30 cbt & psychotherapy relevant abstracts october '14 newsletter

(Abbass, Kisely et al. 2014; Burns, Erickson et al. 2014; Craske, Niles et al. 2014; Craske, Treanor et al. 2014; Dougall, Johnson et al. 2014; Gold, Hilsenroth et al. 2014; Grossmann and Kross 2014; Gyani, Shafran et al. 2014; Harvey, Belanger et al. 2014; Herr, Williams et al. 2014; Hollon, DeRubeis et al. 2014; King, Marston et al. 2014; Kucukgoncu, Yildirim Ornek et al. 2014; Li, Xiong et al. 2014; Lilienfeld, Ritschel et al. 2014; Limb 2014; Mavilidi, Hoogerheide et al. 2014; Moulding, Coles et al. 2014; Niles, Burklund et al. 2014; Olatunji, Kauffman et al. 2014; Owen, Duncan et al. 2014; Radomsky, Alcolado et al. 2014; Ravitz and Watson 2014; Reese, Duncan et al. 2014; Saint Onge, Krueger et al. 2014; Schuman, Slone et al. 2014; Suri, Whittaker et al. 2014; Swartz and Swanson 2014; Takizawa, Maughan et al. 2014; Webster, Dewall et al. 2014)

Abbass, A. A., S. R. Kisely, et al. (2014). ***"Short-term psychodynamic psychotherapies for common mental disorders."*** Cochrane Database Syst Rev 7: CD004687. http://www.ncbi.nlm.nih.gov/pubmed/24984083

BACKGROUND: Since the mid-1970s, short-term psychodynamic psychotherapies (STPP) for a broad range of psychological and somatic disorders have been developed and studied. Early published meta-analyses of STPP, using different methods and samples, have yielded conflicting results, although some meta-analyses have consistently supported an empirical basis for STPP. This is an update of a review that was last updated in 2006. OBJECTIVES: To evaluate the efficacy of STPP for adults with common mental disorders compared with wait-list controls, treatments as usual and minimal contact controls in randomised controlled trials (RCTs). To specify the differential effects of STPP for people with different disorders (e.g. depressive disorders, anxiety disorders, somatoform disorders, mixed disorders and personality disorder) and treatment characteristics (e.g. manualised versus non-manualised therapies). SEARCH METHODS: The Cochrane Depression, Anxiety and Neurosis Group's Specialised Register (CCDANCTR) was searched to February 2014, this register includes relevant randomised controlled trials from The Cochrane Library (all years), EMBASE (1974-), MEDLINE (1950-) and PsycINFO (1967-). We also conducted searches on CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, DARE and Biological Abstracts (all years to July 2012) and all relevant studies (identified to 2012) were fully incorporated in this review update. We checked references from papers retrieved. We contacted a large group of psychodynamic researchers in an attempt to find new studies. SELECTION CRITERIA: We included all RCTs of adults with common mental disorders, in which a brief psychodynamic therapy lasting 40 or fewer hours in total was provided in individual format. DATA COLLECTION AND ANALYSIS: Eight review authors working in pairs evaluated studies. We selected studies only if pairs of review authors agreed that the studies met inclusion criteria. We consulted a third review author if two review authors could not reach consensus. Two review authors collected data and entered it into Review Manager software. Two review authors assessed and scored risk of bias. We assessed publication bias using a funnel plot. Two review authors conducted and reviewed subgroup analyses. MAIN RESULTS: We included 33 studies of STPP involving 2173 randomised participants with common mental disorders. Studies were of diverse conditions in which problems with emotional regulation were purported to play a causative role albeit through a range of symptom presentations. These studies evaluated STPP for this review's primary outcomes (general, somatic, anxiety and depressive symptom reduction), as well as interpersonal problems and social adjustment. Except for somatic measures in the short-term, all outcome categories suggested significantly greater improvement in the treatment versus the control groups in the short-term and medium-term. Effect sizes increased in long-term follow-up, but some of these effects did not reach statistical significance. A relatively small number of studies (N < 20) contributed data for the outcome categories. There was also significant heterogeneity between studies in most categories, possibly due to observed differences between manualised versus non-manualised treatments, short versus longer treatments, studies with observer-rated versus self report outcomes, and studies employing different treatment models. AUTHORS' CONCLUSIONS: There has been further study of STPP and it continues to show promise, with modest to large gains for a wide variety of people. However, given the limited data, loss of significance in some measures at long-term follow-up and heterogeneity between studies, these findings should be interpreted with caution. Furthermore, variability in treatment delivery and treatment quality may limit the reliability of estimates of effect for STPP. Larger studies of higher quality and with specific diagnoses are warranted.

Burns, A. M., D. H. Erickson, et al. (2014). ***"Cognitive-behavioral therapy for medication-resistant psychosis: A meta-analytic review."*** Psychiatr Serv. http://www.ncbi.nlm.nih.gov/pubmed/24686725

OBJECTIVE Support for cognitive-behavioral therapy (CBT) for psychosis has accumulated, with several reviews and meta-analyses indicating its effectiveness for various intended outcomes in a broad variety of clinical settings. Most of these studies, however, have evaluated CBT provided to the subset of people with schizophrenia who continue to experience positive symptoms despite adequate treatment with antipsychotics. Despite several reviews and meta-analyses, a specific estimate of the effects of CBT for patients with medication-resistant positive symptoms, for whom CBT is frequently used in outpatient clinical settings, is lacking. This meta-analysis examined CBT's effectiveness among outpatients with medication-resistant psychosis, both on completion of treatment and at follow-up. METHODS Systematic searches (until May 2012) of the Cochrane Collaborative Register of Trials, MEDLINE, PsycINFO, and PubMed were conducted. Sixteen published articles describing 12 randomized controlled trials were used as source data for the meta-analysis. Effect sizes were estimated using the standardized mean difference corrected for bias, Hedges' g, for positive and general symptoms. RESULTS The trials included a total of 639 individuals, 552 of whom completed the posttreatment assessment (dropout rate of 14%). Overall beneficial effects of CBT were found at posttreatment for positive symptoms (Hedges' g=.47) and for general symptoms (Hedges' g=.52). These effects were maintained at follow-up for both positive and general symptoms (Hedges' g=.41 and .40, respectively). CONCLUSIONS For patients who continue to exhibit symptoms of psychosis despite adequate trials of medication, CBT for psychosis can confer beneficial effects above and beyond the effects of medication.

Craske, M. G., A. N. Niles, et al. (2014). ***"Randomized controlled trial of cognitive behavioral therapy and acceptance and commitment therapy for social phobia: Outcomes and moderators."*** J Consult Clin Psychol. http://www.ncbi.nlm.nih.gov/pubmed/24999670

Objective: Cognitive behavioral therapy (CBT) is an empirically supported treatment for social phobia. However, not all individuals respond to treatment and many who show improvement do not maintain their gains over the long-term. Thus, alternative treatments are needed. Method: The current study (N = 87) was a 3-arm randomized clinical trial comparing CBT, acceptance and commitment therapy (ACT), and a wait-list control group (WL) in participants with a diagnosis of social phobia based on criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994). Participants completed 12 sessions of CBT or ACT or a 12-week waiting period. All participants completed assessments at baseline and posttreatment, and participants assigned to CBT and ACT also completed assessments 6 and 12 months following baseline. Assessments consisted of self-report measures, a public-speaking task, and clinician ratings. Results: Multilevel

modeling was used to examine between-group differences on outcomes measures. Both treatment groups outperformed WL, with no differences observed between CBT and ACT on self-report, independent clinician, or public-speaking outcomes. Lower self-reported psychological flexibility at baseline was associated with greater improvement by the 12-month follow-up in CBT compared with ACT. Self-reported fear of negative evaluation significantly moderated outcomes as well, with trends for both extremes to be associated with superior outcomes from CBT and inferior outcomes from ACT. Across treatment groups, higher perceived control and extraversion were associated with greater improvement, whereas comorbid depression was associated with poorer outcomes. Conclusions: Implications for clinical practice and future research are discussed.

Craske, M. G., M. Treanor, et al. (2014). ***"Maximizing exposure therapy: An inhibitory learning approach."*** Behaviour Research and Therapy 58(0): 10-23. http://www.sciencedirect.com/science/article/pii/S0005796714000606

Exposure therapy is an effective approach for treating anxiety disorders, although a substantial number of individuals fail to benefit or experience a return of fear after treatment. Research suggests that anxious individuals show deficits in the mechanisms believed to underlie exposure therapy, such as inhibitory learning. Targeting these processes may help improve the efficacy of exposure-based procedures. Although evidence supports an inhibitory learning model of extinction, there has been little discussion of how to implement this model in clinical practice. The primary aim of this paper is to provide examples to clinicians for how to apply this model to optimize exposure therapy with anxious clients, in ways that distinguish it from a 'fear habituation' approach and 'belief disconfirmation' approach within standard cognitive-behavior therapy. Exposure optimization strategies include 1) expectancy violation, 2) deepened extinction, 3) occasional reinforced extinction, 4) removal of safety signals, 5) variability, 6) retrieval cues, 7) multiple contexts, and 8) affect labeling. Case studies illustrate methods of applying these techniques with a variety of anxiety disorders, including obsessive-compulsive disorder, posttraumatic stress disorder, social phobia, specific phobia, and panic disorder.

Dougall, D., A. Johnson, et al. (2014). ***"Adverse events and deterioration reported by participants in the PACE trial of therapies for chronic fatigue syndrome."*** Journal of Psychosomatic Research 77(1): 20-26. http://www.sciencedirect.com/science/article/pii/S0022399914001883

(Free full text available) Objective Adverse events (AEs) are health related events, reported by participants in clinical trials. We describe AEs in the PACE trial of treatments for chronic fatigue syndrome (CFS) and baseline characteristics associated with them. Methods AEs were recorded on three occasions over one year in 641 participants. We compared the numbers and nature of AEs between treatment arms of specialist medical care (SMC) alone, or SMC supplemented by adaptive pacing therapy (APT), cognitive behaviour therapy (CBT) or graded exercise therapy (GET). We examined associations with baseline measures by binary logistic regression analyses, and compared the proportions of participants who deteriorated by clinically important amounts. Results Serious adverse events and reactions were infrequent. Non-serious adverse events were common; the median (quartiles) number was 4 (2, 8) per participant, with no significant differences between treatments (P = .47). A greater number of NSAEs were associated with recruitment centre, and baseline physical symptom count, body mass index, and depressive disorder. Physical function deteriorated in 39 (25%) participants after APT, 15 (9%) after CBT, 18 (11%) after GET, and 28 (18%) after SMC (P < .001), with no significant differences in worsening fatigue. Conclusions The numbers of adverse events did not differ significantly between trial treatments, but physical deterioration occurred most often after APT. The reporting of non-serious adverse events may reflect the nature of the illness rather than the effect of treatments. Differences between centres suggest that both standardisation of ascertainment methods and training are important when collecting adverse event data.

Gold, S. H., M. J. Hilsenroth, et al. (2014). ***"Therapeutic alliance in the personal therapy of graduate clinicians: Relationship to the alliance and outcomes of their patients."*** Clin Psychol Psychother. http://www.ncbi.nlm.nih.gov/pubmed/24549582

This is the first study to explore the relationship between aspects of a therapists' personal therapy and the subsequent psychotherapy process and outcome they perform. The participants were 14 graduate clinicians with various experiences in personal therapy, who treated 54 outpatients engaged in short-term psychodynamic psychotherapy at a university-based community clinic. Results demonstrated non-significant relationships between the duration of personal therapy as well as a graduate clinician's overall alliance in their personal therapy with alliance ratings made by themselves as therapists and their patients, as well as the number of psychotherapy sessions attended by patients. However, the clinician's personal therapy alliance was significant and positively related to their patients' rating of outcome. Additionally, a significant negative correlation was observed between the degree of perceived helpfulness in their personal therapy and how these clinicians rated alliances, as the therapist, with their patients. The current findings suggest a relationship between a clinician's personal therapy alliance and the outcome of treatments they conduct. Implications for clinical training and practice as well as future research are discussed. KEY PRACTITIONER MESSAGE: While graduate clinician's personal therapy alliance was not significantly related to their patients' ratings of alliance, it was related to their patients' ratings of outcome. Trainee satisfaction with or quality of their personal therapy may be a more relevant than the amount or duration of their treatment in regard to the process and outcomes of their patients. The findings from retrospective clinician surveys on the helpfulness of their personal therapy may not be entirely consistent with empirical examination of these issues. The relation of personal therapy and outcome may work through improving the therapist's level of adaptive functioning (i.e., psychological-relational-emotional health) and future research should examine this simpler, more parsimonious, explanation for our findings.

Grossmann, I. and E. Kross (2014). ***"Exploring Solomon's paradox: Self-distancing eliminates the self-other asymmetry in wise reasoning about close relationships in younger and older adults."*** Psychological Science 25(8): 1571-1580. http://pss.sagepub.com/content/25/8/1571.abstract

Are people wiser when reflecting on other people's problems compared with their own? If so, does self-distancing eliminate this asymmetry in wise reasoning? In three experiments (N = 693), participants displayed wiser reasoning (i.e., recognizing the limits of their knowledge and the importance of compromise and future change, considering other people's perspectives) about another person's problems compared with their own. Across Studies 2 and 3, instructing individuals to self-distance (rather than self-immerse) eliminated this asymmetry. Study 3 demonstrated that each of these effects was comparable for younger (20–40 years) and older (60–80 years) adults. Thus, contrary to the adage "with age comes wisdom," our findings suggest that there are no age differences in wise reasoning about personal conflicts, and that the effects of self-distancing generalize across age cohorts. These findings highlight the role that self-distancing plays in allowing people to overcome a pervasive asymmetry that characterizes wise reasoning.

Gyani, A., R. Shafran, et al. (2014). ***"The gap between science and practice: How therapists make their clinical decisions."*** Behavior Therapy 45(2): 199-211. http://www.sciencedirect.com/science/article/pii/S0005789413000981

Recent surveys have found that many patients are not receiving empirically supported treatments and that therapists may not update their knowledge of research. Studies have found that therapists prefer to use their clinical experience rather

than research findings to improve their practice, although cognitive behavioral (CB) practitioners have been found to use research more frequently than therapists of other theoretical orientations. The organization in which therapists work has been shown to impact attitudes toward working practices, but studies have not examined whether workplace requirements to use research affect therapists' practice. Studies to date have mainly been conducted in North America. These findings may not be generalizable to the United Kingdom where there is a National Health Service (NHS), which requires the use of empirically supported treatments. The first part of this study aimed to investigate which factors were influential in therapists' choice of theoretical orientation and to see whether CB practitioners differed from other therapists in the factors that influenced their choice of theoretical orientation. The second part tested whether therapists' theoretical orientation or their workplace influenced the frequency with which they used research in their clinical decision-making. The final part investigated whether being a CB practitioner or working in the NHS was associated with having a favorable attitude toward research. An online survey was sent to 4,144 psychological therapists in England; 736 therapists responded (18.5%). Therapists reported that research had little influence over their choice of theoretical orientation and clinical decision-making compared to other factors, specifically clinical experience and supervision. CB practitioners and NHS therapists, regardless of their orientation, were significantly more likely to use research than other therapists and were more likely to have a positive attitude toward research.

Harvey, A. G., L. Belanger, et al. (2014). ***"Comparative efficacy of behavior therapy, cognitive therapy, and cognitive behavior therapy for chronic insomnia: A randomized controlled trial."*** J Consult Clin Psychol 82(4): 670-683. http://www.ncbi.nlm.nih.gov/pubmed/24865869

OBJECTIVE: To examine the unique contribution of behavior therapy (BT) and cognitive therapy (CT) relative to the full cognitive behavior therapy (CBT) for persistent insomnia. METHOD: Participants were 188 adults (117 women; M age = 47.4 years, SD = 12.6) with persistent insomnia (average of 14.5 years duration). They were randomized to 8 weekly, individual sessions consisting of BT (n = 63), CT (n = 65), or CBT (n = 60). RESULTS: Full CBT was associated with greatest improvements, the improvements associated with BT were faster but not as sustained and the improvements associated with CT were slower and sustained. The proportion of treatment responders was significantly higher in the CBT (67.3%) and BT (67.4%) relative to CT (42.4%) groups at post treatment, while 6 months later CT made significant further gains (62.3%), BT had significant loss (44.4%), and CBT retained its initial response (67.6%). Remission rates followed a similar trajectory, with higher remission rates at post treatment in CBT (57.3%) relative to CT (30.8%), with BT falling in between (39.4%); CT made further gains from post treatment to follow up (30.9% to 51.6%). All 3 therapies produced improvements of daytime functioning at both post treatment and follow up, with few differential changes across groups. CONCLUSIONS: Full CBT is the treatment of choice. Both BT and CT are effective, with a more rapid effect for BT and a delayed action for CT. These different trajectories of changes provide unique insights into the process of behavior change via behavioral versus cognitive routes.

Herr, N. R., J. W. J. Williams, et al. (2014). ***"Does this patient have generalized anxiety or panic disorder?: The rational clinical examination systematic review."*** JAMA 312(1): 78-84. http://dx.doi.org/10.1001/jama.2014.5950

Importance In primary care settings, generalized anxiety disorder (GAD) and panic disorder are common but underrecognized illnesses. Identifying accurate and feasible screening instruments for GAD and panic disorder has the potential to improve detection and facilitate treatment. Objective To systematically review the accuracy of self-report screening instruments in diagnosing GAD and panic disorder in adults. Data Sources We searched MEDLINE, PsycINFO, and the Cochrane Library for relevant articles published from 1980 through April 2014.Study Selection Prospective studies of diagnostic accuracy that compared a self-report screening instrument for GAD or panic disorder with the diagnosis made by a trained clinician using Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases criteria. Results We screened 3605 titles, excluded 3529, and performed a more detailed review of 76 articles. We identified 9 screening instruments based on 13 articles from 10 unique studies for the detection of GAD and panic disorder in primary care patients Across all studies, diagnostic interviews determined that 257 of 2785 patients assessed had a diagnosis of GAD while 224 of 2637 patients assessed had a diagnosis of panic disorder. The best-performing test for GAD was the Generalized Anxiety Disorder Scale 7 Item (GAD-7), with a positive likelihood ratio of 5.1 (95% CI, 4.3-6.0) and a negative likelihood ratio of 0.13 (95% CI, 0.07-0.25). The best-performing test for panic disorder was the Patient Health Questionnaire, with a positive likelihood ratio of 78 (95% CI, 29-210) and a negative likelihood ratio of 0.20 (95% CI, 0.11-0.37). Conclusions and Relevance Two screening instruments, the GAD-7 for GAD and the Patient Health Questionnaire for panic disorder, have good performance characteristics and are feasible for use in primary care. However, further validation of these instruments is needed because neither instrument was replicated in more than 1 primary care population.

Hollon, S. D., R. J. DeRubeis, et al. (2014). ***"Effect of cognitive therapy with antidepressant medications vs antidepressants alone on the rate of recovery in major depressive disorder: A randomized clinical trial."*** JAMA Psychiatry. http://dx.doi.org/10.1001/jamapsychiatry.2014.1054

Importance Antidepressant medication (ADM) is efficacious in the treatment of depression, but not all patients achieve remission and fewer still achieve recovery with ADM alone.Objective To determine the effects of combining cognitive therapy (CT) with ADM vs ADM alone on remission and recovery in major depressive disorder (MDD).Design, Setting, and Participants A total of 452 adult outpatients with chronic or recurrent MDD participated in a trial conducted in research clinics at 3 university medical centers in the United States. The patients were randomly assigned to ADM treatment alone or CT combined with ADM treatment. Treatment was continued for up to 42 months until recovery was achieved.Interventions Antidepressant medication with or without CT.Main Outcomes and Measures Blind evaluations of recovery with a modified version of the 17-item Hamilton Rating Scale for Depression and the Longitudinal Interval Follow-up Evaluation.Results Combined treatment enhanced the rate of recovery vs treatment with ADM alone (72.6% vs 62.5%; $t_{451} = 2.45$; $P = .01$; hazard ratio [HR], 1.33; 95% CI, 1.06-1.68; number needed to treat [NNT], 10; 95% CI, 5-72). This effect was conditioned on interactions with severity ($t_{451} = 1.97$; $P = .05$; NNT, 5) and chronicity ($\chi^2 = 7.46$; $P = .02$; NNT, 6) such that the advantage for combined treatment was limited to patients with severe, nonchronic MDD (81.3% vs 51.7%; $n = 146$; $t_{145} = 3.96$; $P = .001$; HR, 2.34; 95% CI, 1.54-3.57; NNT, 3; 95% CI, 2-5). Fewer patients dropped out of combined treatment vs ADM treatment alone (18.9% vs 26.8%; $t_{451} = -2.04$; $P = .04$; HR, 0.66; 95% CI, 0.45-0.98). Remission rates did not differ significantly either as a main effect of treatment or as an interaction with severity or chronicity. Patients with comorbid Axis II disorders took longer to recover than did patients without comorbid Axis II disorders regardless of the condition ($P = .01$). Patients who received combined treatment reported fewer serious adverse events than did patients who received ADMs alone (49 vs 71; $P = .02$), largely because they experienced less time in an MDD episode.Conclusions and Relevance Cognitive therapy combined with ADM treatment enhances the rates of recovery from MDD relative to ADMs alone, with the effect limited to patients with severe, nonchronic depression.Trial Registration clinicaltrials.gov Identifier: NCT00057577

King, M., L. Marston, et al. (2014). ***"Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: A randomized control trial."*** Psychological Medicine 44(09): 1835-1844. http://dx.doi.org/10.1017/S0033291713002377

Background Most evidence in the UK on the effectiveness of brief therapy for depression concerns cognitive behaviour therapy (CBT). In a trial published in 2000, we showed that non-directive counselling and CBT were equally effective in general practice for patients with depression and mixed anxiety and depression. Our results were criticized for including patients not meeting diagnostic criteria for a depressive disorder. In this reanalysis we aimed to compare the effectiveness of the two therapies for patients with an ICD-10 depressive episode. Method Patients with an ICD-10 depressive episode or mixed anxiety and depression were randomized to counselling, CBT or usual general practitioner (GP) care. Counsellors provided nondirective, interpersonal counselling following a manual that we developed based on the work of Carl Rogers. Cognitive behaviour therapists provided CBT also guided by a manual. Modelling was carried out using generalized estimating equations with the multiply imputed datasets. Outcomes were mean scores on the Beck Depression Inventory, Brief Symptom Inventory, and Social Adjustment Scale at 4 and 12 months. Results A total of 134 participants were randomized to CBT, 126 to counselling and 67 to usual GP care. We undertook (1) an interaction analysis using all 316 patients who were assigned a diagnosis and (2) a head-to-head comparison using only those 130 (41%) participants who had an ICD-10 depressive episode at baseline. CBT and counselling were both superior to GP care at 4 months but not at 12 months. There was no difference in the effectiveness of the two psychological therapies. Conclusions We recommend that national clinical guidelines take our findings into consideration in recommending effective alternatives to CBT.

Kucukgoncu, S., F. Yildirim Ornek, et al. (2014). ***"Childhood trauma and dissociation in tertiary care patients with migraine and tension type headache: A controlled study."*** Journal of Psychosomatic Research 77(1): 40-44. http://www.sciencedirect.com/science/article/pii/S0022399914001937

Objective The aims of this study were: i) to compare the severity of somatoform and psychoform dissociation and childhood trauma among migraine patients, tension-type headache patients (TTH), and healthy controls; and, ii) to identify any relationships between headache characteristics and dissociative symptoms and traumatic childhood experiences among tertiary care patients with headache. Methods The study sample consisted of 79 patients with migraine, 49 patients with TTH and 40 healthy controls. They completed the socio-demographic form, Childhood Trauma Questionnaire (CTQ), Dissociative Experiences Scale (DES), and the Somatoform Dissociation Questionnaire (SDQ). Results The average score for childhood emotional abuse was significantly higher in the TTH and migraine patients than in healthy controls; mean scores for emotional neglect and physical abuse were higher in TTH patients than healthy controls; and the total CTQ score was higher in TTH patients than in either migraine patients or healthy controls. Average DES scores were significantly higher in TTH patients versus migraine patients and controls; and SDQ scores were higher in both headache groups than in controls. Headache duration and severity were found to be significantly related to childhood abuse scores among migraine but not TTH patients. Conclusion Our findings support the evidence of a relationship between childhood trauma and migraines, and suggest that childhood traumatic events are common and deleteriously effect migraine characteristics. Also our study suggests that childhood trauma may have a role in TTH. Significant differences in the DES and SDQ scores between groups may be explained by the differences in childhood trauma experiences.

Li, L., L. Xiong, et al. (2014). ***"Cognitive–behavioral therapy for irritable bowel syndrome: A meta-analysis."*** Journal of Psychosomatic Research 77(1): 1-12. http://www.sciencedirect.com/science/article/pii/S0022399914000750

Objective To establish whether cognitive behavioral therapy (CBT) improves the bowel symptoms, quality of life (QOL) and psychological states of irritable bowel syndrome (IBS) patients. Methods Randomized controlled trials (RCTs) of CBT for adult patients with IBS were searched by using PubMed, Scopus and Web of Science. The standardized mean difference (SMD) with 95% confidence intervals (CIs) of the evidence-based outcome measures of the IBS bowel symptoms, QOL and psychological states at post-treatment and follow-up was calculated. Prespecified subgroup analysis was performed. Results Eighteen RCTs satisfied our inclusion criteria. In the subgroup analyses, CBT was more effective in reducing IBS bowel symptoms, QOL and psychological states than waiting list controls at the end of the intervention and short-term follow-up. When compared with controls of basic support and medical treatment, the effect sizes were found to favor CBT for the improvement of IBS bowel symptoms at post-treatment and short-term follow-up, but CBT was not superior to controls in improving QOL and psychological states. When comparing CBT with other psychological controls, the effect sizes were almost non-significant. Conclusions For IBS patients, CBT was superior to waiting list, basic support or medical treatment at the end of treatment but not superior to other psychological treatments. The meta-analysis might be limited by the heterogeneities and small sample sizes of the included studies.

Lilienfeld, S. O., L. A. Ritschel, et al. (2014). ***"Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness."*** Perspectives on Psychological Science 9(4): 355-387. http://pps.sagepub.com/content/9/4/355.abstract

The past 40 years have generated numerous insights regarding errors in human reasoning. Arguably, clinical practice is the domain of applied psychology in which acknowledging and mitigating these errors is most crucial. We address one such set of errors here, namely, the tendency of some psychologists and other mental health professionals to assume that they can rely on informal clinical observations to infer whether treatments are effective. We delineate four broad, underlying cognitive impediments to accurately evaluating improvement in psychotherapy—naive realism, confirmation bias, illusory causation, and the illusion of control. We then describe 26 causes of spurious therapeutic effectiveness (CSTEs), organized into a taxonomy of three overarching categories: (a) the perception of client change in its actual absence, (b) misinterpretations of actual client change stemming from extratherapeutic factors, and (c) misinterpretations of actual client change stemming from nonspecific treatment factors. These inferential errors can lead clinicians, clients, and researchers to misperceive useless or even harmful psychotherapies as effective. We (a) examine how methodological safeguards help to control for different CSTEs, (b) delineate fruitful directions for research on CSTEs, and (c) consider the implications of CSTEs for everyday clinical practice. An enhanced appreciation of the inferential problems posed by CSTEs may narrow the science–practice gap and foster a heightened appreciation of the need for the methodological safeguards afforded by evidence-based practice.

Limb, M. (2014). ***Three in four cancer patients with depression are not getting adequate treatment, studies find***.

Major depression in patients with cancer is often "missed" or "overlooked" such that nearly three quarters are not receiving adequate treatment, research has found. Many of these patients would benefit from a new integrated treatment programme found to be "strikingly" more effective than current care at reducing depression and improving the quality of life, the researchers said. The research findings were contained in three papers, funded by Cancer Research UK and the Scottish government and published simultaneously across three Lancet journals on 28 August (the Lancet, Lancet Psychiatry, and Lancet Oncology) ... 1.) Walker J, Hansen C, Martin P, Symeonides S, Ramesseur R, Murray G, et al. Prevalence, associations and adequacy of treatment of major depression in patients with cancer: a cross sectional analysis of routinely collected data. Lancet

Psychiatry 28 August 2014. http://dx.doi.org/10.1016/S2215-0366(14)70313-X. 2.) Sharpe M, Walker J, Hansen C, Martin P, Symeonides S. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Ocology-2): a multicentre randomised controlled effectiveness trial. Lancet 28 August 2014. http://dx.doi.org/10.1016/S0140-6736(14)61231-9. 3.) Walker J, Hansen C, Martin P, Symeonides S, Gourley C, Wall L, et al. Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3): a multicentre randomised controlled trial in patients with lung cancer. Lancet Oncol 2014;15:1168-76.

Mavilidi, M.-F., V. Hoogerheide, et al. (2014). ***"A quick and easy strategy to reduce test anxiety and enhance test performance."*** Applied Cognitive Psychology 28(5): 720-726. http://dx.doi.org/10.1002/acp.3058

The negative thoughts that anxious children experience while sitting for an exam consume working memory resources at the cost of resources for performing on the exam. In a randomized field experiment (N = 117) with primary school students, we investigated the hypothesis that stimulating students to look through the problems of a math test before they start solving them would reduce anxiety, release these anxiety-related working memory resources, and lead to higher test performance than not allowing students to look ahead in the test. The results confirmed the hypothesis, indicating that the positive effects of looking ahead applied to all students, regardless of their anxiety level (low, medium, or high). The results suggest that by looking ahead in a test, less working memory resources are consumed by intrusive thoughts, and consequently, more resources can be used for performing on the test. Theoretical and practical implications of the results are discussed. (The BPS Digest ... http://digest.bps.org.uk/2014/09/can-this-simple-strategy-reduce.html ... comments "Crucially, the researchers gave half the students one minute at the test start to skim through all 10 of the maths problems - this was the simple intervention ... the remaining students acted as controls and had an extra minute to answer the first problem. The good news is that the children who took a minute to skim through the questions performed better on average than the control students, and this was true regardless of their tendency to experience test-related anxiety ... the skimming ahead strategy certainly seems like a simple method for boosting children's test performance, but it's not clear that this is specifically a way to reduce test anxiety ... Although further studies need to be conducted to show whether the strategy generalises to other topics, such as language, or that a longer period to look ahead will have a greater impact on anxiety and performance, the strategy seems very promising in enabling students to perform up to their maximum potential."

Moulding, R., M. E. Coles, et al. (2014). ***"Part 2: They scare because we care: The relationship between obsessive intrusive thoughts and appraisals and control strategies across 15 cities."*** Journal of Obsessive-Compulsive and Related Disorders 3(3): 280-291. http://www.sciencedirect.com/science/article/pii/S2211364914000177

Cognitive models of Obsessive Compulsive Disorder (OCD) purport that obsessions are normal intrusive thoughts that are misappraised as significant, leading to negative emotional responses and maladaptive attempts to control the thoughts and related emotions. This paper utilised a large multi-national dataset of interview data regarding intrusive thoughts, to investigate three questions related to the cognitive model of OCD and to its stability across cultures. First, the paper aimed to investigate the implicit yet-hitherto-untested assumption of cognitive models that misappraisals and control strategies for intrusive thoughts relate similarly across cultures. Second, this study aimed to build upon recent studies categorising intrusive thoughts into repugnant and non-repugnant categories, by investigating whether the content of intrusive thought moderates the relationship between the thoughts and appraisals and control strategies. Finally, this study aimed to provide further evidence regarding whether general beliefs implicated in cognitive models of OCD (e.g., responsibility, importance of thoughts) influence the occurrence of intrusions via maladaptive appraisals and control strategies. Overall, it was found that while overall intrusive thought frequency, distress, ease and importance of dismissal all varied significantly by site, their relationship with appraisals and control strategies did not. Generally, appraisals and action taken to confront the thought were the more consistent predictors, with the notably caveat that the relationship between thought frequency and appraisals was not strong. Second, repugnant vs. non-repugnant thought-content differed only with respect to thought frequency, but thought-content did not moderate the relationship between intrusive thoughts and control strategies and appraisals. Finally, appraisals and control strategies generally partially mediated the relationship between general OCD-related beliefs and the occurrence of, and distress associated with, intrusive thoughts. The results are taken to add credence to cognitive models of OCD and their validity across cultures.

Niles, A. N., L. J. Burklund, et al. (2014). ***"Cognitive mediators of treatment for social anxiety disorder: Comparing acceptance and commitment therapy and cognitive-behavioral therapy."*** Behav Ther 45(5): 664-677. http://www.ncbi.nlm.nih.gov/pubmed/25022777

OBJECTIVE: To assess the relationship between session-by-session mediators and treatment outcomes in traditional cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) for social anxiety disorder. METHOD: Session-by-session changes in negative cognitions (a theorized mediator of CBT) and experiential avoidance (a theorized mediator of ACT) were assessed in 50 adult outpatients randomized to CBT (n=25) or ACT (n=25) for DSM-IV social anxiety disorder. RESULTS: Multilevel modeling analyses revealed significant nonlinear decreases in the proposed mediators in both treatments, with ACT showing steeper decline than CBT at the beginning of treatment and CBT showing steeper decline than ACT at the end of treatment. Curvature (or the nonlinear effect) of experiential avoidance during treatment significantly mediated posttreatment social anxiety symptoms and anhedonic depression in ACT, but not in CBT, with steeper decline of the Acceptance and Action Questionnaire at the beginning of treatment predicting fewer symptoms in ACT only. Curvature of negative cognitions during both treatments predicted outcome, with steeper decline of negative cognitions at the beginning of treatment predicting lower posttreatment social anxiety and depressive symptoms. CONCLUSIONS: Rate of change in negative cognitions at the beginning of treatment is an important predictor of change across both ACT and CBT, whereas rate of change in experiential avoidance at the beginning of treatment is a mechanism specific to ACT.

Olatunji, B. O., B. Y. Kauffman, et al. (2014). ***"Cognitive-behavioral therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators."*** Behaviour Research and Therapy 58(0): 65-74. http://www.sciencedirect.com/science/article/pii/S0005796714000631

The present investigation employed meta-analysis to examine the efficacy of cognitive–behavioral therapy (CBT) for hypochondriasis/health anxiety as well as potential moderators that may be associated with outcome. A literature search revealed 15 comparisons among 13 randomized-controlled trials (RCTs) with a total sample size of 1081 participants that met inclusion criteria. Results indicated that CBT outperformed control conditions on primary outcome measures at post-treatment (Hedges's g = 0.95) and at follow-up (Hedges's g = 0.34). CBT also outperformed control conditions on measures of depression at post-treatment (Hedges's g = 0.64) and at follow-up (Hedges's g = 0.35). Moderator analyses revealed that higher pre-treatment severity of hypochondriasis/health anxiety was associated with greater effect sizes at follow-up visits and depression symptom severity was significantly associated with a lower in effect sizes at post-treatment. Although effect size did not vary as a function of blind assessment, smaller effect sizes were observed for CBT vs. treatment as usual control conditions than for CBT vs. waitlist control. A dose response relationship was also observed, such that a greater number of CBT sessions was associated

with larger effect sizes at post-treatment. This review indicates that CBT is efficacious in the treatment of hypochondriasis/health anxiety and identifies potential moderators that are associated with outcome. The implications of these findings for further delineating prognostic and prescriptive indicators of CBT for hypochondriasis/health anxiety are discussed.

Owen, J., B. Duncan, et al. (2014). ***"Accounting for therapist variability in couple therapy outcomes: What really matters?"*** J Sex Marital Ther 40(6): 488-502. http://www.ncbi.nlm.nih.gov/pubmed/24965052

This study examined whether therapist gender, professional discipline, experience conducting couple therapy, and average second-session alliance score would account for the variance in outcomes attributed to the therapist. The authors investigated therapist variability in couple therapy with 158 couples randomly assigned to and treated by 18 therapists in a naturalistic setting. Consistent with previous studies in individual therapy, in this study therapists accounted for 8.0% of the variance in client outcomes and 10% of the variance in client alliance scores. Therapist average alliance score and experience conducting couple therapy were salient predictors of client outcomes attributed to therapist. In contrast, therapist gender and discipline did not significantly account for the variance in client outcomes attributed to therapists. Tests of incremental validity demonstrated that therapist average alliance score and therapist experience uniquely accounted for the variance in outcomes attributed to the therapist. Emphasis on improving therapist alliance quality and specificity of therapist experience in couple therapy are discussed.

Radomsky, A. S., G. M. Alcolado, et al. (2014). ***"Part 1—you can run but you can't hide: Intrusive thoughts on six continents."*** Journal of Obsessive-Compulsive and Related Disorders 3(3): 269-279. http://www.sciencedirect.com/science/article/pii/S2211364913000675

Most cognitive approaches for understanding and treating obsessive-compulsive disorder (OCD) rest on the assumption that nearly everyone experiences unwanted intrusive thoughts, images and impulses from time to time. These theories argue that the intrusions themselves are not problematic, unless they are misinterpreted and/or attempts are made to control them in maladaptive and/or unrealistic ways. Early research has shown unwanted intrusions to be present in the overwhelming majority of participants assessed, although this work was limited in that it took place largely in the US, the UK and other 'westernised' or 'developed' locations. We employed the International Intrusive Thoughts Interview Schedule (IITIS) to assess the nature and prevalence of intrusions in nonclinical populations, and used it to assess (n=777) university students at 15 sites in 13 countries across 6 continents. Results demonstrated that nearly all participants (93.6%) reported experiencing at least one intrusion during the previous three months. Doubting intrusions were the most commonly reported category of intrusive thoughts; whereas, repugnant intrusions (e.g., sexual, blasphemous, etc.) were the least commonly reported by participants. These and other results are discussed in terms of an international perspective on understanding and treating OCD.

Ravitz, P. and P. Watson (2014). ***"Interpersonal psychotherapy: Healing with a relational focus."*** FOCUS 12: 275-284. http://focus.psychiatryonline.org/article.aspx?articleid=1892874

Interpersonal psychotherapy (IPT) is a time-limited psychotherapy that focuses on relationship stressors and ways to adaptively engage with social supports. Since the first controlled IPT depression study 40 years ago, new applications of the model have emerged, informed by research and public health needs. Evidence for its effectiveness has led to its inclusion in expert consensus treatment guidelines for the treatment of depression, eating disorders, and bipolar disorder. This paper provides a clinical synthesis of IPT, reviewing adaptations that include: IPT-A, for use with adolescents with depression; interpersonal social rhythm therapy (IPSRT), for patients with bipolar disorder; IPT, for patients with eating disorders; and IPT, for patients with depression in culturally diverse settings. With its clear clinical guidelines, therapist- and patient-friendly approach, and data supporting its effectiveness, IPT is easily integrated into mental health care to help patients with mood or eating disorders and interpersonal problems.

Reese, R. J., B. L. Duncan, et al. (2014). ***"Benchmarking outcomes in a public behavioral health setting: Feedback as a quality improvement strategy."*** J Consult Clin Psychol 82(4): 731-742. http://www.ncbi.nlm.nih.gov/pubmed/24841863

OBJECTIVE: The purpose of this study was to evaluate the effectiveness of a large public behavioral health (PBH) agency serving only clients at or below the federal poverty level that had implemented continuous outcome feedback as a quality improvement strategy. METHOD: The authors investigated the post treatment outcomes of 5,168 individuals seeking treatment for a broad range of diagnoses who completed at least 2 psychotherapy sessions. The Outcome Rating Scale (ORS; Duncan, 2011; Miller & Duncan, 2004) was used to measure outcomes. Clients had a mean age of 36.7 years and were predominantly female (60.7%) and White (67.8%), with 17.7% being Hispanic, 9.3% being African American, and 2.8% being Native American. Forty-six percent were diagnosed with depression, mood, and anxiety disorders; 18.8% were diagnosed with substance abuse disorders; and 14.4% were diagnosed with bipolar disorder and schizophrenia. A subset of clients with a primary diagnosis of a depressive disorder was compared to treatment efficacy benchmarks derived from clinical trials of major depression. Given that the PBH agency had also implemented an outcome management system, the total sample was also compared to benchmarks derived from clinical trials of continuous outcome feedback. RESULTS: Treatment effect sizes of psychotherapy delivered at the PBH agency were comparable to effect size estimates of clinical trials of depression and feedback. Observed effect sizes were smaller, however, when compared to feedback benchmarks that used the ORS. CONCLUSIONS: Services to the poor and disabled can be effective, and continuous outcome feedback may be a viable means both to improve outcomes and to narrow the gap between research and practice.

Saint Onge, J. M., P. M. Krueger, et al. (2014). ***"The relationship between major depression and nonsuicide mortality for U.S. Adults: The importance of health behaviors."*** The Journals of Gerontology Series B: Psychological Sciences and Social Sciences 69(4): 622-632. http://psychsocgerontology.oxfordjournals.org/content/69/4/622.abstract

Objectives. We aim to elucidate the role of health behaviors and health conditions in the association between depression and mortality. First, we examine the relationship between major depression and nonsuicide mortality among U.S. adults aged 50 and older. Second, we examine the relationship between major depression and cardiovascular disease and cancer, by baseline disease status. Third, we examine the role of health behaviors as potential mediators of the association between major depression and cause-specific mortality.Methods. We use data from the 1999 National Health Interview Study linked to the 2006 National Death Index (N = 11,369; M age = 65, deaths = 2,162) and Cox proportional hazards models to describe the relationships among major depression, health behaviors (alcohol use, cigarette smoking, physical activity), and nonsuicide mortality. We examine cause-specific mortality (cardiovascular and cancer) by baseline disease status.Results. Major depression remains associated with a 43% increase in the risk of death over the follow-up period, after we account for sociodemographic characteristics, health behaviors, and health conditions. Major depression is associated with 2.68 times the risk of cardiovascular disease mortality among those who did not have cardiovascular disease at baseline and 1.82 times for those with baseline cardiovascular disease. Health behaviors reduce the hazard ratio by 17% for all nonsuicide mortality, 3% for cardiovascular disease mortality, and 12% for cancer mortality.Discussion. Our results provide evidence of the important role of

health behaviors and health conditions in the depression–mortality relationship and highlight the importance of identifying risk factors for depression among aging adults.

Schuman, D. L., N. C. Slone, et al. (2014). ***"Efficacy of client feedback in group psychotherapy with soldiers referred for substance abuse treatment."*** Psychother Res. http://www.ncbi.nlm.nih.gov/pubmed/24708386

Abstract This study investigated whether routine monitoring of client progress, often called "client feedback," via an abbreviated version of the Partners for Change Outcome Management System (PCOMS) resulted in improved outcomes for soldiers receiving group treatment at an Army Substance Abuse Outpatient Treatment Program (ASAP). Participants (N = 263) were active-duty male and female soldiers randomized into a group feedback condition (n = 137) or a group treatment-as-usual (TAU) condition (n = 126). Results indicated that clients in the feedback condition achieved significantly more improvement on the outcome rating scale (d = 0.28), higher rates of clinically significant change, higher percentage of successful ratings by both clinicians and commanders, and attended significantly more sessions compared to the TAU condition. Despite a reduced PCOMS protocol and a limited duration of intervention, preliminary results suggest that the benefits of client feedback appear to extend to group psychotherapy with clients in the military struggling with substance abuse.

Suri, G., K. Whittaker, et al. (2014). ***"Launching reappraisal: It's less common than you might think."*** Emotion. http://spl.stanford.edu/pdfs/2014 Suri.pdf

Cognitive reappraisal is thought to be ubiquitous. However, no studies have quantified how frequently people reappraise (vs. letting their emotional response go unregulated). To address this issue, the authors created a laboratory decision context in which participants watched a series of negatively valenced images, and in each case had the option of electing to reappraise to decrease negative affect. Given the many benefits and few costs associated with reappraisal, we expected that most images would be reappraised. However, to our surprise, participants implemented reappraisals for only 16% of images (Study 1). Regulatory rates remained low for both low- and high-intensity images, even when another regulatory option (i.e., distraction) was available (Study 2). The authors hypothesized that participants did not proactively reappraise because there were hidden costs associated with reappraisal. They considered 2 classes of costs: overcoming default bias and cognitive effort, and they measured the percentage of trials for which participants chose to reappraise using a fully crossed 2 2 design that examined the effects of removing defaults and of providing support in creating reappraisals. Removing defaults, but not providing reappraisal support, increased rates of reappraisal (Study 3). Everyday decision-making frequently involves default options. These results suggest that contextual variables (such as the presence of defaults) may play a large role in the decision to regulate emotions.

Swartz, H. A. and J. Swanson (2014). ***"Psychotherapy for bipolar disorder in adults: A review of the evidence."*** FOCUS 12: 251-266. http://focus.psychiatryonline.org/article.aspx?articleid=1892872

Although pharmacotherapy is the mainstay of treatment for bipolar disorder, medication offers only partial relief for patients. Treatment with pharmacologic interventions alone is associated with disappointingly low rates of remission, high rates of recurrence, residual symptoms, and psychosocial impairment. Bipolar-specific therapy is increasingly recommended as an essential component of illness management. This review summarizes the available data on psychotherapy for adults with bipolar disorder. We conducted a search of the literature for outcome studies published between 1995 and 2013 and identified 35 reports of 28 randomized controlled trials testing individual or group psychosocial interventions for adults with bipolar disorder. These reports include systematic trials investigating the efficacy and effectiveness of individual psychoeducation, group psychoeducation, individual cognitive-behavioral therapy, group cognitive-behavioral therapy, family therapy, interpersonal and social rhythm therapy, and integrated care management. The evidence demonstrates that bipolar disorder-specific psychotherapies, when added to medication for the treatment of bipolar disorder, consistently show advantages over medication alone on measures of symptom burden and risk of relapse. Whether delivered in a group or individual format, those who receive bipolar disorder-specific psychotherapy fare better than those who do not. Psychotherapeutic strategies common to most bipolar disorder-specific interventions are identified.

Takizawa, R., B. Maughan, et al. (2014). ***"Adult health outcomes of childhood bullying victimization: Evidence from a five-decade longitudinal british birth cohort."*** American Journal of Psychiatry 171(7): 777-784. http://dx.doi.org/10.1176/appi.ajp.2014.13101401

Objective The authors examined midlife outcomes of childhood bullying victimization. Method Data were from the British National Child Development Study, a 50-year prospective cohort of births in 1 week in 1958. The authors conducted ordinal logistic and linear regressions on data from 7,771 participants whose parents reported bullying exposure at ages 7 and 11 years, and who participated in follow-up assessments between ages 23 and 50 years. Outcomes included suicidality and diagnoses of depression, anxiety disorders, and alcohol dependence at age 45; psychological distress and general health at ages 23 and 50; and cognitive functioning, socioeconomic status, social relationships, and well-being at age 50. Results Participants who were bullied in childhood had increased levels of psychological distress at ages 23 and 50. Victims of frequent bullying had higher rates of depression (odds ratio=1.95, 95% CI=1.27–2.99), anxiety disorders (odds ratio=1.65, 95% CI=1.25–2.18), and suicidality (odds ratio=2.21, 95% CI=1.47–3.31) than their nonvictimized peers. The effects were similar to those of being placed in public or substitute care and an index of multiple childhood adversities, and the effects remained significant after controlling for known correlates of bullying victimization. Childhood bullying victimization was associated with a lack of social relationships, economic hardship, and poor perceived quality of life at age 50. Conclusions Children who are bullied—and especially those who are frequently bullied—continue to be at risk for a wide range of poor social, health, and economic outcomes nearly four decades after exposure. Interventions need to reduce bullying exposure in childhood and minimize long-term effects on victims' well-being; such interventions should cast light on causal processes.

Webster, G. D., C. N. Dewall, et al. (2014). ***"The brief aggression questionnaire: Psychometric and behavioral evidence for an efficient measure of trait aggression."*** Aggress Behav 40(2): 120-139. http://www.ncbi.nlm.nih.gov/pubmed/24115185

A key problem facing aggression research is how to measure individual differences in aggression accurately and efficiently without sacrificing reliability or validity. Researchers are increasingly demanding brief measures of aggression for use in applied settings, field studies, pretest screening, longitudinal, and daily diary studies. The authors selected the three highest loading items from each of the Aggression Questionnaire's (Buss & Perry, 1992) four subscales - Physical Aggression, Verbal Aggression, anger, and hostility-and developed an efficient 12-item measure of aggression - the Brief Aggression Questionnaire (BAQ). Across five studies (N = 3,996), the BAQ showed theoretically consistent patterns of convergent and discriminant validity with other self-report measures, consistent four-factor structures using factor analyses, adequate recovery of information using item response theory methods, stable test-retest reliability, and convergent validity with behavioral measures of aggression. The authors discuss the reliability, validity, and efficiency of the BAQ, along with its many potential applications.