K., Hopwood, S., Kenny, L., Kandris, E., et al. (2009). *Archives of General Psychiatry, 65,* 59-667.
DESIGN	RCT (3 groups) including 6-month follow up
PARTICIPANTS	90 adult survivors of a nonsexual trauma who were not taking medication
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to one of 3 treatment conditions: prolonged exposure (imaginal and in vivo), cognitive restructuring or waitlist control. The two treatment conditions comprised 5 weekly 90-minute sessions with structured homework activities.
FINDINGS	At posttreatment and at follow up, fewer participants in the prolonged exposure group had PTSD than those in the other two groups. However, cognitive restructuring was still efficacious at posttreatment and at follow up, but not to the same degree as prolonged exposure.

TITLE OF PAPER	***A randomized controlled trial of cognitive-behavioral treatment for posttraumatic stress disorder in severe mental illness***
AUTHORS AND JOURNAL	Mueser, K. T., Rosenberg, S. D., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., et al. (2008). *Journal of Consulting and Clinical Psychology, 76,* 259-271.
DESIGN	RCT (2 groups) including 3- and 6-month follow up
PARTICIPANTS	108 adults with PTSD and a major mood disorder or schizophrenia/schizoaffective disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (services received prior to enrolment in the study)
PROCEDURE	Participants were randomly allocated to either CBT or TAU. Those in the treatment group received 12-16 sessions of the program, *CBT for PTSD*.
FINDINGS	Those in the CBT group showed significantly greater improvement when compared to those in the control group at posttreatment assessments and at the 3- and 6-month follow up. The effects of CBT were strongest in participants with severe PTSD.

TITLE OF PAPER	***Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting***
AUTHORS AND JOURNAL	Arntz, A., Tiesema, M., & Kindt, M. (2007). *Journal of Behavior Therapy, 38,* 345-370.
DESIGN	RCT (3 groups) including 1- and 6-month follow up
PARTICIPANTS	71 adults with chronic PTSD
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to one of three conditions: imaginal exposure, imaginal exposure with imagery rescripting, or waitlist control. Those in the treatment groups received 10 weekly 90-minute individual sessions. In sessions 5-9, those in the combined treatment group were asked to imagine reacting as they wished they had done while being exposed to the most difficult moments of the traumatic event.
FINDINGS	When compared to a waitlist control, treatment was more effective in reducing the severity of PTSD symptoms than a waitlist. However, there was no significant difference in effectiveness between the two treatment conditions, although there was significantly lower dropout in the imaginal exposure with imagery rescripting group.

TITLE OF PAPER	***Treatment of acute posttraumatic stress disorders with brief cognitive behavioral therapy: A randomized controlled trial***
AUTHORS AND JOURNAL	Sijbrandij, M., Olff, M., Reitsma, J. B., Carlier, I. V. E., de Vries, M. H., Gersons, B. P. R. (2007). *American Journal of Psychiatry, 164,* 82-90.
DESIGN	RCT (2 groups) including 4-month follow up
PARTICIPANTS	143 adults with PTSD
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either brief CBT, which consisted of four weekly 2-hour sessions, or to a waitlist control.
FINDINGS	One week post intervention, the CBT group had significantly fewer symptoms of PTSD than the comparison group. At the 4-month follow up, the difference was smaller and no longer significant. Within the CBT group, those with comorbid depression at baseline had significantly fewer PTSD symptoms at 4-months.

TITLE OF PAPER	***A randomized controlled trial of exposure therapy and cognitive restructuring for posttraumatic stress disorder***
AUTHORS AND JOURNAL	Bryant, R. A., Moulds, M. L., Guthrie, R. M., Dang, S. T., Mastrodomenico, J., Nixon, R. D. V., et al. (2008). *Journal of Consulting and Clinical Psychology, 76,* 695-703.
DESIGN	RCT (4 groups) including 6-month follow up
PARTICIPANTS	118 adult trauma survivors with PTSD
INTERVENTIONS	CBT
COMPARISON GROUPS	Type of exposure
PROCEDURE	Participants were randomly allocated to receive 8 individual sessions of either one of the following: imaginal exposure, in-vivo exposure, both imaginal and in-vivo exposure, or imaginal and in-vivo exposure plus cognitive restructuring.
FINDINGS	A combination of imaginal and in-vivo exposure plus cognitive restructuring resulted in greater treatment effects for both PTSD and depressive symptoms than did exposure alone.

TITLE OF PAPER	***Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: A randomized controlled clinical trial***
AUTHORS AND JOURNAL	Knaevelsrud, C., & Maercker, A. (2007). *BMC Psychiatry*, 7-13.
DESIGN	RCT (2 groups) including 3-month follow up
PARTICIPANTS	96 adults with posttraumatic stress reactions
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to either 10 sessions of internet-based CBT or to a waitlist control. Those in the CBT group were allocated 2 weekly 45-minute writing assignments over a five week period. The CBT intervention closely resembled face-to-face therapy and consisted of 3 phases: self-confrontation, cognitive reconstruction, and social sharing. Each phase had a psychoeducation component.
FINDINGS	PTSD severity and other psychopathological symptoms were significantly improved for the CBT group. In addition, participants in the CBT group showed significantly greater reduction of comorbid depression and anxiety compared to the control group. Treatment effects were maintained at 3 months.

SELF-HELP – PURE SELF HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***A randomised controlled trial to assess the effectiveness of providing self-help information to people with symptoms of acute stress disorder following a traumatic injury***
AUTHORS AND JOURNAL	Scholes, C., Turpin, G., & Mason, S. (2007). *Behaviour Research and Therapy, 45,* 2527-2536.
DESIGN	RCT (2 groups) including 3- and 6-month follow up
PARTICIPANTS	227 accident and emergency attenders
INTERVENTIONS	Pure self-help
COMPARISON GROUPS	No treatment control
PROCEDURE	Accident and emergency attenders were screened for acute stress disorders and randomly assigned to receive a self-help booklet or no information. The self-help booklet was adapted from the one developed by the Australian Centre for Posttraumatic Mental Health.
FINDINGS	Although PTSD, anxiety and depression decreased across time, there were no differences between the groups and the results did not support the efficacy of self-help information as a strategy for preventing PTSD. However, subjective ratings of the usefulness of the self-help booklet were very high.

PSYCHOEDUCATION

TITLE OF PAPER	***Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder***
AUTHORS AND JOURNAL	Australian Centre for Posttraumatic Mental Health. (2007). Melbourne: Author.
DESIGN	Systematic review (8 studies) and review of existing PTSD guidelines
PARTICIPANTS	Adults exposed to trauma, including the acute distress disorder subgroup
INTERVENTIONS	Psychoeducation, CBT (trauma-focused), hypnotherapy
COMPARISON GROUPS	Five therapy groupings (trauma-focused CBT, eye movement desensitisation and reprocessing, stress management, group CBT, and other therapies including hypnotherapy and psychodynamic psychotherapy)
PROCEDURE	Systematic review of RCTs published between 2004 and 2005 of the same five therapy groupings used in the NICE review published 2005. The NICE review compared the five groupings against waitlist or TAU control or against another psychological treatment.
FINDINGS	*Psychoeducation*, when delivered as a stand-alone intervention, was found to be inferior to trauma-focused exposure interventions. *Trauma-focused CBT* was found to be effective in the treatment of PTSD symptoms and comorbid anxiety and depression, as well as in achieving improvements in broader quality of life. There is some evidence that group CBT is more effective than a waitlist control and that non-trauma focused CBT and trauma-focused CBT are equally effective. *Hypnotherapy* was not found to be an effective 'stand alone' intervention when compared to trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR). The evidence is inconclusive as to whether 'other psychological therapies' are more effective than a waitlist.

HYPNOTHERAPY

TITLE OF PAPER	***Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder***
AUTHORS AND JOURNAL	Australian Centre for Posttraumatic Mental Health. (2007). Melbourne: Author.
DESIGN	Systematic review (8 studies) and review of existing PTSD guidelines
PARTICIPANTS	Adults exposed to trauma, including the acute distress disorder subgroup
INTERVENTIONS	Hypnotherapy, CBT (trauma-focused), psychoeducation
COMPARISON GROUPS	Five therapy groupings (trauma-focused CBT, eye movement desensitisation and reprocessing, stress management, group CBT, and other therapies including hypnotherapy and psychodynamic psychotherapy)
PROCEDURE	Systematic review of RCTs published between 2004 and 2005 of the same five therapy groupings used in the NICE review published 2005. The NICE review compared the five groupings against waitlist or TAU control or against another psychological treatment.
FINDINGS	*Hypnotherapy* was not found to be an effective stand-alone intervention when compared to trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR). The evidence is inconclusive as to whether 'other psychological therapies' are more effective than a waitlist. *Trauma-focused CBT* was found to be effective in the treatment of PTSD symptoms and comorbid anxiety and depression, as well as in achieving improvements in broader quality of life. There is some evidence that group CBT is more effective than a waitlist control and that non-trauma focused CBT and trauma-focused CBT are equally effective. *Psychoeducation*, when delivered as a 'stand alone' intervention, was found to be inferior to trauma-focused exposure interventions.

TITLE OF PAPER	***Hypnotherapy in the treatment of chronic combat-related PTSD patients suffering from insomnia***
AUTHORS AND JOURNAL	Abramowitz, E. G., Barak, Y., Ben-Avi, I., & Knobler, H. Y. (2008). *International Journal of Clinical and Experimental Hypnosis, 56,* 270-280.
DESIGN	RCT (2 groups) including 1- month follow up
PARTICIPANTS	32 male combat veterans with chronic PTSD suffering from insomnia
INTERVENTIONS	Hypnotherapy
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	Participants previously treated for a minimum of two months with pharmacotherapy and supportive psychotherapy were randomised to receive either pharmacotherapy for 14 nights or 1.5 hours of supportive hypnotherapy, twice a week for 2 weeks. At the beginning of each hypnotherapy session, 15-20 minutes was spent on production and widening of trance phenomena with emphasis on dissociative bodily features. Direct, open-ended hypnotic work was then performed to deal with present-day symptoms of sleep disturbance. The final part of the session was devoted to reviewing the session and repetition of hypnotic suggestions.
FINDINGS	There was a significant main effect of the hypnotherapy treatment with PTSD symptoms as measured by the Posttraumatic Disorder Scale. This effect was maintained at the 1 month follow up. In addition, those receiving hypnotherapy also had received additional benefits including decreases in intrusions and avoidance reactions and improvements in a range of sleep variables.

Substance-use disorders

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy (and motivational interviewing – MI) and Level II evidence for self-help (primarily CBT-based), solution-focused brief therapy and dialectical behaviour therapy in the treatment of substance-use disorders in adults. A small number of studies, including some with small sample sizes, provided Level III evidence or below for interpersonal psychotherapy, acceptance and commitment therapy and psychodynamic psychotherapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomised controlled trials***
AUTHORS AND JOURNAL	Magill, M., & Ray, L. A. (2009). *Journal of Studies on Alcohol and Drugs, 70,* 516-527.
DESIGN	Meta-analysis (52 studies)
PARTICIPANTS	9308 adults diagnosed with substance-use disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU, no treatment, waitlist control, other type of therapy
PROCEDURE	Review and meta-analysis of RCTs (52 studies contributing to 53 effect sizes) published between 1980 and 2006 investigating the effectiveness of individual and group CBT (either stand alone or as an adjunct therapy).
FINDINGS	CBT demonstrated a small but statistically significant effect over comparison conditions, with the exception of marijuana-use disorder, which had a moderate significant effect. CBT effects were strongest with marijuana users, when compared to no treatment, and these effects may be larger for women than for men when delivered in a brief format.

TITLE OF PAPER	***A randomized controlled pilot study of motivational interviewing of patients with psychotic and drug use disorders***
AUTHORS AND JOURNAL	Martino, S., Carroll, K. M., Nich, C., & Rounsaville, B. J. (2006). *Addiction, 101,* 1479-1492.
DESIGN	RCT (2 groups) including 4-, 8- and 12-week follow up
PARTICIPANTS	44 adults meeting diagnosis for a psychotic and drug use or dependent disorder
INTERVENTIONS	CBT (MI)
COMPARISON GROUPS	Standard psychiatric interview
PROCEDURE	Participants were randomised to either a two-session dual diagnosis motivational interview or a standard interview as a prelude to entering the dual diagnosis program.
FINDINGS	Both types of interview resulted in improved treatment outcomes and there were no significant differences between the two groups. Subsample analyses suggested that the dual diagnosis motivational interview was more effective for cocaine users and the standard interview was more effective for marijuana users.

TITLE OF PAPER	***A motivational intervention trial to reduce cocaine use***
AUTHORS AND JOURNAL	Stein, M. D., Herman, D. S., & Anderson, B. J. (2009). *Journal of Substance Abuse Treatment, 36,* 118-125.
DESIGN	RCT (2 groups) including 6-month follow up
PARTICIPANTS	198 community-based cocaine users (at least weekly use)
INTERVENTIONS	CBT (MI)
COMPARISON GROUPS	Assessment-only control group
PROCEDURE	Participants were randomly allocated to a four-session motivation intervention or an assessment control group. The initial MI session was conducted at the time of the baseline interview and follow-up MI sessions were scheduled 1-, 3- and 6-months post-baseline. Each session lasted 20-40 minutes.
FINDINGS	The motivational intervention was more effective at reducing cocaine use than the assessment-only control condition among those using cocaine at least 15 days a month, although both groups reported reduction in their cocaine use at the 6-month follow up. Among the heavier users, MI significantly reduced cocaine days by 30% beyond the change seen in the control condition. There was no significant between-group difference in abstinence at 6 months.

TITLE OF PAPER	***Randomized-controlled trial of a telephone and mail intervention for alcohol use disorders: Three-month drinking outcomes***
AUTHORS AND JOURNAL	Brown, R. L., Saunders, L. A., Bobula, J. A., Mundt, M. P., & Koch, P. E. (2007). *Alcoholism: Clinical and Experimental Research, 31,* 1372-1378.
DESIGN	RCT (2 groups) including a 3-month follow up
PARTICIPANTS	897 non-treatment seeking adults with alcohol use disorders
INTERVENTIONS	CBT (MI plus drug education)
COMPARISON GROUPS	Minimal contact control
PROCEDURE	Random assignment to treatment and control group was stratified by the participating clinic. Those in the experimental group received 6 telephone sessions based on MI principles and a personalised summary letter in the mail following each session, plus unsolicited feedback on risks and consequences of drinking. Those in the control group received a 4-page healthy lifestyle pamphlet.
FINDINGS	From baseline to 3-month follow up, decreases in risky drinking days and total consumption were significantly larger for males in the MI group compared to controls. Drinking by females in the MI group decreased significantly, but not significantly more than controls.

GROUP

TITLE OF PAPER	***Group psychotherapy for alcohol dependent patients***
AUTHORS AND JOURNAL	Sandahl, C., Herlitz, K., Ahlin, G., & Ronnberg, S. (1998). *Psychotherapy Research, 8,* 361-378.
DESIGN	RCT (2 groups) including 15-month follow up
PARTICIPANTS	49 adults with alcohol dependence
INTERVENTIONS	CBT
COMPARISON GROUPS	Psychodynamic psychotherapy
PROCEDURE	Participants were randomly allocated to either a cognitive behavioural or psychodynamically oriented time-limited group relapse prevention treatment. Treatment consisted of 15 weekly 90-minute group sessions.
FINDINGS	The drinking habits of participants in both treatment groups improved significantly at the 15-month follow-up. A number of participants in the psychodynamic group maintained a more positive drinking pattern during the follow-up period compared to participants in the CBT group who showed gradual deterioration.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	Cognitive-behavioural therapy for substance use disorders in people with psychotic disorders
AUTHORS AND JOURNAL	Baker, A., Bucci, S., Lewin, T. J., Kay-Lambkin, F., Constable, P. M., & Carr, V. J. (2006). *British Journal of Psychiatry, 188,* 439-448.
DESIGN	RCT (2 groups) including 12-month follow up
PARTICIPANTS	130 regular users of alcohol, cannabis and/or amphetamines who also had a non-acute psychotic disorder and were aged 15 years or over
INTERVENTIONS	CBT and motivational interviewing (MI)
COMPARISON GROUPS	TAU (brief education and self-help booklet)
PROCEDURE	Participants were randomly allocated to either CBT/MI or TAU. Those in the CBT/MI group received ten weekly 1-hour sessions of CBT and MI. MI was used in weeks 1-4 and CBT in weeks 5-10.
FINDINGS	Among participants in the CBT/MI group there was a short-term improvement in depression, cannabis use, and general functioning at 12 months. However, after 12 months, there was no differential beneficial effect of the intervention on substance use.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: A randomized controlled trial of clinical efficacy
AUTHORS AND JOURNAL	Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J., & Carr, V. J. (2009). *Addiction, 104,* 378-388.
DESIGN	RCT (3 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	97 adults and adolescents with diagnosed depression (lifetime MDD) and current problematic AOD use
INTERVENTIONS	CBT/MI, self-help with minimal therapist contact
COMPARISON GROUPS	Brief intervention (psychoeducation and MI)
PROCEDURE	All participants received a brief intervention followed by random assignment to no further treatment or to SHADE therapy (**S**elf-**h**elp for **a**lcohol and other drug use and **de**pression), a CBT/MI-based intervention. Those allocated to SHADE therapy were then randomised to receive nine sessions of therapy delivered either by a therapist or via a computer-based program.
FINDINGS	For *depression*, both treatment conditions were more effective than the control condition; however, the therapist-delivered intervention produced greater short-term improvement, with computer delivery matching the effect at 12-month follow-up. For *alcohol* use, all treatments were effective, with therapist delivery showing the largest effect. For *cannabis/hazardous substance* use, the treatment condition was significantly better than the control condition, with computer delivery showing the largest effect.

INTERPERSONAL PSYCHOTHERAPY (IPT)

GROUP

TITLE OF PAPER	***Interpersonal group psychotherapy for comorbid alcohol dependence and non-psychotic psychiatric disorders***
AUTHORS AND JOURNAL	Malat, J., Leszcz, M., Negrete, J. C., Turner, N., Collins, J., Liu, E., et al. (2008). *The American Journal on Addictions, 17,* 402-407.
DESIGN	Case series
PARTICIPANTS	15 adults with problematic alcohol use and a comorbid psychiatric condition or relationship problem as a result of alcohol use
INTERVENTIONS	IPT
COMPARISON GROUPS	None
PROCEDURE	Participants were treated using a brief, manual-guided, modified group interpersonal psychotherapy approach. The group met for 16, two-hour sessions delivered twice weekly. Sessions 1 to 4 focused on anxiety reduction and orientation to therapy, sessions 5 to 14 focused on here-and-now process illumination and interpersonal learning, and the final two sessions focused on treatment termination.
FINDINGS	At posttreatment, the treatment group showed statistically significant improvement in number of drinking days, number of heavy drinking days, and psychological functioning. At the 8-month follow up, improvements were maintained on number of heavy drinking days and psychological functioning. Reductions in reported interpersonal problems across the pre-post assessment period were not significant.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF PAPER	***A preliminary investigation of acceptance and commitment therapy as a treatment for marijuana dependence in adults***
AUTHORS AND JOURNAL	Twohig, M. P., Shoenberger, D., & Hayes, S. C. (2007). *Journal of Applied Behavior Analysis, 40,* 619-632.
DESIGN	Case series including 3-month follow up
PARTICIPANTS	3 adults who met criteria for marijuana dependence
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	Each participants received eight 90-minute weekly individual sessions
FINDINGS	All participants showed large reductions in marijuana intake during treatment. At the 3-month follow up, one was still abstinent and two reported using a reduced level of marijuana.

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

GROUP

TITLE OF PAPER	***Solution-focused group therapy for level 1 substance abusers***
AUTHORS AND JOURNAL	Smock, S. A., Trepper, T. S., Wetchler, J. L., McCollum, E. E., Ray, R., & Pierce, K. (2008). *Journal of Marital and Family Therapy, 34,* 107-120.
DESIGN	RCT (2 groups)
PARTICIPANTS	56 adults with a substance use problem
INTERVENTIONS	SFBT
COMPARISON GROUPS	Problem-focused psychoeducation
PROCEDURE	Participants were randomly assigned to receive six, 1.5 hour sessions of group SFBT or psychoeducation.
FINDINGS	There were significant differences between the two groups on the outcome measures, with only the SFBT group showing significant improvement from pre- to post-treatment.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF PAPER	***Sustained efficacy of dialectical behaviour therapy for borderline personality disorder***
AUTHORS AND JOURNAL	van den Bosch, L. M. C., Koeter, M. W. J., Stijnen, T., Verheul, R., & van den Brink, W. (2005). *Behaviour Research and Therapy, 43,* 1231-1241.
DESIGN	Analysis of 6-month follow-up data, post RCT
PARTICIPANTS	Women with borderline personality disorder with (n=31) and without (n=27) co-morbid problematic substance use
INTERVENTIONS	DBT
COMPARISON GROUPS	TAU (ongoing outpatient treatment from referral source)
PROCEDURE	Participants were randomised to the DBT or TAU condition. Those in the DBT group received weekly individual therapy and attended a weekly group session of 2 to 2.5 hours duration.
FINDINGS	At the 6-month follow up, the benefits of DBT over TAU in terms of reduced alcohol use (but not soft and hard drug use) and lower levels of impulsive and parasuicidal behaviour were sustained.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***Supportive-expressive psychodynamic therapy for cocaine dependence: A closer look***
AUTHORS AND JOURNAL	Crits-Christoph, P., Connolly Gibbons, M. B., Gallop, R., Ring-Kurtz, S., Barber, J. P., Worley, M., et al. (2008). *Psychoanalytic Psychotherapy, 25,* 483-498.
DESIGN	Post-hoc exploratory analysis of data obtained from an RCT
PARTICIPANTS	124 adults with cocaine dependency
INTERVENTIONS	Psychodynamic psychotherapy plus group drug counselling
COMPARISON GROUPS	CBT plus group drug counselling, individual drug counselling plus group drug counselling, group drug counselling
PROCEDURE	In the original RCT, 487 participants were randomly assigned to one of four treatments. Treatment was split into a 6-month active phase and a 3-month booster phase. Individual sessions were 50 minutes and group sessions were 1.5 hours. Supportive-expressive psychodynamic therapy was based on a general manualised treatment.
FINDINGS	Although short-term supportive-expressive psychodynamic therapy was not the most efficacious treatment in the RCT (individual drug counselling was), it still produced large improvements in cocaine use. In addition, there was evidence that it was superior to individual drug counselling on change in family/social problems at the 12-month follow up, particularly for those with relatively more severe difficulties at baseline. For those who achieved early abstinence, supportive-expressive psychodynamic therapy produced comparable drug use outcomes to those produced by individual drug counselling.

GROUP

TITLE OF PAPER	***Group psychotherapy for alcohol dependent patients***
AUTHORS AND JOURNAL	Sandahl, C., Herlitz, K., Ahlin, G., & Ronnberg, S. (1998). *Psychotherapy Research, 8,* 361-378.
DESIGN	RCT (2 groups) including 15-month follow up
PARTICIPANTS	49 adults with alcohol dependence
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomly allocated to either cognitive behavioural or psychodynamically oriented time-limited group relapse prevention treatment. Treatment consisted of 15 weekly 90-minute group sessions.
FINDINGS	The drinking habits of participants in both treatment groups improved significantly at the 15-month follow-up. A majority of participants in the psychodynamic group appeared to maintain a more positive drinking pattern during the follow-up period compared to participants in the CBT group who showed gradual deterioration.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Computer-assisted delivery cognitive-behavioral therapy for addiction: A randomized trial of CBT4CBT***
AUTHORS AND JOURNAL	Carroll, K. M., Ball, S. A., Martino, S., Nich, C. Babuscio, T. A., Nuro, K. F., et al. (2008). *American Journal of Psychiatry, 165,* 881-888.
DESIGN	RCT (2 groups)
PARTICIPANTS	77 adult outpatients seeking treatment for substance dependence
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	TAU (weekly individual and group counselling)
PROCEDURE	Participants were randomly assigned to either computer-based training in CBT skills *(CBT4CBT)* plus TAU or TAU alone. The *CBT4CBT* program consisted of six structured modules developed based on a CBT manual for treating drug addiction.
FINDINGS	Participants using the *CBT4CBT* program submitted significantly fewer drug-positive urine specimens and had longer periods of abstinence during treatment compared with those in TAU.

Anorexia nervosa

SUMMARY OF EVIDENCE

There is Level II evidence for family therapy and psychodynamic psychotherapy in the treatment of anorexia nervosa (AN) in adults. One study provided Level III-2 evidence for cognitive behaviour therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Maintenance treatment for anorexia nervosa: A comparison of cognitive behaviour therapy and treatment as usual***
AUTHORS AND JOURNAL	Carter, J. C., McFarlane, T. L., Bewell, C., Olmsted, M. P., Woodside, D. B., Kaplan, A. S., et al. (2009). *International Journal of Eating Disorders, 42,* 202-207.
DESIGN	Pseudo-randomised controlled trial (2 groups)
PARTICIPANTS	88 adults with AN who had achieved minimum BMI of 19.5 and control of their bingeing/purging symptoms
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (naturalistic, assessment-only control condition)
PROCEDURE	Of the 88 participants, 46 received manualised individual CBT consisting of fifty, 45-minute individual sessions over a 1-year period. The remaining 42 participants in the assessment-only control group were asked to seek follow-up care 'as usual'.
FINDINGS	Time to relapse was significantly longer in the CBT group when compared to the TAU group.

TITLE OF PAPER	***The effectiveness of cognitive behavioral therapy on changing eating disorder symptoms and psychopathology of 32 anorexia nervosa patients at hospital discharge and one year follow-up***
AUTHORS AND JOURNAL	Bowers, W. A., & Ansher, L. S. (2008). *Annals of Clinical Psychiatry, 20,* 79-86.
DESIGN	Case series including 1-year follow up
PARTICIPANTS	32 adults with AN being treated in an inpatient unit
INTERVENTIONS	CBT
COMPARISON GROUPS	None
PROCEDURE	All patients admitted to the inpatient unit received CBT-based interventions and nutritional rehabilitation. The CBT-based interventions include individual CBT, group CBT, and CBT-oriented family therapy.
FINDINGS	At discharge, there was a significant positive change in core eating disorder psychopathology as well as in general psychopathology (including depressive symptoms). At 1-year follow up, some posttreatment changes continued to be significantly different from pretreatment.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Anorexia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Bulik, C., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). *International Journal of Eating Disorders, 40,* 310-320.
DESIGN	Systematic review of RCTs (11 studies)
PARTICIPANTS	549 adolescents and adults diagnosed with AN
INTERVENTIONS	CBT, family therapy
COMPARISON GROUPS	IPT, nutritional counselling, behaviour therapy, TAU (not defined), supportive counselling, family group psychoeducation
PROCEDURE	Systematic review of behavioural interventions for AN. Only 11 RCTs met the inclusion criteria: 2 were rated 'good' and 9 were rated 'fair'. Of the 11 RCTs, 3 were CBT-based and 6 were family therapy-based.
FINDINGS	For adult AN, there was tentative evidence that CBT reduces relapse risk for adults after weight restoration. However, there was no evidence to support the superiority of CBT over other approaches for those in the acutely underweight state. For adults with AN and a comparatively long duration of illness, there is no supportive evidence for the efficacy of family therapy. Family therapy focusing on parental control of re-nutrition is efficacious in treating younger, non-chronic patients. Although most family therapy studies compared one form with another, results from two studies suggested that family therapy was superior to individual therapy for adolescents with a shorter duration of illness.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

TITLE OF PAPER	***Psychological therapies for adults with anorexia nervosa***
AUTHORS AND JOURNAL	Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). *British Journal of Psychiatry, 178,* 216-221.
DESIGN	RCT (4 groups)
PARTICIPANTS	84 adults with AN
INTERVENTIONS	Family therapy, psychodynamic psychotherapy
COMPARISON GROUPS	Cognitive analytic therapy, TAU (supportive therapy)
PROCEDURE	Participants were randomly allocated to one of four treatments: focal psychodynamic psychotherapy (50-minute weekly sessions over 12 months), family therapy (60-minute sessions between weekly and once every 3 weeks), cognitive analytic therapy (50-minute weekly sessions for 20 weeks, then monthly for 3 months), or TAU (30-minute sessions with trainee psychiatrists). Both focal psychodynamic psychotherapy and cognitive analytic therapy involved contact with parents/partners.
FINDINGS	At treatment end, there was modest symptom improvement across all groups; however, participants in the family therapy and psychodynamic psychotherapy groups showed significantly greater improvements than those in the control group.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Anorexia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Bulik, C., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). *International Journal of Eating Disorders, 40,* 310-320.
DESIGN	Systematic review of RCTs (11 studies)
PARTICIPANTS	549 adolescents and adults diagnosed with AN
INTERVENTIONS	Family therapy, CBT
COMPARISON GROUPS	IPT, nutritional counselling, behaviour therapy, TAU (not defined), supportive counselling, family therapy, family group psychoeducation
PROCEDURE	Systematic review of behavioural interventions for AN. Only 11 RCTs met the inclusion criteria: 2 were rated 'good' and 9 were rated 'fair'. Of the 11 RCTs, 3 were CBT-based and 6 were family therapy-based.
FINDINGS	For adults with AN and a comparatively long duration of illness, there is no supportive evidence for the efficacy of *family therapy*. Family therapy focusing on parental control of re-nutrition is efficacious in treating younger, non-chronic patients. Although most family therapy studies compared one form with another, results from two studies suggested that family therapy was superior to individual therapy for adolescents with a shorter duration of illness. For adult AN, there was tentative evidence that *CBT* reduces relapse risk for adults after weight restoration. However, there was no evidence to support the superiority of CBT over other approaches for those in the acutely underweight state.

SCHEMA-FOCUSED THERAPY

GROUP

TITLE OF PAPER	***Motivational enhancement and schema-focused cognitive behaviour therapy in the treatment of chronic eating disorders***
AUTHORS AND JOURNAL	George, L., Thornton, C., Touyz, S. W., Waller, G., & Beaumont, P. J. (2004). *Clinical Psychology, 8,* 81-85.
DESIGN	Case series
PARTICIPANTS	8 adults with chronic AN
INTERVENTIONS	Schema-focused therapy and motivational enhancement therapy
COMPARISON GROUPS	None
PROCEDURE	Participants attended the day hospital 2 days a week for 5 hours a day over 6 months. Each day comprised two 1-hour group and one 90-minute group.
FINDINGS	At the end of treatment, participants displayed an increase in their motivation for change; however no changes were recorded on the subscales of the Young Schema Questionnaire. Although the participants were able to identify maladaptive schema – the five highest scores being: unrelenting standards, defectiveness/shame, emotional deprivation, emotional inhibition, and social isolation – those schema were resistant to change. The low drop-out rate suggests that the treatment is useful in engaging and holding a group of chronic AN patients in therapy.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***Psychological therapies for adults with anorexia nervosa***
AUTHORS AND JOURNAL	Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). *British Journal of Psychiatry, 178,* 216-221.
DESIGN	RCT (4 groups)
PARTICIPANTS	84 adults with AN
INTERVENTIONS	Psychodynamic psychotherapy, family therapy
COMPARISON GROUPS	Cognitive analytic therapy, TAU (supportive therapy)
PROCEDURE	Participants were randomly allocated to one of four treatments: focal psychodynamic psychotherapy (50-minute weekly sessions over 12 months), family therapy (60-minute sessions between weekly and once every 3 weeks), cognitive analytic therapy (50-minute weekly sessions for 20 weeks, then monthly for 3 months), or TAU (30-minute sessions with trainee psychiatrists). Both focal psychodynamic psychotherapy and cognitive analytic therapy involved contact with parents/partners.
FINDINGS	At treatment end, there was modest symptom improvement across all groups; however, participants in the psychodynamic psychotherapy and family therapy groups showed significantly greater improvements than those in the control group.

Bulimia nervosa

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for dialectical behaviour therapy and self-help (primarily CBT-based) in the treatment of bulimia nervosa (BN) in adults. One study provided Level III-3 evidence for interpersonal psychotherapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Bulimia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Shapiro, J. R., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N., & Bulik, C. M. (2007). *International Journal of Eating Disorders, 40,* 337-348.
DESIGN	Systematic review (13 studies)
PARTICIPANTS	1462 adults diagnosed with BN
INTERVENTIONS	CBT, DBT
COMPARISON GROUPS	Control (waitlist, healthy), guided self-help, IPT, BT, supportive-expressive therapy, exercise therapy
PROCEDURE	Systematic review of RCTs of behavioural interventions for BN. Nineteen RCTs met the inclusion criteria: 3 were rated 'good', 10 were rated as 'fair' and 6 were rated as 'poor'. The 6 poor quality studies were not reviewed. Of the remaining 13 studies, 11 focused on CBT, one on DBT, and one on nutritional and stress management. A further five studies trialling self-help methods were also identified (four were rated as 'fair' and one as 'poor').
FINDINGS	There is strong evidence supporting the efficacy of CBT, however, the evidence supporting the efficacy of DBT is weak. When CBT is compared to IPT, both appear equally effective, although symptomatic change appears to be faster for CBT than for IPT thus reducing the time those with BN were exposed to symptoms. The single DBT trial meeting the inclusion criteria showed that those receiving DBT were more likely to reduce their binge eating and purging behaviour and remain abstinent longer than those on a waitlist.

TITLE OF PAPER	***A comparison of sequenced individual and group psychotherapy for patients with bulimia nervosa***
AUTHORS AND JOURNAL	Nevonen, L., & Broberg, A. G. (2006). *International Journal of Eating Disorders, 39,* 117-127.
DESIGN	Comparative study (2 groups) including 2-year follow up
PARTICIPANTS	86 adults with BN on a treatment waiting list
INTERVENTIONS	Combined CBT and IPT
COMPARISON GROUPS	Individual *vs* group format
PROCEDURE	Participants were matched in pairs based on their pretreatment Eating Disorder Inventory-2 scores and randomised to sequenced individual therapy or group therapy. The group treatment consisted of 23 sessions of 2.5 hour duration over 20 weeks. Sessions were bi-weekly for three weeks, then weekly for the remainder of the study. The individual treatment consisted of weekly one-hour sessions for 23 weeks. For each 6-month semester, a maximum of 8 participants were treated in the group condition and 8 were treated in the individual condition.
FINDINGS	In the short-term, no significant outcome differences between the two treatment modalities were found. Over the longer-term, those treated individually tended to improve more than those treated in a group. Participants with more interpersonal problems and less severe bulimic symptoms tended to gain more from group treatment.

TITLE OF PAPER	***A randomized trial comparing the efficacy of cognitive-behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face***
AUTHORS AND JOURNAL	Mitchell, J. E., Crosby, R. D., Wonderlich, S. A., Crow, S., Lancaster, K., Simonich, H., et al. (2008). *Behaviour Research and Therapy, 46,* 581-592.
DESIGN	Comparative study (2 groups) including 12-month follow up
PARTICIPANTS	128 adults diagnosed with BN or EDNOS
INTERVENTIONS	CBT
COMPARISON GROUPS	Face-to-face vs telemedicine
PROCEDURE	Participants were randomised to receive CBT in person or via telemedicine. The treatment was manual-based and consisted of 20 sessions delivered over 16 weeks.
FINDINGS	Bingeing/purging abstinence rates at treatment end were slightly higher for the face-to-face group; however the differences were not statistically significant. Participants receiving face-to-face therapy experienced significantly greater reductions in eating disorder cognitions and interview-assessed depression. Overall, the differences between the groups were few and of marginal clinical significance.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***A comparison of sequenced individual and group psychotherapy for patients with bulimia nervosa***
AUTHORS AND JOURNAL	Nevonen, L., & Broberg, A. G. (2006). *International Journal of Eating Disorders, 39,* 117-127.
DESIGN	Comparative study including 2-year follow up
PARTICIPANTS	86 adults with BN on a treatment waiting list
INTERVENTIONS	Combined CBT and IPT
COMPARISON GROUPS	Individual vs group format
PROCEDURE	Participants were matched in pairs based on their pretreatment Eating Disorder Inventory-2 scores and randomised to sequenced individual therapy or group therapy. The group treatment consisted of 23 sessions of 2.5 hour duration over 20 weeks. Sessions were bi-weekly for three weeks, then weekly for the remainder of the study. The individual treatment consisted of weekly one-hour sessions for 23 weeks. For each 6-month semester, a maximum of 8 participants were treated in the group condition and 8 were treated in the individual condition.
FINDINGS	In the short-term, no significant outcome differences between the two treatment modalities were found. Over the longer-term, those treated individually tended to improve more than those treated in a group. Conversely, participants with more interpersonal problems and less severe bulimic symptoms tended to gain more from group treatment.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF PAPER	***Bulimia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Shapiro, J. R., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N., & Bulik, C. M. (2007). *International Journal of Eating Disorders, 40,* 337-348.
DESIGN	Systematic review of RCTs (13 studies)
PARTICIPANTS	1462 adults diagnosed with BN
INTERVENTIONS	DBT, CBT
COMPARISON GROUPS	Control (waitlist, healthy), guided self-help, IPT, BT, supportive-expressive therapy, exercise therapy
PROCEDURE	Systematic review of behavioural interventions for BN. Nineteen RCTs met the inclusion criteria: 3 were rated ‘good’, 10 were rated as ‘fair’ and 6 were rated as ‘poor’. The 6 poor quality studies were not reviewed. Of the remaining 13 studies, 11 focused on CBT, one on DBT, and one on nutritional and stress management. A further 5 studies trialling self-help methods were also identified (four were rated as ‘fair’ and one as ‘poor’).
FINDINGS	There is strong evidence supporting the efficacy of CBT, however, the evidence supporting the efficacy of DBT is weak. When CBT is compared to IPT, both appear equally effective, although symptomatic change appears to be faster for CBT than for IPT thus reducing the time those with BN are exposed to symptoms. The single DBT trial meeting the inclusion criteria showed that those receiving DBT were more likely to reduce their binge eating and purging behaviour and remain abstinent longer than those on a waitlist.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Randomized controlled trial of CD-ROM-based cognitive-behavioural self-care for bulimia nervosa***
AUTHORS AND JOURNAL	Schmidt, U., Andiappan, M., Grover, M., Robinson, S., Perkins, O., Dugmore, A., et al. (2008). American Journal of Psychiatry, 164, 591-598. *American Journal of Psychiatry, 164,* 591-598.
DESIGN	RCT (2 groups) including 7-month follow up
PARTICIPANTS	97 adults with BN or EDNOS
INTERVENTIONS	Pure self-help
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomised to receive the CBT-based self-help CD-ROM without support for 3 months followed 3 months later by sessions with a therapist depending on clinical need, or to a 3-month waiting list followed by 15 sessions of therapist CBT.
FINDINGS	At the 3-month assessment, the CD-ROM group had significantly fewer bingeing and purging episodes than the control group. At the 7-month follow up, the results were reversed. Group comparisons at 3 and 7 months showed no significant differences for bingeing and purging.

Binge eating

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and self-help (primarily CBT-based), and Level II evidence for dialectical behaviour therapy in the treatment of binge eating disorder (BED) in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Binge-eating disorder treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Brownley, K. A., Berkman, N. D., Sedway, J. A., Lohr, K. N., & Bulik, C. (2007). *International Journal of Eating Disorders, 40,* 337-348.
DESIGN	Systematic review of RCTs (8 studies)
PARTICIPANTS	481 adults diagnosed with BED
INTERVENTIONS	CBT, DBT, self-help – pure and with minimal therapist contact
COMPARISON GROUPS	Waitlist control, IPT
PROCEDURE	Systematic review of behavioural interventions for BED. CBT was the most commonly used approach. Of the 8 trials reviewed, 3 were CBT, 3 were self-help (CBT-based) and 1 was DBT.
FINDINGS	CBT trials included in the review (individual or group) support its effectiveness in reducing the number of binge days or reported binge episodes. CBT also appears to improve the psychological features of BED (e.g., ratings of restraint and hunger). Regarding DBT, further studies are needed to confirm the positive finding that DBT decreases binge eating and eating-related psychopathology and improves negative mood. There is growing evidence to suggest that self-help is efficacious in decreasing binge days, binge-eating episodes, and psychological features associated with BED and in promoting abstinence from binge eating.

TITLE OF PAPER	***Adapted motivational interviewing for women with binge eating disorder: A randomized controlled trial***
AUTHORS AND JOURNAL	Cassin, S. E., von Ranson, K. M., Heng, K., Brar, J., & Wojtowicz, A. E. (2008). *Psychology of Addictive Behaviors, 22,* 417-425.
DESIGN	RCT (2 groups) including 16-week follow up
PARTICIPANTS	108 adults with a current diagnosis of BED
INTERVENTIONS	CBT (adapted MI) and self-help with minimal therapist contact
COMPARISON GROUPS	Control (self-help handbook)
PROCEDURE	Participants were randomly assigned to either the adapted motivational interviewing group or the control group. Both groups received a self-help handbook, *Defeating Binge Eating*, and the adapted MI group also received one individual session of MI *(M = 81.8 minutes)*.
FINDINGS	Participants in both conditions reduced their binge eating frequency over a 16-week follow up period; however, the addition of an MI session significantly improved the outcome. Improvements also generalised to other domains including mood, self-esteem, and quality of life.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF PAPER	***Binge-eating disorder treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Brownley, K. A., Berkman, N. D., Sedway, J. A., Lohr, K. N., & Bulik, C. (2007). *International Journal of Eating Disorders, 40,* 337-348.
DESIGN	Systematic review of RCTs (8 studies)
PARTICIPANTS	481 adults diagnosed with BED
INTERVENTIONS	DBT, CBT, self-help – pure and with minimal therapist contact
COMPARISON GROUPS	Waitlist control, IPT
PROCEDURE	Systematic review of behavioural interventions for BED. CBT was the most commonly used approach. Of the 8 trials reviewed, 3 were CBT, 3 were self-help (CBT-based) and 1 was DBT.
FINDINGS	Regarding DBT, further studies are needed to confirm the positive finding that DBT decreases binge eating and eating-related psychopathology and improves negative mood. CBT trials included in the review (individual or group) support its effectiveness in reducing the number of binge days or reported binge episodes. CBT also appears to improve the psychological features of BED (e.g., ratings of restraint and hunger). There is growing evidence to suggest that self-help is efficacious in decreasing binge days, binge-eating episodes, and psychological features associated with BED and in promoting abstinence from binge eating.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Binge-eating disorder treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Brownley, K. A., Berkman, N. D., Sedway, J. A., Lohr, K. N., & Bulik, C. (2007). *International Journal of Eating Disorders, 40,* 337-348.
DESIGN	Systematic review of RCTs (8 studies)
PARTICIPANTS	481 adults diagnosed with BED
INTERVENTIONS	Self-help – pure and with minimal therapist contact, CBT, DBT
COMPARISON GROUPS	Waitlist control, IPT
PROCEDURE	Systematic review of behavioural interventions for BED. CBT was the most commonly used approach. Of the 8 trials reviewed, 3 were CBT, 3 were self-help (CBT-based) and 1 was DBT.
FINDINGS	There is growing evidence to suggest that self-help is efficacious in decreasing binge days, binge-eating episodes, and psychological features associated with BED and in promoting abstinence from binge eating. CBT trials included in the review (individual or group) support its effectiveness in reducing the number of binge days or reported binge episodes. CBT also appears to improve the psychological features of BED (e.g., ratings of restraint and hunger). Regarding DBT, further studies are needed to confirm the positive finding that DBT decreases binge eating and eating-related psychopathology and improves negative mood.

Adjustment disorder

SUMMARY OF EVIDENCE

Three studies provided Level III evidence or below for cognitive behaviour therapy and mindfulness-based cognitive therapy in the treatment of adjustment disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Reducing long term sickness absence by an activating intervention in adjustment disorders: A cluster randomised controlled trial***
AUTHORS AND JOURNAL	van der Klink, J. J. L., Blonk, R. W. B., Schene, A. H., & van Dijk, F. J. H. (2003). *Occupational and Environmental Medicine, 60,* 429-437.
DESIGN	Pseudo-randomised controlled trial (2 groups) including 3- and 12-month follow up
PARTICIPANTS	192 employees on sickness leave for an adjustment disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	TAU (counselling, instruction about stress)
PROCEDURE	Participants in the study were unable to be randomised as company policy dictated that the fixed relation between patient and occupational physician should remain intact. As an alternative, the occupational physicians delivering the intervention were randomly allocated to either the intervention or control group. The CBT-based intervention comprised a three stage graded activity approach (similar to stress inoculation training). Stage 1 involved psychoeducation and behavioural activation, stage 2 involved indentifying stressors and learning problem-solving skills, and stage 3 was an extension of stage 2, with participants encouraged to put their skills into practice. Participants had 4-5 individual 90-minute consultations in the first 6 weeks of sickness leave, plus a booster session in the first 3 months after the return to work.
FINDINGS	At 3 months, significantly more participants in the CBT group had returned to work compared to the control group. At the 12-month follow up, all participants had returned to work; however, sickness leave was shorter in the intervention group than in the control group.

TITLE OF PAPER	***Coping effectiveness training reduces depression and anxiety following traumatic spinal cord injuries***
AUTHORS AND JOURNAL	Kennedy, P., Duff, J., Evans, M., Beedie, A. (2003). *British Journal of Clinical Psychology, 42,* 42-54.
DESIGN	Non-randomised controlled trial (2 groups)
PARTICIPANTS	85 adult inpatients newly injured with a traumatic injury
INTERVENTIONS	CBT
COMPARISON GROUPS	Matched sample
PROCEDURE	Participants receiving the coping effectiveness training intervention were matched with controls on measures of psychological adjustment and coping. The intervention, which consisted of psychoeducation, cognitive therapy, coping skills training, problem solving, activity scheduling, and relaxation was conducted in seven 60- to 75-minute group sessions over 4 weeks.
FINDINGS	Following the intervention, the treatment group showed a significant reduction in depression and anxiety compared to the matched controls. There was no evidence of a significant change in the pattern of coping strategies used by the treatment group compared to controls.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF PAPER	***Mindfulness-based stress reduction in women with breast cancer***
AUTHORS AND JOURNAL	Tacon, A. M., Caldera, Y., & Ronaghan, C. (2004). *Families, Systems, & Health, 22,* 193-203.
DESIGN	Non-experimental study
PARTICIPANTS	27 women diagnosed with breast cancer
INTERVENTIONS	MBCT
COMPARISON GROUPS	None
PROCEDURE	Participants attended a 1.5 hour, weekly session of MBCT for 8 weeks. They were also provided with audiotapes to facilitate home practice of the techniques learned.
FINDINGS	At the end of treatment, levels of stress and anxiety had reduced significantly and there were also significant and beneficial changes for mental adjustment to cancer and health locus of control scores.

Sleep disorders

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and self help (primarily CBT-based) in the treatment of sleep disorders in adults. One study provided Level IV evidence for mindfulness-based cognitive therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Psychological and behavioral treatment of insomnia: Update of the recent evidence (1998-2004)***
AUTHORS AND JOURNAL	Morin, C. M., Bootzin, R. R., Buysse, D. J., Edinger, J. D., Espie, C. A., & Lichstein, K. L. (2006). *Sleep, 29,* 1398-1414.
DESIGN	Systematic review (37 studies)
PARTICIPANTS	2246 adults with insomnia
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, psychological placebo), other therapies, pharmacotherapy
PROCEDURE	Review of studies (mostly RCTs) published from 1998-2004 where the main sleep diagnosis was primary or comorbid insomnia. The CBT components reviewed were stimulus control, sleep restriction, sleep hygiene education and cognitive therapy.
FINDINGS	CBT produced reliable changes, which were susbtained over time, in several sleep parameters in either primary or comorbid insomnia. Nine studies documented the benefits of CBT in older adults or for facilitating discontinuation of sleep medication in chronic hypnotic users.

TITLE OF PAPER	***Comparative meta-analysis of behavioral interventions for insomnia and their efficacy in middle-aged adults and in older adults 55+ years of age***
AUTHORS AND JOURNAL	Irwin, M. R., Cole, J. C., & Nicassio, P. M. (2006). *Health Psychology, 25,* 3-14.
DESIGN	Meta-analysis (23 studies)
PARTICIPANTS	Middle-aged and older adults with chronic insomnia
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (not defined)
PROCEDURE	Meta-analysis of RCTs investigating CBT or a recognised variant (e.g., stimulus control) for insomnia. Studies were organised on 3 separate dimensions: age cohort (less than 55 years and 55 years and over), behavioural intervention type (omnibus CBT, relaxation-based therapy, and behavioural-only interventions), and sleep outcome (quality, latency, duration, efficiency, and wakenings).
FINDINGS	Moderate to large effects of behavioural treatments for insomnia were found, with no differences between the age cohorts for rate of improvement. Similar effects were found for the 3 treatment modalities across sleep outcomes, except for wakenings after sleep onset where omnibus CBT and behavioural-only interventions were slightly superior to relaxation-only.

OLDER ADULTS

TITLE OF PAPER	***Evidence-based recommendations for the assessment and management of sleep disorders in older persons***
AUTHORS AND JOURNAL	Bloom, H. G., Ahmed, I., Alessi, C. A., Ancoli-Israel, S., Buysse, D. J., Kryger, M. H., et al. (2009). *Journal of the American Geriatric Society, 57,* 761-789.
DESIGN	Systematic review
PARTICIPANTS	Older adults in long-term care settings with a range of sleep disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	Not defined
PROCEDURE	Review of research literature on sleep disorders including insomnia, circadian rhythm sleep disorders, parasomnias and hypersomnias. RCTs, systematic reviews and meta-analyses were the primary focus. However, non-randomised and controlled clinical trials were also included due to the limited number of evidence-based studies on older adults.
FINDINGS	For insomnia, ‘CBT for insomnia’ (CBT-I) is recommended and has level I evidence to support its efficacy. CBT-I combines multiple behavioural approaches (e.g., sleep restriction, stimulus control and cognitive therapy). There is little evidence supporting the efficacy of behavioural intervention in treating advanced sleep-phase disorder, however, due to the low risk, cost and lack of alternative approaches, behavioural interventions are recommended. For hypersomnias, behavioural modification of sleep-wake behaviour is an effective strategy and is supported by level II evidence.

OLDER ADULTS

TITLE OF PAPER	***Evidenced-based psychological treatments for insomnia in older adults***
AUTHORS AND JOURNAL	McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). *Psychology and Ageing, 22,* 18-27.
DESIGN	Literature review (20 studies)
PARTICIPANTS	Adults over 60 years of age suffering from insomnia
INTERVENTIONS	CBT
COMPARISON GROUPS	Not specified
PROCEDURE	Review of RCTs or within-subject trials investigating psychological treatments of insomnia in older adults. To meet criteria as an evidenced-based treatment, studies had to report significant between-group treatment effects and between-group effect sizes of at least .20.
FINDINGS	Two treatments, multicomponent CBT and sleep restriction-sleep compression therapy, met evidence-based criteria for treatment for insomnia in older people. Multicomponent CBT protocols include a combination of sleep hygiene education, stimulus control, sleep restriction, and relaxation training. An additional treatment, stimulus control, partially met criteria for an evidence-based treatment but was without corroborating investigations.

OLDER ADULTS

TITLE OF PAPER	***Cognitive behavioural therapy for patients with primary insomnia or insomnia associated predominately with mixed psychiatric disorders: A randomised clinical trial***
AUTHORS AND JOURNAL	Edinger, J. D., Olsen, M. K., Stechuchak, K. M., Means, M. K., Lineberger, M. D., Kirby, A., et al. (2009). *Sleep, 32,* 499-510.
DESIGN	RCT
PARTICIPANTS	81 veterans with primary or co-morbid insomnia with mixed psychiatric disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	Sleep hygiene education
PROCEDURE	Treatment was delivered in 4 bi-weekly sessions and included sleep education, stimulus control, and time-in-bed restrictions.
FINDINGS	Participants with insomnia and comorbid insomnia improved significantly more than the comparison group in the majority of sleep quality and duration measures examined.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

GROUP

TITLE OF PAPER	***The effects of mindfulness-based stress reduction on sleep disturbance: A systematic review***
AUTHORS AND JOURNAL	Winbush, N. Y., Gross, C. R., & Kreitzer, M. J. (2007). *Explore, 3,* 585-591.
DESIGN	Systematic review (7 studies)
PARTICIPANTS	Adults diagnosed with insomnia
INTERVENTIONS	MBCT (stress reduction focus)
COMPARISON GROUPS	No control, non-equivalent comparison
PROCEDURE	Review of studies investigating the effectiveness of MBCT (stress reduction) for treating sleep disturbance. The intervention is an 8-week, 2.5 hour psychoeducational, skills-based group program. Seven studies of MBCT that reported pre- and post-intervention measures of sleep quality or duration were included in this review.
FINDINGS	Four studies (all uncontrolled) reported significant improvements in sleep quality or duration following MBCT. In the other 3 studies there were no statistical differences between treatment and control conditions.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Self-help therapy for insomnia: A meta-analysis***
AUTHORS AND JOURNAL	Straten, A., & Cuijpers, P. (2009). *Sleep Medicine Reviews, 13,* 61-71.
DESIGN	Meta-analysis (10 studies)
PARTICIPANTS	1000 adults with insomnia
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control, other treatment
PROCEDURE	Meta-analysis of RCTs examining the effect of self-help interventions for insomnia. Effect sizes for the groups compared to waitlist control were calculated separately from effect sizes for groups with face-to-face control.
FINDINGS	Despite moderate effect sizes, results showed that self-help interventions improved sleep efficiency, sleep onset latency, wake after sleep onset, and sleep quality, but not total sleep time. Improvements in sleep were maintained over time. Although based on a very small number of studies, face-to-face treatment was not significantly superior to self-help treatment.

Sexual disorders

SUMMARY OF EVIDENCE

There is Level I evidence for self-help (primarily CBT-based) and Level II evidence for cognitive behaviour therapy and interpersonal psychotherapy in the treatment of sexual disorders in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

GROUP

TITLE OF PAPER	***The treatment of sexually dysfunctional women without partners: A controlled study of three behavioural group approaches***
AUTHORS AND JOURNAL	Stravynski, A., Gaudette, G., Lesage, A., Arbel, N., Bounader, J., Lachance, L., et al. (2007). *Clinical Psychology and Psychotherapy, 14,* 211-220.
DESIGN	RCT (4 groups) including 6- and 12-month follow up
PARTICIPANTS	49 women with sexual dysfunction
INTERVENTIONS	CBT, IPT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to one of four groups: IPT, CBT (sexual dysfunction-orientated therapy), combined treatment, and a waitlist control. Participants attended 15 weekly 90-minute group sessions during the treatment period and 4 six-weekly sessions during the first 6 months of the 12-month follow up. The CBT treatment was based on several programs outlined in the book *Handbook of Sexual Dysfunctions*.
FINDINGS	All treatment groups showed superior improvements compared to the control group. Two thirds of the participants in the treatment groups made clinical gains and one third no longer filled diagnostic criteria. There were no significant differences between the treatment groups with all participants improving to a similar degree. Treatment gains were maintained at follow up.

GROUP

TITLE OF PAPER	***Cognitive-behavioural therapy for women with lifelong vaginismus: Process and prognostic factors***
AUTHORS AND JOURNAL	Ter Kuile, M. M., van Lankveld, J. J. D. M., de Groot, E., Melles, R., Neffs, J., & Zandbergen, M. (2007). *Behaviour Research and Therapy, 45,* 359-373.
DESIGN	RCT (3 groups) including 3- and 12-month follow up
PARTICIPANTS	117 female adults diagnosed with lifelong vaginismus in a heterosexual relationship
INTERVENTIONS	CBT, self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants (couples) were randomly allocated to one of three conditions: guided self-help, CBT (group), or waitlist control. Treatment duration was three months, with 3- and 12-month follow up after termination. All participants received a 50-page manual on the treatment of vaginismus and a CD with spoken instructions for relaxation and sexual fantasy exercise. Those in the self-help group were provided with assistance by telephone in 6, bi-weekly, 15 minute calls. The CBT intervention included gradual exposure, sexual education, relaxation exercises, cognitive therapy and sensate focus exercises.
FINDINGS	There were no significant differences between the two treatment groups. Both treatments resulted in an increase in intercourse, a decrease in fear of coitus, and an enhancement of non-coital penetration behaviour, compared to no treatment.

INTERPERSONAL PSYCHOTHERAPY (IPT)

GROUP

TITLE OF PAPER	***The treatment of sexually dysfunctional women without partners: A controlled study of three behavioural group approaches***
AUTHORS AND JOURNAL	Stravynski, A., Gaudette, G., Lesage, A., Arbel, N., Bounader, J., Lachance, L., et al. (2007). *Clinical Psychology and Psychotherapy, 14,* 211-220.
DESIGN	RCT (4 groups) including 6- and 12-month follow up
PARTICIPANTS	49 women with sexual dysfunction
INTERVENTIONS	IPT, CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly assigned to one of four groups: IPT, CBT (sexual dysfunction-orientated therapy), combined treatment, and a waitlist control. Participants attended 15 weekly 90-minute group sessions during the treatment period and 4 six-weekly sessions during the first 6 months of the 12-month follow up. The CBT treatment was based on several programs outlined in the book *Handbook of Sexual Dysfunctions*.
FINDINGS	All treatment groups showed improvements compared to the control group. Two thirds of the participants in the treatment groups made clinical gains and one third no longer filled diagnostic criteria. There were no significant differences between the treatment groups with all participants improving to a similar degree. Treatment gains were maintained at follow up.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Bibliotherapy in the treatment of sexual dysfunctions: A meta-analysis***
AUTHORS AND JOURNAL	van Lankveld, J. J. D. M. (1998). *Journal of Consulting and Clinical Psychology, 66,* 702-708.
DESIGN	Meta-analysis (12 studies)
PARTICIPANTS	397 adults with sexual dysfunction
INTERVENTIONS	Self-help – pure self-help, and self-help with minimal therapist contact
COMPARISON GROUPS	Control (waitlist, no treatment, placebo)
PROCEDURE	Review and meta-analysis of controlled studies from 1966 to 1996 investigating self-help treatments for sexual dysfunction (most studies reviewed were orgasm disorders). Data from 16 bibliotherapy groups were included in the analysis.
FINDINGS	The meta-analysis demonstrated a substantial effect of self-help (bibliotherapy) for orgasmic disorder. Manuals, when included in treatment, were associated with the largest effect sizes.

GROUP

TITLE OF PAPER	***Cognitive-behavioural therapy for women with lifelong vaginismus: Process and prognostic factors***
AUTHORS AND JOURNAL	Ter Kuile, M. M., van Lankveld, J. J. D. M., de Groot, E., Melles, R., Neffs, J., & Zandbergen, M. (2007). *Behaviour Research and Therapy, 45,* 359-373.
DESIGN	RCT (3 groups) including 3- and 12-month follow up
PARTICIPANTS	117 female adults diagnosed with lifelong vaginismus in a heterosexual relationship
INTERVENTIONS	Self-help with minimal therapist contact, CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants (couples) were randomly allocated to one of three conditions: group CBT, guided self-help, or waitlist control. Treatment duration was three months, with 3- and 12-month follow up after termination. All participants received a 50-page manual on the treatment of vaginismus and a CD with spoken instructions for relaxation and sexual fantasy exercise. Those in the self-help group were provided with assistance by telephone in 6, bi-weekly, 15 minute calls. The CBT intervention included gradual exposure, sexual education, relaxation exercises, cognitive therapy and sensate focus exercises.
FINDINGS	There were no significant differences between the two treatment formats. Both treatments resulted in an increase in intercourse, a decrease in fear of coitus, and an enhancement of non-coital penetration behaviour, compared to no treatment.

TITLE OF PAPER	***Sex therapy through the internet for men with sexual dysfunctions: A pilot study***
AUTHORS AND JOURNAL	Van Diest, S. L., Van Lankveld, J. J. D. M., Leusink, P. M., Slob, A. K., & Gijs, L. (2007). *Journal of Sex and Marital Therapy, 33,* 115-133.
DESIGN	Case series pilot study including 1-month follow up
PARTICIPANTS	21 heterosexual males with erectile dysfunction
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	None
PROCEDURE	The 3-month internet-based treatment was based on the Masters and Johnson (1970) approach, including sensate-focused exercises. Psychoeducation, cognitive therapy, and pharmacotherapy (if needed) were also included. Instructions for the exercises were sent via email. The therapist responded to emails within a week and timing and frequency were left up to the participant and therapist.
FINDINGS	Of the participants, 67% reported an improvement in sexual functioning and 47% reported maintained improvement at 1-month follow up. The majority of participants rated the treatment positively.

PSYCHOEDUCATION

TITLE OF PAPER	***The PsychoedPlusMed approach to erectile dysfunction treatment: The impact of combining a psychoeducational intervention with sildenafil***
AUTHORS AND JOURNAL	Phelps, J. S., Jain, A., & Monga, M. (2004). *Journal of Sex and Marital Therapy, 30,* 305-314.
DESIGN	RCT (2 groups)
PARTICIPANTS	83 men diagnosed with erectile dysfunction and who were in a stable, monogamous relationship
INTERVENTIONS	Psychoeducation plus pharmacotherapy
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	Participants were randomly assigned to either psychoeducation plus pharmacotherapy (sildenafil) or to sildenafil only. The brief intervention, *PsychoedPlusMed*, consisted of a single, 60-90 minute didactic workshop delivered to groups of 6-8 men, plus self-help materials. All participants received 10 doses of sildenafil per month for 6 months.
FINDINGS	Although there was no difference between the groups with regard to treatment effectiveness, those in the *PsychoedPlusMed* group were significantly more satisfied with the treatment overall. They also reported greater satisfaction with how quickly the treatment worked and higher confidence levels in their ability to engage in sexual intercourse.

Pain

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy and self-help (primarily CBT-based) in the treatment of pain disorders in adults. Three studies (two with small sample sizes) provided Level III-3 evidence for acceptance and commitment therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Cognitive and behavioral interventions for the management of chronic neuropathic pain in adults – A systematic review***
AUTHORS AND JOURNAL	van de Wetering, E. J., Lemmens, K. M. M., Nieboer, A. P., & Huijsman, R. (2010). *European Journal of Pain, doi: 10.1016/j.ejpain2009.11.010*.
DESIGN	Systematic review (14 studies) and exploratory meta-analysis (4 studies)
PARTICIPANTS	546 adults with chronic pain or neuralgia
INTERVENTIONS	CBT
COMPARISON GROUPS	None, control (TAU, other treatment)
PROCEDURE	Review of all types of studies (with the exception of unpublished works) investigating the effectiveness of CBT in the management of chronic neuropathic pain. Of the 14 studies included in the review, only one (an RCT) was rated as good quality. An explorative meta-analysis of 4 studies was also conducted.
FINDINGS	The one good quality RCT (n=214) showed some significant effects for the group CBT intervention. Other less methodologically-rigorous studies also reported positive effects on pain and quality of life. However, the meta-analysis did not show a statistical effect of the intervention on pain intensity.

TITLE OF PAPER	***A randomised controlled trial of exposure in vivo for patients with spinal pain reporting fear of work-related activities***
AUTHORS AND JOURNAL	Linton, S. J., Boersma, K., Jansson, M., Overmeer, T., Lindblom, K., & Vlaeyen, J. W. S. (2008). *European Journal of Pain, 12,* 722-730.
DESIGN	RCT (2 groups) including 3-month follow up
PARTICIPANTS	46 adults suffering from long-term back pain and reduced function
INTERVENTIONS	CBT plus TAU (medical monitoring, medication, physical therapy)
COMPARISON GROUPS	Waitlist control plus TAU
PROCEDURE	Participants were randomly allocated to one of two groups: 13 sessions over 3 months of exposure plus TAU or a waitlist control plus TAU. The exposure treatment consisted of behavioural analysis, psychoeducation and graded *in vivo* exposure.
FINDINGS	Participants in the treatment group showed a significantly larger improvement in function compared to the control group. Overall exposure had moderate effects on function, fear, and pain intensity.

GROUP

TITLE OF PAPER	***Multidisciplinary treatment of fibromyalgia: Does cognitive behaviour therapy increase the response to treatment?***
AUTHORS AND JOURNAL	Lera, S. Gelman, S. M., Lopez, M. J., Abenoza, M., Zorrilla, J. G., Castro-Fornieles, J., et al. (2009). *Journal of Psychosomatic Research, 67,* 433-441.
DESIGN	RCT (2 groups) including 6-month follow up
PARTICIPANTS	83 adult women with a diagnosis of fibromyalgia
INTERVENTIONS	CBT plus multidisciplinary treatment
COMPARISON GROUPS	Multidisciplinary treatment
PROCEDURE	Participants were randomly allocated to one of two groups: multidisciplinary treatment alone, or multidisciplinary treatment plus CBT for pain management. The multidisciplinary treatment involved medical treatment administered individually and a program of 14 weekly 1-hour group sessions over 4 months. The CBT program consisted of 15 weekly 90-minute group sessions consisting of psychoeducation, skills training and cognitive restructuring.
FINDINGS	The addition of CBT did not increase the effectiveness of the multidisciplinary treatment; however, participants who experienced fatigue in addition to pain did respond better when also receiving CBT. All outcomes observed posttreatment were maintained at 6-month follow-up.

GROUP

TITLE OF PAPER	***Does a combination of intensive cognitive-behavioural pain management and a spinal implantable device confer any advantage? A preliminary examination***
AUTHORS AND JOURNAL	Molloy, A. R., Nicholas, M. K., Asghari, A., Beeston, L. R., Dehghani, M., Cousins, M. J., et al. (2006). Pain Practice, 6, 96-103.
DESIGN	Comparative study (4 groups)
PARTICIPANTS	31 adults with persistent non-malignant chronic pain
INTERVENTIONS	CBT combined with two types of spinal implantable devices
COMPARISON GROUPS	Order of intervention
PROCEDURE	Participants received one of four interventions based on individual clinical need: spinal cord stimulator followed by CBT, intraspinal drug delivery system followed by CBT, CBT followed by spinal cord stimulator, and CBT followed by intraspinal drug delivery system. The 'CBT for pain management' intervention was conducted as a group program, five days a week for 3 weeks. It included psychoeducation and skills training.
FINDINGS	The combination of a spinal implant device and CBT resulted in significant improvements in affective distress, disability, self-efficacy, and catastrophising but not in pain severity. No order effects were found.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Is cognitive behavioural therapy for chronic fatigue syndrome also effective for pain symptoms?***
AUTHORS AND JOURNAL	Knoop, H., Stulemeijer, M., Prins, J. B., van der Meer, J. W. M., & Bleijenberg, G. (2007). *Behaviour Research and Therapy, 45,* 2034-2043.
DESIGN	Analysis of data from a previous RCT
PARTICIPANTS	32 adolescents and 96 adults with chronic fatigue syndrome who reported chronic pain symptoms
INTERVENTIONS	CBT
COMPARISON GROUPS	Recovery status
PROCEDURE	Adult participants originally received 16 sessions of CBT over 6-months, and adolescents received 10 sessions over 5 months aimed at reducing fatigue. In the current study, participant data were divided into two groups: recovered or non-recovered, depending on their posttreatment fatigue severity score.
FINDINGS	Recovered chronic fatigue participants (both adults and adolescents) reported a significant reduction in pain severity compared to non-recovered participants. They also reported fewer pain locations following CBT treatment.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

GROUP

TITLE OF PAPER	***Acceptance and values-based action in chronic pain: A study of treatment effectiveness and process***
AUTHORS AND JOURNAL	Vowles, K. E., & McCracken, L. M. (2008). *Journal of Consulting and Clinical Psychology, 76,* 397-407.
DESIGN	Case series including 3-month follow up
PARTICIPANTS	171 adults being treated for chronic pain
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	The treatment program explicitly targeted the key processes of ACT, and was used to promote flexible and effective daily functioning, rather than reduce or change pain symptoms. Treatment courses were 3-4 weeks in duration, and consisted of group sessions for five days per week, each lasting 6.5 hours (1.5 hours was psychological content, with the remaining time used for physical conditioning, skills management and health/medical education).
FINDINGS	Posttreatment and at 3-month follow up participants reported significant decreases in depression, pain-related anxiety, disability, and healthcare use, and significant improvements in physical performance outcomes. The acceptance measure showed a particularly large improvement with treatment, and was directly related to improvements in overall functioning.

GROUP

TITLE OF PAPER	***Targeting acceptance, mindfulness, and values-based action in chronic pain: Findings of two preliminary trials of an outpatient group-based intervention (Study 1)***
AUTHORS AND JOURNAL	Vowles, K. E., Wetherell, J. L., & Sorrell, J. T. (2009). *Cognitive and Behavioural Practice, 16,* 49-58.
DESIGN	Case series pilot study
PARTICIPANTS	11 adults suffering from chronic pain
INTERVENTIONS	ACT
COMPARISON GROUPS	None
PROCEDURE	The treatment protocol was designed to be consistent with ACT principles, and focused on the promotion of acceptance, present-focused awareness, and engagement in values-based action. Sessions were administered weekly for 8 weeks, and ran for 90 minutes.
FINDINGS	Because of the pilot nature of the study, results were initially analysed on a case by case basis. Data were then pooled and analysed. Two participants experienced little benefit from treatment, four experienced a relatively large amount of change across outcome measures, and the remainder experienced substantial gains in one or two domains and moderate gains in the other domains. Overall effect sizes were large for acceptance, pain, and depression, medium for disability, and small for pain-related anxiety.

GROUP

TITLE OF PAPER	***Targeting acceptance, mindfulness, and values-based action in chronic pain: Findings of two preliminary trials of an outpatient group-based intervention (Study 2)***
AUTHORS AND JOURNAL	Vowles, K. E., Wetherell, J. L., & Sorrell, J. T. (2009). *Cognitive and Behavioural Practice, 16,* 49-58.
DESIGN	Comparative pilot study
PARTICIPANTS	11 veterans suffering from chronic pain
INTERVENTIONS	ACT
COMPARISON GROUPS	CBT
PROCEDURE	Participants were consecutively assigned to one of two treatment groups: ACT or CBT. The ACT intervention followed the same protocol as in Study 1 (see previous table) and was delivered in four, 90-minute weekly group sessions. The CBT group consisted of five 90-minute group sessions and focused on training participants to control or reduce pain using a number of strategies (e.g., pain monitoring, progressive muscle relaxation).
FINDINGS	Compared with the CBT group, the ACT group showed larger improvements across the majority of outcome measures (acceptance, pain, depression, pain-related anxiety, and disability). With regard to the pain outcome, 4 of the 6 participants allocated to ACT showed moderate improvements in pain severity, whereas only 3 participants in the CBT group showed small improvements.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

GROUP

TITLE OF PAPER	***Mindfulness meditation for symptom reduction in fibromyalgia: Psychophysiological correlates***
AUTHORS AND JOURNAL	Lush, E., Salmon, P., Floyd, A., Studts, J. L., Weissbecker, I., & Sephton, S. E. (2009). *Journal of Clinical Psychology in Medical Settings, 16,* 200-207.
DESIGN	Case series including 2-month follow up
PARTICIPANTS	43 females diagnosed with fibromyalgia
INTERVENTIONS	MBCT
COMPARISON GROUPS	None
PROCEDURE	Three MBCT for stress reduction groups were run. Each group had approximately 15 participants and was delivered in 8 weekly 2.5 hour sessions. Participants were taught a body scan technique, sitting meditation and Hatha yoga. Sessions also focused on stress management including learning to respond, rather than react, to stressors such as pain.
FINDINGS	The main aim was to explore the effects of the intervention on basal sympathetic activation. Of the original sample, 21 provided pretreatment physiological data and 15 provided post treatment data. There was no significant difference in anxiety and depression pre- to post-treatment; however skin conductance level measurements were significantly reduced posttreatment and in all three phases of the recording period.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

GROUP

TITLE OF PAPER	***The internet-based arthritis self-management program: A one-year randomised trial for patients with arthritis or fibromyalgia***
AUTHORS AND JOURNAL	Lorig, K. R., Ritter, P. L., Laurent, D. D., & Plant, K. (2008). *Arthritis & Rheumatism, 59,* 1009-1017.
DESIGN	RCT (2 groups) including 6- and 12-month follow up
PARTICIPANTS	855 adult patients diagnosed with rheumatoid arthritis, osteoarthritis, or fibromyalgia
INTERVENTIONS	Self-help with minimal therapist contact plus TAU (not defined)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomly allocated to either the internet-based *Arthritis Self-Management Program* (ASMP) or to TAU. The ASMP program is focused on reducing pain and improving functioning. Over 6 weeks, participants were asked to log onto the internet website at least 3 times per week for 1-2 hours and participate in weekly activities. They were also mailed a reference book.
FINDINGS	At one year follow up, the intervention group significantly improved in 4 of 6 health status measures and in self-efficacy. Participants with fibromyalgia appeared to benefit the least from the program.

Chronic fatigue

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self-help (primarily CBT-based) and psychoeducation in the treatment of chronic fatigue syndrome in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Efficacy of cognitive behavioural therapy for chronic fatigue syndrome: A meta-analysis***
AUTHORS AND JOURNAL	Malouff, J. M., Thorsteinsson, E. B., Rooke, S. E., Bhullar, N., & Schutte, N. S. (2008). *Clinical Psychology Review, 28,* 736-745.
DESIGN	Meta-analysis (13 studies)
PARTICIPANTS	1371 adults diagnosed with chronic fatigue syndrome
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control, TAU (not defined), another treatment not expected to be helpful (e.g., stretching)
PROCEDURE	Meta-analysis (13 trials with 15 comparisons) of published articles comparing CBT interventions for chronic fatigue syndrome to a control condition.
FINDINGS	Results of the meta-analysis showed that CBT for chronic fatigue is moderately efficacious.

ADULTS

TITLE OF PAPER	***Cognitive-behaviour therapy for chronic fatigue syndrome: Comparison of outcomes within and outside the confines of a randomised controlled trial***
AUTHORS AND JOURNAL	Quarmby, L., Rimes, K. A., Deale, A., Wessely, S., & Chalder, T. (2007). *Behaviour Research and Therapy, 45,* 1085-1094.
DESIGN	Comparative study
PARTICIPANTS	414 adults diagnosed with chronic fatigue syndrome
INTERVENTIONS	CBT
COMPARISON GROUPS	Clinical vs naturalistic setting
PROCEDURE	Fatigue severity and social adjustment scores were compared in terms of change over time for patients who received CBT for chronic fatigue syndrome as part of an RCT with those who received CBT as part of everyday clinical practice.
FINDINGS	Changes in fatigue scores were similar for both groups during treatment; however patients who were allocated to CBT as part of the RCT showed significantly greater reductions in fatigue and improvements in social adjustment at 6-month follow-up than those who received CBT as part of everyday clinical practice.

GROUP

TITLE OF PAPER	***Cognitive-behavioural therapy v. mirtazapine for chronic fatigue and neurasthenia: Randomised placebo-controlled trial***
AUTHORS AND JOURNAL	Stubhaug, B., Lie, S. A., Ursin, H., & Eriksen, H. R. (2008). *The British Journal of Psychiatry, 192,* 217-223.
DESIGN	RCT (4 groups)
PARTICIPANTS	72 adults with chronic fatigue syndrome
INTERVENTIONS	CBT plus pharmacotherapy (mirtazapine)
COMPARISON GROUPS	Placebo medication
PROCEDURE	Participants were initially randomised to 12 weeks of comprehensive CBT, mirtazapine, or placebo. A mixed cross-over combination design was employed at 12 weeks, resulting in 4 groups: CBT plus mirtazapine, CBT plus placebo, mirtazapine plus CBT, and placebo plus CBT. The CBT treatment consisted of two sessions of group therapy per week (1.5 hours of CBT and 1.5 hours of body awareness therapy), combined with a self-managed exercise program.
FINDINGS	At week 12, the treatment effect was significantly higher in the group initially receiving CBT. By 24 weeks, the CBT plus mirtazapine group showed significant improvement compared with the other three treatment groups.

TITLE OF PAPER	***Interventions for the treatment, management and rehabilitation of patients with chronic fatigue syndrome/myalgic encephalyelitis: An updated systematic review***
AUTHORS AND JOURNAL	Chambers, D., Bagnall, A., Hempel, S., & Forbes, C. (2006). *Journal of the Royal Society of Medicine, 99,* 506-520.
DESIGN	Systematic review (70 studies)
PARTICIPANTS	Adults and children with chronic fatigue syndrome or myalgic encephalyelitis
INTERVENTIONS	CBT
COMPARISON GROUPS	Not defined
PROCEDURE	Update of a previous review of all RCTs or CCTs investigating interventions used in the treatment, management or rehabilitation of people with chronic fatigue syndrome or myalgic encephalyelitis. Fifteen new studies were included in the update. Of the behavioural studies included in the review, all were CBT interventions.
FINDINGS	The original review provided support for the efficacy of CBT. Further support for CBT comes from a recent good quality RCT with children and adolescents. CBT was associated with a significant positive effect on fatigue, symptoms, physical functioning and school attendance.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Guided self-instructions for people with chronic fatigue syndrome: Randomised controlled trial***
AUTHORS AND JOURNAL	Knoop, H., van der Meer, J. W. M., & Bleijenburg, G. (2008). *The British Journal of Psychiatry, 193,* 340-341.
DESIGN	RCT (2 groups)
PARTICIPANTS	171 adults with a diagnosis of chronic fatigue syndrome
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to either guided self instructions or to a waitlist control. The 16-week intervention consisted of a CBT-based self-instruction booklet containing information on chronic fatigue syndrome and weekly assignments. Participants were required to contact a CBT therapist to report their progress at least once every two weeks.
FINDINGS	Those in the treatment condition were significantly less fatigued, reported fewer disabilities, scored significantly higher in physical functioning, and more often showed a clinically significant improvement in fatigue at second assessment. Treatment effects were lower for those with more severe CFS.

Somatisation

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for family therapy and psychodynamic psychotherapy in the treatment of somatisation disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***What is the evidence for the efficacy of treatments of somatoform disorders? A critical review of previous intervention studies***
AUTHORS AND JOURNAL	Sumathipala, A. (2007). *Psychosomatic Medicine, 69,* 889-900.
DESIGN	Literature review (6 studies)
PARTICIPANTS	1689 adults (CBT studies only)
INTERVENTIONS	CBT, family therapy, psychodynamic psychotherapy, pharmacotherapy
COMPARISON GROUPS	None
PROCEDURE	Review of highest level of evidence available for efficacy of interventions for people with somatoform disorders. The strength of evidence was assessed from a hierarchy based on study design. Searches were confined to level I (systematic review) and level II (RCT) evidence. If level I evidence was available, the review ceased.
FINDINGS	Level I evidence supporting treatment efficacy was for CBT (5 studies) and pharmacotherapy (1 study) only; however, none of the studies compared psychological to pharmacological treatments. The impact of CBT has been shown to range from reduction of physical symptoms to psychological distress and disability. Limited level II evidence was found for psychodynamic psychotherapy and family therapy. All studies described were over 10 years old.

Hypochondriasis

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and psychoeducation in the treatment of hypochondriasis in adults. One study provided Level III-2 evidence for self help (primarily CBT-based). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Current directions in the treatment of hypochondriasis***
AUTHORS AND JOURNAL	Taylor, S., Asmundson, G. J. G., & Coons, M. J. (2005). *Journal of Cognitive Psychotherapy, 19,* 285-304.
DESIGN	Narrative review and meta-analysis (15 studies)
PARTICIPANTS	448 adults diagnosed with full or abridged hypochondriasis
INTERVENTIONS	CBT, psychoeducation
COMPARISON GROUPS	Pharmacotherapy, waitlist control, TAU
PROCEDURE	Meta-analytic comparison of psychosocial and pharmacological treatments for hypochondriasis.
FINDINGS	The pre-post treatment effect sizes for measures of hypochondriasis suggest that CBT and fluoxetine tended to yield the largest effects for treatment completers with full hypochondriasis. The effects were substantially larger than those of controls conditions. For mixed samples, psychoeducation and CBT tended to yield the largest effect sizes compared to waitlist controls and TAU. For studies reporting follow-up data, results indicated that CBT had the largest effect sizes in studies of full hypochondriasis, and psychoeducation and CBT had the largest effect sizes in studies of mixed full hypochondriasis and abridged hypochondriasis.

TITLE OF PAPER	***Cognitive behavior therapy and paroxetine in the treatment of hypochondriasis: A randomised controlled trial***
AUTHORS AND JOURNAL	Greeven, A., van Balkom, A. J. L. M., Visser, S., Merkelbach, J. W., van Rood, Y. R., van Dyck, R., et al. (2007). *American Journal of Psychiatry, 164,* 91-99.
DESIGN	RCT (3 groups)
PARTICIPANTS	112 adults diagnosed with hypochondriasis
INTERVENTIONS	CBT
COMPARISON GROUPS	Pharmacotherapy, placebo control
PROCEDURE	Participants were randomly allocated to receive 16 weeks of CBT, paroxetine, or a placebo. Those assigned to medication received 12 medication-control visits lasting 20 minutes each. Those assigned to CBT received between 6 and 16 individual CBT sessions, depending on speed of recovery.
FINDINGS	CBT and paroxetine were significantly superior to placebo in treating short-term hypochondriacal symptoms; however, there were no significant differences between CBT and paroxetine. A reduction in comorbid anxiety and depression was also noted in the treatment groups.

TITLE OF PAPER	***Cognitive behavior therapy for hypochondriasis: A randomized controlled trial***
AUTHORS AND JOURNAL	Barsky, A. J., & Ahern, D. K. (2004). *Journal of the American Medical Association, 12,* 1464-1470.
DESIGN	RCT (2 groups) including 6- and 12-month follow up
PARTICIPANTS	187 adults diagnosed with hypochondriasis and subclinical hypochondriasis
INTERVENTIONS	CBT (accompanied by consultation letter to patient's physician)
COMPARISON GROUPS	TAU (medical care)
PROCEDURE	Participants were recruited from two sources: primary care practices (n=80) and community volunteers (n=107) and randomly allocated to either CBT or TAU. The CBT intervention consisted of six 90-minute weekly sessions.
FINDINGS	CBT significantly improved hypochondriacal symptoms (except somatic symptoms), beliefs, and attitudes, and health-related anxiety at both the 6- and 12-month follow-ups.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

TITLE OF PAPER	***Cognitive-behavioural bibliotherapy for hypochondriasis: A pilot study***
AUTHORS AND JOURNAL	Buwalda, F. M., & Bouman, T. K. (2009). *Behavioural and Cognitive Psychotherapy, 37,* 335-340.
DESIGN	Comparative study including 3-month follow-up
PARTICIPANTS	40 adults diagnosed with hypochondriasis
INTERVENTIONS	Pure self-help
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were assigned to either self-help or a waitlist control. Those in the intervention group were given a CBT-based self-help book. Those in the waitlist control group were enrolled into treatment after a second pre-assessment at 6 weeks.
FINDINGS	The self-help intervention was effective in reducing hypochondrical complaints, depressive complaints, and trait anxiety.

PSYCHOEDUCATION

TITLE OF PAPER	***Current directions in the treatment of hypochondriasis***
AUTHORS AND JOURNAL	Taylor, S., Asmundson, G. J. G., & Coons, M. J. (2005). *Journal of Cognitive Psychotherapy, 19,* 285-304.
DESIGN	Narrative review and meta-analysis (15 studies)
PARTICIPANTS	448 adults diagnosed with full or abridged hypochondriasis
INTERVENTIONS	Psychoeducation, CBT
COMPARISON GROUPS	Pharmacotherapy (fluoxetine), waitlist control, TAU
PROCEDURE	Meta-analytic comparison of psychosocial and pharmacological treatments for hypochondriasis.
FINDINGS	The pre-post treatment effect sizes for measures of hypochondriasis suggest that CBT and fluoxetine tended to yield the largest effects for treatment completers with full hypochondriasis. The effects were substantially larger than those of controls conditions. For mixed samples, psychoeducation and CBT tended to yield the largest effect sizes compared to waitlist controls and TAU. For studies reporting follow-up data, results indicated that CBT had the largest effect sizes in studies of full hypochondriasis, and psychoeducation and CBT had the largest effect sizes in studies of mixed full hypochondriasis and abridged hypochondriasis.

TITLE OF PAPER	***Psychoeducation for hypochondriasis: A comparison of a cognitive-behavioural approach and a problem-solving approach***
AUTHORS AND JOURNAL	Buwalda, F. M., Bouman, T. K., & van Duijn, A. J. (2006). *Behaviour Research and Therapy, 45,* 887-899.
DESIGN	RCT (2 groups) including 1- and 6-month follow up
PARTICIPANTS	48 adults diagnosed with hypochondriasis
INTERVENTIONS	Psychoeducation
COMPARISON GROUPS	CBT-based psychoeducation vs problem-solving based psychoeducation
PROCEDURE	Participants were randomly allocated to either the CBT-based course or the problem-solving based course. Both courses were implemented as six 2-hour sessions, each consisting of a mixture of mini-lectures, demonstrations, video illustrations, focused group discussions and brief exercises. A booster session was held 4 weeks after session 6.
FINDINGS	Both interventions produced beneficial effects on measures of hypochondriacal complaints, depression, anxiety and daily functioning. Immediately posttreatment, there were differential effects in favour of the CBT-based course on anxiety and functioning; however, these effect differences were no longer evident at either follow up.

Body dysmorphic

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy in the treatment of body dysmorphic disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***A meta-analysis of psychological and pharmacological treatments for body dysmorphic disorder***
AUTHORS AND JOURNAL	Williams, J., Hadjistavropoulos, T., & Sharpe, D. (2006). *Behaviour Research and Therapy, 44,* 99-111.
DESIGN	Meta-analysis (15 studies)
PARTICIPANTS	214 adults with a primary diagnosis of body dysmorphic disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	A meta-analysis of 15 studies (including RCTs and case series) of the relative effectiveness of psychological versus pharmacological treatment for body dysmorphic disorder.
FINDINGS	Findings support the efficacy of both types of intervention in the treatment of body dysmorphic disorder; however CBT interventions produced superior effects.

TITLE OF PAPER	***Psychopathologic aspects of body dysmorphic disorder: A literature review***
AUTHORS AND JOURNAL	Pavan, C., Simonato, P., Marini, M., Mazzoleni, F., Pavan, L., & Vindigni, V. (2008). *Aesthetic Plastic Surgery, 32,* 473-484.
DESIGN	Literature review
PARTICIPANTS	Adults diagnosed with body dysmorphic disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	A search of the literature was undertaken to review current research, including pharmacologic and psychological approaches for the treatment of body dysmorphic disorder.
FINDINGS	There is evidence in the research literature that CBT is the most effective psychological treatment for body dysmorphic disorder. Recent evidence also suggests that CBT is superior to pharmacotherapy.

Borderline personality disorder

SUMMARY OF EVIDENCE

There is Level I evidence for dialectical behaviour therapy and Level II evidence for schema-focused therapy and psychodynamic psychotherapy in the treatment of borderline personality disorder in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Cognitive therapy versus Rogerian supportive therapy in borderline personality disorder***
AUTHORS AND JOURNAL	Cottraux, J., Note, I. D., Boutitie, F., Milliery. M., Genouihlac, V., Yao, S. N., et al. (2009). *Psychotherapy and Psychosomatics, 78,* 307-317.
DESIGN	RCT (2 groups) including 12-month follow up
PARTICIPANTS	65 adult outpatients diagnosed with borderline personality disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	Rogerian supportive therapy
PROCEDURE	Participants were randomly allocated to either cognitive therapy or to supportive therapy. The duration of both treatments was 12 months.
FINDINGS	Cognitive therapy showed earlier positive effects on hopelessness and impulsivity, demonstrated better long-term outcomes on global measures of improvement, and had lower drop out rates.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF PAPER	***Dialectical behaviour therapy for borderline personality disorder***
AUTHORS AND JOURNAL	Lynch, T. R., Trost, W. T., Salsman, N., & Linehan, M. M. (2007). *Annual Review of Clinical Psychology, 3,* 181-205.
DESIGN	Literature review (8 studies)
PARTICIPANTS	Adults with borderline personality disorder
INTERVENTIONS	DBT
COMPARISON GROUPS	Not defined
PROCEDURE	Critical review of RCTs of manualised DBT for borderline personality disorder.
FINDINGS	DBT has been evaluated and found to be efficacious for the treatment of borderline personality disorder in 7 rigorous RCTs conducted across 4 independent research teams.

TITLE OF PAPER	***A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder***
AUTHORS AND JOURNAL	McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, R. J., & Streiner, D. L. (2009). *American Journal of Psychiatry, 166,* 1365-1374.
DESIGN	RCT (2 groups)
PARTICIPANTS	180 adults diagnosed with borderline personality disorder who had at least two self-injurious episodes in the past 5 years (suicidal or non-suicidal)
INTERVENTIONS	DBT
COMPARISON GROUPS	General psychiatric management
PROCEDURE	Participants were randomly allocated to either one year of DBT or psychiatric management, which comprised case management, dynamically-informed psychotherapy, and symptom-targeted medication management. Those in the DBT group had 1 hour a week of individual therapy and 2 hours a week of group skills training and phone coaching.
FINDINGS	After a year of treatment, both groups showed improvement on the majority of clinical outcome measures and no significant differences between groups were found.

TITLE OF PAPER	***Evaluating three treatments for borderline personality disorder: A multiwave study***
AUTHORS AND JOURNAL	Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). *American Journal of Psychiatry, 164,* 922-928.
DESIGN	RCT (3 groups)
PARTICIPANTS	90 adults with borderline personality disorder
INTERVENTIONS	DBT, psychodynamic psychotherapy
COMPARISON GROUPS	Supportive therapy
PROCEDURE	Participants were randomly allocated to one of 3 interventions: DBT, transference-focused psychotherapy or dynamic supportive therapy. DBT consisted of weekly individual and group sessions, as well as telephone consultation. Transference-focused psychotherapy consisted of 2 individual weekly sessions and supportive treatment consisted of 1 weekly session, with more available if required. At 4-monthly intervals over the 12 month treatment period, blind raters assessed the domains of suicidal behaviour, aggression, impulsivity, anxiety, depression, and social adjustment.
FINDINGS	Over the treatment period participants in all groups showed significant, positive change in depression, anxiety, global functioning and social adjustment. However, differences between groups did emerge. Overall, DBT was predictive of significant improvement in 5 of the 12 variables across the 6 domains, transference-focused psychotherapy in 10 of the 12, and supportive therapy in 6 of the 12.

GROUP

TITLE OF PAPER	***Dialectical behavioural therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomised controlled clinical trial***
AUTHORS AND JOURNAL	Soler, J., Pascual, J. C., Tiana, T., Cebria, A., Barrachina, J., Campins, M. J., et al. (2009). *Behaviour Research and Therapy, 47,* 353-358.
DESIGN	RCT (2 groups)
PARTICIPANTS	60 adults with borderline personality disorder
INTERVENTIONS	DBT
COMPARISON GROUPS	Standard group therapy
PROCEDURE	Participants were randomly allocated to 13 weekly 2-hour group sessions of either DBT skills training or standard group therapy. Only the skills training components of DBT were included in the intervention: interpersonal effectiveness, emotion regulation, mindfulness, and distress tolerance.
FINDINGS	DBT significantly improved several mood and emotional areas (e.g., depression, irritability, and anger) compared with the control treatment and was also associated with a reduction in general psychiatric symptoms.

SCHEMA-FOCUSED THERAPY

GROUP

TITLE OF PAPER	***A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomised controlled trial***
AUTHORS AND JOURNAL	Farrell, J.M., Shaw, I.A., & Webber, M.A. (2009). *Journal of Behaviour Therapy and Experimental Psychiatry, 40,* 317-328.
DESIGN	RCT (2 groups) including 6-month follow up
PARTICIPANTS	32 women diagnosed with borderline personality disorder
INTERVENTIONS	Schema-focused therapy plus TAU (individual psychotherapy)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomised to either group schema-focused therapy or to TAU. The treatment group size was 6 and the program consisted of 30 weekly 90-minute sessions. The program content included emotional awareness training, psychoeducation, distress management training and schema change work.
FINDINGS	Posttreatment there were significant differences between the groups on all measures favouring combined schema-focused therapy and TAU. Furthermore 94% of the treatment group compared to 16% of the control group no longer met criteria for a diagnosis of borderline personality disorder. A trend towards further improvement at the 6-month follow up was present for the treatment group only.

TITLE OF PAPER	***Outpatient psychotherapy for borderline personality disorder***
AUTHORS AND JOURNAL	Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., et al. (2006). *Archives of General Psychiatry, 63,* 649-659.
DESIGN	RCT (2 groups)
PARTICIPANTS	88 adults with borderline personality disorder
INTERVENTIONS	Schema-focused therapy
COMPARISON GROUPS	Psychodynamic psychotherapy
PROCEDURE	Participants were randomly allocated to weekly sessions over 3 years of either schema-focused therapy or transference-focused psychotherapy.
FINDINGS	After 3 years, participants in both groups improved to a significant degree on all measures; however, those receiving schema-focused therapy improved to a greater degree.

TITLE OF PAPER	***Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: A randomized trial***
AUTHORS AND JOURNAL	Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., et al. (2009). *Behavior Research and Therapy, 47,* 961-973.
DESIGN	Design
PARTICIPANTS	RCT (2 groups)
INTERVENTIONS	62 adults with borderline personality disorder
COMPARISON GROUPS	Schema-focused therapy
PROCEDURE	Crisis support
FINDINGS	Participants attending a regular mental healthcare setting were randomly assigned to 18 months of schema-focused therapy either with crisis support or without crisis support. Crisis support involved the therapist being available outside office hours to participants in crisis or in emotional need. Treatment was delivered twice weekly for 45 minutes and addressed the 5 schema modes specific to borderline personality. Participants in both conditions improved significantly on all outcomes measures with the exception of one quality of life measure. No added value of crisis support was found on any outcome measure after 18 months of treatment.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder***
AUTHORS AND JOURNAL	Gregory, R. J., Chlebowski, S., Kang, D., Remen, A. L., Soderberg, M. G., & Stepkovitch, J. (2008). *Psychotherapy: Theory, Research, Practice, Training, 45,* 28-41.
DESIGN	RCT (2 groups)
PARTICIPANTS	30 adult participants with co-occurring borderline personality disorder and alcohol use disorder
INTERVENTIONS	Psychodynamic psychotherapy plus TAU (counselling/therapy, medication management, case management, support groups)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomised to either intervention or control. Those in the intervention group received individual, weekly sessions of manualised dynamic deconstructive psychotherapy for 12 to 18 months.
FINDINGS	Participants in the intervention group showed significant improvements in parasuicidal behaviour, alcohol misuse, institutional care, depression, dissociation, and core BPD symptoms. Those in TAU showed limited change over the same period despite receiving higher average treatment intensity.

TITLE OF PAPER	***Evaluating three treatments for borderline personality disorder: A multiwave study***
AUTHORS AND JOURNAL	Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). *American Journal of Psychiatry, 164,* 922-928.
DESIGN	RCT (3 groups)
PARTICIPANTS	90 adults with borderline personality disorder
INTERVENTIONS	Psychodynamic psychotherapy, DBT
COMPARISON GROUPS	Supportive therapy
PROCEDURE	Participants were randomly allocated to one of 3 interventions: transference-focused psychotherapy, DBT or dynamic supportive therapy. Transference-focused psychotherapy consisted of 2 individual weekly sessions and supportive treatment consisted of 1 weekly session, with more available if required. DBT consisted of weekly individual and group sessions, as well as telephone consultation. At 4-monthly intervals over the 12 month treatment period, blind raters assessed the domains of suicidal behaviour, aggression, impulsivity, anxiety, depression, and social adjustment.
FINDINGS	Over the treatment period participants in all groups showed significant, positive change in depression, anxiety, global functioning and social adjustment. However, differences between groups did emerge. Overall, transference-focused psychotherapy was predictive of significant improvement in 10 of the 12 variables across the 6 domains, DBT in 5 of the 12, and supportive therapy in 6 of the 12.

TITLE OF PAPER	***Outpatient psychotherapy for borderline personality disorder***
AUTHORS AND JOURNAL	Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., et al. (2006). *Archives of General Psychiatry, 63,* 649-659.
DESIGN	RCT (2 groups)
PARTICIPANTS	88 adults with borderline personality disorder
INTERVENTIONS	Psychodynamic psychotherapy
COMPARISON GROUPS	Schema-focused therapy
PROCEDURE	Participants were randomly allocated to weekly sessions over 3 years of either schema-focused therapy or transference-focused psychotherapy.
FINDINGS	After 3 years, participants in both groups improved to a significant degree on all measures; however, those receiving schema-focused therapy improved to a greater degree.

Psychotic disorders

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and family therapy in the treatment of psychotic disorders in adults. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (94 studies)
PARTICIPANTS	Adults with schizophrenia
INTERVENTIONS	CBT (31 studies; *N* = 3052), family therapy (38 studies; *N* = 3134), psychodynamic psychotherapy (4 studies; *N* = 558), psychoeducation (21 studies; *N* = 2016)
COMPARISON GROUPS	Any alternative management strategy
PROCEDURE	Systematic review of clinical evidence published since the 2002 schizophrenia guidelines and meta-analysis of data available from both previous and recent studies.
FINDINGS	*CBT* was effective in reducing rehospitalisation rates up to 18 months posttreatment and there was also evidence indicating that length of stay in hospital was reduced. CBT was effective in reducing symptom severity both at treatment end and at 12 months follow up. When compared with any control or other active treatment, CBT was more effective in reducing depression. Although the evidence for CBT in relation to positive symptoms was more limited, data demonstrated some effect for hallucinations, but not for delusions. Although no RCTs directly compared group CBT with individual CBT, indirect comparisons showed that only individual CBT had robust effects on rehospitalisation, symptom severity and depression. *Family intervention* appears to be an efficacious treatment for schizophrenia. Compared with standard care or other control conditions, family intervention reduced the risk of relapse at treatment end and up to 12 months posttreatment. Family intervention may also be effective in improving additional critical outcomes such as social functioning and disorder knowledge. When indirect comparisons were made between single family intervention and multiple family intervention, the data suggest that only the former may be efficacious in reducing hospital admission. No evidence for the effectiveness of *psychodynamic approaches* in terms of symptoms, functioning or quality of life was found. No new robust evidence for the effectiveness of *psychoeducation* on any of the critical outcomes was found. Psychoeducation was difficult to distinguish from the provision of good quality information as required in standard care, and from family intervention, where information is provided to family members.

TITLE OF PAPER	***Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor***
AUTHORS AND JOURNAL	Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). *Schizophrenia Bulletin, 34,* 523-537.
DESIGN	Systematic review and a series of meta-analyses (34 studies)
PARTICIPANTS	Adults with a diagnosis of schizophrenia
INTERVENTIONS	CBT (individual and group) as an adjunct to TAU
COMPARISON GROUPS	TAU (not described)
PROCEDURE	Review and meta-analyses of RCTs published between 1978 and 2006 investigating CBT for psychosis (CBTp) for schizophrenia. The mean trial sample size was 58 participants (range = 11-353). CBTp trials included targeted positive or negative symptoms, functioning, mood, hopelessness/suicidality, or social anxiety.
FINDINGS	The results of meta-analyses of all CBTp trials in relation to various symptom and functioning outcomes suggest that CBTp has beneficial effects on the target symptom, as well as significant effects for positive and negative symptoms, functioning, mood, and social anxiety. However, there was no effect on hopelessness. Improvements in one domain corresponded with improvements in other domains. There is no evidence to suggest that individual CBTp is any more effective than group CBTp.

TITLE OF PAPER	***An effectiveness trial of cognitive behaviour therapy in a representative sample of outpatients with psychosis***
AUTHORS AND JOURNAL	Farhall, J., Freeman, N. C., Shawyer, F., & Trauer, T. (2009). *British Journal of Clinical Psychology, 48,* 47-62.
DESIGN	RCT (2 groups) including 9- and 18-month follow up
PARTICIPANTS	94 adults with psychotic disorders
INTERVENTIONS	CBT plus TAU (medication and one or more of a range of services including support, illness education and family support in a standard Australian mental health service)
COMPARISON GROUPS	TAU
PROCEDURE	Participants were randomly assigned to either TAU or to treatment. Those in the treatment group received TAU plus 12 to 24 sessions of 'recovery therapy', a form of CBT for psychosis (CBTp) given by staff of the health service.
FINDINGS	Although adverse outcomes (treatment refusal and suicide) were fewer in the CBTp group, there were no significant differences between the two groups on either of the primary measures (Positive and Negative Syndrome Scale and the Hospital Anxiety and Depression Scale), or on any of the secondary measures.

TITLE OF PAPER	***Cognitive-behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: Randomised controlled trial***
AUTHORS AND JOURNAL	Geraty, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). *British Journal of Psychiatry, 192,* 412-423.
DESIGN	RCT (2 pathways, 3 groups) including 24-month follow up
PARTICIPANTS	301 adults with non-affective psychosis and 83 carers
INTERVENTIONS	CBT, family therapy
COMPARISON GROUPS	TAU (standard care including pharmacotherapy)
PROCEDURE	The study comprised two pathways: one for individuals with carers and one for those without carers. Those in the carer pathway were randomly allocated to one of three conditions: CBT plus TAU, family intervention plus CBT, or TAU alone. Those in the non-carer group were randomly allocated to CBT plus TAU or TAU alone. Both treatments were manualised and delivered for 9 months with a planned minimum of 12 sessions and a maximum of 20 sessions.
FINDINGS	Neither intervention had an effect on rates of remission and relapse or on days in hospital at 12 or 24 months. For secondary outcomes, CBT showed a beneficial effect on depression at 24 months but there were no effects for family intervention. For those in the carer pathway, CBT significantly improved delusional distress and social functioning.

GROUP

TITLE OF PAPER	***A randomized controlled trial of group cognitive-behavioral therapy vs. enhanced supportive therapy for auditory hallucinations***
AUTHORS AND JOURNAL	Penn, D. L., Meyer, P. S., Evans, E., Wirth, R. J., Cai, K., & Burchinal, M. (2009). *Schizophrenia Research, 109,* 52-59.
DESIGN	RCT (2 groups) including 3- and 12-month follow up
PARTICIPANTS	65 adults with schizophrenia or schizoaffective disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	Enhanced supportive therapy
PROCEDURE	Participants were randomly assigned to receive 12 weekly 1-hour sessions of either group CBT for auditory hallucinations or group supportive therapy.
FINDINGS	Participants who received CBT were more likely both to resist voices and to rate them as less malevolent through 12-month follow up than those who received enhanced supportive therapy. Group CBT was also associated with lower general and total symptoms on an interviewer-rated symptom measure through 12-month follow up relative to those who received enhanced supportive therapy. At the 12-month follow up, outcomes in both groups showed improvement, with enhanced supportive therapy having specific impact on auditory hallucinations and CBT impacting general psychotic symptoms.

TITLE OF PAPER	***Group cognitive behavioural therapy for schizophrenia: A systematic review of the literature***
AUTHORS AND JOURNAL	Lawrence, R., Bradshaw, T., & Mairs, H. (2006). *Journal of Psychiatric and Mental Health Nursing, 13,* 673-681.
DESIGN	Systematic review (5 studies)
PARTICIPANTS	255 individuals with schizophrenia over 16 years of age
INTERVENTIONS	CBT (group)
COMPARISON GROUPS	Group psychoeducation, waitlist control
PROCEDURE	Systematic review of controlled trials that demonstrated the efficacy of group CBT for individuals with a diagnosis of schizophrenia or schizoaffective disorder. The number of sessions ranged 6 to 16 and treatment length ranged from 6 to 12 weeks. Session duration varied from 1 to 2 hours.
FINDINGS	The results showed that group CBT provides some benefits, mainly around improvements in specific areas of symptomology such as social anxiety and depression. Due to the methodological weaknesses of the studies reviewed, including the absence of an active control group, further research is needed before practice recommendations can be made.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

TITLE OF PAPER	***Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (94 studies)
PARTICIPANTS	Adults with schizophrenia
INTERVENTIONS	Family therapy (38 studies; N = 3134), CBT (31 studies; N = 3052), psychodynamic psychotherapy (4 studies; N = 558), psychoeducation (21 studies; N = 2016)
COMPARISON GROUPS	Any alternative management strategy
PROCEDURE	Systematic review of clinical evidence published since the 2002 schizophrenia guidelines and meta-analysis of data available from both previous and recent studies.
FINDINGS	*Family intervention* appears to be an efficacious treatment for schizophrenia. Compared with standard care or other control conditions, family intervention reduced the risk of relapse at treatment end and up to 12 months posttreatment. Family intervention may also be effective in improving additional critical outcomes such as social functioning and disorder knowledge. When indirect comparisons were made between single family intervention and multiple family intervention, the data suggest that only the former may be efficacious in reducing hospital admission. CBT was effective in reducing rehospitalisation rates up to 18 months posttreatment and there was also evidence indicating that length of stay in hospital was reduced. *CBT* was effective in reducing symptom severity both at treatment end and at 12 months follow up. When compared with any control or other active treatment, CBT was more effective in reducing depression. Although the evidence for CBT in relation to positive symptoms was more limited, data demonstrated some effect for hallucinations, but not for delusions. Although no RCTs directly compared group CBT with individual CBT, indirect comparisons showed that only individual CBT had robust effects on rehospitalisation, symptom severity and depression. No evidence for the effectiveness of *psychodynamic approaches* in terms of symptoms, functioning or quality of life was found. No new robust evidence for the effectiveness of *psychoeducation* on any of the critical outcomes was found. Psychoeducation was difficult to distinguish from the provision of good quality information as required in standard care, and from family intervention, where information is provided to family members.

TITLE OF PAPER	***Cognitive-behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: Randomised controlled trial***
AUTHORS AND JOURNAL	Geraty, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). *British Journal of Psychiatry, 192,* 412-423.
DESIGN	RCT (2 pathways, 3 groups) including 24-month follow up
PARTICIPANTS	301 adults with non-affective psychosis and 83 carers
INTERVENTIONS	Family therapy, CBT
COMPARISON GROUPS	TAU (standard care including pharmacotherapy)
PROCEDURE	The study comprised two pathways: one for individuals with carers and one for those without carers. Those in the carer pathway were randomly allocated to one of three conditions: CBT plus TAU, family intervention plus CBT, or TAU alone. Those in the non-carer group were randomly allocated to CBT plus TAU or TAU alone. Both treatments were manualised and delivered for 9 months with a planned minimum of 12 sessions and a maximum of 20 sessions.
FINDINGS	Neither intervention had an effect on rates of remission and relapse or on days in hospital at 12 or 24 months. For secondary outcomes, CBT showed a beneficial effect on depression at 24 months but there were no effects for family intervention. For those in the carer pathway, CBT significantly improved delusional distress and social functioning.

PSYCHODYNAMIC PSYCHOTHERAPY

TITLE OF PAPER	***Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (94 studies)
PARTICIPANTS	Adults with schizophrenia
INTERVENTIONS	Psychodynamic psychotherapy (4 studies; *N* = 558), CBT (31 studies; *N* = 3052), family therapy (38 studies; *N* = 3134), psychoeducation (21 studies; *N* = 2016)
COMPARISON GROUPS	Any alternative management strategy
PROCEDURE	Systematic review of clinical evidence published since the 2002 schizophrenia guidelines and meta-analysis of data available from both previous and recent studies.
FINDINGS	No evidence for the effectiveness of *psychodynamic* approaches in terms of symptoms, functioning or quality of life was found. *CBT* was effective in reducing rehospitalisation rates up to 18 months posttreatment and there was also evidence indicating that length of stay in hospital was reduced. CBT was effective in reducing symptom severity both at treatment end and at 12 months follow up. When compared with any control or other active treatment, CBT was more effective in reducing depression. Although the evidence for CBT in relation to positive symptoms was more limited, data demonstrated some effect for hallucinations, but not for delusions. Although no RCTs directly compared group CBT with individual CBT, indirect comparisons showed that only individual CBT had robust effects on rehospitalisation, symptom severity and depression. *Family intervention* appears to be an efficacious treatment for schizophrenia. Compared with standard care or other control conditions, family intervention reduced the risk of relapse at treatment end and up to 12 months posttreatment. Family intervention may also be effective in improving additional critical outcomes such as social functioning and disorder knowledge. When indirect comparisons were made between single family intervention and multiple family intervention, the data suggest that only the former may be efficacious in reducing hospital admission. No new robust evidence for the effectiveness of *psychoeducation* on any of the critical outcomes was found. Psychoeducation was difficult to distinguish from the provision of good quality information as required in standard care, and from family intervention, where information is provided to family members.

SOLUTION-FOCUSED BRIEF THERAPY

TITLE OF PAPER	***The effect of different components of psychological therapy on people with delusions: Five experimental single cases***
AUTHORS AND JOURNAL	Jakes, S. C., & Rhodes, J. E. (2003). *Clinical Psychology and Psychotherapy, 10,* 302-315.
DESIGN	Case series
PARTICIPANTS	5 adults with chronic psychosis and a chronic delusion
INTERVENTIONS	SFBT, CBT
COMPARISON GROUPS	Schema-focused cognitive therapy
PROCEDURE	An experimental single-case A-B-C-D design was used. There was a baseline phase followed by three active psychological treatments: SFBT, cognitive therapy (schema-focused), and cognitive therapy (challenging the delusion).
FINDINGS	Overall, 3 out of 5 clients responded to treatment with a large change in degree of belief in their delusion. Two clients improved during SFBT, one client improved during cognitive challenging, and one improved during baseline. RCTs are needed to substantiate the results as the type of therapy and order of treatment were confounded. It is possible that SFBT was effective because it was the first treatment provided.

PSYCHOEDUCATION

TITLE OF PAPER	***Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)***
AUTHORS AND JOURNAL	National Institute for Clinical Excellence (2009). London: Author.
DESIGN	Systematic review and meta-analysis (94 studies)
PARTICIPANTS	Adults with schizophrenia
INTERVENTIONS	Psychoeducation (21 studies; *N* = 2016), CBT (31 studies; *N* = 3052), family therapy (38 studies; *N* = 3134), psychodynamic psychotherapy (4 studies; *N* = 558)
COMPARISON GROUPS	Any alternative management strategy
PROCEDURE	Systematic review and meta-analysis (94 studies)
FINDINGS	No new robust evidence for the effectiveness of *psychoeducation* on any of the critical outcomes was found. Psychoeducation was difficult to distinguish from the provision of good quality information as required in standard care, and from family intervention, where information is provided to family members. *CBT* was effective in reducing rehospitalisation rates up to 18 months posttreatment and there was also evidence indicating that length of stay in hospital was reduced. CBT was effective in reducing symptom severity both at treatment end and at 12 months follow up. When compared with any control or other active treatment, CBT was more effective in reducing depression. Although the evidence for CBT in relation to positive symptoms was more limited, data demonstrated some effect for hallucinations, but not for delusions. Although no RCTs directly compared group CBT with individual CBT, indirect comparisons showed that only individual CBT had robust effects on rehospitalisation, symptom severity and depression. *Family intervention* appears to be an efficacious treatment for schizophrenia. Compared with standard care or other control conditions, family intervention reduced the risk of relapse at treatment end and up to 12 months posttreatment. Family intervention may also be effective in improving additional critical outcomes such as social functioning and disorder knowledge. When indirect comparisons were made between single family intervention and multiple family intervention, the data suggest that only the former may be efficacious in reducing hospital admission. No evidence for the effectiveness of *psychodynamic approaches* in terms of symptoms, functioning or quality of life was found.

HYPNOTHERAPY

TITLE OF PAPER	***Hypnosis for schizophrenia***
AUTHORS AND JOURNAL	Izquierdo de Santiago, A., & Khan, M. *Cochrane Database of Systematic Reviews 2007 (4)*. DOI: 10.1002/14651858. CD004160.pub3.
DESIGN	Systematic review and meta-analysis (3 studies)
PARTICIPANTS	149 adults diagnosed with schizophrenia
INTERVENTIONS	Hypnotherapy
COMPARISON GROUPS	TAU (medication, community psychiatric input, hospitalisation), relaxation, music
PROCEDURE	Systematic review and meta-analysis of randomised or double-blind trials comparing hypnosis with other treatments or standard care. The studies included in the analysis were all conducted before 1983 and interventions were relatively short.
FINDINGS	Due to methodological limitations (including sample size) of the included trials, there was no conclusive evidence that hypnosis was superior to other interventions.

Dissociative disorders

SUMMARY OF EVIDENCE

Few studies investigating the effectiveness of treatments for dissociative disorders have been conducted. In addition, the types of interventions used have not been clearly described, although one study (Level IV) investigating cognitive behaviour therapy reported benefits.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***A review of dissociative disorders treatment studies***
AUTHORS AND JOURNAL	Brand, B. L., Classen, C. C., McNary, S. W., & Zaveri, P. (2009). *The Journal of Nervous and Mental Disease, 197,* 646-654.
DESIGN	Systematic review (13 studies)
PARTICIPANTS	530 adults with a dissociative disorder
INTERVENTIONS	Not defined
COMPARISON GROUPS	None
PROCEDURE	Review of treatment studies for dissociative disorders including 8 non-randomised studies and 5 case studies/case series that used standardised measures. The interventions used in the studies were not clearly defined, although one was CBT-based and one involved cognitive analytic therapy. Treatments were delivered in both inpatient and outpatient settings.
FINDINGS	Despite the lack of well-designed studies on the treatment of dissociative disorders, there is some evidence that treatment provides positive benefits. Benefits include reduction in symptoms of dissociation, depression, general distress, anxiety, and PTSD. Other favourable outcomes include decreased use of medication and improved work and social functioning. Results from the case series and case studies suggest that about two-thirds of those who receive dissociative disorders-focused treatment improve.

Attention deficit & hyperactivity

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy in the treatment of attention deficit hyperactivity disorder (ADHD) in adults. One study provided Level III-1 for dialectical behaviour therapy and one study provided Level IV evidence for mindfulness-based cognitive therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Treatment of adults with attention-deficit/hyperactivity disorder***
AUTHORS AND JOURNAL	Kolar, D., Keller, A., Golfinopoulos, M., Cumyn, L., Syer, C., & Hechman, L. (2008). *Neuropsychiatric Disease and Treatment, 4,* 107-121.
DESIGN	Literature review
PARTICIPANTS	Adults diagnosed with ADHD
INTERVENTIONS	CBT
COMPARISON GROUPS	Not defined
PROCEDURE	Review of psychosocial treatments for adults with ADHD.
FINDINGS	Of the few studies that have been conducted on adults with ADHD, results suggest that stimulant medication combined with psychosocial treatment is the most effective treatment for adults with ADHD. The five CBT studies reviewed all showed benefits; however, the studies were not RCTs and had small sample sizes.

TITLE OF PAPER	***Recent developments in the psychosocial treatment of adult ADHD***
AUTHORS AND JOURNAL	Knouse, L. E., Cooper-Vince, C. C., Sprich, S., & Safren, S. A. (2008). *Expert Review of Neurotherapeutics, 8,* 1537-1548.
DESIGN	Literature review
PARTICIPANTS	Adults diagnosed with ADHD
INTERVENTIONS	CBT, DBT, MBCT
COMPARISON GROUPS	Waitlist control, not defined
PROCEDURE	Review of group and individual psychosocial treatments for adults with ADHD. All group studies were open-trials.
FINDINGS	Results of a group-based CBT program demonstrated effectiveness as 31% of participants showed improvement immediately after treatment and 97% self-reported at least moderate benefit. In the one open trial and one RCT of individual CBT reviewed, those in both treatment groups reported significant reductions in ADHD symptoms after treatment. In both of the DBT studies reviewed, the treatment groups showed significant reductions on symptom rating scales posttreatment. Completers of an MBCT group program reported a significant decrease in inattentive and hyperactive-impulsive symptoms from pre- to post-treatment.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF PAPER	***Recent developments in the psychosocial treatment of adult ADHD***
AUTHORS AND JOURNAL	Knouse, L. E., Cooper-Vince, C. C., Sprich, S., & Safren, S. A. (2008). Expert Review of Neurotherapeutics, 8, 1537-1548.
DESIGN	Literature review
PARTICIPANTS	Adults diagnosed with ADHD
INTERVENTIONS	MBCT, CBT, DBT
COMPARISON GROUPS	Waitlist control, not defined
PROCEDURE	Review of group and individual psychosocial treatments for adults with ADHD. All group studies were open-trials.
FINDINGS	Completers of an MBCT group program reported a significant decrease in inattentive and hyperactive-impulsive symptoms from pre- to post-treatment. Results of a group-based CBT program demonstrated effectiveness as 31% of participants showed improvement immediately after treatment and 97% self-reported at least moderate benefit. In the one open trial and one RCT of individual CBT reviewed, those in both treatment groups reported significant reductions in ADHD symptoms after treatment. In both of the DBT studies reviewed, the treatment groups showed significant reductions on symptom rating scales posttreatment.

DIALECTICAL BEHAVIOURAL THERAPY (DBT)

TITLE OF PAPER	***Recent developments in the psychosocial treatment of adult ADHD***
AUTHORS AND JOURNAL	Knouse, L. E., Cooper-Vince, C. C., Sprich, S., & Safren, S. A. (2008). *Expert Review of Neurotherapeutics, 8,* 1537-1548.
DESIGN	Literature review
PARTICIPANTS	Adults diagnosed with ADHD
INTERVENTIONS	DBT, CBT, MBCT
COMPARISON GROUPS	Waitlist control, not defined
PROCEDURE	Review of group and individual psychosocial treatments for adults with ADHD. All group studies were open-trials.
FINDINGS	In both of the DBT studies reviewed, the treatment groups showed significant reductions on symptom rating scales posttreatment. Results of a group-based CBT program demonstrated effectiveness as 31% of participants showed improvement immediately after treatment and 97% self-reported at least moderate benefit. Completers of an MBCT group program reported a significant decrease in inattentive and hyperactive-impulsive symptoms from pre- to post-treatment. In the one open trial and one RCT of individual CBT reviewed, those in both treatment groups reported significant reductions in ADHD symptoms after treatment.

Depression

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and family therapy in the treatment of depression in adolescents and children, and for interpersonal psychotherapy in the treatment of adolescents only. There is Level II evidence for self-help (primarily CBT-based) with adolescents. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Evidence-based psychosocial treatments for child and adolescent depression***
AUTHORS AND JOURNAL	David-Ferdon, C., & Kaslow, N. J. (2008). *Journal of Clinical Child & Adolescent Psychology, 37*, 62-104.
DESIGN	Systematic review (10 child and 18 adolescent studies)
PARTICIPANTS	Children (≤12 yrs) and adolescents (≥13 yrs) with diagnosed major depression or dysthymia. Those at risk of depression (with elevated depression levels) were also included
INTERVENTIONS	CBT, IPT, family therapy
COMPARISON GROUPS	Control (TAU, waitlist), other therapies
PROCEDURE	Review of RCTs investigating evidenced-based psychosocial treatments for child and adolescent depression published since 1998. All studies included in the analysis met Nathan and Gorman's (2002) criteria for Type 1 or Type 2 studies.
FINDINGS	For children, the evidence supports CBT-based interventions delivered in a child-only group format or a child-plus-parent group format. For adolescents, the evidence supports group CBT and individual IPT.

TITLE OF PAPER	***The empirical status of cognitive-behavioral therapy***
AUTHORS AND JOURNAL	Butler, A. C., Chapman, J. E., Forman, E. M., & Beck. A. T. (2006). *Clinical Psychology Review, 26*, 17-31.
DESIGN	Review of meta-analyses (16 studies)
PARTICIPANTS	9995 adults, adolescents and children with depression in 32 studies across 16 disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, TAU, placebo, no treatment), other therapies (relaxation, supportive therapy, stress management), and pre-post comparisons
PROCEDURE	Review of meta-analyses with effect sizes that contrast CBT with outcomes from various control groups.
FINDINGS	Large effect sizes in favour of CBT were found for adult and adolescent unipolar depression, and for childhood depressive disorders. The effects of CBT were also maintained for substantial periods beyond the cessation of treatment, with relapse rates half those of pharmacotherapy.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF PAPER	***Evidence-based psychosocial treatments for child and adolescent depression***
AUTHORS AND JOURNAL	David-Ferdon, C., & Kaslow, N. J. (2008). *Journal of Clinical Child & Adolescent Psychology, 37,* 62-104.
DESIGN	Systematic review of (10 child and 18 adolescent studies)
PARTICIPANTS	Children (≤12 yrs) and adolescents (≥13 yrs) with diagnosed major depression or dysthymia. Those at risk of depression (with elevated depression levels) were also included
INTERVENTIONS	IPT, CBT, family therapy
COMPARISON GROUPS	Control (TAU, waitlist), other therapies
PROCEDURE	Review of RCTs investigating evidenced-based psychosocial treatments for child and adolescent depression published since 1998. All studies included in the analysis met Nathan and Gorman's (2002) criteria for Type 1 or Type 2 studies.
FINDINGS	For adolescents, the evidence supports group CBT and individual IPT. For children, the evidence supports CBT-based interventions delivered in a child-only group format or a child-plus-parent group format.

TITLE OF PAPER	***A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders***
AUTHORS AND JOURNAL	Feijo de Mello, M., de Jesus Mari, J., Bacaltchuk, J., Verdeil, H., & Neugebauer, R. (2005). E*uropean Archives of Psychiatry and Clinical Neuroscience, 255,* 75 – 82.
DESIGN	Systematic review and meta-analysis (13 studies and 4 meta-analyses)
PARTICIPANTS	2199 adults and adolescents diagnosed with depression
INTERVENTIONS	IPT
COMPARISON GROUPS	Pharmacotherapy, placebo, CBT
PROCEDURE	Review and meta-analysis of RCTs published between 1974 and 2002 investigating IPT for depression.
FINDINGS	IPT was superior to placebo (9 studies) and more effective than CBT in reducing depressive symptoms (3 studies). No differences were found between IPT and medication in treating depression, and the combination of IPT and medication was not superior to medication alone.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

TITLE OF PAPER	***Evidence-based psychosocial treatments for child and adolescent depression***
AUTHORS AND JOURNAL	David-Ferdon, C., & Kaslow, N. J. (2008). *Journal of Clinical Child & Adolescent Psychology, 37,* 62-104.
DESIGN	Systematic review of (10 child and 18 adolescent studies)
PARTICIPANTS	Children (≤12 yrs) and adolescents (≥13 yrs) with diagnosed major depression or dysthymia. Those at risk of depression (with elevated depression levels) were also included
INTERVENTIONS	Family therapy, CBT, IPT
COMPARISON GROUPS	Control (TAU, waitlist), other therapies
PROCEDURE	Review of RCTs investigating evidenced-based psychosocial treatments for child and adolescent depression published since 1998. All studies included in the analysis met Nathan and Gorman's (2002) criteria for Type 1 or Type 2 studies.
FINDINGS	For children, the evidence supports CBT-based interventions delivered in a child-only group format or a child-plus-parent group format. For adolescents, the evidence supports group CBT and individual IPT.

COMBINED ADULTS, ADOLESCENTS & CHILDREN

TITLE OF PAPER	Family therapy for depression
AUTHORS AND JOURNAL	Henken, T., Huibers, M. J., Churchill, R., Resifo, K. K., & Roelofs, J. J. *Cochrane Database of Systematic Reviews 2007.* Issue 3. DOI: 10.1002/14651858.CD006728.
DESIGN	Systematic review (6 studies)
PARTICIPANTS	519 children, adolescents and adults
INTERVENTIONS	Family therapy
COMPARISON GROUPS	CBT, control (TAU, waitlist, no treatment), pharmacotherapy
PROCEDURE	Review of randomised controlled and controlled trials comparing family therapy, which included psychoeducational, behavioural, object relations, solution-focused and systemic, with no intervention or an alternative intervention in which symptoms of depression were the main outcome measure.
FINDINGS	Family therapy was superior to a waitlist or no treatment control; however, when compared to other interventions for depression, it remained unclear as to whether family therapy was effective in comparison to other interventions.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

ADOLESCENTS

TITLE OF PAPER	***A controlled trial of a school-based internet program for reducing depressive symptoms in adolescent girls***
AUTHORS AND JOURNAL	O'Kearney, R., Kang, K., Christensen, H., & Griffiths, K. (2009). *Depression and Anxiety, 26,* 65-72.
DESIGN	Non-randomised study (2 groups) including 20-week follow up
PARTICIPANTS	157 adolescent girls in year 10
INTERVENTIONS	Pure self-help
COMPARISON GROUPS	No treatment control
PROCEDURE	Participants were allocated to MoodGYM, a web-based CBT program for depression, or to the control group based on personal development class membership.
FINDINGS	*MoodGYM* produced a significantly faster rate of decline in self-reported depressive symptoms than the control condition. Those with levels of depression above the clinical cut-off benefited more from *MoodGYM*. The size of the *MoodGYM* effect was not significant immediately post-intervention but was moderate and significant at the 20-week follow up.

Bipolar

SUMMARY OF EVIDENCE

There is Level II evidence for family therapy, as an adjunct to pharmacotherapy, in the treatment of bipolar disorder in adolescents. One study provided Level IV evidence for cognitive behaviour therapy as an adjunct to pharmacotherapy for both adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Child- and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: Development and preliminary results***
AUTHORS AND JOURNAL	Pavuluri, M. N., Graczyk, P. A., Henry, D. B., Carbray, J. A., Heidenreich, J., & Miklowitz, D. J. (2004). *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 528-537.
DESIGN	Case series
PARTICIPANTS	34 adolescents and children with a primary diagnosis of bipolar disorder (paediatric), who were living with a parent or guardian and stabilised on medication
INTERVENTIONS	CBT plus pharmacotherapy
COMPARISON GROUPS	None
PROCEDURE	All participants received a weekly 1-hour session of child- and family-focused CBT for 12 weeks. Most sessions involved child and parent. The treatment comprised 7 steps corresponding to the acronym *RAINBOW*: **r**outine, **a**ffect regulation, **I** can do it!, **n**o negative thoughts and live in the now, **b**e a good friend and a balanced lifestyle for parents, **o**h, how can we solve the problem, and **w**ays to get support.
FINDINGS	Participants showed significant reductions in severity scores on all outcomes measures and significantly higher scores on the Children's Global Assessment Scale compared to pretreatment results. Preliminary results support the potential feasibility of the intervention.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

ADOLESCENTS

TITLE OF PAPER	***Family-focused treatment for adolescents with bipolar disorder***
AUTHORS AND JOURNAL	Miklowitz, D. J., George, E., Axelson, D., Kim, E., Birmaher, B., Schneck, C., et al. (2008). *Archives of General Psychiatry, 65,* 1053-1061.
DESIGN	RCT (2 groups) including 2-year follow up
PARTICIPANTS	58 adolescents with diagnosed bipolar I, or bipolar II, or bipolar NOS
INTERVENTIONS	Family therapy for adolescents plus protocol pharmacotherapy
COMPARISON GROUPS	Enhanced care (psychoeducation and protocol pharmacotherapy)
PROCEDURE	Participants were randomly assigned to family-focused therapy for adolescents, which consisted of 21, 50-minute sessions (12 weekly, 6 bi-weekly, and 3 monthly) plus pharmacotherapy or to enhanced care, which consisted of 3 weeks of psychoeducation plus pharmacotherapy.
FINDINGS	Although there were no group differences in rates of recovery from the index episode, participants in the family-focused therapy group recovered from their baseline depressive symptoms faster than controls. The groups did not differ in time to recurrence of depression or mania, however the family-focused therapy group had shorter times to recovery from depression, less time in depressive episodes, and lower depression severity scores during the 2-year study.

Generalised anxiety

SUMMARY OF EVIDENCE

There is the Level I evidence for cognitive behaviour therapy in the treatment of generalised anxiety disorder (GAD) in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents***
AUTHORS AND JOURNAL	Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). *Journal of Clinical Child & Adolescent Psychology, 37,* 105-130.
DESIGN	Systematic review and meta-analysis (33 studies)
PARTICIPANTS	Children and adolescents with anxiety and phobic disorders
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control, psychological placebo
PROCEDURE	Review of high quality studies on psychosocial treatments that targeted the most prevalent phobic and anxiety disorders in children and adolescents. Most studies met Nathan and Gorman's (2002) criteria for Type 1 (23), Type 2 (7) or Type 3 (3) studies.
FINDINGS	Individual and group CBT, with or without parent involvement, are effective treatments for children and adolescents with anxiety disorders.

ANXIETY DISORDERS

Panic

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Specific phobia

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy in the treatment of specific phobia in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***One-session treatment of specific phobias in youth: A randomized clinical trial in the United States and Sweden***
AUTHORS AND JOURNAL	Ollendick, T. H., Ost, L., Reuterskiold, L., Costa, N., Cederland, R., Sirbu, C., Thompson, E. D., & Jarrett, M. A. (2009). *Journal of Consulting and Clinical Psychology, 77,* 504-516.
DESIGN	RCT (3 groups) including 6-month follow up
PARTICIPANTS	196 children and adolescents with a specific phobia
INTERVENTIONS	CBT
COMPARISON GROUPS	Education support therapy, waitlist control
PROCEDURE	Participants were randomly allocated to one of the three groups: one-session in vivo exposure, education support therapy or waitlist control. Both treatments were maximised to 3 hours and manualised but flexibly implemented.
FINDINGS	Both treatments were superior to the waitlist control, however, the treatment groups were not superior to waitlist on a number of steps completed on the behavioural approach test, self-report, or parent-report measures posttreatment. Posttreatment, in vivo exposure was superior to education support and at the 6-month follow up, those receiving in vivo exposure continued to do better than those in education support.

Social anxiety

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy in the treatment of social anxiety in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

ADOLESCENTS

TITLE OF PAPER	***Cognitive behavior therapy for generalized social anxiety disorder in adolescents: A randomized controlled trial***
AUTHORS AND JOURNAL	Herbert, J. D., Gaudiano, B. A, Rheingold, A. A, Moitra, E., Myers, V. H, Dalrymple, K. L, Brandsma, L. L. (2009). *Journal of Anxiety Disorders, 23,* 167-177.
DESIGN	RCT (3 groups)
PARTICIPANTS	73 adolescents meeting criteria for generalised SAD
INTERVENTIONS	CBT
COMPARISON GROUPS	Psychoeducation
PROCEDURE	Participants were randomly assigned to one of 3 groups: individual CBT, group CBT or group psychoeducation. All conditions involved 12 weeks of psychotherapy. Participants in individual CBT met weekly for 1 hour and those in group CBT and psychoeducation met weekly for 2 hours.
FINDINGS	All three treatments were shown to be equally effective in reducing symptoms and distress and in improving psychosocial functioning, however, the CBT conditions demonstrated greater gains on behavioural measures (role plays and speech giving) compared to psychoeducation.

TITLE OF PAPER	***A selective intervention program for inhibited preschool-aged children of parents with an anxiety disorder: Effects on current anxiety disorders and temperament***
AUTHORS AND JOURNAL	Kennedy, S. J., Rapee, R. M., & Edwards, S. L. (2009). *Journal of the Academy of Child and Adolescent Psychiatry, 48,* 602-609.
DESIGN	RCT (2 groups) including 6-month follow up
PARTICIPANTS	71 preschool-aged children demonstrating high levels of inhibition who had a parent with an anxiety disorder
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Participants were randomly allocated to either an 8-session parent intervention or to a waitlist control. The group-based parent intervention was delivered in 90-minute sessions. It comprised psychoeducation, skills training, exposure, cognitive restructuring, and relapse prevention.
FINDINGS	At the 6-month follow-up, the intervention group showed a significantly greater reduction in anxiety disorders and less interference from anxiety than the control group. In addition, children in the intervention condition showed greater reductions in parent and laboratory-observed measures of behavioural inhibition.

Obsessive compulsive

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy in the treatment of obsessive compulsive disorder (OCD) in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Meta-analysis of randomized, controlled treatment trials for paediatric obsessive-compulsive disorder***
AUTHORS AND JOURNAL	Watson, H. J., & Rees, C. S. (2008). *Child Psychology and Psychiatry, 49,* 489-498.
DESIGN	Meta-analysis (13 studies)
PARTICIPANTS	1016 children and adolescents with OCD
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, placebo), pharmacotherapy
PROCEDURE	A meta-analysis containing 15 treatment comparisons (5 CBT and 10 pharmacological) was conducted on RCTs of paediatric OCD. Only CBT and pharmacotherapy studies met the inclusion criteria.
FINDINGS	Both treatments were significantly superior to control, with CBT yielding a larger treatment effect than pharmacotherapy. The meta-analysis was unable to indicate outright whether CBT was superior to pharmacotherapy in treating OCD due to differences in study design, methodology and patient characteristics.

TITLE OF PAPER	***Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder***
AUTHORS AND JOURNAL	Barrett, P. M., Farrell, L., Pina, A. A., Peris, T. S., & Piacentini, J. (2008). *Journal of Clinical Child & Adolescent Psychology, 37,* 131-155.
DESIGN	Systematic review (16 studies)
PARTICIPANTS	478 children and adolescents with OCD
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, placebo), no control, pharmacotherapy
PROCEDURE	Systematic review and evaluation of published OCD studies. All studies included in the analysis met Nathan and Gorman's (2002) criteria for Type 1, 2, or 3 studies.
FINDINGS	No psychosocial treatments for OCD reviewed met the criteria for a well-established treatment. However, individual exposure-based CBT can be considered a *probably* efficacious treatment and family-focused individual or group-format CBT can be considered *possibly* efficacious treatments. Group CBT without an intensive structured family component remains an experimental treatment because of the absence of control data.

ANXIETY DISORDERS

Posttraumatic stress

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Substance-use disorders

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and family therapy, and Level II evidence for self help (primarily CBT-based) in the treatment of substance-use disorders in adolescents. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. For the treatment of substance-use disorders in children, no recent studies were found.

COGNITIVE BEHAVIOUR THERAPY (CBT)

ADOLESCENTS

TITLE OF PAPER	***On the learning curve: The emerging evidence supporting cognitive-behavioral therapies for adolescent substance abuse***
AUTHORS AND JOURNAL	Waldron, H. B., & Kaminer, Y. (2004). *Addiction, 99,* 93-105.
DESIGN	Literature review
PARTICIPANTS	Adolescents presenting for treatment with substance dependence or abuse
INTERVENTIONS	CBT
COMPARISON GROUPS	Not defined
PROCEDURE	Review of RCTs investigating the efficacy of CBT (individual and group) for adolescent substance abuse. Nathan and Gorman's (2002) criteria for RCTs was used as a guide.
FINDINGS	When taken together, the RCTs reviewed provide support for the efficacy of CBT in reducing adolescent substance use and related problems. Both group and individual CBT demonstrated clinically meaningful reductions in adolescent substance use and were significantly more cost effective when compared to family intervention. An important finding was the significant reduction in substance use from pretreatment to follow up in group CBT.

ADOLESCENTS

TITLE OF PAPER	Adolescent substance abuse treatment: A synthesis of controlled evaluations
AUTHORS AND JOURNAL	Vaughn, M. G., & Howard, M. O. (2004). *Research on Social Work Practice, 14,* 325-335.
DESIGN	Meta-analysis (15 studies)
PARTICIPANTS	1928 adolescents with problematic substance use
INTERVENTIONS	CBT, family therapy
COMPARISON GROUPS	TAU (counselling, basic residential treatment, community services), group psychoeducation, parent training, waitlist control
PROCEDURE	Review of all controlled evaluations of treatments for adolescent substance use between 1988 and 2003. A meta-analysis was conducted to determine effect sizes across the selected studies.
FINDINGS	Group CBT and multidimensional family therapy had the highest level of evidentiary support. Seven other psychological interventions were also found to be effective, but the evidence for their efficacy was not as strong. These were: behaviour therapy, multisystemic therapy, combined CBT and functional family therapy, family systems therapy, functional family therapy, combined life skills with additive programs, and psychoeducation. A number of other interventions had lower levels of effectiveness.

COGNITIVE BEHAVIOUR THERAPY (CBT)

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Cognitive-behavioural therapy for substance use disorders in people with psychotic disorders***
AUTHORS AND JOURNAL	Baker, A., Bucci, S., Lewin, T. J., Kay-Lambkin, F., Constable, P. M., & Carr, V. J. (2006). *British Journal of Psychiatry, 188,* 439-448.
DESIGN	RCT (2 groups) including 12-month follow up
PARTICIPANTS	130 regular users of alcohol, cannabis and/or amphetamines who also had a non-acute psychotic disorder and were aged 15 years or over
INTERVENTIONS	CBT and motivational interviewing (MI)
COMPARISON GROUPS	TAU (brief education and self-help booklet)
PROCEDURE	Participants were randomly allocated to either CBT/MI or TAU. Those in the CBT/MI group received ten weekly 1-hour sessions of CBT and MI. MI was used in weeks 1-4 and CBT in weeks 5-10.
FINDINGS	Among participants in the CBT/MI group there was a short-term improvement in depression, cannabis use, and general functioning at 12 months. However, after 12 months, there was no differential beneficial effect of the intervention on substance use.

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: A randomized controlled trial of clinical efficacy***
AUTHORS AND JOURNAL	Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J., & Carr, V. J. (2009). *Addiction, 104,* 378-388.
DESIGN	RCT (3 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	97 adults and adolescents with diagnosed major depression (lifetime) and current problematic AOD use
INTERVENTIONS	CBT/MI, self help with minimal therapist contact
COMPARISON GROUPS	Brief intervention (psychoeducation and MI)
PROCEDURE	All participants received a brief intervention followed by random assignment to no further treatment or to SHADE (**s**elf-**h**elp for **a**lcohol and other drug use and **de**pression), a CBT/MI-based intervention. Those allocated to SHADE were then randomised to receive nine sessions of therapy delivered either by a therapist or via a computer-based program.
FINDINGS	For *depression*, both treatment conditions were more effective than the control condition; however, the therapist-delivered intervention produced greater short-term improvement, with computer delivery matching the effect at 12-month follow-up. For *alcohol use*, all treatments were effective, with therapist-delivery showing the largest effect. For *cannabis/hazardous substance use*, the treatment condition was significantly better than the control condition, with computer delivery showing the largest effect.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

ADOLESCENTS

TITLE OF PAPER	***Adolescent substance abuse treatment: A synthesis of controlled evaluations***
AUTHORS AND JOURNAL	Vaughn, M. G., & Howard, M. O. (2004). *Research on Social Work Practice, 14,* 325-335.
DESIGN	Meta-analysis (15 studies)
PARTICIPANTS	1928 adolescents with problematic substance use
INTERVENTIONS	Family therapy, CBT
COMPARISON GROUPS	TAU (counselling, basic residential treatment, community services), group psychoeducation, parent training, waitlist control
PROCEDURE	Review of all controlled evaluations of treatments for adolescent substance use between 1988 and 2003. A meta-analysis was conducted to determine effect sizes across the selected studies.
FINDINGS	Multidimensional family therapy and group CBT had the highest level of evidentiary support. Seven other psychological interventions were also found to be effective, but the evidence for their efficacy was not as strong. These were: behaviour therapy, multisystemic therapy, combined CBT and functional family therapy, family systems therapy, functional family therapy, combined life skills with additive programs, and psychoeducation. A number of other interventions had lower levels of effectiveness.

ADOLESCENTS

TITLE OF PAPER	***Family-based therapies for adolescent alcohol and drug use: Research contributions and future research needs***
AUTHORS AND JOURNAL	Liddle, H. A. (2004). *Addiction, 99,* 76-72.
DESIGN	Literature review
PARTICIPANTS	Adolescents with alcohol and other drug problems
INTERVENTIONS	Family therapy
COMPARISON GROUPS	None
PROCEDURE	Review of controlled trials and mechanisms of change studies of family-based treatments for adolescent alcohol and drug use.
FINDINGS	A number of family approaches that have been tested and show promise for treating adolescents were identified in the review, including multisystemic therapy, brief strategic family therapy and multidimensional family therapy. Research suggests that family-based interventions lead to significant reductions in alcohol and drug use and related problems such as family conflict and delinquency.

ADOLESCENTS

TITLE OF PAPER	***Comparison of family therapy outcome with alcohol-abusing, runaway adolescents***
AUTHORS AND JOURNAL	Slesnick, N., & Prestopnik, J. L. (2009). *Journal of Marital & Family Therapy, 35,* 255-277.
DESIGN	RCT (3 groups) including 3-, 9- and 15-month follow up
PARTICIPANTS	119 runaway adolescents with a primary alcohol problem whose family resided within 100 kms of the research site
INTERVENTIONS	Family therapy
COMPARISON GROUPS	TAU (case management and supportive counselling)
PROCEDURE	Eligible adolescents and their families were randomly assigned to one of three conditions: home-based family therapy, office-based family therapy, or TAU. Home-based therapy included individual sessions with family members whereas office-based did not.
FINDINGS	Both family therapy approaches significantly reduced alcohol and drug use compared with TAU at the 15-month follow up, however significantly lower treatment refusal and higher engagement and treatment retention rates were found for those in the home-based family therapy group. Measures of family and adolescent functioning, including psychological functioning and substance use, improved over time in all conditions.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: A randomized controlled trial of clinical efficacy***
AUTHORS AND JOURNAL	Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J., & Carr, V. J. (2009). *Addiction, 104,* 378-388.
DESIGN	RCT (3 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	97 adults and adolescents with diagnosed depression (lifetime MDD) and current problematic AOD use
INTERVENTIONS	Self help with minimal therapist contact, CBT/MI
COMPARISON GROUPS	Brief intervention (psychoeducation and MI)
PROCEDURE	All participants received a brief intervention followed by random assignment to no further treatment or to SHADE therapy (**s**elf-**h**elp for **a**lcohol and other drug use and **de**pression), a CBT/MI-based intervention. Those allocated to SHADE therapy were then randomised to receive nine sessions of therapy delivered either by a therapist or via a computer-based program.
FINDINGS	For *depression*, both treatment conditions were more effective than the control condition; however, the therapist-delivered intervention produced greater short-term improvement, with computer delivery matching the effect at 12-month follow-up. For *alcohol use*, all treatments were effective, with therapist delivery showing the largest effect. For *cannabis/hazardous substance use*, the treatment condition was significantly better than the control condition, with computer delivery showing the largest effect.

Anorexia nervosa

SUMMARY OF EVIDENCE

There is Level I evidence for family therapy in the treatment of anorexia nervosa (AN) in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Anorexia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Bulik, C., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). *International Journal of Eating Disorders, 40,* 310-320.
DESIGN	Systematic review of RCTs (11 studies)
PARTICIPANTS	549 adolescents and adults diagnosed with AN
INTERVENTIONS	CBT, family therapy
COMPARISON GROUPS	IPT, nutritional counselling, behaviour therapy, TAU (not defined), supportive counselling, family group psychoeducation
PROCEDURE	Systematic review of behavioural interventions for AN. Only 11 RCTs met the inclusion criteria: 2 were rated 'good' and 9 were rated 'fair'. Of the 11 RCTs, 3 were CBT-based and 6 were family therapy-based.
FINDINGS	For adults with AN, there was tentative evidence that CBT reduces relapse risk after weight restoration. However, there was no evidence to support the superiority of CBT over other approaches in the acutely underweight state. For adults with AN and a comparatively long duration of illness, there is no supportive evidence for the efficacy of *family therapy*. Family therapy focusing on parental control of re-nutrition is efficacious in treating younger, non-chronic patients. Although most family therapy studies compared one form with another, results from two studies suggested that family therapy was superior to individual therapy for adolescents with a shorter duration of illness.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

COMBINED ADULTS & ADOLESCENTS

TITLE OF PAPER	***Anorexia nervosa treatment: A systematic review of randomized controlled trials***
AUTHORS AND JOURNAL	Bulik, C., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). *International Journal of Eating Disorders, 40,* 310-320.
DESIGN	Systematic review of RCTs (11 studies)
PARTICIPANTS	549 adolescents and adults diagnosed with AN
INTERVENTIONS	Family therapy, CBT
COMPARISON GROUPS	IPT, nutritional counselling, behaviour therapy, TAU (not defined), supportive counselling, family therapy, family group psychoeducation
PROCEDURE	Systematic review of behavioural interventions for AN. Only 11 RCTs met the inclusion criteria: 2 were rated 'good' and 9 were rated 'fair'. Of the 11 RCTs, 3 were CBT-based and 6 were family therapy-based.
FINDINGS	For adults with AN and a comparatively long duration of illness, there is no supportive evidence for the efficacy of *family therapy*. Family therapy focusing on parental control of re-nutrition is efficacious in treating younger, non-chronic patients. Although most family therapy studies compared one form with another, results from two studies suggested that family therapy was superior to individual therapy for adolescents with a shorter duration of illness. For adults with AN, there was tentative evidence that CBT reduces relapse risk after weight restoration. However, there was no evidence to support the superiority of CBT over other approaches in the acutely underweight state.

Bulimia nervosa

SUMMARY OF EVIDENCE

There is Level II evidence for family therapy and self-help (primarily CBT-based) in the treatment of bulimia nervosa (BN) in adolescents. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. For the treatment of bulimia nervosa in children, no recent studies were found.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

ADOLESCENTS

TITLE OF PAPER	***A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa***
AUTHORS AND JOURNAL	Le Grange, D., Crosby, R. D., Rathouz, P. J., & Leventhal, B. L. (2007). *Archives of General Psychiatry, 64,* 1049-1056.
DESIGN	RCT pilot study (2 groups) including 6-month follow up
PARTICIPANTS	80 adolescents diagnosed with BN or partial BN
INTERVENTIONS	Family therapy
COMPARISON GROUPS	Supportive psychotherapy
PROCEDURE	Participants were randomly assigned to receive 20 sessions over 6 months of either family-based therapy or supportive psychotherapy.
FINDINGS	Slightly more family-based therapy participants abstained from binging and purging compared with supportive psychotherapy. At the 6-month follow up, fewer participants in both groups remained abstinent; however, a greater proportion of those participating in family-based therapy remained abstinent.

ADOLESCENTS

TITLE OF PAPER — ***A randomized controlled trial of family therapy and cognitive behaviour therapy guided self-care for adolescents with bulimia nervosa and related disorders***

AUTHORS AND JOURNAL — Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., et al. (2007). *American Journal of Psychiatry, 164,* 591-598.

DESIGN — RCT (2 groups) including 12-month follow up

PARTICIPANTS — 85 adolescents diagnosed with BN or EDNOS

INTERVENTIONS — Family therapy

COMPARISON GROUPS — Self-help with minimal therapist contact

PROCEDURE — Participants were randomly allocated to receive 13 sessions of family therapy plus two individual sessions over a 6-month period or to receive 10 weekly sessions of CBT-guided self care, three monthly follow up sessions, and two optional individual sessions with a close other. The family therapy intervention was adapted from the Maudsley model. The CBT-guided self care intervention used a manual and workbook previously tested with adults with BN.

FINDINGS — At 6 months, those in the CBT-guided self care were significantly more likely to be abstinent from bingeing than those in the family therapy group. However, these differences had disappeared by the 12 month follow up.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

ADOLESCENTS

TITLE OF PAPER — ***A randomized controlled trial of family therapy and cognitive behaviour therapy guided self-care for adolescents with bulimia nervosa and related disorders***

AUTHORS AND JOURNAL — Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., et al. (2007). *American Journal of Psychiatry, 164,* 591-598.

DESIGN — RCT (2 groups) including 12-month follow up

PARTICIPANTS — 85 adolescents diagnosed with BN or EDNOS

INTERVENTIONS — Self-help with minimal therapist contact

COMPARISON GROUPS — Family therapy

PROCEDURE — Participants were randomly allocated to receive 13 sessions of family therapy plus two individual sessions over a 6-month period or to receive 10 weekly sessions of CBT-guided self care, three monthly follow up sessions, and two optional individual sessions with a close other. The family therapy intervention was adapted from the Maudsley model. The CBT-guided self care intervention used a manual and workbook previously tested with adults with BN.

FINDINGS — At 6 months, those in the CBT-guided self care were significantly more likely to be abstinent from bingeing than those in the family therapy group. However, these differences had disappeared by the 12 month follow up.

TITLE OF PAPER	***Cognitive-behavioural therapy for adolescents with bulimic symptomology: The acceptability and effectiveness of internet-based delivery***
AUTHORS AND JOURNAL	Pretorius, N., Arcelus, J., Beecham, J., Dawson, H., Doherty, F., Eislerg, I., et al. (2009). *Behaviour Research and Therapy, 47,* 729-736.
DESIGN	Case series including 6-month follow up
PARTICIPANTS	101 adolescents with BN or EDNOS
INTERVENTIONS	Self-help with minimal therapist contact
COMPARISON GROUPS	None
PROCEDURE	The web-based intervention consisted of 3 components: eight, 45-minute interactive CBT sessions, peer support via electronic message board, and therapist support via e-mail.
FINDINGS	At the end of treatment, participants showed significant improvements in bingeing and purging behaviour, as well as in global EDI scores. These gains were maintained at the 6-month follow up.

Binge eating

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Adjustment disorder

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Sleep disorders

SUMMARY OF EVIDENCE

There is Level II evidence for cognitive behaviour therapy in the treatment of sleep disorders in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

CHILDREN

TITLE OF PAPER	***A systematic review of treatment of settling problems and night waking in young children***
AUTHORS AND JOURNAL	Ramchandani, P., & Wiggs, L. (2000). *British Medical Journal, 320,* 209-213.
DESIGN	Systematic review (9 studies)
PARTICIPANTS	Children under 5 years with settling problems or night waking
INTERVENTIONS	CBT
COMPARISON GROUPS	Control (waitlist, attention, placebo)
PROCEDURE	Review of pharmacological (4 studies) and CBT-based (5 studies) RCTs investigating sleep difficulties in children without other existing physical or mental health problems. The CBT-based interventions included extinction, scheduled waking, and sleep hygiene education.
FINDINGS	In the short-term, medication was the most effective treatment for night waking, but the long-term efficacy for medication was questionable. In contrast, CBT-based interventions showed both short- and long-term effectiveness for treating settling problems and night waking.

Pain

SUMMARY OF EVIDENCE

There is Level IV evidence for cognitive behaviour therapy in the treatment of pain disorders in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	Development and evaluation of a cognitive-behavioural intervention for juvenile fibromyalgia
AUTHORS AND JOURNAL	Degotardi, P. J., Klass, E. S., Rosenberg, B. S., Fox, D. G., Gallelli, K. A., & Gottlieb, B. S. (2006). *Journal of Pediatric Psychology, 31,* 714-723.
DESIGN	Case series
PARTICIPANTS	67 children and adolescents diagnosed with juvenile primary fibromyalgia syndrome and their parents
INTERVENTIONS	CBT
COMPARISON GROUPS	None
PROCEDURE	Participants underwent an 8-week CBT-based intervention covering four modules: psychoeducation, sleep improvement, pain management, and activities of daily living. Parents also underwent education in the treatment of juvenile fibromyalgia and how to coach their child in applying the CBT strategies.
FINDINGS	Posttreatment, participants reported significant reductions in pain, somatic symptoms, anxiety and fatigue. There were also improvements in functional ability and school attendance.

TITLE OF PAPER	***Is cognitive behavioural therapy for chronic fatigue syndrome also effective for pain symptoms?***
AUTHORS AND JOURNAL	Knoop, H., Stulemeijer, M., Prins, J. B., van der Meer, J. W. M., & Bleijenberg, G. (2007). *Behaviour Research and Therapy, 45,* 2034-2043.
DESIGN	Analysis of data from a previous RCT
PARTICIPANTS	32 adolescents and 96 adults with chronic fatigue syndrome who reported chronic pain symptoms
INTERVENTIONS	CBT
COMPARISON GROUPS	Recovery status
PROCEDURE	Adult participants originally received 16 sessions of CBT over 6-months, and adolescents received 10 sessions over 5 months. In the current study, participants were divided into two groups: recovered or non-recovered, depending on their posttreatment fatigue severity score.
FINDINGS	Recovered chronic fatigue participants (both adults and adolescents) reported a significant reduction in pain severity compared to non-recovered participants. They also reported fewer pain locations following CBT treatment.

Chronic fatigue

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy in the treatment of chronic fatigue syndrome in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

ADOLESCENTS

TITLE OF PAPER	***Efficacy of cognitive behavioural therapy for adolescents with chronic fatigue syndrome: Long-term follow-up of a randomised, controlled trial***
AUTHORS AND JOURNAL	Knoop, H., Stulemeijer, M., de Jong, L. W. A. M., Fiselier, T. J. W., & Bleijenberg, G. (2008). Pediatrics, 121, e619-e625.
DESIGN	Analysis of 2-year follow-up data, post RCT
PARTICIPANTS	66 adolescents diagnosed with chronic fatigue syndrome
INTERVENTIONS	CBT
COMPARISON GROUPS	Baseline and posttreatment outcome data
PROCEDURE	Participants in an RCT, including those who received CBT after the waiting period, were contacted for follow up assessment. The mean follow up period was 2.1 years.
FINDINGS	Of the 66 adolescents that were contacted after participating in the original RCT, 50 had received CBT, either during the initial study or following the waiting period. The positive effects of CBT (including less fatigue and functional impairment) were sustained for two years after treatment end.

ADOLESCENTS

TITLE OF PAPER	***Family-focused cognitive behaviour therapy versus psycho-education for chronic fatigue syndrome in 11- to 18-year-olds: A randomized controlled treatment trial***
AUTHORS AND JOURNAL	Chalder, T., Deary, V., Husain, K., & Walwyn, R. *Psychological Medicine 2009*. DOI:10.1017/S003329170999153X.
DESIGN	RCT (2 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	63 adolescents with chronic fatigue syndrome
INTERVENTIONS	CBT
COMPARISON GROUPS	Psychoeducation
PROCEDURE	Participants were randomly assigned to either family-focused CBT or psychoeducation over a 6-month period. The CBT intervention consisted of 13 hourly sessions, offered every two weeks. Particular emphasis was placed on working collaboratively with all family members. Psychoeducation consisted of 4 sessions over 6 months.
FINDINGS	At the 6-month follow up, there were no statistical differences between the two groups on the primary measure (school attendance) or any of the secondary measures (fatigue, functioning); however those in the family-focused CBT group reported greater levels of satisfaction. Those in the family-focused CBT group returned to school more quickly than those in the psychoeducation group; however, the increased school attendance in the CBT group at treatment completion had decreased significantly at the 12-month follow up.

COMBINED ADULTS, ADOLESCENTS & CHILDREN

TITLE OF PAPER	***Interventions for the treatment, management and rehabilitation of patients with chronic fatigue syndrome/myalgic encephalyelitis: An updated systematic review***
AUTHORS AND JOURNAL	Chambers, D., Bagnall, A., Hempel, S., & Forbes, C. (2006). *Journal of the Royal Society of Medicine, 99,* 506-520.
DESIGN	Systematic review (70 studies)
PARTICIPANTS	Adults and children with chronic fatigue syndrome or myalgic encephalyelitis
INTERVENTIONS	CBT
COMPARISON GROUPS	Not defined
PROCEDURE	Update of a previous review of all RCTs or CCTs investigating interventions used in the treatment, management or rehabilitation of people with chronic fatigue syndrome or myalgic encephalyelitis. Fifteen new studies were included in the update. Of the behavioural studies included in the review, all were CBT interventions.
FINDINGS	The original review indicated the efficacy of CBT. Further support for CBT comes from a recent good quality RCT with children and adolescents. CBT was associated with a significant positive effect on fatigue, symptoms, physical functioning and school attendance.

PSYCHOEDUCATION

ADOLESCENTS

TITLE OF PAPER	***Family-focused cognitive behaviour therapy versus psycho-education for chronic fatigue syndrome in 11- to 18-year-olds: A randomized controlled treatment trial***
AUTHORS AND JOURNAL	Chalder, T., Deary, V., Husain, K., & Walwyn, R. *Psychological Medicine 2009*. DOI:10.1017/S003329170999153X.
DESIGN	RCT (2 groups) including 3-, 6- and 12-month follow up
PARTICIPANTS	63 adolescents with chronic fatigue syndrome
INTERVENTIONS	Psychoeducation
COMPARISON GROUPS	CBT
PROCEDURE	Participants were randomly assigned to either family-focused CBT or psychoeducation over a 6-month period. The CBT intervention consisted of 13 hourly sessions, offered every two weeks. Particular emphasis was placed on working collaboratively with all family members. Psychoeducation consisted of 4 sessions over 6 months.
FINDINGS	At the 6-month follow up, there were no statistical differences between the two groups on the primary measure (school attendance) or any of the secondary measures (fatigue, functioning); however those in the family-focused CBT group reported greater levels of satisfaction. Those in the family-focused CBT group returned to school more quickly than those in the psychoeducation group; however, the increased school attendance in the CBT group at treatment completion had decreased significantly at the 12-month follow up.

Somatisation

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

SOMATOFORM DISORDERS

Hypochondriasis

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

SOMATOFORM DISORDERS

Body dysmorphic

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Psychotic disorders

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Dissociative disorders

SUMMARY OF EVIDENCE

In the current review, no recent studies were found to indicate the effectiveness of any interventions for this disorder.

Attention deficit & hyperactivity

SUMMARY OF EVIDENCE

Level I evidence was found for cognitive behaviour therapy in the treatment of attention deficit hyperactivity disorder (ADHD) in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOURAL THERAPY (CBT)

TITLE OF PAPER	***A meta-analysis of behavioural treatments for attention-deficit/hyperactivity disorder***
AUTHORS AND JOURNAL	Fabiano, G. A., Pelham, W. E., Coles, E. K., Gnagy, E. M., Chronis-Tuscano, A., & O'Connor, B. (2009). *Clinical Psychology Review, 29,* 129-140.
DESIGN	Meta-analysis (174 studies)
PARTICIPANTS	2094 children and adolescents diagnosed with ADHD
INTERVENTIONS	CBT
COMPARISON GROUPS	No treatment, pre-post comparisons
PROCEDURE	Meta-analysis of published and unpublished studies (between-group and within-group designs) investigating behavioural therapies (e.g., parent training, classroom behaviour modification) for the treatment of childhood ADHD.
FINDINGS	Behavioural treatments produced large effect sizes and were highly effective. Interventions implemented in home, school, and peer settings improved the functioning of children with ADHD.

CHILDREN

TITLE OF PAPER	***Efficacy of methylphenidate, psychosocial treatments and their combination in school-aged children with ADHD: A meta-analysis***
AUTHORS AND JOURNAL	Van der Oord, S., Prins, P. J. M., Oosterlaan, J., & Emmelkamp, P. M. G. (2008). *Clinical Psychology Review, 28,* 783-800.
DESIGN	Meta-analysis (26 studies)
PARTICIPANTS	Children with a diagnosis of ADHD
INTERVENTIONS	CBT plus pharmacotherapy
COMPARISON GROUPS	Pharmacotherapy
PROCEDURE	Meta-analysis of published RCTs comparing of the treatment efficacy of pharmacotherapy, psychosocial treatments and their combination on ADHD.
FINDINGS	Pharmacotherapy and CBT were both effective in reducing ADHD symptoms. CBT alone resulted in smaller improvements compared to methylphenidate alone or in combination with CBT.

CHILDREN

TITLE OF PAPER	***Psychosocial treatment for preschool-aged children with Attention-Deficit Hyperactivity Disorder***
AUTHORS AND JOURNAL	LaForett, D. R., Murray, D. W., & Kollins, S. H. (2008). *Developmental Disabilities Research Reviews, 14,* 300-310.
DESIGN	Literature review
PARTICIPANTS	Preschool-aged children with ADHD symptoms
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Review of the literature on psychosocial treatments (parent-training approaches, classroom management strategies, and multimodal treatments) for ADHD in preschool children.
FINDINGS	Parent-training interventions had the strongest evidence for improving behavioural outcomes. In addition, programs that were individually delivered, developmentally appropriate, and multimodal (multiple interventions in multiple settings) were the most effective treatment for preschoolers with ADHD.

TITLE OF PAPER	***Efficacy of the Incredible Years Programme as an early intervention for children with conduct problems and ADHD: Long-term follow-up***
AUTHORS AND JOURNAL	Jones, K., Daley, D., Hutchings, J., Bywater, T., & Eames, C. (2008). *Child: Care, Health and Development, 34,* 380-390.
DESIGN	Follow up of previous RCT
PARTICIPANTS	50 preschool-aged children with co-occurring ADHD and conduct problems, whose parents had received the intervention
INTERVENTIONS	CBT
COMPARISON GROUPS	None
PROCEDURE	Examination of the long-term efficacy of the *Incredible Years Parenting Programme*, a behaviourally-based training program for parents of children with ADHD. Child ADHD symptoms were assessed at baseline and at 3 follow-up time points: 6-, 12- and 18-months. At each data collection point, participating families were visited at their home on two occasions within a 3-day interval.
FINDINGS	Significant improvements in ADHD symptoms were observed at 6 months and were maintained over time, with no significant differences found for ADHD symptoms across each follow up.

Conduct and oppositional defiant

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy in the treatment of conduct disorder and oppositional defiant disorder in adolescents and children, and for family therapy in the treatment of children. One study provided Level IV evidence for dialectical behaviour therapy in the treatment of oppositional defiant disorder in adolescents. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF PAPER	***Evidence-based psychosocial treatments for children and adolescents with disruptive behavior***
AUTHORS AND JOURNAL	Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). *Journal of Clinical Child and Adolescent Psychology, 37,* 215-237.
DESIGN	Systematic review (28 studies)
PARTICIPANTS	Children and adolescents with disruptive behaviour as the primary disorder
INTERVENTIONS	CBT, family therapy
COMPARISON GROUPS	Control (waitlist, no treatment, placebo, minimal contact), TAU (community services), problem-solving skills
PROCEDURE	Review of studies conducted between 1996 and 2007 investigating disruptive behaviour in children and adolescents to identify well-conducted studies in order to evaluate treatment effectiveness. This review updates a previous review conducted in 1998 by Brestan and Eyberg. Of 28 studies, 16 evidence-based treatments (EBTs) were identified. Of these, 15 met the Chambless and Hollon (1998) criteria for a 'probably efficacious' treatment and one met criteria for a 'well-established' treatment. All the studies indentified met Nathan and Gorman's (2002) classification as either Type 1 or Type 2 studies.
FINDINGS	No single intervention emerged as superior for disruptive behaviours. However, parent-training was recommended as the first line approach for younger children and the combination of parent and child-training was recommended for older children. For adolescents, multisystemic therapy (a combination of CBT, family therapy and pharmacotherapy) has an evidence base.

CHILDREN

TITLE OF PAPER	***Treatment of oppositional defiant and conduct problems in young Norwegian children: Results of a randomised controlled trial***
AUTHORS AND JOURNAL	Larsson, B., Fossum, S., Clifford, G., Drugli, M. B., Handegard, B. H., & Morch, W. (2009). *European Child and Adolescent Psychiatry, 18,* 42-52.
DESIGN	RCT (3 groups) including 1-year follow-up
PARTICIPANTS	127 children with oppositional defiant disorder or conduct problems
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Children and their parents were randomised into one of three conditions: parent training alone, parent training plus child therapy (two components of the skills-based *Incredible Years* program designed to reduce behavioural problems in children) or a waitlist control. Parent training comprised 12-14 weekly 2.5 hour sessions. Child therapy comprised 18 weekly 2-hour group sessions.
FINDINGS	In comparison to the control condition, both interventions resulted in significant improvements in conduct problems, aggressive behaviours, and parental practices, and a reduction in parental stress. There were no significant differences between the two treatment conditions.

CHILDREN

TITLE OF PAPER	***Evaluation of a targeted cognitive-behavioral program for children with conduct problems – the SNAP under 12 outreach project: Service intensity, age and gender effects on short- and long-term outcomes***
AUTHORS AND JOURNAL	Koegl, C. J., Farrington, D. P., Day, D. M. (2008). *Clinical Child Psychology and Psychiatry, 13,* 419-434.
DESIGN	Program evaluation (RCT methodology)
PARTICIPANTS	80 highly delinquent, clinic-referred children under 12 years
INTERVENTIONS	CBT
COMPARISON GROUPS	Waitlist control
PROCEDURE	Evaluation of a 12-week cognitive-behavioural self-control and problem-solving outreach program called SNAP (Stop Now and Plan). Of the 80 participants referred to SNAP, 30 participated in the initial RCT (16 received an intense version of SNAP and 14 attended a non-recreation group). Data from an additional 50 participants who received SNAP between 1985 and 1996 were included as a matched group. The evaluation therefore included three groups – two from the original study: control and experimental, plus a matched group.
FINDINGS	Significant within-group changes were evident for the experimental and matched groups on measures of delinquent and aggressive behaviour. Effects were larger for girls and older children.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

ADOLESCENTS – GROUP

TITLE OF PAPER	***A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings***
AUTHORS AND JOURNAL	Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T., et al. (2006). *Behaviour Research and Therapy, 44,* 1811-1820.
DESIGN	Case series
PARTICIPANTS	32 young adolescents diagnosed with oppositional defiant disorder
INTERVENTIONS	DBT
COMPARISON GROUPS	None
PROCEDURE	A modified skills training component of DBT was implemented in a 2-hour group therapy format over 16 weeks. The program comprised introductory information, core mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance. Homework exercises were included.
FINDINGS	At posttreatment caregivers reported a decrease in negative behaviours and an increase in positive behaviours. The adolescents themselves reported a significant reduction in internalising symptoms and depression.

FAMILY THERAPY AND FAMILY-BASED INTERVENTIONS

TITLE OF PAPER	***Evidence-based psychosocial treatments for children and adolescents with disruptive behavior***
AUTHORS AND JOURNAL	Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). *Journal of Clinical Child and Adolescent Psychology, 37,* 215-237.
DESIGN	Systematic review (28 studies)
PARTICIPANTS	Children and adolescents with disruptive behaviour as the primary disorder
INTERVENTIONS	Family therapy, CBT
COMPARISON GROUPS	Control (waitlist, no treatment, placebo, minimal contact), TAU (community services), problem-solving skills
PROCEDURE	Review of studies conducted between 1996 and 2007 investigating disruptive behaviour in children and adolescents to identify well-conducted studies in order to evaluate treatment effectiveness. This review updates a previous review conducted in 1998 by Brestan and Eyberg. Of 28 studies, 16 evidence-based treatments (EBTs) were identified. Of these, 15 met the Chambless and Hollon (1998) criteria for a 'probably efficacious' treatment and one met criteria for a 'well-established' treatment. All the studies indentified met Nathan and Gorman's (2002) classification as either Type 1 or Type 2 studies.
FINDINGS	No single intervention emerged as superior for disruptive behaviours. However, parent-training was recommended as the first line approach for younger children and the combination of parent and child-training was recommended for older children. For adolescents, multisystemic therapy (a combination of CBT, family therapy and pharmacotherapy) has an evidence base.

TITLE OF PAPER	***Multisystemic treatment: A meta-analysis of outcome studies***
AUTHORS AND JOURNAL	Curtis, M. M., Ronan, K. R., & Borduin, C. M. (2004). *Journal of Family Psychology, 18,* 411 – 419.
DESIGN	Meta-analysis (11 studies)
PARTICIPANTS	708 adolescents or their parents/caregivers manifesting antisocial behaviour and/or psychiatric symptoms
INTERVENTIONS	Family therapy
COMPARISON GROUPS	Individual therapy, parent training, TAU (not defined)
PROCEDURE	Meta-analysis of published articles identifying the treatment approach as multisystemic and documenting adherence to multisystemic treatment principles. Both primary and secondary studies were included in the analysis.
FINDINGS	Outcomes for multisystemic treatment were significantly better for 70% of adolescents and their families when compared to those receiving alternative treatment. Follow-up data suggest that the positive effects were sustained for up to four years.

Enuresis

SUMMARY OF EVIDENCE

There is Level I evidence for cognitive behaviour therapy and Level II evidence for self help (primarily CBT-based) in the treatment of enuresis in adolescents and children. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

ADOLESCENTS & CHILDREN

TITLE OF PAPER	***Alarm interventions for nocturnal enuresis in children***
AUTHORS AND JOURNAL	Glazener, C. M. A., Evans, J. H. C., & Peto, R. E. *The Cochrane Database of Systematic Reviews 2005*, Issue 2. DOI: 10.1002/14651858.CD002911.pub2.
DESIGN	Systematic review (53 studies)
PARTICIPANTS	3257 children and adolescents (16 years and under) suffering from nocturnal enuresis
INTERVENTIONS	CBT (alarm interventions)
COMPARISON GROUPS	No treatment/waitlist control, behavioural interventions (e.g., reward systems, retention control training), pharmacotherapy
PROCEDURE	Review of randomised or quasi-randomised trials that investigated the effectiveness of enuresis alarms, behavioural and pharmacological interventions for the treatment of nocturnal enuresis in adolescents and children.
FINDINGS	Alarm interventions were more efficacious than waitlist control or no treatment, both during treatment and in terms of continuing success rates after treatment was finished. There was insufficient evidence to suggest a difference between alarms and behavioural interventions due to the small number of trials. Limited evidence suggests that relapse rates decrease when overlearning or dry bed training (both being types of behavioural interventions) were used in conjunction with alarm treatment. Drug treatment alone is unlikely to be followed by sustained improvement.

ADOLESCENTS & CHILDREN

TITLE OF PAPER	***Complex behavioural and educational interventions for nocturnal enuresis in children***
AUTHORS AND JOURNAL	Glazener, C. M. A., Evans, J. H. C., & Peto, R. E. *The Cochrane Database of Systematic Reviews 2004,* Issue 1. DOI: 10.1002/14651858.CD004668.
DESIGN	Systematic review (18 studies)
PARTICIPANTS	1174 children and adolescents (16 years and under) suffering from nocturnal enuresis
INTERVENTIONS	CBT (behavioural interventions)
COMPARISON GROUPS	No treatment/waitlist control, with and without alarms, alternative interventions
PROCEDURE	Review of randomised or quasi-randomised trials (18 trials) that investigated the effectiveness of complex behavioural interventions, (e.g., dry-bed training), and educational interventions (e.g., teaching about enuresis or its management) for the treatment of nocturnal enuresis in adolescents and children.
FINDINGS	Complex interventions used with an alarm treatment were more effective than a no-treatment control in treating nocturnal enuresis. There was insufficient evidence to assess the effectiveness of educational interventions; however, there was some evidence to suggest that direct contact between therapist and family enhanced the effectiveness of complex behavioural interventions.

CHILDREN

TITLE OF PAPER	***Empirically supported treatments in paediatric psychology: Nocturnal enuresis***
AUTHORS AND JOURNAL	Mellon, M. W., & McGrath, M. L. (2000). *Journal of Paediatric Psychology, 25,* 193 – 214.
DESIGN	Systematic review (14 studies)
PARTICIPANTS	Children suffering from nocturnal enuresis
INTERVENTIONS	CBT, hypnotherapy
COMPARISON GROUPS	Alternative active treatments including pharmacotherapy
PROCEDURE	Review of the medical and psychological literature investigating treatments for nocturnal enuresis. Studies reviewed were divided into four groups: studies based on the behavioural principles of classical conditioning and operant learning, selected psychological treatments (including hypnosis), studies of component analysis or process variables, or treatments emphasising the utility of biobehavioural aspects
FINDINGS	The use of the urine alarm was found to be an essential component of treating simple nocturnal enuresis, and an approach that incorporates the urine alarm with desmopressin is the most effective intervention for night time enuresis. Findings also suggest that interventions that focus on improving compliance, such as hypnotherapy, show promising results; however, further well-controlled research is needed.

CHILDREN

TITLE OF PAPER	***The short- and long-term effects of simple behavioural interventions for nocturnal enuresis in young children: A randomised controlled trial***
AUTHORS AND JOURNAL	van Dommelen, P., Kamphuis, M., van Leerdam, F. J., de Wilde, J. A., Rijpstra, A., Campagne, A. E., et al. (2009). *Journal of Pediatrics, 154,* 662-666.
DESIGN	RCT (4 groups) including 3-year follow-up
PARTICIPANTS	570 children (aged 4 to 5 years) diagnosed with mono-symptomatic nocturnal enuresis
INTERVENTIONS	CBT
COMPARISON GROUPS	No treatment control
PROCEDURE	Participants were assigned to one of four conditions: waking child, asking for a password then carrying child to toilet, same as group 1 but without password, reward system (e.g., star chart), or no treatment. Parents were required to keep a daily diary. Treatment finished after 14 consecutive dry nights or at 6-months.
FINDINGS	Reward systems with or without carrying the child to the toilet were associated with fewer failing or relapsing children than no treatment; however, the second condition was the only one that resulted in significantly more dry children than the control. At the 3-year follow up, both carrying groups had the highest (78%) and the control the lowest (69%) percentage of dry children.

CHILDREN

TITLE OF PAPER	***The effects of a contingency contracting program on the nocturnal enuresis of three children***
AUTHORS AND JOURNAL	Stover, A. C., Dunlap, G., & Neff, B. (2008). *Research on Social Work Practice, 18,* 421-428.
DESIGN	Case studies including 3-month follow up
PARTICIPANTS	3 children diagnosed with nocturnal enuresis
INTERVENTIONS	CBT
COMPARISON GROUPS	None
PROCEDURE	The program lasted 16-18 weeks. Contingency contracts, which outlined expected behaviour and reinforcement consequences, were made between caregiver and child on a weekly basis and were reviewed daily after the child awoke. Praise and a sticker or tick were given for contract compliance. The contract was reviewed at the end of the week to determine if the reinforcer had been earned.
FINDINGS	Within seven weeks of treatment, each child went for multiple full weeks without bedwetting. At the 3-month follow-up none of the children was wetting the bed.

SELF-HELP – PURE SELF-HELP AND SELF-HELP WITH MINIMAL THERAPIST CONTACT

CHILDREN

TITLE OF PAPER	***Relapse rate and subsequent parental reaction after successful treatment of children suffering from nocturnal enuresis: A 2½ year follow-up of bibliotherapy***
AUTHORS AND JOURNAL	van Londen, A., van Londen-Barentsen, M. W. M., van Son, M. J. M., & Mulder, G. A. L. A. (1995). *Behavioural Research & Therapy, 33,* 309 – 311.
DESIGN	Analysis of 2.5 year follow-up data, post RCT
PARTICIPANTS	113 children suffering from nocturnal enuresis, whose parents ordered a urine alarm device
INTERVENTIONS	Pure self-help (alarm intervention with parent/child training manual)
COMPARISON GROUPS	Reward/punishment with no alarm intervention, alarm intervention with no child training or reward/punishment
PROCEDURE	Participants were randomly assigned to one of three groups, alarm invention with parent/child training manual (including reward system), reward/punishment system only, or alarm intervention with no reward/punishment.
FINDINGS	The alarm intervention was found to be the most effective at 20 weeks and at the 2.5-year follow up, but the relapse rate was high. However, parents in the treatment condition were more likely to re-implement the treatment at relapse compared to parents in the control conditions who looked for alternatives, including less efficacious alternatives.

HYPNOTHERAPY

CHILDREN

TITLE OF PAPER	***Empirically supported treatments in paediatric psychology: Nocturnal enuresis***
AUTHORS AND JOURNAL	Mellon, M. W., & McGrath, M. L. (2000). *Journal of Paediatric Psychology, 25,* 193 – 214.
DESIGN	Systematic review (14 studies)
PARTICIPANTS	Children suffering from nocturnal enuresis
INTERVENTIONS	Hypnotherapy, CBT
COMPARISON GROUPS	Alternative active treatments including pharmacotherapy (desmopressin)
PROCEDURE	Review of the medical and psychological literature investigating treatments for nocturnal enuresis. Studies reviewed were divided into four groups: studies based on the behavioural principles of classical conditioning and operant learning, selected psychological treatments (including hypnosis), studies of component analysis or process variables, or treatments emphasising the utility of biobehavioural aspects
FINDINGS	The use of the urine alarm was found to be an essential component of treating simple nocturnal enuresis, and an approach that incorporates the urine alarm with desmopressin is the most effective intervention for night time enuresis. Findings also suggest that interventions that focus on improving compliance, such as hypnotherapy, show promising results; however, further well-controlled research is needed.