Evidence-based Psychological Interventions in the Treatment of Mental Disorders

A Review of the Literature

FOURTH EDITION
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APS Australian Psychological Society

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Abbreviations

ABBT	Acceptance-based behaviour therapy
ACT	Acceptance and commitment therapy
ADHD	Attention deficit hyperactivity disorder
BDD	Body dysmorphic disorder
BED	Binge eating disorder
BMI	Body mass index
BPD	Borderline personality disorder
CAT	Cognitive analytic therapy
CBGT	Cognitive behavioural group therapy
CBT	Cognitive behaviour therapy
CRT	Cognitive remediation therapy
DBT	Dialectical behaviour therapy
DDP	Dynamic deconstructive psychotherapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDNOS	Eating disorder not otherwise specified
EFT	Emotion-focused therapy
EMDR	Eye movement desensitisation and reprocessing
ERP	Exposure response prevention
FI	Family intervention
FPT	Focal psychodynamic therapy
GAD	Generalised anxiety disorder
ICD	International Classification of Diseases
IPSRT	Interpersonal and social rhythm therapy
IPT	Interpersonal therapy
IUT	Intolerance of uncertainty therapy
MAGT	Mindfulness and acceptance based group therapy
MANTRA	Maudsley Anorexia Nervosa Treatment for Adults
MBCT	Mindfulness-based cognitive therapy
MBRP	Mindfulness-based relapse prevention
MBSR	Mindfulness-based stress reduction
MCT	Metacognitive therapy
MDFT	Multidimensional family therapy
MET	Motivational enhancement therapy
MFGP	Multifamily group psychoeducation
MI	Motivational interviewing
MST	Multisystemic family-focused therapy
NOS	Not otherwise specified
OCD	Obsessive compulsive disorder
PCT-A	Panic control treatment for adolescents
PHN	Primary Health Networks
PST	Problem-solving therapy
PTSD	Posttraumatic stress disorder
RCT	Randomised controlled/clinical trial
SAD	Social anxiety disorder
SFBT	Solution-focused brief therapy
SFT	Solution-focused therapy
SSRI	Selective serotonin reuptake inhibitors
TAU	Treatment as usual

Review of the Research Literature

BACKGROUND

This document is a systematic review undertaken to update the APS document *Evidence-Based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* (3rd edition). This review was first conducted in 2003 in the context of the Australian government's *Better Outcomes in Mental Health Care* initiative. It was updated in 2006 and again in 2010 with consideration of the introduction of primary healthcare services through the Access to *Allied Psychological Services* (ATAPS) and *Better Outcomes to Mental Health Care* initiative.

The current update takes into account the 2016 Australian government changes to the delivery of primary mental health care services in Australia that aim to make mental health services more accessible and to target groups in the community that are most in need. The latest changes have included major developments that impact on the structure and approaches used in the provision of mental health services, including the establishment of primary health networks (PHNs), replacing Medicare locals as the local coordinating healthcare organisations, along with a suite of mental-health reforms. These reforms include undertaking regional needs assessment and tailoring services to local needs, delivering services within a stepped care approach, making optimal use of digital mental health services, and targeting priority groups such as Aboriginal and Torres Strait Islander people, children and youth, and clinical care coordination for severe and complex mental illness.[1]

PURPOSE AND LIMITATIONS OF THE REVIEW

There is now sufficient evidence to demonstrate that psychological interventions are both effective and cost-effective in the treatment of mental disorders and that these interventions contribute more broadly to the community and the economy through a reduction in need for access to health services generally and increased functioning and employability.[2]

This review is intended to provide the latest evidence about a range of psychological interventions for the treatment of mental disorders to assist in decision making about optimal mental health treatment. This should support the work of the PHNs as well as mental health professionals providing psychological interventions under *Better Access* and other government-funded mental health initiatives.

Information is provided as part of a narrative review with an expert synthesis of the research findings and conclusions, including identification of key limitations. The review does not contain a comprehensive critique of the research undertaken, and readers seeking a detailed understanding of the research methodology and findings should access the source articles.

DISORDERS INCLUDED IN REVIEW[3]

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

Dissociative disorders

[1] For information about the Australian government reforms and guidance on the priority areas, see http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

[2] Levin, C., & Chisholm, D. (2016). Cost-effectiveness and affordability of interventions, policies, and platforms for the prevention and treatment of mental, neurological, and substance use disorders. In V. Patel, D. Chisholm, T. Dua, R. Laxminarayan, & M. E. Medina-Mora (Eds.), *Mental, neurological, and substance use disorders: Disease control priorities* (3rd ed., Vol. 4, pp. 219–236). Washington DC: World Bank.

[3] As directed by the Australian Government, disorders included are based on the International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Chapter V Primary Care Version, excluding dementia, delirium, tobacco use disorder, and mental retardation, with the addition of borderline personality disorder.

Sleep disorders

Sexual disorders

Somatoform disorders

- Pain disorder
- Somatisation disorder
- Hypochondriasis
- Body dysmorphic disorder

Psychotic disorders

Borderline personality disorder

Attention deficit hyperactivity disorder

Conduct disorder (child)

Enuresis (child)

INTERVENTIONS INCLUDED IN THE REVIEW

Health professionals have an obligation to provide services that have an evidence base. Further, most government-funded initiatives demand that psychologists and other mental health professionals working in the primary sector deliver effective, short-term therapies as the most cost-effective approach to psychological intervention. On this basis, this review included a broad range of psychological interventions selected through direction from government and identification of interventions with a large or increasing evidence base. This has led to the inclusion of two interventions not previously reviewed: eye movement desensitisation and reprocessing, and play therapy. In addition, in line with the government's mental health reforms, there was a focus on interventions that use digital approaches.

It should be noted that although the review includes a broad range of interventions, these are not all approved for use in government programs. For example, the Medicare Benefits Schedule specifies that only cognitive behaviour therapy and interpersonal therapy (and narrative therapy for Aboriginal and Torres Strait Islander people) are eligible interventions under the *Better Access to Mental Health Care* initiative. Health professionals providing services under specific government-funded programs should ensure that the intervention selected meets the requirements for service provision under the program.

The following psychological interventions are included in the current review:

- Acceptance and commitment therapy (ACT)
- Cognitive behaviour therapy (CBT)
- Dialectical behaviour therapy (DBT)
- Emotion-focused therapy (EFT)
- Eye movement desensitisation and reprocessing (EMDR)
- Family therapy and family-based interventions
- Hypnotherapy
- Interpersonal psychotherapy (IPT)
- Mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR)
- Narrative therapy
- Play therapy (children)
- Psychodynamic psychotherapy
- Psychoeducation
- Schema-focused therapy
- Self-help
- Solution-focused brief therapy (SFBT)

Acceptance and commitment therapy

Acceptance and commitment therapy (ACT) is based on a contextual theory of language and cognition known as relational frame theory. It makes use of a number of therapeutic strategies, many of which are borrowed from other approaches, including CBT. However, ACT focuses on the context and function of psychological experiences (e.g., thoughts, feelings, and sensations) as the target of interventions, rather than on the actual form or frequency of particular symptoms. In ACT, 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 not 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 connect with their experiences fully and without defence while moving toward valued goals. ACT also helps individuals to identify their values and translate them into specific behavioural goals.[4]

Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. The clinician works with individuals to 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 dysfunctional thoughts with more helpful cognitions, which leads to an alleviation of problem thoughts, emotions, and behaviour. In this review, metacognitive therapy has been included as part of CBT. Skills training (e.g., stress management, social skills training, parent training, and anger management) is another important component of CBT.[5]

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT) is designed to serve five functions: enhance capabilities, increase motivation, enhance generalisation to the natural environment, structure the environment, and improve clinician 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 clinician. 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 to integrate the skills learnt into real-life situations. The fourth mode of therapy is team consultation, which is designed to support clinicians working with difficult clients.[6]

Emotion-focused therapy

Emotion-focused therapy (EFT) 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.[7]

[4] Ruiz, F. J. (2012). Acceptance and commitment therapy versus traditional cognitive behavioral therapy: A systematic review and meta analysis of current empirical evidence. *International Journal of Psychology & Psychological Therapy, 12,* 333–357.

[5] Hofmann, S. G., Asu Asnaani, M. A., Imke, J. J., Vonk, M. A., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy Research, 36,* 427–440.

[6] Yeomans, F. E., Levy, K. N., & Meehan, K. B. (April, 2012). Treatment approaches for borderline personality disorder. *Psychiatric Times, 29,* 42–46.

[7] Johnson, S. M., Burgess Moser, M., Beckes, L., Smith, A., Dalgleish, T., Halchuk, R., … Coan, J. A. (2013). Soothing the threatened brain: Leveraging contact comfort with emotionally focused therapy. *PLoS ONE, 8*(11), e79314. https://doi.org/10.1371/journal.pone.0079314

Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) is a treatment developed by Francine Shapiro to assist clients exposed to traumatic events. The technique uses bilateral stimulation, right/left eye movement, or tactile stimulation, that is said to activate cognitive processes to release emotional experiences that are "trapped" or buried. Although EMDR may be used for different mental health problems, it has been primarily used in trauma therapy. During an EMDR session the clinician helps the client to revisit the traumatic event(s) and connect with the associated thoughts, feelings, and sensations. While doing this the clinician holds a finger about 45 centimetres from the client's face and moves the finger back and forth asking the client to track the movement with his or her eyes. While the client is tracking the movement and recalling the specific traumatic event the clinician works to move the client to more positive thoughts, hence helping him or her to resolve the negative and distressing feelings associated with the event.[8]

Family interventions

In this review, family interventions (including behavioural parent-training interventions) are defined as interventions that explicitly focus on altering interactions between or among family members in order to improve the functioning of the family as a unit, its subsystems, and/or the functioning of the individual members of the family. This framework includes formal family therapy work such as systemic family therapy that views the presenting problem(s) as patterns or systems that need changing and adjusting, rather than viewing problems as residing in a particular person.[9]

Hypnotherapy

Hypnotherapy involves the use of hypnosis, a procedure during which the clinician 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.[10]

Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) 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.[11]

Mindfulness-based cognitive therapy and mindfulness-based stress reduction

Mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) are treatments that emphasise mindfulness meditation as the primary therapeutic technique. MBCT and MBSR are used to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT and MBSR, the emphasis is on changing the relationship to thoughts, rather than challenging them. The aim is to raise awareness at a metacognitive level so that an individual can fully experience cognitions and emotions that pass through the mind that may or may not be based on reality. The goal is not to change the dysfunctional thoughts but to experience them as being real in the present time and separate from the self.[12]

[8] Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal, 18*(1), 71–77.
[9] Hontoria Tuerk, E., McCart, M. R., & Henggeler, S. W. (2012). Collaboration in family therapy. *Journal of Clinical Psychology, 68,* 168–178.
[10] Izquierdo de Santiago, A. & Khan, M. (2009). Hypnosis for schizophrenia. *Cochrane Database of Systematic Reviews 2007*(4). CD004160.pub3. doi:10.1002/14651858
[11] Jakobsen, J. C., Hansen, J. L., Simonsen, S., Simonsen, E., & Gluud, C. (2012). Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: A systematic review of randomized clinical trials with meta-analyses and trial sequential analyses. *Psychological Medicine, 42,* 1343–1357.
[12] Kahl, G. K., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: What is new and what is effective? *Current Opinion Psychiatry, 25,* 522–528.

Narrative therapy

Narrative therapy has been identified as a mode of working of particular value to Aboriginal and Torres Strait Islander people because 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 clinician 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.[13]

Play therapy (for children)

Play therapy uses children's play to engage children in therapy and provide them with age-appropriate language and context to communicate with the clinician. Clinicians trained in play therapy use a systematic approach to identify patterns and themes in a child's play. The clinician's skill is to think analytically about all that is happening in the session, including picking up on verbal and nonverbal cues as well as information that the child communicates symbolically through the use of toys, drawings, and other play activities. In play therapy the clinician must use the play in a skilled way tailored to the child's presentation. For example, the clinician may decide to use games that facilitate discussion in particular areas or may consider that free play is preferable.[14]

Psychodynamic psychotherapy

Short-term psychodynamic psychotherapy is a brief, focal, transference-based therapeutic approach that helps individuals by exploring and working through specific intrapsychic and interpersonal conflicts. It is characterised by the exploration of a focus that can be identified by both the clinician and the individual. This consists of material from current and past interpersonal and intrapsychic conflicts and interpretation through a process in which the clinician 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 intrapsychic structures. Confrontation, clarification, and interpretation are major elements, as well as the clinician's actions in ensuring an alliance when working in the therapeutic relationship to attain conflict resolution and greater self-awareness.[15]

Psychoeducation

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, consequences, and implications of the problem. Information is also provided about medications, prognosis, and alleviating and aggravating variables, as well as early signs of relapse and how these signs 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 fulfilling lives.[16]

Schema-focused therapy

Schema-focused therapy emphasises identifying and changing maladaptive schemas and the associated ineffective coping strategies. Schemas are psychological constructs that include beliefs that people have about themselves, the world, and other people, and that are the product of how their 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 an environment created 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.[12]

[13] Etchison, M., & Kleist, D. M. (2000). Review of narrative therapy research and utility. *The Family Journal: Counseling and Therapy for Couples and Families, 8*(1), 61–66.
[14] Homeyer, L. E., & Morrison, M. O. (2008). Play therapy: Practice, issues, and trends. *American Journal of Play, 1,* 210–228.
[15] Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98–109.
[16] Saito-Tanji, Y., Tsujimoto, E., Taketani, R., Yamamoto, A., & Ono, H. (2016). Effectiveness of simple individual psychoeducation for bipolar II disorder. *Case Reports in Psychiatry, 2016,* 6062801. http://dx.doi.org/10.1155/2016/6062801

Self-help – Pure self-help and self-help with minimal therapist contact

Self-help therapy (also known as bibliotherapy) is used as either 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 clinician (guided self-help), whereas others do not (pure self-help).

Solution-focused brief therapy

Solution-focused brief therapy (SFBT) is a brief resource-oriented and goal-focused therapeutic approach that helps individuals change by constructing solutions. It aims to increase optimism and positive expectancies along with the experience of positive emotions to improve outcomes. SFBT includes using specific techniques such as miracle and scaling questions to draw on clients' strengths and resources to create new meaning for clients that provides a more positive future outlook.[17]

[17] Franklin, C., Zhang, A., Froerer, A., & Johnson, S. (2016). Solution focused brief therapy: A systematic review and meta-summary of process research. *Journal of Marital and Family Therapy, 43*(1), 16–30.

Establishing an Evidence Base

Reviews of research literature to guide best practice in clinical application require a systematic evaluation process. In this review, we evaluate the latest research using evidence ratings from the Australian government's National Health and Medical Research Council (NHMRC).[18]

The NHMRC is Australia's peak body for health and medical research and has adopted a comprehensive and systematic approach known as the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach to evaluation as part of the development of Australian clinical guidelines. In this literature review, we do not aim to undertake a systematic analysis of available research or develop clinical guidelines. Rather, our aim in this document is to report on the outcomes of research findings.

The full GRADE approach has therefore not been adopted. Within this review, the NHMRC evidence hierarchy, which evaluates the probability that a study design can answer the research question being posed, has been adopted. The NHMRC evidence hierarchy is provided in Section 2.1.

The allocation of a level of evidence based on this hierarchy can assist mental health professionals in decision making when considering the effectiveness of an intervention based on the level of support for its use in latest research evidence. As a consequence, use of a level provides a way to quantify the evidence and direct health professionals in what is considered best practice when treating particular mental health disorders.

NHMRC LEVELS OF EVIDENCE

Level I	A meta-analysis or a systematic review of level II studies that included a quantitative analysis
Level II	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among consecutive persons with a defined clinical presentation
Level III-1	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)
Level III-2	A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study • Interrupted time series with a control group
Level III-3	A comparative study without concurrent controls: • Historical control study • Two or more single arm study • Interrupted time series without a parallel control group
Level IV	Case series with either posttest or pretest/posttest outcomes

Source: NHMRC additional levels of evidence and grades for recommendations for developers of guidelines

[18] National Health and Medical Research Council. (2009). *NHMRC additional levels of evidence and grades for recommendations for developers of guidelines.* Retrieved from www.nhmrc.gov.au/_files_nhmrc/file/guidelines/developers/nhmrc_levels_grades_evidence_120423.pdf

OTHER FACTORS THAT IMPACT ON RESEARCH EVIDENCE

As well as considering the level of evidence assigned to research studies, the NHMRC cautions that this is not sufficient for making treatment recommendations. The quality, relevance, and strength of the evidence must be considered. In summarising the research studies evaluated in this review, where possible, information about the strengths, limitations, and quality of the research was noted. However, as already indicated, systematic analysis of studies was not within the purview of this document.

In preparing this review it is acknowledged that there may be many variables at play in an individual's treatment that may not be captured in traditional research approaches using a randomised controlled trial (RCT). Although the RCT has long been considered the gold standard for evaluating the effectiveness of interventions, increasingly research designs or research questions may not lend themselves to investigation using an RCT. There may, for example, be aspects of an individual's presentation or the treatment conditions that make it impossible to undertake randomisation or to eliminate bias even with the adoption of the most rigorous research methodology.[19]

Much has been written about the importance of the therapeutic relationship, the clinician's training and experience, and the client's attitudes, preferences, and adherence to treatment. Health professionals must use their professional judgement in determining the most appropriate intervention approach based on the best available evidence along with the relevant client and contextual factors.

Finally, evidence is available only where rigorous investigation has been undertaken. The absence of evidence does not therefore necessarily equate to an intervention being ineffective.

[19] West, S. G., Duan, N., Pequegnat, W., Gaist, P., Des Jarlais, D. C., Holtgrave, D., … Mullen, P. D. (2008). Alternatives to the randomised controlled trial. *American Journal of Public Health, 98,* 1359–1366.

Methodology

PUBLICATION SOURCES

Only comprehensive electronic databases were used for sourcing literature. These were:

- 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)
- Psychology and Behavioural Sciences Collection
- SocINDEX
- National Library of Medicine (US)

In addition, high quality clinical guidelines were included if they met the selection criteria, including those from the following 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)
- American Psychological Association (www.apa.org)

SELECTION OF ARTICLES

The review includes literature that had been peer reviewed and published in scientific journals or as part of a clinical guideline after 2010. Where multiple articles with the same level of evidence were identified, we selected the most recent and robust article. Where no studies were identified that met criteria that could be aligned against one of the NHMRC levels of evidence, or where studies after 2010 did not provide additional information relevant to specific populations (e.g., older adults or refugees) or a specific context (e.g., inpatient settings), the information provided in the third edition of this review was retained as the latest research. If no available research studies existed for a particular intervention in the treatment of a specific disorder that is made clear in the section summary.

Where there was uncertainty regarding the inclusion of articles, this was discussed at team meetings that were held on a weekly basis from March to November 2017.

No unpublished studies or grey literature[20] were included in this review.

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

Meta-analytical studies and systematic reviews

A meta-analysis is a formal quantitative study designed to systematically assess high quality research studies (usually RCTs) in order to make a determination about the findings of a body of research (two or more high quality RCTs). 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 subgroup.

A systematic review is a literature review focused on a particular question to identify, evaluate, and synthesise all relevant high quality research (usually RCTs). The quality of studies included in a systematic review is carefully considered on the basis of predefined criteria. Systematic reviews can vary in the extent to which they are used to evaluate, analyse, and synthesise research studies. For the purposes of the current review, systematic reviews were included only if they involved some form of methodological and analytical evaluation of the research studies.

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

Randomised controlled trials

A randomised controlled trial (RCT) is an experimental study in which empirical and measurable data are gathered and analysed to answer a research question. Unlike research conducted in a naturalistic setting, in experimental studies it is possible to implement strategies that aim to control potential confounding variables. 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 enable comparisons. The primary purpose of randomisation is to create groups as similar as possible, with the intervention being the differentiating variable.

Pseudorandomised controlled trials

Some studies may mimic RCTs but the participants are not allocated to treatment and control groups through pure randomisation methods. These types of studies are called pseudorandomised controlled trials because group allocation is conducted in a nonrandom way using methods such as alternate allocation, allocation by day of week, or odd-even study numbers.

Nonrandomised controlled trials

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

Comparative studies

An investigation involving statistical analyses that is based on 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.

Case series

In a case series study, all participants receive the intervention, and its effectiveness is evaluated by comparing measures taken at baseline (the beginning of treatment) with measures taken at the end of treatment.

ADDITIONAL CRITERIA GUIDING SELECTION OF ARTICLES

The following criteria also impacted on the selection of research studies included in this review. Some of these criteria were put in place as a result of the scope of the project commissioned by the Australian government (e.g., selection of disorders and interventions), the time frame in which the task was to be undertaken, and the need to provide the information in a concise and accessible form.

- Adult studies were included in this review if participants in the studies were identified as having a clear diagnosis of one of the disorders listed on page 5. Studies reporting on subclinical populations were excluded. In preparing this review, we acknowledge that there can be a reluctance to provide a diagnosis for children and adolescents, particularly in the case of young children. Therefore, for the child and adolescent sections the criteria for study inclusion was broadened to include published studies that involved children and adolescents presenting with clinical symptoms of a disorder, rather than requiring a formal diagnosis to have been determined.

- In reviewing the child and adolescent research, a child was defined as being up to 12 years of age and an adolescent as being between 13 and 18 years.

- In the child and adolescent studies, family members are often involved in the treatment, even where this is not specifically determined to be family therapy. Family interventions were included only if it was clear that either family therapy or family-based therapy was being provided.

ALLOCATING A LEVEL OF EVIDENCE

Following selection and review of articles, the six levels defined by the NHMRC were applied to identify the strength of the evidence base for particular interventions. In addition to the levels, where relevant, the strengths and limitations of the methodology used in the research were highlighted.

The most robust level of evidence was selected to be incorporated into the review. Once the highest level of evidence was identified, articles that were categorised as having a lower level of evidence were included only if they provided additional information not captured in the article selected as reflecting the highest evidence level.

Presentation of the Literature

The research evidence has been provided in two sections. The first section contains the research for interventions addressing mental disorders in adults, and the second section contains the findings for children and adolescents. Within both of these sections, research evidence for each disorder is presented. Each subsection begins with a synopsis outlining the key findings for that subsection. This is followed by a summary table of the research study identified as providing the highest level of evidence for each psychological intervention investigated for the disorder covered in the subsection. In some instances, such as where one high-level study is clearly identified, or in the case of low-prevalence studies where little formal research may have been conducted, there may be as few as one, or at times, no interventions identified that meet selection criteria. Where no studies meeting criteria for a specific intervention or disorder could be identified, this was made clear in the synopsis at the beginning of the subsection.

In reporting the findings for a specific intervention and disorder, the most robust evidence is presented first, regardless of the year of publication. Where the same level of evidence was assigned to more than one intervention, these interventions are listed in alphabetical order. The review provides only a snapshot of each study, focusing primarily on providing a brief summary of the method and key findings. For more comprehensive information about the study, its findings, and conclusions, the full research article should be sourced.

In updating this review and aligning with government priority areas, there has been expansion of the review to include reference to clinician type, identification of studies using e-therapy approaches, and identification of studies that have involved investigation of psychological interventions for specific population groups, including Aboriginal and Torres Strait Islander and cross-cultural populations.

In some cases for the child and adolescent disorders, no research studies that met our criteria were identified for specific disorders and those disorders are therefore not represented in the body of the review. They are:

- Adjustment disorder
- Somatisation disorder
- Hypochondriasis
- Dissociative disorder

In addition, no evidence that met our criteria was found to support the use of narrative therapy for any disorder across adults, adolescents, or children.

REPORTING OF INDIVIDUAL STUDIES

Each study is presented in the following framework:

- Title, author(s), and source
- Design (e.g., meta-analysis)
- Whether follow-up data were collected
- Format (e.g., individual, group, online)
- Participant information
- Clinician type
- Intervention(s)
- Comparison group(s)
- Procedure
- Results and conclusions

Where studies included multiple interventions or disorders and therefore have relevance to different sections within the review, they appear only once and, where relevant, reference is made back to the original summary of the study.

FRONT-END SUMMARY TABLES

Along with the detailed sections, two summary tables have been prepared to communicate the research evidence in a concise way. These are provided as a front-end summary of the findings, and appear on the following pages.

ADULTS	Level I	Level II	Level III	Level IV
Adjustment disorder	-	Psychodynamic	CBT (Level III-2)	-
Anxiety disorders				
Generalised anxiety disorder	CBT	Online CBT(G+UG), ACT, Online ACT(G), MBCT, MBSR, MCT, Psychodynamic therapy, Online Psychodynamic therapy(G), Psychoeducation (group)	-	-
Obsessive compulsive disorder	CBT (ERP), Online CBT(G), Computer-based ERP (G)	ACT, FI, MBCT, MCT	-	-
Panic disorder	CBT	Online CBT(G+UG), ACT, Psychodynamic therapy	-	MBCT
Posttraumatic stress disorder	CBT (trauma-focused), EMDR	DBT, EFT, MCT, MBSR	-	-
Social anxiety disorder	CBT, Online CBT	ACT, IPT, MBSR, Psychodynamic therapy	-	-
Specific phobia	CBT (exposure)	Computer-based exposure (G+UG), Virtual reality-based exposure (G+UG)	-	-
Attention deficit hyperactivity disorder	CBT	Online CBT(G+UG), DBT, MCT, MBCT, Psychoeducation	-	-
Borderline personality disorder	DBT, Psychodynamic therapy, Schema therapy	ACT, CBT, IPT, Psychoeducation	-	MBCT
Dissociative disorders	-	-	-	Psychodynamic therapy
Eating disorders				
Anorexia nervosa	-	CBT (eating-disorder focused), Online CBT, FI, Psychodynamic therapy	-	DBT
Binge eating disorder	CBT	Online CBT(G), Bibliotherapy (G), DBT, IPT, MBSR, Psychoeducation	EFT (Level III-3)	ACT
Bulimia nervosa	CBT	Online CBT(G), Bibliotherapy, DBT	IPT (Level III-3)	Psychoeducation
Mood disorders				
Bipolar disorder	CBT	FI, MBCT, Psychoeducation	-	IPSRT
Depression	CBT, Online CBT(G+UG), IPT, MBCT, PST, Psychodynamic therapy, Psychoeducation	ACT, Online ACT(G), DBT, EFT, EMDR, FI, Online PST(G), Schema therapy, SFT	-	MCT
Psychotic disorders	CBT, FI, Psychoeducation	ACT, MCT	Psychodynamic therapy (Level III-2)	-
Sexual disorders	CBT (including systematic desensitisation)	IPT, Psychoeducation	MBCT (Level III-2)	-
Sleep disorders	CBT, Online CBT (G+UG), MBSR	-	-	-
Somatoform disorders				
Body dysmorphic disorder	CBT	Online CBT(G), MCT	-	ACT
Hypochondriasis	CBT, Psychoeducation	Online CBT (G+UG), ACT, Bibliotherapy, MBCT	-	MCT
Pain disorder	-	ACT, Online ACT(G), CBT	-	-
Somatisation disorder	-	CBT	-	-
Substance use disorders	CBT (including motivational interviewing)	ACT, DBT, FI, Mindfulness-based relapse prevention, Psychodynamic therapy	-	IPT, Psychoeducation

ACT: Acceptance and commitment therapy
CBT: Cognitive behaviour therapy
CAT: Cognitive analytic therapy
CRT: Cognitive remediation therapy
DBT: Dialectical behaviour therapy
EFT: Emotion-focused therapy
EMDR: Eye movement desensitisation and reprocessing
ERP: Exposure and response prevention
FI: Family intervention
IPSRT: Interpersonal and social rhythm therapy
IPT: Interpersonal psychotherapy
MBCT: Mindfulness-based cognitive therapy
MBSR: Mindfulness-based stress reduction
MCT: Metacognitive therapy
PST: Problem-solving therapy
SFT: Solution-focused therapy
G: Guided; **UG**: Unguided

CHILDREN AND ADOLESCENTS	Level I	Level II	Level III	Level IV
Adjustment disorder	-	-	-	-
Anxiety disorders				
Generalised anxiety disorder	-	CBT (7–17 years)	-	-
Obsessive compulsive disorder	CBT (3–18 years)	Online CBT(G) (12–17 years)	-	-
Panic disorder	-	CBT (panic control treatment; 11–17 years)	-	-
Posttraumatic stress disorder	CBT (3–18 years)	CBT (trauma-focused, 3–17 years), EMDR (8–18 years)	-	-
Social anxiety disorder	CBT (8–17 years)	Online CBT(G) (8–17 years)	-	-
Specific phobia	-	CBT (7–17 years), Psychoeducation (7–17 years)	-	-
Attention deficit hyperactivity disorder	Behavioural therapy (6–18 years), FI (3–15 years)	Play-based therapy (5–11 years), Psychoeducation (3–20 years)	-	-
Borderline personality disorder	-	-	CAT (15–18 years; Level III-3)	DBT (13–19 years), Psychodynamic therapy (14–19 years)
Conduct disorder	CBT (2–17 years), FI (2–17 years)	FI (11–18 years), Online FI (2–9 years), Psychodynamic (12–19 years)	-	-
Dissociative disorders	-	-	-	-
Eating disorders				
Anorexia nervosa	FI (12–18 years)	-	-	CBT (13–17 years)
Binge eating disorder	-	CBT (12–18 years)	-	-
Bulimia nervosa	FI (12–18 years)	CBT, Psychodynamic therapy (14–18 years)	-	-
Enuresis	Behaviour therapy (alarm therapy, 3–16 years, Standard uropathy, 5–18 years)	Behaviour therapy (simple therapy, 4–5 years)	-	-
Mood disorders				
Bipolar disorder	-	CBT (7–13 years), FI (9–17 years), Psychoeducation (8–12 years)	-	-
Depression	CBT (12–18 years), Online CBT (adolescents), IPT (12–18 years)	CBT (7–12 years)	IPT (preadolescent)-	-
Psychotic disorders	-	CRT (12–18 years), FI (12–18 years)	-	-
Sleep disorders	Behaviour therapy (0–5 years)	CBT (7–19 years), Online CBT (12–19 years), MBCT (12–17 years)	-	-
Somatoform disorders				
Body dysmorphic disorder	-	CBT (12–18 years)	-	-
Hypochondriasis	-	-	-	-
Pain disorder	CBT (6–18 years)	ACT (10–14 years), Hypnotherapy (5–18 years)	-	-
Somatisation disorder	-	-	-	-
Substance use disorders	FI (12–18 years)	Group CBT (12–18 years)	-	-

ACT: Acceptance and commitment therapy
CBT: Cognitive behaviour therapy
CAT: Cognitive analytic therapy
CRT: Cognitive remediation therapy
DBT: Dialectical behaviour therapy
EFT: Emotion-focused therapy
EMDR: Eye movement desensitisation and reprocessing
ERP: Exposure and response prevention
FI: Family intervention
IPSRT: Interpersonal and social rhythm therapy
IPT: Interpersonal psychotherapy
MBCT: Mindfulness-based cognitive therapy
MBSR: Mindfulness-based stress reduction
MCT: Metacognitive therapy
PST: Problem-solving therapy
SFT: Solution-focused therapy
G: Guided; **UG:** Unguided

DEPRESSION

SUMMARY OF EVIDENCE

There is Level I evidence for CBT and online CBT (clinician-guided and unguided), interpersonal therapy, mindfulness-based cognitive therapy, problem-solving therapy, psychodynamic therapy, and psychoeducation in the treatment of depression in adults. There is Level II evidence for acceptance and commitment therapy and online acceptance and commitment therapy (with minimal clinician support), dialectical behaviour therapy, emotion-focused therapy, eye movement desensitisation and reprocessing (based on one study with a small sample size), family interventions (specifically family psychoeducation based on one study with a small sample size), online problem-solving therapy (clinician-guided), schema therapy (based on one RCT) and solution-focused therapy (also based on one RCT) in the treatment of depression in adults. Level IV evidence was found for metacognitive therapy, but this is based on only one small case series study. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with the most recently available RANZCP guidelines for mood disorders.[21] The guidelines indicate that treatment effects for a range of well-established interventions such as CBT and interpersonal therapy are similar across many acute subpopulations of depressed patients (e.g., older, postpartum, inpatient, and primary-care people) and treatment modalities, with some benefits for individual versus group delivery and for supported versus unsupported online interventions. Some studies have indicated that psychological interventions such as CBT may be as effective as pharmacological treatments for reducing mild to moderate depression provided the treating clinician is appropriately experienced and trained. Particularly for individuals with more persistent or severe depressive symptoms, clinical guidelines recommend a combined treatment approach of antidepressants with psychological therapy, which has been shown to be more effective than either approach alone.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Comparative effectiveness of psychological treatments for depressive disorders in primary care: Network meta-analysis***
AUTHOR(S) AND SOURCE	Linde, K., Rücker, G., Sigterman, K., Jamil, S., Meissner, K., Schneider, A., & Kriston, L. (2015). *Family Practice, 16,* 103. doi:10.1186/s12875-015-0314-x
DESIGN	Meta-analysis (37 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Individual, online, (clinician-guided and unguided), telephone
PARTICIPANTS	7,024 adults diagnosed with a depressive disorder in the acute phase of a depressive episode. The mean ages of participants ranged from 30 to 81 years, and an average of 73% were female.
TREATING CLINICIAN(S)	Psychologist (the majority of studies), therapist (not defined), physician, nurse, counsellor, psychiatrist, social worker
INTERVENTION(S)	CBT, problem solving therapy, interpersonal therapy, psychodynamic therapy.
COMPARISON GROUP(S)	Pharmacotherapy, TAU, placebo treatment, alternative psychological intervention
PROCEDURE	Meta-analysis of RCTs up to December 2013 investigating the relative efficacy of psychological interventions for the treatment of depressive disorders in adults. Across studies, participants received between six and 16 therapy sessions, with a median treatment length of 12 weeks (range 6 to 26 weeks).
SUMMARY OF FINDINGS	For the main treatment outcome of response to treatment, face-to-face CBT, remotely-delivered (e.g., telephone) CBT, and no or minimal clinician contact CBT were found to be significantly more effective than TAU or placebo. Furthermore, remote clinician-led, guided self-help and no or minimal contact CBT had treatment effects similar to face-to-face CBT.

[21] Malhi, G. S., Bassett, D., Boyce, P., Bryant, R., Fitzgerald, P. B., Fritz, K., … Porter, R. (2015). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Australian & New Zealand Journal of Psychiatry, 49,* 1087–1206.

TITLE OF ITEM	***Efficacy and acceptability of group cognitive behavioral therapy for depression: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Okumura, Y., & Ichikura, K. (2014). *Journal of Affective Disorders, 164,* 155–164.
DESIGN	Systematic review and meta-analysis (35 studies)
FOLLOW-UP	Not reported
FORMAT	Group
PARTICIPANTS	3,356 adults diagnosed with depression or with elevated depressive symptoms. In 23 studies, participants' initial depression severity was moderate to severe. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Nonactive controls (e.g., TAU, waitlist, pill placebo), low-intensity psychosocial interventions (e.g., computerised CBT, guided self-help, physical activity programs), middle-intensity group-based psychosocial interventions (e.g., relaxation training), high-intensity psychosocial interventions (e.g., individual CBT, IPT, behavioural activation, nondirective counselling)
PROCEDURE	Review of RCTs published between 1994 and 2013 on the efficacy and acceptability of group CBT for patients with depression compared with four intensity levels of psychosocial interventions: nonactive, low-intensity, middle-intensity, and high-intensity interventions. Across studies, the median number of sessions was 12 and the median length of session was 90 minutes. Group sizes ranged from 7–10 people per group. Most of the group sessions were run weekly.
SUMMARY OF FINDINGS	A medium effect size in favour of group CBT was found compared with nonactive controls. There was insufficient evidence to determine whether group CBT was more efficacious compared with low- or high-intensity interventions due to the limited number of RCTs comparing these conditions; however, an earlier meta-analysis demonstrated an additional treatment advantage of individual CBT relative to group CBT.

TITLE OF ITEM	***Brief psychotherapy for depression: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Nieuwsma, J. A., Trivedi, R. B., McDuffie, J., Kronish, I., Benjamin, D., & Williams, J. W. (2012). *International Journal of Psychiatry in Medicine, 43*(2), 129–151.
DESIGN	Systematic review and meta-analysis (15 studies, six on CBT)
FOLLOW-UP	8 to 52 weeks
FORMAT	Individual, group
PARTICIPANTS	Across the six CBT studies, 713 adults with major depressive disorder, dysthymic disorder, or minor depression in acute-phase treatment. The mean ages of participants ranged from 34.5 to 74 years, and an average of 72.7% were female.
TREATING CLINICIAN(S)	Psychologist, CBT clinician, graduate students
INTERVENTION(S)	CBT (six studies), problem-solving therapy (eight studies), MBCT (one study)
COMPARISON GROUP(S)	TAU, telephone case management, minimal contact, waitlist.
PROCEDURE	Systematic review and meta-analysis of published RCTs between January 2000 and August 2010 to determine the efficacy of brief (≤ eight sessions) evidence-based psychotherapies for depression. Participants received an average of eight sessions of mostly individually-delivered CBT. Sessions were mostly weekly or fortnightly.
SUMMARY OF FINDINGS	A medium effect size was found in favour of CBT for the acute-phase treatment of depression compared with pooled control conditions. This is comparable to studies of antidepressants and standard duration psychotherapies for depression (with the exception of moderate to severe depression where a greater number of sessions has been shown to be more effective than fewer).

TITLE OF ITEM	***Internet- and mobile-based depression interventions for people with diagnosed depression: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Königbauer, J., Letsch, J., Doebler, P., Ebert, D., & Baumeister, H. (2017). *Journal of Affective Disorders, 223,* 28–40.
DESIGN	Systematic review and meta-analysis (19 studies)
FOLLOW-UP	Nil to 3 years
FORMAT	Online and mobile-based (clinician guided or unguided)
PARTICIPANTS	Adults diagnosed with depression. The mean age of participants was 41.4 years, and 70% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, attention or psychological placebo (e.g., online psychoeducation, discussion group, self-help booklet)
PROCEDURE	Systematic review and meta-analysis of RCTs published up to June 2016 investigating the effectiveness of internet- and mobile-based interventions for adults with depression. Treatment lasted a mean of 8.7 weeks (range 4 to 12 weeks) and comprised a mean of 9.4 treatment modules. Where clinician support was provided, clinicians provided a mean of 94 minutes of support per participant. An average of 80% of treatment modules were completed.
SUMMARY OF FINDINGS	A large effect size in favour of CBT-based internet and mobile interventions was found on depressive symptoms compared with waitlist control. Comparisons could not be made between internet and mobile interventions and attention/psychological placebo. Baseline to posttreatment within-group effects ranged from medium to large, with effects remaining large at follow-up.

TITLE OF ITEM	***Computer-based psychological treatments for depression: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Richards, D., & Richardson, T. (2012). *Clinical Psychology Review, 32,* 329–342
DESIGN	Systematic review (40 studies) and meta-analysis (19 studies)
FOLLOW-UP	Not reported
FORMAT	Online (clinician guided or unguided)
PARTICIPANTS	10,499 adults diagnosed with depression or who demonstrated self-reported depressive symptoms. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	For the clinician-assisted interventions, therapists (details not reported), trainee therapists, other health professionals, nonclinical staff
INTERVENTION(S)	CBT-based psychological interventions
COMPARISON GROUP(S)	Waitlist control, TAU
PROCEDURE	Systematic review and meta-analysis of RCTs published between March 2001 and March 2011 on the overall effectiveness of computer-based psychological treatments for depression, and an examination of the impact of support types on drop-out rate and retention. All but one study investigated CBT-based programs consisting of between four and 12 online modules.
SUMMARY OF FINDINGS	Computer-based interventions were significantly more effective than were control conditions at reducing depressive symptoms with large effect sizes, with the largest treatment effects demonstrated for clinician-guided interventions. Studies with no support had considerably higher levels of dropout compared with studies with administrative support and clinician guidance, with clinician guided therapy demonstrating the lowest levels of dropout.

TITLE OF ITEM	***Group metacognitive therapy for severe antidepressant and CBT resistant depression: A baseline-controlled trial***
AUTHOR(S) AND SOURCE	Papageorgiou, C., & Wells, A. (2015). *Cognitive Therapy and Research, 39,* 14–22.
DESIGN	Case series
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	Ten adults with treatment-resistant major depressive disorder on antidepressant medication who had failed to respond fully to at least two previous trials of antidepressant medication and at least 12 sessions of CBT. The mean age of the sample was 41.7 years, and eight participants were female.
TREATING CLINICIAN(S)	Clinical psychologist
INTERVENTION(S)	Group metacognitive therapy (*n* = 10)
COMPARISON GROUP(S)	No-treatment baseline period
PROCEDURE	Participants waited between 2 and 7 weeks in a no-treatment baseline monitoring period before commencing treatment. The MCT intervention comprised 12 x 2-hour weekly group sessions and two booster sessions between posttreatment and follow-up.
SUMMARY OF FINDINGS	Metacognitive therapy was associated with significant improvements across all outcomes including depression, with treatment gains maintained at 6-month follow-up. Analyses of recovery rates showed that 70% of participants were classified as recovered and 20% as improved at both posttreatment and follow-up. During the baseline period, depressive symptoms were relatively stable with changes occurring only after the introduction of the group MCT intervention.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Interpersonal psychotherapy for depression: A meta-analysis***
AUTHOR(S) AND SOURCE	Cuijpers, P., Geraedts, A. S., van Oppen, P., Andersson, G., Markowitz, J. C., & van Straten, A. (2011). *American Journal of Psychiatry, 168,* 581–592.
DESIGN	Meta-analysis (38 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Individual, group
PARTICIPANTS	4,356 adults and adolescents with a depressive disorder or elevated level of depressive symptoms. In 29 studies, participants met diagnostic criteria, and only six studies included adolescent samples. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal psychotherapy (IPT)
COMPARISON GROUP(S)	Waitlist, TAU, placebo, alternative psychological intervention, pharmacotherapy, combined IPT, and pharmacotherapy.
PROCEDURE	Meta-analysis of RCTs published up to January 2010 investigating the efficacy of IPT for the treatment of depression. Most studies were individually delivered, and participants received a mean of 13.4 treatment sessions (range six to 24).
SUMMARY OF FINDINGS	A medium effect size in favour of IPT was found for depressive symptoms compared with standard treatment or no treatment. Separate meta-analyses comparing IPT with alternative psychological interventions, and combination therapy with IPT alone, did not yield significant treatment effects.

TITLE OF ITEM	***Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: A systematic review of randomized clinical trials with meta-analyses and trial sequential analyses***
AUTHOR(S) AND SOURCE	Jakobsen, J. C., Hansen, J. L., Simonsen, S., Simonsen, E., & Gluud, C. (2012). *Psychological Medicine, 42,* 1343–1357.
DESIGN	Systematic review and meta-analysis (seven studies)
FOLLOW-UP	One study reported a 9-month follow-up period.
FORMAT	Individual, group, combined individual and group
PARTICIPANTS	741 adults diagnosed with major depressive disorder. The mean ages of participants ranged from 30.6 to 42.7 years, and in all studies over half were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal psychotherapy (IPT)
COMPARISON GROUP(S)	Cognitive therapy (CT)
PROCEDURE	Systematic review and meta-analysis of RCTs published up to August 2010 assessing the effects of cognitive therapy versus interpersonal psychotherapy in the treatment of major depressive disorder. All studies must have adhered to a treatment manual to be included in the study. The length of the intervention period ranged from eight weekly sessions to 24 weekly sessions.
SUMMARY OF FINDINGS	Results of the systematic review demonstrated comparable results among the intervention groups, with the effect of CT not differing significantly from the effect of IPT on any outcome measure at posttreatment.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***The effect of mindfulness-based cognitive therapy for prevention of relapse in major depressive disorder: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Piet, J., & Hougaard, E. (2011). *Clinical Psychology Review, 31,* 1032–1040.
DESIGN	Systematic review and meta-analysis (six studies)
FOLLOW-UP	14 to 18 months
FORMAT	Group
PARTICIPANTS	593 adults diagnosed with recurrent major depressive disorder (MDD) in remission. The mean age of participants was 46 years, and 74% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBCT
COMPARISON GROUP(S)	TAU, placebo plus clinical management, maintenance antidepressant medication
PROCEDURE	Review of published RCTs until November 2010 to evaluate the effectiveness of MBCT for the prevention of relapse or recurrence among patients with recurrent MDD in remission. The MBCT interventions were conducted according to the treatment manual by Segal et al. (2002)[22] comprising eight x 120–180-minute sessions of group MBCT delivered weekly.
SUMMARY OF FINDINGS	The addition of MBCT to TAU significantly reduced the risk of relapse. Relapse rates were 38% for the MBCT group compared with 58% for TAU and placebo plus clinical management.

[22] Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York, NY: Guilford.

TITLE OF ITEM	***Meta-analysis of group mindfulness-based cognitive therapy for decreasing symptoms of acute depression***
AUTHOR(S) AND SOURCE	Lenz, S., Hall, J., & Smith, L. B. (2016). *The Journal for Specialists in Group Work, 41,* 44–70.
DESIGN	Meta-analysis (31 studies)
FOLLOW-UP	Not reported
FORMAT	Group
PARTICIPANTS	2,352 adults diagnosed with depression. Of the studies that reported gender and age, the mean age of participants was 43.7 years, and 73% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBCT
COMPARISON GROUP(S)	Waitlist control, alternative treatment
PROCEDURE	Meta-analysis of published RCTs from 2000 to 2014 to estimate the treatment effect of MBCT in group format for treating the symptoms of depression, compared with no treatment (waitlist control) or alternative group interventions. The MBCT interventions were conducted according to the treatment manual by Segal et al. (2002), comprising eight x 120–180-minute sessions of group MBCT delivered weekly.
SUMMARY OF FINDINGS	A large treatment effect size was found in favour of MBCT compared with waitlist control. The four studies reporting follow-up data also yielded a large effect size, indicating that treatment outcomes were maintained over time. When compared with alternative group interventions (i.e., group psychoeducation and group CBT), MBCT was significantly more effective at reducing depressive symptoms, with a medium effect size reported. This magnitude of effect was reduced over time to a small treatment effect (using data from seven studies), suggesting that the relative efficacy of MBCT compared with alternative treatments may level out over time.

PROBLEM-SOLVING THERAPY (PST)

TITLE OF ITEM	***Meta-analysis of problem solving therapy for the treatment of major depressive disorder in older adults***
AUTHOR(S) AND SOURCE	Kirkham, J. G., Choi, N., & Seitz, D. P. (2016). *International Journal of Geriatric Psychiatry, 31,* 526–535.
DESIGN	Systematic review (eight studies) and meta-analysis (six studies)
FOLLOW-UP	12 weeks to 6 months
FORMAT	Individual, group
PARTICIPANTS	569 older adults diagnosed with major depressive disorder. The mean age of participants was 74.1 years, and the majority were female (gender data across studies were not reported). Although all but one study excluded adults with dementia, four studies included older adults with some degree of cognitive impairment.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Problem-solving therapy (PST)
COMPARISON GROUP(S)	Waitlist, supportive therapy, TAU
PROCEDURE	Systematic review and meta-analysis of RCTs examining the effectiveness of PST for the treatment of major depressive disorder in older adults. PST was delivered weekly in the majority of included studies and the length of treatment ranged from five to 12 sessions. All but one study was individually-delivered.
SUMMARY OF FINDINGS	Compared with pooled control conditions, there was a significant reduction in mean depression scores for the PST group, with a corresponding large effect size. In studies that included an outcome measure of disability, PST significantly reduced disability compared with pooled controls, with a medium effect size demonstrated. Studies using up to eight sessions of PST demonstrated increased treatment efficacy compared with those using more than eight sessions, where no between-group differences were observed.

TITLE OF ITEM	***Brief psychotherapy for depression: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Nieuwsma, J. A., Trivedi, R. B., McDuffie, J., Kronish, I., Benjamin, D., & Williams, J. W. (2012). *International Journal of Psychiatry in Medicine, 43,* 129–151.
DESIGN	Systematic review and meta-analysis (15 studies, eight on PST)
FOLLOW-UP	6 to 52 weeks
FORMAT	Individual, group
PARTICIPANTS	991 adults diagnosed with major depressive disorder, dysthymic disorder, or minor depression in acute-phase treatment. The mean ages of participants ranged from 34.5 to 74 years, and an average of 72.6% were female.
TREATING CLINICIAN(S)	Psychologists, nurses, allied health professionals, graduate students, psychiatrists, trained GPs, social workers, counsellors
INTERVENTION(S)	Brief problem-solving therapy (eight studies), brief CBT (six studies), MBCT (one study)
COMPARISON GROUP(S)	Placebo, waitlist, TAU, pharmacotherapy alone
PROCEDURE	Systematic review and meta-analysis of published RCTs between January 2000 and August 2010 to determine the efficacy of brief evidence-based psychotherapies for depression. Participants received on average six sessions of brief problem-solving therapy.
SUMMARY OF FINDINGS	Brief PST was found to be efficacious for the acute-phase treatment of depression in primary care compared with pooled control conditions, with a small effect size demonstrated. The relatively few studies included in the review did not allow for comparisons of variables such as depression severity.

TITLE OF ITEM	***Online cognitive behavioral therapy and problem-solving therapy for depressive symptoms: Exploring mechanisms for change***
AUTHOR(S) AND SOURCE	Warmerdam, L., van Straten, A., Jongsma, J., Twisk, J., & Cuijpers, P. (2010). *Journal of Behavior Therapy and Experimental Psychiatry, 41,* 64–70.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Online (clinician guided)
PARTICIPANTS	263 adults with clinically significant depressive symptomatology. The average age of participants was 45 years, and 71% were female.
TREATING CLINICIAN(S)	None
INTERVENTION(S)	PST (*n* = 88), CBT (*n* = 88)
COMPARISON GROUP(S)	Waitlist control (*n* = 87)
PROCEDURE	Participants were randomly assigned to online CBT (eight lessons, one lesson per week with one follow-up lesson at 12 weeks), online PST (5 weeks, one lesson per week), or a waitlist control group. Participants in both intervention groups were supported via email during the intervention period to help them work through the online modules. Supporting clinicians spent on average 20 minutes per week per participant providing feedback and answering questions.
SUMMARY OF FINDINGS	Both interventions were significantly more effective than no intervention at reducing depressive symptoms, with medium effect sizes found posttreatment for both treatment conditions.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update***
AUTHOR(S) AND SOURCE	Driessen, E., Hegelmaier, L. M., Abbass, A. A., Barber, J. P., Dekker, J. J. M., Van, H. L., … Cujpers, P. (2015). *Clinical Psychology Review, 42,* 1–15.
DESIGN	Meta-analysis (54 studies)
FOLLOW-UP	Nil to 4.6 years
FORMAT	Individual, group, online
PARTICIPANTS	3,946 adults diagnosed with major depressive disorder. The mean age of participants across studies in the short-term psychodynamic therapy (STPP) condition was 40.1 years, and 74.7% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	STPP
COMPARISON GROUP(S)	Waitlist control, TAU, antidepressant medication, pill placebo, alternative psychological intervention, nondirective counselling
PROCEDURE	Meta-analysis evaluating the effectiveness of STPP for major depressive disorder. Across studies, participants received on average 17.7 sessions of STPP (range three to 80), and the majority of interventions were individually delivered (43 studies).
SUMMARY OF FINDINGS	Short-term psychodynamic therapy was significantly more effective than was pooled control conditions at posttreatment, with medium effect sizes on measures of depression, general psychopathology, and quality of life. From posttreatment until up to 6-month follow-up, effect sizes for depression and interpersonal functioning were small and not significantly different from immediate-posttreatment measures. Significant anxiety and general psychopathology symptom decreases were noted from posttreatment to 6-month follow-up, with large and small effect sizes respectively. Individual STPP was not found to be significantly different from other therapies at posttreatment or follow-up. However, other therapies were found to be significantly superior to group STPP at posttreatment.

PSYCHOEDUCATION

TITLE OF ITEM	***The effect of psychoeducation for depression: A meta-analysis 2010–2016***
AUTHOR(S) AND SOURCE	Moreno-Lacalle, R. (2016). *The Philippine Journal of Nursing, 86*(2), 36–43.
DESIGN	Meta-analysis (11 studies)
FOLLOW-UP	None
FORMAT	Individual, group, online
PARTICIPANTS	1,560 adults diagnosed with depression. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducation
COMPARISON GROUP(S)	TAU
PROCEDURE	Meta-analysis of RCTs published between 2010 and 2016 investigating the effectiveness of psychoeducation for the treatment of depression. Intervention length ranged from a single session of psychoeducation to 16 sessions delivered over an 8-month period.
SUMMARY OF FINDINGS	At posttreatment, a small treatment effect in favour of psychoeducation was found for depression scores of intervention group members compared with pooled controls. Studies were highly heterogeneous and varied widely in terms of treatment content and delivery method. Studies with longer treatment duration were found to be more effective than were shorter duration interventions.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***A parallel group randomised open blinded evaluation of acceptance and commitment therapy for depression after psychosis: Pilot trial outcomes (ADAPT)***
AUTHOR(S) AND SOURCE	Gumley, A., White, R., Briggs, A., Ford, I., Barry, S., Stewart, C., … McLeod, H. (2017). *Schizophrenia Research, 183,* 143–150.
DESIGN	Pilot RCT
FOLLOW-UP	5 months
FORMAT	Individual
PARTICIPANTS	29 adults meeting diagnostic criteria for both major depression and schizophrenia. The mean age of participants was 46.5 years, and 65.5% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	ACT plus standard care (*n* = 15)
COMPARISON GROUP(S)	Standard care (*n* = 14)
PROCEDURE	Participants were randomly allocated to ACT for depression after psychosis (ACT) plus standard care, or standard care alone. Participants in the intervention group received individual ACT over a 5-month period. Standard care included any TAU (including medication and services from a specialist mental health service). Participants received a mean of 15.4 sessions of therapy.
SUMMARY OF FINDINGS	On one of the two primary outcome measures, a statistically significant treatment effect for depressive symptomatology was found in favour of the ACT group at posttreatment compared with the comparison group(s), but not at follow-up. This equated to a medium between-group effect size.

TITLE OF ITEM	***Acceptance and commitment therapy for depression: A preliminary randomized clinical trial for unemployed on long-term sick leave***
AUTHOR(S) AND SOURCE	Folke, F., Parling, T., & Melin, L. (2012). *Cognitive and Behavioral Practice, 19,* 583–594.
DESIGN	RCT
FOLLOW-UP	18 months
FORMAT	Group
PARTICIPANTS	34 adults diagnosed with depression. The mean age of participants was 43.2 years, and 88.2% were female.
TREATING CLINICIAN(S)	Psychology master's students
INTERVENTION(S)	ACT plus TAU (*n* = 18)
COMPARISON GROUP(S)	TAU (*n* = 16)
PROCEDURE	Participants were randomly allocated to ACT or TAU conditions. Participants in the ACT condition received one 60–90 minute individual therapy session followed by five x 120–180 minute group therapy sessions. Participants in the ACT condition had access to the same care as did those in the comparison group, which may have included access to a general physician.
SUMMARY OF FINDINGS	From baseline to posttreatment, a medium to large treatment effect in favour of the ACT group was found on the primary outcome measure of depression. Medium effect sizes were also demonstrated in favour of ACT on general mental health from baseline to posttreatment and from posttreatment to follow-up.

TITLE OF ITEM	***Internet-based behavioral activation and acceptance-based treatment for depression: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Carlbring, P., Hagglund, M., Luthstro, A., Dahlin, M., Kadowaki, A., Vernmark, K., & Andersson, G. (2013). *Journal of Affective Disorders, 148,* 331–337.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Online (clinician guided)
PARTICIPANTS	80 adults diagnosed with major depression of mild to moderate severity. The mean age of participants was 44.4 years, and 82.5% were female.
TREATING CLINICIAN(S)	Minimal support delivered by clinical psychology students
INTERVENTION(S)	Behavioural activation (BA) and acceptance-based intervention (*n* = 40)
COMPARISON GROUP(S)	Waitlist control (*n* = 40)
PROCEDURE	Participants were randomly allocated to an online ACT and BA program or a waitlist control. The online intervention consisted of seven online modules encompassing both behavioural activation and acceptance-based components with minimal clinician contact, and was delivered over an 8-week period. Participants completed an average of five modules out of the seven.
SUMMARY OF FINDINGS	Participants in the intervention group improved significantly more on measures of depression and anxiety than did the control group. A large between-group effect size was found for depression and a medium effect size for anxiety at posttreatment in favour of the intervention group. Treatment gains from posttreatment to follow-up were maintained. Twenty-five percent of participants reached remission in the intervention group compared with 5% in the control group.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Adaptation of dialectical behavior therapy skills training group for treatment-resistant depression***
AUTHOR(S) AND SOURCE	Harley, R., Sprich, S., Safren, S., Jacobo, M., & Fava, M. (2008). *The Journal of Nervous and Mental Disease, 196,* 136–143.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	24 adult outpatients diagnosed with major depressive disorder with ongoing depressive symptoms despite medication treatment. The mean age of participants was 41.8 years, and 75% were female. The mean depression scores at baseline were in the mild to moderate range.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Dialectical behaviour therapy-based skills training (*n* = 12)
COMPARISON GROUP(S)	Waitlist control (TAU) (*n* = 12)
PROCEDURE	Participants were randomly allocated to DBT-based skills training (a modified version of the original DBT skills intervention for patients with borderline personality disorder) or a waitlist control. The intervention consisted of 16 weekly 90-minute group sessions with weekly homework assignments. A total of 19 participants completed the full 16 weeks of the study.
SUMMARY OF FINDINGS	Although both the intervention and waitlist group demonstrated improvement of depressive symptoms over time, the DBT group demonstrated significantly greater improvement. Effect sizes were large.

EMOTION-FOCUSED THERAPY (EFT)

TITLE OF ITEM	***Telephone-administered psychotherapy for depression***
AUTHOR(S) AND SOURCE	Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Honos-Webb, L., Vella, L., & Tasch, E. T. (2005). *Archives of General Psychiatry, 62,* 1007–1014.
DESIGN	RCT
FOLLOW-UP	3, 6, 9, and 12 months
FORMAT	Telephone
PARTICIPANTS	127 adults diagnosed with depression and with functional impairment due to multiple sclerosis. The mean age of participants was 47.9 years, and 77.2% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	EFT (*n* = 65)
COMPARISON GROUP(S)	CBT (*n* = 62)
PROCEDURE	Participants were randomised to receive weekly 50-minute sessions of telephone-administered supportive EFT or telephone-administered CBT for 16 weeks, according to manualised procedures. All but seven participants of the total sample completed the 16 weeks of treatment.
SUMMARY OF FINDINGS	Treatment gains were significant for both groups, with improvements over the 16 weeks significantly 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.

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR)

TITLE OF ITEM	***Effect of eye movement desensitization and reprocessing (EMDR) on depression in patients with myocardial infarction (MI)***
AUTHOR(S) AND SOURCE	Gauhar, Y. W. M. (2016). *Journal of EMDR Practice and Research, 10*(2), 59–69.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Individual
PARTICIPANTS	26 outpatients with a diagnosis of major depressive disorder who had experienced a stressful life event. The mean age of participants who completed the study was 29.4 years, and the majority were female (10 out of 17 who completed all assessments).
TREATING CLINICIAN(S)	EMDR-certified practitioner with a master's degree in applied psychology
INTERVENTION(S)	EMDR (*n* = 13)
COMPARISON GROUP(S)	Waitlist control (*n* = 13)
PROCEDURE	Participants were randomly assigned to receive one of two groups: EMDR which consisted of six to eight treatment sessions delivered weekly, or a waitlist control group.
SUMMARY OF FINDINGS	Analyses were performed on 17 participants who completed the posttreatment assessment. Participants in the intervention group demonstrated significant within-group pre- to post-treatment improvement on all outcome measures. Large within-group effect sizes were found on measures of depression, quality of life, and trauma symptoms. Large between-group treatment effects were also found for all outcome measures in favour of the intervention group compared with the waitlist group at posttreatment. Treatment effects were maintained for the 10 participants in the intervention group who were assessed at follow-up.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Family psychoeducation for major depression: A randomised controlled trial***
AUTHOR(S) AND SOURCE	Shimazu, K., Shimodera, S., Mino, Y., Nishida, A., Kamimura, N., Sawada, K., … Inoue, S. (2011). *The British Journal of Psychiatry, 198,* 385–390.
DESIGN	RCT
FOLLOW-UP	9 months
FORMAT	Group
PARTICIPANTS	57 adults diagnosed with depression and primary family members. The mean age of participants in the two groups was 59.2 and 60.9 years, respectively, and 55.6% were male.
TREATING CLINICIAN(S)	Two psychiatrists and a clinical psychologist
INTERVENTION(S)	Family psychoeducation plus TAU (*n* = 25)
COMPARISON GROUP(S)	TAU (*n* = 32)
PROCEDURE	Participants were randomly allocated to the family psychoeducation intervention or the control group. The family psychoeducation intervention consisted of four fortnightly courses attended by up to five people, without the participation of the patients. Only one family member per patient attended. TAU consisted of bi-weekly visits to a treating psychiatrist as part of standard outpatient treatment.
SUMMARY OF FINDINGS	All participants allocated to the intervention completed all four sessions. Time to relapse was significantly longer in the intervention group than in the control group. Remission rates at 9-month follow-up were 83% and 33% in the intervention and control groups, respectively, demonstrating a significant between-group difference.

SCHEMA THERAPY

TITLE OF ITEM	***Psychotherapy for depression: A randomised clinical trial comparing schema therapy and cognitive behavior therapy***
AUTHOR(S) AND SOURCE	Carter, J. D., McIntosh, V. V., Jordan, J., Porter, R. J., Frampton, C. M., & Joyce, P. R. (2013). *Journal of Affective Disorders, 151,* 500–505.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	100 outpatients diagnosed with major depression. The mean age of participants was 38 years, and 69% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Schema therapy (*n* = 50)
COMPARISON GROUP(S)	CBT (*n* = 50)
PROCEDURE	Participants were randomised to weekly therapy sessions of schema therapy or CBT for 6 months, followed by monthly sessions for 6 months. Participants in the schema therapy condition received a mean of 18 weekly sessions and 4.3 monthly sessions, and those in the CBT condition received a mean of 15.9 weekly and 3.3 monthly sessions.
SUMMARY OF FINDINGS	No significant differences in outcome measures were found between the two therapies. The two interventions produced similar rates of improvement in terms of treatment response, remission, and recovery.

SOLUTION-FOCUSED THERAPY (SFT)

TITLE OF ITEM	***Randomized trial on the effectiveness of long- and short-term psychotherapy on psychiatric symptoms and working ability during a 5-year follow-up***
AUTHOR(S) AND SOURCE	Knekt, P., Lindfors, O., Sares-Jäske, L., Virtala, E., & Härkänen, T. (2013). *Nordic Journal of Psychiatry, 67,* 59–68.
DESIGN	RCT
FOLLOW-UP	5 years
FORMAT	Individual
PARTICIPANTS	326 adults meeting diagnostic criteria for a mood or anxiety disorder. The majority of participants (84.7%) were diagnosed with a mood disorder. The mean age of participants in the three groups was 31.6, 32.1, and 33.6 years, respectively, and an average of 75.8% were female.
TREATING CLINICIAN(S)	Details not reported
INTERVENTION(S)	SFT (*n* = 97), short-term psychodynamic therapy (SPT) (*n* = 101)
COMPARISON GROUP(S)	Long-term psychodynamic therapy (LPT) (*n* = 128)
PROCEDURE	Participants were randomly allocated to one of three treatment conditions: SFT, SPT, or LPT. Only SFT was manualised. The frequency of SFT sessions was flexible, but was usually one session every second or third week up to a maximum of 12 sessions over an 8-month period. LPT was delivered two to three times per week across a period of approximately three years, and SPT was scheduled for a single 20-minute session per week. The mean length of treatment was 7.5 months, 5.7 months, and 31.3 months in the SFT, SPT, and LPT groups, respectively.
SUMMARY OF FINDINGS	All therapies resulted in significantly reduced depressive symptoms over the course of the study, with the most significant degree of improvement occurring during the first year for those in the SFT and SPT groups. During the first year of follow-up, participants receiving either of the short-term therapies (SFT and SPT) improved more quickly in terms of depressive symptoms than did those receiving long-term therapy. At 3-year follow-up, a stronger treatment effect was found in the long-term therapy group for both depressive and anxiety symptoms compared with SFT and SPT. However, by the final 2 years of the study, the differences in mean depression scores between the long- and short-term therapies were no longer apparent. No significant differences were found between the two short-term therapies on any measure across the 5-year period.

BIPOLAR DISORDER

SUMMARY OF EVIDENCE

Pharmacotherapy is the first-line treatment for bipolar disorder, both during the acute phase and for the prevention of future episodes. However, there is broad agreement that optimal treatment for bipolar disorder involves a combination of pharmacotherapy and adjunctive psychological therapy (Malhi et al., 2015).

There is Level I evidence for CBT in the treatment of bipolar disorder in adults. Level II evidence supports the use of family interventions, mindfulness-based cognitive therapy (based on one RCT and for comorbid anxiety symptoms only), and psychoeducation. Level IV evidence was found for interpersonal and social rhythm therapy (based on three studies with small sample sizes). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are largely in line with the most recently available National Institute for Clinical Excellence guidelines (2014)[23] for bipolar disorder which recommend high intensity psychological interventions (i.e., cognitive behavioural therapy, interpersonal therapy, or behavioural couple therapy).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological interventions for adults with bipolar disorder: Systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S., Morriss, R., … Kendall, T. (2016). *The British Journal of Psychiatry, 208,* 213–222.
DESIGN	Systematic review (55 studies) and meta-analysis (48 studies)
FOLLOW-UP	Nil to 143 weeks (2 years 9 months)
FORMAT	Individual, group
PARTICIPANTS	6,010 adults diagnosed with bipolar I or II disorder. The mean ages of participants ranged from 26 to 55 years, and between 9% and 77% of participants across the studies were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, psychoeducation, MBCT, DBT, family-focused therapy
COMPARISON GROUP(S)	TAU, active control (supportive therapy)
PROCEDURE	Systematic review and meta-analysis of RCTs published between 1984 and January 2014 evaluating the efficacy of psychological interventions for adults with bipolar disorder on symptoms of depression and mania, relapse, response, discontinuation, hospital admission, quality of life, and psychosocial functioning. Of the studies investigating CBT, participants received on average 28 weeks (range 12–39 weeks) of treatment.
SUMMARY OF FINDINGS	Results of studies evaluating CBT for bipolar disorder indicate small to medium effect sizes posttreatment on quality of life measures in favour of group CBT compared with TAU. At follow-up, both individual and group CBT were more effective than was TAU at reducing the risk of hospitalisation, and individual CBT was more effective than was TAU at reducing the risk of depressive relapse.

[23] nice.org.uk/guidance/cg185

TITLE OF ITEM	***Efficacy of cognitive-behavioral therapy in patients with bipolar disorder: A meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Chiang, K-J., Tsai, J-C., Liu, D., Lin, C-H., Chiu, H-L., & Chou, K-R. (2017). *PLOS One, 12*(5). doi:10.1371/journal.pone.0176849
DESIGN	Meta-analysis (19 studies)
FOLLOW-UP	Nil to 24 months
FORMAT	Individual, group
PARTICIPANTS	1,384 adults with bipolar I or II disorder. The mean ages of participants ranged from 34.7 to 44 years. Information regarding gender was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT plus medication
COMPARISON GROUP(S)	TAU
PROCEDURE	Meta-analysis and systematic review of RCTs published to July 2016 investigating the outcomes of patients with bipolar disorder being treated with CBT plus medication. The number of CBT treatment sessions ranged from eight to 30 across studies, and the duration of sessions ranged from 45 to 120 minutes.
SUMMARY OF FINDINGS	Medium treatment effects were found in favour of CBT compared with TAU on the primary outcome measures of depressive symptoms and mania severity as well as secondary outcome measures of psychosocial functioning and relapse rate. Subgroup analyses revealed that treatment durations greater than 90 minutes per session were associated with larger treatment effects than were sessions shorter than 90 minutes.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Family-focused treatment for caregivers of patients with bipolar disorder***
AUTHOR(S) AND SOURCE	Perlick, D. A., Miklowitz, D. J.,Lopez, N., Chou, J., Kalvin, C. Adzhiashvili, V., & Aronson, A. (2010). *Bipolar Disorders, 12,* 627–637.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Group (family)
PARTICIPANTS	46 primary caregivers of adults diagnosed with bipolar I or II disorder. The mean age of the caregivers and patients was 52.9 years and 34.2 years, respectively, and 73.5% of all participants were female (patients and caregivers).
TREATING CLINICIAN(S)	Experienced clinicians (undefined) trained in FFT and CBT
INTERVENTION(S)	Family-focused treatment (CBT-based) (*n* = 25)
COMPARISON GROUP(S)	Health education (*n* = 21)
PROCEDURE	The primary family caregivers of 46 patients with bipolar disorder were randomly assigned to either a manualised 12–15 session CBT-based family-focused intervention or an eight- to 12-session health education intervention delivered via videotape. Participants in the intervention group attended a mean of 14.3 sessions over 4.7 months, and those in the comparison group attended a mean of 8.1 sessions.
SUMMARY OF FINDINGS	Medium and large effect sizes in favour of the family-focused treatment group were found for caregiver's depressive symptoms and caregiver health, respectively, compared with caregivers in the health education group. The group effect for caregiver burden was also significant, with a large effect size. When caregivers participated in the intervention group, the patients with bipolar disorder showed significant decreases in depressive symptoms relative to patients whose caregivers participated in the health education group, with a medium to large effect size. Those in the intervention group also demonstrated significant reductions on mania symptomatology, although to a lesser extent (with a corresponding small effect size).

TITLE OF ITEM	***A randomised controlled trial of carer-focussed multi-family group psychoeducation in bipolar disorder***
AUTHOR(S) AND SOURCE	Madigan, K., Egan, P., Brennan, D., Hill, S., Maguire, B., … O'Callaghan, E. (2012). *European Psychiatry, 27,* 281–284.
DESIGN	RCT
FOLLOW-UP	1 and 2 years
FORMAT	Group (family)
PARTICIPANTS	47 caregivers and 34 patients diagnosed with bipolar disorder. The mean age of patients and their caregivers was 42 years and 52 years, respectively, and 59% of all participants were female.
TREATING CLINICIAN(S)	Psychiatric nurse and psychiatric social worker
INTERVENTION(S)	Multifamily group psychoeducation (MFGP) (*n* = 18)
COMPARISON GROUP(S)	Solution-focused group therapy (SFGP) (*n* = 19), TAU (*n* = 10)
PROCEDURE	Caregivers of patients with bipolar disorder were randomly allocated to one of three conditions: multifamily group psychoeducation, solution-focused group therapy, or TAU. Both active interventions comprised five x 2-hour manualised sessions delivered over a 5-week period.
SUMMARY OF FINDINGS	Caregivers who were randomised to either of the two active interventions had significantly improved knowledge and reduced overall burden and psychological distress at both 1- and 2-year follow-up, compared with the TAU group. There were no significant differences between MFGP and SFGP at either follow-up time point on any outcome measure. Compared with the TAU group, improvement in quality of life was demonstrated for participants with bipolar disorder whose carers attended either active intervention at both 1- and 2-year follow-up. A marginal improvement in global functioning at 1-year posttreatment was also found in participants whose caregivers received the MFGP intervention; however, this improvement was not maintained at 2-year follow-up.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***A randomized controlled trial of mindfulness-based cognitive therapy for bipolar disorder***
AUTHOR(S) AND SOURCE	Perich, T., Manicavasagar, V., Mitchell, P. B., Ball, J. R., & Hadzi-Pavlovic, D. (2013). *Acta Psychiatrica Scandinavica, 127,* 333–343.
DESIGN	RCT
FOLLOW-UP	3, 6, 9, and 12 months
FORMAT	Group
PARTICIPANTS	95 adults diagnosed with bipolar I or II disorder. The mean age of participants was not reported. Sixty-five percent of participants were female.
TREATING CLINICIAN(S)	Psychologist
INTERVENTION(S)	Mindfulness-based cognitive therapy (MBCT) (*n* = 48)
COMPARISON GROUP(S)	TAU (*n* = 47)
PROCEDURE	Participants were randomly allocated to MBCT or TAU. The MBCT intervention consisted of weekly 120–150-minute group sessions delivered over an 8-week period. Groups comprised four to eight people. Participants in the TAU group received weekly handouts via email or mail comprising information about bipolar disorder. Participants completed an average of seven MBCT treatment sessions.
SUMMARY OF FINDINGS	There were no significant differences between the groups on time to first recurrence of a mood episode, total number of recurrences, depression, or mania over the 12-month period. However, participants in the intervention group had significantly lower scores on state anxiety compared with the TAU group, with similar trends noted for trait anxiety.

PSYCHOEDUCATION

TITLE OF ITEM	***The impact of a simple individual psycho-education program on quality of life, rate of relapse and medication adherence in bipolar disorder patients***
AUTHOR(S) AND SOURCE	Javadpour, A., Hedayati, A., Dehbozorgi, G-R., & Azizi, A. (2013). *Asian Journal of Psychiatry, 6,* 208–213.
DESIGN	RCT
FOLLOW-UP	6, 12, and 18 months (post-randomisation)
FORMAT	Individual
PARTICIPANTS	108 adults diagnosed with bipolar disorder in the remission phase following hospital discharge. The mean age of participants was not reported. Just over half (51.2%) of the participants were female.
TREATING CLINICIAN(S)	Psychiatry resident
INTERVENTION(S)	Psychoeducation plus standard pharmacotherapy (n = 54)
COMPARISON GROUP(S)	Standard pharmacotherapy (n = 54)
PROCEDURE	The intervention consisted of eight weekly 50-minute individual therapy sessions followed by brief, monthly telephone support (10-minute duration) for 18 months. Participants received an average of 7.3 therapy sessions and an average of 15.3 follow-up telephone calls.
SUMMARY OF FINDINGS	Eighty-six of the original 108 participants completed the full 18-month follow-up study period and were included in the analysis. Participants in the intervention group demonstrated significantly better medication adherence and quality of life and significantly fewer instances of relapse and hospital admission compared with the control group over the 18-month study period.

TITLE OF ITEM	***A randomized head to head trial of MoodSwings.net.au: An internet based self-help program for bipolar disorder***
AUTHOR(S) AND SOURCE	Lauder, S., Chester, A., Castle, D., Dodd, S., Gliddon, E., Berk, L., … Berk, M. (2015). *Journal of Affective Disorders, 171,* 13–21.
DESIGN	RCT
FOLLOW-UP	3, 6, and 12 months
FORMAT	Online (clinician guided)
PARTICIPANTS	156 adults diagnosed with bipolar disorder. The mean age of participants in the two intervention groups was 39.9 and 41.4 years, and 74.6% were female.
TREATING CLINICIAN(S)	None
INTERVENTION(S)	'MoodSwings' online psychoeducation (n = 78)
COMPARISON GROUP(S)	'MoodSwings Plus' online psychoeducation (with the addition of CBT-based tools within the program) (n = 78)
PROCEDURE	Participants were randomised to one of two online psychoeducational programs consisting of five core modules: A basic version, called MoodSwings containing psychoeducation material and asynchronous discussion boards, and a more interactive program, MoodSwings Plus, combining the basic psychoeducation material and discussion boards with elements of CBT.
SUMMARY OF FINDINGS	Participants in both intervention groups demonstrated reductions in negative mood symptoms and improvements in functionality, quality of life, and medication adherence. The MoodSwings-Plus group showed a greater number of within-group changes of small to medium effect size on symptoms and functioning, quality of life, and social support both for depressed and elevated mood. A medium effect size in favour of MoodSwings-Plus was also found in relation to improvement on self-reported symptoms of mania at 12-month follow-up.

INTERPERSONAL AND SOCIAL RHYTHM THERAPY (IPSRT)

TITLE OF ITEM	***Group interpersonal and social rhythm therapy for bipolar depression***
AUTHOR(S) AND SOURCE	Hoberg, A. A., Ponto, J., Nelson, P. J., & Frye, M. A. (2013). *Perspectives in Psychiatric Care, 49,* 226–234.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	12 weeks
FORMAT	Group
PARTICIPANTS	Nine adults diagnosed with bipolar I or II depression. The mean age of participants was 41.2 years, and 77% were female.
TREATING CLINICIAN(S)	Psychiatric clinical nurse specialist with training in interpersonal therapy and group therapy
INTERVENTION(S)	Interpersonal and social rhythm therapy (IPSRT) plus adjunctive medication
COMPARISON GROUP(S)	None
PROCEDURE	Seven of the nine participants who began treatment completed all group sessions. Participants first attended two 60-minute individual therapy sessions, followed by six 60-minute group IPSRT sessions over a 2-week period (three sessions per week). Topics of group discussion were adapted from the IPSRT treatment manual.
SUMMARY OF FINDINGS	Six participants, all female, were included in the final analysis. Compared with baseline scores, mean depression scores were significantly lower at posttreatment and follow-up. At posttreatment, one-half of participants met remission criteria, which was reduced to one participant at follow-up. Furthermore, from baseline to follow-up, functioning scores improved significantly.

TITLE OF ITEM	***Randomized, controlled trial of interpersonal and social rhythm therapy for young people with bipolar disorder***
AUTHOR(S) AND SOURCE	Inder, M. L., Crowe, M. T., Luty, S. E., Carter, J. D., Moor, S., Frampton, C. M., & Joyce, P. R. (2015). *Bipolar Disorders, 17,* 128–138.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	100 young adults aged 15–36 diagnosed with bipolar I or II disorder. The mean age of participants was 26.6 years, and 76% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal and social rhythm therapy (IPSRT) (n = 49)
COMPARISON GROUP(S)	Specialist supportive care (n = 51)
PROCEDURE	Participants were randomly allocated to receive IPSRT or specialist supportive care (a manualised psychoeducational and supportive therapy). Clinicians met with participants weekly for 3 months, fortnightly for up to 6 months, and then fortnightly to monthly for 12 months. Therapy frequency was tailored to individual patients' needs, with participants receiving an average of 26.2 sessions of IPSRT.
SUMMARY OF FINDINGS	There were significant reductions in depressive and mania symptoms and improvements in social adjustment from baseline to posttreatment in both intervention groups. However, there were no statistically significant differences between the two interventions on any outcome measure.

TITLE OF ITEM	***A randomized pilot study of psychotherapy and quetiapine for the acute treatment of bipolar II depression***
AUTHOR(S) AND SOURCE	Swartz, H. A., Frank, E., & Cheng, Y. (2012). *Bipolar Disorder, 14,* 211–216.
DESIGN	Pilot RCT
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	25 adults diagnosed with bipolar II disorder (currently depressed). The mean age of participants in the two intervention groups was 40.1 and 32.1 years, and 60% were female.
TREATING CLINICIAN(S)	Master's level clinicians
INTERVENTION(S)	Interpersonal and social rhythm therapy (IPSRT; *n* = 14)
COMPARISON GROUP(S)	Pharmacotherapy (quetiapine; *n* = 11)
PROCEDURE	Participants were randomly assigned to either IPSRT or quetiapine. Participants in the IPSRT condition received weekly, 45-minute therapy sessions over a period of 12 weeks. They received on average 8.5 sessions over the treatment period. Participants assigned to quetiapine met weekly with a psychiatrist for medication management.
SUMMARY OF FINDINGS	Significant improvements in depressive and hypomanic symptoms were demonstrated in both treatment groups over time, with no significant between-group differences on any outcome measure. Response rates (defined as a greater than 50% reduction in depression scores without an increase in mania scores) were 29% and 27% in the IPSRT and quetiapine groups, respectively.

GENERALISED ANXIETY DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT for the treatment of generalised anxiety disorder in adults. Level II evidence was found for acceptance and commitment therapy, metacognitive therapy (based on a single RCT), mindfulness-based cognitive therapy, mindfulness-based stress reduction, psychodynamic therapy, and psychoeducation. In addition, Level II evidence supports the online modalities of CBT (clinician-guided and unguided), acceptance and commitment therapy (clinician-guided), and psychodynamic therapy (clinician-guided) for adults with generalised anxiety disorder. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological treatment of generalized anxiety disorder: A meta-analysis***
AUTHOR(S) AND SOURCE	Cuijpers, P., Sijbrandij, M., Koole, S., Huibers, M., Berking, M., & Andersson, G. (2014). *Clinical Psychology Review, 34,* 130–140.
DESIGN	Meta-analysis (41 studies, 35 of which examined CBT)
FOLLOW-UP	3 to 24 months
FORMAT	Individual (29 studies), group (five studies), online (five studies), guided self-help (one study), unknown (one study)
PARTICIPANTS	2,132 adults diagnosed with GAD. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, ACT, problem-solving therapy, metacognitive therapy, psychodynamic therapy, biofeedback
COMPARISON GROUP(S)	Waitlist control, pill placebo, pharmacotherapy, alternative psychological intervention, TAU
PROCEDURE	Meta-analysis of RCTs published up to April 2012 examining the effects of psychological treatments for GAD. Cognitive behavioural therapies were evaluated in 35 of the included studies. In the majority of studies, the interventions consisted of 12 or fewer sessions (range four to 37), and in almost all studies a treatment manual was used to guide treatment.
SUMMARY OF FINDINGS	Compared with results from pooled controls, a large effect size across outcome measures in favour of CBT was found. Although the numbers of studies were fewer, moderate to large effect sizes were also observed for behavioural and relaxation interventions (without the cognitive therapy component).

TITLE OF ITEM	***Cognitive behaviour therapy for generalized anxiety disorder: Is CBT equally efficacious in adults of working age and older adults?***
AUTHOR(S) AND SOURCE	Kishita, N., & Laidlawb, K. (2017). *Clinical Psychology Review, 52,* 124–136.
DESIGN	Meta-analysis (15 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group
PARTICIPANTS	770 adults diagnosed with GAD. The mean ages of participants ranged from 35 to 50.3 years for the studies of working-aged adults, and from 66.2 to 70.6 years for the studies of older adults. The gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, nonspecific psychological treatment, weekly phone calls, discussion group, nondirective supportive therapy
PROCEDURE	Meta-analysis of RCTs comparing the efficacy of CBT for GAD for adults of working age and older adults. Participants received on average 13 sessions of CBT (range eight to 25 sessions), with the majority of studies using traditional CBT approaches (i.e., cognitive therapy, progressive muscle relaxation, exposure, problem solving).
SUMMARY OF FINDINGS	A large effect size in favour of CBT on GAD was found for adults of working age compared with pooled controls, and a medium effect of CBT on GAD was found for older adults. Although the effect size was larger for adults of working age than for older adults, the difference was not statistically significant.

TITLE OF ITEM	***Transdiagnostic versus disorder-specific and clinician-guided versus self-guided internet-delivered treatment for generalized anxiety disorder and comorbid disorders: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Dear, B. F., Staples, L. G., Terides, M. D., Karin, E., Zou, J., Johnston, L., … Titov, N. (2015). *Journal of Anxiety Disorders, 36,* 63–77.
DESIGN	RCT
FOLLOW-UP	3, 12, and 24 months
FORMAT	Online (clinician-guided and unguided)
PARTICIPANTS	338 adults with at least mild symptoms of GAD; however, on average 86% met diagnostic criteria for GAD at baseline. The mean age of participants was 43.8 years, and 76% were female.
TREATING CLINICIAN(S)	Clinical psychologists (for the clinician-guided conditions)
INTERVENTION(S)	Transdiagnostic online CBT (TD-CBT; *n* = 170), clinician-guided online CBT (CG-CBT; *n* = 168)
COMPARISON GROUP(S)	Disorder-specific online CBT (DS-CBT; *n* = 168), self-guided online CBT (SG-CBT; *n* = 170)
PROCEDURE	Participants were randomly allocated to receive one of two CBT treatment approaches (TD-CBT or DS-CBT) and randomised again into one of two treatment-delivery formats (CG-CBT or SG-CBT). Both interventions consisted of five lessons of online CBT delivered over an 8-week period. Both courses were based on the same model of online CBT, with the core difference being the way in which the content was presented and taught, rather than the skills taught.
SUMMARY OF FINDINGS	All treatment conditions resulted in significant and large improvements across outcome measures and time. For the transdiagnostic versus disorder-specific comparison, large within-group effects were demonstrated for both interventions for generalised anxiety symptoms and depressive symptoms from baseline to posttest and at each follow-up point. A medium effect size in favour of the TD-CBT group at 24-month follow-up was found for generalised anxiety symptoms. Medium effect sizes were also demonstrated in favour of the TD-CBT group in terms of depressive symptoms at posttreatment, 12-month follow-up, and 24-month follow-up. Similarly for the clinician versus self-guided comparisons, both conditions resulted in large within-group effects across time on all outcome measures, but in no significant between-group differences at any time point, indicating that the delivery format did not significantly alter the effectiveness of CBT as an intervention.

TITLE OF ITEM	***Telephone-delivered cognitive behavioral therapy and telephone-delivered nondirective supportive therapy for rural older adults with generalized anxiety disorder: A randomized clinical trial***
AUTHOR(S) AND SOURCE	Brenes, G. A., Danhauer, S. C., Lyles, M. F., Hogan, P. E., & Miller, M. E. (2015). *JAMA Psychiatry, 72,* 1012–1020.
DESIGN	RCT
FOLLOW-UP	2 and 4 months (post randomisation)
FORMAT	Telephone
PARTICIPANTS	141 adults aged 60 or older diagnosed with GAD. Approximately 74% of participants were aged between 60 and 69, and 81.6% were female.
TREATING CLINICIAN(S)	Two graduate-level social workers and one clinical psychologist
INTERVENTION(S)	Telephone-delivered CBT (*n* = 70)
COMPARISON GROUP(S)	Telephone-delivered nondirective supportive therapy (*n* = 71)
PROCEDURE	Participants were randomly allocated to receive telephone- delivered CBT or nondirective supportive therapy. Participants in the intervention group received between nine and 11 weekly 50-minute manualised CBT sessions. The nondirective supportive therapy group received ten weekly 50-minute telephone sessions based on a protocol encompassing supportive and reflective communications without the provision of advice or coping strategies. Both groups received four booster sessions at 2, 4, 8, and 12 weeks posttreatment. Approximately 75% and 81% of participants in the CBT and nondirective supportive therapy groups, respectively, completed the required number of sessions (nine for CBT and 10 for nondirective supportive therapy).
SUMMARY OF FINDINGS	Participants in both groups demonstrated significant reductions in anxiety symptoms and worry over time. At 4-month follow-up, there was a significantly greater decline in worry for participants who received CBT compared with those who received nondirective supportive therapy. Furthermore, a significantly greater proportion of participants in the CBT condition achieved a meaningful response to treatment compared with the nondirective supportive therapy group by treatment end.

TITLE OF ITEM	***Randomized controlled trial on the effectiveness of metacognitive therapy and intolerance-of-uncertainty therapy for generalized anxiety disorder***
AUTHOR(S) AND SOURCE	Van der Heiden, C., Muris, P., & van der Molen, H. T. (2012). *Behaviour Research and Therapy, 50,* 100–109.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	126 adults diagnosed with GAD. The mean age of participants was 35 years, and 73% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	Metacognitive therapy (*n* = 54)
COMPARISON GROUP(S)	Intolerance-of-uncertainty therapy (*n* = 52), delayed treatment control (*n* = 20)
PROCEDURE	Participants were randomised to one of three groups: metacognitive therapy, intolerance-of-uncertainty therapy (psychoeducation around the role of the intolerance of uncertainty in the maintenance of worry and anxiety, problem-solving and addressing cognitive avoidance) or a delayed-treatment control group. Participants in the delayed-treatment control group were randomised to the two treatment groups after 14 weeks and were included in the final analyses. Both interventions were manualised and consisted of 14 weekly 45-minute therapy sessions. Participants received an average of 12 sessions across treatment groups.
SUMMARY OF FINDINGS	There were large within-group effect sizes at posttreatment and 6-month follow-up for both the metacognitive therapy and intolerance-of-uncertainty therapy groups, indicating that both interventions were effective in improving GAD symptom severity. However, medium between-group effect sizes were found on all outcome measures at both posttreatment and follow-up, favouring metacognitive therapy as the more effective treatment method.

TITLE OF ITEM	***Group metacognitive therapy for repetitive negative thinking in primary and non-primary generalized anxiety disorder: An effectiveness trial***
AUTHOR(S) AND SOURCE	McEvoy, P. M., Erceg-Hurn, D. M., Anderson, R. A., Campbell, B. N. C., Swan, A., Saulsman, L. M., … Nathan, P. R. (2015). *Journal of Affective Disorders, 175,* 124–132.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	1 month
FORMAT	Group
PARTICIPANTS	52 adults with a diagnosis of GAD. The mean age of participants was 38 years, and 60% were female.
TREATING CLINICIAN(S)	Psychologists and provisional psychologists under supervision
INTERVENTION(S)	Metacognitive therapy (*n* = 52)
COMPARISON GROUP(S)	None
PROCEDURE	Participants were referred to a specialist community mental health clinic and were invited to participate in the metacognitive therapy group if they met criteria for GAD. The metacognitive therapy intervention consisted of six 2-hour weekly sessions. Eighty–eight percent of participants attended at least five sessions, and 71% of participants attended the 1-month follow-up assessment.
SUMMARY OF FINDINGS	The metacognitive therapy intervention produced large treatment effects on all outcome measures, with very large effects on measures of negative metacognitions, worry, and repetitive negative thinking. These treatment effects increased from posttreatment to follow-up.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***A randomized clinical trial comparing an acceptance-based behavior therapy to applied relaxation for generalized anxiety disorder***
AUTHOR(S) AND SOURCE	Hayes-Skelton, S. A., Roemer, L., & Orsillo, S. M. (2013). *Journal of Consulting and Clinical Psychology, 81,* 761–773.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	81 adults diagnosed with GAD. The mean age of participants was 32.9 years, and 65.4% were female.
TREATING CLINICIAN(S)	Doctoral students in clinical psychology
INTERVENTION(S)	Acceptance-based behaviour therapy (ABBT; *n* = 40)
COMPARISON GROUP(S)	Applied relaxation (*n* = 41)
PROCEDURE	Participants were randomised to receive either manualised ABBT (an acceptance-based approach developed specifically for GAD) or manualised applied relaxation. Both interventions consisted of 16 weekly 60-minute sessions, except for the initial four sessions which lasted 90 minutes. Participants in both groups completed an average of approximately 13 therapy sessions.
SUMMARY OF FINDINGS	Sixty-three participants completed treatment and were included in the analyses. Large significant treatment effects were demonstrated over time on all primary and secondary outcome measures for both groups, indicating that the severity of GAD was reduced irrespective of treatment condition. Treatment gains were maintained at follow-up for both conditions. There were no significant between-group effects at any time point.

TITLE OF ITEM	***Internet-delivered acceptance-based behaviour therapy for generalized anxiety disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Dahlin, M., Andersson, G., Magnusson, K., Johansson, T., Sjogren, J., Hakansson, A., … Carlbring, P. (2016). *Behaviour Research and Therapy, 77,* 86–95.
DESIGN	RCT
FOLLOW-UP	6 months (for the intervention group only)
FORMAT	Online (clinician-guided)
PARTICIPANTS	103 adults diagnosed with GAD. The mean age of participants was 39.5 years, and 83.5% were female.
TREATING CLINICIAN(S)	Clinical psychology graduate students
INTERVENTION(S)	Acceptance-based behaviour therapy (ABBT; *n* = 52)
COMPARISON GROUP(S)	Waitlist control (*n* = 51)
PROCEDURE	Participants were randomly allocated to a clinician-guided online ABBT condition or waitlist control. The ABBT intervention consisted of seven modules focusing on the central components of mindfulness, acceptance, and valued action. Participants were required to complete one module per week. However, they were given up to 9 weeks to complete the course. Participants sent a weekly report to a clinician outlining the work they had completed, and they received support and help if needed.
SUMMARY OF FINDINGS	With the exception of quality of life, medium to large between-group effect sizes were found in favour of online ABBT compared with waitlist controls on all outcome measures at posttreatment. Treatment gains for the intervention group were either maintained or improved during the 6-month follow-up period.

TITLE OF ITEM	***A randomised controlled trial of acceptance and behaviour therapy and cognitive-behaviour therapy for generalised anxiety disorder***
AUTHOR(S) AND SOURCE	Avdagic, E., Morrissey, S. A., & Boschen, M. J. (2014). *Behaviour Change, 31,* 110–130.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Group
PARTICIPANTS	51 adults diagnosed with GAD. The mean age of participants was 36.2 years, and 66.7% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	ACT (*n* = 25)
COMPARISON GROUP(S)	CBT (*n* = 26)
PROCEDURE	Participants were randomly allocated to receive either manualised ACT or manualised CBT group therapy across a period of 6 weeks. Group therapy was conducted with between four and six participants per group, and sessions were of 2 hours duration in both conditions.
SUMMARY OF FINDINGS	Thirty-eight participants completed treatment and were included in the analyses. Both interventions demonstrated large within-group effect sizes on almost all outcome measures at posttreatment, with treatment gains maintained at follow-up. Both groups showed similar degrees of improvement on all measures with no significant between-group differences at follow-up. Compared with the CBT group at posttreatment, the ACT group demonstrated significantly greater reduction of worry symptoms; however, at follow-up this difference was no longer significant. Similar results were found at posttreatment when, compared with the CBT group, a larger proportion of ACT participants were considered improved or recovered, but no differences were noted at follow-up.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***Mindfulness-based cognitive therapy v. group psychoeducation for people with generalised anxiety disorder: Randomised controlled trial***
AUTHOR(S) AND SOURCE	Wong, S. Y. S., Yip, B. H. K., Mak, W. W. S., Mercer, S., Cheung, E. Y. L., Ling, C. Y. M. … Ma, H. S. W. (2016). *The British Journal of Psychiatry, 209,* 68–75.
DESIGN	RCT
FOLLOW-UP	3 months for all conditions; six and 9 months for the MBCT and psychoeducation groups.
FORMAT	Group
PARTICIPANTS	182 adults with a diagnosis of GAD. The mean age of participants was 50 years, and 79.1% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	MBCT (*n* = 61), psychoeducation (*n* = 61)
COMPARISON GROUP(S)	TAU (*n* = 60)
PROCEDURE	Participants were randomly allocated to one of three conditions: group psychoeducation, MBCT, or TAU. Both active interventions were manual-based, consisted of weekly 2-hour sessions over 8 weeks, and were designed to be comparable in terms of structure and clinician contact time. Participants received an average of 6.4 and 7.1 therapy sessions in the MBCT and psychoeducation groups, respectively.
SUMMARY OF FINDINGS	Compared with the TAU group, both the MBCT and psychoeducation groups showed clinically significant reductions in anxiety symptoms at posttreatment and 3-month follow-up. Psychoeducation, but not MBCT, was significantly more effective than was TAU in reducing worry at 3-month follow-up. Although follow-up data were not available for the control group, both anxiety and worry symptoms continued to decrease significantly at each follow-up time point for both active intervention groups. There were no significant between-group differences at either follow-up time point.

MINDFULNESS-BASED STRESS REDUCTION (MBSR)

TITLE OF ITEM	***Randomized controlled trial of mindfulness meditation for generalized anxiety disorder: Effects on anxiety and stress reactivity***
AUTHOR(S) AND SOURCE	Hoge, E. A., Bui, E., Marques, L., Metcalf, C. A., Morris, L. K., Robinaugh, D. J., … Simon, N. M. (2013). *Journal of Clinical Psychiatry, 74,* 786–792.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	93 adults diagnosed with GAD. The mean age of participants was 39 years, and 51% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBSR (*n* = 48)
COMPARISON GROUP(S)	Active control (stress management education; *n* = 45)
PROCEDURE	Participants were randomly allocated to either MBSR or a stress management education group. All participants underwent a social stress test before and after treatment which included an 8-minute public speaking task followed by a 5-minute mental arithmetic task. The MBSR intervention comprised eight weekly 2-hour group sessions with a 4-hour "retreat". The stress management intervention consisted of eight weekly 2-hour group lecture-style sessions, with one 4-hour physical health and wellbeing speciality class.
SUMMARY OF FINDINGS	Participants who completed at least one session of treatment were included in the analyses. Both groups demonstrated statistically significant improvements on all outcome measures including anxiety symptoms, sleep quality, and stress reactivity as measured by the social stress test. However, on all but one outcome measure (one of the three measures of anxiety), participants in the MBSR group demonstrated significantly greater improvement on all outcome measures.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Long-term effects of short-term psychodynamic psychotherapy and cognitive-behavioural therapy in generalized anxiety disorder: 12-month follow-up***
AUTHOR(S) AND SOURCE	Salzer, S., Winkelbach, C., Leweke, F., Leibing, E., & Leichsenring, F. (2011). *The Canadian Journal of Psychiatry, 56,* 503–508.
DESIGN	RCT
FOLLOW-UP	6 and 12 months
FORMAT	Individual
PARTICIPANTS	57 adults with a primary diagnosis of GAD. The mean age of participants was 42.5 years, and 80.7% were female.
TREATING CLINICIAN(S)	Details not reported
INTERVENTION(S)	Short-term psychodynamic therapy (*n* = 28)
COMPARISON GROUP(S)	CBT (*n* = 29)
PROCEDURE	In the original RCT, participants were randomly allocated to either short-term psychodynamic therapy or CBT. The intervention for both groups consisted of 30 weekly 50-minute sessions carried out according to treatment manuals. Participants completed a mean of 28.8 sessions of CBT and 29.1 sessions of psychodynamic therapy.
SUMMARY OF FINDINGS	Both therapeutic interventions resulted in significant and mostly large within-group improvements in symptoms of anxiety, worry, and depression from baseline to 12-month follow-up. Large between-group effect sizes in favour of CBT were found on measures of trait anxiety and worry. For all other outcome measures, between-group effect sizes in favour of CBT were small to medium.

TITLE OF ITEM	***Internet-based psychodynamic versus cognitive behavioral guided self-help for generalized anxiety disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Andersson, G., Paxling, B., Roch-Norlund, P., Östman, G., Norgren, A., Almlöv, J., … Silverberg, F. (2012). *Psychotherapy and Psychosomatics, 81,* 344–355.
DESIGN	RCT
FOLLOW-UP	3 and 18 months
FORMAT	Online (clinician-guided)
PARTICIPANTS	81 adults diagnosed with GAD. The mean age of participants was 40.1 years, and 76.5% were female.
TREATING CLINICIAN(S)	Psychologists and psychology students provided weekly written feedback and encouragement to participants
INTERVENTION(S)	Online psychodynamic therapy (*n* = 27)
COMPARISON GROUP(S)	Online CBT (n = 27), waitlist control (*n* = 27)
PROCEDURE	Participants were randomly allocated to one of three groups: online psychodynamic therapy, online CBT, or waitlist control. Both active interventions consisted of eight text-based treatment modules delivered on a weekly basis over 8 weeks. In both interventions, participants were required to submit writing tasks to clinicians for feedback on a weekly basis.
SUMMARY OF FINDINGS	No statistically significant between-group differences on any outcome measure were observed immediately posttreatment across the three groups. However, compared with waitlist control, at 3 and 18-month follow-up, participants who completed treatment demonstrated significant medium- and large effect sizes in the online psychodynamic therapy and online CBT groups, respectively, on the primary outcome measure of worry. Clinically significant improvements were observed in both intervention groups, with 45% and 65% of participants in the online psychodynamic therapy and online CBT groups, respectively, still fulfilling criteria for GAD diagnosis. At 18-month follow-up, these rates declined to 27% and 33% for the online psychodynamic therapy and online CBT groups, respectively.

PSYCHOEDUCATION

See Wong et al. (2016) under MBCT for generalised anxiety disorder for summary of findings related to psychoeducation.

PANIC DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT in the treatment of panic disorder in adults. Level II evidence supports the use of online CBT (clinician-guided and unguided), acceptance and commitment therapy (based on one small RCT), and short-term psychodynamic therapy (based on one small RCT). Additionally, there is Level IV evidence for mindfulness-based cognitive therapy in the treatment of panic disorder in adults (based on two small case series). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological therapies for panic disorder with or without agoraphobia in adults: A network meta-analysis***
AUTHOR(S) AND SOURCE	Pompoli, A., Furukawa, T. A., Imai, H., Tajika, A., Efthimiou, O., & Salanti, G. (2016). *Cochrane Database of Systematic Reviews, 2016*(4), CD011004. doi:10.1002/14651858. CD011004. pub2
DESIGN	Systematic review (60 studies) and meta-analysis (54 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group
PARTICIPANTS	3,021 adults with a primary diagnosis of panic disorder with or without agoraphobia. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, behaviour therapy, cognitive therapy, psychoeducation, supportive therapy, third-wave CBT interventions (i.e., MBCT, ACT, metacognitive therapy, schema therapy), psychodynamic therapies
COMPARISON GROUP(S)	Waitlist control, no treatment, attention placebo, psychological placebo, alternative intervention.
PROCEDURE	Systematic review and meta-analysis of all relevant RCTs published to March 2015 focusing on adults with a formal diagnosis of panic disorder with or without agoraphobia
SUMMARY OF FINDINGS	Behaviour therapy, cognitive therapy, and CBT were shown to be significantly better than was waitlist control in terms of short-term remission, with large effect sizes. When small study effects were taken into account for short-term remission, CBT remained significantly more effective than was waitlist. However, compared with behaviour therapy for short-term remission, the effect size was reduced to small. A small treatment effect in favour of CBT was also found. Similarly in terms of short-term improvement, CBT, cognitive therapy, and behaviour therapy were significantly better than was waitlist, with large effect sizes. Compared with applied relaxation, a large effect size in favour of short-term psychodynamic therapy was found in terms of short-term improvement and remission; however, this was based on only one study.

TITLE OF ITEM	***Efficacy of group psychotherapy for panic disorder: Meta-analysis of randomized, controlled trials***
AUTHOR(S) AND SOURCE	Schwartze, D., Barkowski, S., Strauss, B., Burlingame, G. M., Barth, J., & Rosendahl, J. (2017). *Group Dynamics: Theory, Research, and Practice, 21,* 77–93.
DESIGN	Meta-analysis (15 studies)
FOLLOW-UP	Nil to 2 years
FORMAT	Group
PARTICIPANTS	864 adults diagnosed with panic disorder with or without agoraphobia. The mean age of participants was 37 years, and 70% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Group CBT (14 studies), group cognitive therapy (one study)
COMPARISON GROUP(S)	Waitlist control, minimal contact, alternative treatment (i.e., individual CBT, pharmacotherapy, relaxation)
PROCEDURE	Meta-analysis of all available RCTs published since 1990 on the efficacy of group therapies for the treatment of adult panic disorder. The treatment could be based on any theoretical approach, but only studies that applied CBT or cognitive therapy (without the exposure component) were included.
SUMMARY OF FINDINGS	Compared with no-treatment control, a large and significant effect in favour of group therapy was found on panic and agoraphobic symptoms as well as on secondary measures of general anxiety and depression. There were no significant differences between group therapy and the alternative treatments as a whole (i.e., individual CBT, pharmacotherapy, and relaxation). However, only a small number of studies were identified for each type of alternative treatment. Follow-up data were available for three studies only, and therefore data were not able to be analysed by meta-analysis.

TITLE OF ITEM	***Disorder-specific versus transdiagnostic and clinician-guided versus self-guided internet-delivered treatment for panic disorder and comorbid disorders: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Fogliati, V. J., Dear, B. F. Staples, L. G., Terides, M. D., Sheehan, J., Johnston, L., … Titov, N. (2016). *Journal of Anxiety Disorders, 39,* 88–102.
DESIGN	RCT
FOLLOW-UP	3, 12, and 24 months
FORMAT	Online (clinician-guided vs self-guided)
PARTICIPANTS	145 adults with symptoms consistent with panic disorder; 132 participants met diagnostic criteria. The mean age of participants was 41.4 years, and 79% were female.
TREATING CLINICIAN(S)	Three psychologists and one CBT-trained counsellor
INTERVENTION(S)	Transdiagnostic online CBT (TD-CBT; *n* = 72), self-guided online CBT (SG-CBT; *n* = 73)
COMPARISON GROUP(S)	Disorder-specific online CBT (DS-CBT; *n* = 73), clinician-guided online CBT (CG-CBT; *n* = 72)
PROCEDURE	Participants were randomly allocated to one of four treatment conditions: TD-CBT, SG-CBT, DS-CBT and CG-CBT. Courses included five lessons delivered online over 8 weeks, and shared the same overall format. The TD-CBT presented a broad range of therapeutic information and skills relevant to psychological distress generally. The DS-CBT treatment was specifically designed to target symptoms of panic disorder. Participants in the clinician-guided condition received weekly telephone or email contact designed to be approximately 10 minutes per contact.
SUMMARY OF FINDINGS	All treatment conditions were associated with large within-group treatment effects for panic disorder symptomatology, and medium to large treatment effects on symptoms of depression, generalised anxiety, and social anxiety at posttreatment and at 3-, 12-, and 24-month follow-up. There were no significant differences on any outcome measure across time between the TD-CBT and DS-CBT groups, or between the CG-CBT and SG-CBT groups.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Treating treatment-resistant patients with panic disorder and agoraphobia using psychotherapy: A randomized controlled switching trial***
AUTHOR(S) AND SOURCE	Gloster, A. T., Sonntag, R., Hoyer, J., Meyer, A. H., Heinze, S., Ströhle, A., … Wittchen, H-U. (2015). *Psychotherapy and Psychosomatics, 84,* 100–109.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	43 adults with treatment-resistant panic disorder with agoraphobia. The mean age of participants was 37.1 years, and 73.4% were female. Participants had previously unsuccessfully undergone a mean of 42.2 therapy sessions and had tried a mean of 2.1 pharmacological agents.
TREATING CLINICIAN(S)	Graduate students of a CBT university training centre
INTERVENTION(S)	ACT (*n* = 33)
COMPARISON GROUP(S)	Waitlist control (*n* = 10)
PROCEDURE	Participants were randomly allocated to receive a 4-week manualised ACT intervention adapted for panic disorder or waitlist control. The intervention consisted of eight, twice-weekly sessions lasting between 90 and 120 minutes over a 4-week period.
SUMMARY OF FINDINGS	Compared with the waitlist group, large between-group effect sizes were demonstrated in favour of the ACT group at posttreatment in terms of panic/agoraphobic symptoms and general functioning. Treatment gains for the intervention group were either maintained or further improved at the 6-month follow-up across all primary and secondary outcomes. Furthermore, the number of comorbid symptoms was significantly reduced at follow-up for participants in the ACT group.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Implementing panic-focused psychodynamic psychotherapy into clinical practice***
AUTHOR(S) AND SOURCE	Beutel, M. E., Scheurich, V., Knebel, A., Michal, M., Wiltink, J., Graf-Morgenstern, M., … Subic-Wrana, C. (2013). *The Canadian Journal of Psychiatry, 58,* 326–334.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	54 adults diagnosed with panic disorder with or without agoraphobia. The mean age of participants was 36.2 years, and 57.4% were female.
TREATING CLINICIAN(S)	Clinicians trained in panic-focused psychodynamic therapy, and certified CBT clinicians.
INTERVENTION(S)	Panic-focused psychodynamic therapy (*n* = 36)
COMPARISON GROUP(S)	CBT (*n* = 18)
PROCEDURE	Participants were randomly allocated in a 2:1 ratio to receive a brief, time-limited form of psychodynamic therapy developed for panic disorder or CBT plus exposure. Both interventions were manualised. The psychodynamic therapy intervention comprised 24 x 50-minute sessions twice-weekly over a period of 12 weeks. The CBT intervention was completed over the same 12-week period and with the same amount of clinician contact, with the exception of the exposure sessions that varied in length (up to 2 hours).
SUMMARY OF FINDINGS	At posttreatment and follow-up, both interventions achieved significant reduction of panic symptoms with large within-group effect sizes at both time points. CBT was significantly more effective than was psychodynamic therapy at posttreatment, with a medium between-group effect size observed. However, this difference was no longer significant at 6-month follow-up, with treatment effects remaining large and comparable for both groups. Remission was achieved by 44.4% and 61.1% of participants in the PFPP and CBT groups, respectively, at posttreatment, with a small between-group effect size in favour of CBT. This difference was no longer apparent at follow-up.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***Effectiveness of a mindfulness-based cognitive therapy program as an adjunct to pharmacotherapy in patients with panic disorder***
AUTHOR(S) AND SOURCE	Kim, B., Lee, S-H., Kim, Y. W., Choi, T. K., Yook, K., Suh, S. Y., … Yook, K-H. (2010). *Journal of Anxiety Disorders, 24,* 590–595.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	1 year
FORMAT	Group
PARTICIPANTS	23 adults diagnosed with panic disorder with or without agoraphobia. The mean age of participants was 41.2 years, and 57% were male. Participants were required to have been on medication for at least 6 months.
TREATING CLINICIAN(S)	Psychiatrists with 3 years' experience with MBCT
INTERVENTION(S)	MBCT (*n* = 23)
COMPARISON GROUP(S)	None
PROCEDURE	All participants completed the MBCT group intervention, which consisted of weekly 90-minute sessions over an 8-week period. The intervention was manualised and delivered according to standard MBCT protocol, but adapted for panic disorder and the Korean context. Medication adherence was monitored weekly by psychiatrists. Seventeen of the original 23 participants completed the 1-year follow-up assessment.
SUMMARY OF FINDINGS	Clinically significant reductions in symptom severity were found on both clinician-administered and self-report measures from pre- to post-treatment, with large effect sizes for the clinician-administered measures of general anxiety and panic disorder severity, and small to medium effect sizes for the self-report measures of general anxiety, anxiety sensitivity, and agoraphobic symptoms. Fifteen of the 17 participants who were assessed at follow-up no longer met diagnostic criteria for panic disorder.

TITLE OF ITEM	***Impact of mindfulness-based cognitive therapy on intolerance of uncertainty in patients with panic disorder***
AUTHOR(S) AND SOURCE	Kim, M. K., Lee, K. S., Kim, B., Choi, T. K., & Lee, S-H. (2016). *Psychiatry Investigation, 13,* 196–202.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	Not reported
FORMAT	Group
PARTICIPANTS	69 adults diagnosed with panic disorder with or without agoraphobia. The mean age of participants was 37.9 years, and 64% were female.
TREATING CLINICIAN(S)	Psychiatrists
INTERVENTION(S)	MBCT (*n* = 69)
COMPARISON GROUP(S)	None
PROCEDURE	All participants underwent the manualised MBCT intervention for panic disorder, which involved weekly 90-minute group therapy sessions over 8 weeks. Participants were split into nine groups, with up to eight participants in each group. Twenty-seven participants were excluded from the analysis because they failed to attend at least seven sessions.
SUMMARY OF FINDINGS	Forty-two of the original 69 participants were included in the analysis. Large within-group effect sizes were demonstrated from pre- to post-treatment for panic and depressive symptomatology, and there was a medium effect size for the measure of intolerance of uncertainty.

SPECIFIC PHOBIA

SUMMARY OF EVIDENCE

There is Level I evidence for CBT (particularly exposure therapy) in the treatment of specific phobia in adults. There is Level II evidence for virtual reality exposure therapy and computer-based exposure (both clinician-guided and unguided) in the same population. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological approaches in the treatment of specific phobias: A meta-analysis***
AUTHOR(S) AND SOURCE	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)
FOLLOW-UP	2 weeks to 14 months
FORMAT	Not reported
PARTICIPANTS	1,193 adults with specific phobias. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	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. Treatments were classified as either an exposure treatment (e.g., in-vivo exposure, imaginal exposure, systematic desensitisation, EMDR, flooding), nonexposure treatment (e.g., progressive muscle relaxation, cognitive therapy), or placebo treatments. Participants received on average three therapy sessions, and 46% of the studies used only one session of treatment.
SUMMARY OF FINDINGS	Both exposure-based CBT and nonexposure treatments outperformed waitlist and placebo control conditions, with large effect sizes observed. Compared with nonexposure treatments, exposure-based treatments led to significantly greater improvement in symptoms at both posttreatment and follow-up, with medium effect sizes observed. Compared with other forms of exposure (e.g., imaginal) a medium effect size in favour of in-vivo exposure treatments was found at posttreatment; however, this difference was no longer apparent at follow-up. Furthermore, exposure treatments augmented with cognitive interventions did not outperform exposure treatments alone. Although single-session treatments were effective, a greater number of treatment sessions was associated with more favourable outcomes.

TITLE OF ITEM	***Interventions for individuals with high levels of needle fear: Systematic review of randomized controlled trials and quasi-randomized controlled trials***
AUTHOR(S) AND SOURCE	McMurtry, C. M., Noel, M., Taddio, A., Antony, M. M., Asmundson, G. J. G., Riddell, R. P. … Shah, V. (2015). *The Clinical Journal of Pain, 31*(10 Suppl), S90–S98.
DESIGN	Systematic review and meta-analysis (11 studies, including five studies using adult samples only)
FOLLOW-UP	Nil to 1 year
FORMAT	Individual, computer-based
PARTICIPANTS	Children and adults with a high degree of needle fear or phobia related to needles. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Varied across adult studies including graduate students, psychologists, nurses, and dentists
INTERVENTION(S)	Exposure-based interventions
COMPARISON GROUP(S)	Educational pamphlet, telephone support, muscle tension (without exposure)
PROCEDURE	Systematic review and meta-analysis of RCTs and quasirandomized controlled trials synthesising the evidence for exposure-based behavioural interventions for the management of needle fear in adults and children. The exposure interventions ranged from a single 3-hour session to six 1-hour weekly sessions. Only articles that included adult samples were included in the summary of findings.
SUMMARY OF FINDINGS	Compared with muscle tension, in-vivo exposure-based therapy with adults significantly reduced fear of needles at posttreatment with a large effect size. This was no longer evident at 1-year follow-up. A medium effect size was found in favour of multiple sessions of in-vivo exposure at posttreatment compared with single sessions; however, this was no longer significant at 1-year follow-up. Computer-based and imaginal exposure (i.e., not in vivo) therapies demonstrated some benefit on specific fear with a medium effect size observed, but not for acute fear during a voluntary injection. Compared with exposure alone, a large effect size in favour of applied tension was found for reducing fainting at both posttreatment and 1-year follow-up.

TITLE OF ITEM	***Virtual reality versus computer-aided exposure treatments for fear of flying***
AUTHOR(S) AND SOURCE	Tortella-Feliu, M., Botella, C., Llabres, J., Bretón-López, J. M., del Amo, A. R., Banos, R. M., & Gelabert, J. M. (2011). *Behavior Modification, 35,* 3–30.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Virtual reality, computer-aided exposure
PARTICIPANTS	60 adults diagnosed with specific phobia. The mean age of participants was 37 years, and 60% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Virtual reality exposure therapy (n = 19)
COMPARISON GROUP(S)	Computer-aided exposure with clinician support (n = 20), computer-aided self-help (n = 21)
PROCEDURE	Participants were randomly allocated to one of three groups: Virtual reality assisted by a clinician supporting participants throughout the therapy and using cognitive strategies to challenge dysfunctional beliefs; computer-aided with clinician, where the clinician was present throughout the exposure sessions but was not directly involved in the therapeutic process; and a completely self-administered computer-aided exposure condition. For all conditions a maximum of six 1-hour twice-weekly sessions were delivered. Participants were familiarised with the programs before beginning exposure according to their unique treatment condition.
SUMMARY OF FINDINGS	There were no significant between-group differences for any of the conditions. All three conditions demonstrated significant and large within-group treatment effects across all outcome measures from both pretreatment to posttreatment and at 1 year follow-up, although the effects were smaller at follow-up.

SOCIAL ANXIETY DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT (including in-vivo exposure) and online CBT for the treatment of social anxiety disorder in adults. Level II evidence supports the use of acceptance and commitment therapy, interpersonal therapy (based on a single RCT), mindfulness-based stress reduction (based on a single RCT), and psychodynamic therapy (based on a single RCT) in the same population. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence (2013)[24] for social anxiety disorder, which recommend individual CBT as first-line treatment and CBT-based self-help (clinician guided) or short-term psychodynamic therapy as other treatment options.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological and pharmacological interventions for social anxiety disorder in adults: A systematic review and network meta-analysis***
AUTHOR(S) AND SOURCE	Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D. M., Ades, A. E., & Pilling, S. (2014). *Lancet Psychiatry, 1,* 368–376.
DESIGN	Systematic review and meta-analysis (101 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group, self-help (bibliotherapy), online
PARTICIPANTS	13,164 adults diagnosed with social anxiety disorder (SAD). The mean age of participants was 36 years, and 52% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, exposure, self-help with and without support, psychodynamic therapy, "other psychological interventions" (i.e., IPT, mindfulness, supportive therapy), pharmacotherapies, exercise promotion
COMPARISON GROUP(S)	Waitlist, pill placebo, psychological placebo, alternative psychological interventions, pharmacotherapies
PROCEDURE	Systematic review and meta-analysis of RCTs published between 1988 and 2013 of psychological and pharmacological interventions for adults with social anxiety disorder to identify which interventions were the most effective for the acute treatment of SAD. The mean duration of treatment was 12 weeks (range 2 to 28 weeks).
SUMMARY OF FINDINGS	All psychological interventions apart from exercise promotion and other psychological therapies had greater effects on treatment outcomes relative to waitlist, with large effect sizes found for individual and group CBT, exposure and social skills, and self-help with and without support (although larger treatment effects were found for self-help with support). A medium effect size was found in favour of psychodynamic therapy compared with waitlist. The most efficacious psychological intervention was manualised individual CBT following the Clark and Wells (1995)[25] model. Furthermore, compared with psychodynamic therapy and other psychological interventions, large effect sizes were found in favour of individual CBT. Combined psychological and pharmacological treatments produced large effect sizes. However, there was no evidence to suggest that combined treatments were more effective than were either alone.

[24] nice.org.uk/guidance/cg159

[25] Clark, D. M, & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. Liebowitz, D. A. Hope & F. R. Schneier (Eds.), *Social phobia: diagnosis, assessment and treatment (pp.* 69–93). New York: Guildford Press.

TITLE OF ITEM	***Meta-analysis of technology-assisted interventions for social anxiety disorder***
AUTHOR(S) AND SOURCE	Kampmanna, I. L., Emmelkampa, P. M. G., & Morina, N. (2016). *Journal of Anxiety Disorders, 42,* 71–84.
DESIGN	Meta-analysis (37 studies)
FOLLOW-UP	Nil to 48 months
FORMAT	Online, virtual reality
PARTICIPANTS	2,991 adults diagnosed with SAD. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	None
INTERVENTION(S)	Online CBT, virtual reality exposure therapy
COMPARISON GROUP(S)	Waitlist control, online discussion, alternative active intervention, CBT in an alternative format (e.g., individual, group, unguided)
PROCEDURE	Meta-analysis of RCTs published between 1985 and June 2015 investigating the efficacy of technology-assisted interventions for adults with SAD. Participants received between five and 15 sessions of online CBT (with an average of 7.9 sessions), and between eight and 14 sessions of virtual reality exposure therapy (with an average of 10.7 sessions).
SUMMARY OF FINDINGS	Compared with passive control conditions, a large effect size was found in favour of online CBT on SAD symptom severity at posttreatment, but not at follow-up (based on only two studies). Additionally, compared with active control conditions, small effects in favour of online CBT were found on SAD symptom severity at posttreatment and to a lesser extent at follow-up. Virtual reality exposure therapy was also shown to be more effective than were passive control conditions at posttreatment on SAD symptoms, with a large effect size.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Randomized controlled trial of cognitive behavioral therapy and acceptance and commitment therapy for social phobia: Outcomes and moderators***
AUTHOR(S) AND SOURCE	Craske, M. G., Niles, A. N., Burklund, L. J., Wolitzky-Taylor, K. B., Vilardaga, J. C. P., Arch, J. J., … Lieberman, M. D. (2014). *Journal of Consulting and Clinical Psychology, 82,* 1034–1048.
DESIGN	RCT
FOLLOW-UP	3 and 9 months
FORMAT	Individual
PARTICIPANTS	87 adults diagnosed with social phobia. The mean age of participants was 28.4 years, and 54% were male.
TREATING CLINICIAN(S)	Clinical psychology doctoral students and recent graduates with at least 2 years of supervised practice.
INTERVENTION(S)	ACT (*n* = 29)
COMPARISON GROUP(S)	CBT (*n* = 33), waitlist control (*n* = 25)
PROCEDURE	Participants were randomly allocated to one of three conditions: ACT, CBT, or waitlist control. Participants in the two active conditions received 12 weekly manualised 1-hour treatment sessions, matched on number of sessions devoted to exposure. Clinicians completed follow-up booster phone calls (20–35 minutes' duration) once a month for 6 months following the 12-week treatment period.
SUMMARY OF FINDINGS	Compared with the waitlist control group, participants in both the ACT and CBT groups demonstrated significantly reduced scores on symptom measures, with no significant between-group differences for the intervention groups at posttreatment or follow-up. Effect sizes for both groups were large compared with waitlist control participants. Improvements were maintained at 3- and 9-months' follow-up for ACT and CBT groups.

TITLE OF ITEM	***Mindfulness and acceptance-based group therapy versus traditional cognitive behavioral group therapy for social anxiety disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Kocovski, N. L., Fleming, J. E., Hawley, L. L., Huta, V., & Antony, M. M. (2013). *Behaviour Research and Therapy, 51,* 889–898.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Group
PARTICIPANTS	137 adults diagnosed with SAD, but data from only 91 participants were available at posttreatment. The mean age of participants was 34.7 years, and 55.5% were female.
TREATING CLINICIAN(S)	Psychologist and psychiatrist
INTERVENTION(S)	Mindfulness and acceptance-based group therapy (*n* = 53)
COMPARISON GROUP(S)	Cognitive behavioural group therapy (*n* = 53), waitlist control (*n* = 31)
PROCEDURE	Participants were randomly allocated to one of three groups: mindfulness (an ACT-based group approach developed specifically for SAD), CBT, or waitlist control. The interventions both consisted of 12 weekly 2-hour group sessions plus a brief check-in at 3-month follow-up. Both interventions were manualised. Participants completed a mean of 9.8 and 10.2 therapy sessions in the CBT and mindfulness groups, respectively.
SUMMARY OF FINDINGS	Compared with waitlist control, both mindfulness and CBT demonstrated significant improvements on SAD symptom severity and depression from baseline to follow-up, with small to medium within-group effect sizes. There were no significant between-group effects on any measure for the intervention groups. Treatment gains were maintained at follow-up.

TITLE OF ITEM	***Guided and unguided acceptance and commitment therapy for social anxiety disorder and/or panic disorder provided via the Internet and a smartphone application: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Ivanova, E., Lindner, P., Ly, K. H., Dahlin, M., Vernmark, K., Andersson, G., & Carlbring, P. (2016). *Journal of Anxiety Disorders, 44,* 27–35.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Online smartphone application (guided and unguided)
PARTICIPANTS	152 adults diagnosed with SAD and/or panic disorder, with 74% of the sample primarily suffering from SAD. The mean age of participants was 35.3 years, and 64.5% were female.
TREATING CLINICIAN(S)	Clinical psychology masters students
INTERVENTION(S)	Clinician-guided smartphone-based ACT program (*n* = 50), unguided smartphone-based ACT program (*n* = 51)
COMPARISON GROUP(S)	Waitlist control (*n* = 51)
PROCEDURE	Participants were randomised to one of three groups: a clinician-guided online ACT program, the same program unguided, and a waitlist control group. The ACT-based program consisted of eight modules comprising different ACT-based principles. The smartphone application corresponded to the content of the eight modules and could be used to complete homework tasks/exercises and to rate mood. Participants were encouraged to complete one module per week, but had 10 weeks to complete treatment. The clinician support consisted of twice-per-week feedback for a total of 15 minutes per participant per week to support treatment progress sent via the smartphone application. On average, participants completed six of the eight treatment modules.
SUMMARY OF FINDINGS	The clinician-guided group accessed and completed more modules on the smartphone application than did the unguided group. No significant differences were found between the guided and unguided groups for participants suffering primarily from SAD. Within-group effect sizes were large for both intervention groups; however, compared with the waitlist control group, a large and significant between-group effect was found only for participants with SAD as the primary diagnosis. All observed improvements were maintained at the 12-month follow-up.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Cognitive therapy vs interpersonal psychotherapy in social anxiety disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Stangier, U., Schramm, E., Heidenreich, T., Berger, M., & Clark, D. M. (2011). *Archives of General Psychiatry, 68,* 692–700.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Individual
PARTICIPANTS	117 adults diagnosed with SAD. The mean age of participants was 35.5 years, and 55.3% were female.
TREATING CLINICIAN(S)	Clinical psychologists and psychiatrists
INTERVENTION(S)	IPT (*n* = 38), CT (*n* = 38)
COMPARISON GROUP(S)	Waitlist control (*n* = 41)
PROCEDURE	Participants were randomly allocated to cognitive therapy, interpersonal therapy, or waitlist control. The two intervention conditions received 16 weekly manualised individual therapy sessions of generally 50-minutes' duration, with a booster session 2-months posttreatment.
SUMMARY OF FINDINGS	Both the cognitive therapy and interpersonal therapy were significantly more effective than was being on the waitlist control for treatment response and secondary outcome measures of social anxiety and depression. Large effect sizes were found for both intervention groups compared with the waitlist group. Cognitive therapy was significantly more effective than was interpersonal therapy at both posttreatment and follow-up, with small to medium effect sizes found across measures at both time points.

MINDFULNESS-BASED STRESS REDUCTION (MBSR)

TITLE OF ITEM	***Group CBT versus MBSR for social anxiety disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Goldin, P. R., Morrison, A., Jazaieri, H., Brozovich, F., Heimberg, R., & Gross, J. J. (2016). *Journal of Consulting and Clinical Psychology, 84,* 427–437.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Group
PARTICIPANTS	108 adults diagnosed with SAD. The mean age of participants was 32.7 years, and 55.6% were female.
TREATING CLINICIAN(S)	Clinical psychologists for CBT and certified MBSR instructor
INTERVENTION(S)	MBSR (*n* = 36), CBT (*n* = 36)
COMPARISON GROUP(S)	Waitlist control (*n* = 36)
PROCEDURE	Participants were randomly assigned to MBSR, CBT, or waitlist control. Participants receiving CBT met in groups of six for 12 x 2.5-hour sessions. Both interventions were manualised, with the MBSR intervention adapted to match the duration of the CBT intervention so that participants in MBSR also received 12 weekly 2.5 hour sessions. Participants in both groups attended an average of 10.4 therapy sessions.
SUMMARY OF FINDINGS	Compared with waitlist control at posttreatment, both MBSR and CBT resulted in significant reductions in social anxiety symptoms, with large between-group effects for both interventions. Treatment outcomes were maintained at follow-up, with no significant differences from posttest to follow-up. There were no significant differences between MBSR and CBT. The only improvement in favour of the CBT group compared with MBSR was a greater reduction in the frequency of subtle avoidance behaviours (safety behaviours), with a large effect size demonstrated.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicentre randomized controlled trial***
AUTHOR(S) AND SOURCE	Leichsenring, F., Salzer, S., Beutel, M. E., Herpertz, S., Hiller, W., Hoyer, J., … Leibing, E. (2013). *American Journal of Psychiatry, 170,* 759–767.
DESIGN	RCT
FOLLOW-UP	6, 12 and 24 months
FORMAT	Individual
PARTICIPANTS	495 adults diagnosed with social anxiety disorder. The mean age of participants was 35.2 years, and 54.6% were female.
TREATING CLINICIAN(S)	Clinical psychologists and physicians
INTERVENTION(S)	Psychodynamic therapy (*n* = 207)
COMPARISON GROUP(S)	CBT (*n* = 209), waitlist control (*n* = 79)
PROCEDURE	Participants were randomly allocated to psychodynamic therapy, CBT, or waitlist control in a ratio of 3:3:1. Both active interventions were manualised and involved up to 25 individual 50-minute sessions delivered on a weekly basis. Participants in both groups completed a mean of 25 therapy sessions.
SUMMARY OF FINDINGS	Both interventions were significantly more effective than was waitlist control, with medium to large effect sizes found in favour of the active interventions on response and remission rates. Compared with psychodynamic therapy at posttreatment, a small effect size in favour of CBT was found on rates of remission. Compared with the psychodynamic therapy group, small but significant between-group differences were also found in favour of CBT on measures of social anxiety and interpersonal problems. No significant differences were found at any follow-up point between the psychodynamic therapy and CBT groups. Data from only 43% of the CBT group and 26% of the psychodynamic group were available at 24-month follow-up.

OBSESSIVE-COMPULSIVE DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT incorporating exposure and response prevention in the treatment of obsessive compulsive disorder in adults. There is further Level I evidence for CBT-based self-help, particularly guided self-help in the form of computer-based ERP and online CBT. Level II evidence was found for acceptance and commitment therapy, family interventions (based on a very small preliminary RCT), metacognitive therapy, and mindfulness-based cognitive therapy (for residual symptoms, based on a single small RCT). In the current review, there was insufficient evidence to indicate that any of the other interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive behavioral treatments of obsessive-compulsive disorder. A systematic review and meta-analysis of studies published 1993–2014***
AUTHOR(S) AND SOURCE	Ost, L-G., Havnen, A., Hansen, B., & Kvale, G. (2015). *Clinical Psychology Review, 40,* 156–169.
DESIGN	Systematic review and meta-analysis (37 studies)
FOLLOW-UP	Nil to 5 years
FORMAT	Individual, group, online
PARTICIPANTS	2,414 adults diagnosed with OCD. The mean age of participants was 34.7 years, and a mean of 57.9% were female.
TREATING CLINICIAN(S)	For the studies that reported type of treating clinicians, clinicians were psychologists, psychiatrists, social workers, or a mix of professions.
INTERVENTION(S)	CBT (including ERP, cognitive therapy, or a combination of ERP and cognitive therapy)
COMPARISON GROUP(S)	Placebo control (psychological or drug), waitlist control, alternative psychological intervention, pharmacotherapy
PROCEDURE	Systematic review and meta-analysis of RCTs examining CBT interventions for adult OCD published between 1993 and 2014. The method of CBT included ERP with no cognitive therapy components using both in-vivo and imaginal exposure techniques, cognitive therapy with no ERP components, and a combination of ERP and cognitive therapy. Treatment duration ranged from 3 to 24 weeks (mean = 12.7 weeks), and the number of therapy sessions ranged from eight to 26 sessions (mean = 14.7 sessions).
SUMMARY OF FINDINGS	At posttreatment, very large effect sizes were observed in favour of CBT compared with waitlist and placebo conditions for OCD symptomatology. The effect sizes for comparisons between individual and group treatment, as well as ERP and cognitive therapy, were very small and not significant, suggesting that treatment format or type of CBT intervention does not impact on treatment outcomes. Compared with antidepressant medication, a medium effect size in favour of ERP/CBT was found (based on two studies); however, ERP plus pharmacotherapy produced more favourable outcomes with a small effect size compared with ERP or cognitive therapy alone at posttreatment. Active treatment conditions as a whole produced large within-group effect sizes at both posttreatment and follow-up.

TITLE OF ITEM	***Pharmacological and psychotherapeutic interventions for management of obsessive-compulsive disorder in adults: A systematic review and network meta-analysis***
AUTHOR(S) AND SOURCE	Skapinakis, P., Caldwell, D. M., Hollingworth, W., Bryden, P., Fineberg, N. A., Salkovskis, P., … Lewis, G. (2016). *Lancet Psychiatry, 3,* 730–739.
DESIGN	Systematic review (64 studies) and meta-analysis (54 studies)
FOLLOW-UP	Not reported
FORMAT	Individual
PARTICIPANTS	6,652 adults diagnosed with OCD. The mean ages of participants ranged from 24.6 to 41.4 years, and a mean of 52.7% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Behaviour therapy (including ERP), cognitive therapy, CBT, antidepressant medications
COMPARISON GROUP(S)	Placebo control (psychological or drug), waitlist control, antidepressant medication, cognitive therapy, CBT, behaviour therapy
PROCEDURE	Systematic review and meta-analysis of RCTs published up to February 2016 comparing the relative efficacy of all available treatments for OCD. Eligible interventions were all antidepressant medications and psychological interventions recommended by current OCD treatment guidelines. Across studies, the intervention duration ranged from 4 to 20 weeks.
SUMMARY OF FINDINGS	Results from this study confirmed previous research findings that support the use of CBT and its variants and antidepressant medication for the treatment of OCD. Compared with drug placebo, most active interventions were associated with significant reductions in mean OCD scores from baseline to posttreatment. These interventions included behaviour therapy, cognitive therapy, and CBT. Furthermore, compared with antidepressants, psychological interventions were associated with a significantly larger reduction in mean scores. It is important to note that in the majority of cases, participants were permitted to continue any antidepressant medication throughout studies in which psychological interventions were the active intervention.

TITLE OF ITEM	***A systematic review and meta-analysis of self-help therapeutic interventions for obsessive-compulsive disorder: Is therapeutic contact key to overall improvement?***
AUTHOR(S) AND SOURCE	Pearcy, C. P., Anderson, R. A., Egan, S. J., & Rees, C. S. (2016). J*ournal of Behavior Therapy and Experimental Psychiatry, 51,* 74–83.
DESIGN	Systematic review and meta-analysis (18 studies)
FOLLOW-UP	Nil to 6 months
FORMAT	Online (guided and unguided), computer-based, bibliotherapy
PARTICIPANTS	1,570 adults with a primary diagnosis of OCD or displaying symptoms of OCD. Most studies included participants with moderately severe OCD ratings. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, exposure and response prevention (ERP), bibliotherapy (based on ERP, metacognitive therapy and alternative treatment approaches such as association splitting and competitive memory training)
COMPARISON GROUP(S)	Waitlist control, nonactive control (i.e., relaxation, supportive therapy), alternative psychological intervention, TAU
PROCEDURE	A systematic review and meta-analysis of RCTs and quasiexperimental studies of self-help treatments for OCD, published up to March 2015. Studies were classified and analysed depending on amount of therapeutic contact (minimal contact, predominantly self-help, and self-administered) and therapy type (bibliotherapy, internet-based, computer-based). The duration of interventions ranged from 3 to 17 weeks, with an average of 8.5 weeks.
SUMMARY OF FINDINGS	There was an overall moderate effect size associated with self-help treatments for OCD at posttreatment. Effect sizes were grouped based on degree of clinician contact. As therapeutic contact increased, treatment effect sizes also increased. Compared with pooled control conditions, at posttreatment, a small effect size for self-administered therapies (based on CBT and metacognitive therapy), a medium effect size for predominantly self-help therapies (based on ERP and CBT), and a large effect size for the minimal-contact self-help therapies were found (based on ERP and CBT). There was a fairly high average dropout rate (28.7%) across the studies, with the majority of dropouts occurring in the self-administered self-help interventions.

TITLE OF ITEM	***Efficacy of technology-delivered cognitive behavioural therapy for OCD versus control conditions, and in comparison with therapist-administered CBT: Meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Dèttore, D., Pozza, A., & Andersson, G. (2015). *Cognitive Behaviour Therapy, 44,* 190–211.
DESIGN	Meta-analysis (eight studies)
FOLLOW-UP	Nil to 26 weeks
FORMAT	Online, telephone, video, computer, bibliotherapy
PARTICIPANTS	420 people, primarily adults, diagnosed with OCD or having scores higher than a predetermined cut-off on self-report measures of OCD (one study only). One study included a sample of young people. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Details not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, attention/relaxation control, face-to-face CBT
PROCEDURE	Meta-analysis of all available RCTs investigating the efficacy of technology-delivered CBT on OCD symptoms compared with control conditions and clinician-administered CBT. Across studies, treatment duration ranged from 6 to 17 weeks. One study included young people aged less than 16; however, the meta-analysis produced comparable results when this study was removed from the analysis.
SUMMARY OF FINDINGS	Compared with pooled control conditions on OCD symptom measures, technology-delivered CBT was associated with a large overall treatment effect at both posttreatment and at follow-up. A medium effect size in favour of clinician-administered CBT compared with technology-delivered CBT was also found; however, the authors found this to be a nonsignificant result after failing to meet their predetermined significance cut-off.

TITLE OF ITEM	***Randomized-controlled trial on a novel (meta-) cognitive self-help approach for obsessive-compulsive disorder ("myMCT")***
AUTHOR(S) AND SOURCE	Hauschildt, M., Schröder, J., & Moritz, S. (2016). *Journal of Obsessive-Compulsive and Related Disorders, 10,* 26–34.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Written (self-help book)
PARTICIPANTS	128 adults diagnosed with OCD. The mean age of participants was 39 years, and 67.2% were female.
TREATING CLINICIAN(S)	None
INTERVENTION(S)	MCT (n = 64)
COMPARISON GROUP(S)	Psychoeducation (n = 64)
PROCEDURE	Participants were randomised to receive either self-administered MCT or psychoeducation. The manualised MCT (myMCT) intervention developed by the study authors involved working through a self-help book over a 4-week period. The psychoeducation group received standardised information material about OCD. There was no contact with a clinician during any stage of the study.
SUMMARY OF FINDINGS	Although both groups demonstrated a reduction of OCD symptoms at posttreatment, compared with the psychoeducation group the myMCT group demonstrated a significantly greater reduction in symptoms. The results indicated a small to medium effect size for total OCD symptoms, and a medium to large effect size for obsessions from pre- to post-treatment for the intervention group. Significant between-group differences were also noted for self-reported measures of depression and cognitive biases in favour of the intervention group. The significant treatment effects on OCD and depressive symptoms, however, were not maintained at follow-up.

TITLE OF ITEM	***Metacognitive therapy (MCT), fluvoxamine, and combined treatment in improving obsessive-compulsive, depressive and anxiety symptoms in patients with obsessive-compulsive disorder (OCD)***
AUTHOR(S) AND SOURCE	Shareh, H., Gharraee, B., Atef-Vahid, M. K., & Eftekhar, M. (2010). *Iranian Journal of Psychiatry and Behavioral Sciences, 4*(2), 17–25.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	21 outpatient adults diagnosed with OCD who were not receiving pharmacotherapy during the previous month. The mean age of participants was 26.8 years, and 52.6% were female. Two participants dropped out prior to treatment commencement.
TREATING CLINICIAN(S)	Graduates in clinical psychology, supervised by experienced clinical psychologists
INTERVENTION(S)	MCT (*n* = 7)
COMPARISON GROUP(S)	Fluvoxamine (antidepressant SSRI) (*n* = 6), combined MCT and fluvoxamine (*n* = 6)
PROCEDURE	Participants were randomised to one of three conditions: manualised MCT, combined MCT plus medication, or medication alone. Participants received 10 weekly 45–60-minute sessions of individual therapy. Participants in the fluvoxamine group were monitored by a psychiatrist and received 50 to 300 mg of the medication for 10 weeks. The combination treatment group received both MCT and 50 to 300 mg of fluvoxamine for 10 weeks.
SUMMARY OF FINDINGS	At posttreatment, all participants in the MCT group and 83.3% of participants in the combined treatment group met recovery criteria, compared with only one participant in the fluvoxamine group. Significant and large treatment effects were found in favour of both the MCT and the combined treatment groups on all measures (OCD symptom severity, anxiety, and depression), compared with the fluvoxamine-only group. There were no significant differences between MCT and the combined treatment group on any outcome measure.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***A randomized clinical trial of acceptance and commitment therapy versus progressive relaxation training for obsessive-compulsive disorder***
AUTHOR(S) AND SOURCE	Twohig, M. P., Hayes, S. C., Plumb, J. C., Pruitt, L. D., Collins, A. B., Hazlett-Stevens, H., & Woideneck, M. R. (2010). *Journal of Consulting and Clinical Psychology, 78,* 705–716.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Individual
PARTICIPANTS	79 adults diagnosed with OCD. The mean age of participants was 37 years, and 61% were female.
TREATING CLINICIAN(S)	Clinical psychology students
INTERVENTION(S)	ACT (*n* = 41)
COMPARISON GROUP(S)	Progressive relaxation training (PRT) (*n* = 38)
PROCEDURE	Participants were randomly allocated to ACT or PRT, both of which consisted of eight weekly 1-hour individual therapy sessions. Both conditions were based on standardised protocols. Dropout rates were low in both groups: Four ACT participants (9.8%) and five PRT participants (13.2%) attended only one or two sessions.
SUMMARY OF FINDINGS	Participants in both treatment conditions showed significant improvement in OCD symptom severity at posttest and follow-up. However, compared with PRT, ACT produced significantly greater within-group improvements in OCD severity at posttreatment and follow-up, with large effect sizes observed at both time points. Large and medium between-group effects in favour of ACT were also found for the secondary measure of depression at posttreatment and follow-up, respectively.

TITLE OF ITEM	***A randomized clinical trial of a brief family intervention to reduce accommodation in obsessive-compulsive disorder: A preliminary study***
AUTHOR(S) AND SOURCE	Thompson-Hollands, J., Abramovitch, A., Tompson, M. C., & Barlow, D. H. (2015). *Behavior Therapy, 46,* 218–229.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Family
PARTICIPANTS	18 adults diagnosed with OCD and their family members. The mean age of participants was 35.4 years, and 66.7% were female.
TREATING CLINICIAN(S)	Psychologist
INTERVENTION(S)	Brief family intervention (*n* = 9)
COMPARISON GROUP(S)	No treatment (*n* = 9)
PROCEDURE	All 18 participants who had OCD received TAU consisting of weekly outpatient exposure and ritual prevention sessions over a 25-week study period. Family members of the participants were randomly allocated to a brief manualised family intervention or no treatment. The family intervention consisted of psychoeducation and skills training in reducing accommodation (participation in rituals, avoidance and other behaviours that support a family member's OCD) and comprised two hour-long sessions spaced two weeks apart, without the patient present. Most family members were spouses/partners (72%), but there were also parents (22%) and siblings (6%). Participants receiving TAU completed an average of 17.8 sessions over the study period.
SUMMARY OF FINDINGS	At Weeks 8 and 16, large between-group treatment effects on the OCD symptom measure were found for participants whose family members received the family intervention compared with family members who did not receive the intervention. No significant between-group differences were found at Weeks 4 or 25, although the difference approached significance in favour of the intervention group at Week 25. Furthermore, change in family accommodation at Week 4 significantly improved prediction of patients OCD symptoms at Week 8.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***Mindfulness-based cognitive therapy as an augmentation treatment for obsessive compulsive disorder***
AUTHOR(S) AND SOURCE	Key, B. L., Rowa, K., Bieling, P., McCabe, R., & Pawluk, E. J. (2017). *Clinical Psychology & Psychotherapy, 24,* 1109–1120.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	36 adults diagnosed with OCD. Participants were recruited from a tertiary mental health clinic. The mean age of participants was 43.3 years, and 52.8% were male.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	MBCT (*n* = 18)
COMPARISON GROUP(S)	Waitlist control (*n* = 18)
PROCEDURE	MBCT was provided to participants following a course of group CBT with only partial recovery. Participants were randomly allocated to either MBCT or waitlist control. The manualised MBCT program was adapted for OCD and consisted of one 2-hour group session each week for a period of 8 weeks. Participants were given an audio recording of guided mindfulness exercises to practise at home.
SUMMARY OF FINDINGS	Compared with the waitlist control, significant reductions were demonstrated for the MBCT group from pre- to post-treatment on measures of OCD symptom severity, depression, anxiety, and obsessive beliefs with large treatment effect sizes, as well as increases on measures of self-compassion and mindfulness skills with medium treatment effect sizes.

POSTTRAUMATIC STRESS DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT, particularly trauma-focused CBT that includes exposure-based elements. There is also Level I evidence for eye movement desensitisation and reprocessing for the treatment of posttraumatic stress disorder in adults. Level II evidence was found for dialectical behaviour therapy (based on a single RCT conducted in a residential setting with highly experienced treating clinicians), emotion-focused therapy, metacognitive therapy (based on a single small study), and mindfulness-based stress reduction.

Some evidence was found for hypnotherapy; however, this was based on a single, poor quality meta-analysis of just five studies. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder***
AUTHOR(S) AND SOURCE	Australian Centre for Posttraumatic Mental Health. (2013). Melbourne: Author.
DESIGN	Systematic review and meta-analysis
FOLLOW-UP	Nil to 9 months
FORMAT	Individual, group, online
PARTICIPANTS	Adults with a diagnosis of posttraumatic stress disorder (PTSD) or acute stress disorder (ASD). The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Trauma-focused CBT
COMPARISON GROUP(S)	No treatment, waitlist control, TAU, alternative psychological intervention
PROCEDURE	Systematic review and meta-analysis of RCTs published from 2005 to 2011 examining the relative efficacy of psychological interventions for the treatment of PTSD or ASD. The same evidence from the 2007 guidelines (derived from the previous 1996–2004 search) was retained where no new evidence was identified.
SUMMARY OF FINDINGS	When compared with waitlist control or TAU, studies consistently favoured CBT over control conditions on the primary outcome measure of PTSD symptom severity as well as on secondary outcome measures including depressive and anxiety symptoms, and social and occupational functioning, at posttreatment. Follow-up data are less consistent, with varied results reported from none to some advantage of CBT at follow-up. There is also evidence of group CBT and online CBT interventions being more effective than waitlist/minimal attention control. Trauma-focused CBT interventions have been shown to be more effective for the treatment of PTSD than supportive counselling, psychoeducation, and self-help (CBT-based). A small number of low quality studies also indicated no significant differences between treatment outcomes for trauma-focused CBT and EMDR. Trauma-focused CBT has demonstrated effectiveness across a variety of populations (e.g., sexual assault victims, people injured in motor vehicle accidents, war veterans) as well as for acute stress disorder and acute PTSD.

TITLE OF ITEM	***Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults***
AUTHOR(S) AND SOURCE	Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). *Cochrane Database of Systematic Reviews, 2013*(12), CD003388. doi:10.1002/14651858.CD003388.pub4
DESIGN	Systematic review and meta-analysis (70 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group
PARTICIPANTS	4,761 adults diagnosed with chronic PTSD. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Experienced clinicians (not specified)
INTERVENTION(S)	Trauma-focused CBT, EMDR
COMPARISON GROUP(S)	Waitlist control, TAU, alternative psychological intervention (nontrauma-focused CBT, supportive therapy, nondirective counselling, psychodynamic therapy, present-centred therapy)
PROCEDURE	Systematic review and meta-analysis of RCTs published up to April 2013 to assess the effectiveness of psychological therapies for the treatment of chronic PTSD in adults.
SUMMARY OF FINDINGS	Relative to waitlist control and TAU, individual trauma-focused CBT and EMDR reduced the severity of PTSD symptoms significantly, with large effect sizes. There were no significant differences between individual trauma-focused CBT and EMDR groups immediately posttreatment. At follow-up, a medium effect size in favour of individual trauma-focused CBT compared with nontrauma-focused CBT was found, as well as medium to large effect sizes in favour of individual trauma-focused CBT, EMDR (with regard to self-reported PTSD symptoms only), and nontrauma-focused CBT compared with other therapies, both immediately posttreatment and at follow-up. Compared with waitlist and TAU groups, a large treatment effect in favour of group trauma-focused CBT at both posttreatment and follow-up was demonstrated.

TITLE OF ITEM	***Distance-delivered interventions for PTSD: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Olthuis, J. V., Wozney, L., Asmundson, G. J. G., Cramm, H., Lingley-Pottie, P., & McGrath, P. J. (2016). *Journal of Anxiety Disorders, 44*, 9–26.
DESIGN	Systematic review and meta-analysis (19 studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Telephone, internet/email, mail, videoconferencing
PARTICIPANTS	1,491 adults with a diagnosis of PTSD or subclinical PTSD (17 studies had either the entire sample or the majority of participants with a diagnosis of PTSD). The majority of participants (65.3%) across studies were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Clinician-guided distance-delivered interventions (cognitive and/or behavioural approaches)
COMPARISON GROUP(S)	Face-to-face interventions, waitlist control, TAU, supportive therapy, medication management, other distance-delivered interventions.
PROCEDURE	Systematic review and meta-analysis of RCTs published to July 2016 investigating the efficacy of clinician-guided distance-delivered interventions for PTSD. All studies investigated CBT-based interventions, including some variants (e.g., behavioural activation, exposure, cognitive processing, and mindfulness-based interventions). Interventions were mostly delivered on a weekly basis, with treatment duration ranging from 6 to 15 weeks. Clinician contact ranged from 100 minutes to 1,260 minutes over the course of treatment.
SUMMARY OF FINDINGS	A large within-group effect size was found for PTSD outcome measures, with PTSD symptoms significantly improving from pre- to post-treatment and at short- (3 to 6 months) and long-term (12 month) follow-up. Within-group depression and quality of life outcomes had similar results, with medium posttreatment and follow-up effects. Compared with waitlist control, distance-delivered interventions were superior in reducing PTSD symptoms, with a medium to large effect size. Although the meta-analysis indicated no significant differences on PTSD outcomes between distance-delivered interventions and face-to-face interventions at posttreatment, at 3 to 6 months follow-up, face-to-face interventions were shown to be superior to distance-delivered interventions.

TITLE OF ITEM	***Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., … Barbui, C. (2017). *PLoS ONE, 12*(2), e0171030. doi:10.1371/journal.pone.0171030
DESIGN	Systematic review (14 studies) and meta-analysis (12 studies)
FOLLOW-UP	2 to 12 months
FORMAT	Individual, group
PARTICIPANTS	888 adult refugees or asylum seekers diagnosed with PTSD who had resettled in high-income countries. The age and gender of participants was not reported. Only 543 participants were included in the subgroup analyses for PTSD outcomes.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Narrative exposure therapy (a manualised short-term version of trauma-focused CBT), CBT, trauma-focused therapy, family group intervention, culture-sensitive oriented peer support
COMPARISON GROUP(S)	Waitlist control, TAU
PROCEDURE	Systematic review and meta-analysis of RCTs and controlled clinical trials published up to July 2016 investigating the efficacy of psychosocial interventions on PTSD outcomes in asylum seekers and refugees resettled in high-income countries. Participants received an average of 17 face-to-face therapy sessions (range three to 25 sessions).
SUMMARY OF FINDINGS	Compared with pooled control conditions, psychosocial interventions were more effective in decreasing PTSD and depressive symptoms at posttreatment, with a large effect size. The positive treatment outcomes for PTSD symptoms, however, were not apparent at follow-up. Narrative exposure therapy was the most-supported intervention.

TITLE OF ITEM	***Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial***
AUTHOR(S) AND SOURCE	Wells, A., Walton, D., Lovell, K., & Proctor, D. (2015). *Cognitive Therapy and Research, 39,* 70–80.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Individual
PARTICIPANTS	32 adults with a diagnosis of PTSD with symptoms present for at least 3 months. Twenty participants were male, and 12 were female. The mean age of participants was 41.2 years.
TREATING CLINICIAN(S)	Clinical psychology students
INTERVENTION(S)	Metacognitive therapy (MCT) (n = 11)
COMPARISON GROUP(S)	Prolonged exposure (n = 11), waitlist control (n = 10)
PROCEDURE	Participants were randomised to MCT, prolonged exposure, or waitlist control groups. Participants in the active treatment conditions received weekly 60-minute sessions of therapy over an 8-week intervention period, following manualised procedures.
SUMMARY OF FINDINGS	Compared with the waitlist control group, both active interventions resulted in greater reduction in PTSD symptoms, depression, and anxiety, with large treatment effects at both posttreatment and follow-up. Treatment effects on the primary outcome measure of PTSD symptom reduction were more rapid for MCT than for prolonged exposure. At posttreatment, participants in the MCT group showed significantly greater within-group effect sizes on PTSD symptom reduction than did those receiving prolonged exposure. However, between-group differences were no longer significant at follow-up.

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR)

TITLE OF ITEM	***Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder***
AUTHOR(S) AND SOURCE	Australian Centre for Posttraumatic Mental Health. (2013). Melbourne: Author.
DESIGN	Systematic review and meta-analysis
FOLLOW-UP	Nil to 9 months
FORMAT	Individual, group, online
PARTICIPANTS	Adults with a diagnosis of PTSD or acute stress disorder (ASD). The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Eye movement desensitization and reprocessing (EMDR)
COMPARISON GROUP(S)	No treatment, waitlist control, TAU, alternative psychological intervention
PROCEDURE	Systematic review and meta-analysis of RCTs published from 2005 to 2011 examining the relative efficacy of psychological interventions for the treatment of PTSD or ASD.
SUMMARY OF FINDINGS	Compared with waitlist control, EMDR was shown to be more effective for improving clinician-rated PTSD symptoms, depression, and anxiety. Two small studies with moderate to high risk of bias demonstrated effectiveness favouring EMDR over TAU. Across three studies with a moderate to high risk of bias, EMDR was shown to have superior treatment effects compared with stress management and supportive counselling. Six small trials of poor to average quality indicated no clinically significant differences between trauma-focused CBT and EMDR.

TITLE OF ITEM	***Efficacy of eye-movement desensitization and reprocessing for patients with post traumatic-stress disorder: A meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Chen, Y-R., Hung, K-W., Tsai, J-C., Chu, H., Chung, M-H., Chen, S-R., … Chou, K-R. (2014). *PLoS ONE, 9*(8), e103676. doi:10.1371/journal.pone.0103676
DESIGN	Meta-analysis (26 studies) (4 studies included child samples)
FOLLOW-UP	Not reported
FORMAT	Individual
PARTICIPANTS	1,133 individuals (of whom 979 were adults) diagnosed with PTSD. Of the studies that provided age data, the mean ages of participants ranged from 8.4 to 62 years. Gender data was not reported.
TREATING CLINICIAN(S)	EMDR clinician (details not reported, but in 14 studies the clinician was a psychologist)
INTERVENTION(S)	EMDR
COMPARISON GROUP(S)	Relaxation, waitlist, placebo, standard care, active listening, stress management, alternative psychological intervention
PROCEDURE	Meta-analysis of RCTs published between 1991 and 2013 investigating the efficacy of EMDR on symptoms of PTSD, depression, anxiety, and subjective distress in patients with PTSD. Almost all (24 of 26) studies used a manual to deliver the intervention. Across studies, participants received on average five sessions of EMDR (range one to 12), with session length ranging from 50 minutes to 2 hours.
SUMMARY OF FINDINGS	Reductions in PTSD symptoms, depression, and anxiety were significant following EMDR therapy, with moderate effect sizes across outcome measures. The overall reduction in subjective distress following EMDR therapy was significant, with a large effect size. Subgroup analyses revealed that treatment duration greater than 60 minutes was superior to shorter treatment duration, significantly reducing both anxiety and depression. Furthermore, greater symptom reduction was observed in studies where clinicians experienced in PTSD group therapy were used, compared with groups led by clinicians without such experience.

TITLE OF ITEM	***Eye movement desensitization and reprocessing versus cognitive-behavioural therapy for adult posttraumatic stress disorder***
AUTHOR(S) AND SOURCE	Chen, L., Zhang, G., Hu, M., & Liang, X. (2015). *Journal of Nervous and Mental Disease, 203,* 443–451.
DESIGN	Systematic review and meta-analysis (11 studies)
FOLLOW-UP	Not reported
FORMAT	Not reported
PARTICIPANTS	424 adults diagnosed with PTSD. Of the studies that reported age and gender, the mean ages of participants ranged from 32 to 63.5 years, and there were generally more females than males.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	EMDR
COMPARISON GROUP(S)	Variants of CBT (i.e., trauma-focused CBT, exposure plus cognitive restructuring, prolonged exposure, imaginal exposure, stress inoculation training)
PROCEDURE	Systematic review and meta-analysis of RCTs published up to August 2013 examining the efficacy of EMDR relative to CBT on PTSD symptoms for adults diagnosed with PTSD.
SUMMARY OF FINDINGS	In relation to PTSD symptoms at posttreatment, a small but significant difference was found in favour of EMDR over CBT. Small effect sizes in favour of EMDR when compared with CBT were also found on PTSD subscales for intrusion and arousal measures. There were no significant between-group differences for the PTSD avoidance subscale.

HYPNOTHERAPY

TITLE OF ITEM	***Australian guidelines for the treatment of acute stress disorder and post-traumatic stress disorder***
AUTHOR(S) AND SOURCE	Australian Centre for Posttraumatic Mental Health. (2013). Melbourne: Author.
DESIGN	Systematic review and meta-analysis
FOLLOW-UP	Not reported
FORMAT	Not reported
PARTICIPANTS	Adults with a diagnosis of PTSD or acute stress disorder (ASD). The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Hypnotherapy
COMPARISON GROUP(S)	No treatment, waitlist control, TAU, alternative psychological interventions
PROCEDURE	Systematic review and meta-analysis of RCTs published from 2005 to 2011 examining the relative efficacy of psychological interventions for the treatment of PTSD and ASD
SUMMARY OF FINDINGS	Based on the four studies on hypnotherapy included in the review, the authors concluded that there was insufficient evidence to suggest that hypnotherapy was more effective than waitlist control for the treatment of PTSD in adults. The guidelines recommend that adults diagnosed with PTSD should be offered trauma-focused CBT or EMDR as first-line treatment.

TITLE OF ITEM	***A meta-analysis for the efficacy of hypnotherapy in alleviating PTSD symptoms***
AUTHOR(S) AND SOURCE	Rotaru, T-S., & Rusu, A. (2016). *International Journal of Clinical and Experimental Hypnosis, 64,* 116–136.
DESIGN	Meta-analysis (5 studies)
FOLLOW-UP	1 month to 2 years
FORMAT	Not reported
PARTICIPANTS	386 individuals with a diagnosis of PTSD. Four studies used adult samples, and one study used children. The mean ages of participants ranged from 9.8 to 42 years, and 52.8% were female.
TREATING CLINICIAN(S)	Hypnotherapists (one study), psychiatrists experienced in hypnotherapy (one study). The clinician type for the remaining studies was not reported.
INTERVENTION(S)	Hypnotherapy
COMPARISON GROUP(S)	Pharmacotherapy, placebo control, waitlist control, nontreatment control
PROCEDURE	Meta-analysis of all relevant RCTs on the efficacy of hypnosis-based interventions as standalone interventions in reducing PTSD symptomatology. Hypnotherapeutic methodologies varied. One study adopted a cognitive-behavioural focus, another used a symptom-oriented hypnotherapy approach, a third study used a spiritual-hypnosis-assisted therapy approach, and the final two studies both comprised a manualised hypnotherapy approach (abreactive ego state therapy). In three studies, participants received a single session of therapy, in one study they received four sessions, and in the fifth study participants received a mean of 14.4 sessions.
SUMMARY OF FINDINGS	The mean weighted effect size was large and in favour of the hypnosis-based interventions at posttreatment compared with pooled control conditions. The effect sizes of the two RCTs that used the manualised abreactive ego state therapy were large compared with the other interventions which produced medium effect sizes at posttreatment and at follow-up. However, the study results are only partially reliable due to the small number of studies included in the meta-analysis, the small numbers of participants within studies, and the large variation in the results between studies.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Dialectical behaviour therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: A randomised controlled trial***
AUTHOR(S) AND SOURCE	Bohus, M., Dyer, A. S., Priebe, K., Krüger, A., Kleindienst, N., Schmahl, C., … Steil, R. (2013). *Psychotherapy and Psychosomatics, 82,* 221–233.
DESIGN	RCT
FOLLOW-UP	18 and 24 weeks
FORMAT	Individual and group
PARTICIPANTS	74 adult women diagnosed with PTSD related to childhood sexual abuse, with and without borderline personality disorder (BPD). The mean age of participants was 35.9 years.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	DBT-PTSD program (n = 36)
COMPARISON GROUP(S)	Waitlist control (n = 38)
PROCEDURE	Participants were randomly assigned to either DBT or waitlist. The highly structured DBT-PTSD program consisted of twice-weekly, 45-minute sessions of individual therapy over 12 weeks, plus weekly group therapy sessions. Participants in the DBT-PTSD group received on average 25 individual treatment sessions across an average of 12.5 weeks. Participants in the waitlist group received 6 months of any treatment of their choice with the exception of DBT-PTSD, before being offered the DBT intervention.
SUMMARY OF FINDINGS	Compared with the control group, participants in the intervention group demonstrated significantly greater reductions in PTSD symptoms, with large between-group effect sizes. Subgroup analyses on PTSD symptoms revealed that significant between-group differences were evident for participants both with and without a diagnosis of BPD, with similar large effect sizes.

EMOTION-FOCUSED THERAPY (EFT)

TITLE OF ITEM	***A randomized controlled trial of 7-day intensive and standard weekly cognitive therapy for PTSD and emotion-focused supportive therapy***
AUTHOR(S) AND SOURCE	Ehlers, A., Hackmann, A., Grey, N., Wild, J., Liness, S., Albert, I., … Clark, D. M. (2014). *The American Journal of Psychiatry, 171,* 294–304.
DESIGN	RCT
FOLLOW-UP	27 and 40 weeks post-randomisation
FORMAT	Individual
PARTICIPANTS	121 adults diagnosed with chronic PTSD. The mean age of participants was 38.9 years, and 58.7% were female.
TREATING CLINICIAN(S)	Clinical psychologists and nurse therapists
INTERVENTION(S)	Intensive cognitive therapy (*n* = 30)
COMPARISON GROUP(S)	Emotion-focused supportive therapy (*n* = 30), standard weekly cognitive therapy (*n* = 31), waitlist (*n* = 30)
PROCEDURE	Participants were randomly allocated to one of four conditions: standard manualised cognitive therapy, intensive 7-day cognitive therapy, manualised emotion-focused supportive therapy, or waitlist control. Participants in the standard cognitive therapy group and those in the emotion-focused group received up to 20 hours of therapy spread evenly over the 3.5 month intervention period. Those allocated to the intensive cognitive therapy condition received up to 18 hours of therapy over 1 week. Across groups, participants received an average of 10 therapy sessions over the 14 week period, plus an average of two optional booster sessions following treatment completion.
SUMMARY OF FINDINGS	All active treatments resulted in greater reduction of PTSD symptoms compared with waitlist control. Participants who received intensive and standard cognitive therapy experienced greater symptom reduction at posttreatment and follow-up than did the emotion-focused group. However, the emotion-focused group also experienced large within-group treatment effects from baseline to posttreatment on PTSD symptoms and depression. Although effective, treatment effects for emotion-focused therapy were approximately half the size of both cognitive therapy groups across most outcome measures.

MINDFULNESS-BASED STRESS REDUCTION (MBSR)

TITLE OF ITEM	***Mindfulness-based stress reduction for posttraumatic stress disorder among veterans: A randomized clinical trial***
AUTHOR(S) AND SOURCE	Polusny, M. A., Erbes, C. R., Thuras, P., Moran, A., Lamberty, G. J., Collins, R. C., … Lim, K. O. (2015). *Journal of the American Medical Association, 314,* 456–465.
DESIGN	RCT
FOLLOW-UP	2 months
FORMAT	Group
PARTICIPANTS	116 veterans diagnosed with PTSD. The mean age of participants was 58.5 years, and 84.5% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBSR (*n* = 58)
COMPARISON GROUP(S)	Present-centered group therapy (*n* = 58)
PROCEDURE	Participants were randomly assigned to receive a manualised MBSR therapy modified for PTSD consisting of nine sessions of group therapy (eight weekly 2.5 hour group sessions, plus a daylong retreat), or present-centred group therapy, an active-control condition consisting of nine weekly 90-minute group sessions focusing on current life problems.
SUMMARY OF FINDINGS	Although PTSD symptomatology improved significantly from baseline to follow-up for both groups, the MBSR group demonstrated significantly greater improvements compared with the present-centred group, with a large effect size. Compared with the control group, participants in the MBSR group also demonstrated significant improvements in quality of life and mindfulness skills. Furthermore, participants in the MBSR group were more likely to show clinically significant treatment benefits at follow-up.

SUBSTANCE USE DISORDERS

SUMMARY OF EVIDENCE

There is Level I evidence for CBT (including motivational interviewing and contingency management) in the treatment of substance use disorders in adults. There is Level II evidence for acceptance and commitment therapy,[26] dialectical behaviour therapy (based on one small RCT), family interventions, mindfulness-based relapse prevention (for relapse prevention), and psychodynamic therapy. Level IV evidence was found for interpersonal therapy (based on one small study) and psychoeducation (based on one small study). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence (2011)[27] for alcohol-use disorders which recommend, for moderate and severe alcohol dependence and after successful withdrawal, the use of adjunctive individual psychological interventions (i.e., cognitive behavioural therapies, behavioural therapies, or social network and environment-based therapies) focused specifically on alcohol misuse.

It should be noted that a review of drug therapies was outside the scope of the current literature review, although it is acknowledged that pharmacotherapy is a first-line treatment for some substance use disorders. With regard to psychosocial interventions, however, CBT has the highest level of evidence across different types of substance use disorders.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychosocial interventions for psychostimulant misuse***
AUTHOR(S) AND SOURCE	Minozzi, S., Saulle, R., De Crescenzo, F., & Amato, L. (2016). *Cochrane Database of Systematic Reviews, 2016*(9), CD011866. doi:10.1002/14651858.CD011866.pub2
DESIGN	Systematic review (52 studies) and meta-analysis (47 studies)
FOLLOW-UP	2 to 36 months
FORMAT	Individual, group, self-help (various delivery formats)
PARTICIPANTS	6,923 adults with a diagnosis of psychostimulant misuse (dependence or problematic use). The mean age of participants was 36.7 years, and 63% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, contingency management, motivational interviewing, IPT, psychodynamic therapy, 12-step approach
COMPARISON GROUP(S)	No treatment, TAU, other psychosocial intervention, pharmacotherapy
PROCEDURE	Systematic review and meta-analysis of RCTs published up to November 2015 investigating the effects of psychosocial interventions for psychostimulant misuse in adults. Treatment duration ranged from 1 to 9 months (mean 4 months).
SUMMARY OF FINDINGS	Compared with no treatment, significant treatment effects in favour of contingency management were found on measures of dropout, likelihood of continuous abstinence at end of treatment and follow-up, and likelihood of longest period of abstinence. Significant treatment effects in favour of CBT were also found for likelihood of continuous abstinence at end of treatment and likelihood of longest period of abstinence. Compared with TAU, significant treatment effects in favour of CBT were found for measures of dropout and likelihood of abstinence at follow-up. Significant treatment effects in favour of contingency management were also found for likelihood of abstinence at the end of treatment. No conclusions could be made regarding which psychosocial interventions were the most effective.

[26] Although one meta-analysis (Lee, E. B., An, W., Levin, M. E., & Twohig, M. P. (2015). An initial meta-analysis of acceptance and commitment therapy for treating substance use disorders. *Drug and Alcohol Dependence, 155,* 1–7) was also identified, only three of the included studies in the meta-analysis demonstrated significant outcomes, making the results of the meta-analysis difficult to interpret.

[27] nice.org.uk/guidance/cg115

TITLE OF ITEM	***Psychosocial interventions for cannabis use disorder***
AUTHOR(S) AND SOURCE	Gates, P. J., Sabioni, P., Copeland, J., Le Foll, B., & Gowing, L. (2016). *Cochrane Database of Systematic Reviews, 2016*(5), CD005336. doi:10.1002/14651858.CD005336.pub4
DESIGN	Systematic review and meta-analysis (23 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group
PARTICIPANTS	4,045 adults diagnosed with cannabis abuse or dependence (cannabis use disorder). The mean age of participants was 28.2 years, and most participants were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, motivational interviewing / motivational enhancement therapy (MET), contingency management, psychoeducation, mindfulness-based meditation
COMPARISON GROUP(S)	Inactive control, TAU, other psychosocial intervention
PROCEDURE	Systematic review of RCTs published up to July 2015 investigating the efficacy of psychosocial interventions (without pharmacological intervention) for cannabis use disorder in adults within outpatient or community settings. Treatment duration ranged from 1 to 16 months (mean 4 months).
SUMMARY OF FINDINGS	The interventions with the best evidence for reducing the frequency of cannabis use, increasing the likelihood of point-prevalence and continuous abstinence, and reducing cannabis dependence severity were CBT, MET, and combined CBT plus MET with the addition of contingency management, which further improved treatment outcomes. Individuals who received interventions lasting more than four sessions or treatment duration longer than 1 month demonstrated greater improvements compared with those receiving briefer interventions.

TITLE OF ITEM	***Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification***
AUTHOR(S) AND SOURCE	Amato, L., Minozzi, S., Davoli, M., & Vecchi, S. (2011). *Cochrane Database of Systematic Reviews, 2011*(9), CD005031. doi:10.1002/14651858.CD005031.pub4
DESIGN	Systematic review and meta-analysis (11 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, family (one study)
PARTICIPANTS	1,592 adults diagnosed with opioid dependence. The mean age of participants was 34.8 years, and 67.6% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychosocial interventions (contingency management, community reinforcement, structured counselling, family intervention) plus pharmacological treatments
COMPARISON GROUP(S)	Pharmacological treatments alone
PROCEDURE	Systematic review to evaluate the effectiveness of any psychosocial plus pharmacological interventions versus pharmacological interventions alone for opioid detoxification in adults.
SUMMARY OF FINDINGS	When analysed as a group, psychosocial interventions combined with pharmacological intervention were significantly more effective than were pharmacological interventions alone in reducing the number of drop-outs, the use of opiates during treatment and at follow-up, compliance (clinic absences during treatment), and engagement in further treatment. Contingency management combined with pharmacological interventions was also significantly more effective than were pharmacological interventions alone in reducing the number of drop-outs, the use of opiates during treatment, and compliance.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Acceptance and commitment therapy versus cognitive behavioral therapy in the treatment of substance use disorder with incarcerated women***
AUTHOR(S) AND SOURCE	Lanza, P. V., Garcia, P. G., Lamelas, F. R., & Gonzalez-Menendez, A. (2014). *Journal of Clinical Psychology, 70,* 644–657.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	50 incarcerated women diagnosed with a substance use disorder, with a mean age of 33.2 years
TREATING CLINICIAN(S)	An experienced professional in clinical psychology, and doctoral level student
INTERVENTION(S)	ACT (*n* = 18)
COMPARISON GROUP(S)	CBT (*n* = 19), waitlist control (*n* = 13)
PROCEDURE	Participants were randomly allocated to one of three conditions: ACT, CBT, or a waitlist control group. Both active interventions were manualised and conducted simultaneously, and comprised 16 weekly 90-minute group sessions.
SUMMARY OF FINDINGS	At posttreatment, both experimental groups demonstrated statistically significant improvements compared with the control group. When active conditions were compared, at posttreatment CBT was significantly more effective than was ACT in reducing anxiety sensitivity. At follow-up, ACT was significantly more effective than was CBT in reducing drug use and reducing the percentage of participants who met diagnostic criteria for a comorbid psychiatric disorder.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Outcome of dialectical behaviour therapy for concurrent eating and substance use disorders***
AUTHOR(S) AND SOURCE	Courbasson, C., Nishikawa, Y., & Dixon, L. (2012). *Clinical Psychology and Psychotherapy, 19,* 434–449.
DESIGN	RCT
FOLLOW-UP	3 and 6 months
FORMAT	Group and individual
PARTICIPANTS	25 women diagnosed with concurrent substance use disorder and eating disorder, with a mean age of 32.5 years
TREATING CLINICIAN(S)	Clinician, social worker, and psychologist
INTERVENTION(S)	DBT (*n* = 13)
COMPARISON GROUP(S)	TAU (group CBT; *n* = 8)
PROCEDURE	Participants were randomly allocated to either DBT or TAU. Four participants dropped out prior to treatment commencement. Both DBT and TAU were 1-year outpatient programs. The TAU condition consisted of weekly 90-minute group therapy primarily based on motivational interviewing, CBT, and relapse prevention strategies. The DBT intervention consisted of a weekly 2-hour skills training group plus a weekly 1-hour individual therapy session.
SUMMARY OF FINDINGS	Between-group effect sizes could not be calculated due to dropout within the TAU group. At posttreatment, 3- and 6-month follow-up, substance use severity scores were significantly lower than baseline scores. A medium within-group effect size was found for substance use severity at posttreatment, which was reduced to a small treatment effect at 3 and 6-month follow-up.

FAMILY INTERVENTIONS

TITLE OF ITEM	***A randomized controlled trial of family intervention for co-occurring substance use and severe psychiatric disorders***
AUTHOR(S) AND SOURCE	Mueser, K. T., Glynn, S. M., Cather, C., Xie, H., Zarate, R., Smith, L. F., … Feldman, J. (2013). *Schizophrenia Bulletin, 39,* 658–672. doi:10.1093/schbul/sbr203
DESIGN	RCT
FOLLOW-UP	6 to 36 months
FORMAT	Family
PARTICIPANTS	108 adults with cooccurring substance use and psychiatric disorders, and their families. The mean age of the client group was 33.6 years, and 70.4% were male.
TREATING CLINICIAN(S)	Clinicians with advanced training in clinical psychology
INTERVENTION(S)	Family intervention for dual disorders (*n* = 52)
COMPARISON GROUP(S)	Family education (*n* = 56)
PROCEDURE	Participants were randomly allocated to one of two manualised family-based interventions: family intervention for dual disorders and a briefer family education intervention. Family education was provided in single-family sessions and involved 1-hour sessions over 6 to 8 weeks. The family intervention sessions were provided on a declining contact basis, with weekly sessions for the first 3 months, biweekly sessions for the subsequent 6 months, and monthly sessions thereafter.
SUMMARY OF FINDINGS	Over the study period, participants in both groups demonstrated significant improvements across outcome measures, including degree of substance use, overall psychiatric symptom severity, and global functioning. There were no significant differences between groups in substance use severity, with the exception of men in the family intervention program demonstrating fewer days of drinking over the course of the study compared with those in family education.

MINDFULNESS-BASED RELAPSE PREVENTION

TITLE OF ITEM	***Relative efficacy of mindfulness-based relapse prevention, standard relapse prevention, and treatment as usual for substance use disorders: A randomized clinical trial***
AUTHOR(S) AND SOURCE	Bowen, S., Witkiewitz, K., Clifasefi, S. L., Grow, J., Chawla, N., Hsu, S. H., … Larimer, M. E. (2014). *JAMA Psychiatry, 71,* 547–556.
DESIGN	RCT
FOLLOW-UP	3-, 6-, and 12-month follow-up
FORMAT	Group
PARTICIPANTS	286 adults who had completed initial chemical dependency treatment for substance use disorders. The mean ages of the three groups ranged from 37.2 to 39.1 years, and 71.5% were male.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Mindfulness-based relapse prevention (MBRP; *n* = 103)
COMPARISON GROUP(S)	Standard relapse prevention (*n* = 88), TAU (*n* = 95)
PROCEDURE	The intervention occurred during the standard 12-month period of after-care treatment. Participants were randomly allocated to one of three conditions: MBRP, standard relapse prevention, or TAU. The MBRP program, based on MBCT and MBSR, consisted of eight weekly 2-hour group sessions of 6–10 participants. The standard relapse prevention group matched the MBRP condition in time, format, group size, and scope of assigned homework. TAU consisted of abstinence-based and process-oriented weekly or twice-weekly group discussions of 90-minute duration.
SUMMARY OF FINDINGS	At 3-month follow-up, there were no significant differences between any groups on drug use days, any drug use, heavy drinking days, or any heavy drinking. At 6-month follow-up, the two relapse prevention groups reported 31% fewer days of heavy drinking and a significantly higher probability of abstinence from drug use compared with the TAU group. There were no significant differences between standard relapse prevention and MBRP groups at 6-month follow-up. At 12-month follow-up, compared with the standard relapse prevention group, the MBRP group reported 31% fewer drug-use days and a significantly higher probability of not engaging in any heavy drinking.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Dynamic deconstructive psychotherapy versus optimized community care for borderline personality disorder co-occurring with alcohol use disorders***
AUTHOR(S) AND SOURCE	Gregory, R. J., DeLucia-Deranja, E., & Mogle, J. A. (2010). *The Journal of Nervous and Mental Disease, 198,* 292–298.
DESIGN	Follow-up of RCT
FOLLOW-UP	18 months
FORMAT	Individual
PARTICIPANTS	30 adults diagnosed with borderline personality disorder (BPD) and active alcohol abuse or dependence were included in the original RCT. However, only 16 participated in the follow-up study. The mean age of participants was 28.7 years, and 80% were female.
TREATING CLINICIAN(S)	Psychiatrist and psychiatry residents in their third year of postgraduate education.
INTERVENTION(S)	Dynamic deconstructive therapy (DDP)
COMPARISON GROUP(S)	Optimised community care (OCC)
PROCEDURE	Participants were recruited from a sample of 30 adults enrolled in a 12-month RCT of DDP versus OCC. The DDP treatment involved individual weekly 1-hour sessions over a period of 12 to 18 months. Optimised community care included individual therapy, medication management, drug and alcohol counselling, self-help groups, and case management.
SUMMARY OF FINDINGS	A large effect size in favour of DDP compared with OCC was found for BPD symptoms and depression between baseline and follow-up. Those in the DDP group displayed significant reductions in heavy drinking behaviour from baseline to 18-month follow-up, with a large effect size observed. Participants in OCC reported significantly heavier drinking at 12 months (posttreatment) than those receiving DDP; however, these differences were no longer significant at 18-month follow-up.

TITLE OF ITEM	***Supportive-expressive psychodynamic therapy for cocaine dependence: A closer look***
AUTHOR(S) AND SOURCE	Crits-Christoph, P., Connolly Gibbons, M. B., Gallop, R., Ring-Kurtz, S., Barber, J. P., Worley, M., … Hearon, W. B. (2008). *Psychoanalytic Psychotherapy, 25,* 483–498.
DESIGN	Post-hoc exploratory analysis of data obtained from an RCT
FOLLOW-UP	12, 15, and 18 months
FORMAT	Group
PARTICIPANTS	487 adults diagnosed with cocaine dependency. The mean age of participants was 34 years, and 77% were male.
TREATING CLINICIAN(S)	Cognitive therapy-trained clinicians, supportive-expressive therapy-trained clinicians, and drug counsellors.
INTERVENTION(S)	Psychodynamic therapy plus group drug counselling
COMPARISON GROUP(S)	CBT plus group drug counselling, individual drug counselling plus group drug counselling, group drug counselling
PROCEDURE	487 adults were randomly assigned to one of four treatments in the original RCT. Treatment was split into a 6-month active phase and a 3-month booster phase. During the first 12 weeks of the active phase, 50-minute individual therapy sessions were scheduled twice weekly, and these were reduced to once per week at Week 13 and monthly during the booster phase. Group sessions were held once per week during the active phase and lasted 90 minutes. All treatment programs were manualised. Participants attended an average of nine group treatment sessions across treatment conditions.
SUMMARY OF FINDINGS	Although short-term psychodynamic therapy was not the most efficacious treatment in the RCT (individual drug counselling was), the treatment produced significant and large reductions in cocaine use. In addition, psychodynamic therapy was superior to individual drug counselling on change in family/social problems at 12-month follow-up, particularly for those with more severe difficulties at baseline. For those who achieved early abstinence, supportive-expressive psychodynamic therapy produced comparable drug use outcomes to individual drug counselling.

TITLE OF ITEM	***Time-limited group psychotherapy for moderately alcohol dependent patients: A randomized controlled clinical trial***
AUTHOR(S) AND SOURCE	Sandahl, C., Herlitz, K., Ahlin, G., & Ronnberg, S. (1998). *Psychotherapy Research, 8,* 361–378.
DESIGN	RCT
FOLLOW-UP	15 months
FORMAT	Group
PARTICIPANTS	49 adults diagnosed with alcohol dependence. The mean age of participants was 46.5 years, and 56% were female.
TREATING CLINICIAN(S)	Psychodynamically oriented clinicians and cognitive-behavioural-oriented clinicians
INTERVENTION(S)	Psychodynamic therapy (*n* = 25)
COMPARISON GROUP(S)	CBT (*n* = 24)
PROCEDURE	Participants were randomly allocated to either CBT or psychodynamically oriented time-limited group relapse prevention treatment. Treatment consisted of 15 weekly 90-minute group sessions.
SUMMARY OF FINDINGS	The drinking habits of participants in both groups improved significantly at 15-month follow-up. The majority of participants in the psychodynamic group maintained a more positive drinking pattern during the follow-up period compared with participants in the CBT group, who showed gradual deterioration.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***A pilot study of interpersonal psychotherapy for alcohol-dependent women with co-occurring major depression***
AUTHOR(S) AND SOURCE	Gamble, S. A., Talbot, N. L., Cashman-Brown, S. M., He, H., Poleshuck, E. L., Connors, G. J., & Conner, K. R. (2013). *Substance Abuse, 34,* 233–241.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	32 weeks
FORMAT	Individual
PARTICIPANTS	14 women diagnosed with alcohol dependence and major depressive disorder within the context of a chemical dependency program. The mean age of participants was 36.4 years.
TREATING CLINICIAN(S)	Chemical dependency program clinicians
INTERVENTION(S)	IPT
COMPARISON GROUP(S)	None
PROCEDURE	Participants received a manualised eight-session IPT intervention in addition to their standard group-based chemical dependency treatment program. The chemical dependency treatment program was an abstinence-oriented group-based program delivered three times each week for 90 minutes per session over a 24-week period. Participants completed a mean of five treatment sessions over a mean of 14 weeks.
SUMMARY OF FINDINGS	When delivered as an adjunct intervention to a chemical dependency program, IPT significantly reduced participants' drinking behaviour and depressive symptoms from baseline to posttreatment, with treatment effects maintained at follow-up. The percentage of days abstinent from alcohol increased from 55% at baseline to 87% posttreatment.

PSYCHOEDUCATION

TITLE OF ITEM	***Feasibility and acceptability of the 'HABIT' group programme for comorbid bipolar and alcohol and substance use disorders***
AUTHOR(S) AND SOURCE	Biseul, I., Icick, R., Seguin, P., Bellivier, F., & Scott, J. (2017). *Clinical Psychology and Psychotherapy, 24,* 887–898.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	12 adults diagnosed with concurrent alcohol and substance use disorder and bipolar disorder. However, only six participants attended at least one therapy session. The mean age of those who began treatment was 52.5 years, and four were male.
TREATING CLINICIAN(S)	Medical doctor and psychologist
INTERVENTION(S)	Psychoeducation
COMPARISON GROUP(S)	None
PROCEDURE	All participants attended the same therapy group in addition to their regular outpatient psychiatric care. The HABIT program is an integrated 14-session group therapy approach adapted for people with co-occurring bipolar disorder and substance use disorder. Sessions run for 2 hours and include elements of psychoeducation, CBT, and mindfulness-based relapse prevention.
SUMMARY OF FINDINGS	Levels of alcohol and substance use demonstrated some reductions over time, particularly in relation to alcohol misuse. Overall, 66% of participants had significant reductions in alcohol and substance use scores from baseline to posttreatment. Although 50% of participants' alcohol consumption reduced significantly at posttreatment, only 33% of sedative users and 17% of cannabis users achieved significant reductions in substance use.

ANOREXIA NERVOSA

SUMMARY OF EVIDENCE

There is Level II evidence for CBT (eating disorder-focused) and online CBT (for treatment completers only), family interventions, and psychodynamic therapy in the treatment of anorexia nervosa in adults. Level IV evidence was found for dialectical behaviour therapy (based on two small studies). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence (2017)[28] for eating disorders which recommend considering one of the following interventions: individual eating-disorder-focused cognitive behavioural therapy, the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), or specialist supportive clinical management (SSCM).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***A randomised controlled trial of three psychological treatments for anorexia nervosa***
AUTHOR(S) AND SOURCE	Byrne, S., Wade, T., Hay, P., Touyz, S., Fairburn, C. G., Treasure, J., … Crosby, R. D. (2017). *Psychological Medicine, 47,* 2823–2833.
DESIGN	RCT
FOLLOW-UP	6 and 12 months
FORMAT	Individual
PARTICIPANTS	120 adults diagnosed with anorexia nervosa. The mean age of participants was 26.2 years, and 95.8% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Enhanced CBT (n = 39)
COMPARISON GROUP(S)	Maudsley Anorexia Nervosa Treatment for Adults (MANTRA; n = 41), specialist supportive clinical management (SSCM; n = 40)
PROCEDURE	Participants were randomly allocated to one of three intervention groups: enhanced CBT (a CBT intervention specific to eating disorders), MANTRA, or SSCM. Across conditions, participants were offered between 25 and 40 sessions (50 minutes in duration) over a 10-month period, depending on initial body mass index (BMI) of < 16 = 40 sessions, 16 ≥ 17.5 = 30 sessions, 17.6 ≥ 18.5 = 25 sessions). Both the enhanced CBT and MANTRA interventions were manualised. The SSCM intervention combined clinical management and supportive therapy. In the 12 months' posttreatment, participants were able to access up to six booster sessions.
SUMMARY OF FINDINGS	Sixty per cent of participants completed treatment. All three conditions resulted in clinically significant improvements in BMI and reduction of eating disorder psychopathology at posttreatment. Significant improvements were maintained at 12-month follow-up. There were no significant differences between the three conditions with regard to BMI or eating disorder psychopathology. Although the difference was not significant, enhanced CBT was superior in its ability to produce healthy BMI scores in participants at 12-month follow-up (59% compared with 47.5% in SSCM and 44% in MANTRA groups).

[28] nice.org.uk/guidance/ng69

TITLE OF ITEM	***Internet-based relapse prevention for anorexia nervosa: Nine-month follow-up***
AUTHOR(S) AND SOURCE	Fitcher, M. M., Quadflieg, N. & Lindner, S. (2013). *Journal of Eating Disorders, 1,* 23.
DESIGN	RCT
FOLLOW-UP	9 months
FORMAT	Online (unguided)
PARTICIPANTS	210 women diagnosed with anorexia nervosa, with a mean age of 24 years. All participants received approximately 90 days of inpatient treatment prior to commencing the relapse prevention intervention.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT relapse prevention program (*n* = 92)
COMPARISON GROUP(S)	No-treatment control (*n* = 118)
PROCEDURE	Women who had completed inpatient treatment were randomly allocated to online CBT or a no-treatment control group. The internet intervention consisted of nine monthly internet-based CBT relapse-prevention sessions supported by automated emails and text messages.
SUMMARY OF FINDINGS	Fifty-two percent of participants in the intervention group completed all nine relapse prevention sessions. No significant differences in BMI or eating disorder psychopathology were reported between the intervention and control groups. However, when compared with partial completers (i.e., fewer than eight sessions completed) and the control group, participants who completed the entire web-based intervention exhibited significant increases in BMI posttreatment and at follow-up.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Psychological therapies for adults with anorexia nervosa: Randomised controlled trial of out-patient treatments***
AUTHOR(S) AND SOURCE	Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). *British Journal of Psychiatry, 178,* 216–221.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Individual, family
PARTICIPANTS	84 adults diagnosed with anorexia nervosa. The mean age of participants was 26.3 years, and 98% were female.
TREATING CLINICIAN(S)	Three clinicians comprising a psychologist, doctor, and social worker
INTERVENTION(S)	Family therapy, focal psychoanalytic therapy, cognitive analytic therapy
COMPARISON GROUP(S)	TAU (supportive therapy)
PROCEDURE	Participants were randomly allocated to one of four treatments: family therapy (60-minute sessions between weekly and once every 3 weeks for 12 months), focal psychoanalytic therapy (50-minute weekly sessions over 12 months), cognitive-analytic therapy (50-minute weekly sessions for first 20 weeks, then monthly for 3 months), or TAU (30-minute sessions with trainee psychiatrists for 12 months). All active conditions involved contact with partners and/or parents. Participants in the three active therapy groups received a mean of 13.6, 24.9, and 12.9 sessions of family therapy, psychoanalytic therapy, and cognitive analytic therapy, respectively.
SUMMARY OF FINDINGS	Fifty-four participants completed the full year of treatment. At treatment end, there was modest symptom reduction across all groups, with no significant between-group differences on psychiatric symptoms; however, participants in the family-therapy and psychoanalytic-therapy groups showed significantly greater weight gain compared with those in the control group.

TITLE OF ITEM	***Family-based therapy for young adults with anorexia nervosa restores weight***
AUTHOR(S) AND SOURCE	Chen, E. Y., Weissman, J. A., Zeffiro, T. A., Yiu, A. Eneva, K. T., Arlt, J. M., & Swantek, M. J. (2016). *International Journal of Eating Disorders, 49,* 701–707.
DESIGN	Case series
FOLLOW-UP	6 and 12 months
FORMAT	Family
PARTICIPANTS	22 young adults (20 females, two males) diagnosed with anorexia nervosa or atypical anorexia nervosa and their support adult(s). The mean age of participants was 21 years.
TREATING CLINICIAN(S)	Social workers and clinicians with at least a master's degree
INTERVENTION(S)	Family intervention adapted for young adults with anorexia nervosa
COMPARISON GROUP(S)	None
PROCEDURE	A family intervention was delivered to participants in 18–20 sessions over a 6-month period. Participants had at least one support person accompany them to therapy sessions. Participants attended an average of 12 family intervention sessions over an average of 17 weeks.
SUMMARY OF FINDINGS	Large within-group effect sizes were reported for BMI increases between baseline and posttreatment and between baseline and each follow-up time point. Large within-group treatment effects were also reported for eating disorder psychopathology posttreatment and at 6- and 12-month follow-up. Moderate effect size improvements were seen at posttreatment for eating disorder obsessions and compulsions, and for global functioning, which increased to large effects at follow-up.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): Randomised controlled trial***
AUTHOR(S) AND SOURCE	Zipfel, S., Wild, B., Gross, G., Friederich, H. C., Teufel, M., Schellberg, D.,… Herzog, W. (2014). *The Lancet, 383,* 127–137.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Individual
PARTICIPANTS	242 women diagnosed with anorexia nervosa or subclinical anorexia nervosa. The mean age of participants was 27.7 years.
TREATING CLINICIAN(S)	Medical doctors and psychologists specialising in anorexia nervosa
INTERVENTION(S)	Focal psychodynamic therapy (FPT; *n* = 80)
COMPARISON GROUP(S)	Enhanced CBT (*n* = 80), optimised TAU (*n* = 82)
PROCEDURE	Participants were randomly allocated to one of three groups: FPT (a type of psychodynamic therapy specific to eating disorders), enhanced CBT, or optimised TAU (which included outpatient therapy and structured care by the family doctor). The FPT and enhanced CBT interventions were manualised treatments delivered over a 10-month period (an average of 40 sessions in total).
SUMMARY OF FINDINGS	At both posttreatment and follow-up, BMI had increased substantially for all participants, with large within-group treatment effects reported across all three groups. There were no significant between-group differences at posttreatment or follow-up on BMI. Although enhanced CBT was more effective in terms of speed of weight gain, FPT was found to have the best effect on recovery. More specifically, no differences in global outcome were found for any of the groups between baseline and posttreatment; however, at 12-month follow-up, participants in the FPT group were found to have had a significantly higher recovery rate (35%) compared with the optimised TAU group (13%). No significant differences in recovery were found between enhanced CBT and TAU or enhanced CBT and FPT.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Adapting dialectical behavior therapy for outpatient adult anorexia nervosa—A pilot study***
AUTHOR(S) AND SOURCE	Chen, E. Y., Segal, K., Weissman, J., Zeffiro, T. A., Gallop, R., Linehan, M. M., … Lynch, T. R. (2015). *International Journal of Eating Disorders, 48,* 123–132.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	Case series 1: No follow-up Case series 2: 6 and 12 months
FORMAT	Individual
PARTICIPANTS	Case Series 1: Six adult women (mean age 32.3 years) diagnosed with subclinical or full anorexia nervosa Case Series 2: Nine adult women (age range 19–51 years) diagnosed with anorexia nervosa
TREATING CLINICIAN(S)	Primarily psychologists
INTERVENTION(S)	Case Series 1: Standard dialectical behaviour therapy (DBT) Case Series 2: Standard DBT augmented with radical openness skills
COMPARISON GROUP(S)	None
PROCEDURE	Case Series 1: Treatment comprised standard manualised DBT therapy, individually-delivered DBT skills training, 24-hour phone coaching, and clinician consultation team meetings. The duration of treatment was determined at the beginning of treatment between the client and clinician (treatment durations were between 4 and 24 months). The primary outcome measure was BMI, which was assessed at each therapy session. Case Series 2: Standard DBT as described in Case Series 1 was augmented with an additional 8-week skills module that addressed over-controlled emotions and behaviours. Eating disorder psychopathology was also assessed. The duration of treatment ranged from 4 to 24 months.
SUMMARY OF FINDINGS	Case series 1: All but one of the participants completed treatment. A medium within-group treatment effect was found from baseline to posttreatment. No follow-up assessments were completed. Case series 2: Eight of the nine participants received the DBT and augmented skills training intervention. A large within-group effect size was found from baseline to posttreatment for BMI and was maintained at both 6- and 12-month follow-up. Eating disorder psychopathology also improved following treatment, with a medium within-group effect reported posttreatment, which was maintained at 6-month follow-up but declined to a small effect at 12 months.

TITLE OF ITEM	***Radically open-dialectical behaviour therapy for adult anorexia nervosa: Feasibility and outcomes from an inpatient program***
AUTHOR(S) AND SOURCE	Lynch, T. R., Gray, K. L. H., Hempel, R. J., Titley, M., & Chen, E. Y. (2013). *BMC Psychiatry, 13,* 293.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	47 adults (45 female, two male) diagnosed with anorexia nervosa. The mean age of participants was 29.7 years.
TREATING CLINICIAN(S)	Psychiatric nurses, psychiatrists, psychologists, dietitians, occupational therapists, and family clinicians trained in radically open DBT.
INTERVENTION(S)	Standard DBT augmented with radical openness skills
COMPARISON GROUP(S)	None
PROCEDURE	The study was conducted at an inpatient eating disorder unit. The intervention involved weekly 1-hour individual therapy sessions, weekly skills training classes (including an 8-week radical openness skills training module), telephone coaching (as needed), and weekly clinician consultation team meetings. The duration of treatment ranged from 3 to 53 weeks.
SUMMARY OF FINDINGS	A total of 34 participants (72.3%) completed the treatment program. Significant improvements in BMI and eating disorder-related quality of life, and reductions in eating disorder psychopathology and psychological distress were reported posttreatment compared with baseline. The effect sizes were all large. At treatment completion, 35% of participants were reported to be in full remission and 55% were in partial remission.

BULIMIA NERVOSA

SUMMARY OF EVIDENCE[29]

There is Level I evidence for CBT in the treatment of bulimia nervosa among adults. Level II evidence was found for online (guided) and self-help (bibliotherapy) based CBT, as well as dialectical behaviour therapy. There is Level III-3 evidence for interpersonal therapy (based on one small study) and Level IV evidence for psychoeducation (based on one small study). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence for eating disorders (2017) and the RANZCP Clinical Practice Guidelines for eating disorders[30] which recommend bulimia nervosa-focused CBT as first-line treatment.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***The efficacy of cognitive-behavioural therapy for eating disorders: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Linardon, J., Wade, T., Garcia, X., & Brennan, L. (2017). *Journal of Clinical and Consulting Psychology, 85,* 1080–1094.
DESIGN	Systematic review and meta-analysis (79 studies, with 37 studies included on bulimia nervosa)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Individual, group, online, self-help (bibliotherapy)
PARTICIPANTS	Individuals diagnosed with bulimia nervosa, anorexia nervosa, or binge eating disorder. All but one study included in the bulimia nervosa studies included adult samples. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Inactive control (e.g., waitlist, TAU), active control (i.e., a non-CBT psychological treatment), pharmacotherapy
PROCEDURE	Systematic review and meta-analysis of RCTs on the efficacy of CBT for the treatment of eating disorders. Subgroup analyses were undertaken on type of eating disorder, treatment format, comparison condition, follow-up period (less than 12 months vs more than 12 months), and type of CBT treatment. Most included studies on bulimia nervosa were individually delivered.
SUMMARY OF FINDINGS	For the bulimia nervosa studies, compared with inactive and active controls, clinician-led CBT (individual or group format) was significantly more effective at posttreatment on measures of remission, binge/purge frequency and cognitive symptomatology. Posttreatment effect sizes were large for binge/purge frequencies and small for cognitive symptoms compared with inactive control. CBT was also significantly more effective than being in an active control group. However, effect sizes for all outcome measures were small. One study demonstrated a large effect size in favour of CBT compared with inactive control at short-term follow-up for binge/purge frequency. At long-term follow-up, a small effect size in favour of CBT compared with active control was found (based on 10 studies). Based on nine guided self-help studies, medium effect sizes were found in favour of CBT compared with inactive control on remission rate and cognitive symptoms posttreatment.

[29] The majority of studies identified in the current review included mixed diagnostic samples (e.g., eating disorder not otherwise specified [EDNOS)], binge eating disorder) rather than individuals with a sole diagnosis of bulimia nervosa.

[30] Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., … Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. *Australian & New Zealand Journal of Psychiatry, 48,* 977–1008.

TITLE OF ITEM	***Group therapy for people with bulimia nervosa: Systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Polnay, A., James, V. A. W., Hodges, G. D., Munro, C., & Lawrie, S. M. (2014). *Psychological Medicine, 44,* 2241–2254.
DESIGN	Systematic review and meta-analysis (10 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Group
PARTICIPANTS	484 women diagnosed with bulimia nervosa, with a mean age of 24.3 years.
TREATING CLINICIAN(S)	Psychologist, provisional psychologist, therapist, nurse
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, individual CBT, alternative intervention delivered individually or in group format
PROCEDURE	Meta-analysis of RCTs published up to April 2013 examining the comparative efficacy of group CBT to active treatment comparisons on remission from binge eating or vomiting for adults with bulimia nervosa. Participants attended a mean of 16.5 therapy sessions.
SUMMARY OF FINDINGS	Compared with waitlist control, a medium effect size in favour of group CBT was found for frequency of binges per week and depression posttreatment. Additionally, two studies demonstrated evidence of effectiveness for remission at end of treatment in favour of group CBT. At follow-up, there was insufficient evidence to allow conclusions. One study comparing group CBT with individual CBT provided evidence of effectiveness in favour of individual CBT in relation to remission posttreatment.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***An adaptive randomized trial of dialectical behaviour therapy and cognitive behavior therapy for binge-eating***
AUTHOR(S) AND SOURCE	Chen, E. Y., Cacioppo, J., Fettich, K., Gallop, R., McCloskey, M. S., Olino, T., & Zeffiro, T. A. (2017). *Psychological Medicine, 47,* 703–717.
DESIGN	RCT
FOLLOW-UP	6 and 12 months
FORMAT	Individual and group
PARTICIPANTS	109 women diagnosed with bulimia nervosa or binge eating disorder, with a mean age of 38.2 years
TREATING CLINICIAN(S)	Psychology master's-level clinicians
INTERVENTION(S)	DBT (*n* = 36)
COMPARISON GROUP(S)	CBT (*n* = 31), guided self-help (*n* = 42)
PROCEDURE	Individuals who had previously undergone a guided CBT-based self-help program with an initial weak response to treatment were randomly allocated to DBT or CBT. Those who had a good response to the guided self-help treatment continued treatment of up to 24 weekly 20- to 30-minute sessions with a clinician and were compared with the randomised groups. The DBT and CBT groups received weekly manualised sessions comprising a 2-hour group therapy session, a 1-hour individual session, 2 hours with a consultation team, and availability of 24-hour phone coaching over 6 months.
SUMMARY OF FINDINGS	For the primary outcome measure of binge eating frequency, large within-group effect sizes were found for all three groups from baseline to posttreatment. Reduction in binge eating frequency during treatment was significantly faster for the guided self-help group compared with DBT and CBT, although effect sizes were small. Treatment gains significantly diminished at 12-month follow-up for all groups, but were more effectively maintained in DBT compared with guided self-help, demonstrated by a small to medium effect size. There were no significant between-group differences at 6 and 12-month follow-up.

TITLE OF ITEM	***Appetite-focused dialectical behavior therapy for the treatment of binge eating with purging: A preliminary trial***
AUTHOR(S) AND SOURCE	Hill, D. M., Craighead, L. W., & Safer, D. L. (2011). *International Journal of Eating Disorders, 44,* 249–261.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	32 women with a diagnosis of bulimia nervosa (81% of sample) or subclinical bulimia nervosa. The mean age of participants was 21.9 years.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	DBT (*n* = 18)
COMPARISON GROUP(S)	Delayed treatment control (*n* = 14)
PROCEDURE	Participants were randomly assigned to either DBT or a 6-week delayed treatment group. The manualised and adapted appetite-focused DBT (DBT-AF) treatment comprised 12 individual sessions over 12 weeks; the first six sessions were of 90-minutes duration, and the final six were 1-hour sessions.
SUMMARY OF FINDINGS	At mid-treatment (6 weeks), participants in the DBT group reported lower past-month frequency of objective binge episodes and lower frequency of purges compared with the control group, with large effect sizes observed. Compared with the control group, medium to large effect sizes in favour of the DBT group were also found for eating disorder psychopathology, positive affect, and depression at mid-treatment. For the most part, large within-group effect sizes were found for the DBT group from baseline to posttreatment on all outcome measures.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***A brief form of interpersonal psychotherapy for adult patients with bulimic disorders: A pilot study***
AUTHOR(S) AND SOURCE	Arcelus, J., Whight, D., Brewin, N., & McGrain, L. (2012). *European Eating Disorders Review, 20,* 326–330.
DESIGN	Matched case-control study with historical control
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	10 women with a diagnosis of bulimia nervosa or EDNOS with bulimic features (including binge eating disorders). The mean age of participants was 30.5 years.
TREATING CLINICIAN(S)	Clinicians trained in interpersonal psychotherapy
INTERVENTION(S)	Brief IPT (*n* = 10)
COMPARISON GROUP(S)	Standard IPT (*n* = 10), waitlist (*n* = 10)
PROCEDURE	The 10 women who participated in the study were matched with 10 individuals who had completed the original 16-session IPT for bulimic disorders treatment protocol and an additional 10 people on a waitlist. The brief 10-session version of manualised IPT for bulimic disorders was delivered on a weekly basis, with sessions lasting 45-minutes.
SUMMARY OF FINDINGS	Scores on measures of eating disorder psychopathology, number and severity of bingeing and purging behaviour, and depression were significantly reduced for the intervention group from baseline to posttreatment. Compared with the waitlist control group, significant differences were also found in favour of the two IPT groups for eating disorder psychopathology, but not for number of binges or purging episodes.

PSYCHOEDUCATION

TITLE OF ITEM	***The effect of pre-treatment psychoeducation on eating disorder pathology among patients with anorexia nervosa and bulimia nervosa***
AUTHOR(S) AND SOURCE	Tatham, M., Athanasia, E., Dodd, J., & Waller, G. (2016). *Advances in Eating Disorders, 4,* 167–175.
DESIGN	Case series with pre- and post-test
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	97 adults with a diagnosis of bulimia nervosa (n = 43) or anorexia nervosa (n = 54). 93.8% of participants were female. The age of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducation
COMPARISON GROUP(S)	None
PROCEDURE	Prior to being seen for individual therapy, all participants undertook a four-session psychoeducation group intervention consisting of weekly 90-minute sessions, followed by one 30-minute individual review session. Participants were grouped according to eating disorder diagnosis, and scores were compared for each diagnostic group separately.
SUMMARY OF FINDINGS	Significant differences from pre- to post-treatment were found for the 43 participants with bulimia nervosa. Significant improvements were demonstrated for all but one of the eating disorder psychopathology subscales at posttreatment. The effect sizes were all within the small to medium range. There were no significant changes in levels of bingeing or purging.

BINGE EATING DISORDER (BED)

SUMMARY OF EVIDENCE

There is Level I evidence for CBT for the treatment of binge eating disorder (BED) in adults. There is Level II evidence for guided online CBT, dialectical behaviour therapy and guided dialectical behaviour therapy-based self-help (bibliotherapy), interpersonal therapy, mindfulness-based stress reduction (based on one study), and psychoeducation. Level III-3 evidence was found for emotion-focused therapy (based on one study) and Level IV evidence for acceptance and commitment therapy (based on one study with a small sample size). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence (2017) for eating disorders which recommends offering a BED-focused guided self-help program or eating-disorder-focused cognitive behavioural therapy (either in group or individual format).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Binge-eating disorder in adults: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Brownley, K. A., Berkman, N. D., Peat, C. M., Lohr, K. N.,Cullen, K. E., Bann, C. M., & Bulik, C. M. (2016). *Annals of Internal Medicine, 165,* 409–420.
DESIGN	Systematic review (34 studies) and meta-analysis (16 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Individual, group, self-help (guided and unguided)
PARTICIPANTS	Adults diagnosed with BED. The mean ages of participants ranged from 36 to 47 years, and 77% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, psychodynamic IPT, pharmacotherapy
COMPARISON GROUP(S)	Waitlist, placebo control, TAU, pharmacotherapy, alternative psychological intervention, diet counselling, behavioural weight loss
PROCEDURE	Systematic review and meta-analysis of RCTs published up to May 2016 investigating the effectiveness of psychological and pharmacologic therapies for adults with BED. Treatment duration ranged from 6 weeks to 6 months.
SUMMARY OF FINDINGS	Of the studies included in the meta-analysis, five evaluated clinician-led CBT and the remaining 11 evaluated different pharmacotherapies. Clinician-led CBT led to significant improvements on binge eating outcomes, including abstinence, compared with pooled control conditions. On the basis of qualitative analysis, clinician-led CBT consistently improved eating-related psychopathology and reduced binge eating frequency.

TITLE OF ITEM	***Randomized controlled trial of an internet-based cognitive-behavioral treatment program for binge-eating disorder***
AUTHOR(S) AND SOURCE	Wagner, B., Nagl, M., Dölemeyer, R., Klinitzke, G., Steinig, J., Hilbert, A., & Kersting, A. (2016). *Behavior Therapy, 47,* 500–514.
DESIGN	RCT
FOLLOW-UP	3, 6, and 12 months
FORMAT	Online (clinician-guided)
PARTICIPANTS	139 adults diagnosed with BED. The mean age of participants was 35.1 years, and 96.4% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Online CBT (*n* = 69)
COMPARISON GROUP(S)	Waitlist control (*n* = 70)
PROCEDURE	Participants were randomly assigned to either an online CBT program or a waitlist control group. The online CBT treatment program consisted of 11 personalised structured writing assignments and individualised feedback from trained clinicians, which participants participated in over a 16-week period with a mean of 13.8 treatment sessions.
SUMMARY OF FINDINGS	At posttreatment, the number of binge eating episodes and extent of eating disorder psychopathology demonstrated significant improvement with large between-group effect sizes in favour of the CBT group compared with the waitlist group. Large within-group treatment effects were found for the intervention group at each follow-up point on all outcomes measures.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Moderators of dialectical behavior therapy for binge eating disorder: Results from a randomized controlled trial***
AUTHOR(S) AND SOURCE	Robinson, A. H., & Safer, D. L. (2012). *International Journal of Eating Disorders, 45,* 597–602.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	101 adults diagnosed with BED. The mean age of participants was 52.2 years, and 85% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	DBT for BED
COMPARISON GROUP(S)	Active comparison group therapy
PROCEDURE	Participants were randomly allocated to either manualised DBT or a comparison treatment group. Both treatments comprised 20 weekly 2-hour group sessions. The comparison group sessions followed a nondirective supportive therapy approach.
SUMMARY OF FINDINGS	In relation to binge eating outcomes at posttreatment, participants with avoidant personality disorder in the DBT group experienced fewer binge days in the previous month relative to those randomised to the comparison group. Participants with an early (as opposed to later) onset of overweight and dieting and who were randomised to comparison group experienced poorer posttreatment outcomes and higher binge frequencies at posttreatment compared with those in the DBT group.

TITLE OF ITEM	***A randomized wait-list controlled pilot study of dialectical behaviour therapy guided self-help for binge eating disorder***
AUTHOR(S) AND SOURCE	Masson, P. C., von Ranson, K. M., Wallace, L. M., & Safer, D. L. (2013). *Behaviour Research and Therapy, 51,* 723–728.
DESIGN	Pilot RCT
FOLLOW-UP	6 months (intervention group only)
FORMAT	Guided self-help (bibliotherapy)
PARTICIPANTS	60 adults diagnosed with BED. The mean age of participants was 42.8 years, and 88.3% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	DBT (*n* = 30)
COMPARISON GROUP(S)	Waitlist control (*n* = 30)
PROCEDURE	Participants were randomly allocated to guided self-help DBT or waitlist control. Participants in the intervention group received a DBT-based self-help manual for BED encompassing psychoeducation as well as activities and exercises. Participants attended one in-person 45-minute orientation session and received six bi-weekly 20-minute support phone calls over the 13 weeks of treatment.
SUMMARY OF FINDINGS	At posttreatment, 30% and 10% of the DBT and waitlist group, respectively, had dropped out of the study. Large between-group treatment effects were found in favour of the DBT group on all outcome measures, including binge frequency and eating disorder psychopathology, at posttreatment. At follow-up, scores for binge frequency and eating disorder psychopathology remained significantly lower than baselines scores, with medium to large within-group effect sizes observed.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Long-term efficacy of psychological treatments for binge eating disorder***
AUTHOR(S) AND SOURCE	Hilbert, A., Bishop, M. E., Stein, R. I., Tanofsky-Kraff, M., Swenson, A. K., Welch, R. R., & Wilfley, D. E. (2012). *The British Journal of Psychiatry, 200,* 232–237.
DESIGN	Follow-up of RCT
FOLLOW-UP	1 and 4 years
FORMAT	Group
PARTICIPANTS	90 adults diagnosed with BED. The reported mean age of the two intervention groups was 45.7 and 44.0 years, and 78.9% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	IPT (*n* = 45)
COMPARISON GROUP(S)	CBT (*n* = 45)
PROCEDURE	Participants in the original RCT were randomly allocated to either CBT or IPT. Both treatments were manualised and consisted of 20 weekly 90-minute group sessions, with three additional individual sessions. The follow-up assessment was completed by 75.3% of participants.
SUMMARY OF FINDINGS	Both groups yielded significant and comparable long-term remission rates and clinically significant improvement in eating disorder psychopathology. There was a tendency to relapse among participants in the CBT group over the follow-up period, with a significant decline in recovery rates from posttreatment and 1-year follow-up to long-term follow-up. Abstinence rates for the IPT group did not change over the follow-up period.

TITLE OF ITEM	***Rapid response in psychological treatments for binge eating disorder***
AUTHOR(S) AND SOURCE	Hilbert, A., Hildebrandt, T., Agras, W. S., & Wilfley, D. E. (2015). *Journal of Consulting and Clinical Psychology, 83,* 649–654.
DESIGN	Secondary analysis of RCT
FOLLOW-UP	6, 12, 18, and 24 months
FORMAT	Individual
PARTICIPANTS	205 adults diagnosed with BED. Participant demographics were not reported.
TREATING CLINICIAN(S)	Master's and doctoral level students in clinical psychology or nutrition under supervision.
INTERVENTION(S)	IPT, guided self-help-based CBT
COMPARISON GROUP(S)	Behavioural weight loss (BWL)
PROCEDURE	All treatments were manualised and conducted individually over a 24-week period. The guided self-help CBT intervention involved 10 x 25-minute sessions with a clinician, with weekly treatment for the first four sessions, bi-weekly for the second two, and monthly for the final four sessions. The IPT treatment was adapted for BED and included 19 x 50- to 60-minute sessions over 24 weeks. The first three sessions were scheduled during the first 2 weeks, followed by 12 weekly sessions, and ending with four sessions at 2-week intervals. Behavioural weight loss involved 16 weekly 50-minute sessions followed by four bi-weekly sessions.
SUMMARY OF FINDINGS	The initial RCT indicated greater reductions in binge eating over a 2-year follow-up period for both IPT and CBT groups compared with the BWL group. The rapid responders (achieving a 70% reduction in binge eating after 4 weeks of treatment) in the CBT condition had significantly greater rates of remission than did nonrapid responders 6 to 18 months following treatment. IPT was shown to be equally efficacious for both rapid and nonrapid responders on remission from binge eating. On measures of eating disorder psychopathology, rapid responders in the CBT and IPT groups demonstrated lower scores compared with nonrapid responders in each treatment condition.

MINDFULNESS-BASED STRESS REDUCTION (MBSR)

TITLE OF ITEM	***Mindfulness-based eating awareness training (MB-EAT) for binge eating: A randomized clinical trial***
AUTHOR(S) AND SOURCE	Kristeller, J., Wolever, R. Q., & Sheets, V. (2014). *Mindfulness, 5,* 282–297.
DESIGN	RCT
FOLLOW-UP	1 and 4 months
FORMAT	Group
PARTICIPANTS	150 adults diagnosed with BED (66.7%) or who partially met the diagnostic criteria. The mean age of participants was 46.6 years, and 88% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Mindfulness-based eating awareness training (n = 53)
COMPARISON GROUP(S)	CBT-based psychoeducation (n = 50), waitlist control (n = 47)
PROCEDURE	140 participants were randomly allocated to a mindfulness-based intervention (a program based on MBSR), a psychoeducational CBT-based program, or a waitlist control. Due to logistical constraints, 10 participants were not assigned to conditions by means of randomisation. Participants in both active groups received a manualised 12-session group intervention comprising nine weekly sessions and, following these, three booster sessions once per month. In both treatment conditions, sessions were of 90 minutes' duration, except for sessions one (1 hour) and six (2 hours).
SUMMARY OF FINDINGS	Large within-group treatment effects were found for both active conditions from baseline to follow-up on most outcome measures, including binge eating and depression. Large between-group treatment effects were also found in favour of the active groups compared with waitlist control on binge eating. Of those meeting BED diagnostic criteria at baseline, 80% and 82% of those in the mindfulness-based and psychoeducation groups, respectively, no longer met BED criteria at 1-month follow-up, compared with 38% of those in the waitlist group. At 4-month follow-up, 95% and 76% of participants in the mindfulness-based and psychoeducation groups respectively no longer met diagnostic criteria for BED; however, these rates were not statistically different to the waitlist group (48%).

PSYCHOEDUCATION

See Kristeller, Wolever, and Sheets (2014) above for a summary of findings related to psychoeducation.

EMOTION-FOCUSED THERAPY (EFT)

TITLE OF ITEM	***The rate and shape of change in binge eating episodes and weight: An effectiveness trial of emotionally focused group therapy for binge-eating disorder***
AUTHOR(S) AND SOURCE	Compare, A., & Tasca, G. A. (2016). *Clinical Psychology and Psychotherapy, 23,* 24–34.
DESIGN	Nonrandomised comparative study with concurrent control
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	126 adults diagnosed with BED. The mean ages of participants in the two treatment groups were 50.8 and 51.1 years, and 54% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	EFT (n = 63)
COMPARISON GROUP(S)	EFT and dietary counselling (n = 63)
PROCEDURE	Participants were assigned to the treatment condition based on consensus among treating clinicians. The EFT treatment was a manualised program delivered via 20 weekly 60- to 90-minute group therapy sessions. Four groups of 10–15 people per group were treated over a 5-month period. The combined therapy group received an additional 12 weekly 1-hour individual dietary counselling sessions in the first 3 months, followed by eight weekly 30-minute group sessions (in addition to EFT sessions) for the final 2 months.
SUMMARY OF FINDINGS	Binge eating episodes decreased significantly over the 20 sessions of therapy for both treatment conditions, with no between-group differences. Change in weight within both conditions was also significant from baseline to posttreatment; however, the rate of change was more rapid for the combined-treatment condition. Participants with an earlier response to treatment were more likely to have improved binge eating and weight outcomes at 6-month follow-up.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***A pilot study of an acceptance-based behavioral treatment for binge eating disorder***
AUTHOR(S) AND SOURCE	Juarascio, A. S., Manasse, S. M., Espel, H. M., Schumacher, L. M., Kerrigan, S., & Forman, E. M. (2017). *Journal of Contextual Behavioral Science, 6,* 1–7.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	3 months
FORMAT	Group
PARTICIPANTS	19 women diagnosed with BED, with a mean age of 38.3 years
TREATING CLINICIAN(S)	Clinical psychologists and clinical psychology doctoral students supervised by a psychologist
INTERVENTION(S)	Acceptance-based behaviour therapy
COMPARISON GROUP(S)	None
PROCEDURE	The intervention involving core elements of behavioural therapy for binge eating and acceptance-based strategies was delivered weekly over 10 weeks to three groups of five to seven participants. The first two sessions were 120 minutes each, and the remaining sessions were 90 minutes.
SUMMARY OF FINDINGS	At mid-treatment (Week 5), 56% of participants achieved early remission of binge eating symptoms, which increased to 59% at posttreatment and 60% at 3-month follow-up. Measures of binge frequency, global eating disorder symptomatology, depression, and quality-of-life all improved significantly from baseline to posttreatment, with treatment effects maintained at follow-up.

ADJUSTMENT DISORDER

SUMMARY OF EVIDENCE

Few studies investigating the effectiveness of treatments for adjustment disorders have been published. Level II evidence was found for psychodynamic therapy, and Level III-2 evidence for CBT for 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.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***The effectiveness of brief versus intermediate duration psychodynamic psychotherapy in the treatment of adjustment disorder***
AUTHOR(S) AND SOURCE	Ben-Itzhak, S., Bluvstein, I., Schreiber, S., Aharonov-Zaig, I., Maor, M. Lipnik, R., & Bloch, B. (2012). *Journal of Contemporary Psychotherapy, 42,* 249–256.
DESIGN	RCT
FOLLOW-UP	9 months (for the brief therapy group only)
FORMAT	Individual
PARTICIPANTS	91 adults diagnosed with adjustment disorder began treatment, but only 66 completed the treatment program and were included in the analysis. The mean age of participants was 43.6 years, and 78.8% were female.
TREATING CLINICIAN(S)	Seven clinical psychologists and two psychiatric social workers.
INTERVENTION(S)	Brief psychodynamic therapy (n = 48)
COMPARISON GROUP(S)	Intermediate psychodynamic therapy (n = 43)
PROCEDURE	Participants were randomly allocated to either a brief 12-session psychodynamic therapy condition delivered over a 3-month period or a longer psychodynamic therapy condition of approximately 48 sessions delivered over a 12-month period.
SUMMARY OF FINDINGS	Participants in both treatment groups demonstrated significant improvements on measures of psychiatric symptom severity, psychological distress, and wellbeing after 3 months of therapy. Significant improvements were maintained at posttreatment for the intermediate therapy group on measures of psychiatric symptom severity and distress. There were no significant differences between conditions at follow-up (which was posttreatment for the intermediate therapy group).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Interventions to facilitate return to work in adults with adjustment disorders***
AUTHOR(S) AND SOURCE	Arends, I., Bruinvels, D. J., Rebergen, D. S., Nieuwenhuijsen, K., Madan, I., Neumeyer-Gromen, A. … Verbeek, J. H. (2012). *Cochrane Database of Systematic Reviews, 2012*(12), CD006389. doi:10.1002/14651858.CD006389.pub2
DESIGN	Systematic review and meta-analysis (9 studies)
FOLLOW-UP	10 months to 2 years
FORMAT	Not reported
PARTICIPANTS	1,546 adults diagnosed with adjustment disorder. Participant demographics were not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT (5 studies), problem-solving therapy (4 studies)
COMPARISON GROUP(S)	No treatment, TAU (occupational physicians or general practitioners)
PROCEDURE	Systematic review and meta-analysis of all available RCTs published up to 2011 evaluating the effectiveness of interventions to facilitate the return to work of adults with adjustment disorders compared with no or other treatment.
SUMMARY OF FINDINGS	Based on low and moderate quality evidence, CBT was not found to increase the rate at which workers partially or fully returned to work and did not significantly reduce complaints of distress when compared with no treatment at 1-year follow-up. Based on moderate quality evidence (from one study), problem solving therapy significantly reduced time to partial return to work at 1-year follow-up compared with TAU. However, further moderate quality evidence (based on two studies) indicated no significant effect of problem-solving therapy in reducing the number of days until full return to work at 1-year follow-up.

TITLE OF ITEM	***Work-focused treatment of common mental disorders and return to work: A comparative outcome study***
AUTHOR(S) AND SOURCE	Lagerveld, S. E., Blonk, R. W. B., Brenninkmeijer, V., Wijngaards-de Meij, L., & Schaufeli, W. B. (2012). *Journal of Occupational Health Psychology, 17,* 220–234.
DESIGN	Nonrandomised comparative study with concurrent control
FOLLOW-UP	1, 3, 6, 9, and 12 months
FORMAT	Individual
PARTICIPANTS	168 adults on sick leave diagnosed with one of four common mental health disorders. Most participants (67%) were diagnosed with adjustment disorder. The mean age of participants was 40.7 years, and 60% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	CBT (n = 79)
COMPARISON GROUP(S)	Work-focused CBT (n = 89)
PROCEDURE	Participants were allocated to the treatment conditions based on logistics (proximity to home). Both interventions were manualised and were based on the same CBT protocol, with the addition of a module focusing on work and the return to work in the work-focused CBT condition. Participants in both groups received a mean of 11 therapy sessions over the course of 5.5 months of therapy.
SUMMARY OF FINDINGS	There was a significant difference between groups in favour of work-focused CBT for the proportion of participants who had fully resumed work at 3 and 6 months' follow-up. A significant decrease in mental health problems over time was demonstrated in both groups, and there were no significant between-group differences at the 12-month follow-up.

TITLE OF ITEM	***Counseling in primary care improves depression and quality of life***
AUTHOR(S) AND SOURCE	Carta, M. G., Petretto, D., Adamo, S., Bhat, K. M., Lecca, M. E., Mura G. … Moro, M. F. (2012). *Clinical Practice & Epidemiology in Mental Health, 8,* 152–157.
DESIGN	Nonrandomised comparative study with concurrent control
FOLLOW-UP	Not reported
FORMAT	Individual
PARTICIPANTS	64 patients between 16 and 68 years of age (mean age 42) with a diagnosis of depressive episode, adjustment disorder with depressed mood, or dysthymia. Most participants (56.3%) were diagnosed with adjustment disorder, and 65.6% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	CBT plus TAU (n = 34)
COMPARISON GROUP(S)	TAU (n = 30)
PROCEDURE	The control group was selected and matched with the intervention group by severity of depression, age, and gender. The intervention group received TAU by GPs plus manualised CBT which was delivered every 2 weeks over a 6-month period. The control group received TAU provided by GPs.
SUMMARY OF FINDINGS	Depressive symptomatology decreased in both conditions; however, participants in the CBT group demonstrated greater improvement than did the control group at posttreatment. Scores on quality of life also improved significantly for participants in the CBT group from baseline to posttreatment, but not for those in the control group.

SLEEP DISORDERS

SUMMARY OF EVIDENCE

There is Level I evidence for CBT delivered individually, in groups, online (guided and unguided), and via smartphone application for the treatment of sleep disorders in adults. There is also Level I evidence for mindfulness-based interventions; however, this conclusion is based on a meta-analysis of six studies with relatively small samples. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive behavioral therapy for insomnia comorbid with psychiatric and medical conditions: A meta-analysis***
AUTHOR(S) AND SOURCE	Wu, J. Q., Appleman, E. R., Salazar, R. D., & Ong, J. C. (2015). *JAMA Internal Medicine, 175,* 1461–1472.
DESIGN	Meta-analysis (37 studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Individual, self-help (various delivery formats)
PARTICIPANTS	2,187 adults diagnosed with insomnia comorbid with a psychiatric and/or medical condition. The mean ages of participants ranged from 31.4 to 73.1 years, and 65.4% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, symptom monitoring, TAU, sleep hygiene education, alternative active treatment (e.g., pharmacotherapy, MBSR)
PROCEDURE	Meta-analysis of RCTs published up to 2014 to examine the efficacy of CBT for insomnia comorbid with psychiatric and/or medical conditions. Number of treatment sessions ranged from two to 10 sessions.
SUMMARY OF FINDINGS	At posttreatment, effect sizes in favour of CBT were in the medium to large range across most sleep parameters, including sleep efficiency, sleep onset latency, wake after sleep onset, and sleep quality. Studies that could be included in subgroup analyses for follow-up indicated that treatment effects were maintained, with a medium effect size. Increasing the number of sessions was associated with slightly improved sleep quality outcomes.

TITLE OF ITEM	***A meta-analysis of group cognitive behavioral therapy for insomnia***
AUTHOR(S) AND SOURCE	Koffel, E. A., Koffel, J. B., & Gehrman, P. R. (2015). *Sleep Medicine Reviews, 19,* 6–16.
DESIGN	Meta-analysis (eight studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Group
PARTICIPANTS	608 adults with a diagnosis of insomnia. The mean ages of participants ranged from 45 to 67.8 years, and 79.4% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, TAU, active control (education, sleep monitoring with diaries)
PROCEDURE	Meta-analysis of RCTs published up to May 2013 investigating the effectiveness of CBT delivered in group format for adults with insomnia. The number of group therapy sessions ranged from four to eight, with session length ranging from 60 to 120 minutes.
SUMMARY OF FINDINGS	For participants receiving group CBT, large within-group effect sizes were found on measures of sleep onset latency, wake time after sleep onset, sleep efficiency, and sleep quality from pre-to post-treatment. Effect sizes remained large for sleep efficiency and sleep quality at follow-up, with medium treatment effects found for sleep onset latency, wake time after sleep onset, and total sleep time. Compared with pooled controls, medium to large between-group effect sizes in favour of CBT were found across most sleep-related parameters at both posttreatment and follow-up.

TITLE OF ITEM	***Internet-based cognitive–behavioural therapy for insomnia (ICBT-i): A meta-analysis of randomised controlled trials***
AUTHOR(S) AND SOURCE	Ye, Y-Y., Chen, N-k., Chen, J., Liu, J., Lin, L., Liu, Y-z., … Jiang, X-j. (2016). *BMJ Open, 6,* e010707. doi:10.1136/bmjopen-2015-010707
DESIGN	Meta-analysis (15 studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Online (guided and unguided)
PARTICIPANTS	1,604 adults with a diagnosis of insomnia. The mean ages of participants ranged from 36.9 to 59.6 years, and 70.5% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist control, TAU, alternative format CBT, online control.
PROCEDURE	Meta-analysis of RCTs published up to June 2016 evaluating the efficacy of online CBT for the treatment of insomnia in adults. Treatment duration ranged from 5 to 9 weeks.
SUMMARY OF FINDINGS	Compared with pooled controls, significant improvements from pre- to post-test were associated with CBT for sleep onset latency, total sleep time, sleep efficiency, and wake after sleep onset. Online CBT also significantly reduced the number of nocturnal awakenings and insomnia severity. Treatment gains remained significant at follow-up for measures of sleep onset latency, total sleep time, sleep efficiency, and wake after sleep onset.

TITLE OF ITEM	***Self-help cognitive-behavioral therapy for insomnia: A meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Ho, F. Y-Y., Chung, K-F., Yeung, W-F., Ng, T. H., Kwan, K-S., Yung, K. P., & Cheng, S. K. (2015). *Sleep Medicine Reviews, 19,* 17–28.
DESIGN	Meta-analysis (20 studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Self-help (varied delivery formats including online, booklets, and telephone)
PARTICIPANTS	2,411 adults diagnosed with insomnia according to diagnostic criteria or based on psychometric assessments. The mean age of participants was 49.3 years, and 74.2% were female.
TREATING CLINICIAN(S)	Not specified
INTERVENTION(S)	Self-help CBT
COMPARISON GROUP(S)	Waitlist control, clinician-administered CBT, routine care, no treatment, placebo.
PROCEDURE	Meta-analysis of RCTs published up to May 2013 evaluating the efficacy of self-help interventions across a range of delivery formats for adults with insomnia. In 12 studies, self-help was delivered in booklet form (with and without supplementary audio and video recordings), with the remaining studies mostly using online self-help. Treatment duration ranged from 4 days to 9 weeks, with an average of 5.2 weeks. In six studies, telephone consultation was included, ranging from three to eight sessions of 5–30 minutes each with clinical psychologists, counsellors, social workers, or psychology students.
SUMMARY OF FINDINGS	Dropout rate ranged from 0 to 44.4%, with an average of 14.5%. Self-help interventions were significantly more effective than was waitlist control, routine care, and no treatment, with medium to large effect sizes in favour of CBT at posttreatment for sleep efficiency, sleep onset latency, and wake after sleep onset. Small to medium effect sizes were also found in favour of CBT for total sleep time, number of awakenings, sleep quality, depression, and anxiety. Larger effect sizes were found for studies that included telephone consultation. Treatment effects remained significant for CBT compared with waitlist, routine care, or no treatment for sleep efficiency at 1 to 3 months' follow-up.

TITLE OF ITEM	***Mobile phone-delivered cognitive behavioral therapy for insomnia: A randomized waitlist controlled trial.***
AUTHOR(S) AND SOURCE	Horsch, C. H. G., Lancee, J., Griffioen-Both, F., Spruit, S., Fitrianie, S., Neerincx, M. A., … Brinkman, W-P. (2017). *Journal of Medical Internet Research, 19*(4), e70. doi:10.2196/jmir.6524
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Smartphone application
PARTICIPANTS	151 adults diagnosed with insomnia (the sample was considered to have relatively mild insomnia). The mean age of participants was 39.7 years, and 62.3% were female.
TREATING CLINICIAN(S)	Not specified
INTERVENTION(S)	CBT (n = 74)
COMPARISON GROUP(S)	Waitlist control (n = 77)
PROCEDURE	Participants randomly allocated to either CBT for insomnia delivered by a fully automated mobile phone application, or waitlist control. The program duration was 6 to 7 weeks, depending on participant adherence.
SUMMARY OF FINDINGS	Participants in the intervention group had significantly greater improvements than did waitlist control at posttreatment, with medium to large effect sizes observed on the primary outcome measures of insomnia severity and sleep efficiency. Improvements on all outcome measures except number of awakenings remained significant at follow-up.

MINDFULNESS-BASED STRESS REDUCTION (MBSR)

TITLE OF ITEM	***Mindfulness meditation for insomnia: A meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Gong, H., Ni, C-X., Liu, Y-Z., Zhang, Y., Su, W-J., Lian, Y-J., … Jiang, C-L. (2016). *Journal of Psychosomatic Research, 89,* 1–6.
DESIGN	Meta-analysis (six studies)
FOLLOW-UP	Details of follow-up periods were not reported. The meta-analysis was undertaken only on pre- to post-treatment data.
FORMAT	Individual, group
PARTICIPANTS	330 adults diagnosed with insomnia or sleep disorders, or who had a subjective complaint of sleep without a clinical diagnosis. Of the studies that reported participant age, the mean ages ranged from 42.9 to 66.3 years, and 55.9% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBSR (four studies), MBCT (one study), mindfulness meditation (one study)
COMPARISON GROUP(S)	Waitlist control, attention control (education or nondirective therapies), alternative active treatment
PROCEDURE	Meta-analysis of RCTs published to July 2015 examining the effectiveness of mindfulness-based interventions for the treatment of insomnia in adults. The intervention period ranged from 6 to 8 weeks.
SUMMARY OF FINDINGS	Participant dropout rate varied, ranging from very low (3.3%) to high (50%). Compared with pooled controls, a significant and medium effect size was found for sleep quality in favour of mindfulness-based interventions at posttreatment. Compared with pooled controls, a small to medium effect size was also found in favour of mindfulness-based interventions for total wake time. None of the remaining sleep parameters were statistically significant.

SEXUAL DISORDERS

SUMMARY OF EVIDENCE

There is Level I evidence for CBT including systematic desensitisation (based on a small number of studies within a meta-analysis) for the treatment of sexual disorders in adults. Level II evidence was found for interpersonal therapy and psychoeducation, and Level III-2 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 ITEM	***Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Fruhauf, S., Gerger, H., Schmidt, H. M., Munder, T., & Barth, J. (2013). *Archives of Sexual Behavior, 42,* 915–933.
DESIGN	Systematic review and meta-analysis (20 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group, self-help (bibliotherapy, internet-based)
PARTICIPANTS	Across studies, 1,041 adults diagnosed with sexual dysfunction. The reported age range of participants was 19 to 67 years.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Systematic desensitisation, CBT, psychoeducation
COMPARISON GROUP(S)	Waitlist control
PROCEDURE	Systematic review and meta-analysis of all available studies published from 1980 to 2009 examining the efficacy of psychological interventions for people with sexual dysfunction.
SUMMARY OF FINDINGS	In relation to symptom severity, a large effect size in favour of CBT was found compared with waitlist (based on two studies) for the treatment of vaginismus. One study provided evidence supporting psychoeducation compared with waitlist in the treatment of female orgasmic disorder, with a medium effect size observed. Small (based on three studies) and medium (based on one study) treatment effects were found in favour of systematic desensitisation compared with waitlist in the treatment of female orgasmic disorder and mixed sexual dysfunctions, respectively.

TITLE OF ITEM	***A randomized clinical trial comparing group cognitive–behavioral therapy and a topical steroid for women with dyspareunia***
AUTHOR(S) AND SOURCE	Bergeron, S., Khalifé, S., Dupuis, M. J., & McDuff, P. (2016). A randomized clinical trial comparing group cognitive–behavioral therapy and a topical steroid for women with dyspareunia. *Journal of Consulting and Clinical Psychology, 84,* 259–268.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	97 women diagnosed with provoked vestibulodynia, with a mean age of 27 years
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	CBT (*n* = 52)
COMPARISON GROUP(S)	Topical steroid (*n* = 45)
PROCEDURE	Participants were randomised to either group CBT or a topical steroid condition. The manualised CBT intervention consisted of 10 x 2-hour sessions over a 13-week period. The steroid condition comprised a twice-daily application of the steroid cream and reading educational material about provoked vestibulodynia and its day-to-day management.
SUMMARY OF FINDINGS	Both treatment groups reported statistically significant reductions in pain from baseline to posttreatment and 6-month follow-up; however, those in the CBT group reported significantly more pain reduction at 6-month follow-up. Similarly, both groups significantly improved on sexual functioning at posttreatment and follow-up; however, sexual functioning for the CBT group was significantly better than for participants in the steroid condition group at 6-month follow-up.

TITLE OF ITEM	***Clinical outcomes of a new self-help booklet for premature ejaculation***
AUTHOR(S) AND SOURCE	Kempeneers, P., Andrianne, R., Bauwens, S., Georis, I., Pairoux, J-F., & Blairy, S. (2012). *The Journal of Sexual Medicine, 9,* 2417–2428.
DESIGN	RCT
FOLLOW-UP	10 to 14 months
FORMAT	Self-help (bibliotherapy)
PARTICIPANTS	392 men with a diagnosis of premature ejaculation. The mean age of participants was 39.1 years.
TREATING CLINICIAN(S)	None
INTERVENTION(S)	Bibliotherapy (CBT; *n* = 326)
COMPARISON GROUP(S)	Waitlist control (*n* = 66)
PROCEDURE	Of the 392 participants, one-fifth were randomly selected to be on a 2-month waitlist before receiving the CBT-based bibliotherapy treatment developed by the authors, The Practical Guide of PE (in French). Posttest questionnaires were completed by 120 participants 4 to 8 months after receiving the self-help book, with a follow-up assessment on 79 participants at 10 to 14 months posttreatment.
SUMMARY OF FINDINGS	Significant improvements were found for the intervention group on all self-report outcome measures of sexual functioning, both at posttreatment (4 to 8 months following receipt of the self-help book) and at follow-up (10 to 14 months posttreatment).

TITLE OF ITEM	***The effectiveness of an internet-based psychological treatment program for female sexual dysfunction***
AUTHOR(S) AND SOURCE	Jones, L. M., & McCabe, M. P. (2011). *International Society for Sexual Medicine, 8,* 2781–2792.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Online (clinician guided)
PARTICIPANTS	53 women experiencing a female sexual disorder, but it is unclear whether participants met diagnostic criteria. Only 39 participants completed the treatment. The reported mean ages of the two groups were 34.9 and 33.3 years, respectively.
TREATING CLINICIAN(S)	Email contact with a clinical psychology doctoral student
INTERVENTION(S)	CBT (*n* = 26)
COMPARISON GROUP(S)	Waitlist control (*n* = 27)
PROCEDURE	Participants were randomly assigned to online CBT or waitlist. The CBT-based program consisted of three components: communication skills training, sensate focus exercises, and regular email contact with a clinician. The program consisted of five treatment modules and was designed to be completed within approximately 10 weeks.
SUMMARY OF FINDINGS	Compared with the control group, the treatment group reported significantly greater improvements in sexual functioning, sexual satisfaction, and relationship-related outcomes (including communication, sexual intimacy, and emotional intimacy) from baseline to posttreatment. Treatment gains were largely maintained at follow-up.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***The treatment of sexually dysfunctional women without partners: A controlled study of three behavioural group approaches***
AUTHOR(S) AND SOURCE	Stravynski, A., Gaudette, G., Lesage, A., Arbel, N., Bounader, J., Lachance, L., … Lamontagne, Y. (2007). *Clinical Psychology and Psychotherapy, 14,* 211–220.
DESIGN	RCT
FOLLOW-UP	6 and 12 months
FORMAT	Group
PARTICIPANTS	49 women diagnosed with sexual dysfunction. The mean ages of the four groups ranged from 39.2 to 41.4 years.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	IPT, CBT, combined IPT and CBT
COMPARISON GROUP(S)	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 four 6-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.
SUMMARY OF FINDINGS	All treatment groups showed superior improvements compared with the control group. Two-thirds of participants in the treatment groups made clinical gains and one-third no longer fulfilled 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.

PSYCHOEDUCATION

TITLE OF ITEM	***Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Fruhauf, S., Gerger, H., Schmidt, H. M., Munder, T., & Barth, J. (2013). *Archives of Sexual Behavior, 42,* 915–933.
DESIGN	Systematic review and meta-analysis (20 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group, self-help (bibliotherapy, internet-based)
PARTICIPANTS	1,041 adults diagnosed with sexual dysfunction. The reported age range of participants was 19 to 67 years.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducation, systematic desensitisation, CBT
COMPARISON GROUP(S)	Waitlist control
PROCEDURE	Systematic review and meta-analysis of all available studies published from 1980 to 2009 examining the efficacy of psychological interventions for people with sexual dysfunction
SUMMARY OF FINDINGS	In relation to symptom severity, a large effect size in favour of CBT was found compared with waitlist (based on two studies) for the treatment of vaginismus. One study provided evidence supporting psychoeducation compared with waitlist in the treatment of female orgasmic disorder, with a medium effect size. Compared with waitlist, small (based on three studies) and medium (based on one study) treatment effects were found in favour of systematic desensitisation in the treatment of female orgasmic disorder and mixed sexual dysfunctions, respectively.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***Mindfulness-based group therapy for women with provoked vestibulodynia***
AUTHOR(S) AND SOURCE	Brotto, L. A., Basson, R., Smith, K. B., Driscoll, M., & Sadownik, L. (2015). *Mindfulness, 6,* 417–432.
DESIGN	Nonrandomised comparative study with concurrent control
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	85 women diagnosed with provoked vestibulodynia. The mean ages of the two treatment groups were 39.0 and 40.4 years.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBCT (n = 62)
COMPARISON GROUP(S)	Waitlist control (n = 23)
PROCEDURE	Participants were assigned to MBCT or waitlist control. The MBCT treatment consisted of four 2-hour group sessions delivered every 2 weeks and encompassing mindfulness meditation skills, CBT, and psychoeducation.
SUMMARY OF FINDINGS	There were statistically significant reductions in sexual distress and pain-related measures (including pain self-efficacy, pain catastrophizing, pain vigilance, and allodynia) from pre- to post-treatment and from posttreatment to follow-up. Depressive symptoms also significantly decreased from pre- to post-treatment, but no further improvements were made from posttreatment to follow-up.

TITLE OF ITEM	***Group mindfulness-based therapy significantly improves sexual desire in women***
AUTHOR(S) AND SOURCE	Brotto, L. A., & Basson, R. (2014). *Behaviour Research and Therapy, 57,* 43–54.
DESIGN	Pseudorandomised controlled trial
FOLLOW-UP	6 months
FORMAT	Group
PARTICIPANTS	115 women aged 19 to 65 with a DSM-IV-TR diagnosis of hypoactive sexual desire disorder (HSDD) or female sexual arousal disorder (FSAD). Mean ages were 40.8 years for the treatment group and 42.2 years for the control group.
TREATING CLINICIAN(S)	Sexual medicine clinicians with experience in mindfulness-based therapy
INTERVENTION(S)	Mindfulness-based cognitive behavioural sex therapy (n = 67)
COMPARISON GROUP(S)	Waitlist control (n = 48)
PROCEDURE	Controlled trial to determine the effectiveness of mindfulness-based cognitive behavioural sex therapy for women with low sexual desire. About half of participants were not randomised to treatment/control groups due to clinical requirements to treat in a timely manner, or participant-scheduling difficulties. MBCST consisted of psychoeducation about sexual desire response, as well as components of CBT integrated with mindfulness practice. Participants attended a total of 4 group sessions, each 2 weeks apart, and comprising four to seven women.
SUMMARY OF FINDINGS	In comparison to the waitlist condition, MBCST effectively improved sexual desire, arousal, satisfaction, and functioning at posttreatment. In both treatment and control conditions, sex-related distress and depressive symptoms significantly decreased. Overall, improvements in sexual desire were associated with increases in mindfulness and a reduction in depressive symptoms.

PAIN DISORDER

SUMMARY OF EVIDENCE

There is a vast amount of research on chronic pain at various anatomical sites (e.g., back pain, chest pain, pelvic pain, headaches) as well as for disorders that are frequently associated with chronic pain conditions (e.g., fibromyalgia, irritable bowel syndrome, arthritis), and conditions classified under the term "medically unexplained physical symptoms". However, little research has been conducted that addresses pain disorder defined as a discrete diagnostic category. In keeping with the scope of the current review, only studies that included participants diagnosed with pain disorders as defined by ICD-10 or DSM have been included.

Based on these criteria, there is Level II evidence for CBT (delivered to groups) for the treatment of pain disorder in adults. There is further Level II evidence for acceptance and commitment therapy, both group-delivered (based on one small RCT) and guided online delivery (based on one RCT and with positive treatment outcomes for "treatment adherers" only). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***The effectiveness of group acceptance and commitment therapy on pain intensity, pain catastrophizing and pain-associated anxiety in patients with chronic pain***
AUTHOR(S) AND SOURCE	Nasiri, A., & Kazemi-Zahrani, H. (2015). *Asian Social Science, 11*(26), 112–120.
DESIGN	RCT
FOLLOW-UP	1 month
FORMAT	Group
PARTICIPANTS	30 adults diagnosed with chronic pain disorder living in Iran. The mean ages of the two groups were 38 and 41 years, and 88% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	ACT (n = 15)
COMPARISON GROUP(S)	Control (not specified) (n = 15)
PROCEDURE	Participants randomly allocated to group ACT or an unspecified control condition. The ACT group therapy consisted of weekly 90-minute sessions of therapy over an 8-week period.
SUMMARY OF FINDINGS	Compared with the control group, participants in the ACT group demonstrated significant improvements in pain intensity, pain catastrophising, and pain-associated anxiety at posttreatment, with treatment effects maintained at 1-month follow-up.

TITLE OF ITEM	***Internet-based guided self-help intervention for chronic pain based on acceptance and commitment therapy: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Trompetter, H. R., Bohlmeijer, E. T., Veehof, M. M., & Schreurs, K. M. G. (2015). *The Journal of Behavioral Medicine, 38,* 66–80.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Online (clinician guided)
PARTICIPANTS	238 adults assessed as having a chronic pain disorder, but only 172 participants completed the treatment. The mean ages of the intervention and comparison groups were 52 and 53 years, and 76% were female.
TREATING CLINICIAN(S)	Recent psychology graduates under supervision
INTERVENTION(S)	ACT (*n* = 82)
COMPARISON GROUP(S)	Expressive writing (*n* = 79), waitlist (*n* = 77)
PROCEDURE	Participants were randomly allocated to one of three conditions: an online guided self-help ACT intervention, an online control intervention based on expressive writing, or a waitlist control. The ACT intervention, Living with Pain, consisted of nine online modules designed to be completed within 9 to 12 weeks. Those assigned to expressive writing completed a nine-module internet intervention, also designed to be completed within 9 to 12 weeks. After brief psychoeducation, participants were required to make entries in an online personal diary about experiences and emotions related to chronic pain or other stressful situations three times per week for 15 minutes. Email support from psychology graduates was provided to participants in both active groups for guidance, encouragement, and support once per week.
SUMMARY OF FINDINGS	On the primary outcome measure of pain interference, small and medium treatment effects were found in favour of ACT at posttreatment and follow-up, respectively, compared with the expressive writing group. No significant differences were found for ACT compared with waitlist. However, when differences between treatment adherers were assessed (i.e., those who engaged in the intervention for at least 3 hours per week), significant improvements with medium effect sizes were found for the ACT group compared with waitlist at both posttreatment and follow-up.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Effective group training for patients with unexplained physical symptoms: A randomized controlled trial with a non-randomized 1-year follow-up***
AUTHOR(S) AND SOURCE	Zonneveld, L. N. L., van Rood, Y. R., Timman, R., Kooiman, C. G., van't Spijker, A., & Busschbach, J. J. V. (2012). *PLoS ONE, 7*(8). doi:10.1371/journal.pone.0042629
DESIGN	RCT
FOLLOW-UP	3 and 12 months
FORMAT	Group
PARTICIPANTS	162 adults diagnosed with chronic pain disorder (61.1%) or undifferentiated somatoform disorder (38.9%). The mean ages of the two groups were 44 and 46 years, respectively, and 80.9% were female.
TREATING CLINICIAN(S)	Community mental health service
INTERVENTION(S)	CBT (*n* = 84)
COMPARISON GROUP(S)	Waitlist control (*n* = 78)
PROCEDURE	Participants were randomly allocated to group CBT or a waitlist control. The manualised group treatment, Coping With the Consequences of Unexplained Physical Symptoms, consisted of weekly 2-hour sessions over a 13-week period. Participants received a mean of 11 treatment sessions.
SUMMARY OF FINDINGS	Compared with the waitlist condition at posttreatment, a small to medium effect size in favour of group CBT was found on the physical domain of the quality of life measure, but not on the mental domain. Additionally, the intensity of a broad range of psychological problems and psychopathology symptoms was reduced for the CBT group at posttreatment, with small to medium effect sizes. Treatment effects were either maintained or slightly improved over the two follow-up time points.

HYPOCHONDRIASIS

SUMMARY OF EVIDENCE

There is Level I evidence for CBT and psychoeducation for the treatment of hypochondriasis in adults. There is Level II evidence for cognitive behaviour-therapy based self-help (clinician-guided and unguided online and bibliotherapy), acceptance and commitment therapy (group-based), and mindfulness-based cognitive therapy. Level IV evidence was found for metacognitive therapy based on a single, very small study. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive behaviour therapy for health anxiety: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Cooper, K., Gregory, J. D., Walker, I., Lambe, S., & Salkovskis, P. M. (2017). *Behavioural and Cognitive Psychotherapy, 45,* 110–123.
DESIGN	Systematic review and meta-analysis (14 studies)
FOLLOW-UP	6 and 12 months' follow-up data were available
FORMAT	Individual, group, online (guided and unguided)
PARTICIPANTS	1,544 adults with clinical or subclinical hypochondriasis. Eleven of the 14 studies included participants meeting diagnostic criteria for hypochondriasis. The mean ages across studies ranged from 34 to 68.7 years, and 62.4% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, psychoeducation
COMPARISON GROUP(S)	Waitlist, TAU, pharmacotherapy, placebo, other psychological therapy, psychosocial support
PROCEDURE	Systematic review and meta-analysis of RCTs published between 1979 and 2014 investigating the efficacy of CBT for clinical and subclinical hypochondriasis in adults
SUMMARY OF FINDINGS	Compared with pooled control conditions on health anxiety measures, large treatment effect sizes were found in favour of CBT at posttreatment, 6 months' follow-up (based on seven comparisons), and 12-month follow-up (based on six comparisons). When subgroup analyses were conducted according to comparison group, a large effect size remained compared with waitlist, and a medium to large effect size was found compared with TAU and other active treatments.

TITLE OF ITEM	***Cognitive-behavioral therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators***
AUTHOR(S) AND SOURCE	Olatunji, B. O., Kauffman, B. Y., Meltzer, S., Davis, M. L., Smits, J. A. J., & Powers, M. B. (2014). *Behaviour Research and Therapy, 58,* 65–74.
DESIGN	Meta-analysis (13 studies)
FOLLOW-UP	Details of follow-up periods not reported
FORMAT	Not reported
PARTICIPANTS	1,081 adults diagnosed with hypochondriasis or with clinical levels of health anxiety. The mean ages ranged from 35 to 68.9 years.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Waitlist, TAU, psychological placebo, pill placebo
PROCEDURE	Meta-analysis of RCTs published between 1966 and 2014 investigating the effectiveness of CBT and moderators of treatment of hypochondriasis or health anxiety in adults. The number of treatment sessions ranged from three to 16.
SUMMARY OF FINDINGS	On primary and secondary outcome measures, CBT led to significantly better treatment outcomes compared with pooled control conditions, with a large effect size at posttreatment. The treatment effect was reduced to a small effect size at follow-up. A significant relationship was also found between number of treatment sessions and effect size (based on nine studies), with more sessions associated with larger effect sizes at posttreatment.

TITLE OF ITEM	***Exposure-based cognitive–behavioural therapy via the internet and as bibliotherapy for somatic symptom disorder and illness anxiety disorder: Randomised controlled trial***
AUTHOR(S) AND SOURCE	Hedman, E., Axelsson, E., Andersson, E., Lekander, M., & Ljtsson, B. (2016). *The British Journal of Psychiatry, 209,* 407–413.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Online (clinician guided and unguided) and self-help (bibliotherapy)
PARTICIPANTS	132 adults with a DSM-5 diagnosis of somatic symptom disorder or illness anxiety disorder (89.4% met DSM-IV criteria for hypochondriasis). The mean ages of the groups ranged from 35.4 to 41.5 years, and 74.2% were female.
TREATING CLINICIAN(S)	Psychologists (for the clinician-guided condition)
INTERVENTION(S)	Clinician guided online CBT (n = 32), unguided online CBT (n = 33), bibliotherapy (n = 34)
COMPARISON GROUP(S)	Waitlist control (n = 33)
PROCEDURE	Participants were randomly allocated to one of four conditions: clinician-guided online CBT, unguided online CBT, unguided bibliotherapy, or waitlist control. All active treatments had the same content and duration of treatment (12 text-based modules across 12 weeks), but differed in terms of degree of clinician guidance and format (internet versus self-help book). The main component of the treatments was systematic exposure to health anxiety-related situations or events, in combination with response prevention. Participants in the clinician-guided condition received correspondence over email from a designated clinician who provided feedback on homework tasks and general guidance as needed for progressing through treatment.
SUMMARY OF FINDINGS	Participants in the unguided online CBT group completed significantly fewer treatment modules than did those in the clinician–guided group. Large between-group effect sizes were found for all active treatment conditions compared with waitlist control on the primary outcome measure of health anxiety. Large within-group treatment effects were demonstrated for all active conditions compared with waitlist at posttreatment and follow-up, with the largest effect for the clinician-guided condition and the smallest for bibliotherapy.

TITLE OF ITEM	***Metacognitive therapy in the treatment of hypochondriasis: A systematic case series***
AUTHOR(S) AND SOURCE	Bailey, R., & Wells, A. (2014). *Cognitive Therapy and Research, 38,* 541–550.
DESIGN	Case series, with pretest and posttest
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	Four adults diagnosed with hypochondriasis. The mean age of participants was 46.7 years, and three participants were female.
TREATING CLINICIAN(S)	PhD psychology graduate under supervision by a clinical psychologist
INTERVENTION(S)	Metacognitive therapy
COMPARISON GROUP(S)	None
PROCEDURE	Participants were assigned to a no-treatment baseline phase for 3 to 4 weeks prior to beginning treatment to observe the stability in the outcome measures. The manualised metacognitive therapy intervention consisted of weekly 1-hour sessions. Participants received between six and nine individual therapy sessions.
SUMMARY OF FINDINGS	All measures were stable during the no-treatment baseline phase. From baseline to posttreatment, all participants demonstrated significant improvements on measures of hypochondriacal symptom severity, anxiety, and depression. Treatment gains were maintained at follow-up.

PSYCHOEDUCATION

TITLE OF ITEM	***Current directions in the treatment of hypochondriasis***
AUTHOR(S) AND SOURCE	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)
FOLLOW-UP	Nil to 12 months
FORMAT	Individual, group
PARTICIPANTS	448 adults diagnosed with hypochondriasis or with subclinical hypochondriasis. The mean ages ranged from 24 to 48 years, and 63.9% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducation, CBT
COMPARISON GROUP(S)	Pharmacotherapy (fluoxetine), waitlist control, TAU
PROCEDURE	Meta-analysis of controlled and uncontrolled studies comparing psychosocial and pharmacological treatments for hypochondriasis in adults. Participants received between six and 17 treatment sessions, across a range of 6 to 21 weeks.
SUMMARY OF FINDINGS	The pre- to post-treatment effect sizes for measures of hypochondriasis suggest that CBT (based on four studies) and fluoxetine (based on two studies) tended to yield the largest effects for treatment completers with full hypochondriasis. For mixed samples, psychoeducation (based on two studies) and CBT (based on one study) yielded the largest effect sizes compared with waitlist controls and TAU. For studies reporting follow-up data, results indicated that CBT (based on four studies) had the largest effect sizes in studies of full hypochondriasis, and psychoeducation (based on two studies) and CBT (based on one study) had the largest effect sizes in studies of mixed full hypochondriasis and abridged hypochondriasis.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Acceptance and commitment group therapy (ACT-G) for health anxiety: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Eilenberg, T., Fink, P., Jensen, J. S., Rief, W., & Frostholm, L. (2016). *Psychological Medicine, 46,* 103–115.
DESIGN	RCT
FOLLOW-UP	3 and 6 months
FORMAT	Group
PARTICIPANTS	126 adults diagnosed with severe health anxiety and assessed as having hypochondriasis. The mean age of participants in the treatment and comparison groups was 37 and 35.5 years respectively. 70.6% of participants were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	ACT (*n* = 63)
COMPARISON GROUP(S)	Waitlist control (*n* = 63)
PROCEDURE	Participants were randomly allocated to manualised group ACT or waitlist control. Treatment involved nine weekly 3-hour group therapy sessions, with an additional booster session 1 month after the final session.
SUMMARY OF FINDINGS	Compared with waitlist, a large between-group effect size in favour of ACT was found for the primary outcome measure of illness worry at posttreatment, with treatment effects maintained at 6-month follow-up. Participants in the ACT group also demonstrated significantly greater improvement on secondary measures of emotional distress and mental health-related quality of life, with small to medium effect sizes observed across outcomes at follow-up.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***A randomized clinical trial of mindfulness-based cognitive therapy versus unrestricted services for health anxiety (hypochondriasis)***
AUTHOR(S) AND SOURCE	McManus, F., Surawy, C., Muse, K., Vazquez-Montes, M., & Williams, J. M. G. (2012). *Journal of Consulting and Clinical Psychology, 80,* 817–828.
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Group
PARTICIPANTS	74 adults diagnosed with hypochondriasis. The mean age of participants in the treatment and comparison groups was 41.3 and 43.9 years, respectively. 78.4% of participants were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBCT plus unrestricted usual services (*n* = 36)
COMPARISON GROUP(S)	TAU (*n* = 38)
PROCEDURE	Participants were randomly allocated to either MBCT in addition to TAU, or TAU alone. The manualised MBCT intervention consisted of weekly 2-hour sessions delivered over an 8-week period. Participants attended a mean of 6.5 intervention sessions.
SUMMARY OF FINDINGS	Compared with TAU alone, a medium between-group effect size in favour or MBCT plus TAU was found on the primary outcome measure of health anxiety at both posttreatment and follow-up. General levels of anxiety and depression did not differ between the groups at any time point. Significantly fewer participants in the MBCT group met diagnostic criteria for hypochondriasis at both posttreatment and follow-up.

BODY DYSMORPHIC DISORDER (BDD)

SUMMARY OF EVIDENCE

There is Level I evidence for CBT for the treatment of body dysmorphic disorder (BDD) in adults. Level II evidence supports online CBT (clinician guided) and metacognitive therapy (based on one small RCT). Level IV evidence was found for acceptance and commitment therapy (group and individual; based on one small study). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive-behavioral therapy for body dysmorphic disorder: A systematic review and meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Harrison, A., Fernández de la Cruz, L., Enander, J., Radua, J., & Mataix-Cols, D. (2016). *Clinical Psychology Review, 48,* 43–51.
DESIGN	Systematic review and meta-analysis (seven studies)
FOLLOW-UP	Details about follow-up periods were not reported
FORMAT	Individual (five studies), group (one study), online (one study)
PARTICIPANTS	299 people diagnosed with BDD, mostly adults but one study included an adolescent sample. The mean ages of participants ranged from 16 to 36.5 years, and 81.6% participants were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	No treatment, waitlist control, alternative psychological intervention
PROCEDURE	Systematic review and meta-analysis of RCTs of CBT for BDD published up to November 2015. Across studies, participants received between eight and 14 sessions of therapy.
SUMMARY OF FINDINGS	At posttreatment, compared with pooled control conditions a large significant effect size in favour of CBT was found for measures of BDD symptom severity. Follow-up data from three studies indicated that treatment gains were maintained 2 to 4 months posttreatment. A medium treatment effect in favour of CBT was also found on measures of depression and insight/delusionality posttreatment.

TITLE OF ITEM	***Therapist guided internet based cognitive behavioural therapy for body dysmorphic disorder: Single blind randomised controlled trial***
AUTHOR(S) AND SOURCE	Enander, J., Andersson, E., Mataix-Cols, D., Lichtenstein, L., Alström, K., Andersson, G., … Rück, C. (2016). *The British Medical Journal, 352,* 241. https://doi.org/10.1136/bmj.i241
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Online (clinician-guided)
PARTICIPANTS	94 adults diagnosed with BDD. The mean ages of participants in the two groups were 34 and 31 years, and 85.1% were female.
TREATING CLINICIAN(S)	Clinical psychology students supervised by a clinical psychologist
INTERVENTION(S)	Online CBT (*n* = 47)
COMPARISON GROUP(S)	Online supportive therapy (*n* = 47)
PROCEDURE	Participants were randomly allocated to clinician-guided online CBT or online supportive therapy. The online intervention consisted of eight modules delivered over 12 weeks with contact via email to a designated clinician. Clinicians spent a median of 13 minutes per week per participant, providing feedback on homework assignments and general support throughout the intervention. Participants assigned to supportive therapy received unlimited access to a clinician over email. Clinicians spent a median of 6 minutes per participant per week responding to emails.
SUMMARY OF FINDINGS	Significant and large between-group effect sizes were found in favour of the online CBT group on the primary outcome measure of BDD symptom severity, both at posttreatment and follow-up. Small to medium between-group effects were also demonstrated on secondary measures of depression and global functioning at posttreatment and follow-up in favour of the intervention group.

TITLE OF ITEM	***Metacognitive therapy for body dysmorphic disorder patients in Iran: Acceptability and proof of concept***
AUTHOR(S) AND SOURCE	Rabiei, M., Mulkens, S., Kalantari, M., Molavi, H., & Bahrami, F. (2012). *Journal of Behavior Therapy and Experimental Psychiatry, 43,* 724–729.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	20 adults diagnosed with BDD. The mean age of participants was 25.2 years, and 90% were female.
TREATING CLINICIAN(S)	Clinical psychologist
INTERVENTION(S)	Metacognitive therapy (*n* = 10)
COMPARISON GROUP(S)	Waitlist control (*n* = 10)
PROCEDURE	Participants were randomly allocated to one of two groups: metacognitive therapy or waitlist. The intervention consisted of eight weekly 45 to 60-minute therapy sessions delivered according to a manual.
SUMMARY OF FINDINGS	Mean scores on the measure of BDD symptom severity and secondary outcome measure of thought fusion significantly improved for those in the intervention group from baseline to posttreatment compared with the control group, with treatment results maintained at follow-up.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Acceptance-based exposure therapy for body dysmorphic disorder: A pilot study***
AUTHOR(S) AND SOURCE	Linde, J., Rück, C., Bjureberg, J., Ivanov, V. Z., Djurfeldt, D. R., & Ramnerö, J. (2015). *Behavior Therapy, 46,* 423–431.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	6 months
FORMAT	Group and individual
PARTICIPANTS	21 adults diagnosed with BDD. The mean age of participants was 27.3 years, and 61.9% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	ACT
COMPARISON GROUP(S)	None
PROCEDURE	Participants received a manualised acceptance-based exposure therapy intervention consisting of 12 weekly 180-minute group sessions and weekly individual 60-minute sessions beginning in the third week of treatment. Participants completed a mean of 10 group and six individual therapy sessions over the intervention period.
SUMMARY OF FINDINGS	A significant reduction from baseline to posttreatment was found on the primary outcome measure of BDD symptom severity, with a large within-group effect size. Treatment effects were maintained at follow-up. Large effect sizes were also demonstrated for secondary measures of depression and disability at posttreatment.

SOMATISATION DISORDER

SUMMARY OF EVIDENCE

There is a vast amount of research on conditions classified under the term "medically unexplained physical symptoms", somatoform disorders more broadly, and "abridged somatisation disorder" (generally defined as meeting four of the six somatic symptoms for somatisation disorder). Furthermore, some researchers conceptualise somatisation disorders as including conditions such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome. However, little research has been conducted that addresses somatisation disorder defined as a discrete diagnostic category.

In keeping with the scope of the current review, only studies that included participants diagnosed with somatisation disorders as defined by ICD-10 or DSM have been included.

Based on these criteria, there is Level II evidence for CBT for 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 ITEM	***Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults***
AUTHOR(S) AND SOURCE	van Dessel, N., den Boeft, M., van der Wouden, J. C., Kleinstäuber, M., Leone, S. S., Terluin, B., … van Marwijk, H. (2014). *Cochrane Database of Systematic Reviews, 2014*(11), CD011142. doi:10.1002/14651858.CD011142.pub2
DESIGN	Systematic review (21 studies) and meta-analysis (19 studies)
FOLLOW-UP	2 weeks to 2 years
FORMAT	Individual, group
PARTICIPANTS	2,658 adults with medically unexplained physical symptoms (nine studies) or who met diagnostic criteria for somatisation disorder or somatoform disorder (three studies), somatisation symptoms (five studies), or bodily distress syndrome (four studies). The mean age was 43 years in all included studies, ranging from 35 to 49 years. Most studies comprised more females than males.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, mindfulness-based interventions, psychodynamic therapy
COMPARISON GROUP(S)	Wait list, TAU, enhanced or structured care, alternative therapy
PROCEDURE	Systematic review and meta-analysis of RCTs and cluster RCTs published up to November 2013 to assess the effectiveness of nonpharmacological interventions for somatoform disorders and medically unexplained physical symptoms in adults. Across studies, the mean number of sessions ranged from one to 13 over a period of 1 day to 9 months.
SUMMARY OF FINDINGS	Psychological therapies as a whole were found to be more effective than TAU and waitlist in terms of the reduction of symptom severity, but effect sizes were small. For the studies in which CBT was investigated, compared with TAU or waitlist, CBT was shown to be significantly more effective in reducing the severity of somatic symptoms at posttreatment, with a small to medium treatment effect. Results were maintained up to 1 year follow-up. The overall quality of the evidence was considered to be low.

BORDERLINE PERSONALITY DISORDER (BPD)

SUMMARY OF EVIDENCE

There is Level I evidence for dialectical behaviour therapy, psychodynamic therapy, and schema therapy (based on a meta-analysis of five variable-quality studies) for the treatment of borderline personality disorder (BPD) in adults. There is Level II evidence for group-based acceptance and commitment therapy (based on one small pilot RCT), CBT, interpersonal therapy, and psychoeducation (although effectiveness across outcome measures was limited). Level IV evidence was found for mindfulness-based cognitive therapy. However, this was based on a single, very small feasibility study. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). *JAMA Psychiatry, 74,* 319–328.
DESIGN	Systematic review and meta-analysis (33 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Individual, group
PARTICIPANTS	2,256 adults diagnosed with BPD
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	DBT, psychodynamic therapies, CBT
COMPARISON GROUP(S)	TAU, supportive therapy, ad hoc control group
PROCEDURE	Systematic review and meta-analysis of RCTs published up to November 2015 investigating the efficacy of psychotherapies for the treatment of BPD in adults. Treatment duration ranged from 2.5 to 24 months, and the number of sessions ranged from 6 to 312.
SUMMARY OF FINDINGS	When subgroup analyses were undertaken based on intervention, DBT and psychodynamic therapies were the only interventions shown to be more effective than pooled control conditions. Based on nine studies, a small effect size was found in favour of DBT at posttreatment, and a medium effect size was found at follow-up based on four studies. Small to medium effects were found in favour of psychodynamic therapies at both posttreatment (based on seven studies) and follow-up (based on two studies).

PSYCHODYNAMIC THERAPY

See Cristea et al. (2017) in the previous section for a summary of findings related to psychodynamic therapy.

SCHEMA THERAPY

TITLE OF ITEM	***Schema therapy for personality disorders: A review***
AUTHOR(S) AND SOURCE	Jacob, G. A., & Arntz, A. (2013). *International Journal of Cognitive Therapy, 6,* 171–185.
DESIGN	Meta-analysis (5 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group
PARTICIPANTS	204 adults diagnosed with borderline personality disorder. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Schema therapy
COMPARISON GROUP(S)	TAU, alternative psychological intervention, telephone crisis support, no comparison group (two studies)
PROCEDURE	Meta-analysis of available studies using schema therapy for the treatment of BPD in adults including case series, open trials, and RCTs. Treatment duration across the five studies ranged from 10 weeks to 3 years.
SUMMARY OF FINDINGS	From pre- to post-treatment, a large effect size in favour of schema therapy was found on measures of BPD psychopathology. Larger effect sizes were observed for studies with longer treatment duration (i.e., between 18 and 36 months).

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Acceptance and commitment therapy group treatment for symptoms of borderline personality disorder: A public sector pilot study***
AUTHOR(S) AND SOURCE	Morton, J., Snowdon, S., Gopold, M., & Guymer, E. (2012). *Cognitive and Behavioral Practice, 19,* 527–544.
DESIGN	Pilot RCT
FOLLOW-UP	13 weeks
FORMAT	Group
PARTICIPANTS	41 adult outpatients with four or more of the nine BPD DSM-IV diagnostic criteria (participants met on average six criteria). The mean ages of participants in the two groups were 35.6 and 34 years, and 92.7% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	ACT plus TAU (n = 21)
COMPARISON GROUP(S)	TAU control (n = 20)
PROCEDURE	Participants were randomly allocated to either a brief group-based ACT intervention consisting of 12 x 2-hour weekly therapy sessions, or TAU which typically consisted of medication management, low-key support, and crisis support if needed. Participants in the TAU group were offered the ACT intervention after 13 weeks.
SUMMARY OF FINDINGS	Significantly greater improvements from baseline to posttreatment were found for the intervention group when compared with the control group on the primary outcome measure, self-rated BPD symptoms. This was associated with a large within-group effect size. Secondary outcome measures of anxiety and hopelessness also improved significantly more for the ACT group compared with the control group, with small and large within-group effect sizes respectively. Based on data from 10 participants, treatment gains were maintained at follow-up for the intervention group.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Influence of therapist competence and quantity of cognitive behavioural therapy on suicidal behaviour and inpatient hospitalisation in a randomised controlled trial in borderline personality disorder: Further analyses of treatment effects in the BOSCOT study***
AUTHOR(S) AND SOURCE	Norrie, J., Davidson, K., Tata, P., & Gumley, A. (2013). *Psychology and Psychotherapy: Theory, Research and Practice, 86,* 280–293.
DESIGN	Secondary analysis of RCT
FOLLOW-UP	6 and 12 months
FORMAT	Individual
PARTICIPANTS	106 adults diagnosed with BPD. The mean age of participants was 31.9 years, and 84% were female.
TREATING CLINICIAN(S)	Mental health nurses and an occupational therapist
INTERVENTION(S)	CBT plus TAU (*n* = 54)
COMPARISON GROUP(S)	TAU (*n* = 52)
PROCEDURE	In the initial RCT, participants were randomly allocated to one of two groups: CBT adapted for personality disorders plus TAU or TAU alone. The intervention consisted of up to 30 sessions of CBT over 12 months. Participants received an average of 16 sessions (ranging from 0 to 35 sessions) over the 12-month period, with 51% of participants receiving 15 or more sessions.
SUMMARY OF FINDINGS	Results of the initial RCT indicated a statistically significant improvement over the 2-year treatment and follow-up period for both groups on primary and secondary outcome measures. The intervention group demonstrated greater improvements on one of the primary outcome measures, number of suicide attempts, compared with TAU. When taking into account the impact of therapy duration and clinician competence, CBT was estimated to be more effective when delivered by a competent clinician with therapy duration of up to 15 sessions.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Combined therapy with interpersonal psychotherapy adapted for borderline personality disorder: A 2-years follow-up***
AUTHOR(S) AND SOURCE	Bozzatello, P., & Bellino, S. (2016). *Psychiatry Research, 240,* 151–156.
DESIGN	Follow-up of RCT
FOLLOW-UP	2 years
FORMAT	Individual
PARTICIPANTS	55 adults diagnosed with BPD. The mean age of participants included in the follow-up study was 26 years, and 70.5% were female.
TREATING CLINICIAN(S)	Clinicians (details not reported)
INTERVENTION(S)	Fluoxetine plus IPT (*n* = 27)
COMPARISON GROUP(S)	Fluoxetine plus clinical management (*n* = 28)
PROCEDURE	In the initial RCT, participants had been randomly allocated to two treatment conditions: fluoxetine plus IPT, or fluoxetine plus clinical management. All participants received 20–40 mg fluoxetine per day over 32 weeks, and those in the intervention group received 34 sessions of manualised IPT adapted for BPD.
SUMMARY OF FINDINGS	Thirty participants completed the full 2-year follow-up assessments. In the original RCT, participants in both treatment groups had improved significantly over the treatment period with some additional benefits apparent for those in the combined fluoxetine plus IPT group, including a reduction in the severity of anxiety symptoms, improvements in subjective psychological and social functioning, and reductions in the severity of BPD symptoms. At the 2-year follow-up, some advantages were maintained for the combined therapy group including treatment gains on some of the core BPD symptoms (impulsivity and interpersonal relationships) and domains of subjective quality of life (psychological and social functioning).

PSYCHOEDUCATION

TITLE OF ITEM	***Comparing effectiveness of treatments for borderline personality disorder in communal mental health care: The Oulu BPD study***
AUTHOR(S) AND SOURCE	Leppanen, V., Hakko, H., Sintonen, H., & Lindeman, S. (2016). *Community Mental Health Journal, 52,* 216–227.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	71 adults diagnosed with BPD, with 51 completing the 1-year intervention period. The mean ages of the two participant groups were 31.9 and 32.2 years, and 85.9% were female.
TREATING CLINICIAN(S)	Psychiatric nurses and an occupational therapist
INTERVENTION(S)	Psychoeducation (*n* = 24)
COMPARISON GROUP(S)	TAU (*n* = 47)
PROCEDURE	Participants were randomly allocated to either a manualised psychoeducation group intervention based on schema therapy and aspects of dialectical behaviour therapy, or TAU. Those in the intervention group attended a total of 40 x 90-minute psychoeducational group sessions across a 1-year period (approximately one session per week), as well as individual weekly 45–60 minute therapy sessions.
SUMMARY OF FINDINGS	After 1 year of treatment, BPD symptoms significantly decreased in both the treatment and control groups. The mean scores between the two groups were not significantly different. Compared with TAU, participants in the intervention group also demonstrated significant improvements in quality of life measures.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***A feasibility study of mindfulness-based cognitive therapy for individuals with borderline personality disorder***
AUTHOR(S) AND SOURCE	Sachse, S., Keville, S., & Feigenbaum, J. (2011). *Psychology and Psychotherapy: Theory, Research and Practice, 84,* 184–200.
DESIGN	Case series
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	22 adults diagnosed with BPD. The mean age of participants was 39 years, and 86.4% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	MBCT
COMPARISON GROUP(S)	None
PROCEDURE	All participants received the manualised MBCT intervention adapted for individuals with BPD, which consisted of eight weekly 2-hour group therapy sessions. Participants attended a mean of 4.9 sessions, with 72.7% of the sample considered treatment completers (attended at least four sessions).
SUMMARY OF FINDINGS	Participants significantly improved on measures of attentional control from pre- to post-treatment, with small to medium effect sizes. For those who completed treatment, significant reductions were found from pre- to post-treatment on depressive symptoms. Individuals who demonstrated improvements in mindfulness also showed significant improvements on frequency of experiencing symptoms of physical dissociation.

PSYCHOTIC DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT, family interventions, and psychoeducation (with most evidence for group and family format) for the treatment of psychotic disorders in adults. Level II evidence was found for acceptance and commitment therapy and metacognitive therapy, and Level III-2 evidence for psychodynamic therapy. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective. These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence for psychosis and schizophrenia in adults (2014),[31] which recommend CBT and family interventions in conjunction with antipsychotic medication.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***A systematic review and meta-analysis of low intensity CBT for psychosis***
AUTHOR(S) AND SOURCE	Hazell, C. M., Hayward, M., Cavanagh, K., & Strauss, C. (2016). *Clinical Psychology Review, 45,* 183–192.
DESIGN	Systematic review and meta-analysis (10 studies)
FOLLOW-UP	Nil to 18 months
FORMAT	Individual, group
PARTICIPANTS	631 adults diagnosed with a psychotic disorder. The mean participant age was 38.8 years, and 65% were male.
TREATING CLINICIAN(S)	Clinical psychologists, psychiatrists, ”other professionals”, CBT trained clinicians
INTERVENTION(S)	CBT for psychosis
COMPARISON GROUP(S)	TAU, supportive therapy, alternative format CBT
PROCEDURE	Systematic review and meta-analysis evaluating the efficacy of low-intensity CBT for psychosis. Low intensity CBT was defined as interventions designed with fewer than 16 face-to-face sessions. Across studies, participants received a mean of nine therapy sessions (range = six to 15 sessions).
SUMMARY OF FINDINGS	Small to medium effect sizes were found across all outcome measures in favour of CBT compared with pooled control conditions. On the primary outcome measure of psychotic symptoms, a significant between-group medium effect size was found in favour of CBT at posttreatment. This reduced to a small to medium treatment effect at follow-up. Number of sessions or therapy format did not significantly impact on the effectiveness of the intervention.

[31] nice.org.uk/guidance/cg178

TITLE OF ITEM	***Efficacy and specificity of computer-assisted cognitive remediation in schizophrenia: A meta-analytical study***
AUTHOR(S) AND SOURCE	Grynszpan, O., Perbal, S., Pelissolo, A., Fossati, P., Jouvent, R., Dubal, S., & Perez-Diaz, F. (2011). *Psychological Medicine, 41,* 163–173.
DESIGN	Meta-analysis (16 studies)
FOLLOW-UP	Not reported
FORMAT	Computer-based (clinician-guided and unguided)
PARTICIPANTS	805 adults diagnosed with schizophrenia or schizoaffective disorder. The mean ages of participants ranged from 20.3 to 50 years.
TREATING CLINICIAN(S)	Details not reported
INTERVENTION(S)	Cognitive remediation
COMPARISON GROUP(S)	TAU, placebo, valid treatment, vocational program
PROCEDURE	Meta-analysis of RCTs published up to January 2009 evaluating computer-assisted cognitive remediation for schizophrenia. The duration of treatment ranged from 3 to 104 weeks.
SUMMARY OF FINDINGS	Computer-assisted cognitive remediation significantly enhanced general cognition, with a small to medium effect size. A significant medium effect size was found for the social cognition domain. Improvements were also significant for measures of verbal memory, working memory, attention, and speed of processing, with small effect sizes across measures.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Individualized metacognitive therapy for delusions: A randomized controlled rater-blind study***
AUTHOR(S) AND SOURCE	Andreou, C., Wittekind, C. E., Fieker, M., Heitz, U., Veckenstedt, R., Bohn, F., & Moritz, S. (2017). *Journal of Behavior Therapy and Experimental Psychiatry, 56,* 144–151.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	92 adults with a diagnosis of a schizophrenia spectrum disorder being treated at a psychosis centre. The mean age of participants was 36 years, and 55.4% were male.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	Metacognitive therapy (MCT; n = 46)
COMPARISON GROUP(S)	Active control (n = 46)
PROCEDURE	Participants were randomly allocated to MCT or an active control. The MCT intervention was a manualised intervention consisting of 12 twice-weekly 45–60 minute therapy sessions. The active control involved completion of a computerised cognitive training program targeting cognitive dysfunctions commonly encountered in patients with psychosis. Participants received a maximum of 12 x 45–60 minute sessions. Participants in the intervention and control groups received a mean of 8.3 and 5.6 sessions, respectively.
SUMMARY OF FINDINGS	Participants in the MCT group demonstrated a significantly greater decrease in the primary outcome measure of delusion severity at posttreatment compared with the control group. Treatment effects were more pronounced for participants who attended four or more therapy sessions. No significant between-group differences were apparent at follow-up.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Do family interventions improve outcomes in early psychosis? A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Claxton, M., Onwumere, J., & Fornells-Ambrojo, M. (2017). *Frontiers in Psychology, 8*(371). doi:10.3389/fpsyg.2017.00371
DESIGN	Systematic review and meta-analysis (14 studies)
FOLLOW-UP	Nil to 5 years
FORMAT	Family intervention
PARTICIPANTS	1,278 young people at risk or with a diagnosis of early psychosis. Three studies included participants under 18 years of age, and the remaining studies comprised samples aged 15 and above (mean ages were generally greater than 20).
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Family interventions
COMPARISON GROUP(S)	Standard care, nonstructured group intervention
PROCEDURE	Systematic review and meta-analysis of relevant studies published up to June 2016 evaluating the efficacy of family interventions in early psychosis. The length of treatment varied across studies, ranging from a once-off 3-hour workshop to 18 sessions of therapy, delivered across a range of 4 weeks to 24 months.
SUMMARY OF FINDINGS	Compared with pooled controls, family interventions did not significantly reduce symptoms by the end of treatment; however, a large effect size in favour of family interventions was found for symptom improvement extending to 2 years follow-up. General functioning significantly improved and risk of relapse decreased in the family intervention groups compared with pooled controls, with medium effect sizes observed at posttreatment; however, these treatment gains were not maintained at follow-up.

PSYCHOEDUCATION

TITLE OF ITEM	***Psychoeducation for schizophrenia***
AUTHOR(S) AND SOURCE	Xia, J., Merinder, L. B., & Belgamwar, M. R. (2013). *Cochrane Database of Systematic Reviews, 2013*(6), CD002831. doi:10.1002/14651858.CD002831.pub2
DESIGN	Meta-analysis (44 studies)
FOLLOW-UP	Details of follow-up periods were not reported
FORMAT	Mostly group and family format although a small number were a combination of individual and group or family arrangements
PARTICIPANTS	5,142 adults diagnosed with schizophrenia or schizoaffective disorder. The age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducation plus standard care
COMPARISON GROUP(S)	Standard care alone
PROCEDURE	Meta-analysis of RCTs published to November 2012 investigating the efficacy of psychoeducational interventions for schizophrenia when added to standard care. Study duration ranged from a single session to 5 years, with the median intervention duration being 12 weeks.
SUMMARY OF FINDINGS	Compared with standard care alone, psychoeducation significantly reduced rate of relapse, readmission to hospital, and length of hospital stay, and also encouraged medication compliance in the short and long terms. Additionally, results suggest that psychoeducation promotes better social and global functioning and improves quality of life.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Acceptance and commitment therapy for psychosis: Randomised controlled trial***
AUTHOR(S) AND SOURCE	Shawyer, F., Farhall, J., Thomas, N., Hayes, S. C., Gallop, R., Copolov, D., & Castle, D. J. (2017). *The British Journal of Psychiatry, 210,* 140–148.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	96 adults with a diagnosis of schizophrenia or schizoaffective disorder. The mean age of participants was 36.1 years, and 61.5% were male.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	ACT (*n* = 49)
COMPARISON GROUP(S)	Befriending (*n* = 47)
PROCEDURE	Participants were randomly allocated to ACT or a "befriending" intervention. The manualised ACT intervention was adapted for psychosis and consisted of eight x 50-minute weekly to fortnightly sessions delivered over a 3-month period. The befriending intervention was delivered under the same conditions as the intervention group and consisted of engaging in conversation about everyday topics while avoiding discussion about symptoms and problems. Participants in the intervention and control groups completed a mean of 7.0 and 7.2 sessions of therapy respectively.
SUMMARY OF FINDINGS	There were no significant differences between groups on the primary outcome measure of overall mental state (positive and negative symptoms); however, those in the ACT group demonstrated greater within-group improvements in positive symptoms at follow-up with a medium effect size. Furthermore, a medium effect size in favour of the ACT group was found from baseline to follow-up for amount of distress related to auditory hallucinations.

TITLE OF ITEM	***The feasibility and acceptability of a brief acceptance and commitment therapy (ACT) group intervention for people with psychosis: The 'ACT for life' study***
AUTHOR(S) AND SOURCE	Johns, L. C., Oliver, J. E., Khondoker, M., Byrne, M., Jolley, S., Wykes,T., … Morris, E. M. J. (2016). *Journal of Behavior Therapy and Experimental Psychiatry, 50,* 257–263.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	12 weeks
FORMAT	Group
PARTICIPANTS	69 adults with psychosis in routine community psychosis services. The mean age of participants was 33.6 years, and 58% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	ACT
COMPARISON GROUP(S)	None
PROCEDURE	The manualised ACT intervention was run in 13 groups of four to eight participants and consisted of four x 2-hour weekly skill-building workshops. Participants attended a mean of three therapy sessions.
SUMMARY OF FINDINGS	Participants demonstrated significant improvement in functioning and mood from baseline to follow-up, with within-group effect sizes ranging from small to medium across outcome measures.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Five-year follow-up of supportive psychodynamic psychotherapy in first-episode psychosis: Long-term outcome in social functioning***
AUTHOR(S) AND SOURCE	Harder, S., Koester, A., Valbak, K., & Rosenbaum, B. (2014). *Psychiatry:Interpersonal and Biological Processes, 77,* 155–168.
DESIGN	Cohort study
FOLLOW-UP	3 years
FORMAT	Individual
PARTICIPANTS	269 individuals who had experienced the first psychotic episode of a schizophrenia spectrum disorder. The median age at study inclusion was 23.7 years (range 16 to 36 years), and 67% were male.
TREATING CLINICIAN(S)	Psychologists and psychiatrists
INTERVENTION(S)	Supportive psychodynamic therapy (SPP) plus TAU (*n* = 119)
COMPARISON GROUP(S)	TAU alone (*n* = 150)
PROCEDURE	Participants across 14 psychiatric centres participated in the longitudinal study and were offered either manualised SPP in addition to TAU or TAU alone for a period of 2 years, and then followed for an additional 3 years.
SUMMARY OF FINDINGS	During the first 2 years of treatment, participants in the SPP group improved significantly more than did the comparison group on measures of social function and general psychopathology, with medium to large between-group effect sizes on positive and negative symptoms, general symptom level, and social function. However, the treatment effects observed in the first 2 years of treatment were no longer significant at 3 year follow-up based on results from the 148 participants who completed the assessment.

DISSOCIATIVE DISORDERS

SUMMARY OF EVIDENCE

Few studies investigating the effectiveness of treatments for dissociative disorders have been published. In addition, the interventions used have not been clearly described, although one study demonstrated Level IV evidence for psychodynamic therapy in the treatment of dissociative disorders in adults.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Lipid levels in dissociative disorders: Effects of psychodynamic psychotherapy***
AUTHOR(S) AND SOURCE	Damsa, C., Lazignac, C., Miller, N., Maris, S., Adam, E., & Rossignon, K. (2014). *Psychiatric Quarterly, 85,* 369–376.
DESIGN	Case series with pretest and posttest
FOLLOW-UP	None
FORMAT	Individual
PARTICIPANTS	32 adults diagnosed with a dissociative disorder. The mean age of participants was 38.2 years, and 27 participants were female.
TREATING CLINICIAN(S)	Psychiatrist
INTERVENTION(S)	Psychodynamic therapy
COMPARISON GROUP(S)	None
PROCEDURE	Participants received weekly 1-hour therapy sessions over 8 weeks. Primary outcomes included participants' scores on the Dissociative Experiences Scale and Clinical Global Impression and Improvement Scale.
SUMMARY OF FINDINGS	A significant reduction in participants' Dissociative Experiences Scale scores from baseline to posttreatment was reported. Furthermore, 83% of patients met the study's criteria for success posttreatment. Treatment was considered a success if patients experienced a 20% or more reduction on the Dissociative Experiences Scale or 30% or more reduction on the Clinical Global Impression and Improvement Scale posttreatment.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT for the treatment of attention deficit hyperactivity disorder (ADHD) in adults. There is Level II evidence for online CBT (clinician guided and unguided), dialectical behaviour therapy (based on two small RCTs), metacognitive therapy, mindfulness-based cognitive therapy (based on two small RCTs), and psychoeducation (based on one pilot RCT). In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with the most recently available guidelines from the National Institute for Clinical Excellence (2018)[32] for ADHD in children, young people, and adults which recommend drug treatment as first-line treatment. However, where psychological treatment is preferred or where pharmacotherapy has proven to be only partially effective or ineffective, CBT should be offered.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Meta-analysis of cognitive-behavioral treatments for adult ADHD***
AUTHOR(S) AND SOURCE	Knouse, L. E., Teller, J., & Brooks, M. A. (2017). *Journal of Consulting and Clinical Psychology, 85,* 737–750.
DESIGN	Meta-analysis (32 studies)
FOLLOW-UP	Details of follow-up periods were not reported. The meta-analysis was undertaken only on pre- to post-treatment data.
FORMAT	Individual, group, combined individual and group, self-help (internet-based)
PARTICIPANTS	896 adults with a diagnosis of ADHD. The mean age and gender of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Active control (attention-matched comparison treatments), nonactive control (waitlist control).
PROCEDURE	Meta-analysis of controlled and uncontrolled studies published up to December 2015 investigating the efficacy of CBT for the treatment of adult ADHD.
SUMMARY OF FINDINGS	Posttreatment effect sizes on self-report and clinician-assessed ADHD symptoms ranged from small to large in favour of CBT compared with pooled controls. Medium to large within-group effect sizes were found for CBT from pre- to post-treatment across outcome measures. Neither treatment length nor number of sessions was associated with effect sizes.

[32] nice.org.uk/guidance/ng87

TITLE OF ITEM	***Internet-based cognitive behavioural therapy for adults with ADHD in outpatient psychiatric care: A randomized trial***
AUTHOR(S) AND SOURCE	Pettersson, R., Söderström, S., Edlund- Söderström, K., & Nilsson, K. W. (2017). *Journal of Attention Disorders, 21,* 508–521.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Online (clinician guided)
PARTICIPANTS	45 adults diagnosed with ADHD. The mean ages of participants in the three groups were 39.6, 38.9, and 33.8 years, and 64.4% were female.
TREATING CLINICIAN(S)	Psychologist, occupational therapist
INTERVENTION(S)	Internet-delivered CBT (*n* = 13), internet-delivered CBT with weekly group sessions (*n* = 14)
COMPARISON GROUP(S)	Waitlist control (*n* = 18)
PROCEDURE	Participants were randomly allocated to one of three groups: internet-delivered CBT, internet-delivered CBT with weekly group therapy sessions, or waitlist control. Both CBT interventions consisted of nine treatment modules plus a follow-up module designed to be worked through sequentially. The condition with weekly group sessions used the internet intervention in the context of group therapy and followed the content of the 10 modules in each therapy session. Groups met for 3 hours once per week for 10 weeks.
SUMMARY OF FINDINGS	A large between-group effect size was found in favour of the internet-delivered CBT conditions on the primary outcome measure of ADHD symptoms compared with waitlist control at both posttreatment and follow-up. No significant differences were found at posttreatment or follow-up between the two active interventions.

TITLE OF ITEM	***Efficacy of meta-cognitive therapy for adult ADHD***
AUTHOR(S) AND SOURCE	Solanto, M., Marks, D. J., Wasserstein, J., Mitchell, K., Abikoff, H., Alvir, J. M. J., & Kofman, M. D. (2010). *The American Journal of Psychiatry, 167,* 958–968.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	88 adults diagnosed with ADHD. The mean ages of participants in the two groups were 41 and 42.4 years, and 65.9% were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	Metacognitive therapy (*n* = 45)
COMPARISON GROUP(S)	Supportive therapy (*n* = 43)
PROCEDURE	Participants were randomly allocated to receive metacognitive therapy or supportive therapy. Both treatment conditions consisted of weekly 2-hour group therapy sessions delivered over a 12-week period. The supportive therapy condition controlled for nonspecific aspects of treatment by providing support while avoiding direct discussion of therapeutic strategies.
SUMMARY OF FINDINGS	Sixty-five participants completed the 12-week programs. Compared with those in supportive therapy group, participants in the metacognitive therapy group demonstrated significantly greater improvement on the inattention/memory subscale of the ADHD symptom measure from pre- to post-treatment. Both groups demonstrated significant improvements from pre- to post-treatment for ADHD symptoms, with no significant difference between the groups.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Pilot randomized controlled trial of dialectical behavior therapy group skills training for ADHD among college students***
AUTHOR(S) AND SOURCE	Fleming, A. P., McMahon, R. J., Moran, L. R., Peterson, A. P., & Dreessen, A. (2015). *Journal of Attention Disorders, 19,* 260–271.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Group
PARTICIPANTS	33 young adults aged between 18 and 24 diagnosed with ADHD. The mean age of participants in the two groups was 21 years, and 57.6% were male.
TREATING CLINICIAN(S)	Graduate students in clinical psychology (supervised by a psychologist)
INTERVENTION(S)	DBT (*n* = 17)
COMPARISON GROUP(S)	Skills handout (*n* = 16)
PROCEDURE	Participants were randomly allocated to one of two groups: DBT skills training or self-guided skills training handouts. The DBT intervention was delivered according to a DBT skills training protocol and comprised eight weekly 90-minute group therapy sessions, 7 weekly 10 to 15-minute individual phone coaching consultations, plus a single 90-minute booster session during the follow-up period. Participants in the control group received 34 pages of skills handouts drawn from an adult ADHD treatment manual. All but one participant in the DBT group completed treatment.
SUMMARY OF FINDINGS	Medium to large within-group treatment effects were found for the intervention group at posttreatment on ADHD symptoms, quality of life, and depression. Treatment gains were maintained at follow-up, and a small treatment effect became significant for the anxiety measure. Large between-group effect sizes in favour of DBT were found for the total ADHD symptom measure and quality of life at posttreatment. At follow-up, large treatment effects remained on the total ADHD symptom measure and were also found on the ADHD inattention subscale in favour of DBT. Furthermore, compared with the control group, a significantly greater proportion of participants were considered treatment responders and recovered at posttreatment and follow-up.

TITLE OF ITEM	***Reduced ADHD symptoms in adults with ADHD after structured skills training group: Results from a randomized controlled trial***
AUTHOR(S) AND SOURCE	Hirvikoski, T., Waaler, E., Alfredsson, J., Pihlgren, C., Holmström, A., Johnson, A., … Nordström, A-L. (2011). *Behaviour Research and Therapy, 49,* 175–185.
DESIGN	RCT
FOLLOW-UP	3 and 12 months. Only data from baseline to posttreatment were reported in the study.
FORMAT	Group
PARTICIPANTS	51 Swedish adults diagnosed with ADHD. The mean ages of participants in the two groups were 40.7 and 37.2 years, and 62.7% were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	DBT (*n* = 26)
COMPARISON GROUP(S)	Discussion group (*n* = 25)
PROCEDURE	Participants were randomised to DBT-based skills training or a parallel loosely structured discussion group. Both groups received 14 x 2-hour group therapy sessions. The DBT-based intervention followed standard manualised protocol with a small number of adaptations to the Swedish context. Those in the control group attended discussion groups where facilitators provided support and encouragement to group members but avoided the use of any treatment components included in DBT group sessions.
SUMMARY OF FINDINGS	General wellbeing increased in both groups by posttreatment; however, participants in the DBT-based group demonstrated significantly greater reduction of ADHD symptoms than did those in the control group. The DBT group were also significantly more likely to be categorised as treatment responders.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***Effects of mindfulness-based cognitive therapy on neurophysiological correlates of performance monitoring in adult attention-deficit/hyperactivity disorder***
AUTHOR(S) AND SOURCE	Schoenberg, P. L. A., Hepark, S., Kan, C. C., Barendregt, H. P., Buitelaar, J. K., & Speckens, A. E. M. (2014). *Clinical Neurophysiology 125,* 1407–1416.
DESIGN	RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	50 adults diagnosed with ADHD. The mean ages of participants in the two groups were 39.5 and 33.9 years, and 52.3% were female.
TREATING CLINICIAN(S)	Psychiatrist
INTERVENTION(S)	MBCT (*n* = 26)
COMPARISON GROUP(S)	Waitlist control (*n* = 24)
PROCEDURE	Participants were randomly allocated to either MBCT or waitlist control. The MBCT intervention, adapted from the protocol for depression, consisted of 12 weekly 3-hour therapy sessions.
SUMMARY OF FINDINGS	Participants receiving MBCT demonstrated significantly greater improvements on the clinical outcome measures compared with the control group. Significant reductions were shown on measures of inattention, hyperactivity/impulsivity, and global ADHD symptoms from pre- to post-treatment.

TITLE OF ITEM	***A randomized controlled trial of mindfulness-based cognitive therapy for college students with ADHD***
AUTHOR(S) AND SOURCE	Gu, Y., Xu, G., & Zhu, Y. (2017). *Journal of Attention Disorders, 22,* 388–399.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Individual
PARTICIPANTS	54 young adults aged between 19 and 24 diagnosed with ADHD. The mean age was 20 years, and 55.6% were male.
TREATING CLINICIAN(S)	Psychiatrists
INTERVENTION(S)	MBCT (*n* = 28)
COMPARISON GROUP(S)	Waitlist control (*n* = 26)
PROCEDURE	Participants were randomly allocated to MBCT or waitlist control. The MBCT intervention, based on the standard protocol for depressive disorders, was adjusted to be delivered in individual format and consisting of six weekly 1-hour therapy sessions.
SUMMARY OF FINDINGS	Large within-group treatment effects were found for MBCT from pre- to post-treatment for ADHD and depressive and anxiety symptoms. Similarly, a large between-group effect size in favour of MBCT was found on ADHD and depressive and anxiety symptoms at posttreatment compared with waitlist control. All within-group treatment effects remained significant and large at follow-up for the MBCT group, whereas, compared with waitlist, only the ADHD symptom measure remained significant at follow-up.

PSYCHOEDUCATION

TITLE OF ITEM	***Psychoeducation for adults with attention deficit hyperactivity disorder vs. cognitive behavioral group therapy: A randomized controlled pilot study***
AUTHOR(S) AND SOURCE	Vidal, R., Bosch, R., Nogueira, M., Gomez-Barros, N., Valero, S., Palomar, G., … Ramos-Quiroga, J. A. (2013). *The Journal of Nervous and Mental Disease, 201,* 894–900.
DESIGN	Pilot RCT
FOLLOW-UP	None
FORMAT	Group
PARTICIPANTS	32 adults diagnosed with ADHD. The mean age of participants was 39.5 years, and 53.1% of participants were female.
TREATING CLINICIAN(S)	Psychologists
INTERVENTION(S)	Psychoeducation (*n* = 17)
COMPARISON GROUP(S)	CBT (*n* = 15)
PROCEDURE	Participants were randomised to receive psychoeducation or CBT. Both treatment conditions consisted of 12 weekly 2-hour group therapy sessions delivered over a period of 3 months. Thirty participants completed treatment.
SUMMARY OF FINDINGS	No significant differences were found on any outcome measure between the two treatment groups. Participants in both groups demonstrated significant improvements on ADHD symptoms, as well as for secondary outcome measures including quality of life, anxiety, and depression, with small effect sizes.

DEPRESSION

SUMMARY OF EVIDENCE

There is Level I evidence for CBT and online CBT (clinician-There is Level I evidence for both CBT and interpersonal therapy as effective interventions for adolescents (12 years and older) with depression. There is Level II evidence for the use of CBT among depressed preadolescent children (7 to 12 years). There is Level III evidence for interpersonal psychotherapy in the treatment of preadolescent children (7 to 12 years) with depression. Regarding online interventions, there is Level I evidence for online CBT for adolescents with depression. One review, however, questioned the robustness of findings due to methodological inconsistencies and/or insufficient sample sizes. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are largely in line with the most recent guidelines from the National Institute for Clinical Excellence on depression in children and young people (2017).[33] While the guidelines note that there is very little good quality evidence that one type of psychological therapy is superior to others, the guidelines recommend CBT, interpersonal therapy, family interventions, or psychodynamic therapy for children and young people with moderate to severe depression. It should be noted, however, that the evidence for psychodynamic therapy and family interventions is limited. Pharmacotherapy, either alone or in combination with psychological therapy, is another consideration for young people with moderate to severe depression. Guided self-help therapy such as written CBT-based materials and telephone support from a clinician is an alternative treatment option for milder cases of depression.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Efficacy and acceptability of cognitive behavioral therapy for depression in children: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Yang, L., Zhou, X., Zhou, C., Zhang, Y., Pu, J., Liu, L., … Xie, P. (2017). *Academic Pediatrics, 17,* 9–16
DESIGN	Systematic review and meta-analysis (9 studies)
FOLLOW-UP	1 to 9 months
FORMAT	Group
PARTICIPANTS	306 children aged 7 to 13 with clinically significant depressive symptoms. The mean age across all RCTs was 10.5 years, and 63.0% were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT, including cognitive restructuring, interpersonal problem solving, self-control, and relaxation training
COMPARISON GROUP(S)	165 children were randomised to a waitlist control (n = 32), nontreatment (n = 82), or psychological placebo (n = 51)
PROCEDURE	Systematic review and meta-analysis of 9 RCT studies published between 1987 and 2004. The reviewed studies incorporated CBT interventions for preadolescent children with clinically significant depressive symptoms.
SUMMARY OF FINDINGS	Results for the CBT group were significantly better than results for the pooled control groups (waitlist, nontreatment, and placebo) at both posttreatment and follow-up, with small to moderate effect sizes. CBT was more effective than was nontreatment, but not more effective than waitlist or placebo.

[33] nice.org.uk/guidance/cg28

TITLE OF ITEM	***CBT for children with depressive symptoms: A meta-analysis***
AUTHOR(S) AND SOURCE	Arnberg, A., & Ost, L.-G. (2014). *Cognitive Behaviour Therapy, 43,* 275–288.
DESIGN	Meta-analysis (10 studies)
FOLLOW-UP	1 to 9 months
FORMAT	Group (8 studies) and individual (2 studies)
PARTICIPANTS	523 children and adolescents aged 8 to 17, with clinical or subclinical depressive symptoms on self-reported measures. The mean age across all studies was 10.5 years, and 54.2% were male.
TREATING CLINICIAN(S)	Clinicians with varying levels of experience
INTERVENTION(S)	CBT, primarily incorporating psychoeducation methods
COMPARISON GROUP(S)	Control condition (waitlist, attention placebo, or waitlist+TAU). One study compared treatment via videoconferencing with face-to-face delivery.
PROCEDURE	Meta-analysis evaluating 10 RCTs published between 1980 and 2009, with a focus on CBT interventions for adolescents with clinically significant depressive symptoms
SUMMARY OF FINDINGS	There was overall support for CBT in pediatric populations with depressive symptoms. In comparison to results from attention placebo and waitlist control groups, CBT was found to be effective with moderate effect sizes. Within the CBT group, there was a large effect size from pre- to post-assessment, and also at follow-up.

TITLE OF ITEM	***Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis***
AUTHOR(S) AND SOURCE	Zhou, X., Hetrick, S. E., Cuijpers, P., Qin, B., Barth, J., Whittington, C. J., … Xie, P. (2015). *World Psychiatry, 14,* 207–222
DESIGN	Systematic review and meta-analysis (52 studies, 33 of which included CBT)
FOLLOW-UP	1 to 24 months
FORMAT	Not reported
PARTICIPANTS	1,149 children and adolescents (excluding controls) aged 7 to 18 with a diagnosis of depression or clinically significant depressive symptoms
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT and eight other interventions such as interpersonal, psychodynamic, and problem-solving therapy
COMPARISON GROUP(S)	Waitlist, psychological placebo, nontreatment, TAU
PROCEDURE	A network meta-analysis investigating the efficacy of 52 RCTs published between 1980 and 2013, incorporating multiple psychotherapeutic interventions. Thirty-three RCTs targeted CBT interventions for children and adolescents with depressive symptoms and were analysed in relation to control conditions.
SUMMARY OF FINDINGS	Compared with most control groups (waitlist, placebo, and TAU), CBT was effective in reducing depressive symptoms at both posttreatment (medium to large effect sizes) and follow-up (small to large effect sizes). In comparison with other interventions, CBT was found to be more effective than was play therapy at posttreatment, and more effective than problem-solving therapy at follow-up (large effect sizes).

TITLE OF ITEM	***Psychotherapy, pharmacotherapy, and their combination for adolescents with major depressive disorder: A meta-analysis***
AUTHOR(S) AND SOURCE	Singh, N., & Reece, J. (2014). *The Educational and Developmental Psychologist, 31,* 47–65
DESIGN	Meta-analysis (15 CBT-only studies)
FOLLOW-UP	6 months (10 studies), more than 6 months (4 studies), and less than 6 months (1 study)
FORMAT	Group and individual
PARTICIPANTS	998 children and adolescents aged 8 to 17 with a primary diagnosis of major depressive disorder.
TREATING CLINICIAN(S)	Clinicians of varying qualifications and experience
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Control conditions (placebo, waitlist, or unspecified) for RCTs, or no control condition for open naturalistic studies
PROCEDURE	Meta-analysis of RCT and open naturalistic studies published between 1996 and 2011, investigating the efficacy of CBT-based interventions among adolescents. The primary treatment outcome was calculated as the average of all depression measurements used within each study.
SUMMARY OF FINDINGS	Within group pre- to post-treatment analyses indicated CBT to be an effective form of treatment for adolescents with a diagnosis of major depressive disorder, producing a very large effect size. Moderator analysis indicated no difference between RCTs and open naturalistic studies in relation to the primary treatment outcome.

TITLE OF ITEM	***Computerised therapies for anxiety and depression in children and young people: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Pennant, M. E., Loucas, C. E., Whittington, C., Creswell, C., Fonagy, P., Fuggle, P., … Kendall, T. (2015). *Behaviour Research and Therapy, 67,* 1–18.
DESIGN	Systematic review and meta-analysis (7 studies targeting depression)
FOLLOW-UP	Nil to 4 weeks
FORMAT	Online
PARTICIPANTS	279 young people aged 11 to 25 with a diagnosis of depression or elevated depressive symptoms
TREATING CLINICIAN(S)	None: self-administered
INTERVENTION(S)	Computerised CBT
COMPARISON GROUP(S)	Waitlist, no treatment, TAU, or computerised attention program
PROCEDURE	Systematic review and meta-analysis of RCTs published between 2009 and 2014 investigating the efficacy of computerised CBT interventions among young people with depression. Treatment outcomes were measured as changes in self-rated depression.
SUMMARY OF FINDINGS	Compared with the pooled control groups, computerised CBT treatment groups had significantly reduced self-rated depressive symptoms. The effect size was considered moderate for participants with mild to medium depressive symptoms. The authors, however, did not consider this finding to be robust due to small sample sizes and methodological inconsistencies. Four of the seven studies were noted to have had high attrition rates.

TITLE OF ITEM	***Internet and computer-based cognitive behavioral therapy for anxiety and depression in youth: A meta-analysis of randomized controlled outcome trials***
AUTHOR(S) AND SOURCE	Ebert, D. D., Zarski, A.-C., Christensen, H., Stikkelbroek, Y., Cuijpers, P., Berking, M., & Riper, H. (2015). *PLoS ONE, 10*(3), e0119895.
DESIGN	Meta-analysis (4 studies targeting depression)
FOLLOW-UP	1 to 6 months
FORMAT	Computer, mobile, or online
PARTICIPANTS	481 people aged 11 to 25 with a diagnosis of depression or elevated depressive symptoms
TREATING CLINICIAN(S)	None: self-administered
INTERVENTION(S)	Computerised CBT, internet CBT
COMPARISON GROUP(S)	Waitlist, placebo
PROCEDURE	Meta-analysis of RCTs published between 2011 and 2012, investigating the efficacy of computerised or internet CBT interventions among young people with depression. Treatment outcomes were measured as changes in self-rated and/or observer-rated depressive symptoms.
SUMMARY OF FINDINGS	In comparison with results for controls, computerised CBT treatment effectively reduced depressive symptoms, yielding a large effect size. Similarly, when pooled with seven additional studies (targeting anxiety or anxiety/depression), a moderate effect size indicated that computerised CBT treatment alleviated depressive symptoms more effectively than did being in a control group. Dropout/attrition rates were not reported.

TITLE OF ITEM	***Game-based digital interventions for depression therapy: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Li, J., Theng, Y.-L., & Foo, S. (2014). *Cyberpsychology, Behavior and Social Networking, 17,* 519–527.
DESIGN	Systematic review (2 relevant RCTs)
FOLLOW-UP	5 weeks to 3 months
FORMAT	Game-based
PARTICIPANTS	219 adolescents aged from 12 to 19 (mean ages were 14.9 to 15.6 years) with clinically significant depressive symptoms or a diagnosed depressive disorder
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Computerised CBT delivered on a digital gaming platform known as SPARX
COMPARISON GROUP(S)	TAU, waitlist
PROCEDURE	Systematic review aimed at evaluating studies incorporating a range of game-based digital interventions on depression across the lifespan. A small subset of the studies were two RCTs focusing on depression in adolescents, both of which were published in 2012. The treatment outcome was based on the reduction in depressive symptoms on psychometrically validated measures from pre- to post-treatment, and from pretreatment to follow-up.
SUMMARY OF FINDINGS	In comparison with results from controls, the computerised CBT treatment was found to significantly reduce depressive symptoms among adolescents at posttreatment. However, the effect sizes varied greatly between the RCTs, from very small to very large. This variation occurred despite identical assessment measures being used in the RCTs and them delivering the intervention via the same game-based platform (SPARX). In their explanation of the discrepancy, the reviewers noted that the study with a very large effect included a comparatively small sample of adolescents who were excluded from mainstream education, limiting its generalisability to other populations.

INTERPERSONAL PSYCHOTHERAPY (IPT)

TITLE OF ITEM	***Efficacy and acceptability of interpersonal psychotherapy for depression in adolescents: A meta-analysis of randomized controlled trials***
AUTHOR(S) AND SOURCE	Pu, J., Zhou, X., Liu, L., Zhang, Y., Yang, L., Yuan, S., … Xie, P. (2017). *Psychiatry Res, 253,* 226–232.
DESIGN	Meta-analysis (7 studies)
FOLLOW-UP	Nil to 18 months
FORMAT	Individual, group, or combined (individual + group)
PARTICIPANTS	538 adolescents aged 11 to 18 with a diagnosis of depression or clinically significant depressive symptoms. The mean age across all studies was 15.0 years and a majority of participants (ranging from 57% to 85%) were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal psychotherapy
COMPARISON GROUP(S)	TAU, waitlist, psychological placebo
PROCEDURE	RCTs published between 1999 and 2010 were included in a meta-analysis aiming to investigate the efficacy of IPT interventions among adolescents with depression. The primary treatment outcome was a reduction in depression rating from baseline to posttreatment. The secondary outcome, remission rate, was measured as a decrease in depression rating scores of greater than 50%.
SUMMARY OF FINDINGS	In comparisons with results from pooled controlled groups, IPT was found to be an effective form of treatment for adolescents with depression, yielding a large effect size. Similar results were found when IPT was analysed separately against each type of control group. Among the four studies reporting a remission rate, IPT was more successful than control conditions (45.7% of cases vs 22.8%). For two studies with follow-up data, results from IPT indicated that it was more effective at long-term reduction in depressive symptoms than being in a control group, with a large effect size.

TITLE OF ITEM	***Interpersonal psychotherapy for depression: A meta-analysis***
AUTHOR(S) AND SOURCE	Cuijpers, P., Geraedts, A. S., van Oppen, P., Andersson, G., Markowitz, J. C., & van Straten, A. (2011). *The American Journal of Psychiatry, 168,* 581–592.
DESIGN	Meta-analysis of five studies targeting adolescents (sourced from a larger analysis of 16 studies)
FOLLOW-UP	Not reported
FORMAT	Individual, group, or combined (individual + group). All adolescent studies adapted the IPT manual to the needs of the target population.
PARTICIPANTS	569 participants defined as adolescents (ages not reported) with a diagnosis of depression or clinically significant depressive symptoms
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal psychotherapy
COMPARISON GROUP(S)	TAU, waitlist, placebo
PROCEDURE	Meta-analysis designed to synthesise research on the effects of IPT for individuals with depression. Five RCTs published between 1999 and 2009 were incorporated in the analysis of IPT vs control conditions. The primary outcome measure was a change in symptoms measured on a depression rating scale.
SUMMARY OF FINDINGS	In comparison to pooled control groups, IPT was found to significantly reduce depression severity among adolescents, with a medium to large effect size. Due to the broad nature of the review, the authors did not undertake further subanalyses of the data from studies that included an adolescent sample.

TITLE OF ITEM	***Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis***
AUTHOR(S) AND SOURCE	Zhou, X., Hetrick, S. E., Cuijpers, P., Qin, B., Barth, J., Whittington, C. J., … Xie, P. (2015). *World Psychiatry, 14,* 207–222.
DESIGN	Systematic review and meta-analysis (52 studies, 8 of which included IPT)
FOLLOW-UP	Nil to 18 months
FORMAT	Not reported
PARTICIPANTS	344 children and adolescents (excluding controls) aged 11 to 18 with a diagnosis of depression or clinically significant depressive symptoms
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Interpersonal psychotherapy and eight other interventions such as CBT, psychodynamic therapy, play therapy and problem-solving.
COMPARISON GROUP(S)	Waitlist, psychological placebo, TAU, no treatment.
PROCEDURE	Network meta-analysis investigating the efficacy of 52 RCTs published between 1980 and 2013, incorporating multiple psychotherapeutic interventions. Eight RCTs targeted IPT interventions for children and adolescents with depressive symptoms and were analysed in relation to control conditions.
SUMMARY OF FINDINGS	Compared with most control groups (waitlist, placebo, and TAU), IPT was effective in reducing depressive symptoms at both posttreatment (medium to large effect sizes) and follow-up (small to large effect sizes). When compared with other interventions, IPT was found to be more effective than was play therapy at posttreatment and more effective than problem-solving therapy at follow-up (large effect sizes).

TITLE OF ITEM	***Family-based interpersonal psychotherapy for depressed preadolescents: Examining efficacy and potential treatment mechanisms***
AUTHOR(S) AND SOURCE	Dietz, L. J., Weinberg, R. J., Brent, D. A., & Mufson, L. (2015). *Journal of the American Academy of Child & Adolescent Psychiatry, 54,* 191–199.
DESIGN	RCT
FOLLOW-UP	N/A
FORMAT	Fourteen-session treatment attended by the child and at least one parent. There were 3 treatment phases: initial (sessions 1–5), middle (sessions 6–10), and termination (sessions 11–14).
PARTICIPANTS	42 preadolescents (aged 7 to 12 years) diagnosed with a depressive disorder according to DSM-IV criteria
TREATING CLINICIAN(S)	Clinicians with degrees in clinical psychology and specific psychotherapeutic training for pediatric depression
INTERVENTION(S)	Family-based interpersonal psychotherapy (FB-IPT; n = 29)
COMPARISON GROUP(S)	Child-centred therapy group (n = 13) described as a supportive nondirected treatment, which is in line with standard community care for pediatric depression
PROCEDURE	RCT study designed to compare the efficacy of family-based IPT with child-centred therapy among preadolescent children with a depressive disorder. Treatment outcomes were remission percentage from pre- to post-treatment, as well as change in depressive symptoms at posttreatment.
SUMMARY OF FINDINGS	At posttreatment, remission rates for the FB-IPT group (66%) were more than double that of the child-centred therapy group (31%). Additionally, there was a significant decrease in depressive symptoms for the FB-IPT group compared with the child-centred therapy group.

BIPOLAR DISORDER

SUMMARY OF EVIDENCE

There is Level II evidence in support of family interventions for children and adolescents (9 to 17 years) with emerging symptoms of, or at high risk of developing, bipolar disorder, as well as adolescents (12 to 18 years) diagnosed with bipolar disorder. There is also Level II evidence for psychoeducational therapy for preadolescents (8 to 12 years) with bipolar disorder or clinically relevant symptoms, and CBT for a slightly wider age range (7 to 13 years). These findings are based on single RCTs and should therefore be interpreted cautiously. Nevertheless, all interventions included family elements, suggesting that this is an important consideration in the effective treatment of children with bipolar disorder. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are largely in line with the most recent guidelines from the National Institute for Clinical Excellence on bipolar disorder (2016).[34] One notable difference is that the guidelines suggest that interpersonal therapy in addition to CBT is an appropriate treatment option for young people with bipolar depression. Family therapy is suggested if there is no response after 4 to 6 weeks of treatment. Adjunct pharmacotherapy is seen as appropriate for moderate to severe cases of bipolar depression.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Child- and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: A randomized clinical trial***
AUTHOR(S) AND SOURCE	West, A. E., Weinstein, S. M., Peters, A. T., Katz, A. C., Henry, D. B., Cruz, R. A., & Pavuluri, M. N. (2014). *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 1168-1178.e1161.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual, with the child, parent(s) and/or family
PARTICIPANTS	69 children aged 7 to 13 (mean age 9.2 years, 42% female) with a bipolar spectrum disorder diagnosis in accordance with DSM-IV-TR criteria. Participants were required to be stabilised on medication.
TREATING CLINICIAN(S)	Clinical psychology pre- and post-doctoral trainees, who completed a 3 hour training session specific to the intervention
INTERVENTION(S)	Adjunctive child- and family-focused CBT
COMPARISON GROUP(S)	TAU
PROCEDURE	The intervention comprised 12 manualised weekly sessions, each 60 to 90 minutes in length. The control condition comprised 12 unstructured weekly sessions. The primary outcome measures were parent-rated symptom severity and clinician-rated global functioning.
SUMMARY OF FINDINGS	Child- and family-focused CBT was effective in reducing mania symptoms at posttreatment, with a medium to large effect size. Participants in the child- and family-focused CBT group experienced further reduction in mania symptoms at follow-up, but this long-term trajectory did not significantly differ from that of controls. Child- and family-focused CBT resulted in higher bipolar improvement rates than seen in controls, both at posttreatment (88% vs 21%) and follow-up (93% vs 46%). However, this effect is likely to be an overestimate given that baseline symptoms for the control group were significantly higher than were those for the CBT group. Depression symptom severity was significantly reduced in the child- and family-focused CBT group compared with controls on parent-reported measures at posttreatment and at follow-up, and the effect size was medium. In terms of global psychosocial functioning, there was no significant effect at posttreatment, but a small to medium effect at follow-up. Treatment comparability was affected by attendance rates and drop-out rates: TAU participants completed an average of 11.3 sessions compared with 6.9 sessions for the TAU group, and less than half of the TAU participants (48.5%) completed treatment, compared with 88.2% of child- and family-focused CBT participants.

[34] nice.org.uk/guidance/cg185

FAMILY INTERVENTIONS

TITLE OF ITEM	***Early intervention for symptomatic youth at risk for bipolar disorder: A randomized trial of family-focused therapy***
AUTHOR(S) AND SOURCE	Miklowitz, D. J., Schneck, C. D., Singh, M. K., Taylor, D. O., George, E. L., Cosgrove, V. E., … Chang, K. D. (2013). *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 121–131.
DESIGN	RCT
FOLLOW-UP	1 year
FORMAT	Individual, with the child, parent(s), and/or siblings
PARTICIPANTS	40 children and adolescents aged 9 to 17 (mean age 12.3 years) who had both: a) a current diagnosis of a bipolar disorder-not otherwise specified (NOS), major depressive disorder or cyclothymic disorder, and b) a first-degree relative with bipolar disorder I or II. Half of all participants were diagnosed with bipolar disorder-NOS at baseline.
TREATING CLINICIAN(S)	Trained clinicians who had completed a workshop on a high-risk version of family-focused therapy
INTERVENTION(S)	Family-focused therapy – high-risk version
COMPARISON GROUP(S)	Psychoeducation
PROCEDURE	Participants were randomly allocated to either the family-focused therapy or psychoeducation group. Family-focused therapy consisted of 12 x 1-hour sessions across a period of 4 months (eight weekly, four biweekly), and the psychoeducation group had one or two sessions. However, additional "crisis sessions" were arranged as required. The primary outcome measures were mood symptoms.
SUMMARY OF FINDINGS	Across the 1-year study timeframe, the family-focused intervention was significantly more effective in reducing mania symptoms than was the control condition, with a medium effect size. This effect held when controlling for the type of diagnosis (bipolar disorder-NOS, MDD or cyclothymic disorder) at baseline. Participants in the family-focused therapy group recovered from baseline mood (depressive and hypomanic) symptoms in an average of 13 weeks, significantly faster than the 21.3 weeks for controls. The authors noted that the treatment effect was more pronounced in families with high expressed emotion.

TITLE OF ITEM	***Pharmacotherapy and family-focused treatment for adolescents with bipolar I and II disorders: A 2-year randomized trial***
AUTHOR(S) AND SOURCE	Miklowitz, D. J., Schneck, C. D., George, E. L., Taylor, D. O., Sugar, C. A., Birmaher, B., … Axelson, D. A. (2014). *The American Journal of Psychiatry, 171,* 658–667.
DESIGN	RCT
FOLLOW-UP	2 year follow-up
FORMAT	Family
PARTICIPANTS	145 adolescents diagnosed with bipolar I or II disorder. The mean age of participants was 15.6 years, and 54.5% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Family-focused treatment (FFT) plus pharmacotherapy (n = 72)
COMPARISON GROUP(S)	Enhanced care plus pharmacotherapy (n = 73)
PROCEDURE	Participants were randomly assigned to pharmacotherapy plus FFT or to pharmacotherapy plus three weekly sessions of enhanced care (family psychoeducation). The FFT intervention consisted of 21 x 50-minute family therapy sessions delivered over a 9-month period (12 weekly, six biweekly, then every 3 months) that included psychoeducation, communication enhancement training, and problem-solving skills training. Families receiving the FFT received a mean of 15.4 therapy sessions.
SUMMARY OF FINDINGS	Compared with those in the enhanced care group, adolescents in the FFT group demonstrated a significantly greater increase from year 1 to year 2 in the proportion of weeks without manic symptoms. There were no between-group differences for time to improvement or illness recurrence, or the proportion of weeks with illness.

PSYCHOEDUCATION

TITLE OF ITEM	***Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders***
AUTHOR(S) AND SOURCE	Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). *Archives Of General Psychiatry, 66,* 1013–1021.
DESIGN	RCT
FOLLOW-UP	18 months
FORMAT	Group
PARTICIPANTS	165 preadolescent children aged 8 to 12 (mean age 9.9 years) with a diagnosed bipolar spectrum disorder (BPSD; 70% of participants) or depressive disorder (30%). Approximately three-quarters of participants were male.
TREATING CLINICIAN(S)	Doctoral-level clinicians who had completed specific training and weekly group supervision
INTERVENTION(S)	Multifamily psychoeducational therapy in addition to TAU
COMPARISON GROUP(S)	Waitlist and TAU
PROCEDURE	Participants were randomly assigned to either the multifamily psychoeducational therapy intervention group (n = 78) or waitlist control (n = 87). In the intervention group, children and at least one parent attended 8 x 90-minute psychoeducation sessions. Parents and children attended separate group sessions. The primary outcome measure was overall mood symptoms.
SUMMARY OF FINDINGS	At 12 months' follow-up, the intervention group had significantly reduced mood symptom severity compared with waitlist control, generating a medium effect size. Further analysis was performed on the waitlist control group as they began receiving multifamily psychoeducational therapy after 12 months, and that group was reassessed at 18 months. The treatment effect did not attain statistical significance, which the authors speculate was due to the intervention requiring more than 6 months to be effective. The high levels of attrition may also have affected the treatment response for the waitlist control group. Risk of developing BPSD was significantly lower in the intervention group (16%) compared with waitlist control (60%).

GENERALISED ANXIETY DISORDER

SUMMARY OF EVIDENCE

There is Level II evidence for CBT (individual and group-delivered) among preadolescent and adolescent children (7–17 years) with generalised anxiety disorder (GAD). The identified RCTs had some notable limitations, with one study reporting a small sample size, and the other grouping GAD with anxiety disorders that tend to coexist and respond similarly to CBT interventions. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with a recently published Cochrane systematic review, "Cognitive behavioural therapy for anxiety disorders in children and adolescents" (2015)[35] in which it was not possible to draw conclusions about the effectiveness of CBT for GAD at follow-up.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Remission after acute treatment in children and adolescents with anxiety disorders: Findings from the CAMS***
AUTHOR(S) AND SOURCE	Ginsburg, G. S., Sakolsky, D., Piacentini, J., Walkup, J. T., Coffey, K. A., Keeton, C. P., … March, J. (2011). *Journal of Consulting and Clinical Psychology, 79,* 806–813.
DESIGN	RCT incorporating CBT, pharmacological, and combination treatment conditions.
FOLLOW-UP	Nil
FORMAT	Individual
PARTICIPANTS	488 children and adolescents aged 7 to 17 (50% female) with a diagnosis of GAD, separation anxiety disorder, and/or social phobia. These three diagnoses were grouped together due to previous evidence of strong comorbidity and similar response to both CBT and selective serotonin reuptake inhibitor (SSRI) treatment.
TREATING CLINICIAN(S)	Clinicians with postgraduate or doctoral qualifications and experience treating anxiety in youth
INTERVENTION(S)	CBT ("Coping Cat" protocol), which was adapted to the individuals' age and developmental level (n = 139)
COMPARISON GROUP(S)	Pharmacological treatment (sertraline; n = 133), combination treatment (CBT+sertraline; n = 140), placebo (clinical management with pill placebo; n = 76)
PROCEDURE	A multisite RCT study designed to measure remission rates for youth with anxiety disorders for CBT, pharmacological, and combination treatments. CBT participants attended 12 x 60 minute treatment sessions across the 12-week treatment period. Two additional sessions were attended by parents only.
SUMMARY OF FINDINGS	Results were pooled for participants with GAD, separation anxiety disorder, and social phobia diagnoses. There was no difference in remission rates between participants with a baseline diagnosis of GAD or separation anxiety disorder. Furthermore, participants with a diagnosis of social phobia were less likely to achieve remission than were those with GAD or separation anxiety disorder. At posttreatment, participants in the CBT and pharmacological interventions were more likely to no longer meet diagnosis when compared with placebo controls, based on small to medium effect sizes. On the same measure of remission, the combination treatment condition was more effective than the placebo condition (large effect size) and more effective than either pharmacological or CBT treatments alone (small/medium effect sizes). There was no measurable difference between CBT and pharmacological treatments with regard to diagnosis status at posttreatment.

[35] http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD004690.pub4/abstract;jsessionid=9EBFA6C29B5C90D1D2D1E71871A8EDC1.f01t01

TITLE OF ITEM	***The efficacy of a group-based, disorder-specific treatment program for childhood GAD – A randomized controlled trial***
AUTHOR(S) AND SOURCE	Holmes, M. C., Donovan, C. L., Farrell, L. J., & March, S. (2014). *Behaviour Research and Therapy, 61,* 122–135
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Group
PARTICIPANTS	42 preadolescent children aged 7 to 12 (mean age 9.6 years) meeting DSM-IV-TR criteria for a diagnosis of GAD. Children with comorbid anxiety diagnoses were included provided that GAD was the primary diagnosis.
TREATING CLINICIAN(S)	Provisionally registered psychologists supervised by registered clinical psychologists.
INTERVENTION(S)	Cognitively focused treatment program titled No Worries! created specifically to target GAD (n = 20). The program incorporates CBT components, including psychoeducation, relaxation training, and the A-B-C model.
COMPARISON GROUP(S)	Waitlist (n = 22)
PROCEDURE	This RCT was designed to evaluate a disorder-specific treatment program for preadolescents with GAD. The intervention consisted of 10 x 90-minute weekly sessions as well as two booster sessions after 1 month and 3 months. Parents attended seven sessions plus boosters.
SUMMARY OF FINDINGS	The cognitive-focused intervention significantly reduced anxiety symptoms at posttreatment in comparison with results from waitlist controls, with a large effect size. A similarly large posttreatment effect size was reported for improvement in clinician-rated functioning attributed to the intervention. Compared with waitlist controls, significantly more children in the intervention group were GAD-free at posttreatment. At the 3-month follow-up, 100% of the treatment group no longer met criteria for GAD, and 50% were free of all anxiety-related disorders.

PANIC DISORDER

SUMMARY OF EVIDENCE

There is Level II evidence for the use of CBT, and specifically panic control treatment for adolescents (PCT-A), for the treatment of adolescents (11 to 17 years) with a diagnosis of panic disorder with or without agoraphobia. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Moderators of intensive cognitive behavioral therapy for adolescent panic disorder: The roles of fear and avoidance***
AUTHOR(S) AND SOURCE	Elkins, R. M., Gallo, K. P., Pincus, D. B., & Comer, J. S. (2016). *Child and Adolescent Mental Health, 21,* 30–36.
DESIGN	RCT
FOLLOW-UP	6 weeks
FORMAT	Individual, family
PARTICIPANTS	54 adolescents aged 11 to 17 (mean age 15.3 years) with a principal diagnosis of panic disorder with or without agoraphobia.
TREATING CLINICIAN(S)	Doctoral candidates and doctoral fellows of clinical psychology
INTERVENTION(S)	Panic Control Treatment for Adolescents (PCT-A; *n* = 37)
COMPARISON GROUP(S)	Waitlist (*n* = 13)
PROCEDURE	Follow-up analysis of an RCT by the same authors which aimed to determine the effectiveness of an intensive PCT-A intervention for adolescents with panic disorder. PCT-A was delivered over an 8-day period, with sessions up to 8 hours in length that included substantial parent involvement. Treatment elements included rapport building, psychoeducation, fear and avoidance hierarchy development, cognitive restructuring, and a variety of exposure techniques.
SUMMARY OF FINDINGS	There was a main treatment effect for PCT-A, with significant reductions in panic disorder severity at 6 weeks' follow-up compared with waitlist controls. Further analysis of moderating variables indicated that the treatment was most effective for adolescents with low or moderate levels of fear and avoidance. The authors suggested that adolescents with severe fear and avoidance may not be suited to a condensed or intense forms of PCT-A.

TITLE OF ITEM	***Cognitive-behavioral treatment of panic disorder in adolescence***
AUTHOR(S) AND SOURCE	Pincus, D. B., May, J. E., Whitton, S. W., Mattis, S. G., & Barlow, D. H. (2010). *Journal of Clinical Child & Adolescent Psychology, 39,* 638–649.
DESIGN	RCT
FOLLOW-UP	3 to 6 months
FORMAT	Individual, family
PARTICIPANTS	26 adolescents aged 14 to 17 (mean age 15.8 years) with a principal DSM-IV diagnosis of panic disorder with or without agoraphobia. Almost three-quarters (73%) of participants were female.
TREATING CLINICIAN(S)	Doctoral level clinical psychologists or doctoral students in clinical psychology
INTERVENTION(S)	Panic Control Treatment for Adolescents (PCT-A; *n* = 13)
COMPARISON GROUP(S)	Self-monitoring condition (*n* = 13)
PROCEDURE	This is the first RCT to determine the efficacy of PCT-A as a treatment for adolescents with panic disorder. The intervention was delivered across 11 x 50-minute weekly sessions and incorporated psychoeducation, cognitive restructuring, exposure techniques, skill review, and some parent involvement.
SUMMARY OF FINDINGS	At posttreatment, PCT-A was more effective in reducing clinical severity ratings of panic disorder than was the control condition (large effect size). Further treatment effects were found for measures of self-reported anxiety sensitivity, general anxiety, and depressive symptoms, all accompanied by large effect sizes. All treatment effects were maintained at both 3 and 6 months' follow-up.

SPECIFIC PHOBIA

SUMMARY OF EVIDENCE

There is Level II evidence for CBT and psychoeducation in the treatment of specific phobia in children and adolescents (7 to 17 years). More recently published RCTs contained various methodological limitations that impact on the quality of evidence and were therefore not included in the present review. In this review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***One-session treatment of specific phobias in youth: A randomized clinical trial in the United States and Sweden***
AUTHOR(S) AND SOURCE	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
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	196 children and adolescents (7 to 16 years) meeting the diagnostic criteria for a specific phobia
TREATING CLINICIAN(S)	Clinicians with postgraduate qualifications and specific training in one-session treatment (in-vivo exposure)
INTERVENTION(S)	Brief exposure-based therapy (n = 85)
COMPARISON GROUP(S)	Education support therapy (n = 70), waitlist (n = 41)
PROCEDURE	Participants were randomly allocated to one of three groups: Brief exposure-based therapy, education-support therapy, or waitlist control. Both treatments were maximised to 3 hours and manualised, but flexibly implemented.
SUMMARY OF FINDINGS	Both active conditions were more effective at reducing symptom severity than was being on a waitlist. However, treatment groups were not more effective than being on a waitlist 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 participants receiving in-vivo exposure continued to do better than did those in education support.

TITLE OF ITEM	***Brief psycho-social interventions in the treatment of specific childhood phobias: A controlled trial and a 1-year follow-up***
AUTHOR(S) AND SOURCE	Flatt, N., & King, N. (2010). *Behaviour Change, 27,* 130–153.
DESIGN	RCT
FOLLOW-UP	1 year
FORMAT	Individual
PARTICIPANTS	43 children and adolescents aged 7 to 17 years (mean age 11.2 years) with a DSM-IV diagnosis of specific phobia
TREATING CLINICIAN(S)	A psychologist specialising in childhood anxiety and CBT techniques, assisted by psychology master's students
INTERVENTION(S)	CBT (single-session exposure; *n* =17)
COMPARISON GROUP(S)	Waitlist (*n* = 11), psychoeducation (The Child Confidence Program; *n* =15)
PROCEDURE	RCT designed to evaluate the effectiveness of single-session exposure treatment and psychoeducation for the treatment of assorted specific phobias in children and adolescents. The exposure treatment was delivered in a single session of up to 3 hours and incorporated a hierarchy of behavioural exercises in conjunction with cognitive therapy techniques. The psychoeducation program consisted of educational information and supportive therapy with the aim of enhancing self-efficacy. Parents were minimally involved in both treatment groups.
SUMMARY OF FINDINGS	Single-session exposure (CBT) and psychoeducation were both more effective at reducing behavioural avoidance and increasing self-efficacy at postassessment when compared with results from waitlist controls (all large effect sizes). Furthermore, global functioning significantly improved for both treatment groups posttreatment. There were no significant between-group differences between the single-session exposure and psychoeducation interventions. Improvements with regard to behavioural avoidance and self-efficacy, but not functioning levels, were maintained at 1-year follow-up.

PSYCHOEDUCATION

See Flatt and King (2010) under CBT for a summary of findings related to psychoeduation.

SOCIAL ANXIETY DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT among children and adolescents (aged 8 to 17 years) with social anxiety disorder (SAD). There is Level II evidence for online clinician-guided CBT interventions (both generic and disorder-specific) for youth aged 8 to 17 with social anxiety disorder. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Social anxiety disorder: recognition, assessment and treatment, 2013).[36] The guidelines further suggest the involvement of parents/carers, particularly for the treatment of young children. It is suggested that interventions consist of 8–12 sessions delivered individually (45 minutes per session) or in a group format (90 mins per session).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***A comprehensive meta-analysis of cognitive-behavioral interventions for social anxiety disorder in children and adolescents***
AUTHOR(S) AND SOURCE	Scaini, S., Belotti, R., Ogliari, A., & Battaglia, M. (2016). *Journal of Anxiety Disorders, 42,* 105–112.
DESIGN	Meta-analysis (13 pre-post studies; 10 between-group studies)
FOLLOW-UP	Nil to 12 months
FORMAT	Not reported
PARTICIPANTS	550 children and adolescents aged 8 to 17 (mean ages ranged from 10.1 to 16.1) with a diagnosis of SAD. The proportion of males ranged from 0% to 62% across individual studies.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Several variations of CBT
COMPARISON GROUP(S)	Waitlist
PROCEDURE	This systematic review and meta-analysis was intended to quantify the effects of CBT interventions for children and adolescents with SAD. Studies published between 2000 and 2014 were included in the review. Between-groups meta-analysis was conducted for studies with waiting list controls (10 studies), and pre–post analysis was conducted for studies with or without waiting list controls (13 studies).
SUMMARY OF FINDINGS	CBT interventions were found to be more effective than pooled waiting list controls at reducing SAD symptom severity (medium to large effect size). Additionally, CBT significantly reduced SAD symptom severity from pre- to post-treatment, and from pre-treatment to follow-up, accompanied by large effect sizes. CBT interventions were associated with further reductions in symptom severity from posttreatment to follow-up, with a small effect size. More treatment sessions and treatment weeks predicted greater success for CBT interventions.

[36] nice.org.uk/guidance/cg159

TITLE OF ITEM	***Generic versus disorder specific cognitive behavior therapy for social anxiety disorder in youth: A randomized controlled trial using internet delivery***
AUTHOR(S) AND SOURCE	Spence, S. H., Donovan, C. L., March, S., Kenardy, J. A., & Hearn, C. S. (2017). *Behaviour Research and Therapy, 90,* 41–57
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual online (clinician-guided)
PARTICIPANTS	125 youth aged 8 to 17 (mean age 11.3 years) with a DSM-5 diagnosis of SAD. Seventy-five percent of all participants were female.
TREATING CLINICIAN(S)	Psychologists with training in the specific intervention
INTERVENTION(S)	Generic CBT (BRAVE-ONLINE; *n* = 48); social anxiety- specific CBT (*n* = 47)
COMPARISON GROUP(S)	Waitlist (*n* = 30)
PROCEDURE	An RCT was designed to evaluate two online behaviour therapy interventions (generic and disorder-specific) for youth with SAD. Each intervention consisted of 10 x 60- minute sessions and incorporated brief clinician support and feedback. Booster sessions were provided at 1 and 2 months following treatment completion.
SUMMARY OF FINDINGS	In comparison to results from waitlist controls, the combined CBT interventions were more effective at reducing clinical symptoms and improving global functioning among youth (large effect sizes). Notably, the social anxiety-specific intervention was no more effective than generic CBT at improving clinical outcomes. Further, clinical improvements were identified at 6 months' follow-up for those receiving generic CBT. On average, participants completed just under half (47.5%) of the 10 sessions. A greater number of completed sessions was associated with better clinical improvement at 6 months' follow-up, but not at posttreatment.

OBSESSIVE-COMPULSIVE DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for CBT as a treatment for obsessive compulsive disorder (OCD) among both children and adolescents (3 to 18 years of age). There is Level II evidence for clinician-supported online CBT for adolescents (12 to 17 years of age). However, two-thirds of participants were not responsive to online CBT. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Obsessive-compulsive disorder and body dysmorphic disorder, 2005).[37] The guidelines emphasise the involvement of parents/carers with either group or individual format interventions depending on the child's preference. It is suggested that clinician-guided self-help interventions may be suitable for children or adolescents with mild OCD-related functional impairment.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive behavioral and pharmacological treatments of OCD in children: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Öst, L.-G., Riise, E. N., Wergeland, G. J., Hansen, B., & Kvale, G. (2016). *Journal of Anxiety Disorders, 43, 58–69.*
DESIGN	Systematic review and meta-analysis (25 CBT studies)
FOLLOW-UP	Nil to 24 months (mean 5.5 months)
FORMAT	Individual, group, and family
PARTICIPANTS	1,195 children and adolescents aged 3 to 18 (mean 12.4 years) with a diagnosis of OCD according to DSM or ICD. Almost half (48.8%) of the participants were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Pharmacotherapy (selective serotonin reuptake inhibitors; SSRIs), various including TAU, waitlist, relaxation, placebo
PROCEDURE	Meta-analysis designed to evaluate the efficacy of CBT interventions for OCD among children and adolescents when compared with pharmacotherapy (SSRIs) and controls. The review incorporated studies from 1990 to 2015.
SUMMARY OF FINDINGS	In comparison with results from pooled controls, CBT was found to be effective at reducing symptom severity among children and adolescents, with a moderate effect size. SSRI treatment yielded a similar effect size on equivalent clinical measures. Subanalyses indicated that the effect of CBT on symptom severity was large in comparison with placebo controls and very large compared with waitlist controls. In comparison with pooled controls, combination (CBT and SSRI) studies produced a large effect size for the reduction of OCD symptoms. However, this was based on two studies only. At posttreatment, approximately half of the participants in the CBT and CBT+SSRI groups no longer met diagnostic criteria for OCD, compared with a quarter of those in SSRI-only groups. Recovery rates at follow-up were not significantly different between the intervention groups. The researchers noted that attrition rates for pharmacotherapy groups were significantly higher than those associated with CBT.

[37] nice.org.uk/guidance/cg31

TITLE OF ITEM	***Psychological treatment of obsessive-compulsive disorder in children and adolescents: A meta-analysis***
AUTHOR(S) AND SOURCE	Rosa-Alcázar, A. I., Sánchez-Meca, J., Rosa-Alcázar, Á., Iniesta-Sepúlveda, M., Olivares-Rodríguez, J., & Parada-Navas, J. L. (2015). *The Spanish Journal of Psychology, 18,* E20
DESIGN	Meta-analysis (17 RCTs, 28 one-group studies, 1 two-groups study)
FOLLOW-UP	Not reported
FORMAT	Individual, group, and family
PARTICIPANTS	1,164 youth up to 18 years of age (mean ages ranging from 6 to 15.5 years) with a diagnosis of obsessive compulsive disorder. The median proportion of females was 46.2%.
TREATING CLINICIAN(S)	Psychologists, or psychologists in training
INTERVENTION(S)	CBT (most including an exposure response prevention component)
COMPARISON GROUP(S)	1 psychodynamic therapy group, inactive controls, pill-placebo
PROCEDURE	Meta-analysis designed to evaluate the efficacy of CBT treatment techniques in pediatric OCD based on a review of studies published from 1983 to 2014
SUMMARY OF FINDINGS	CBT interventions were associated with large effect sizes from pre- to post-treatment in reducing symptom severity among children and adolescents with OCD. Effect sizes for CBT treatment were large regardless of whether the intervention was individual, group, or family format. Clinician-assessed symptoms indicated a larger effect than did self-report symptoms. However, both attained statistical significance. A comparison between the mean effect of CBT groups on OCD symptom severity and the mean effect of control groups revealed an overall large effect size for CBT. In addition further reduction in symptom severity was found at follow-up, with a large effect size. Detailed analysis revealed that the most successful CBT interventions incorporated exposure response prevention (ERP), cognitive strategies, and relapse prevention.

TITLE OF ITEM	***Therapist-guided, internet-delivered cognitive-behavioral therapy for adolescents with obsessive-compulsive disorder: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Lenhard, F., Andersson, E., Mataix-Cols, D., Rück, C., Vigerland, S., Högström, J., … Serlachius, E. (2017). *Journal of the American Academy of Child & Adolescent Psychiatry, 56,* 10–19.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Online (clinician and parent supported)
PARTICIPANTS	67 adolescents aged 12 to 17 (mean age 14.6 years) meeting DSM-5 criteria for OCD. Just under half (46%) of all participants were female.
TREATING CLINICIAN(S)	Psychologists with experience in pediatric OCD and CBT
INTERVENTION(S)	CBT (BarnInternetProjektet or BiP OCD; $n = 33$)
COMPARISON GROUP(S)	Waitlist ($n = 34$)
PROCEDURE	RCT designed to determine whether online CBT would be effective in reducing symptoms among adolescents with OCD. The intervention comprised 12 weekly online “chapters” consisting of psychoeducation (4 chapters), exposure response prevention (6 chapters), and relapse prevention (2 chapters). On average, clinicians spent 17.5 minutes per week reading patient exercises and providing individual feedback.
SUMMARY OF FINDINGS	CBT was more effective than waitlist in reducing OCD symptom severity among adolescents, with a medium to large effect size. Further within-group symptom reductions were reported at 3 months’ follow-up, accompanied by a very large effect size. Based on clinician consensus, a quarter of CBT participants were classified as responders at posttreatment compared with none in the control group. The proportion of CBT responders increased to one-third at follow-up. Fifteen percent of those receiving CBT treatment no longer met criteria for OCD at posttreatment. This increased to 26% at follow-up. All controls continued to meet diagnostic criteria for OCD. An average of 8.5 chapters (out of 12) were completed, with approximately a quarter of participants completing all chapters. However, there was no significant relationship between number of completed chapters and symptom severity at posttreatment.

POSTTRAUMATIC STRESS DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for the use of CBT for children and adolescents (3 to 18 years) with a diagnosis of, or who are at high risk of developing, posttraumatic stress disorder (PTSD). Level II evidence supports the specific use of trauma-focused CBT among the same population. Further Level II evidence supports EMDR for the treatment of PTSD or subthreshold PTSD among children and adolescents (8 to 18 years). Studies typically combined participants meeting full PTSD diagnostic criteria with those not meeting all diagnostic criteria. For this reason, findings should be interpreted as a general guide. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are, on the whole, consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children, 2005)[38] which recommend trauma-focused CBT for the treatment for PTSD in children and young people. Regarding chronic paediatric PTSD, the guidelines suggest incorporating 8–12 weekly sessions, delivered in a consistent manner by the same person.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents***
AUTHOR(S) AND SOURCE	Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2013). Evidence-Based Child Health: *A Cochrane Review Journal, 8,* 1004–1116.
DESIGN	Meta-analysis (14 RCTs)
FOLLOW-UP	1 to 12 months
FORMAT	Various (details not reported)
PARTICIPANTS	758 children or adolescents aged 3 to 18 who were either (a) exposed to a traumatic event or (b) diagnosed with PTSD. No further demographic details were reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Various (e.g., CBT, exposure-based, psychodynamic, narrative, supportive counselling, EMDR; *n* not reported)
COMPARISON GROUP(S)	Details not reported
PROCEDURE	Meta-analysis to determine the effectiveness of psychological interventions for the treatment of PTSD in children and adolescents. Any RCTs published prior to 2012 were included for analysis.
SUMMARY OF FINDINGS	CBT was determined to be the most empirically supported psychological intervention for children and adolescents with PTSD. There were significant reductions in both PTSD and depression symptoms for CBT groups in comparison with pooled controls, and these results were maintained up to 1 month following treatment (large effect sizes). Due to the relatively small number of RCTs until this article was published, there was insufficient evidence to draw conclusions about the effectiveness of CBT at 1-year follow-up.

[38] nice.org.uk/guidance/cg26

TITLE OF ITEM	***Cognitive behavioral therapy for the treatment of pediatric posttraumatic stress disorder: A review and meta-analysis***
AUTHOR(S) AND SOURCE	Kowalik, J., Weller, J., Venter, J., & Drachman, D. (2011). *Journal of Behavior Therapy and Experimental Psychiatry, 42,* 405–413.
DESIGN	Systematic review and meta-analysis (8 RCTs)
FOLLOW-UP	3 months to 2 years
FORMAT	Individual, family
PARTICIPANTS	624 children and adolescents (3 to 17 years) who had a history of sexual abuse, who met criteria for a PTSD, or who were at high risk of developing PTSD
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT
COMPARISON GROUP(S)	Active control groups (e.g., unstructured support therapy, nondirective-supportive treatment, child-centred therapy)
PROCEDURE	A systematic review designed to examine the efficacy of CBT on pediatric PTSD. RCTs published between 1996 and 2010 were included for analysis.
SUMMARY OF FINDINGS	In comparison with results from active pooled controls, CBT was determined to be efficacious for the treatment of PTSD among pediatric populations. Specifically, outcomes for participants receiving CBT interventions were favourable on total problems and internalising and externalising indices, and were accompanied by small to medium effect sizes.

TITLE OF ITEM	***Effectiveness of trauma-focused cognitive behavioral therapy for children and adolescents: A randomized controlled trial in eight German mental health clinics***
AUTHOR(S) AND SOURCE	Goldbeck, L., Muche, R., Sachser, C., Tutus, D., & Rosner, R. (2016). *Psychotherapy and Psychosomatics, 85,* 159–170.
DESIGN	RCT
FOLLOW-UP	Nil
FORMAT	Individual; caregiver supported
PARTICIPANTS	159 children aged 7 to 17 (mean age 13 years) with clinically significant posttraumatic stress symptoms requiring treatment. Three-quarters met full diagnostic criteria for PTSD, and 71% were female.
TREATING CLINICIAN(S)	Clinicians with at least postgraduate training and an average 8.3 years' experience
INTERVENTION(S)	Trauma-focused CBT (n = 76)
COMPARISON GROUP(S)	Waitlist (n = 83)
PROCEDURE	RCT designed to investigate the effectiveness of trauma-focused CBT in a clinical setting for youth experiencing significant posttraumatic stress symptoms. The trauma-focused CBT intervention consisted of 12 x 90-minute sessions, some of which were attended by caregivers. The treatment incorporated stabilisation/skill building, exposure/cognitive processing, and safety/future development.
SUMMARY OF FINDINGS	Trauma-focused CBT was more effective than the waitlist control condition in reducing PTSD symptom severity among youth at posttreatment, with a medium effect size. There was a very large within-group treatment effect size for trauma-focused CBT from pre- to post-treatment. In terms of recovery, significantly more trauma-focused CBT participants (44.7%) no longer met PTSD criteria at posttreatment, compared with waitlist controls (28.9%). Furthermore, global functioning was significantly higher for the trauma-focused-CBT group than for controls at posttreatment, accompanied by a medium effect size.

TITLE OF ITEM	***Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial***
AUTHOR(S) AND SOURCE	Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). *Journal of Child Psychology and Psychiatry, 52,* 853–860.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual, family
PARTICIPANTS	64 children aged 3 to 6 (mean age 5.3 years) with four or more PTSD symptoms, including at least one symptom of recurring traumatic thoughts or memories (Criterion B) or avoidance symptom (Criterion C). Two-thirds of all participants were male.
TREATING CLINICIAN(S)	Licensed social workers
INTERVENTION(S)	Trauma-focused CBT (*n* = 40)
COMPARISON GROUP(S)	Waitlist (*n* = 24)
PROCEDURE	A controlled trial to evaluate the effectiveness of trauma-focused CBT to treat PTSD among very young children. Treatment consisted of 12 sessions (session length was not reported) according to a manualised protocol, incorporating psychoeducation, recognition of feelings, coping-skill training, graduated exposure (via drawings, imaginal, and in vivo), and safety planning. Parents were involved in all 12 sessions but were not present for the entire time.
SUMMARY OF FINDINGS	In comparison with waitlist controls, trauma-focused CBT resulted in a significant reduction in PTSD symptoms at posttreatment (large effect size). Between-group reductions of similar magnitude were reported for symptoms of major depressive disorder (large effect), separation anxiety disorder (medium to large effect), and oppositional defiant disorder (large effect). These results were maintained at 6 months posttreatment. However, almost two-thirds (64%) of participants completing the treatment were unable to be located at follow-up.

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR)

TITLE OF ITEM	***Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: A multicenter randomized clinical trial***
AUTHOR(S) AND SOURCE	Roos, C., Oord, S., Zijlstra, B., Lucassen, S., Perrin, S., Emmelkamp, P., & Jongh, A. (2017). *Journal of Child Psychology and Psychiatry and Allied Disciplines, 58,* 1219–1228.
DESIGN	RCT
FOLLOW-UP	3 to 12 months
FORMAT	Individual
PARTICIPANTS	103 children and adolescents aged 8 to 18 (mean age 13.1 years) with a DSM-IV diagnosis of PTSD or subthreshold PTSD. Most (57.3%) participants were female.
TREATING CLINICIAN(S)	Clinical psychologists who had completed courses in EMDR and cognitive behavioural writing therapy
INTERVENTION(S)	EMDR (*n* = 43)
COMPARISON GROUP(S)	Waitlist (*n* = 18), cognitive behavioural writing therapy (*n* = 42)
PROCEDURE	RCT designed to evaluate the effectiveness of EMDR in comparison to cognitive behavioral writing therapy and waitlist controls among children and adolescents with single-trauma PTSD. Both EMDR and writing therapy interventions consisted of up to 6 x 45-minute sessions. EMDR was delivered according to an eight-phase protocol that included history taking, treatment planning, preparation, reprocessing, installation of a positive cognition, checking for and processing residual body sensations, positive closure, and evaluation.
SUMMARY OF FINDINGS	At posttreatment, PTSD remission rates were significantly higher for both EMDR (92.5%) and cognitive behavioural writing therapy (90.2%) treatment groups than for waitlist controls (52.9%). At 12 months' follow-up, no children in the EMDR group met diagnostic criteria for PTSD, but 18.4% (7 participants) continued to meet criteria for subthreshold PTSD. On measures of clinical symptoms, EMDR significantly reduced trauma-related cognitions (small to medium effect size), child-reported symptoms of anxiety and depression (small to medium effect), and parent-reported emotional/behavioural symptoms (large effect), in comparison with controls.

SUBSTANCE USE DISORDERS

SUMMARY OF EVIDENCE

There is Level I evidence for the use of family interventions for adolescents (12 years and older) with substance use disorders. Multidimensional family therapy appears to be most beneficial for adolescents presenting with the highest levels of substance use. Additionally, Level II evidence supports group-based CBT among the same population. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with the most recently published guidelines from the National Institute for Clinical Excellence on alcohol use disorders (Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011). The guidelines recommend several specific family interventions (multidimensional, brief strategic, and functional) as well as multisystemic therapy for the treatment of adolescents with alcohol use problems.

FAMILY INTERVENTIONS

TITLE OF ITEM	***The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis***
AUTHOR(S) AND SOURCE	Tanner-Smith, E. E., Wilson, S. J., & Lipsey, M. W. (2013). *Journal of Substance Abuse Treatment, 44,* 145–158.
DESIGN	Meta-analysis (45 primarily RCT studies)
FOLLOW-UP	Not reported
FORMAT	Individual, family, group
PARTICIPANTS	Adolescents aged 14 to 20 (mean age 16.5 years) with a substance use disorder. Two-thirds of the pooled sample were male. The total number of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT; family therapy; psychoeducation
COMPARISON GROUP(S)	Various (motivational interviewing, pharmacotherapy, TAU)
PROCEDURE	A systematic review and meta-analysis of studies evaluating the effectiveness of several psycho-interventions on adolescents with substance use disorders. The review incorporated 45 studies published between 1981 and 2008.
SUMMARY OF FINDINGS	Family therapy was the only intervention significantly more effective than pooled comparison groups for treating substance use disorders among adolescents (small effect size). Additionally, family therapy was more successful when compared specifically with psychoeducation or group/mixed counselling, accompanied by small to medium effect sizes. CBT produced better outcomes than did no treatment or TAU. However, the effect did not attain statistical significance.

[39] nice.org.uk/guidance/cg115

TITLE OF ITEM	***Effectiveness of multidimensional family therapy with higher severity substance-abusing adolescents: Report from two randomized controlled trials***
AUTHOR(S) AND SOURCE	Henderson, C. E., Greenbaum, P. E., Dakof, G. A., & Liddle, H. A. (2010). *Journal of Consulting and Clinical Psychology, 78,* 885–897.
DESIGN	Secondary analysis of 2 RCTs
FOLLOW-UP	3 to 12 months
FORMAT	Family
PARTICIPANTS	224 adolescents aged 12 to 17 (mean age 15 years) with cannabis use disorder, alcohol use disorder, or another substance use disorder. Approximately 80% of participants were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Multidimensional family therapy (MDFT; *n* = 212)
COMPARISON GROUP(S)	Individually focused CBT (*n* = 112), TAU with enhanced services (*n* = 100)
PROCEDURE	Secondary analysis of two RCTs investigating the effectiveness of MDFT interventions for substance abuse among adolescents. The analysis compared MDFT with both individually focused CBT and enhanced services.
SUMMARY OF FINDINGS	On measures of problem severity, approximately three-quarters of family therapy participants showed clinically significant improvements. Around one-third of the family therapy group showed clinically significant improvements on measures of substance use frequency. For the overall sample, family therapy was not significantly more effective than were CBT or enhanced TAU. However, further analysis revealed that, for adolescents experiencing higher levels of substance use at baseline, family therapy was more effective than was CBT in reducing substance use severity after 30 days. Additionally, family therapy was more effective in decreasing substance use frequency than was enhanced TAU (after 90 days) among adolescents with higher levels of pretreatment substance use. Findings suggest that family-based treatment is most effective for youth experiencing more severe symptoms of substance use.

TITLE OF ITEM	***Comparison of family therapy outcome with alcohol-abusing, runaway adolescents***
AUTHOR(S) AND SOURCE	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
FOLLOW-UP	3 months, 9 months, 15 months
FORMAT	Family
PARTICIPANTS	119 runaway adolescents with a primary alcohol problem whose family resided within 100 kms of the research site
TREATING CLINICIAN(S)	Master's level clinicians with 2 to 5 years' experience
INTERVENTION(S)	Home-based family therapy (*n* = 37), office-based family therapy (*n* = 40)
COMPARISON GROUP(S)	TAU (*n* = 42)
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. Both family therapy interventions consisted of 16 x 50-minute sessions.
SUMMARY OF FINDINGS	Compared with TAU, both family therapy approaches significantly reduced alcohol and drug use at the 15-month follow-up. 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 improved in all conditions. Additionally, compared with TAU, there were significantly fewer substance use diagnoses at 3-month follow-up in the family therapy groups.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Evidence base on outpatient behavioral treatments for adolescent substance use: Updates and recommendations 2007–2013***
AUTHOR(S) AND SOURCE	Hogue, A., Henderson, C. E., Ozechowski, T. J., & Robbins, M. S. (2014). *Journal of Clinical Child & Adolescent Psychology, 43,* 695–720.
DESIGN	Systematic review (19 efficacy studies, 7 of which included CBT)
FOLLOW-UP	Not reported
FORMAT	Group, individual
PARTICIPANTS	Adolescents aged 12 to 19 with clinically significant substance use symptoms. The total number of participants was not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	CBT-G (group), CBT for insomnia (individual)
COMPARISON GROUP(S)	Psychoeducation, motivational interviewing, family intervention, or controls (TAU, psychological placebo group)
PROCEDURE	Review of RCT studies published between 2006 and 2013 investigating the effectiveness of psychological interventions among adolescents with substance use problems
SUMMARY OF FINDINGS	Group-based CBT was found to be more effective than psychoeducation or “interaction” controls and approximately equal to the family intervention for reducing substance use symptoms among adolescents. CBT which was not found to be more effective than the non-CBT interventions.

ANOREXIA NERVOSA

SUMMARY OF EVIDENCE

There is Level I evidence for family interventions for adolescents (12 years and older) with anorexia nervosa. Findings from additional RCT studies suggest that multi-family approaches, parent-only sessions, and/or adjunctive inpatient refeeding should be used to enhance family-based interventions. There is Level IV evidence for enhanced CBT among youth aged 13 to 17 with anorexia nervosa. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Eating disorders: Recognition and treatment, 2017).[40] However, in addition to anorexia-focused family therapy and CBT-enhanced therapy, the guidelines suggest use of adolescent-focused therapy for anorexia nervosa as an alternative treatment option.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Couturier, J., Kimber, M., & Szatmari, P. (2013). *International Journal of Eating Disorders, 46,* 3–11
DESIGN	Systematic review and meta-analysis (4 RCTs including anorexia nervosa)
FOLLOW-UP	6 to 12 months
FORMAT	Family
PARTICIPANTS	194 people aged 11 to 23 meeting DSM-IV-TR criteria for anorexia nervosa. Further demographic information was not reported.
TREATING CLINICIAN(S)	Various
INTERVENTION(S)	Family intervention (*n* = 102)
COMPARISON GROUP(S)	Various modalities of individual therapy (*n* = 101), including adolescent-focused individual therapy, individual CBT self-guided care, and supportive therapy
PROCEDURE	Meta-analysis to determine the efficacy of family-based therapeutic approaches versus individual therapy for anorexia nervosa among adolescents. Four RCTs between 1987 and 2010 met the inclusion criteria. The primary outcome measure was remission from eating disorder symptomatology.
SUMMARY OF FINDINGS	At posttreatment, there was no difference between individual and family interventions at achieving remission for adolescents with anorexia nervosa. However, compared with individual therapy, family intervention achieved higher rates of remission at 6 to 12 months follow-up (48% vs 33%). This meta-analysis did not include a report on within-group effectiveness for the two intervention types.

[40] nice.org.uk/guidance/ng69

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy?***
AUTHOR(S) AND SOURCE	Dalle Grave, R., Calugi, S., Doll, H. A., & Fairburn, C. G. (2013). *Behaviour Research and Therapy, 51*(1), R9–R12.
DESIGN	Case series
FOLLOW-UP	14 months
FORMAT	Individual, family
PARTICIPANTS	49 female outpatients aged 13 to 17 (mean age 15.5 years) meeting DSM-IV criteria for anorexia nervosa, excluding amenorrhoea
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Enhanced CBT
COMPARISON GROUP(S)	N/A
PROCEDURE	The case series aimed to establish both immediate and long-term outcomes of enhanced CBT among an adolescent outpatient sample. Enhanced CBT was delivered as 40 x 45-minute sessions over a 40-week period. Most sessions were held with the patient only, but eight additional 15-minute sessions were attended by both patient and parents.
SUMMARY OF FINDINGS	Two-thirds of adolescents receiving enhanced CBT completed the full 40-week treatment without further support and were classified as responders. At posttreatment, the mean BMI percentile increase was 26.9% and a third of the adolescents reached 95% of their ideal body weight. Substantial improvements were recorded on measures of eating disorder psychopathology and general psychiatric features. These results were maintained at follow-up with further improvements for BMI percentile and approximately 90% of adolescents having minimal residual eating disorder psychopathology.

TITLE OF ITEM	***Inpatient cognitive behavior therapy for adolescents with anorexia nervosa: Immediate and longer-term effects***
AUTHOR(S) AND SOURCE	Dalle Grave, R., Calugi, S., El Ghoch, M., Conti, M., & Fairburn, C. G. (2014). *Frontiers in Psychiatry, 5,* 14. http://doi.org.ezproxy1.library.usyd.edu.au/10.3389/fpsyt.2014.00014
DESIGN	Case series
FOLLOW-UP	6 months, 12 months
FORMAT	Individual, group, family
PARTICIPANTS	27 inpatients aged 13 to 17 (mean age 16 years), with a DSM-IV diagnosis of anorexia nervosa (excluding amenorrhea). All but one of the participants were female.
TREATING CLINICIAN(S)	Clinical psychologists
INTERVENTION(S)	Enhanced CBT
COMPARISON GROUP(S)	N/A
PROCEDURE	The case series was designed to evaluate the effectiveness of enhanced CBT for adolescents with severe anorexia nervosa. The intervention was delivered at an inpatient eating disorder unit and consisted of 20 weeks of treatment. It was regarded as an immersive therapy treatment, with the unit providing 24-hour/7 days per week support consistent with the CBT-enhanced framework. Treatment was delivered in a range of formats including group, individual, family, and parent only.
SUMMARY OF FINDINGS	All but one of the participants completed treatment. At posttreatment, 96.2% of those completing treatment had a BMI ≥ 18.5. Increases in BMI were accompanied by substantial decreases in eating disorder behaviour and psychiatric features. More than 85% of the cohort completed a follow-up assessment at 12 months, with the majority (82.6%) maintaining a BMI at or above 18.5.

BULIMIA NERVOSA

SUMMARY OF EVIDENCE

There is Level I evidence for the use of family interventions for female adolescents (12 years and older) with bulimia nervosa. Furthermore, there is Level II evidence for CBT and psychodynamic therapy for females aged 14 and above. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Eating disorders: Recognition and treatment, 2017), which recommend bulimia nervosa-focused family therapy and individual eating disorder-focused CBT as the psychological treatments of choice.

FAMILY INTERVENTIONS

See Le Grange et al. (2015) under CBT for bulimia nervosa for additional findings related to family interventions.

TITLE OF ITEM	***Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis***
AUTHOR(S) AND SOURCE	Couturier, J., Kimber, M., & Szatmari, P. (2013). *International Journal Of Eating Disorders, 46,* 3–11
DESIGN	Systematic review and meta-analysis (2 RCTs including bulimia nervosa)
FOLLOW-UP	6 months
FORMAT	Family
PARTICIPANTS	165 young people aged 12 to 20 meeting DSM-IV-TR criteria for bulimia nervosa or eating disorder not otherwise specified. Further demographic information was not reported.
TREATING CLINICIAN(S)	Various
INTERVENTION(S)	Family intervention (n = 82)
COMPARISON GROUP(S)	Various modalities of individual therapy (n = 83), including adolescent-focused individual therapy, individual CBT self-guided care, and supportive therapy
PROCEDURE	Meta-analysis to determine the efficacy of family-based therapeutic approaches versus individual therapy for bulimia nervosa among adolescents. Two RCTs, both published in 2007, met the inclusion criteria.
SUMMARY OF FINDINGS	At posttreatment, there was no difference between individual and family interventions at achieving abstinence from bingeing or purging for adolescents with bulimia nervosa. However, compared with individual therapy, family intervention achieved higher rates of abstinence at 6 months follow-up (29% vs 16%). This meta-analysis did not contain information about within-group effectiveness for the two intervention types.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive-behavioral and psychodynamic therapy in female adolescents with bulimia nervosa: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Stefini, A., Salzer, S., Reich, G., Horn, H., Winkelmann, K., Bents, H., … Kronmüller, K.-T. (2017). *Journal of the American Academy of Child & Adolescent Psychiatry, 56,* 329-335
DESIGN	RCT
FOLLOW-UP	12 months
FORMAT	Individual
PARTICIPANTS	81 females aged 14 to 20 (mean age 18.7 years) with a DSM-IV diagnosis of full (78%) or partial (22%) bulimia nervosa.
TREATING CLINICIAN(S)	Psychologists trained in the manualised treatments
INTERVENTION(S)	CBT (*n* = 39)
COMPARISON GROUP(S)	Psychodynamic therapy (*n* = 42)
PROCEDURE	RCT designed to compare the efficacy of CBT with psychodynamic therapy for the long-term treatment of adolescents with bulimia nervosa. Both interventions comprised up to 60 sessions across a 12-month period, consistent with usual treatment practice for bulimia nervosa in Germany.
SUMMARY OF FINDINGS	On measures of bulimia nervosa remission rates from the beginning to end of treatment, both CBT and psychodynamic therapy interventions were effective and were accompanied by large effect sizes. There was no significant difference between the treatment groups at posttreatment (33% vs 31%) and the outcomes were stable at 12 months, follow-up. On secondary measures, CBT was more effective at alleviating symptoms of binge eating and purging (small effect sizes), and psychodynamic therapy was successful at alleviating eating concern (small effect size).

TITLE OF ITEM	***Randomized clinical trial of family-based treatment and cognitive-behavioral therapy for adolescent bulimia nervosa***
AUTHOR(S) AND SOURCE	Le Grange, D., Lock, J., Agras, W. S., Bryson, S. W., & Jo, B. (2015). *Journal of the American Academy of Child & Adolescent Psychiatry, 54,* 886–894. e882.
DESIGN	RCT
FOLLOW-UP	6 months, 12 months
FORMAT	Individual
PARTICIPANTS	130 adolescents aged 12 to 18 (mean age 15.8 years) diagnosed with bulimia nervosa or partial bulimia nervosa (binge eating/purging once or more per week for 6 months) according to DSM-IV criteria. Ninety-four percent of participants were female.
TREATING CLINICIAN(S)	Psychologist, social worker, or child psychiatrist
INTERVENTION(S)	CBT adapted for adolescents (*n* = 58)
COMPARISON GROUP(S)	Family intervention for adolescent bulimia nervosa (*n* = 52)
PROCEDURE	RCT designed to evaluate the efficacy of CBT in relation to family intervention for adolescents with bulimia nervosa. All treatments consisted of 18 sessions delivered over a period of 6 months.
SUMMARY OF FINDINGS	At posttreatment, abstinence rates improved for both the intervention and comparison group. The family-based intervention achieved significantly higher bingeing and purging abstinence rates than did CBT (39% vs 20%) among adolescents with full or partial bulimia nervosa. On the same abstinence measure, the family intervention continued to outperform CBT at 6 months' follow-up (44% vs 25%). However, at 12 months' follow-up, the difference between the two interventions was no longer significant (49% vs 32%). Overall, the family-based intervention for bulimia nervosa appears to be the preferred treatment for more rapid and sustained abstinence rates.

PSYCHODYNAMIC THERAPY

See Stefini et al. (2017) under CBT for bulimia nervosa for a summary of findings related to psychodynamic therapy.

BINGE EATING DISORDER (BED)

SUMMARY OF EVIDENCE

There is Level II evidence for the use of CBT for female adolescents (12 to 18 years) with (BED). This evidence is limited to a single pilot RCT with a small sample size, so results should be interpreted with caution. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Eating disorders: Recognition and treatment, 2017), which recommends CBT as the psychological treatment of choice. It further advises that this therapy can be delivered as a self-help program or in the form of group or individual sessions (eating disorder-focused CBT).

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive behavioral treatment for recurrent binge eating in adolescent girls: A pilot trial***
AUTHOR(S) AND SOURCE	DeBar, L. L., Wilson, G. T., Yarborough, B. J., Burns, B., Oyler, B., Hildebrandt, T., … Striegel, R. H. (2013). *Cognitive and Behavioral Practice, 20,* 147–161
DESIGN	Pilot RCT
FOLLOW-UP	6 months
FORMAT	Primarily individual, with minimal parental involvement
PARTICIPANTS	26 female adolescents aged 12 to 18 (mean age 15.1 years) who reported recurrent binge eating episodes (at least one per week) during a 3-month period. 52% of all participants met criteria for BED, and 32% met criteria for recurrent binge eating.
TREATING CLINICIAN(S)	Counsellors and health professionals with postgraduate training
INTERVENTION(S)	Developmentally adapted CBT (*n* = 13)
COMPARISON GROUP(S)	Waitlist (*n* = 13)
PROCEDURE	RCT to test the efficacy of a developmentally adapted version of CBT for treating female adolescents with recurrent binge eating behaviour. Participants attended eight core sessions and four optional supplementary sessions on topics of interpersonal relations, behaviour activation, and emotional regulation. Parents attended an initial orientation session and were provided with psychoeducation about eating behaviours.
SUMMARY OF FINDINGS	Compared with 50% in the waitlist group, all participants in the CBT group were abstinent from binge eating at 6 months' follow-up, and the effect size was large. Compared with waitlist controls, adolescent females in the CBT group had significantly fewer bingeing episodes at posttreatment, producing a medium to large effect size.

SLEEP DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for behavioural interventions to treat sleep problems among young children (0 to 5 years of age), and there is Level II evidence for behavioural interventions to treat problems initiating and maintaining sleep among school-aged children (4 to 13 years of age). There is Level II evidence for CBT to treat adolescents (12 to 19 years of age) with insomnia (group and clinician-guided online delivery), for school-aged children with behavioural insomnia (7 to 13 years of age), as well as CBT plus bright light therapy for adolescents (11 to 18 years of age) with delayed sleep phase difficulties. The latter is supported by a small-scale RCT, so results should be interpreted with caution. Additional Level II evidence supports multicomponent cognitive behaviour / mindfulness therapy among highschool-aged adolescents with sleep problems and elevated anxiety. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Systematic review and meta-analysis of behavioral interventions for pediatric insomnia***
AUTHOR(S) AND SOURCE	Meltzer, L. J., & Mindell, J. A. (2014). *Journal of Pediatric Psychology, 39,* 932–948.
DESIGN	Systematic review and meta-analysis (16 controlled trials)
FOLLOW-UP	3 to 12 months
FORMAT	Various (individual, group, family-based)
PARTICIPANTS	2,133 children aged 0 to 13 years with insomnia, defined as “bedtime problems” for young children (mean age 3 years), or “difficulties initiating and maintaining sleep” for school-aged children (mean age 7.2 years). Just over half (54%) of all participants were male.
TREATING CLINICIAN(S)	Various (e.g., psychologist, nurse, physician)
INTERVENTION(S)	A variety of behavioural therapies (e.g., CBT for insomnia, graduated extinction, scheduled awakenings, bedtime fading / positive routines) delivered in person or via the internet
COMPARISON GROUP(S)	TAU, waitlist control, placebo, and/or historical controls
PROCEDURE	Sixteen controlled studies with publication dates between 1989 and 2012. Eleven of these studies targeted interventions for young children (0 to 5 years of age) and three focused on school-aged children and adolescents. No studies focused solely on adolescents.
SUMMARY OF FINDINGS	For children aged 0 to 5 years, behavioural interventions successfully reduced sleep-onset latency, night waking duration, and night waking frequency at posttreatment, compared with pooled controls (small to medium effect sizes). The effects were not statistically significant at long term follow-up, although the authors noted that fewer studies incorporated follow-up assessments. For school-aged children (4 to 13 years of age), night waking duration was significantly reduced in the behavioural interventions group compared with pooled controls (small to medium effect size). Furthermore, school-aged children receiving a behavioural intervention achieved substantially higher sleep efficiency than did controls, accompanied by a large effect size.

TITLE OF ITEM	***Efficacy of cognitive behavioral therapy for insomnia in adolescents: A randomized controlled trial with internet therapy, group therapy and a waiting list condition***
AUTHOR(S) AND SOURCE	de Bruin, E. J., Bögels, S. M., Oort, F. J., & Meijer, A. M. (2015). *Sleep, 38,* 1913–1926.
DESIGN	RCT (3 groups)
FOLLOW-UP	2 months
FORMAT	Group
PARTICIPANTS	116 adolescents aged 12 to 19 (mean age 15.9 years) meeting DSM-IV diagnostic criteria for primary insomnia. Almost three-quarters (71.8%) of the participants were female.
TREATING CLINICIAN(S)	CBT-trained sleep clinicians
INTERVENTION(S)	CBT for adolescent insomnia, delivered either in a group setting (n = 39) or via the internet (n = 39). The protocol was adapted from the adult version.
COMPARISON GROUP(S)	Waitlist control group (n = 38)
PROCEDURE	RCT designed to determine the efficacy of CBT for insomnia among adolescents experiencing insomnia. Both the group- and internet–based CBT interventions comprised six weekly sessions incorporating psychoeducation, sleep hygiene, restriction of time in bed, stimulus control, cognitive therapy, and relaxation techniques. Group CBT for insomnia consisted of 1.5-hour sessions comprising 6 to 8 adolescents, and online CBT was delivered via a guided self-help website and included feedback from a clinician.
SUMMARY OF FINDINGS	CBT for insomnia was found to be an efficacious treatment for adolescents with primary insomnia, with medium to large effect sizes. Compared with the waitlist group, CBT (both group and online) resulted in a higher proportion of adolescents achieving clinically significant improvements (24–57% versus 0–20%) in day-to-day-functioning. Similarly, there was a significantly higher proportion of participants exceeding the cut-off for high-end state functioning in the CBT groups (63–91%) compared with waitlist controls (31–40%). These results were significant at both posttreatment and follow-up assessments. The authors noted that there were no significant differences between the group- and online-CBT treatments.

TITLE OF ITEM	***A randomised controlled trial of cognitive-behaviour therapy for behavioural insomnia of childhood in school-aged children***
AUTHOR(S) AND SOURCE	Paine, S., & Gradisar, M. (2011). *Behaviour Research and Therapy, 49,* 379–388
DESIGN	RCT
FOLLOW-UP	1 to 6 months
FORMAT	Individual
PARTICIPANTS	42 children aged 7 to 13 (mean age 9.3 years) diagnosed with behavioural insomnia of childhood. More than half of the participants (57.1%) were male.
TREATING CLINICIAN(S)	Psychologists with some degree of postgraduate training in clinical psychology
INTERVENTION(S)	CBT (n = 21)
COMPARISON GROUP(S)	Waitlist control condition (n = 21)
PROCEDURE	RCT to evaluate CBT as a treatment for school-aged children with behavioural insomnia of childhood characterised by sleep-onset-associated problems. The CBT intervention comprised six 45 to 60-minute sessions held on a weekly or biweekly basis and involved components of behavioural sleep medicine and anxiety treatment (e.g., cognitive restructuring, graduated exposure).
SUMMARY OF FINDINGS	Compared with waitlist controls at posttreatment, CBT significantly improved sleep latency, wake after sleep onset, and both objective and subjective sleep efficiency among children with behavioural insomnia of childhood (large effect sizes). Furthermore, CBT significantly reduced problematic sleep associations and separation anxiety at both posttreatment and follow-up (based on within-group analyses). Notably, at 6 months' follow-up, none of children in the CBT group met diagnostic criteria for behavioural insomnia of childhood.

TITLE OF ITEM	***A randomized controlled trial of cognitive-behavior therapy plus bright light therapy for adolescent delayed sleep phase disorder***
AUTHOR(S) AND SOURCE	Gradisar, M., Dohnt, H., Gardner, G., Paine, S., Starkey, K., Menne, A., … Trenowden, S. (2011). *Sleep, 34,* 1671–1680.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual
PARTICIPANTS	49 adolescents aged 11 to 18 (mean age 14.6 years) meeting ICD diagnostic criteria for delayed phase sleep disorder. Just over half of the participants (53%) were male.
TREATING CLINICIAN(S)	Registered psychologists and provisionally registered psychologists undergoing postgraduate training
INTERVENTION(S)	CBT plus bright light therapy (*n* = 26)
COMPARISON GROUP(S)	Waitlist (*n* = 23)
PROCEDURE	Designed to evaluate CBT + bright light therapy for adolescents with delayed sleep phase disorder, participants attended six 45-minute to 60-minute individual sessions consisting of morning bright light therapy, cognitive restructuring, and sleep education. At least one parent attended each of the sessions.
SUMMARY OF FINDINGS	Compared with waitlist controls, the CBT intervention demonstrated improvements across all outcome measures at posttreatment, including sleep onset latency (medium to large effect size), rise time (large effect size), daytime sleepiness (large effect size), and total sleep time (small to large effect size). At posttreatment, 87% of adolescents in the CBT intervention group no longer met diagnostic criteria for delayed phase sleep disorder, compared with 18% in the waitlist group, which was a significant result. Fifteen participants completed the 6-month follow-up, and the same proportion (87%) no longer qualified for a delayed phase sleep disorder diagnosis.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

TITLE OF ITEM	***The SENSE study: Post intervention effects of a randomized controlled trial of a cognitive–behavioral and mindfulness-based group sleep improvement intervention among at-risk adolescents***
AUTHOR(S) AND SOURCE	Blake, M., Waloszek, J. M., Schwartz, O., Raniti, M., Simmons, J. G., Blake, L., … Trinder, J. (2016). *Journal of Consulting and Clinical Psychology, 84,* 1039–1051.
DESIGN	RCT
FOLLOW-UP	Nil
FORMAT	Group
PARTICIPANTS	123 adolescents in school years 7 to 10 (mean age 14.4 years) with clinically significant symptoms of sleep problems. 58% of all participants were female.
TREATING CLINICIAN(S)	Clinical psychologists or psychologists undergoing postgraduate training
INTERVENTION(S)	Multicomponent CBT/mindfulness-based group sleep intervention (Sleep SENSE; *n* = 60)
COMPARISON GROUP(S)	Study skills educational program (Study SENSE; *n* = 63)
PROCEDURE	Sleep SENSE comprised seven weekly 90-minute sessions and incorporated a variety of modules including psychoeducation, sleep goals, stimulus control, sleep hygiene, and worry management. Six of the seven sessions included mindfulness practice/skill development.
SUMMARY OF FINDINGS	Compared with the educational program, at posttreatment, adolescents in the CBT/mindfulness intervention reported significant improvement with regard to subjective sleep quality (medium effect size), sleep onset latency (small effect size), and daytime sleepiness (small effect size). Additionally, CBT/mindfulness was significantly more effective at reducing objectively measured sleep onset latency (medium effect size) and anxiety (small effect size) than the educational program at posttreatment. There were no differences detected between the two conditions on measures of total sleep time, waking after sleep onset, or depressive symptoms.

PAIN DISORDERS

SUMMARY OF EVIDENCE

Level I evidence supports the use of face-to-face CBT among children and adolescents (6 to 18 years of age) with chronic abdominal pain, headaches/migraine, or fibromyalgia. There is Level II evidence for acceptance and commitment therapy for the treatment of adolescents (10 to 14 years of age) with longstanding idiopathic pain. Further Level II evidence supports gut-directed hypnotherapy for children and adolescents (5 to 18 years of age) with recurrent abdominal pain or irritable bowel syndrome. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***The effectiveness of cognitive behavioural therapy for pain in childhood and adolescence: A meta-analytic review***
AUTHOR(S) AND SOURCE	Lonergan, A. (2016). *Irish Journal of Psychological Medicine, 33,* 251–264.
DESIGN	Meta-analysis (9 RCTs)
FOLLOW-UP	Nil to 12 months
FORMAT	Various (individual, family, group, self-help)
PARTICIPANTS	771 children aged from 6 to 18 (mean ages ranged from 9 to 12.4 years) experiencing chronic pain in the form of recurrent abdominal pain, headaches/migraine, or fibromyalgia. A majority (64% to 94%) of the participants in each RCT were female.
TREATING CLINICIAN(S)	Described by the authors as experienced therapists
INTERVENTION(S)	CBT (n = 401)
COMPARISON GROUP(S)	Various control groups (e.g., waitlist, intensive medical care, psychoeducation, coping skills training, self-monitoring; n = 370)
PROCEDURE	Meta-analysis of RCTs published between 1994 and 2014 focusing on CBT interventions for children and adolescents experiencing chronic pain. Results were analysed separately for recurrent abdominal pain (n = 5), headaches/migraine (n = 2), and fibromyalgia (n = 2).
SUMMARY OF FINDINGS	CBT was found to be more effective at reducing intensity of recurrent abdominal pain symptoms across child and parent-reported measures (large effect sizes), than the pooled control condition, and these improvements were maintained at follow-up. Clinically significant improvements in self-reported pain intensity were 56–91% for CBT groups versus 9–45% for control groups. For those with headaches/migraine, CBT was found to be significantly more effective at reducing pain intensity when compared to the control condition, with a small effect size. There were clinically significant improvements in pain intensity for 54–56% of those receiving CBT versus 40% waiting to receive treatment. Similarly, CBT was significantly more effective at reducing pain intensity for children and adolescents with fibromyalgia, than the pooled control condition (medium effect size), reducing to a small effect size at follow-up. On measures of functional disability, those in the CBT were found to have increased reduction in recurrent abdominal pain (large effect), headache/migraine (moderate effect), and fibromyalgia (small effect) when compared to the pooled control group.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

TITLE OF ITEM	***Evaluating the effectiveness of exposure and acceptance strategies to improve functioning and quality of life in longstanding pediatric pain–a randomized controlled trial***
AUTHOR(S) AND SOURCE	Wicksell, R. K., Melin, L., Lekander, M., & Olsson, G. L. (2009). *Pain, 141,* 248–257.
DESIGN	RCT
FOLLOW-UP	3.5 and 6.5 months
FORMAT	Individual
PARTICIPANTS	32 children and adolescents aged 10 to 18 (mean age 14.8 years) with longstanding idiopathic pain. Seventy-eight percent of participants were female.
TYPE OF TREATING CLINICIAN(S)	Psychologists trained in CBT and ACT
INTERVENTION(S)	ACT (*n* = 16)
COMPARISON GROUP(S)	TAU (multidisciplinary treatment including amitriptyline; *n* = 16)
PROCEDURE	RCT to evaluate the effectiveness of an ACT-based intervention for the treatment of longstanding pain in a pediatric population. The intervention emphasised ACT principles of exposure and acceptance and consisted of 10 x 60 minute weekly sessions. Up to two additional sessions were conducted with the parents.
SUMMARY OF FINDINGS	At posttreatment, children and adolescents receiving ACT treatment reported reduced pain impairment beliefs, reduced pain interference, and improved mental health compared with TAU (moderate to large effect sizes). When extending the analysis from pretreatment to 6.5 months' follow-up, the ACT group continued to perform better than did the TAU group on pain impairment beliefs. Within-groups effect sizes were mostly large for ACT treatment across all outcome measures of functioning and quality of life.

HYPNOTHERAPY

TITLE OF ITEM	***Gut-directed hypnotherapy for functional abdominal pain or irritable bowel syndrome in children: A systematic review***
AUTHOR(S) AND SOURCE	Rutten, J. M., Reitsma, J. B., Vlieger, A. M., & Benninga, M. A. (2013). *Archives of Disease in Childhood, 98,* 252–257.
DESIGN	Systematic review (2 RCTs)
FOLLOW-UP	1 to 12 months
FORMAT	Individual
PARTICIPANTS	74 children aged 5 to 18 with functional abdominal pain, recurrent abdominal pain, or irritable bowel syndrome. Further demographic details were not reported.
TREATING CLINICIAN(S)	One study included an experienced hypnotherapist, but the other study did not specify the clinician type.
INTERVENTION(S)	Gut-directed hypnotherapy (*n* = 41), which incorporates controlling symptoms, general relaxation, ego-strengthening, changing cognitive perspectives, and coping skills.
COMPARISON GROUP(S)	TAU + supportive therapy (*n* = 33)
PROCEDURE	Systematic review to determine the efficacy of hypnotherapy for children and adolescents with abdominal pain or irritable bowel syndrome. RCTs published between 2006 and 2012 were included for analysis. The treatment period for the included studies was 1 to 3 months.
SUMMARY OF FINDINGS	Due to varying outcome measures, the two studies were not combined in the statistical analyses. However, in both studies children receiving hypnotherapy reported significantly less pain at posttreatment compared with controls. One study indicated a 67% reduction in pain days per month compared with 21% in controls, and the difference was significant both at posttreatment and 1-month follow-up. The second study indicated that pain intensity during a 1-week period was significantly reduced for the hypnotherapy group compared with controls. In the same study, treatment success at 12-month follow-up was determined to be 85% for hypnotherapy versus 25% for the control group, which was a significant result.

BODY DYSMORPHIC DISORDER (BDD)

SUMMARY OF EVIDENCE

There is Level II evidence for CBT to treat adolescents (12 to 18 years of age) with BDD. This evidence is supported by a single pilot RCT, so results should be interpreted with caution. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Obsessive-compulsive disorder and body dysmorphic disorder, 2005).[41] The involvement of parents or carers is recommended, along with adapting the interventions to suit the developmental age of the child.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Long-term outcomes of cognitive-behavior therapy for adolescent body dysmorphic disorder***
AUTHOR(S) AND SOURCE	Krebs, G., De la Cruz, Monzani, Bowyer, Anson, Cadman, … Mataix-Cols. (2017). *Behavior Therapy, 48,* 462–473.
DESIGN	RCT with follow-up
FOLLOW-UP	12 months
FORMAT	Individual, family
PARTICIPANTS	30 adolescents aged 12 to 18 (mean age 16 years) meeting DSM-IV diagnostic criteria for BDD had been involved in an initial pilot study in which they were allocated to either an intervention or control group. Twenty-six participants were part of a 12-month follow-up. A majority of participants (86.7%) were female.
TREATING CLINICIAN(S)	Clinical psychologists with extensive CBT experience
INTERVENTION(S)	Developmentally tailored CBT (n = 15)
COMPARISON GROUP(S)	Control condition (psychoeducation and weekly telephone contact; n = 15)
PROCEDURE	Pilot RCT to determine the efficacy of CBT for the treatment of adolescent BDD. CBT treatment consisted of 14 sessions delivered over 4 months, with psychoeducation and other sessions attended by parents.
SUMMARY OF FINDINGS	Compared with controls, the adolescents receiving CBT showed significant improvements on a measure of BDD symptoms at posttreatment (large effect size). These results were maintained at 2 months' follow-up and were accompanied by a large effect size. At the 12-month follow-up, 50% of the 26 participants were classified as responders and 23% as in remission. However, the authors noted that most patients continued to be symptomatic at 12 months, suggesting additional long-term treatment is warranted.

[41] nice.org.uk/guidance/cg31

BORDERLINE PERSONALITY DISORDER (BPD)

SUMMARY OF EVIDENCE

There is Level III-3 evidence for the use of cognitive analytic therapy for adolescents (15 to 18 years of age) with borderline personality disorder (BPD). There is Level IV evidence for dialectical behaviour therapy, but not emotion regulation training, as an effective treatment for female adolescents (13 to 19 years of age) with BPD. Additional Level IV evidence supports psychodynamic therapy as an intervention for adolescents (14 to 19 years of age) with borderline personality disorder. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Early intervention for adolescents with borderline personality disorder: Quasi-experimental comparison with treatment as usual***
AUTHOR(S) AND SOURCE	Chanen, A. M., Jackson, H. J., McCutcheon, L. K., Jovev, M., Dudgeon, P., Yuen, H. P., … Clarkson, V. (2009). *Australian & New Zealand Journal of Psychiatry, 43,* 397–408.
DESIGN	Quasiexperimental
FOLLOW-UP	24 months
FORMAT	Individual, family, group
PARTICIPANTS	110 adolescents aged 15 to 18 (mean age 16.3 years) fulfilling at least partial DSM-IV criteria for BPD. Approximately 40% of participants met full criteria for BPD, and 75% of all participants were female.
TREATING CLINICIAN(S)	Clinical psychologists who had completed CBT therapy training
INTERVENTION(S)	Cognitive analytic therapy[42] (CAT; *n* = 41)
COMPARISON GROUP(S)	TAU (*n* = 32), early intervention good clinical care (*n* = 37)
PROCEDURE	Quasiexperimental study to evaluate the effectiveness of early CAT for BPD in relation to good clinical care and TAU. CAT and good clinical care consisted of up to 24 weekly sessions, while TAU had no limit on sessions. All intervention types included combinations of individual, family, and group components.
SUMMARY OF FINDINGS	Both the treatment and control groups demonstrated improvements on all primary outcome measures from baseline to 24-month follow-up. At posttreatment, the CAT intervention was more effective than early intervention clinical care at reducing externalising psychopathology among adolescents who met BPD criteria. CAT was also more successful than TAU at reducing both internalising and externalising pathologies. At 24 months from baseline, compared with TAU, CAT was associated with lower levels of externalising psychopathology and a faster rate of improvement, on both internalising and externalising measures.

[42] CAT is included in this section given the considerable overlap with CBT principles.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

TITLE OF ITEM	***Dialectical behavioral therapy for adolescents (DBT-A): A clinical trial for patients with suicidal and self-injurious behavior and borderline symptoms with a 1-year follow-up***
AUTHOR(S) AND SOURCE	Fleischhaker, C., Böhme, R., Sixt, B., Brück, C., Schneider, C., & Schulz, E. (2011). *Child and Adolescent Psychiatry and Mental Health, 5,* 3.
DESIGN	Case series
FOLLOW-UP	1 year
FORMAT	Individual, family/group
PARTICIPANTS	12 female adolescents aged 13 to 19 experiencing self-injurious or suicidal behaviour during the previous 16 weeks and partially fulfilling DSM-IV criteria for BPD. Ten participants (83%) met full diagnostic criteria for BPD.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	DBT for adolescents (*n* = 12)
COMPARISON GROUP(S)	None
PROCEDURE	Pilot study to determine whether DBT for adolescents is effective for treating BPD symptoms and suicidal or nonsuicidal behaviour. The intervention was delivered in an outpatient setting over 16 to 24 weeks and comprised one individual session and one family/group session per week.
SUMMARY OF FINDINGS	DBT reduced the mean number of diagnostic criteria met from baseline (5.8 criteria met) to 1-year follow-up (2.8 criteria met). Across the 1-year period, within-group effect sizes for primary outcome measures ranged from medium (aggressive and delinquent behaviours) to large (depression, internalising behaviours, interpersonal sensitivity). Additionally, although two-thirds of participants had attempted suicide at least once prior to treatment, no suicide attempts were recorded during the treatment or follow-up period.

TITLE OF ITEM	***Emotion regulation training for adolescents with borderline personality disorder traits: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Schuppert, H. M., Timmerman, M. E., Bloo, J., van Gemert, T. G., Wiersema, H. M., Minderaa, R. B., … Nauta, M. H. (2012). *Journal of the American Academy of Child & Adolescent Psychiatry, 51,* 1314–1323.
DESIGN	RCT
FOLLOW-UP	12 months (6 months posttreatment)
FORMAT	Group
PARTICIPANTS	109 adolescents aged 14 to 19 (mean age 16.0 years), referred for emotional regulation or features of BPD. Approximately three-quarters of participants fulfilled five or more DSM-IV criteria (range 3 to 9 criteria) for BPD, and 96% of participants were female.
TREATING CLINICIAN(S)	Clinicians with postgraduate training and at least 2 years' experience in therapy with adolescents with BPD features.
INTERVENTION(S)	Emotion-regulation training, which incorporates elements of DBT, CBT, and mindfulness therapy (*n* = 54)
COMPARISON GROUP(S)	TAU (*n* = 55)
PROCEDURE	RCT to evaluate the effectiveness of emotional regulation training as an intervention for adolescents with BPD symptoms. Treatment focused on improving control over intense emotions and improving a broad range of coping skills. The intervention was delivered through 17 x 105-minute weekly group sessions as well as two booster sessions in the subsequent 12 weeks.
SUMMARY OF FINDINGS	Although within-group improvements were reported for both emotion-regulation training and TAU groups, at posttreatment the emotion-regulation training intervention was no more effective than TAU at reducing severity of BPD symptoms, reducing general psychopathology, or improving quality of life. Compared with 12% of the TAU group, 19% of the intervention group was reported to be in remission at posttreatment. At 12 months' follow-up, the intervention group remission rate increased to 33%. However, the equivalent statistic for TAU was not reported due to design limitations.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Early intervention for borderline personality disorder: Psychodynamic therapy in adolescents***
AUTHOR(S) AND SOURCE	Salzer, S., Cropp, C., & Streeck-Fischer, A. (2014). *Zeitschrift für Psychosomatische Medizin und Psychotherapie, 60,* 368–382.
DESIGN	Case series
FOLLOW-UP	Nil
FORMAT	Individual, group
PARTICIPANTS	28 adolescents aged 14 to 19 (mean age 16.9 years) meeting DSM-IV criteria for BPD. More than three-quarters of the participants were female.
TREATING CLINICIAN(S)	Clinicians trained in the psychoanalytic-interaction method
INTERVENTION(S)	Psychoanalytic-interaction method of psychodynamic therapy (n = 28)
COMPARISON GROUP(S)	None
PROCEDURE	A case series to evaluate psychodynamic therapy among adolescents with BPD in an inpatient setting. The average treatment period was approximately 30 weeks and consisted of three 30-minute individual sessions and one 45-minute group session per week. Some additional treatment elements, such as occupational therapy and parent counselling, were provided.
SUMMARY OF FINDINGS	Psychodynamic therapy was found to be an effective intervention on a number of primary outcome measures. Almost 40% of participants were deemed to be in remission from BPD at posttreatment. On a measure of global functioning, there was a large within-group effect size from pre- to post-treatment, even controlling for the effect of adjunctive pharmacotherapy. Additional pre–post improvements were noted on measures of global psychological distress (medium effect size), psychosocial impairment (large effect size), interpersonal problems, and self-reported features of BPD (small to medium effect sizes).

SUMMARY OF EVIDENCE

There is Level II evidence for the use of family interventions among adolescents (up to 18 years of age) with an early onset psychotic disorder. Level II evidence also supports cognitive remediation therapy for adolescents (12 to 18 years of age) with early-onset schizophrenia or schizoaffective disorder. However, the long-term benefits of cognitive remediation therapy are limited to cognitive, rather than functional, improvements. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Psychosis and schizophrenia in children and young people, 2016).[43] The guidelines note that antipsychotic medication is the typical treatment of choice for young people with schizophrenia. However, family interventions and/or CBT may be appropriate as an adjunct to pharmacotherapy.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Cognitive remediation therapy in adolescents with early-onset schizophrenia: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Puig, O., Penadés, R., Baeza, I., De la Serna, E., Sánchez-Gistau, V., Bernardo, M., & Castro-Fornieles, J. (2014). *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 859–868.
DESIGN	RCT
FOLLOW-UP	3 months
FORMAT	Individual
PARTICIPANTS	50 adolescents aged 12 to 18 (mean age 16.8) with a DSM-IV-TR diagnosis of schizophrenia (88%) or schizoaffective disorder (12%). Fifty-two percent of all participants were male.
TREATING CLINICIAN(S)	Clinical psychologist with experience in child and adolescent clinical management
INTERVENTION(S)	Cognitive remediation therapy[44] (*n* = 25)
COMPARISON GROUP(S)	TAU (*n* = 25)
PROCEDURE	RCT to determine the efficacy of cognitive remediation therapy for adolescents with early-onset schizophrenia. The CRT intervention consisted of two sessions per week for 20 weeks. Sessions comprised mainly paper-and-pencil tasks, with scaffolding used to match the skills of each participant.
SUMMARY OF FINDINGS	At posttreatment, compared with TAU, CRT was effective in improving cognitive functioning for the domains of verbal memory (large effect size), working memory, and executive functions (medium effect sizes). Similarly, those in the CRT group had improved daily living skills and global functioning at posttreatment, compared with controls (medium effect sizes). Cognitive gains were maintained at follow-up, but functional gains were not. Notably, a substantial 21 participants dropped out of the study before posttreatment; these adolescents were more likely to have a diagnosis of schizoaffective disorder or a higher IQ than those who completed treatment.

[43] nice.org.uk/guidance/cg155

[44] Cognitive remediation therapy is included in this section given the considerable overlap with CBT principles.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Intervention for adolescents with early-onset psychosis and their families: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Calvo, A., Moreno, M., Ruiz-Sancho, A., Rapado-Castro, M., Moreno, C., Sánchez-Gutiérrez, T., … Mayoral, M. (2014). *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 688–696.
DESIGN	RCT
FOLLOW-UP	Nil
FORMAT	Individual, group
PARTICIPANTS	Fifty-five adolescents with a mean age of 16.5, meeting criteria for one of the following DSM-IV diagnoses: schizophrenia, schizoaffective disorder, schizophreniform disorder, bipolar disorder, major depressive disorder with psychotic features, brief psychotic disorder, or psychosis not otherwise specified. Inclusion required the presence of either delusions or hallucinations before the age of 18.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Psychoeducational problem-solving (*n* = 27), based on the psychoeducational model and multi-family treatment.
COMPARISON GROUP(S)	Nonstructured group intervention (*n* = 28)
PROCEDURE	RCT to determine the efficacy of a multi-component psychoeducational family intervention for adolescents with early-onset psychosis. The treatment comprised two phases: initiation (3 individual sessions) and group (12 sessions of 90 minutes each, every 15 days). Adolescents and parents attended separate individual and group sessions which were run in parallel.
SUMMARY OF FINDINGS	Compared with the nonstructured group intervention, the psychoeducational treatment resulted in significantly reduced negative symptoms (medium effect size). Furthermore, adolescents receiving the psychoeducational intervention had fewer visits to the emergency department at posttreatment, in comparison with the nonstructured group intervention (medium effect size). No other results reached statistical significance.

TITLE OF ITEM	***Family-focused treatment for adolescents and young adults at risk for psychosis: Results of a randomized trial***
AUTHOR(S) AND SOURCE	Miklowitz, D. J., O'Brien, M. P., Schlosser, D. A., Addington, J., Candan, K. A., Marshall, C., … Cannon, T. D. (2014). *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 848–858.
DESIGN	RCT
FOLLOW-UP	6-month follow-up
FORMAT	Family
PARTICIPANTS	129 adolescents and young adults meeting criteria for one of three prodromal syndromes: attenuated positive symptoms with worsening in the past year, brief intermittent psychosis, or genetic risk and deterioration. The mean age of participants was 17.4, and 42.6% were female.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Family-focused therapy for individuals at clinical high risk of psychosis (FFT-CHR) (*n* = 66)
COMPARISON GROUP(S)	Enhanced care (*n* = 63)
PROCEDURE	Multisite randomised trial investigating the efficacy of an adaptation of family-focused therapy, FFT-CHR, for individuals at high risk of psychosis. The intervention was administered to participants and their parents across 18 x 1-hour family sessions (12 weekly and six biweekly sessions) over a 6-month period. The enhanced care condition consisted of three weekly psychoeducational family sessions. FFT-CHR participants received an average of 11 treatment sessions.
SUMMARY OF FINDINGS	Compared with the enhanced care treatment, participants in the FFT-CHR group demonstrated significantly greater improvements in attenuated positive symptoms from baseline to 6-month follow-up (medium effect size). Negative symptom reduction was demonstrated regardless of treatment group, with no significant between-group differences.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

SUMMARY OF EVIDENCE

There is Level I evidence for the use of CBT, specifically, behaviour therapy, for children and adolescents with attention deficit hyperactivity disorder (ADHD). Behavioural or CBT appears most effective when incorporated in multicomponent interventions (12 to 18 years of age) or as adjunctive therapy to medication (6 to 11 years of age). There is further Level I evidence supporting family interventions (specifically behavioural parent training) for children and young adolescents (3 to 15 years of age) with ADHD. Level II evidence supports play-based interventions targeting social skills in children (5 to 11 years of age) with ADHD, as well as psychoeducation for children and adolescents (3 to 20 years of age) with ADHD and their parents. It is noted that therapy for ADHD is often combined with problem-solving strategies and assertiveness/communication training, indicating that these additional therapeutic components may be important. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Attention deficit hyperactivity disorder: Diagnosis and management, 2018).[45] The guidelines recommend group-based interventions for school-age children, their parents, and carers, but note that individual psychological treatment is appropriate for older age groups in some cases. Pharmacological treatment is indicated as the treatment of choice for young people with severe ADHD or for those who do not respond to psychological interventions.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Treatment of attention-deficit/hyperactivity disorder in adolescents: A systematic review***
AUTHOR(S) AND SOURCE	Chan, E., Fogler, J. M., & Hammerness, P. G. (2016). *Journal of the American Medical Association, 315,* 1997–2008.
DESIGN	Systematic review (10 RCTs)
FOLLOW-UP	Nil to 6 months (details not reported)
FORMAT	Individual
PARTICIPANTS	916 adolescents aged 12 to 18 with ADHD. Various proportions of participants across studies were taking ADHD medication during treatment. No further demographic details were reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Multi-component treatments incorporating behavioural (e.g., behaviour contingency management), cognitive behavioural, and skills training interventions (e.g., organisational skills) (*n* not reported)
COMPARISON GROUP(S)	TAU, community care, waitlist (ns not reported)
PROCEDURE	Systematic review to evaluate the effectiveness pharmacological and psychosocial interventions for adolescents with ADHD. The review of psychosocial treatment approaches incorporated 10 RCTs published between 2006 and 2017, two of which were CBT-only.
SUMMARY OF FINDINGS	Compared with control conditions, multi-component behavioural treatments were found to improve functional outcomes among adolescents with ADHD. These outcomes included academic and organisational skills (medium to large effect sizes) as well as parent ratings of their child's ADHD-related symptoms (small to medium effect sizes). The authors noted that findings for the two CBT-only studies were inconclusive, suggesting that CBT is most effective when combined with other behavioural and training components.

[45] nice.org.uk/guidance/NG87

TITLE OF ITEM	***The long-term outcomes of interventions for the management of attention-deficit hyperactivity disorder in children and adolescents: A systematic review of randomized controlled trials***
AUTHOR(S) AND SOURCE	Parker, J., Wales, G., Chalhoub, N., & Harpin, V. (2013). *Psychology Research and Behavior Management, 6,* 87–99.
DESIGN	Systematic review (5 RCTs incorporating behaviour therapy)
FOLLOW-UP	12 to 96 months
FORMAT	Various (details not reported)
PARTICIPANTS	1,057 children aged 6 to 11 years with a diagnosis of ADHD. Over half of all participants (54.7%) were from a single cohort spanning four RCTs.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Combined behavioural management and pharmaceutical interventions (5 RCTs; *n* not reported)
COMPARISON GROUP(S)	Control conditions (e.g., community care/behavioural treatment alone, medication alone, placebo; *n* not reported)
PROCEDURE	Systematic review to evaluate the long-term outcomes of pharmaceutical, nonpharmaceutical, and combined interventions among children with ADHD. Studies published between 1982 and 2012 were included for analysis.
SUMMARY OF FINDINGS	A moderate to high level of evidence was found to support combined behavioural and pharmacological interventions for the treatment of ADHD among children. The findings were applicable to measures of core ADHD symptoms as well as academic performance, both at 14 months' follow-up. Furthermore, within-group analysis for the same period indicated that combined interventions (medium to large effect size) may be more effective than behaviour therapy or community care alone (small to medium effect size). Combined interventions did not differ from medication alone on core ADHD symptoms; however, combined treatment was superior on measures of social and academic skills.

FAMILY INTERVENTIONS

TITLE OF ITEM	***Behavioral interventions in attention-deficit/hyperactivity disorder: A meta-analysis of randomized controlled trials across multiple outcome domains***
AUTHOR(S) AND SOURCE	Daley, D., Van der Oord, S., Ferrin, M., Danckaerts, M., Doepfner, M., Cortese, S., … European ADHD Guidelines Group. (2014). *Journal of the American Academy of Child & Adolescent Psychiatry, 53,* 835–847.
DESIGN	Meta-analysis (32 RCTs published between 1986 and 2012)
FOLLOW-UP	Not reported
FORMAT	Individual, family
PARTICIPANTS	2,077 children and adolescents aged 3 to 15 meeting diagnostic criteria for ADHD. Most participants were male (ranging from 62% to 100%). Various proportions of the children were also receiving adjunctive medication.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	A variety of behavioural interventions (e.g., contingency management, behaviour therapy, CBT; *n* = 964) with the majority of studies examining behavioural parent training both with and without the child.
COMPARISON GROUP(S)	TAU, waitlist, attention control, placebo, counselling (*n* = 1,113)
PROCEDURE	Systematic review and meta-analysis focusing on a broad range of child and parent outcomes for behavioural interventions targeting adolescents with ADHD
SUMMARY OF FINDINGS	In comparison to pooled control groups, behavioural therapies were found to be effective for ADHD symptoms (small to medium effect size) at posttreatment. Treatment effects were also found for child social skills (medium effect size), conduct problems, and academic performance (small effect sizes). Behavioural therapies were effective on measures of parenting quality (medium effect size), and parenting self-concept (small to medium effect size).

PLAY-BASED THERAPY

TITLE OF ITEM	***A randomised controlled trial of a play-based intervention to improve the social play skills of children with attention deficit hyperactivity disorder (ADHD)***
AUTHOR(S) AND SOURCE	Wilkes-Gillan, S., Bundy, A., Cordier, R., Lincoln, M., & Chen, Y. W. (2016). *PloS One, 11*(8), e0160558.
DESIGN	RCT
FOLLOW-UP	1 month
FORMAT	Group, family
PARTICIPANTS	29 children aged 5 to 11 with a DSM-IV diagnosis of ADHD. Further demographic details were not provided.
TREATING CLINICIAN(S)	Clinician with experience facilitating a play-based intervention
INTERVENTION(S)	Play-based intervention focusing on social play skills (n = 15)
COMPARISON GROUP(S)	Waitlist (n = 14)
PROCEDURE	RCT to evaluate whether a play-based intervention can effectively improve social play skills for children with ADHD. The program consisted of seven 1-hour weekly sessions that were attended by the child, a playmate, and parents. Parents received training in Week 1 about how to deliver home modules. In subsequent weeks, edited video footage of the play sessions was shown to the children and parents, and both positive and negative behaviours were identified and discussed.
SUMMARY OF FINDINGS	The children's social play skills, as scored by a blind rater, were found to improve significantly more for the play-based intervention than for waitlist controls (pre- to post-treatment). After the waitlist group received the same treatment, within-group analysis of the combined data indicated that the play-based intervention significantly improved social play skills from to pre- to post-treatment, and from pretreatment to follow-up (large effect sizes). Overall, the improvements were maintained at 1-month follow-up.

PSYCHOEDUCATION

TITLE OF ITEM	***Is psychoeducation for parents and teachers of children and adolescents with ADHD efficacious? A systematic literature review***
AUTHOR(S) AND SOURCE	Montoya, A., Colom, F., & Ferrin, M. (2011). *European Psychiatry, 26,* 166–175.
DESIGN	Systematic review (7 studies)
FOLLOW-UP	10 weeks to 24 months
FORMAT	Various (e.g., group, individual, family)
PARTICIPANTS	2,034 children and adolescents (3 to 20 years) diagnosed with ADHD according to DSM-III or DSM-IV criteria. Further demographic details were not reported.
TREATING CLINICIAN(S)	Psychiatrists, clinical assistants, psychologists, and/or social workers
INTERVENTION(S)	Psychoeducation, defined as a "mainly informative intervention that integrates both psychotherapeutic and educational components". Many of the included studies combined psychoeducation with problem-solving strategies or training in communication/assertiveness.
COMPARISON GROUP(S)	Four studies were RCTs with control conditions (details not provided), and three studies were pre-post intervention designs.
PROCEDURE	Systematic review to evaluate evidence for psychoeducation programs in relation to clinical outcomes for children and adolescents with ADHD. Qualitative analysis was conducted on seven articles published between 1980 and 2010. Three of the included studies applied psychoeducation to the child's parents, a further three involved the child and his/her family, and one study targeted teachers.
SUMMARY OF FINDINGS	Psychoeducation demonstrated positive treatment effects for a number of ADHD-related outcome measures, including the child's behaviour, parent and child satisfaction, and the child's knowledge of ADHD. Improvements were also found regarding the children's attitude toward medication and their adherence to medical recommendations.

CONDUCT DISORDER

SUMMARY OF EVIDENCE

There is Level I evidence for the use of CBT and family interventions (specifically parent training interventions) to treat children and adolescents (2 to 17 years of age) with clinically significant conduct problems. Level II evidence supports the use of online family interventions (specifically parent training interventions) for children (2 to 9 years of age) with disruptive behaviour, as well as multisystemic family interventions for adolescents (11 to 18 years of age) with externalising behaviour problems. Level II evidence also supports psychodynamic therapy (based on a single small RCT) for adolescent in-patients (12 to 19 years of age) with mixed disorders of conduct and emotion. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are, on the whole, consistent with the most recently published guidelines from the National Institute for Clinical Excellence (Antisocial behaviour and conduct disorders in children and young people: Recognition and management, 2017).[46] The guidelines emphasise the importance of involving parents and carers in the treatment of both younger and older children.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***A meta-analysis of long-term outpatient treatment effects for children and adolescents with conduct problems***
AUTHOR(S) AND SOURCE	Fossum, S., Handegård, B. H., Adolfsen, F., Vis, S. A., & Wynn, R. (2016). *Journal of Child and Family Studies, 25,* 15–29.
DESIGN	Meta-analysis (56 studies; 32 RCTs)
FOLLOW-UP	3 to 18 months
FORMAT	Various
PARTICIPANTS	2,821 children and adolescents aged 2 to 17 (mean ages ranged from 3.4 to 14.5 years) with clinically significant conduct problems
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Thirty RCTs focused on behaviour therapy (defined as various formats of parent training) and CBT (i.e., interventions focusing on children's anger management, social skills, and problem-solving skills), and two studies incorporated family interventions (*n* not reported)
COMPARISON GROUP(S)	Various control groups (e.g., waitlist, TAU; *n* not reported)
PROCEDURE	Meta-analysis investigating long-term outcomes of psychosocial interventions for adolescents experiencing conduct problems. Articles published between 1984 and 2010 were included in the analysis.
SUMMARY OF FINDINGS	In comparison with pooled controls, CBT and behavioural (parent training) interventions were found to have positive treatment effects for children and adolescents with conduct problems, from pre- to post-treatment (medium to large effect size). The intervention modalities with the most enduring posttreatment effects included CBT elements, either alone or in combination with behaviour therapy. No studies indicated significant increases in conduct problems during follow-up periods, which was considered a successful outcome for problems of this nature.

FAMILY INTERVENTIONS

See Fossum et al. (2016) immediately above for a summary of findings related to family interventions.

[46] nice.org.uk/guidance/cg158

TITLE OF ITEM	***A randomized controlled trial evaluating the efficacy of Triple P Online with parents of children with early-onset conduct problems***
AUTHOR(S) AND SOURCE	Sanders, M. R., Baker, S., & Turner, K. M. (2012). *Behaviour Research and Therapy, 50,* 675–684.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Family, online (unguided)
PARTICIPANTS	116 children aged 2 to 9 (mean 4.7 years) with elevated disruptive behaviour. Approximately two-thirds of all participants were male.
TREATING CLINICIAN(S)	N/A
INTERVENTION(S)	Triple P Online intervention, described as an intensive online positive parenting program (n = 60)
COMPARISON GROUP(S)	Internet use as usual (n = 56)
PROCEDURE	RCT to evaluate the Triple P Online intervention, a self-directed online parenting program targeted at parents of children with disruptive behaviour. The intervention consisted of eight modules focusing on the acquisition and use of 17 positive parenting skills such as ”time-out” and ”descriptive praise”. Central to the program was an emphasis on parents’ self-regulation, agency, and self-efficacy.
SUMMARY OF FINDINGS	In comparison with the control group, the Triple P intervention was found to be effective at improving outcomes on measures of child behavioural problems (large effect sizes), dysfunctional parenting style (medium effect), parental role confidence (medium to large effects), and parental anger (small effects). Clinical and reliable change analysis identified a significant reduction in child behavioural problems (ECBI intensity and problem subscales) from clinically elevated to within normal range. The treatment effects were, on the whole, maintained at 6 months’ follow-up.

TITLE OF ITEM	***An independent randomized clinical trial of multisystemic therapy with non-court-referred adolescents with serious conduct problems***
AUTHOR(S) AND SOURCE	Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., … Guth, C. (2013). *Journal of Consulting and Clinical Psychology, 81,* 1027–1039.
DESIGN	RCT
FOLLOW-UP	6 to 18 months
FORMAT	Family, individual, group
PARTICIPANTS	164 adolescents aged 11 to 18 (mean age 14.6 years) who were in self-contained behaviour intervention classrooms as a result of significant conduct problems. A large proportion of participants (83%) were male.
TREATING CLINICIAN(S)	Clinicians with at least bachelor’s level qualifications in psychology, humanities, or social sciences
INTERVENTION(S)	Multisystemic family-focused therapy (MST), targeting disturbance in the behaviours of individuals, family members, and friends (n = 84)
COMPARISON GROUP(S)	Treatment-as-usual (TAU; n = 80)
PROCEDURE	MST is described as a principle-based, family-focused program designed to empower parents to better manage their child’s social and personal life. Family members attended a variety of session types, including parent training, parent-only, and adolescent-only sessions. Details of the length and number of sessions were not reported.
SUMMARY OF FINDINGS	At posttreatment, both child- and parent-reported externalising problems were significantly reduced in the MST group compared with TAU (small effect sizes). These reductions continued to be significant at both follow-up time points, with small to medium effect sizes. No treatment effects were found for the equivalent teacher reports of externalising problems. On secondary measures, there was no treatment effect for drug use or delinquent behaviour, but there were significant reductions in school absences, permissive parenting, and parental mental health problems, in comparison to the TAU group.

PSYCHODYNAMIC THERAPY

TITLE OF ITEM	***Psychodynamic therapy for adolescents suffering from co-morbid disorders of conduct and emotions in an in-patient setting: A randomized controlled trial***
AUTHOR(S) AND SOURCE	Salzer, S., Cropp, C., Jaeger, U., Masuhr, O., & Streeck-Fischer, A. (2014). *Psychological Medicine, 44,* 2213–2222.
DESIGN	RCT
FOLLOW-UP	6 months
FORMAT	Individual, group, family
PARTICIPANTS	66 adolescents aged 14 to 19 (mean age 16.5 years) meeting ICD-10 criteria for mixed disorders of conduct and emotion. Approximately two-thirds of the participants were female.
TREATING CLINICIAN(S)	Clinicians trained in psychodynamic treatment and with a mean 9 years of professional experience
INTERVENTION(S)	Manualised psychodynamic therapy (*n* = 32)
COMPARISON GROUP(S)	Waitlist control group (*n* = 34)
PROCEDURE	RCT with the aim of evaluating manualised psychodynamic therapy for the treatment of adolescents with comorbid disorders of conduct and emotion within an in-patient setting. Treatment consisted of three 30-minute sessions of individual therapy and one 45-minute group therapy session per week. Additional elements included parent counselling, occupational therapy, and weekly ward rounds. Treatment was completed after a mean duration of 34 weeks.
SUMMARY OF FINDINGS	The rate of remission from mixed disorder of conduct and emotion was significantly higher among the psychodynamic therapy treatment group (71.9%) compared with controls (8.8%) at posttreatment. There was a significant reduction in overall behavioural difficulties for the treatment group in comparison with controls (small effect). However, there was no significant treatment effect for overall psychological distress. These results held at 6 months' follow-up, as did the rate of remission.

ENURESIS

SUMMARY OF EVIDENCE

There is Level I evidence for CBT (specifically behaviour therapy) in the form of alarm therapy to treat children and adolescents (3 to 16 years of age) with nocturnal enuresis. Further Level I evidence supports standard uropathy, also a behavioural therapy, for children and adolescents (5 to 18 years of age) with daytime incontinence. There is Level II evidence for self-managed, simple behavioural therapies in the treatment of very young children (4 to 5 years of age) with nocturnal enuresis. In the current review, there was insufficient evidence to indicate that any of the remaining interventions were effective.

These conclusions are in line with the most recent guidelines from the National Institute for Clinical Excellence (Nocturnal enuresis in children and young people, 2011).[47] The guidelines indicate that alarm therapy is typically offered to children 7 years and older. However, it may be beneficial for some children under 7 years of age.

COGNITIVE BEHAVIOUR THERAPY (CBT)

TITLE OF ITEM	***Alarm interventions for nocturnal enuresis in children***
AUTHOR(S) AND SOURCE	Glazener, C. M. A., Evans, J. H. C., & Peto, R. E. (2005). *The Cochrane Database of Systematic Reviews, 2005*(2), CD002911. doi:10.1002/14651858.CD002911.pub2
DESIGN	Systematic review & meta-analysis (53 studies)
FOLLOW-UP	Nil to 2.6 years
FORMAT	Individual
PARTICIPANTS	3,257 children and adolescents (3 to 16 years) suffering from nocturnal enuresis. Further demographic details not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Alarm interventions (i.e., alarms activated by bed wetting to wake the child, which may be in the form of a bell, buzzer, or visual signal; *n* = 2,412)
COMPARISON GROUP(S)	No treatment/waitlist, behavioural interventions (e.g., reward systems, retention control training), pharmacotherapy. (For pooled controls, *n* = 845.)
PROCEDURE	Review of randomised or quasirandomised trials that investigated the effectiveness of other behavioural interventions and pharmacological interventions versus enuresis alarms for the treatment of nocturnal enuresis in adolescents and children
SUMMARY OF FINDINGS	The use of alarm interventions was more efficacious than being on 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. Drug treatment alone is unlikely to be followed by sustained cure.

[47] nice.org.uk/guidance/cg111

TITLE OF ITEM	***Standard urotherapy as first-line intervention for daytime incontinence: A meta-analysis***
AUTHOR(S) AND SOURCE	Schäfer, S., Niemczyk, J., Von Gontard, A., Pospeschill, M., Becker, N., & Equit, M. (2017). *European Child & Adolescent Psychiatry.* https://doi.org/10.1007/s00787-017-1051–6
DESIGN	Meta-analysis (15 RCTs)
FOLLOW-UP	2 to 48 months
FORMAT	Not reported
PARTICIPANTS	1,609 children and adolescents aged 5 and older (mean ages ranged from 7 to 10.8 years). All were being treated for daytime urinary incontinence (DUI).
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Standard uropathy (behavioural intervention)
COMPARISON GROUP(S)	Various control conditions
PROCEDURE	A meta-analysis to determine the effectiveness of standard uropathy as a first-line treatment for daytime incontinence among children and adolescents. Some studies specifically addressed the diagnostic subtypes of urge incontinence and dysfunctional voiding. The intervention typically included elements of psychoeducation, instructions for micturition behaviour, guidelines for drinking and eating, symptom documentation, and supportive contact with treatment teams.
SUMMARY OF FINDINGS	Standard uropathy was found to increase the probability of recovery by seven times in comparison with control conditions. The authors calculate that approximately 56 patients out of 100 remit from DUI within the course of a year following treatment with standard uropathy. This compares with a remission rate of only 15 out of 100 per year for those not receiving standard uropathy treatment.

TITLE OF ITEM	***The efficacy of alarm therapy versus desmopressin therapy in the treatment of primary mono-symptomatic nocturnal enuresis: A systematic review***
AUTHOR(S) AND SOURCE	Perrin, N., Sayer, L., & While, A. (2015). *Primary Health Care Research & Development, 16,* 21–31.
DESIGN	Systematic review (8 RCTs)
FOLLOW-UP	1 to 12 months
FORMAT	Not reported
PARTICIPANTS	816 children and adolescents aged 5 to 17 diagnosed with primary monosymptomatic nocturnal enuresis. Further demographic details were not reported.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Alarm therapy incorporating a bed mat alarm or body-worn alarm that vibrates or emits a loud noise as soon as voiding is detected (n = 322)
COMPARISON GROUP(S)	Psychopharmacological therapy (desmopressin; n = 490)
PROCEDURE	Systematic review to determine the effectiveness of alarm therapy in comparison with a widely used pharmacological therapy for the treatment of enuresis in children and adolescents. Articles published between 1986 and 2011 were included for analysis.
SUMMARY OF FINDINGS	At posttreatment, 7 of the 8 studies indicated no difference between alarm therapy and desmopressin therapy, suggesting that both are equally effective for treating nocturnal enuresis. However, for those studies including follow-up data, alarm therapy resulted in significantly lower relapse rates and higher rates of continence than did desmopressin. Long-term findings demonstrate that alarm therapy was up to 5.5 times more effective than was desmopressin therapy.

TITLE OF ITEM	***The short- and long-term effects of simple behavioural interventions for nocturnal enuresis in young children: A randomised controlled trial***
AUTHOR(S) AND SOURCE	van Dommelen, P., Kamphuis, M., van Leerdam, F. J., de Wilde, J. A., Rijpstra, A., Campagne, A. E., Verkerk, P. H. (2009). *Journal of Pediatrics, 154,* 662–666.
DESIGN	RCT (4 groups)
FOLLOW-UP	3 years
FORMAT	Individual, self-managed
PARTICIPANTS	570 children aged 4 to 5 diagnosed with monosymptomatic nocturnal enuresis. Sixty percent of all participants were male.
TREATING CLINICIAN(S)	Not reported
INTERVENTION(S)	Three self-managed behavioural therapies (i.e., lifting with password, n = 140; lifting without password, *n* = 143; star chart reward system, *n* = 143)
COMPARISON GROUP(S)	No-treatment (*n* = 144)
PROCEDURE	Participants were assigned to one of four conditions: (1) waking child, asking for a password, then carrying child to toilet; (2) same as group 1 but without password; (3) reward system (e.g., star chart); or (4) no treatment. Parents were required to keep a daily diary. Treatment finished after 14 consecutive dry nights or at 6 months.
SUMMARY OF FINDINGS	Reward systems with or without carrying the child to the toilet were associated with fewer failing or relapsing children than no treatment; however, Condition (2) 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%) percentage and the control the lowest (69%) percentage of dry children.