

Evidence Tables

Matrics Cymru / Matrics Plant



Index

Evidence Tables

A Rationale for the Matrics Cymru Evidence Tables: Evidence-Based Practice (EBP) and Practice-Based Evidence (PBE)	5
The evidence tables	7
The development of the Matrics Cymru evidence tables	7
Key areas for development	8
Services for children, young people (CYP) and families	9
How to use the Matrics Cymru evidence tables	9
Which Therapies? - The Evidence Base	11
Grading the evidence table	13

Adult and Children and Young Person's Mental Health

Bipolar	17
Body dysmorphic disorder	19
Borderline personality disorder	21
Depression	23
Eating disorders	29
Generalised anxiety disorder	43
Health anxiety	45
Non psychotic affective disorders in the perinatal period	48

Index

Adult and Children and Young Person’s Mental Health

Obsessive compulsive disorder	55
Open Dialogue	59
Panic disorder with/without agoraphobia	63
Perinatal mental health – common mental health problems	68
Post traumatic stress disorder	77
Schizophrenia/psychosis	93
Social anxiety disorder	100
Specific phobias	104

Substance misuse	106
------------------	-----

Older Adults

Anxiety disorders in later life	109
Depression in later life	111
Personality disorder in later life	114
Severe and enduring conditions	115

Index

Dementia

Depression and anxiety in the person with dementia and their caregivers	116
Cognition (and quality of life)	118
Living well with dementia	119
Insomnia	121
Stress and distress in dementia	122
Specific interventions in response to stress and distress	124

The Evidence Tables

A Rationale for the Matrics Cymru Evidence Tables: Evidence-Based Practice (EBP) and Practice-Based Evidence (PBE)

In the field of psychological therapy, there has long been a drive to “bridge the gap” between practice and research¹. This has led to recognition that both evidence-based practice (EBP) and practice-based evidence (PBE) are necessary to the dissemination of high-quality interventions which can be delivered in routine clinical settings.

Evidence-Based Practice is informed by high quality research studies such as randomised controlled trials (RCTs) in which the primary focus is on controlling variables such as presenting difficulty, diagnosis and the presence or otherwise of comorbidities, in order to make a valid comparison between the treatment effect of different therapies. Participants in these studies are randomly assigned to different treatment groups, often including an option for no active treatment. Systematic reviews and meta-analyses draw together findings from these studies to provide an overview of the evidence

for specific interventions. Systematic reviews have an important role in summarising the quality and strength of evidence across a range of sometimes contradictory studies and ordinarily form the mainstay of clinical guidelines published by organisations such as the National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and the World Health Organization (WHO). These guidelines have provided scientific support for the continued provision of effective therapies.

There are, however, issues arising from relying on this type of guideline in isolation². Issues of concern include the use of diagnostic classification or distinct presenting problem in most randomised controlled trials (RCTs)³. Hence, RCTs may be seen to be unrepresentative of the real clinical world because mental health problems rarely occur in isolation. Clinicians might conclude that guidance based only on RCTs is of limited value in terms of its practical application to many service users.

In addition, some therapies lend themselves more easily to evaluation through RCTs than others, which is likely to bias the evidence base in their favour. Further, reliance on diagnoses to guide treatment is recognised to have implications and limitations. Matrics Cymru, in

1 Barkham, M. & Mellor-Clark, J. (2003) Bridging Evidence-Based Practice and Practice-Based Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies. *Clinical Psychology and Psychotherapy*. (2003), 10, 319-327

2 Mulder, 2018 <https://pubmed.ncbi.nlm.nih.gov/28710065/>

3 Johnstone, L. (2014) A Straight Talking Introduction to Psychiatric Diagnosis. Ross-on-Wye: PCCS Books

setting out levels of practice, highlights the key role of formulation and supervised practice alongside consideration of the evidence base in order to deliver effective person-centred intervention. The use of guidance developed from best evidence for clinical work should be informed by an awareness of the issues raised in relevant critiques⁴.

There is however, a significant and substantive body of evidence-based on functional diagnosis which has informed the development of agreed clinical guidance and practice. Where there are apparent gaps in the evidence to support some interventions, this does not necessarily indicate that treatments that are excluded from such guidelines have been shown to be ineffective; it can simply mean that studies of sufficient methodological rigour have not yet been completed and reported. In the absence of RCT based evidence, EBP may sometimes be informed by studies of lower methodological quality, such as non-randomised comparison studies, cohort studies or case control series. Treatment guidelines normally identify the level of evidence involved in supporting specific recommendations in order to make this transparent to the reader.

Practice-Based Evidence [PBE]⁵ involves the collection and evaluation of evidence collected from service users within clinical services. Practice-based evidence is of greatest value when it is collected systematically on a continuous basis and when it is used to evaluate the impact of specific clinical and service-related

interventions. PBE offers an opportunity to use benchmarking and case tracking to incorporate observations from clinical practice and compare these against anticipated outcomes based on evidence-based guidance. Evidence from the Practice Research Network (PRN) for improving access to psychological therapies (IAPT)⁶ shows that the most effective IAPT services in England routinely employ these methods to enable clinicians to monitor, reflect and improve their practice. This approach to improving services relies on the practice of continuous monitoring and recording of outcomes during and at the end of interventions.

The routine collection and analysis of practice-based evidence can be seen as complementary to evidence-based practice. These two forms of evidence have great potential to feed into each other, so that the routine collection of practice-based evidence can inform service delivery where the findings of trial-based research may not be fully representative of the kinds of diverse and co-occurring difficulties service users may experience and present with for therapy.

A structured methodology described as quality improvement collaborative review (QUIC-R) supports the evaluation of existing research literature alongside practice-based evidence. There is early support from clinicians and service users from across Wales for a National Repository for Practice-Based Evidence. Development of a repository is likely to help to support the introduction of models

4 Johnstone, L. (2014) A Straight Talking Introduction to Psychiatric Diagnosis. Ross-on-Wye: PCCS Books

5 Barkham, M. and Margison, F. 'Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus', in Freeman, C. & Power, M. (ed), Handbook of evidence-based psychotherapies: A guide for research and practice (Chichester: John Wiley & Sons, Ltd., 2007).

6 <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/iapt>

of implementation science (e.g., the Hexagon model)⁷. This would potentially enable clinicians in Wales to make use of routine data collection to take an evidence informed approach and to consider modifications that might be required to established interventions in order to make them more accessible and appropriate for populations in Wales in a way that is consistent with extant policy. In the more immediate future, it is highly likely that reviews of evidence (particularly for those areas where research is limited) will indicate, where necessary, evidence that is less rigorous and is more akin to practice-based evidence. Research will be graded accordingly for transparency but in the context of a robust assessment and formulation, clinicians may choose to offer an intervention supported by PBE.

The Evidence Tables

The evidence tables in Matrics Cymru use a similar format to those published in the Scottish Matrix evidence tables (2015). These draw upon EBP and are based on existing diagnostic frameworks, as used by NICE and more generally in mental health research.

The various SIGN⁸ and NICE guidelines represent a transparent and rigorous interrogation of the evidence base for mental health problems and as for the Scottish Matrix (2015), form the basis of the Matrics Cymru tables. As evidence tables are updated and new ones added, these will be incorporated in the document available on the Improvement Cymru website. The date at which the table was

developed/last reviewed will be clearly indicated in the titles e.g., Bipolar-Disorder (2017), Post Traumatic Stress Disorder (2021).

The Development of the Matrics Cymru Evidence Tables

The Matrics Cymru evidence tables are intended to provide a summary of the information on the evidence base for the effectiveness of particular psychological therapies for particular mental health problems.

To develop the initial Matrics Cymru evidence tables in 2017, Wales-based clinicians were invited to review the Scottish Matrix (2015) evidence tables. Within each diagnostic classification, the evidence from the various guidelines was collated by clinicians specialising in that area and further input was sought from individuals with identified expertise. They were asked to develop similar tables for each diagnostic difficulty by scrutinising relevant contemporary research studies.

A process for collaborative review and updating the tables, ensuring that they consider evidence related to the needs of service users across the life span, alongside the needs of specific populations (such as those with learning disabilities) and with wider scope to transdiagnostic models of practice where these are frequently delivered in statutory services, was commenced in 2020.

7 Metz, A. & Louison, L. (2018) The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013).

8 <https://www.sign.ac.uk/>

The structured methodology QUIC-R, is based on the approaches used by NICE and SIGN, and was developed with the intention that this should be followed in updating existing tables and in developing new tables. The methodology specified that small working groups of clinicians and academics with specialist knowledge of the field would be developed to review changes in the evidence and with the involvement of individuals with lived experience, develop new and updated tables.

The Matrics Cymru Leadership and Infrastructure Project (MCLIP) developed a collaboration with colleagues updating the Matrix Tables in Scotland⁹ to allow adoption of tables developed by the other country. In order to inform adjustment and development of tables appropriate to each nation, both Scotland and Wales agreed to invite representation from the other nation in table update groups. This collaborative approach is both prudent and efficient in ensuring that the available research resources in both countries are used to best effect.

New evidence tables will be developed and published as part of a rolling programme according to priorities set out and agreed with the National Psychological Therapies Management Committee (NPTMC), which works in partnership with service users and will cover mental health services for children and young people, adults and older adults. The tables continue to focus on common mental health problems and disorders, but in addition will broaden scope to include new tables on transdiagnostic problems which might occur alongside a range of disorders (e.g., problems with regulation of emotions) and

transdiagnostic interventions (interventions which might be effective across a number of different types of difficulty).

This document will become a living document, subject to regular updates as new tables are developed. There will be multiple areas of specialism across the document.

Key areas for development

The intention is that future tables should be inclusive of populations such as older adults and people with a learning disability, where increased efforts may be required to ensure engagement and co-creation of research outcomes and the collection of PBE. Unless otherwise indicated, clinicians should be able to extrapolate from the evidence tables to these populations, so that with appropriate adjustments and modifications, recommended therapies can be offered. Feedback from listening groups/engagement events conducted with practitioners across Wales working in multiple specialties and service areas indicate a number of themes for possible modification including extending the period of engagement and socialisation to the intervention, using adapted materials and where appropriate, including carers or significant others.

9 <https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland>

Services for children, young people (CYP) and families

Psychological therapies play a particularly important role in mental health services for children and young people. This remains an under-researched area compared to mental health therapies for adults and much of the evidence of “what works for whom” in relation to children and young people comes from the adult or generic psychological therapies literature.

It is noted that the use of diagnostic, rather than developmental and normative frameworks for describing effective practice may not always be appropriate in psychological services for children and young people. A fuller discussion and clarification of ways of working psychologically with CYP is set out in *Matrices Plant*¹⁰. New iterations of the evidence tables will include specific reference to CYP where relevant evidence exists as appropriate, as long as the conceptualisation of the presenting problem is a good fit and sits alongside a developmental and systemic view of the child or young person. Where the table is awaiting review, practitioners are referred to the Scottish Matrix.

How to use the Matrices Cymru Evidence Tables

Effectiveness and Cost-Effectiveness

The evidence base for any intervention, as currently defined in SIGN and NICE guidelines, will generally tell us one of three things:

- There is evidence in the literature for the effectiveness of the intervention and if this is the case, the intervention will then be rated on the quality of the available evidence
- There is no clear evidence in the literature for the effectiveness of the intervention. It is recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective and it may be that the approach has not yet been adequately evaluated
- There is evidence in the literature the intervention is ineffective, or indeed harmful.

In the first and last cases, the implications are clear:

- Health boards should ensure access to at least one therapy with the highest level evidence for each of the presenting problems shown in the tables and ensure that individuals have access to an alternative with evidence at level A, B or C. To ensure the provision of prudent, effective care, the alternative therapy

¹⁰ *Matrices Plant Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales (2021) Improvement Cymru.*

provided should be that with the strongest evidence (p26)¹¹

- Where an intervention has been demonstrated to be ineffective or harmful, it should not be provided within the NHS
- Where a therapy or intervention has not been adequately evaluated, there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognised or have been evaluated as being of benefit to service users in spite of the lack of a tradition of high-quality EBP research. There is no suggestion that these services should be dismantled, but it is crucial that health boards begin to systematically collect their own good quality evidence [PBE] around the effectiveness of such services. Not only is this essential for good governance, it engages service users and practitioners in a process of local evaluation, ensuring dynamic quality improvement, will contribute to the wider evidence base and help ensure that investments are effective in the longer term. The introduction of the Improvement Cymru Outcomes Initiative will help to support the routine collection of such evidence.

When using the tables as an aid to strategic planning, it is important to scope local expertise alongside gaps in service provision and build upon the experience already available. Services need to be able to demonstrate that they are working towards providing evidence-based services in a developmental way.

Where two or more treatment options are comparable in terms of effectiveness, then issues of equity, empowerment, effectiveness and efficiency¹² should be considered. Cost effectiveness as an aspect of efficiency, is highly relevant in ensuring equitable and increased access of provision for psychological therapies within a finite resource.

Factors which need to be taken into account include:

- the cost of treatment in terms of training, therapist time and other resources, taking account of models of service delivery and service user uptake
- the investment required in training staff to deliver the intervention effectively, taking into account levels of skills/knowledge already available within the system
- the sustainability of training to maintain the service in the long term
- the efficiency of training (i.e., what percentage of time the trained staff are able to deliver the intervention within the service)
- the capacity of the system
- relevant outcome measures which can inform practice both at local and national levels
- issues of service user choice and acceptability
- flexibility for adaptation according to individual needs (e.g.,

11 <https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-programmes/mental-health/psychological-therapies/resources-psychological-therapies/matrics-cymru-guidance-for-delivering-evidence-based-psychological-therapies-in-wales/>

12 Adult Mental Health Services: A National Service Framework for Wales, 2002, Welsh Government- <https://www.wamhinpc.org.uk/sites/default/files/adult-mental-health-nsf-april-02.pdf>

neurodiversity, issues related to later life).

From a clinical standpoint and indeed a human rights perspective, individual need and choice is paramount and access to interventions matched to need and choice should be seamless and not be based on the part of the service (e.g., primary vs secondary care) in which the individual is being seen.

Which Therapies? - The Evidence Base

Currently, the evidence tables continue to support the efficacy of cognitive behavioural therapy (CBT) for many disorders. Health boards would therefore be wise to continue to develop expertise in CBT based approaches. A strong CBT foundation will put health boards in a good position, both to provide many of the 'high intensity' interventions necessary and to deliver psychological interventions at the 'low intensity' level appropriate for mild/moderate mental health problems. Most of the evidence-based 'low intensity' options, including self-management, problem-solving and computerised or online packages, are derived from CBT principles.

The psychological therapies health boards choose to provide will be guided by:

- population need and service user preferences and feedback
- the services they already have
- the expertise available locally
- findings from existing service evaluation and quality improvement initiatives

- the advice of the national and the local Psychological Therapy Management Committees (PTMCs)
- current and future Wales national policy/strategic requirements.

It is important that service users and carers (where appropriate), are engaged meaningfully in this decision-making process. Decisions about what interventions or therapy to undertake should be made through a collaborative process, through discussion between the service and service user - informed by clinical judgement, as well as the available evidence. The following link provides a brief summary of the way in which we can use the research evidence, clinical judgement and experience and patient choice, together to support decisions about intervention [What is Evidence Based Practice? - YouTube](#).

It is also crucial that the field of psychological therapy continues to evolve and therapeutic advances or innovative service developments should not be stifled by the rigid application of current guidelines. Trials of new therapies, or of new applications of existing therapies and new paradigm research trials, will generally be organised by national research networks and the local PTMCs can contribute to this process by facilitating access to service user data (adhering to formal research ethical requirements) and by developing collaborations with active research groups. PTMCs can also encourage service innovation, based on the evidence as it currently stands and support the robust evaluation of new projects. However, the needs and preferences of service users must remain paramount and appropriate research protocols must be adopted wherever innovative approaches are being trialed.

Definitions used in the tables

Term	Definition
Level of Severity	<p>A description of the level of severity of the problem and an indicator of potential level of functioning. Following definitions provided by NICE, the terms mild, moderate and severe are used in this document to describe different levels of mental health problems.</p> <p>A <i>mild</i> mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life.</p> <p>A <i>moderate</i> mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.</p> <p>A <i>severe</i> mental health problem is when a person has many symptoms that can make their daily life extremely difficult.</p>
Level of Service	Where service users are most likely to be treated most effectively.
Intensity of Intervention	<p>Low intensity interventions are structured/manualised, brief interventions aimed at transient or mild to moderate mental health problems, ordinarily delivered by practitioners working in an informed and skilled way.</p> <p>High intensity/specialist interventions are formal psychological therapies based on a psychological formulation delivered by a practitioner working at an enhanced or highly specialist level of expertise and are ordinarily aimed at moderate to severe mental health problems.</p>
What Intervention?	The interventions are those that are recommended by the strongest evidence base.
Level of Evidence	This is the level of evidence of efficacy, as detailed below.
Level of Efficacy	This refers to the degree of symptom/functional improvement on key outcomes that one might expect from the intervention based on research findings. Level of efficacy is often based on metrics such as “effects size”, which describes the degree of improvement of an intervention group in relation to that of a control condition. Levels of efficacy are described as low, medium or high and reflect improvements in symptoms that are small, moderate or large in size.

Grading the Evidence Table

SIGN	NICE	Matrics Cymru 2017	Matrics Cymru 2021
<p>A</p> <p>At least one meta-analysis, systematic review, or RCT rated as high quality and with a low risk of bias and directly applicable to the target population</p> <p>OR</p> <p>A body of evidence consisting principally of well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias, directly applicable to the target population and demonstrating overall consistency of results.</p>	<p>A</p> <p>At least one RCT as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-1) without extrapolation.</p>	<p>A</p> <p>At least one meta-analysis or systematic review clearly supports the efficaciousness of the therapy for this problem</p> <p>OR</p> <p>In the absence of such reviews, there is at least one RCT of high quality that is directly relevant to the problem.</p>	<p>A</p> <p>At least one meta-analysis, systematic review or high quality RCT, with low risk of bias clearly supporting the efficacy of the intervention for the problem in the target population and as part of a body of literature of overall good quality addressing the specific recommendation.</p>

<p>B</p> <p>A body of evidence including high quality systematic reviews of case control or cohort studies; or high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal, directly applicable to the target population and demonstrating overall consistency of results</p> <p>OR</p> <p>Extrapolated evidence from high quality or well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.</p>	<p>B</p> <p>Well conducted clinical studies but no randomised clinical trials on the topic of recommendation.</p>	<p>B</p> <p>Well conducted, but non-randomised, clinical studies, or RCTs of lower quality, as part of a generally consistent literature and directly relevant to this problem.</p>	<p>B</p> <p>Well conducted, but non-randomised, clinical studies, or RCTs of lower quality, as part of a generally consistent literature and directly relevant to the target population and problem and demonstrating overall consistency of results.</p> <p>This might include high quality systematic reviews of case control or cohort studies, or high-quality case control or cohort studies with a very low risk of confounding or bias.</p> <p>OR</p> <p>Extrapolated evidence from high quality or well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.</p>
--	--	--	--

<p>C</p> <p>A body of evidence including well conducted case control or cohort studies with a low risk of confounding or bias, directly applicable to the target population and demonstrating overall consistency of results</p> <p>OR</p> <p>Extrapolated evidence from high quality systematic reviews of case control or cohort or studies</p> <p>OR</p> <p>Extrapolated evidence from high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.</p>	<p>C</p> <p>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level iv). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.</p>	<p>C</p> <p>Evidence from case series studies and widely held expert opinion which suggests that this therapy has potential to be efficacious in treating this problem, but no RCTs or other high-quality studies have yet been conducted.</p>	<p>C</p> <p>In the absence of more robust evidence, a body of evidence from well conducted case series or cohort studies with a low risk of confounding or bias, directly applicable to the target population, which suggests that the intervention can be efficacious in improving or treating the problem</p> <p>OR</p> <p>Extrapolated evidence from well conducted systematic reviews of case-control or cohort studies with a low risk of confounding or bias</p> <p>OR</p> <p>Extrapolated evidence from high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.</p>
---	--	--	--

<p>D</p> <p>Non-analytic studies, e.g., case reports, case series</p> <p>OR</p> <p>Expert opinion</p> <p>OR</p> <p>Extrapolated evidence from well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.</p>			<p>D</p> <p>Evidence from non-analytic studies, e.g., case reports, case series</p> <p>OR</p> <p>Expert committee report or opinion of respected and trustworthy authorities (such as NICE, SIGN, WHO, APA¹³, BPS¹⁴, RCPsych¹⁵, BABCP¹⁶, ACP¹⁷ or expert consensus guidelines) ratified by the Welsh QUIC-R¹⁸ process. This grading indicates that directly applicable studies of good quality are absent or not readily available</p> <p>OR</p> <p>Extrapolated evidence from well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.</p>
--	--	--	---

13 American Psychological Association

14 British Psychological Society

15 Royal College of Psychiatrists

16 British Association for Behavioural and Cognitive Psychotherapy

17 Association of Child Psychotherapists

18 Quality Improvement Collaborative Review

Adult and Children and Young Person's Mental Health

Bipolar (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Severe and enduring - recently diagnosed	All	Low	"Beating Bipolar" internet-based psycho-educational programme	B ^{8,9}
Severe and enduring - in recovery and taking medication	Secondary care	High	CBT focused on relapse prevention Group psycho-education (e.g., Bipolar Education Programme Cymru) Family intervention	A ^{1,6,7} A ^{1,6} B ⁶
Severe and enduring - in an acute episode of bipolar disorder and taking medication	Secondary care	High	CBT for patients with fewer than 12 previous episodes Interpersonal and social rhythm therapy	A ^{2,3} A ⁴
Severe and enduring	Secondary care	<u>High</u>	Functional remediation for improvement in functional outcomes	A ¹⁰

References

1. Beynon, S., Soares-Weiser, K., Woolacott, N. Geddes, J.R. (2008) Psychosocial interventions for the prevention of relapse in bipolar disorder: systematic review of controlled trials. *British Journal of Psychiatry*, 192, 5–11.
2. Scott, J. Paykel, E.S. Morriss, R. Bentall, R. Kinderman, P. Johnson, T. Abbot, R. Hayhurst, H. (2006) Cognitive behavioural therapy for severe and recurrent bipolar disorders: randomised control trial. *British Journal of Psychiatry*, 188, 313–320.
3. Scott, J. Colom, F. Vieta, E. (2007) A meta-analysis of relapse rates with adjunctive psychological therapies compared to usual psychiatric treatment for bipolar disorders. *International Journal of Neuropsychopharmacology*, 10, 123–129.
4. Miklowitz, D.J. Otto, M.W. Frank, E. et al (2007) Psychosocial Treatments for bipolar depression: a one year randomized trial from the Systematic Treatment Enhancement Program. *Archives of General Psychiatry*, 64, 419–426.
5. Kessing, L.V. Hansen, H.V. Hvenegaard, A. Christensen, E.M. Dam, H. Gluud, C. Wetterslev, J. (2013) Early Intervention Affective Disorders (EIA) Trial Group. Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial. *British Journal of Psychiatry*, 202, 212–219.
6. National Collaborating Centre for Mental Health (2014) Bipolar Disorder: the management and assessment of bipolar disorder in adults, children and young people in primary and secondary care. (NICE Clinical Guideline 185). National Institute for Health and Clinical Excellence.
7. Morriss, R. Faizal, M.A. Jones, A.P. Williamson, P.R. Bolton, C.A. McCarthy, J.P. (2007) Interventions for helping people recognize early signs of recurrence in bipolar disorder. *Cochrane Database of Systematic Reviews* 2007, Issue 1. Art. No.: CD004854. DOI: 10.1002/14651858.CD004854.pub2.
8. Smith, D.J. Griffiths, E. Poole, R. di Florio, A. Barnes, E. Kelly, M.J. Craddock, N. Hood, K. Simpson, S. (2011) Beating Bipolar: exploratory trial of a novel internet-based psycho-educational treatment for bipolar disorder. *Bipolar Disorders*, 13: 571–577. doi: 10.1111/j.1399-5618.2011.00949.x
9. Poole R. Simpson S.A. Smith D.J. (2012) Internet-based psycho-education for bipolar disorder: a qualitative analysis of feasibility, acceptability and impact. *BMC Psychiatry*, 12:139. doi: 10.1186/1471-244X-12-139.
10. Torrent, C. Martinez-Aran, A. del Mar, B.C. Reinares, M. Daban, C. Sole, B. Rosa, A.R. Tabares-Seisdedos, R. Popovic, D. Salamaro, M. & Vieta, E. (2012) Long-term outcomes of cognitive impairment in bipolar disorder. *Journal of Clinical Psychiatry*, 73, e899–e905.

Body Dysmorphic Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate/Severe	All	Low	Group CBT	B ³
			Exposure response prevention (ERP)	B ⁴
			Disorder specific CBT	B ⁵
			Eye movement desensitisation and reprocessing (EMDR)	C ¹

Some dissatisfaction with one's body is a common phenomenon and therefore would not necessarily be expected to come to the attention of mental health services. It is only when the degree of distress caused by this is significant and it begins to impact on an individual's functioning that it might warrant NHS treatment. As such, services are only likely to see individuals who are moderate/severe in presentation. The evidence base that exists does not distinguish between these levels of severity.

Evidence base

CBT has been tested within RCTs (e.g., 5). The group CBT (3) was tested against waiting list and was conducted in small groups for eight two-hour sessions. 82% of trial participants no longer met diagnostic criteria by end of treatment and 77% at follow up; the study sample was of women. Individual CBT was tested (5), albeit with a small sample of only 19 individuals; a 50% reduction in symptoms on the Yale-Brown obsessive compulsive scale (Y-BOCS) was achieved.

Behavioural Therapy (BT) in the form of ERP has been tested, albeit only in small trials, most of which were uncontrolled (4). Suggestions that it could be effective were supported by significant outcomes, which were maintained in those who participated in a maintenance programme.

A number of case studies have also been published. EMDR recommendation is based on a case series in which six of seven individuals experienced significant improvement and five maintained this over time (1). In general, the studies appear to indicate that psychotherapy has an improved effect when compared with trials of medication alone (2, 6).

References

1. Brown, K.W. McGoldrick, T. & Buchanan, R. (1997) Body Dysmorphic Disorder: Seven Cases Treated with EMDR. *Behavioural and Cognitive Psychotherapy*, 25, 203-207.
2. Ipser, J.C. Sander, C. & Stein, D.J. (2009) Pharmacotherapy and psychotherapy for body dysmorphic disorder. (Review). *The Cochrane Library*. 1, 1-17.
3. Rosen, J.C. Reiter, J. & Orosan, P. (1995) Cognitive-Behavioural Body Image Therapy for Body Dysmorphic Disorder. *Journal of Consulting and Clinical Psychology*, 63, 263-269.
4. McKay, D. Todaro, J. Neziroglu, F. Campisi, T. Moritz, E.K. & Yaryura-Tobias, J.A. (1997) Body Dysmorphic Disorder: a preliminary evaluation of treatment and maintenance using exposure with response prevention. *Behaviour, Research and Therapy*, 35, 67-70.
5. Veale, D. Gournay, K. Dryden, W. Boockock, A. Shah, F. Willson, R. & Walburn, J. (1996) Body Dysmorphic Disorder: A Cognitive Behavioural model and pilot randomised controlled trial. *Behaviour, Research and Therapy*, 34, 717-729.
6. Williams, J. Hadjistavropoulos, T. & Sharpe, D. (2006) A meta-analysis of psychological and pharmacological treatment for body dysmorphic disorder. *Behaviour, Research and Therapy*, 44, 99-111.

Borderline Personality Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Severe	Secondary care or specialist outpatient	High	Dialectical behaviour therapy (DBT) Schema-focused CBT Systems training for emotional predictability and problem-solving (STEPPS) Transference-focused psychotherapy CBT for personality disorders individual therapy (30 sessions over one year) Cognitive analytic therapy (CAT)	A ^{1,2} A ^{1,2} A ^{1,2} A ^{1,2} A ⁴ B ³ – One RCT for a less severely affected group with minimal/low self-harm.
	Secondary/Specialist partial day hospital	High	Mentalisation based day hospital	A ^{1,2}

References

1. National Institute of Health and Clinical Excellence (NICE; 2009) Treatment and Management of Borderline Personality Disorder. (CG78) London: National Institute of Health and Clinical Excellence.
2. Stoffers, J.M., Völlm, B.A., Rücker, G., Timmer, A., Huband, N. & Lieb, K. (2012) Psychological Therapies for People with BPD, The Cochrane Library, 2012, Issue 12.
3. Clarke, S. Thomas, P. & James, K. (2013) Cognitive-analytic therapy for personality disorder: randomized controlled trial. *British Journal of Psychiatry*, 202, 129-134.
4. Davidson, K., Norrie, J., Tyrer, P., Gumley, A. Tata, P., Murray, H. & Palmer, S. (2006) The effectiveness of cognitive behaviour therapy for borderline personality disorder: results from the borderline personality disorder study of cognitive therapy (BOSCOT) trial. *Journal of Personality Disorder* 20, 450–465
5. Ioana, A. Cristea, PhD; Claudio Gentili, M.D. PhD; Carmen D. Cotet, PhD; Daniela Palomba, MD; Corrado Barbui, MD; Pim Cuijpers, PhD. 2017, Efficacy of Psychotherapies for Borderline Personality Disorder, A Systematic Review and Meta-analysis. *JAMA Psychiatry*.

Depression (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild-Moderate	Primary care	Low	Computerised CBT (CCBT) within the context of guided self-help	A
			Guided self-help based on CBT behaviour principles	A ^{30,31,32}
			Multi modal CBT	A ³³
		High	Behavioural activation (BA)	A ^{1,2}
			CBT	A ^{7**, 8*, 15*, 17}
			Interpersonal psychotherapy (IPT)	A ^{3, 8*, 15*, 16, 17}
			Problem-solving therapy	A ^{8*, 15*, 17}
			Brief psychodynamic therapy	A ¹³
			Nondirective supportive therapies/person-centred counselling	A ^{5, 6, 8*, 9, 10}
			Couples therapy	A ^{20, 21}
			Interpersonal counselling	B ^{18***}
		High	Art therapy	C ²⁴
Severe (non-chronic)	Secondary care	High	CBT	A ¹⁹

Treatment-resistant depression (lack of response after six weeks on standard antidepressant medication)	Primary care	High	CBT	A ^{12,12a}
Chronic (>2yrs) major depression	Secondary care	High	Psychological therapies (in general) + antidepressant medication Music therapy	B ⁴ C ^{28,29}
Prevention of relapse in recurrent depression	Primary/Secondary care	High	Mindfulness-based cognitive therapy (MBCT)	A ¹⁴ , 22**** ²⁷

* Statistically significant effect, but effect size [ES] is small

** ES=0.71, but lower in higher quality studies (0.53) than in lower quality studies (0.90)

*** Advantage for IPC was clearest for first episode, less severely depressed patients

**** But almost half in either condition relapsed in two year follow-up

Therapies which have been specifically developed to treat depression, such as CBT (D), IPT and BA are all clearly and about equally efficacious, but the effect sizes are not large. Using methods of delivery, other than face-to-face individual therapy, appears to be no less effective in delivering CBT within primary care settings (15).

Less condition-specific therapies, such as problem-solving therapy, nondirective supportive therapies/person-centred counselling and brief psychodynamic therapy appear to have some efficacy. MBCT has some efficacy in the prevention of relapse in recurrent depression, but the most recent study shows less positive results (27). In treating chronic depression and "treatment-resistant" depression, psychological therapies may have some additional benefit to medication. However, "treatment-resistant depression" is itself a protean concept (26). It is unclear whether psychological therapies are efficacious in the treatment of dysthymia. In treating severe, but non-chronic depression, CBT enhances recovery rates as compared with antidepressant medication alone (19), but Axis II co-morbidity, which was present in half of the participants and is typical of patients in secondary care services, resulted in much lower recovery rates in both conditions.

In considering factors associated with outcome, there is some evidence that higher initial depression severity, early improvement in therapy and completing therapy as intended all predict better outcomes, while a personality disorder and negative expectations for treatment predict poorer response (23). It seems possible that more frequent sessions early on, plus positive preparation for therapy, will enhance outcomes.

Cochrane Reviews are currently in development for the psychological treatment of depression and it is recommended that these are consulted when they become available.

References

1. Ekers, D., Richards, D. & Gilbody, S.D. (2007) A meta-analysis of randomized trials of behavioural treatment of depression. *Psychological Medicine*, 38, 611-623.
2. Cuijpers, P., van Straten, A. & Warmerdam, L. (2007) Behavioural activation treatments of depression: a meta-analysis. *Clinical Psychology Review*, 27, 318-326.
3. Cuijpers, P. et al (2011) Interpersonal Psychotherapy for Depression: a meta-analysis. *American Journal of Psychiatry*, 168, 581-592.
4. Cuijpers, P. et al (2010) Psychotherapy for chronic major depression and dysthymia: a meta-analysis. *Clinical Psychology Review*, 30, 51-62.
5. King, M, Marston, L. & Bower, P. (2014) Comparison of non-directive counselling and cognitive- behavioural therapy for patients presenting in general practice with an ICD10 diagnosis of depressive episode: a randomized controlled trial. *Psychological Medicine*, 44, 1835-1844.
6. Cuijpers, P. et al (2012) The efficacy of non-directive supportive therapy for adult depression: a meta-analysis. *Clinical Psychology Review*, 32(4), 280-291.
7. Cuijpers, P. et al (2013) A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Canadian Journal of Psychiatry*, 58(7), 376-385.
8. Cape, J. et al (2010) Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *BMC medicine*, 8(1), 38.
[Brief versions of CBT, NDST/counselling and PST were all found to be effective in primary care of depressed patients, but the effect sizes were all small and smaller than in lengthier versions of these treatments.]
9. Cuijpers, P. et al (2008) Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology*, 76(6), 909.
Very little difference between various PTs in treating mild-moderate depression in adults. IPT appeared to be most efficacious, NDST least

efficacious and CBT had highest drop-out rates, but the authors caution against drawing sweeping conclusions from their analysis.

10. Braun, SR., Gregor, B. & Traun, U.S. (2012) Comparing Bona Fide Psychotherapies of Depression in Adults with two meta-analytical approaches. *PLoS ONE* 8(6), e68135. doi: 10.1371/journal.pone.0068135
Little evidence of differential overall efficacy between CBT, IPT, BA or DYN, but all were superior to NDST.
11. Cuijpers, P. et al (2010) The effects of psychotherapy for adult depression are overestimated: a meta-analysis of study quality and effect size. *Psychological Medicine*, 40(02), 211-223.
Few studies met rigorous quality standards. These studies produced only a small effect size (ES) while poorer quality studies had larger ES. Suggests that literature has over-estimated benefits of PT for depression. The number needed to treat [NNT] in the better quality studies is 8, compared with 2 in the lower-quality studies.
12. Wiles, N. et al (2013) Cognitive behavioural therapy as an adjunct to pharmacotherapy for primary care based patients with treatment resistant depression: results of the CoBaIT randomised controlled trial. *The Lancet*, 381(9864), 375-384.
- 12a. Wiles, N.J. et al (2016) Long-term effectiveness and cost-effectiveness of Cognitive Behavioural Therapy as an adjunct to pharmacotherapy for treatment-resistant depression in primary care: follow-up of the CoBaIT randomized controlled trial. *Lancet Psychiatry*, 3, 137-144.
13. Leichsenring, F. (2001) Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: a meta-analytic review. *Clinical Psychology Review*, 21, 401-419.
14. Piet, J. & Hougaard, E. (2011) The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: a systematic review and meta-analysis. *Clinical Psychology Review*, 31, 1032-1040.
15. Linde, K. et al (2015) Efficacy and acceptability of pharmacological treatments for depressive disorders in primary care: Systematic review and network meta-analysis. *The Annals of Family Medicine*, 13(1), 69-79.
16. van Hees, ML. et al (2013) The effectiveness of individual interpersonal psychotherapy as a treatment for major depressive disorder in adult outpatients: a systematic review. *BMC Psychiatry*, 13(1), 22.
17. Barth, J. et al (2013) Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *PLOS Medicine*, 10, 1-17.
18. Menchetti, M. et al (2014) Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomised controlled trial. *The British Journal of Psychiatry*, 204(2), 144-150.
19. Hollon, S.D. 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*, 71(10), 1157-1164.
20. Leff, J. et al (2000) The London Depression Intervention Trial Randomised controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: clinical outcome and costs. *The British Journal of Psychiatry*, 177(2), 95-100.
 21. Barbato, A. & D'Aranzo, B. (2008) Efficacy of Couple Therapy as a Treatment for Depression: a Meta-Analysis. *Psychiatric Quarterly*, 79, 121-132. Based on the Cochrane review by the authors, this paper concludes that there is only poor quality evidence on the efficacy of Couple Therapy and recommend it only for use with mild-moderate depression where there is clearly "relationship distress".
 22. Kuyken, W. et al (2015) Effectiveness and cost-effectiveness of mindfulness-based cognitive therapy compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (PREVENT): a randomised controlled trial. *The Lancet*.
 23. Schindler, A., Hiller, W. & Witthöft, M. (2013) What predicts outcome, response, and drop-out in CBT of depressive adults? A naturalistic study. *Behavioural and Cognitive Psychotherapy*, 41(03), 365-370.
 24. Uttley L. et al (2015) Systematic review and economic modeling of the clinical effectiveness and cost-effectiveness of art therapy among people with non-psychotic mental health disorders. *Health Technology Assessment* 19(18).
 25. Littlewood E. et al (2015) A randomized controlled trial of computerised cognitive behaviour therapy for the treatment of depression in primary care: the Randomized Evaluation of the Effectiveness and Acceptability of Computerised Therapy (REEACT) trial. *Health Technology Assessment*, 19(101)
 26. Malhi, G.S. & Byrow, Y. (2016) Is treatment-resistant depression a useful concept? *Evidence Based Mental Health* 19, 1-3.
 27. Huijbers, M.J. et al (2016) Discontinuation of antidepressant medication after mindfulness-based cognitive therapy for recurrent depression: randomised controlled non-inferiority trial. *British Journal of Psychiatry* bjp.bp.115.168971.
 28. Maratos, A. et al (2008) Music Therapy for Depression. *Cochrane Database of Systematic Reviews*, 2008, 1.
 29. Erkkila, J. et al (2011) Individual Music Therapy for Depression: Randomised Controlled Trial. *British Journal of Psychiatry*, 199, 132-139.
 30. Scottish Intercollegiate Guidelines Network (SIGN) Non-pharmaceutical management of depression. Edinburgh: SIGN; 2010.(SIGN publication no. 114)[cited 10 June 2010]
 31. Gellatly, J., Bower, P., Hennessy, S., Richards, D., Gilbody, S., Lovell, K. What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. [References]. *Psychological Medicine*. 2007; 37(9):1217-28.
 32. National Institute for Health and Clinical Excellence. Depression: The treatment and management of depression in adults. NICE: 2009. Available from url: <http://guidance.nice.org.uk/CG90/NICEGuidance/doc/English>.

33. de Mello, M,F., de Jesus Mari, J., Bacaltchuk J., Verdeli, H. & Neugebauer, R. A. systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. European Archives of Psychiatry & Clinical Neuroscience 2005; 255(2):75-82.

Eating Disorders

Anorexia Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	<p>Advice about the help and support available such as self-help groups and internet resources</p> <p>Medication should not be used as the sole or primary treatment for anorexia nervosa</p>	<p>C³¹</p> <p>C^{30,34}</p>
Mild - Moderate	Secondary care/Specialist eating disorders services	High	CBT-enhanced (CBT-E)	A ^{11,14,15}
Moderate - Severe	Secondary care/Specialist eating disorders services	High	<p>Family interventions</p> <p>Choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas. These may include: CBT, IPT, psychodynamic therapy, CAT and motivational enhancement therapy (MET).</p>	<p>A^{8,10,19,20,21,27,32,37}</p> <p>C^{30,31}</p>

Binge Eating Disorder (2017)

Binge Eating Disorder (BED) is a disorder in which individuals engage in uncontrollable episodes of binge eating but do not use compensatory behaviours (National Institute for Health and Care Excellence)³⁰.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Subclinical/Mild	Primary care	Low	Evidence-based self-help programme	A ^{6,9,30,35,38}
			Guided self-help	A ^{3,29,33}
			Internet based guided self-help	A ^{112,13}
Moderate - Severe	Secondary care	Low	Guided CBT self-help	A ^{3,29,33}
			Internet based guided self-help	A ^{112,13}
		High	CBT for binge eating disorder (CBT-BED)	A ^{17,21,30}
			Cognitive behavioural therapy-enhanced (CBT-E)	A ^{11,14,15}
			IPT	A ³⁰

Bulimia Nervosa (2021)

Bulimia in Children and Adults – July 2021

Bulimia is a severe form of eating disorder that can result in serious medical morbidity and a range of psychosocial comorbidities^{1,2}. The impact of living with and caring for an individual who has bulimia can also be severe. For many people who have bulimia, the long-term course of the condition is chronic, with less than half of people with bulimia who seek treatment achieving full recovery^{3,4}. Research indicates that the higher the frequency of binge eating and purging behaviours, the poorer the prognosis for recovery^{5,6}. The prevalence of bulimia among women is 0.5% and 0.1% among men⁸.

There are many forms of behavioural presentations of bulimia. The condition is characterised by cycling patterns of restriction of food intake, followed by uncontrolled and distressing episodes of binge eating, followed by purging behaviours. Purging behaviours can include a range of compensatory behaviours, including voluntarily vomiting, use of laxatives and excessive exercise, or a combination of these behaviours by the same individual. There is also increasing awareness in clinical services, accompanied by increased need to provide appropriate care and treatment for individuals with Type 1 diabetes who restrict their insulin intake as a method of managing their weight. Detailed screening and assessment are therefore required in order to obtain an accurate profile of how each person is experiencing bulimia as presentations vary extensively. Sensitive and supportive assessment is crucial. Early intervention has been shown to improve outcomes and reduce the cost of treatment for bulimia⁸. The review of services for people with eating disorders by Welsh Government in 2018⁹ included a recommendation that treatment for eating disorders should begin within four weeks of referral and within one week in urgent cases. All treatment for bulimia should be undertaken alongside clinically appropriate monitoring of the person's physical health where the severity of their condition warrants this.

Treatment for Children and Young People

There are two forms of therapy that are consistently reported to be effective in the treatment of bulimia with high efficacy among children and young people. These are family-based treatments¹⁰ and models of CBT¹¹ that are specifically tailored to address bulimia. The evidence indicates that these approaches are equally effective in the long-term for children and young people who have bulimia¹². However, if there is a high level of conflict within the family, then a family-based approach is less likely to be helpful and in such circumstances, CBT is more effective¹³. There are a range of other therapies that are supported by evidence for their effectiveness, though less extensively than with family-based treatment and CBT. Dialectical behavioural therapy¹⁴ is supported by a limited amount of evidence for its effectiveness for bulimia, though no direct RCT has as yet been undertaken with children and young people with bulimia. Similarly, emotion-focused family therapy is supported by case reviews but has not yet been studied in a controlled manner. Psychodynamic therapy¹⁵ is supported for use with this population by evidence from a single RCT. These latter three therapies are therefore recommended in circumstances where family-based treatment and CBT are considered by the clinician to not be appropriate for the child or young person, are declined or they prove not to be effective.

Children and young people are often ambivalent about engaging in psychological treatment for bulimia and attempting therapeutic change. Clinicians should therefore assess, monitor and seek to improve motivation, where necessary, throughout the treatment process. Whereas evidence exists to support the delivery of motivation-focused therapy for adults with bulimia, evidence is not available for the delivery of such therapy with children and young people at this stage. It is important that the child and the family are fully supported throughout the process by eating disorders specialist staff and therefore, when a child is engaged in one-to-one therapy, their family should receive concurrent direct support from the eating disorders team¹⁶. Moreover, children and young people and their families should have access to peer support when needed¹⁷, which could be available through NHS Wales services or third sector organisations.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy
All levels	Parts 1 & 2	High	Family-based treatment for bulimia	A ^{18,19,20,21,22}	High
All levels	Parts 1 & 2	High	A form of CBT that is specific to eating disorders (e.g., CBT-E etc.)	A ²²	High
If the above therapies are considered by the clinician to not be appropriate for the service user, are declined or they prove not to be effective, then the following therapies should be considered:					
All levels	Parts 1 & 2	High	Psychodynamic therapy	B ¹⁵	High
All levels	Parts 1 & 2	High	Emotion-focused family therapy	C ²³	Undocumented
All levels	Parts 1 & 2	High	Dialectical behavioural therapy-informed	D ²²	Undocumented

Treatment for Adults

A range of therapies have consistent support from the literature as being highly effective in addressing bulimia among adults. These are guided self-help (based on CBT specific to bulimia)^{24,25,26,27} models of CBT, specifically tailored to addressing bulimia^{24,25,26,28,29,30,31,32,33,34,35,36} and interpersonal psychotherapy^{24,31,37,38}. Interpersonal psychotherapy should be available to service users, particularly where the condition is assessed to be a maladaptive interpersonal coping strategy as part of a psychological formulation. As the literature on the effectiveness of family-based treatment for bulimia that has been previously cited extends to late adolescence, this therapy approach is included as a recommendation for adult services to make available for the young adults on their caseloads. This is particularly relevant when they are transitioning from children's services and have successfully engaged with that treatment approach under children's services. In addition, virtual-reality based cue exposure intervention is supported by RCT evidence as effective in addressing any residual episodes of binge eating at the conclusion of an episode of psychological therapy. In circumstances where these therapies are considered by the clinician not to be appropriate for the service user, are declined by the service user or prove not to be effective, then a range of other therapies can be considered. For instance, motivation-focused therapy is supported by a range of RCTs. Both integrated cognitive affective therapy and a mindfulness-based modified form of dialectical behavioural therapy are supported by evidence of high efficacy, though only from a small number of RCTs. Currently, compassion-focused therapy is supported by a series of case studies and an uncontrolled trial and psychodynamic therapy has a number of RCTs indicating its effectiveness, though estimates of its effectiveness is slightly less than that reported for CBT and interpersonal therapy.

Based on the evidence for the effectiveness of guided self-help for bulimia, services sometimes recommend self-help books based on a cognitive behavioural model. Whilst service users often value reading recommendations and report anecdotally that this has been beneficial, clinicians should be aware that there is little research into this unguided approach to self-help for bulimia. Service users should also have access to peer support based on emerging evidence of peer mentorship as an effective adjunctive intervention³⁹ for people with bulimia. Such peer support could be available through NHS Wales services or third sector organisations.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy
All levels	Parts 1 & 2	Low	Guided self-help based on a form of CBT that is specific to bulimia	A ^{24,25,26,27}	High
All levels	Parts 1 & 2	High	A form of CBT that is specific to bulimia (e.g., CBT-E; CBT-T etc.)	A ^{24,25,26,28,29,30,31,32,33,34,35,36,40,41}	High
All levels	Parts 1 & 2	High	Interpersonal psychotherapy	A ^{24,31,37,38}	High
All levels	Parts 1 & 2	High	Family-based treatment ¹⁰	A ^{18,19,20,21,22}	High
All levels	Parts 1 & 2	High	Virtual-reality based cue exposure for residual symptoms following completion of other form of psychological therapy	B ^{42,43}	High
If the above therapies are considered by the clinician to not be appropriate for the service user, are declined or they prove not to be effective, then the following therapies should be considered:					
All levels	Parts 1 & 2	High	Motivation-focused therapy	B ^{44,45,46}	High
All levels	Parts 1 & 2	High	Integrated cognitive affective therapy	B ⁴⁷	High
All levels	Parts 1 & 2	High	Mindfulness-based dialectical behavioural therapy	A ¹⁴	High
All levels	Parts 1 & 2	High	Psychodynamic therapy	A ⁴⁸	Medium-High
All levels	Parts 1 & 2	High	Compassion-focused therapy	C ^{49,50}	Undocumented

Guidelines for Specific Service User Groups

There are a number of issues relating to comorbidities that need to be considered in the delivery of psychological therapies for bulimia, as follows:

- For service users who have comorbid affective or personality disorders, more frequent sessions or a longer duration of therapy may need to be considered⁵¹
- For service users who are undertaking a form of CBT that is tailored to addressing bulimia and who experience difficulties with mood intolerance, clinical perfectionism, low self-esteem or interpersonal difficulties, modules that directly address these issues should be incorporated into the therapy. However, these additional modules should not be included for service users who do not experience these difficulties, as evidence indicates that this would reduce the effectiveness of the therapy in such cases^{52,53}
- A clinician who is delivering psychological therapy to a service user who has bulimia and diabetes should liaise with their local diabetes service to seek consultation on the delivery of the therapy
- For service users who have complex issues relating to a history of trauma, psychological therapy should be delivered by clinicians who are trained and experienced in working with trauma issues
- Service users who have comorbid mental health issues should have access to psychological therapy to address those comorbid issues, unless research indicates that therapy for that condition should not be delivered if the service user has comorbid bulimia.

When working with service users from black and minority ethnic communities, consideration should be given to including their family members in any psychological therapy that is being undertaken^{54,55,56,57,58}. Clinicians delivering psychological therapies may also need to consider making adaptations to the treatment that take account of any relevant cultural and/or religious practices that relate to food and/or eating patterns. There is no evidence available regarding the effectiveness of the various psychological therapies cited in these recommendations for males, older adults or adults with learning disabilities, or whether the effectiveness of the therapies is influenced by sexual orientation or gender identity.

Guidelines for the Delivery of Psychological Therapies

Delivery of the psychological therapies outlined in these recommendations needs to take account of the following principles:

- CBT based guided self-help can be delivered effectively online^{59,60,61,62,63,64,65,66,67,68} and so could be made available in this form as an alternative to guided self-help with direct clinician contact, though delivery with direct clinician contact needs to be also available
- CBT based guided self-help can be delivered by unqualified staff when in receipt of appropriate training and supervision
- Therapeutic maintenance and support delivered via an online maintenance programme, or by clinicians via email/text messaging can be considered following completion of an episode of psychological therapy^{69,70}
- Psychological therapies can be delivered either on an individual basis or in a group, provided that several individual therapy sessions are initially undertaken before the service user starts in the group^{45,71,72,73}. Family-based treatment for children and adolescents can be delivered to families separately or in multi-family group format^{74,75}
- Service users may require a series of different forms of psychological therapy in order to fully achieve recovery. The need and appropriateness of further psychological therapy should be considered at the conclusion of each episode
- Therapists should adhere to the particular model of psychological therapy that they are delivering as this maximises the effectiveness of the therapy^{76,77}
- All forms of psychological therapies recommended in these guidelines should be delivered by clinicians in specialist roles within specialist eating disorders teams, within an early intervention service model.

References

1. Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007) The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, 61(3), 348-358.
2. Swanson, S. A., Crow, S. J., Le Grange, D., Swendsen, J., & Merikangos, K. R. (2011) Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. *Archives of General Psychiatry*, 68(7), 714-723.
3. Castellini, G., Lo, S. C., Mannocci, E., Ravaldi, C., Rotella, C. M., Faravelli, C. et al. (2011) Diagnostic crossover and outcome predictors in eating disorders according to DSM-IV and DSM-V proposed criteria: a 6-year follow-up study. *Psychosomatic Medicine*, 73(3), 270-279.

4. Steinhausen, H. & Weber, S. (2009) The outcome of bulimia nervosa: findings from one-quarter century of research. *American Journal of Psychiatry*, 166(12), 1331-1341.
5. Bulik, C. M., Sullivan, P. F., Joyce, P. R., Carter, F. A. & McIntosh, V. V. (1998) Predictors of 1-year treatment outcome in bulimia nervosa. *Comprehensive Psychiatry*, 39(4), 206-214.
6. Turnbull, J. L. (1997) Predictors of outcome for two treatments for bulimia nervosa: short and long-term. *International Journal of Eating Disorders*, 21(1), 17-22.
7. Hudson, J., Hiripi, E., Harrison, G. Jr., & Kessler, R. (2007) The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, 3, 348-358.
8. Reas, D., Williamson, D., Corby, K., & Zucker, N. (2000) Duration of illness predicts outcome for bulimia nervosa: A long-term follow-up study. *International Journal of Eating Disorders*, 27, 428-434.
9. Welsh Government (2018) Eating Disorders Service Review.
10. Lock, J., le Grange, D., Agras, W., & Dare, C. (2001) Treatment manual for anorexia nervosa: A family-based approach. New York: Guildford Press.
11. Waller, G., Cordery, H., Corstophine, E. et al. (2007) Cognitive behavioural therapy for eating disorders: A comprehensive treatment guide. Cambridge: Cambridge University Press.
12. Schmidt, U., Lee, S., Beecham, J. et al. (2007) A randomized controlled trial of family therapy and cognitive behaviour therapy guided self-care for adolescents with bulimia nervosa and related disorders. *The American Journal of Psychiatry*, 164, 592-598.
13. Le Grange, D., Lock, J., Agras, W. et al. (2015) Randomized clinical trial of family-based treatment and cognitive-behavioural therapy for adolescent bulimia nervosa. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54, 886-894.
14. Masuda, A. & Hill, M. (2013) Mindfulness as therapy for disordered eating: A systematic review. *Neuropsychiatry*, 3, 433-447.
15. Stefani, A., Salzer, S., Reich, G. et al. (2017) Cognitive-behavioural and psychodynamic therapy in female adolescents with bulimia nervosa: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56, 329-335.
16. McMaster, R., Beale, B., Hillege, S. et al. (2004) The parent experience of eating disorders: Interactions with health professionals. *International Journal of Mental Health Nursing*, 13, 67-73.
17. Pasold, T., Boateng, B., & Portilla, M. (2010) The use of a parent support group in the outpatient treatment of children and adolescents with eating disorders. *The Journal of Treatment & Prevention*, 18, 318-332.

18. Couturier, J., Kimber, M., & Szatmari, P. (2013) Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders*, 46, 3-11.
19. Hamadi, L. & Holliday, J. (2020) Moderators and mediators of outcome in treatments for anorexia nervosa and bulimia nervosa in adolescents: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*, 53, 3-19.
20. Herpertz-Dahlmann, B. (2017) Treatment of eating disorders in child and adolescent psychiatry. *Current Opinion in Psychiatry*, 30, 438-445.
21. Lock, J. (2011) Evaluation of family treatment models for eating disorders. *Current Opinion in Psychiatry*, 24, 274-279.
22. Varchol, L. & Cooper, H. (2009) Psychotherapy approaches for adolescents with eating disorders. *Current Opinion in Pediatrics*, 21, 457-464.
23. Johnson, S. & Maddeaux, J. (1998) Emotionally focused family therapy for bulimia: Changing attachment patterns. *Psychotherapy*, 35, 238-247.
24. Ghaderi, A., Odeberg, J., Gustafsson, S. et al. (2018) Psychological, pharmacological, and combined treatments for binge eating disorder: a systematic review and meta-analysis. *PeerJ* 6:e5113; DOI 10.7717/peerj.5113.
25. Slade, E., Keeney, E., Mavranouzouli, I. et al. (2018) Treatments for bulimia nervosa: a network meta-analysis. *Psychological Medicine*, 48, 2629-2636.
26. Svaldi, J., Schmitz, F., Baur, J. et al. (2019) Efficacy of psychotherapies and pharmacotherapies for Bulimia nervosa. *Psychological Medicine*, 49, 898-910.
27. Yim, S. & Schmidt, U. (2019) Experiences of computer-based and conventional self-help interventions for eating disorders: A systematic review and meta-synthesis of qualitative research.
28. Costa, M. & Melnik, T. (2016) Effectiveness of psychosocial interventions in eating disorders: An overview of Cochrane systematic reviews. *Einstein*, 14, 235-277.
29. Grenon, R., Carlucci, S., Brugnera, A. et al. (2019) Psychotherapy for eating disorders: A meta-analysis of direct comparisons. *Psychotherapy research*, 29, 833-845.
30. Hay, P. (2013) A systematic review of evidence for psychological treatments in eating disorders. *International Journal of Eating Disorders*, 46, 462-469.
31. Hay, P., Bacaltchuk, J., Stefano, S. et al. (2009) Psychological treatments for bulimia nervosa and bingeing. *Cochrane Database of Systematic Reviews* (4) Article Number CD000562.
32. de Jong, M., Schoorl, M., & Hoek, H. (2018) Enhanced cognitive behavioural therapy for patients with eating disorders: a systematic review. *Current Opinion in Psychiatry*, 31, 436-444.

-
33. Linardon, J., Messer, M., Fuller-Tyszkiewicz, M. (2018) Meta-analysis of the effects of cognitive-behavioural therapy for binge-eating-type disorders on abstinence rates in nonrandomized effectiveness studies: Comparable outcomes to randomized, controlled trials? *International Journal of Eating Disorders*, 51, 1303-1311.
 34. Linardon, J., Wade, T., de la Piedad Garcia, X. et al. (2017) The efficacy of cognitive-behavioural therapy for eating disorders: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*, 85, 1080-1094.
 35. Shapiro, J., Berkman, N., Brownley, K. et al. (2007) Bulimia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*. 40, 321-336.
 36. Thompson-Brenner, H., Glass, S. & Westen, D. (2003) A multidimensional meta-analysis of psychotherapy for bulimia nervosa. *Clinical Psychology: Science & Practice*, 10, 269-287.
 37. Hilbert, A. & Brahler, E. (2012) Interpersonal psychotherapy for eating disorders: A systematic and practical review. *Verhaltenstherapie*, 22, 149-157.
 38. Miniati, M., Callari, A., Maglio, A. et al. (2018) Interpersonal psychotherapy for eating disorders: current perspectives. *Psychology Research & Behaviour Management*, 11, 353-369.
 39. Ranzenhofer, L., Wilhelmy, M., Hochschild, A. et al. (2020) Peer mentorship as an adjunct intervention for the treatment of eating disorders: A pilot randomized trial. *International Journal of Eating Disorders*, 53, 767-779.
 40. de Jong, M., Schoorl, M., & Hoek, H. (2018) Enhanced cognitive behavioural therapy for patients with eating disorders: A systematic review. *Current Opinion in Psychiatry*, 31, 436-444.
 41. Linardon, J., Wade, T., de la Piedad Garcia, et al. (2017) The efficacy of cognitive-behavioural therapy for eating disorders: A systematic review and meta-analysis. *Journal of Consulting & Clinical Psychology*, 85, 1080-1094.
 42. Ferrer-Garcia, M., Gutierrez-Maldonado, J., Pla-Sanjuanelo, J. et al. (2017) A randomised controlled comparison of second-level treatment approaches for treatment-resistant adults with bulimia nervosa and binge eating disorder: Assessing the benefits of virtual reality cue exposure therapy. *European Eating Disorders Review*, 25, 479-490.
 43. Ferrer-Garcia, M., Pla-Sanjuanelo, J., Dakanalis, A. et al. (2019) A randomized trial of virtual reality-based cue exposure second-level therapy and cognitive behaviour second-level therapy for bulimia nervosa and binge-eating disorder: Outcome at six-month followup. *Cyberpsychology, Behaviour, & Social Networking*, 22, 60-68.
 44. Hotzel, K., von Brachel, R., Schmidt, U. et al. (2014) An internet-based program to enhance motivation to change in females with symptoms of an eating disorder: A randomized controlled trial. *Psychological Medicine*, 44, 1947-1963.
-

-
45. Katzman, M., Bara-Carril, N., Rabe-Hesketh, S. et al. (2010) A randomized controlled two-stage trial in the treatment of bulimia nervosa, comparing CBT versus motivational enhancement in phase 1 followed by group versus individual CBT in phase 2. *Psychosomatic Medicine*, 72, 656-663.
 46. Vella-Zarb, R., Mills, J., Westra, H. et al. (2015) A randomized controlled trial of motivational interviewing and self-help versus psychoeducation and self-help for binge eating. *International Journal of Eating Disorders*, 48, 328-332.
 47. Wonderlich, S., Peterson, C., Crosby, R. et al. (2014) A randomized controlled comparison of integrative cognitive-affective therapy (ICAT) and enhanced cognitive-behavioural therapy (CBT-E) for bulimia nervosa. *Psychological Medicine*, 44, 2462-2463.
 48. De-Bacco, C., Marzola, E., Fassino, S. et al. (2017) Psychodynamic psychotherapies for feeding and eating disorders. *Minerva Psichiatrica*, 58, 162-180.
 49. Gale, C., Gilbert, P., Read, N. et al. (2014) An evaluation of the impact of introducing compassion focused therapy to a standard treatment programme for people with eating disorders. *Clinical Psychology & Psychotherapy*, 21, 1-12.
 50. Williams, M., Tsivos, Z., Brown, S. et al. (2017) Compassion-focussed therapy for bulimia nervosa and bulimic presentations: A preliminary case series. *Behaviour Change*, 34, 199-207.
 51. Tobin, D. (1995) Integrative psychotherapy for bulimic patients with comorbid personality disorders. *Journal of Psychotherapy Integration*, 5, 245-264.
 52. Fairburn, C., Cooper, Z., Doll, H. et al. (2009) Transdiagnostic cognitive-behavioural therapy for patients with eating disorders: A two-site trial with 60-week follow-up. *American Journal of Psychiatry*, 166, 311-319.
 53. Thompson-Brenner, H., Shingleton, R., Thompson, D. et al. (2016) Focused vs broad enhanced cognitive behavioural therapy for bulimia nervosa with comorbid borderline personality: A randomized controlled trial. *International Journal of Eating Disorders*, 49, 36-49.
 54. Binkley, J. & Koslofsky, S. (2017) Una familia unida: Cultural adaptation of family-based therapy for bulimia with a depressed Latina adolescent. *Clinical Case Studies*, 16, 25-41.
 55. Patmore, J., Meddaoui, B., & Feldman, H. (2019) Cultural considerations for treating Hispanic patients with eating disorders: A case study illustrating the effectiveness of CBT in reducing bulimia nervosa symptoms in a Latina patient. *Journal of Clinical Psychology*, 75, 2006-2021.
 56. Perez, M., Ohrt, T., & Hoek, H. (2016) Prevalence and treatment of eating disorders among Hispanics/Latino Americans in the United States. *Current Opinion in Psychiatry*, 29, 378-382.
 57. Reyes-Rodriguez, M., Watson, H., Barrio, C. et al. (2019) Family involvement in eating disorder treatment among Latinas. *Eating Disorders: The Journal of Treatment & Prevention*, 27, 205-229.
-

-
58. Shea, M., Cachelin, F., Gutierrez, G. et al. (2016) Mexican American women's perspectives on a culturally adapted cognitive-behavioural therapy guided self-help program for binge eating. *Psychological Services*, 13, 31-41.
 59. Aardoom, J., Dingemans, A., & van Furth, E. (2016) Web-based fully automated self-help with different levels of therapist support for individuals with eating disorder symptoms: A randomized controlled trial. *Journal of Medical Internet Research*, 18, e159.
 60. Fitzsimmons-Craft, E., Taylor, B., Graham, A. et al. (2020) Effectiveness of a digital cognitive behaviour therapy – guided self-help intervention for eating disorders in college women. *JAMA Network Open*, 3: e2015633. Doi:10.1001/jamanetworkopen.2020.15633.
 61. Haderlein, T. (2019) Efficacy of technology-based eating disorder treatment: A meta-analysis. *Current Psychology: A Journal of Diverse Perspectives on Diverse Psychological Issues*, DOI: <https://doi.org/10.1007/s12144-019-00448-x>.
 62. Hildebrandt, T., Michaelides, A., Mackinnon, D. et al. (2017) Randomized controlled trial comparing smartphone assisted versus traditional guided self-help for adults with binge eating. *International Journal of Eating Disorders*, 50, 1313-1322.
 63. Ter Huurne, E., de Haan, H., Postel, M. et al. (2015) Web-based cognitive behavioural therapy for female patients with eating disorders: Randomized controlled trial. *Journal of Medical Internet Research*, 17, e152.
 64. Ljotsson, B., Lundin, C., Mitsell, K. (2007) Remote treatment of bulimia nervosa and binge eating disorder: A randomized trial of Internet-assisted cognitive behavioural therapy. *Behaviour Research & Therapy*, 45, 649-661.
 65. Machado, P. & Rodrigues, T. (2019) Treatment delivery strategies for eating disorders. *Current Opinion in Psychiatry*, 32, 498-503.
 66. Schlegl, S., Bürger, C., Schmidt, L. et al. (2015) The potential of technology-based psychological interventions for anorexia and bulimia nervosa: A systematic review and recommendations for future research. *Journal of Medical Internet Research*, 17, e85.
 67. Wagner, G., Penelo, E., Wanner, C. et al. (2013) Internet-delivered cognitive-behavioural therapy v. conventional guided self-help for bulimia nervosa: Long-term evaluation of a randomised controlled trial. *The British Journal of Psychiatry*, 202, 135-141.
 68. Zerwas, S., Watson, H., Hotmeier, S. et al. (2016) CBT4BN: A randomized controlled trial of online chat and face-to-face group therapy for bulimia nervosa. *Psychotherapy & Psychosomatics*, 86, 47-53.
 69. Bauer, S., Okon, E., Meerman, R. et al. (2012) Technology-enhanced maintenance of treatment gains in eating disorders: Efficacy of an intervention delivered via text messaging. *Journal of Consulting & Clinical Psychology*, 80, 700-706.
 70. Jacobi, C., Beintner, I., Fittig, E. et al. (2017) Web-based aftercare for women with bulimia nervosa following inpatient treatment: Randomized controlled efficacy trial. *Journal of Medical Internet Research*, 19, e321.
-

-
71. Carter, R., Yanykulovitch-Levy, D., Wertheim, H., et al. (2016) Group cognitive behavioural treatment in female soldiers diagnosed with binge/purge eating disorders. *Eating Disorders: The Journal of Treatment & Prevention*, 24, 338-353.
 72. Telch, C., Agras, W., Rossiter, E., et al. (1990) Group cognitive-behavioural treatment for the nonpurging bulimic: An initial evaluation. *Journal of Consulting & Clinical Psychology*, 58, 629-635.
 73. Wilfley, D., Agras, W., Telch, C. et al. (1993) Group cognitive-behavioural therapy and group interpersonal psychotherapy for the nonpurging bulimic individual: A controlled comparison. *Journal of Consulting & Clinical Psychology*, 61, 296-305.
 74. Gelin, Z., Fuso, S., Hendrick, S. et al. (2015) The effects of a multiple family therapy on adolescents with eating disorders: An outcome study. *Family Process*, 54, 160-172.
 75. Stewart, C., Baudinet, J., Hall, R. et al. (2019) Multi-family therapy for bulimia nervosa in adolescence: A pilot study in a community eating disorder service. *Eating Disorders: The Journal of Treatment & Prevention*, 14, 1-17.
 76. Folke, S., Daniel, S., Gondan, M. et al. (2017) Therapist adherence is associated with outcome in cognitive-behavioural therapy for bulimia nervosa. *Psychotherapy*, 54, 195-200.
 77. Loeb, K., Wilson, G., Labouvie, E. et al. (2005) Therapeutic alliance and treatment adherence in two interventions for bulimia nervosa: A study of process and outcome. *Journal of Consulting & Clinical Psychology*, 73, 1097-1107.

Generalised Anxiety Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild (PSWQ<45)	Primary care	Low	Multi-Modal CBT Guided self-help Large group psychoeducation based on CBT principles	A ¹¹ B ^{2,4} B ¹⁰
Moderate – Severe (PSWQ 45-60)	Primary care/Secondary care	High	Disorder-specific CBT (8-16 sessions) Applied relaxation (8-16 sessions)	A ^{1,3,6,7} A ^{3,6}

The Penn State Worry Questionnaire (PSWQ, 8) assesses severity of generalised anxiety disorder (GAD) and the Work and Social Adjustment Scale (WSAS, 9) can help to assess the impact of GAD on functioning.

In treating GAD, both CBT and applied relaxation appear to be equally effective in the short-term, but two recent high-quality meta-analyses (3, 6) suggest that CBT is more effective in the longer term. The research also suggests that there may be better results from newer CBT therapies for GAD, including meta-cognitive therapy, intolerance of uncertainty therapy and acceptance-based behaviour therapy (5).

The mean number of CBT sessions is reported in one meta-analysis as 16 and in another as no more than 12 (3, 6). Another found no superior efficacy of 15 sessions over 9 sessions (4).

References

1. Ballenger, J. C., Davidson, J. R., Lecrubier, Y., Nutt, D. J., Borkovec, T. D., Rickels, K., ... & Wittchen, H. U. (2001) Consensus statement on generalized anxiety disorder from the International Consensus Group on Depression and Anxiety. *The Journal of Clinical Psychiatry*, 11, 53-8.
2. Bowman, D., Scogin, F., Floyd, M., Patton, E., & Gist, L. (1997) Efficacy of self-examination therapy in the treatment of generalized anxiety disorder. *Journal of Counselling Psychology*, 44, 267-273.
3. Cuijpers, P., Sibbrandij, M., Koole, S., Huibers, M., Berking, M., & Andersson, G. (2014) Psychological treatment of generalized anxiety disorder: A meta-analysis. *Clinical Psychology Review*, 34, 130-140.
4. Cuijpers, P., & Schuurmans, J. (2007) Self-help Interventions for Anxiety Disorders: An Overview. *Current Psychiatry Reports*, 9(4), 284-290.
5. Durham, R. C., Fisher, P. L., Dow, M. G., Sharp, D., Power, K. G., Swan, J. S., & Morton, R. V. (2004). Cognitive behaviour therapy for good and poor prognosis generalized anxiety disorder: A clinical effectiveness study. *Clinical Psychology & Psychotherapy*, 11(3), 145-157.
6. Hanrahan, F., Field, A., Jones, F., & Davey, G. (2103) A meta-analysis of cognitive therapy for worry in generalized anxiety disorder. *Clinical Psychology Review*, 33, 120-132.
7. Hunot, V., Churchill, R., Teixeira, V., & Silva de Lima., M. (2010) Cochrane Review: Psychological therapies for people with generalised anxiety disorder. Retrieved from: http://www.cochrane.org/CD001848/DEPRESSN_psychological-therapies-for-people-with-generalised-anxiety-disorder Accessed 13/05/15
8. Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990) Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, 28, 487-495.
9. Mundt, J. M., Marks, I. M., Shear, M. K., & Greist, J. M. (2002) The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *British Journal of Psychiatry*, 180, 461-464.
10. White, J. (1998) 'Stress control' large group therapy for generalised anxiety disorder: two year follow-up. *Behavioural and Cognitive Psychotherapy*, 26, 237-245.
11. Twomey C, O'Reilly G, Byrne M. Effectiveness of cognitive behavioural therapy for anxiety and depression in primary care: a metanalysis. *Family Practice* 2014; Sept 22.pii cmu060. (Review) PMID: 25248976

Health Anxiety (2017)

This condition is also known in DSM-V as illness anxiety disorder and was previously known as hypochondriasis.

This evidence table is not intended to apply to individuals experiencing somatic symptom disorder, or medically unexplained disorders such as chronic fatigue syndrome.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild (BAI = 10-18)	Primary	Low	Internet based CBT/mindfulness programme for health anxiety Behavioural stress management Bibliotherapy using CBT literature Disorder-specific, group-based CBT	A ⁴ A ⁷ B ¹ B ^{2,3}
Moderate (BAI = 19-29)	Primary	High	Exposure and response prevention (ERP) Disorder-specific individual CBT of 6-12 sessions	A ⁶ A ^{6,7,11,14,15,16}
Severe (BAI = 30+)	Primary/Secondary care	High	Disorder-specific individual CBT of 12-16 sessions Disorder-specific mindfulness based cognitive therapy group (MBCT)	A ^{13,16} A ^{8,10}

All the studies included were based on protocols designed specifically to target health anxiety as opposed to more generic treatment packages.

Mild

The Bibliotherapy trial (1) was small (40 participants) though was randomised, with a TAU control group. The information used was Understanding

Health Anxiety: A self-help guide for sufferers and their families written by Kuchemann and Sanders (1999). The self-help was not guided.

The group-based interventions were very small trials (2, 3), only one of which was randomised against a waiting list control. The interventions were variable in terms of content though both were based on CBT protocols.

The internet-based programme is based on one study (4) using a protocol designed by the research group based in Sweden. Though the title of the paper suggests it is aimed at 'severe health anxiety', we recommend caution as the cut-offs for health anxiety on specific measures are not clear and the sample group appear to be chronically affected (as opposed to severely affected). It was a guided programme including elements of internet contact between participants.

Behavioural stress management (BST) was considered by the Cochrane Review to be sufficiently different from CBT to be regarded as a separate form of treatment. It involves a form of systematic desensitisation using applied relaxation along with assertiveness, time management and worry control strategies. It gained a significant positive result in one study (7).

Moderate

A Cochrane Review in 2009 (5) was based on six studies considered acceptably rigorous in terms of design. Two studies compared cognition therapy (CT) v waiting list (6, 7), reporting that CT did significantly better than waiting list. Three studies looked at CBT vs other controls, also providing significant results. There are a number of other studies suggesting efficacy using CBT and it is clearly the most studied form of psychotherapy for use with health anxiety as discussed in a meta-analysis of CBT trials (16). One study looked at behavioural therapy [ERP] with significant outcomes. It was commented that generally candidates found the treatments acceptable.

Severe

The Cochrane Review also assessed any relationship between effect size within studies and the number of treatment sessions offered. It was found that increasing the treatment sessions to 16 resulted in a greater effect, so that it would appear sensible to recommend higher session numbers of CBT for those experiencing more severe problems.

MBCT has only recently been studied in terms of health anxiety. There has been one pilot study (10), a qualitative study and a randomised control study (8). The overall impression is that there appears to be a high rate of acceptability of the treatment, with lower dropout rates than in CBT studies. The randomised study looked at a chronically affected population, many of whom had received psychological treatments previously. As such, it may be that as with depressed mood, there is a suggestion that mindfulness-based CBT could be useful for a treatment resistant population.

Other interventions

One study (15) compared a short-term psychodynamic against CBT and waiting list. Those receiving CBT made significant gains, whilst the psychodynamic approach failed to do so.

Other aspects

Health anxiety is a phenomenon that straddles physical healthcare environments as well as mental health. As such, some studies (e.g., 12) have made attempts to look at treating health anxiety in physical healthcare environments. These demonstrate promise and further studies would be useful to expand on the flexibility of the interventions in terms of location, as well as the practitioners delivering the interventions in Wales.

References

1. Jones, F. (2002) The Role of Bibliotherapy in health anxiety: an experimental study. *British Journal of Community Nursing*, 7, 498-502.
2. Stern, R., & Fernandez, M. (1991) Group cognitive and behavioural treatment of hypochondriasis. *British Medical Journal*, 303, 1229-31.
3. Avia, M. D., Ruiz, M. A., Olivares, M. E., Crespo, M., Guisado, A. B., Sánchez, A., & Varela, A. (1996) The meaning of psychological symptoms: effectiveness of a group intervention with hypochondriacal patients. *Behaviour Research and Therapy*, 34(1), 23-31.
4. Hedman, E., Andersson, G., Ljottson, B., Ruck, C., Mortberg, E., Asmundson, J.G., & Lindefors, N. (2011) Internet-based cognitive behavioural therapy for severe health anxiety: randomised control trial. *British Journal of Psychiatry*, 198, 230-236.
5. Thomson, A. B., & Page, L. A. (2007) Psychotherapies for hypochondriasis. *Cochrane Database of Systematic Reviews*, 4, 1-43.
6. Visser, S., & Bouman T.K. (2001) The treatment of hypochondriasis: exposure plus response prevention vs cognitive therapy. *Behaviour Research and Therapy*, 39, 423-442.
7. Clark, D. M., Salkovskis, P., Hackmann, A., Wells, A., Fennell, M., Ludgate, J., Ahmad, S., Richards, H. C., & Gelder, M. (1998) Two psychological treatments for hypochondriasis. A randomised control trial. *British Journal of Psychiatry*, 173, 218-25.
8. McManus, F., Surawy, C., Muse, K., Vazquez-Montes, M., Williams, J. M. G. (2012) A randomised clinical trial of mindfulness-based cognitive therapy versus unrestricted services for health anxiety. *Journal of Consulting and Clinical Psychology*, 80, 817-828.
9. Nakao, M., Shinozaki, Y., Ahern, D. K., Barsky, A. J. (2011) Anxiety as a predictor of improvements in somatic symptoms and health anxiety associated with cognitive behavioural intervention in hypochondriasis. *Psychotherapy and Psychosomatics*. 80, 151-158.

10. Lovas, D. A., Barsky, A. J. (2010) Mindfulness based cognitive therapy for hypochondriasis, or severe health anxiety: A pilot study. *Journal of Anxiety Disorders*, 24, 931-935.
11. Barsky, A. J., & Ahern, D. K. (2004) Cognitive Behaviour Therapy for Hypochondriasis. A randomised control trial. *JAMA*. 291, 1464-1470.
12. Seivewright, H., Green, J., Salkovskis, P., Barrett, B., Nur, U., & Tyrer, P. (2008) Cognitive Behaviour Therapy for health anxiety in a genitourinary medicine clinic: randomised controlled trial. *British Journal of Psychiatry*. 193, 332-337.
13. Salkovskis, P. M., Warwick, H. M. C., Deale, A. C. (2003) Cognitive behavioural treatment for severe and persistent health anxiety. *Brief Treatment and Crisis Intervention*, 3, 353-367.
14. Warwick, H. M. C., Clark, D. M., Cobb, A. M., & Salkovskis, P. M. (1996) A controlled trial of cognitive behavioural treatment of hypochondriasis. *British Journal of Psychiatry*, 169, 189-195.
15. Sorenson, P., Birket-Smith, M., Wattar, U., Buemann, L., & Salkovskis, P. M. (2011) A randomised clinical trial of cognitive behavioural therapy versus short term psychodynamic psychotherapy versus no intervention for patients with hypochondriasis. *Psychological Medicine*, 41, 431-441.
16. Olatunji, B. O., Kauffman, B. Y., Meltzer, S., Davis, M. L., Smits, J. A. J., & Powers, M. B. (2014) Cognitive-Behavioural therapy for hypochondriasis/ health anxiety: A meta-analysis of treatment outcome and moderators. *Behaviour Research and Therapy*, 58, 65-74.

Non Psychotic Affective Disorders in the Perinatal Period (2017)

Maternal mental health problems during pregnancy and the postpartum present a major public health problem that requires urgent attention^{1,2}. Depressive and anxiety disorders are the most common mental health problems during pregnancy and the first postnatal year. A meta-analysis has estimated the prevalence of minor and major depression¹⁷ across the nine months of pregnancy at 18.4%³, with a 12.7% prevalence estimate for a clinical diagnosis of major depression. Similarly, a second meta-analysis has estimated the prevalence of depression during the first three postnatal months at 19.4%⁴, with a prevalence estimate of 7.1% for major depression. Less is known about the prevalence of perinatal anxiety disorders. Prevalence estimates for antenatal anxiety disorders range between 11.8% and 15.3%, whereas for postnatal anxiety disorders estimates range between 8% and 20.4%^{5,6,7,8,9,10,11}. The high comorbidity between perinatal depression and anxiety is well recognised and antenatal anxiety is a strong predictor of postnatal depression^{5,12}.

Psychological interventions for the treatment of perinatal mental health problems are strongly indicated², with such indications most pertinent in the perinatal context given the potential risks to foetal and infant development associated with psychotropic medication exposure^{2,13}. Yet the evidence base for psychological interventions for the treatment of perinatal mental health problems is underdeveloped and large RCTs are largely lacking in this area². The existing evidence base is focused on the prevention and treatment of postnatal depression. The systematic literature search that informed the

current evidence table did not identify any RCTs that specifically targeted perinatal anxiety disorders. Similarly, there are few large scale RCTs for the treatment of antenatal depression. In line with the most recent NICE guidance² for antenatal and postnatal mental health problems and in the absence of perinatal-specific psychological interventions for a particular presenting problem (e.g., obsessive compulsive disorder (OCD)), the reader is referred to the other disorder specific evidence tables specified in Matrics Cymru. The evidence table below does not cover interventions that specifically target either difficulties in the mother-infant relationship or in the infant's mental health and wellbeing. Please see the Scottish Matrix for Children and Young People (2014)¹⁴.

In line with the Scottish Matrix (2015)¹⁵ and NICE (2014)², psychological therapies for non-psychotic affective disorders during the perinatal period should:

- Be timely, with assessment offered within two weeks of referral and interventions offered within one month of assessment
- Be delivered by psychological therapists with an understanding of the unique nature of the perinatal context, the developmental needs of the infant and the impact that this can have on assessment and treatment
- Be delivered within a stepped care model of service delivery with high intensity interventions offered within two weeks, should a low intensity intervention not result in symptom reduction and/or an improvement in functioning
- Be delivered by psychological therapists with knowledge of the additional clinical features and risk factors associated with perinatal mental health problems
- Consider the service user's preference in terms of the type (e.g., CBT vs. IPT) of intervention and the mode and place of delivery (e.g., group vs. individual; home vs. clinical setting)
- Consider the need for additional perinatal mental health support (e.g., psychological interventions for difficulties in the mother-infant relationship)
- Consider the wider family context and the impact of perinatal mental health on the mother-infant and couple relationships.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild/Moderate	Primary care/Third sector	Low	<p>Guided self-help: Internet or booklet behavioural activation or CBT informed with telephone or face-to-face support for antenatal or postnatal depression</p> <p>Group delivered mindfulness intervention for antenatal anxiety and depression (8 weeks)</p>	<p>A^{16,17,18}</p> <p>C^{19,20}</p>
Prevention/Early intervention	Primary care/Third sector/ Specialist perinatal community mental health service	Low	<p>Individual or group delivered psychoeducational intervention to prevent postnatal depression</p> <p>Individual or group delivered IPT to prevent postnatal depression</p> <p>Individual or group delivered CBT to prevent postnatal depression</p> <p>Group delivered mindfulness-based CBT to prevent postnatal depression</p> <p>Antenatal hypnotherapy to improve postnatal psychological wellbeing</p> <p>Group delivered CBT for perinatal anxiety</p>	<p>A^{21,22,23}</p> <p>A^{21,23}</p> <p>A^{21,24,25}</p> <p>B²⁶</p> <p>C²⁷</p> <p>C²⁸</p>

Moderate/Severe	Secondary care/Specialist perinatal community mental health service	High	Individual CBT for postnatal depression	A ^{25,29}
			Individual or group delivered IPT for antenatal or postnatal depression	A ^{25,29}
			Individual CBT for antenatal depression	B ³⁰
			Individual CBT for postnatal OCD	C ³¹

- All the studies included psychological interventions designed specifically to target perinatal affective disorders and the parenthood context as opposed to more generic treatment packages
- For the systematic reviews and meta-analyses cited in the evidence table, it is important to hold in mind the following decisions and observations made during the review process. The systematic literature search identified a number of different systematic reviews and meta-analyses on the efficacy of psychological interventions in the perinatal context. Likely due to the paucity of individual treatment studies, these reviews typically pooled together a heterogeneous group of psychological interventions that vary in: (1) the individual study design (e.g., the inclusion of RCTs and non-RCTs in the same meta-analysis/review); (2) the level of severity of the presenting problems under-going treatment both within and across studies; (3) the 'intensity' of the intervention in terms of the number of sessions, the frequency of contact, the mode of delivery and the hours of face to face contact; (4) the content of the psychological interventions under scrutiny whereby there are wide-ranging definitions of CBT (e.g., studies with a primarily behavioural component are pooled together with studies that include both cognitive and behavioural components). Also, studies that integrate brief CBT techniques into routine clinical care delivered by non-mental health specialists are included with studies that evaluate a manualised group or individualised-formulation-driven treatment delivered by a specialist psychological therapist. Due to these constraints, only the higher quality systematic reviews that focus on RCTs or have conducted meta-analyses that take the aforementioned limitations into consideration were included in the evidence table.

References

1. Maternal Mental Health Alliance (MMHA) campaign. Maternal Mental Health is Everyone's Business: Supporting Women and their Families (2014).
2. NICE (2014) Antenatal and Postnatal Mental Health, Clinical Management and Service Guidance (CG192).
3. Gavin, N.I. et al. (2005) Perinatal Depression. A systematic review of prevalence and incidence. American Journal of Obstetrics and Gynaecologists, 106, 1071-1083.
4. Gaynes, B. N. et al. (2005) Perinatal depression: Prevalence, screening accuracy and screening outcomes. Rockville MD: Agency for Healthcare Research and Quality.
5. Heron J., et al. (2014) The course of anxiety and depression through pregnancy and the postpartum in a community sample, Journal of Affective Disorders, 80, 65-73.
6. Orr, S. et al. (2007) Maternal Prenatal Pregnancy-Related Anxiety and Spontaneous Preterm Birth in Baltimore, Maryland. Psychosomatic Medicine, 69, 566-570.
7. Ramchandani, P. G. et al. (2006) Early parental and child predictors of recurrent abdominal pain at school age: results of a large population-based study. Journal of the American Academy of Child and Adolescent Psychiatry, 45, 729-736.
8. Reck, C. et al. (2008) Prevalence, onset and comorbidity of postpartum anxiety and depressive disorders. Acta Psychiatrica Scandinavica, 118, 6, 459-468.
9. Vesga-López, O. et al. (2008) Psychiatric disorders in pregnant and postpartum women in the United States. Archive of General Psychiatry, 65, 805-815.
10. Austin M.P., et al. G. (2010) Depressive and anxiety disorders in the postpartum period: how prevalent are they and can we improve their detection? Archives of Women's Mental Health, 13, 395-401.
11. O'Donnell, K. J. et al. (2014) The persisting effect of maternal mood in pregnancy on childhood psychopathology. Development and Psychopathology, 26, 393-403.
12. Milgrom, J. et al. (2007) Antenatal risk factors for postnatal depression. A large prospective study. Journal of Affective Disorders, 108, 147-157.
13. Waters, C.S. et al. (2014) Antenatal Depression and Children's Developmental Outcomes: Potential Mechanisms and Treatment Options. European Child and Adolescent Psychiatry, 23, 957-971.

14. The Scottish Government (2014) The Matrix Evidence Tables, Children and Young People.
15. The Scottish Government (2014) The Matrix Evidence Tables, Adult Mental Health.
16. O'Mahen, H.A., et al. (2013) Internet-based behavioral activation-treatment for postnatal depression (Netmums): a randomized controlled trial. *Journal of Affective Disorders*, 150, 3, 814-822.
17. O'Mahen, H.A., et al. (2014) Netmums: a phase II randomized controlled trial of a guided Internet behavioural activation treatment for postpartum depression. *Psychological Medicine*, 44, 1675-1689.
18. Milgrom, J., et al. (2011) Towards Parenthood: An Antenatal Intervention to Reduce Depression, Anxiety and Parenting Difficulties. *Journal of Affective Disorders*, 130, 3, 385-394.
19. Vieten, C., & Astin, J. (2008) Effects of a mindfulness-based intervention during pregnancy on prenatal stress and mood: results of a pilot study. *Archives of Women's Mental Health*, 11, 67-74.
20. Dunn, C., et al. (2012) Mindful pregnancy and childbirth: effects of a mindfulness-based intervention on women's psychological distress and well-being in the perinatal period. *Archives of Women's Mental Health*, 15, 139-143.
21. Clatworthy, J. (2012) The effectiveness of antenatal interventions to prevent postnatal depression in high-risk women. *Journal of Affective Disorders*, 137, 25-34.
22. Sockell, L.E., Epperson, C.N., & Barber, J.P. (2011) A meta-analysis of treatments for perinatal depression. *Clinical Psychology Review*, 31, 839-849.
23. Dennis, C.L., & Dowswell, T. (2013) Psychosocial and psychological Interventions for the prevention of postnatal depression. *Cochrane Database of Systematic Reviews*, CD001134.
24. Sockel, L.E. (2015) A systematic review of the efficacy of cognitive behavioural therapy for treating and preventing perinatal depression. *Journal of Affective Disorders*, 177, 7-21.
25. O'Connor, E., et al. (2016) Primary care screening for, and treatment of, depression in pregnant and postpartum women. Evidence report and systematic review for the US preventive services task force. *JAMA*, 315, 388-406.
26. Dimidjian, S., et al. (2016) Staying well during pregnancy and the postpartum: A pilot randomised trial of mindfulness-based cognitive therapy for the prevention of depressive relapse/recurrence. *Journal of Consulting and Clinical Psychology*, 84, 134-145.
27. Guse, T., Wissing, M., & Hartman, W. (2006) The effect of a prenatal hypnotherapeutic programme on postnatal maternal psychological well-being. *Journal of Reproductive and Infant Psychology*, 24, 163-177.

-
28. Green, S.M., et al. (2015) Cognitive-behavioural group treatment for perinatal anxiety: a pilot study. *Archives of Women's Mental Health*, 18, 631-638.
 29. Dennis, C.L., & Hodnett, E. (2007) Psychosocial and psychological interventions for treating postpartum depression. *Cochrane Database of Systematic Reviews*, CD006116.
 30. Burns, A.J, et al. (2013) A pilot randomised controlled trial of Cognitive Behavioural Therapy for antenatal depression. *BMC Psychiatry*, 13, 33.
 31. Challacombe, F.L., & Salkovskis, P.M. (2011) Intensive cognitive-behavioural treatment for women with postnatal obsessive-compulsive disorder: A consecutive case series. *Behaviour Research and Therapy*, 49, 422-426. *Health Anxiety* (2017)

Obsessive Compulsive Disorder (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	Self-help	B ¹
			CCBT	B ^{2,4,5}
			Telephone intervention	B ³
		High	Group CBT	B ^{6,9}
			Group exposure response prevention (ERP)	B ⁷
Moderate	Secondary care	High	CBT (incl. ERP)	A ^{10,11,12}
			ERP	A ¹³
Severe	Secondary care	High	CBT/ERP	B ¹⁴
Chronic	Secondary care	High	CBT/ERP + antidepressant medication	B ^{15,16}
Treatment-resistant OCD	Secondary care	High	CBT - Intensive session protocol	C ¹⁷
Hoarding	Secondary care	High	Specialised CBT for hoarding	B ^{18,19}

Main findings

- CBT (incl. ERP) is effective in reducing OCD symptoms compared to treatment as usual¹⁰. However, effect sizes are generally lower at follow-up (=0.43) compared to post treatment (=1.39)¹¹ and drop outs for ERP can be as high as 40%
- Medication is also effective in treating OCD but there is evidence that ERP/CBT (alone) is more effective than medication (alone)^{6,13}
- The benefit of adding medication to CBT or ERP in the treatment of OCD has been shown in some studies^{15,14} but not in others¹³

- Adding anti-psychotics to an antidepressant can increase treatment gains in OCD, but this is still inferior to a combination of ERP and antidepressant¹⁶
- There is some evidence that higher doses of Citalopram, Fluoxetine and Paroxetine (antidepressants) may be more efficacious than lower doses in treating OCD¹⁴
- Group CBT/ERP has been shown to be both comparable⁹ and inferior⁸ to 1:1 therapy for OCD
- Some studies show CBT and/or ERP are more effective in OCD than CT¹⁰ but others find them equivalent¹²
- No evidence exists for the efficacy of psychoanalysis in the treatment of OCD and insufficient evidence is available to support the use of other psychological therapies, hypnosis, or homeopathy^{10,14}
- The efficacy of CBT/ERP is influenced by differences in baseline severity of OCD in some meta-analyses¹⁰, but not others¹¹
- There is some evidence for a positive relationship between increased number of hours of therapist input and reduced OCD symptomatology in some studies², but not in others¹¹. Training family members may also improve ERP outcomes
- There is some evidence that guided self-help, cCBT and telephone intervention are helpful, but more research is needed as studies have been small, methodologically flawed^{14,2} or not compared to ERP/CBT treatments that have proven efficacy^{3,4,5}
- There is some consensus that intensive 1:1 treatment may be useful for treating treatment resistant OCD, but more research is needed^{14,17}
- Relapse may occur after successful treatment so people should be re-referred as soon as possible, rather than placed on a routine waiting list¹⁴
- Hoarding appears to be distinct from OCD¹⁸ and may require CBT adapted for hoarding¹⁹.

Main conclusions: Guidelines

Some new studies have been conducted since both the NICE guidelines for OCD, 2005¹⁴ and the NICE Guidance Update for OCD, 2013 (e.g., 3, 4, 5, 16). However, overall recommendations remain largely the same:

- Adults with mild OCD should be offered self-help or group CBT/ERP in the first instance
- If poor response to above, people should be offered more intensive 1:1 CBT/ERP
- Adults with moderate OCD should be offered intensive CBT/ERP (more than 10 therapy hours) or an antidepressant

- Adults with severe OCD should be offered intensive CBT/ERP (more than 10 therapy hours) and an antidepressant.

Main conclusions: Research base

Few studies assess the relative effectiveness of CBT/ERP vs. medication; many studies allow for the concurrent use of psychotropic medication and most RCTs consist of small sample sizes with <30 participants per group¹⁰. This presents major confounds in assessing the relative and independent effectiveness of CBT/ERP. Thus, although there are some exceptions (e.g., 13), more research needs to be done in this area.

References

1. Mataix-Cols, D. and Marks, I. M. (2006) Self-help with minimalist therapist contact for obsessive-compulsive disorder: a review. *European Psychiatry*, 21, 75-80.
2. Lovell, K. and Bee, P. (2011) Optimising treatment resources for OCD: a review of the evidence base for technology-enhanced delivery. *Journal of Mental Health*, 20, 525-42.
3. Vogel, P. A., Solem, S., Hagen, K., Moen et al. (2014) A pilot randomized controlled trial of videoconference-assisted treatment for obsessive-compulsive disorder. *behaviour research and therapy*, 63, 162-168.
4. Mahoney, A.E.J., Mackenzie, A., Williams, A.D., Smith, J. and Andrews, G. (2014) Internet cognitive behavioural treatment for obsessive compulsive disorder: A randomised controlled trial, *Behaviour research and therapy*, 63, 99-106.
5. Herbst, N., Voderholzer U., Thiel N., Schaub R. et al. (2014) No talking, just writing! Efficacy of an internet-based cognitive behavioral therapy with exposure and response prevention in obsessive compulsive disorder. *Psychotherapy and psychosomatic*, 83.3, 165-175.
6. Sousa, M.B., Isolan, L.R., Oliveira, R.R., Manfro, G. et al. (2006) A randomized clinical trial of cognitive-behavioral group therapy and sertraline in the treatment of obsessive-compulsive disorder. *Journal of Clinical Psychiatry*, 67, 1133-9
7. McLean, P.D., Whittal, M.L., Thordarson, D.S., Taylor, S. et al. (2001) Cognitive versus behavior therapy in the group treatment of obsessive-compulsive disorder. *Journal Consulting and Clinical Psychology*, 69, 205-14.
8. Fisher, P. L. and Wells, A. (2005) How effective are cognitive and behavioral treatments for obsessive-compulsive disorder? A clinical significance analysis. *Behaviour Research and Therapy*, 43, 1543-1558.
9. Jónsson, H., Hougaard, E. and Bennedsen, B.E. (2011) Randomized comparative study of group versus individual cognitive behavioural therapy for obsessive compulsive disorder. *Acta Psychiatry Scandinavia*, 123, 387-97

10. Gava, I., Barbui, C., Aguglia, E., Carlino, D., et al. (2007) Psychological treatments versus treatment as usual for obsessive compulsive disorder (OCD). *Cochrane Database of Systematic Reviews*, 2, 2.
11. Olatunji, B. O., Davis, M. L., Powers, M. B., and Smits, J. A. (2013) Cognitive-behavioral therapy for obsessive-compulsive disorder: A meta-analysis of treatment outcome and moderators. *Journal of psychiatric research*, 47, 33-41.
12. Cottraux, J., Note, I., Yao, S.N., et al. (2001) A randomized controlled trial of cognitive therapy versus intensive behavior therapy in obsessive compulsive disorder. *Psychotherapy and Psychosomatics*, 70, 288-297.
13. Foa, E.B., Liebowitz, M.R., Kozak, M.J, Davies, et al. (2005) Randomized, Placebo-Controlled Trial of Exposure and Ritual Prevention, Clomipramine, and Their Combination in the Treatment of Obsessive-Compulsive Disorder, *American Journal of Psychiatry*, 162,151-161
14. National Institute for Health and Clinical Excellence (NICE; 2005) Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder.
15. Eddy, K. T., Dutra, L., Bradley, R., & Westen, D. (2004) A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive-compulsive disorder. *Clinical Psychology Review*, 24,1011-1030.
16. Simpson, H.B., Foa, E., Liebowitz, M., Huppert, et al. (2013) Cognitive-behavioral therapy vs risperidone for augmenting serotonin reuptake inhibitors in obsessive-compulsive disorder: a randomized clinical trial. *JAMA psychiatry*, 70.11, 1190-1199.
17. Oldfield, V.B., Salkovskis, P.M., and Taylor, T. (2011) Outcome of a time-intensive cognitive-behaviour therapy programme for obsessive-compulsive disorder and a matched comparison group. *British Journal of Clinical Psychology*, 50, 7-18.
18. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders. 5th edition. Washington, DC: American Psychiatric Publishing.
19. Steketee, G., Frost, R., Tolin, D., Rasmussen, J. and Brown, T. (2010) Waitlist-Controlled Trial of Cognitive Behavior Therapy for Hoarding Disorder, *Depression & Anxiety*, 27, 476-484.
20. Kozak, M.J., Leibowitz, M.R., and Foa, E.B. (2000) Cognitive behaviour therapy and pharmacotherapy for obsessive-compulsive disorder: the NIMH-sponsored collaborative study. In *Obsessive-Compulsive Disorder: Contemporary Issues in Treatment* (eds. W.K. Goodman, M.V. Rudorfer, & J.D. Maser), pp. 501-530. Mahwah, New Jersey: Lawrence Erlbaum Associates.
21. Veale, D., and Roberts, A. (2014) Obsessive-compulsive disorder. *British Medical Journal*, 348.
22. Thompson-Hollands, J., Abramovitch, A., Tompson, M. and Barlow, D. H. (2014) A Randomized Clinical Trial of a Brief Family Intervention to Reduce Accommodation in Obsessive-Compulsive Disorder: A Preliminary Study. *Behavior Therapy*. 56, 30-8.

Open Dialogue (2023)

Open Dialogue (OD) is a whole systems approach to providing interventions and organising services for people presenting with a first episode of psychosis or other mental health crisis. It involves continuity of care as a key organising principle, delivered through regular 'network meetings' with the service user, their key family or friends and a consistent group of mental health professionals. There is an explicit aim to provide an alternative to traditional models of mental health service provision, which can, for some people, exacerbate a sense of powerlessness about their care and to seek to reduce the risk of over-medicalising mental health problems. Seven key principles are widely agreed to define the model¹: (1) Immediate Help; (2) A Social Network Perspective; (3) Flexibility and Mobility; (4) Responsibility; (5) Psychological Continuity; (6) Tolerance of Uncertainty and (7) Providing a forum for change through Dialogue.

OD was initially developed and evaluated mainly in Finland and Western Lapland¹⁻³, subsequently the approach has been developed widely with published studies in other Scandinavian countries⁴, the United States (US)⁵⁻⁶ and Canada⁷. Most of the published literature has reported on the delivery of OD to young people with acute psychosis, in both primary and secondary care contexts and some recent adaptations have expanded this to people in a wider range of acute mental health crises, who are experiencing a significant impact on personal or social functioning. These published studies have involved considerable variation in both the implementation of and fidelity to the key principles. No randomised control trials (RCTs) have yet compared the effectiveness of OD in producing clinical or functional benefits with any alternative treatments. Most studies have involved non-experimental designs and only one has included a control group². Methodological issues include lack of randomisation, small samples, unblinded assessment of outcomes and retrospective diagnosis⁸. The evidence for clinical or functional benefits for adolescents and adults presenting with an acute episode of psychosis or a mental health crisis is summarised in the evidence table below.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy
Severe	Usually Part 2	High	Open Dialogue	C	Unknown

Evidence from non-randomised studies suggests that OD may help recovery from acute psychosis and lead to improved long-term outcomes³. Qualitative studies indicate that service users report positive experiences of OD, the benefits of openness and transparency within OD network meetings and more constructive relationships with mental health staff. There are interesting findings relating to how change occurs within open dialogue meetings, through valuing and tolerating uncertainty, improving trust and facilitating multiple perspectives within the network meetings⁹. Currently there are no published evaluations of OD applications in other mental health conditions, for older adults, or people with neurodiversity and or intellectual difficulties.

Given its systemic nature and the challenges of implementation in different health care cultures (discussed further below), OD will require evaluation in high quality studies in a UK NHS context to clarify its effectiveness. The ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness) research programme¹⁰, which is currently in progress, includes a multi-site, two-arm cluster randomised controlled trial to assess clinical and cost effectiveness in comparison with treatment as usual. The primary outcome is time to relapse after recovery, with secondary outcomes including service costs, user defined recovery, service user satisfaction and staff experience. It is expected to report in 2023.

In Wales, there are currently two implementation sites which have been successful in gaining transformational funding to train mental health professionals in OD. Evaluation of these programmes is currently ongoing.

Practical and systemic issues, barriers and challenges to adherence involved in the implementation of OD in the NHS mental health service context

OD is intended to be a radical alternative to established practice and some of its characteristics may make retaining integrity to the original model challenging to implement in traditional mental health settings. Some studies have reported a number of specific difficulties in achieving high quality implementation within an American context. These include:

- Culture: Implementation requires 'a shift of organisational culture' and can create resistance. Staff in New York City⁶ report finding that OD involved 'unlearning traditional understanding of mental health problems and adopting a clinical attitude that is dramatically different from traditional roles in mental health'. In Vermont⁷, some staff refused to participate in the collaborative network meetings.
- Consistency: The same practitioners work with a specific network through the episode of care across in-patient and out-patient settings. This directly conflicts with the structure of many conventional services and has been dropped in some implementations^{7,8}.
- Training: Teams are multidisciplinary and all practitioners should have undertaken substantial OD training. There are reports of difficulties in finding time for staff to be trained; receiving approval from managers to participate in the trainings and developing a curriculum that effectively teaches the core principles of this practice and provides the necessary clinical experience⁹.

To meet these challenges, organisational willingness and readiness need to be clearly present before OD implementation and careful consideration should be given to possible systemic obstacles which can threaten fidelity to the model, such as time pressures preventing access to adequate training and supervision for staff; rigidity in referral and allocation processes and traditional hierarchical structures.

Recommendations for practice-based evidence collection in Welsh implementation of OD. Core outcome measures and systemic considerations

OD operates as a relational, dialogical, whole systems approach and a way to organise services. Over and above symptom resolution for the patient, it aims for improvements in social functioning and in the relationships between people accessing support, professionals, families and social networks. These changes cannot all be captured through standard RCT methodologies and more comprehensive evaluation requires a range of research methods, including qualitative approaches⁸.

To evaluate the effectiveness of OD systems in helping individuals in crisis, it will be critical for practice-based evidence to evaluate broader outcomes beyond symptomatology and relapse, to include quality of life e.g., Manchester Short Assessment of Quality of Life (MANSA¹¹), user defined recovery e.g., the service user defined questionnaire about the Process of Recovery (QPR¹²), extent and quality of social networks and purposeful time use. Evaluation projects might helpfully reference the current "Outcome Measures Companion Guide"¹³ as devised by Improvement Cymru (2021) as a relevant and current framework for quality, person centred evaluation. It is recommended that future evaluations also make use of qualitative as well as quantitative data, with clear reference to practice and the experience of individuals, families and networks of support.

References

1. Seikkula, J. (1994) When the boundary opens: family and hospital in co-evolution. *Journal of Family Therapy*, 16, 401-414
2. Seikkula J, Alakare B, Aaltonen J, Holma, J., Rasinkangas, A., & Lehtinen, K. (2003) Open Dialogue approach: treatment principles and preliminary results of a two-year follow up on first episode schizophrenia. *Ethical and Human Sciences and Services* 5:163–182.
3. Seikkula J, Alakare B, Aaltonen J. (2011) The comprehensive open-dialogue approach in Western Lapland: II. Long term stability of acute psychosis outcomes in advanced community care. *Psychosis: Psychological, Social and Integrative Approaches*, 3(3), 192-204
4. Buus, N., Kragh Jacobsen, E., Bojesen, A. B., Bikic, A., Müller-Nielsen, K., Aagaard, J., et al. (2019). The association between open dialogue to young danes in acute psychiatric crisis and their use of health care and social services: A retrospective register-based cohort study. *International Journal of Nursing Studies*, 91, 119-127. doi:<https://doi.org/10.1016/j.ijnurstu.2018.12.015>.
5. Gordon, C., Gidugu, V., Rogers, E. S., DeRonck, J., & Ziedonis, D. (2016). Adapting Open Dialogue for Early-Onset Psychosis into the U.S. Health Care Environment: A Feasibility Study. *Psychiatric services (Washington, D.C.)*, 67(11), 1166–1168. <https://doi.org/10.1176/appi.ps.201600271>.
6. Hopper, K., Van Tiem, J., Cubellis, L., & Pope, L. (2020). Merging intentional peer support and dialogic practice: Implementation lessons from parachute NYC. *Psychiatric Services*, 71(2), 199-201. [Merging Intentional Peer Support and Dialogic Practice: Implementation Lessons From Parachute NYC - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/35111111/).

7. Florence, A. C., Jordan, G., Yasui, S., & Davidson, L. (2020). Implanting Rhizomes in Vermont: A Qualitative Study of How the Open Dialogue Approach was Adapted and Implemented. *The Psychiatric quarterly*, 91(3), 681–693. <https://doi.org/10.1007/s1126-020-09732-7>.
8. Freeman AM, Tribe RH, Stott JCH, Pilling S. Open Dialogue: A Review of the Evidence. *Psychiatric Services*. 2019 Jan 1;70(1):46-59. doi: 10.1176/appi.ps.201800236. Erratum in: *Psychiatr Serv*. 2018 Dec 1;69(12):1273. PMID: 30332925.
9. Gidugu, V., Rogers, E. S., Gordon, C., Elwy, A. R., & Drainoni, M.-L. (2021). Client, family, and clinician experiences of Open Dialogue-based services. *Psychological Services*, 18(2), 154–163. <https://doi.org/10.1037/ser0000404>.
10. Pilling, S., Clarke, K., Parker, G., James, K., Landau, S., Weaver, T., et al. (2022). Open dialogue compared to treatment as usual for adults experiencing a mental health crisis: Protocol for the ODESSI multi-site cluster randomised controlled trial. *Contemporary Clinical Trials*, 113, 106664. doi:<https://doi.org/10.1016/j.cct.2021.106664>.
11. Priebe, S., Huxley, P., Knight, S., & Evans, S. (1999). Application and results of the Manchester Short Assessment of Quality of Life (MANSA). *The International journal of social psychiatry*, 45(1), 7–12. <https://doi.org/10.1177/002076409904500102>.
12. Neil, S. T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W., et al. (2009). The questionnaire about the process of recovery (QPR) A measurement tool developed in collaboration with service users. *Null*, 1(2), 145-155. doi:10.1080/17522430902913450
13. Improvement Cymru (2021) Outcome Measures Companion Guide. <https://phw.nhs.wales/services-and-teams/improvement-cymru/our-work/mental-health/outcome-measures/outcome-measure-tools-companion>.

Panic Disorder with/without Agoraphobia (2017)

The Panic Disorder Severity Scale (PDSS) provides a measurement of the severity of panic (5).

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Subclinical (prevention of PD among those presenting with panic attacks but not meeting PD diagnostic criteria)	Primary care	Low	Stepped-care programme comprising educational booklet; detailed self-help manual; five x 2 hour group CBT	A ³²
Mild	Primary care	Low	Minimal therapy contact CBT (4-6 hours) with a. Bibliotherapy b. Internet-delivery	A ^{6,18} A ^{2,3,12,13,26}
Moderate	Primary care	Low	Therapist-supported self-help CBT (6-12 hours) a. Bibliotherapy b. Computer assisted (e.g., Fear Fighter) c. Internet-delivered CBT, with therapist contact (up to 6 hours) d. Group CBT (8-18 hours)	A ^{7,15,22} A ^{10,19} A ^{3,8,12,13,26} A ^{15,23,25}

Moderate to severe, following positive response to CBT	Primary care/Secondary care	High	Maintenance – CBT following CBT <ul style="list-style-type: none"> ▪ Reduced change of relapse ▪ Reduced work and social improvement 	A ³³
Severe	Primary care/Secondary care	High	Individual therapist-directed CBT (16-20 sessions) with supplementary written material Group CBT (14 sessions) Exposure & relaxation/breathing training Virtual reality exposure Brief CBT (7 sessions)	A ^{16,17,18,20,23} A ²³ A ²⁴ A ²¹ A ²³
Chronic or treatment resistant	Secondary care/Specialist service; in-patient care	High	Individual therapist-directed CBT (up to 20 sessions)	C

References

1. Butler, A. C., Chapman, J. E., Forman, E. M. & Beck, A. T. (2006) The empirical status of cognitive behavioural therapy: a review of meta-analyses. *Clinical Psychology Review*, 26, 17-31.
2. Carlbring, P., Bohman, S., Brunt, S., Buhrman, M., Westling, B. E., Ekselius, L., & Andersson, G. (2006) Remote treatment of panic disorder: a randomized trial of internet-based cognitive behavior therapy supplemented with telephone calls. *American Journal of Psychiatry*, 163(12), 2119-2125.
3. Carlbring, P., Nilsson-Ihrfelt, E., Waara, J., Kollenstam, C., Buhrman, M., Kaldø, V., ... & Andersson, G. (2005) Treatment of panic disorder: live therapy vs. self-help via the Internet. *Behaviour research and therapy*, 43(10), 1321-1333.
4. Faretta, E. (2013). EMDR and Cognitive Behavioral Therapy in the Treatment of Panic Disorder: A Comparison. *Journal of EMDR Practice and Research*, 7(3), 121-133.

5. Furukawa, T. A., Katherine Shear, M., Barlow, D. H., Gorman, J. M., Woods, S. W., Money, R., & Leucht, S. (2009) Evidence-based guidelines for interpretation of the Panic Disorder Severity Scale. *Depression and anxiety*, 26(10), 922-929.
6. Gould, R. A. & Clum, G. A. (1993) A meta-analysis of self-help treatment approaches. *Clinical Psychology Review*, 13, 169-186.
7. Gould, R. A. & Otto, M. H. (1995) A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, 15, 819-844.
8. Hedman, E., Ljótsson, B., Rück, C., Bergström, J., Andersson, G., Kaldø, V., ... & Lindefors, N. (2013) Effectiveness of Internet-based cognitive behaviour therapy for panic disorder in routine psychiatric care. *Acta Psychiatrica Scandinavica*, 128(6), 457-467.
9. Kenardy, J., McCafferty, K. & Rosa, V. (2003) Internet-delivered indicated prevention for anxiety disorders: a randomised controlled trial. *Behavioural and Cognitive Therapy*, 31, 279-289.
10. Kenardy, J., Dow, M. G. T., Johnston, D. W., Newman, M. G., Thomson, A., & Taylor, C. B. (2003) A comparison of delivery methods of cognitive-behavioural therapy for panic disorder: an international multicenter trial. *Journal of Consulting and Clinical Psychology*, 71, 1068-1075.
11. Kim, B., Lee, S. H., Kim, Y. W., Choi, T. K., Yook, K., Suh, S. Y., ... & Yook, K. H. (2010) Effectiveness of a mindfulness-based cognitive therapy program as an adjunct to pharmacotherapy in patients with panic disorder. *Journal of Anxiety Disorders*, 24(6), 590-595.
12. Kiropoulos, L. A. Klein, B., Austin, D. W., Gilson, K., Pier, C., Mitchell, J. & Ciechomski, L. (2008) Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face CBT? *Journal of Anxiety Disorders*, 22, 1273-1284.
13. Klein, B., Richards, J. C. & Austin, D. W. (2006) Efficacy of internet therapy for panic disorder. *Journal of Behaviour Therapy and Experimental Psychiatry*, 37, 213-238.
14. Knuts, I. J., Esquivel, G., Overbeek, T., & Schruers, K. R. (2015) Intensive behavioral therapy for agoraphobia. *Journal of affective disorders*, 174, 19-22.
15. Lidren, D. M., Watkins, P. L., Gould, R. A., Clum, G. A., Asterino, M., & Tulloch, H. L. (1994) A comparison of bibliography and group therapy in the treatment of panic disorder. *Journal of Consulting and Clinical Psychology*, 62, 865-869.
16. Meuret, A. E., Twohig, M. P., Rosenfield, D., Hayes, S. C., & Craske, M. G. (2012) Brief acceptance and commitment therapy and exposure for panic disorder: A pilot study. *Cognitive and Behavioral Practice*, 19(4), 606-618.
17. Mitte, K. (2005) A meta-analysis of the efficacy of psycho-and pharmacotherapy in panic disorder with and without agoraphobia. *Journal of Affective Disorders*, 88, 27-45.

18. Newman, M. G., Erickson, T., Przeworski, A., & Dzus, E. (2003) Self-help and minimal contact therapies for anxiety disorders: Is human contact necessary for therapeutic efficacy? *Journal of Clinical Psychology*, 59, 251-274.
19. National Institute for Health and Clinical Excellence (2006) Computerised cognitive behaviour therapy for depression and anxiety: Review of Technology Appraisal 51. (TA97). London: National Institute of Health and Clinical Excellence.
20. Oei, T. P. S., Llamas, M., Devilly, G. J. (1999) The efficacy and cognitive processes of cognitive behaviour therapy in the treatment of panic disorder with agoraphobia. *Behavioural and Cognitive Psychotherapy*, 27, 63-88.
21. Pelissolo, A., Zaoui, M., Aguayo, G., Yao, S. N., Roche, S., Ecochard, R., & Cottraux, J. (2012) Virtual reality exposure therapy versus cognitive behavior therapy for panic disorder with agoraphobia: A randomized comparison study *Journal of CyberTherapy & Rehabilitation*, 5(1), 35-43
22. Power, K. G., Sharp, D. M., Swanson, V. & Simpson, R. J. (2000) Therapist contact in cognitive behaviour therapy for panic disorder and agoraphobia in primary care. *Clinical Psychology and Psychotherapy*, 7, 37-46.
23. Roberge, P., Marchand, A., Reinhartz, D., & Savard, P. (2008) Cognitive-behavioural treatment for panic disorder with agoraphobia a randomized, control trial and cost-effectiveness analysis. *Behaviour Modification*, 32(3), 333-351.
24. Sánchez-Meca, J., Rosa-Alcázar, A. I., Marín-Martínez, F., & Gómez-Conesa, A. (2010) Psychological treatment of panic disorder with or without agoraphobia: a meta-analysis. *Clinical Psychology Review*, 30(1), 37-50.
25. Sharp, D. M., Power, K. G., & Swanson, V. (2004) A comparison of the efficacy and acceptability of group versus individual cognitive behaviour therapy in the treatment of panic disorder and agoraphobia in primary care. *Clinical Psychology and Psychotherapy*, 11, 73-82.
26. Spek, V., Cuijpers, P., Nyklíček, I., Riper, H., Keyzer, J. & Pop, V. (2007) Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychological Medicine*, 37, 319-328.
27. Swinson, R. P., Soulios, C., Cox, B. J., & Kuch, K. (1992) Brief treatment of emergency room patients with panic attacks. *American Journal of Psychiatry*, 149, 944-946
28. Telch, M. J., Lucas, J. A., Schmidt, N. B., Hanna, H. H., Jaimez, T. L. & Lucas, R. A. (1993) Group cognitive behavioural treatment of panic disorder. *Behaviour Research and Therapy*, 31, 279-287
29. Van Apeldoorn, F. J., Van Hout, W. J. P. J., Mersch, P. P. A., Huisman, M., Slaap, B. R., Hale, W. W., ... & Den Boer, J. A. (2008) Is a combined therapy more effective than either CBT or SSRI alone? Results of a multicenter trial on panic disorder with or without agoraphobia. *Acta Psychiatrica Scandinavica*, 117(4), 260-270.

-
30. van Apeldoorn, F. J., Timmerman, M. E., Mersch, P. P. A., van Hout, W. J., Visser, S., van Dyck, R., & den Boer, J. A. (2010) A Randomized Trial of Cognitive-Behavioral Therapy or Selective Serotonin Reuptake Inhibitor or Both Combined for Panic Disorder With or Without Agoraphobia: Treatment Results Through 1-Year Follow-Up [CME]. *Journal of Clinical Psychiatry*, 71(5), 574.
 31. Vos, S. P. F., Huibers, M. J. H., Diels, L., & Arntz, A. (2012) A randomized clinical trial of cognitive behavioural therapy and interpersonal psychotherapy for panic disorder with agoraphobia. *Psychological medicine*, 42(12), 2661-2672.
 32. Baillie, A.J. and Rapee, R.M. (2001) Brief stepped intervention for panic attacks. Unpublished PhD Thesis. Macquarie University, Sydney.
 33. White, Kamila, S.; Payne, Laura,A.; Gorman, Jack,M.; Shear, M.Katherine; Woods, Scott,W.; et al (2013) Does Maintenance CBT contribute to long-term response of panic disorder with or without agoraphobia? A randomized controlled clinical trial. *Journal of Consulting and Clinical Psychology*, 81(1), 47-57

Perinatal mental health – common mental health problems (2023)

“For ease and clarity of writing, we use the terms woman/women within these documents. Within this we acknowledge that not all birthing people identify as women”.

Common mental health problems in the perinatal period are mental health problems that occur during pregnancy (**antenatal**) and within one-year after birth (**postnatal**). This overall timeframe is referred to as the perinatal period. These presentations, commonly depression and anxiety disorders, show a high degree of comorbidity (e.g., coexisting perinatal depression and anxiety), have strong predictive capacity (e.g., antenatal depression is a predictor of postnatal depression)¹ and require further assessment and monitoring².

The management of common mental health problems in the perinatal period involves addressing a wide range of often interconnected challenges. These include the risk of harm (to mother and foetus/baby) associated with untreated mental health disorders³; possible risks associated with the use of psychotropic medication in the perinatal period⁴ and some degree of uncertainty related to the potential benefits, risks and harm of pharmacological and psychological interventions for perinatal mental health disorders². Hence, healthcare professionals should have the capacity to understand these challenges, as well as to recognise, routinely assess, refer and provide interventions for perinatal mental health disorders as required. A coordinated care approach should be adopted, inclusive of service user preference and acceptability of interventions during pregnancy and post-natally, particularly in terms of pharmacology. This approach should include the development of an integrated care plan that specifies the treatment plan for the mental health disorder and the roles of healthcare professionals involved in coordinating care, monitoring schedules and providing treatment². View [Perinatal Mental Health Good Practice Principles](#) guide.

This review covers approaches that can help prevent and treat non-psychotic mental health disorders in the perinatal period, with particular focus on common mental health difficulties such as depression and anxiety. Full guidance on identifying, assessing and managing mental health disorders in the perinatal period can be found in the National Institute for Health and Care Excellence (NICE) guidance². The management of psychosis and bipolar disorder in the perinatal period is covered in the sections on [bipolar disorder](#) and [schizophrenia/psychosis](#). Please refer to relevant recommendations for the management of specific mental health conditions not covered within the perinatal recommendations elsewhere in this document.

For Post Traumatic Stress Disorder (PTSD) and birth related trauma [from miscarriage, traumatic birth, stillbirth, or neonatal death] the evidence tables for PTSD apply, trauma symptoms are often overlooked or mis-identified as depression. Prevention of trauma and PTSD in the perinatal period is contingent on psychologically informed maternity care⁵. Single-session high-intensity psychological interventions that focus on ‘debriefing’/‘guided re-living’ of the trauma experience are not recommended for women who have experienced traumatic births².

Prevalence: The prevalence of perinatal mental health disorders varies in relation to both the mental health condition and the perinatal period. In the UK, prevalence estimates for perinatal depression have ranged from 7.4% to 14.8% for antenatal depression (higher levels reported in the third trimester), with prevalence estimates of 7.4% - 12.8% reported in the postnatal period⁶. Prevalence estimates for perinatal anxiety disorders, across its multiple classifications, have ranged between 11.8% to 15.3% for antenatal anxiety, with an estimated 8% prevalence rate reported for postnatal anxiety⁶.

Prevention

The antenatal and postnatal periods provide a window of opportunity for healthcare providers to identify women who might be at risk of developing mental health problems, or women with presentations that might be of concern to healthcare practitioners. It presents an opportunity to deliver psychological interventions for the prevention, early intervention and treatment of mental health disorders.

There is high-level evidence to support the delivery of cognitive behavioural based approaches for universal prevention of antenatal depression. The moderate effect sizes demonstrated by these interventions make these approaches viable options for the prevention of depression in the antenatal period without the need to identify high-risk pregnant women.

E-health interventions have also been shown to be effective in the universal prevention of perinatal depression. The emerging evidence supporting the use of e-health interventions, as well as the advantages of anonymity and increased access to care, could make this remotely accessed intervention particularly attractive for mental health disorders characterised by high prevalence⁷.

In addition to universal preventive interventions, there is evidence to support the delivery of psychological interventions to prevent depression in women at high-risk, e.g., women with a history of depression, or those facing socioeconomic situations that place them at high risk of depression. Such interventions include psychoeducation and counselling interventions based on Cognitive Behavioural Therapy (CBT)/Interpersonal Psychotherapy (IPT).

Other CBT based interventions include facilitated self-help interventions (recommended by NICE) for women in the perinatal period with subthreshold depressive or anxiety symptoms. Based on NICE's recommendations, guided CBT based interventions can be delivered either face-to-face or remotely; consist of six to eight sessions and be supported by a trained practitioner.

Ambiguity exists as to what is classed as prevention or early intervention. To ensure consistency and clarity, interventions are classed as preventive if; (I) explicitly stated in evaluation studies; (II) delivered universally as preventive interventions; (III) delivered to women (in the perinatal period) at high-risk of depression or anxiety. Interventions are classed as early interventions if delivered to women (in the perinatal period) with subthreshold symptom levels. Given the ambiguity and overlap, prevention/early intervention are combined in the table.

Prevention of Common Mental Health Problems in the Perinatal Period

Level of Severity	Level of Service	Intensity of Intervention	What intervention?	Level of Evidence
Prevention/Early Intervention	Part 1 services	Low	Psychoeducation to prevent postnatal depression in at risk women ⁸	A
			Psychoeducation to prevent postnatal depression ^{7,9}	
			Individual or group delivered IPT for postnatal depression ¹⁰⁻¹²	A
			Individual or group delivered CBT for postnatal depression ¹²⁻¹⁴	A
			Counselling interventions based on CBT/IPT for perinatal depression in at risk women ^{13,15}	A
			CB-based approaches for universal prevention of antenatal depression ¹⁶	A
			E-health interventions for universal prevention of perinatal depression ⁷	A
			Facilitated/guided self-help interventions based on CBT principles for perinatal depression ¹⁷	B
			Group delivered mindfulness-based CBT for postnatal depression in at risk pregnant women ¹⁸	B
			Acceptance and Commitment Therapy for antenatal anxiety ¹⁹	C

Treatment

Interventions are classed as treatment if; (I) explicitly stated in evaluation studies; (II) delivered to women (in the perinatal period) with above threshold symptom levels; or (III) delivered to women with diagnosis of depressive or anxiety disorder. Psychological interventions with medium to high levels of evidence have been included in the evidence table below. These are classified as A-C. This is to be consistent with the aim to focus on interventions with the highest levels of efficacy and the strongest levels of evidence where this exists.

There is high-level evidence for facilitated self-help based on CBT principles for the treatment of **perinatal depression and anxiety**. For such interventions, NICE recommends the use of self-help materials, with in-person or remote support provided by a trained practitioner². This approach to delivery of care provides a flexible, cost-effective option that has the potential to increase choice for women in the perinatal period with common mental health problems and be provided primarily in Part 1 services as part of a stepped/stratified approach to the treatment. There is also high-level evidence for psychologically informed sessions (based on cognitive behavioural or person-centred principles) for the treatment of **postnatal depression**²⁰. This offers another first-step alternative for use in primary care settings.

There is strong evidence of high efficacy for CBT and IPT for the treatment of **perinatal depression**. In contrast, there is evidence suggestive of potential benefits for CBT and IPT for the treatment of **perinatal anxiety**, but does not translate to significant efficacy, as evidenced by the small effect sizes in meta-analyses of between-group comparisons. The NICE Guideline Development Group considered it reasonable to extrapolate from a nonpregnant population² and recommended that low-intensity or high-intensity psychological interventions be offered in line with recommendations, as set out in existing guidelines for [Generalised Anxiety Disorder](#), [Panic Disorder](#), [Obsessive-Compulsive Disorder](#), [Social Anxiety Disorder](#) and [Post Traumatic Stress Disorder](#) in these Evidence tables and referenced in NICE²¹⁻²⁴.

Systematic literature reviews and meta-analysis have assessed the effectiveness of mindfulness-based interventions for the treatment of non-psychotic perinatal mental health disorders. The results from these reviews were inconsistent and did not unilaterally report the efficaciousness of mindfulness-based interventions for this purpose. Deviation from traditional mindfulness-based interventions i.e., cognitive therapy based e.g., Mindfulness-Based Cognitive Therapy (MBCT) and stress reduction based e.g., Mindfulness-Based Stress Reduction (MBSR) may have contributed to some of the negligible effect sizes observed. However, based on the overview of results, a low efficacy level has been attributed to mindfulness-based interventions (in general) for the treatment of **perinatal anxiety and depression**. There is also evidence that these interventions are reasonably well accepted by women.

Evaluation of Acceptance Commitment Therapy (ACT) in women in the perinatal period has shown promising results for **depression** outcomes, but these estimates are subject to substantial methodological variation. The absence of high-quality RCTs, systematic literature reviews and meta-analysis

assessing ACT's effectiveness limit the strength of evidence for this intervention. NICE recommends low-intensity psychological intervention (e.g., facilitated self-help) for anxiety disorders in the perinatal period. However, for specific anxiety disorders e.g., social anxiety disorder, high intensity interventions (e.g. CBT) are recommended as first-line treatment.

Treatment of Common Mental Health Problems in the Perinatal Period

Level of Severity	Level of Service	Intensity of Intervention	What intervention?	Level of Evidence
Mild/Moderate	Usually part 1	Low	Individual guided self-help based on CBT principles (and including behavioural activation and problem-solving techniques) for perinatal depression ²⁵⁻²⁷	A
All levels	Usually part 1	Low	Psychologically informed sessions based on cognitive behavioural or person-centred principles for postnatal depression ²⁰	A
Mild/Moderate	Usually part 1	Low	Facilitated self-help for perinatal anxiety (includes e-health interventions) ²⁸	A
			Mindfulness-based interventions for perinatal anxiety and depression ²⁹⁻³¹	A
Moderate/Severe	Part 1 and part 2	High	CBT for perinatal depression ³²⁻³⁴	A
			IPT for perinatal depression ³⁵	A
			CBT for perinatal anxiety ³⁶⁻³⁸	A
			IPT for perinatal anxiety ³⁵	A
		Low	Acceptance and Commitment Therapy for perinatal depression ³⁹⁻⁴²	B
		High	Individual CBT for postnatal OCD ^{36, 43}	B

References

1. Heron J, O'Connor TG, Evans J, Golding J, Glover V, ALSPAC Study Team. The course of anxiety and depression through pregnancy and the postpartum in a community sample. *J Affect Disord* 2004 May;80(1):65-73.
2. NICE. Antenatal and postnatal mental health: clinical management and service guidance Clinical guideline. 2014; Available at: <https://www.nice.org.uk/guidance/cg192>. Accessed September/6, 2021.
3. Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, et al. MBBRACE Saving Lives Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. 2021.
4. Biffi A, Cantarutti A, Rea F, Locatelli A, Zanini R, Corrao G. Use of antidepressants during pregnancy and neonatal outcomes: An umbrella review of meta-analyses of observational studies. *J Psychiatr Res* 2020 May;124:99-108.
5. NHS England. Supporting mental healthcare in a maternity and neonatal setting: Good practice guide and case studies. 2021; Available at: <https://www.england.nhs.uk/publication/supporting-mental-healthcare-in-a-maternity-and-neonatal-setting-good-practice-guide-and-case-studies/>, 2021.
6. Centre for Mental Health LS of E. The Costs of Perinatal Mental Health Problems. 2014; Available at: <https://www.centreformentalhealth.org.uk/publications/costs-perinatal-mental-health-problems>, 2022.
7. Haga SM, Drozd F, Lisøy C, Wentzel-Larsen T, Slinning K. Mamma Mia - A randomized controlled trial of an internet-based intervention for perinatal depression. *Psychol Med* 2019 Aug;49(11):1850-1858.
8. Lara MA, Navarro C, Navarrete L. Outcome results of a psycho-educational intervention in pregnancy to prevent PPD: a randomized control trial. *J Affect Disord* 2010 Apr;122(1-2):109-117.
9. NHS Wales. Matrics Cymru-The Evidence Tables Evidence Tables Index. 2017; Available at: <https://phw.nhs.wales/services-and-teams/improvement-cymru/our-work/mental-health/psychological-therapies/resources-psychological-therapies/evidence-tables-evidence-tables-matrics-cymru/> Accessed Feb 2023.
10. Dennis C, Dowswell T. Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Syst Rev* 2013 Feb 28;(2):CD001134. doi(2):CD001134.
11. Sockol LE, Epperson CN, Barber JP. A meta-analysis of treatments for perinatal depression. *Clin Psychol Rev* 2011 Jul;31(5):839-849.
12. Clatworthy J. The effectiveness of antenatal interventions to prevent postnatal depression in high-risk women. *J Affect Disord* 2012 Mar;137(1-3):25-34.

13. O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU. Primary Care Screening for and Treatment of Depression in Pregnant and Postpartum Women: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA* 2016 Jan 26;315(4):388-406.
14. Sockol LE. A systematic review of the efficacy of cognitive behavioral therapy for treating and preventing perinatal depression. *J Affect Disord* 2015 May 15;177:7-21.
15. Tandon SD, Ward EA, Hamil JL, Jimenez C, Carter M. Perinatal depression prevention through home visitation: a cluster randomized trial of mothers and babies 1-on-1. *J Behav Med* 2018 Oct;41(5):641-652.
16. Yasuma N, Narita Z, Sasaki N, Obikane E, Sekiya J, Inagawa T, et al. Antenatal psychological intervention for universal prevention of antenatal and postnatal depression: A systematic review and meta-analysis. *J Affect Disord* 2020 Aug 1;273:231-239.
17. Trevillion K, Ryan EG, Pickles A, Heslin M, Byford S, Nath S, et al. An exploratory parallel-group randomised controlled trial of antenatal Guided Self-Help (plus usual care) versus usual care alone for pregnant women with depression: DAWN trial. *J Affect Disord* 2020 Jan 15;261:187-197.
18. Dimidjian S, Goodman SH, Felder JN, Gallop R, Brown AP, Beck A. Staying well during pregnancy and the postpartum: A pilot randomized trial of mindfulness-based cognitive therapy for the prevention of depressive relapse/recurrence. *J Consult Clin Psychol* 2016 Feb;84(2):134-145.
19. Vakilian K, Zarei F, Majidi A. Effect of Acceptance and Commitment Therapy (ACT) on Anxiety and Quality of Life During Pregnancy: A Mental Health Clinical Trial Study. *Iranian Red Crescent Medical Journal* 2019;21(8).
20. Morrell CJ, Slade P, Warner R, Paley G, Dixon S, Walters SJ, et al. Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. *BMJ* 2009 Jan 15;338:a3045.
21. NICE. Generalised anxiety disorder and panic disorder in adults: management. 2020; Available at: <https://www.nice.org.uk/guidance/cg113>, 2021.
22. NICE. Obsessive-compulsive disorder and body dysmorphic disorder: treatment. 2005; Available at: <https://www.nice.org.uk/guidance/cg31>, 2021.
23. NICE. Social anxiety disorder: recognition, assessment and treatment. 2013; Available at: <https://www.nice.org.uk/guidance/cg159>, 2021.
24. NICE. Post-traumatic stress disorder. 2018; Available at: <https://www.nice.org.uk/guidance/ng116>, 2021.
25. Forsell E, Bendix M, Holländare F, Szymanska von Schultz B, Nasiell J, Blomdahl-Wetterholm M, et al. Internet delivered cognitive behavior therapy for antenatal depression: A randomised controlled trial. *J Affect Disord* 2017 Oct 15;221:56-64.
26. O'Mahen HA, Richards DA, Woodford J, Wilkinson E, McGinley J, Taylor RS, et al. Netmums: a phase II randomized controlled trial of a guided Internet behavioural activation treatment for postpartum depression. *Psychol Med* 2014 Jun;44(8):1675-1689.

27. O'Mahen HA, Woodford J, McGinley J, Warren FC, Richards DA, Lynch TR, et al. Internet-based behavioral activation--treatment for postnatal depression (Netmums): a randomized controlled trial. *J Affect Disord* 2013 Sep 25;150(3):814-822.
28. Bayrampour H, Trieu J, Tharmaratnam T. Effectiveness of eHealth Interventions to Reduce Perinatal Anxiety: A Systematic Review and Meta-Analysis. *J Clin Psychiatry* 2019 Jan 22;80(1):18r12386. doi: 10.4088/JCP.18r12386.
29. Hall HG, Beattie J, Lau R, East C, Anne Biro M. Mindfulness and perinatal mental health: A systematic review. *Women Birth* 2016 Feb;29(1):62-71.
30. Shi Z, MacBeth A. The Effectiveness of Mindfulness-Based Interventions on Maternal Perinatal Mental Health Outcomes: a Systematic Review. *Mindfulness (N Y)* 2017;8(4):823-847.
31. Lever Taylor B, Cavanagh K, Strauss C. The Effectiveness of Mindfulness-Based Interventions in the Perinatal Period: A Systematic Review and Meta-Analysis. *PLoS One* 2016 May 16;11(5):e0155720.
32. Shortis E, Warrington D, Whittaker P. The efficacy of cognitive behavioral therapy for the treatment of antenatal depression: A systematic review. *J Affect Disord* 2020 Jul 1;272:485-495.
33. Li Z, Liu Y, Wang J, Liu J, Zhang C, Liu Y. Effectiveness of cognitive behavioural therapy for perinatal depression: A systematic review and meta-analysis. *J Clin Nurs* 2020 Sep;29(17-18):3170-3182.
34. Huang L, Zhao Y, Qiang C, Fan B. Is cognitive behavioral therapy a better choice for women with postnatal depression? A systematic review and meta-analysis. *PLoS One* 2018 Oct 15;13(10):e0205243.
35. Sockol LE. A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women. *J Affect Disord* 2018 May;232:316-328.
36. Marchesi C, Ossola P, Amerio A, Daniel BD, Tonna M, De Panfilis C. Clinical management of perinatal anxiety disorders: A systematic review. *J Affect Disord* 2016 Jan 15;190:543-550.
37. Maguire PN, Clark GI, Wootton BM. The efficacy of cognitive behavior therapy for the treatment of perinatal anxiety symptoms: A preliminary meta-analysis. *J Anxiety Disord* 2018 Dec;60:26-34.
38. Nillni YI, Mehralizade A, Mayer L, Milanovic S. Treatment of depression, anxiety, and trauma-related disorders during the perinatal period: A systematic review. *Clin Psychol Rev* 2018 Dec;66:136-148.
39. Hosseini N, Poh L, Baranovich D, Razak N. Reducing depression in pregnancy and postpartum period through acceptance and commitment therapy: a review of depression reduction among Iranian women. *International Journal of Education, Psychology and Counseling* 2020;5:232-244.
40. Kazemeyni M, Bakhtiari M, Nouri M. Effectiveness of acceptance and commitment group therapy on postpartum depression and psychological flexibility. - *skums-jcnm* 2018;6(4):20-31.

41. Shojaeifar S, Akbari T, Jamiliyan H. Effect of Acceptance and Commitment Therapy on Postpartum Depression in Unwanted Pregnancies. *J Mazandaran Univ Med Sci* 2019;29(175):47-56.
42. Waters CS, Annear B, Flockhart G, Jones I, Simmonds JR, Smith S, et al. Acceptance and Commitment Therapy for perinatal mood and anxiety disorders: A feasibility and proof of concept study. *Br J Clin Psychol* 2020 Nov;59(4):461-479.
43. Challacombe FL, Salkovskis PM, Woolgar M, Wilkinson EL, Read J, Acheson R. A pilot randomized controlled trial of time-intensive cognitive-behaviour therapy for postpartum obsessive-compulsive disorder: effects on maternal symptoms, mother-infant interactions and attachment. *Psychol Med* 2017 Jun;47(8):1478-1488.

Acknowledgements:

With thanks to the NICE team for their published clinical management and service guidance on antenatal and postnatal mental health² and to the Scottish Advisory Group for Common Mental Health Problems in the Perinatal Period; Angus Mac Beth, Dwynwen Myers, Fiona Fraser, Paula Shiels, Josephine Stewart, Alison Robertson, Clare Thompson, Jenny Patterson, Jillian Taylor, Susan McConachie, Kirsten Coull, Marisa Forte, Justine Anderson, Leah Cronin, Hannah Welstead, Regina Esiovwa.

Post Traumatic Stress Disorder

PTSD in Children and Young People (2021)

Prevalence

In the UK, in a recent study¹, just over 30% of young people experienced trauma and 7.8% developed post traumatic stress disorder (PTSD) by the age of 18 years. There is a greater likelihood of PTSD and Complex PTSD (CPTSD)² in 'at risk' child populations, i.e., those who have experienced adverse childhood experiences (highly stressful, potentially traumatic events) such as abuse or neglect³.

Early identification and assessment

Early identification of symptoms is important in children and young people. Questions about exposure to commonly experienced potentially traumatic events should be included during any mental health assessment of children and young people, with screening for the presence of PTSD symptoms, if confirmed. There are many freely available structured interviews and questionnaires available to assess post-traumatic stress symptoms and PTSD in children and young people. The International Trauma Questionnaire for Children and Adolescents (ITQ-CA)^{4,5} is a freely available measure of PTSD and CPTSD symptoms in children and adolescents according to ICD-11 diagnostic criteria. A measure based on the DSM-5⁶ diagnostic manual is the Child and Adolescent Trauma Screen (CATS)⁷. Should screening measures be utilised, it is important that when a child or adolescent screens positively for PTSD or CPTSD symptoms, this is used alongside a robust clinical assessment of endorsed difficulties.

Working with families

Assessment of children and adolescents should include assessment of the system in which they live, as their symptoms will both influence and be influenced by what else is happening within the system. It is important to consider whether parent(s)/caregiver(s) are experiencing mental health problems, in particular in instances of shared trauma. There is some evidence that parental distress can negatively impact a child's outcomes in treatment^{8,9}. Trauma-focused cognitive behavioural therapy (TF-CBT) was found to be less effective in reducing children's PTSD symptoms when both children's pre-treatment PTSD symptoms and caregivers' depression or unhelpful trauma-related beliefs were more severe⁸.

Where assessment involves very young children (0-3 years), this should include an evaluation of the behaviour of the child with particular reference to developmental stage and attachment status. An understanding of attachment theory is important for clinicians. In all children, the range of potential post-traumatic mental health problems includes behavioural and attentional problems as well as problems with anxiety and mood. Interventions for comorbid problems such as depression, anxiety and substance use in children and young people who have experienced trauma are as important as for PTSD/CPTSD¹⁰.

Parents/caregivers need to be involved to some degree to promote continued engagement in therapy such as ensuring that the rationale for the work and strategies is understood (particularly true in TF-CBT) and to have the opportunity to answer questions. Parents and carers play varied and important roles in therapy, including supporting children and young people to attend the sessions, to help them complete any homework tasks and to be able to 'self-regulate.' They often act as co-therapists in order to support practice tasks (such as exposure hierarchies, behavioural experiments), to support generalising learning and reduce dropout rates^{11,12}.

Intervention

Interventions need to be tailored to meet the developmental needs of an individual child. There are many well validated protocols developed specifically for children and young people and these should be used in preference to modifying an adult protocol¹³. The developmental stage and capabilities of the child should be kept in mind - chronological age does not necessarily equate to levels of cognitive functioning and developmental mastery. Even children as young as 5 can engage with cognitive therapy given age appropriate material¹⁴ and EMDR may be adapted to match a child or young person's developmental stage, attention span, language abilities, verbal reasoning skills and level of insight.

Matrics Plant (NHS Wales)¹⁵ highlights the importance of utilising creative and developmentally appropriate ways of engaging children and young people, including engagement with adults in the young person's system, as children may be dependent on adults to access and benefit from services.

Preventing PTSD

Currently there is limited research informing early interventions to reduce traumatic stress symptoms in children and young people. In line with the NICE guidelines¹⁶, Matrics Cymru recommends against individual single session psychological debriefing based on two studies^{17,18} which did not demonstrate any benefit in the reduction of PTSD symptoms and suggested that the intervention may slow recovery. One RCT¹⁹ identified a significant reduction in developing PTSD with a targeted family psychosocial intervention. Whilst not reaching level B evidence rating, one small pilot study²⁰ demonstrated that self-directed online psychoeducation involving young people exposed to acute trauma was feasible to deliver and was engaging for children. More research is required to explore the effectiveness and reach of web-based interventions.

There are a number of pragmatic approaches that are likely to be helpful for infants, children and young people after a traumatic event. Key is the presence of a safe, respectful, predictable and regulated adult²¹. Re-establishing routines around mealtimes and sleeping can be reassuring and provide a sense of stability and safety to a young person. Encouraging social connections within family members and the extended family is important, as well as keeping connected to religious communities, school communities and youth groups. It is helpful to adopt an approach of active listening to a child or young person and to value a young person's cultural identity as part of the healing process. A period of "active monitoring" in the first month may

be appropriate to see if symptoms naturally improve and to allow professionals to target those children and young people with impairing traumatic symptoms to access targeted support¹⁶.

Prevention (0-3 Months Post Trauma)

The Panic Disorder Severity Scale (PDSS) provides a measurement of the severity of panic (5).

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
All levels	Parts 1 & 2	High	Psychosocial intervention: Child and family traumatic stress intervention (CFTSI) ¹⁹	B	Medium

Treating PTSD

There is more evidence for the treatment of PTSD in children and young people than for its prevention, although there is less evidence for children than is available for the treatment of PTSD in adults. There are several effective psychological treatments for PTSD in children and young people, including TF-CBT, cognitive therapy for PTSD (CT-PTSD) and prolonged exposure therapy for adolescents (PE-A).

Although there is a greater weight of grade A evidence supporting TF-CBT as an effective treatment for PTSD in children and young people, EMDR also achieves an A grade level of evidence due to the growing amount of research meeting this standard. NICE guidelines¹⁶ recommend EMDR as a second line intervention for children and young people with PTSD who have not responded to or engaged with TF-CBT. A meta-analysis²² found TF-CBT marginally more effective in reducing PTSD symptoms post treatment than EMDR and therefore, EMDR is graded as 'medium to high' for efficacy.

There are a number of other therapies with lower strength efficacy that are not included in the table but are of emerging interest. For example, there is insufficient research currently to recommend narrative exposure therapy for children (KIDNET) as an effective therapy for children and young people with PTSD. However, a multi-centre RCT (YOURTREAT)²³ exploring the efficacy of KIDNET as a treatment for young refugees with PTSD versus treatment as usual is underway.

There is also growing evidence to support group-based interventions for young people in the youth justice system (Target-A)²⁴. Transdiagnostic or modular approaches that target underlying mechanisms common to different mental health problems is an area of research interest and development.

Potential targets for intervention in these approaches might include improving social support, or working with maladaptive coping styles, cognitive biases and behavioural avoidance.

Currently, there is a lack of evidence for the treatment of CPTSD in children and young people. It is unclear if specific interventions are required to treat CPTSD as compared with PTSD in children and young people. In the absence of a current evidence base for the treatment of CPTSD, it may be helpful to use the current recommended first line treatments for PTSD, whilst taking into account the disturbances in self-organisation which are a feature of CPTSD. That may result in longer courses of treatment being required²⁵. It may be helpful to consider the need for stabilisation work before recommending delivery of a trauma-focused intervention to a child or young person with CPTSD.

Finally, it is important to note that it is beyond the scope of this document to differentiate recommendations around direct psychological therapy provision based on specific age groups, however, consideration should be given to this as evidence continues to emerge.

Treatment

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
Individual intervention					
All levels	Part 1 & 2	High	TF-CBT with child, TF-CBT with child and parent/carer ^{26,27}	A	High
All levels	Part 1 & 2	High	EMDR ^{28,29,30}	A	Medium to high
All levels	Part 1 & 2	High	Pre-school TF-CBT	B	Medium
All levels	Part 1 & 2	High	CT-PTSD ^{31,32}	B	Medium
All levels	Part 1 & 2	High	Prolonged exposure for adolescents (PE-A) ^{33,34}	B	Medium
Stepped or phased care approach*					
All levels	Part 1 or 2	High	Developmentally adapted version of cognitive processing therapy (D-CPT) ³⁵	B	High

*Standard care is the reasonable amount of care a person should provide to another. Stepped care is providing the least intrusive and most effective treatment initially, only stepping up to provide more intensive input as clinically needed.

References

1. Lewis, S.J., Arseneault, L., Caspi, A., et al. (2019) The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *Lancet Psychiatry*, 6, 247-56.
2. World Health Organization. (2018) International classification of diseases for mortality and morbidity statistics (11th Revision). Available from: <https://icd.who.int> <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559> (Accessed 23 April).

3. Frewen, P., Zhu, J. & Lanius, R. (2019) Lifetime traumatic stressors and adverse childhood experiences uniquely predict concurrent PTSD, complex PTSD, and dissociative subtype of PTSD symptoms whereas recent adult non-traumatic stressors do not: results from an online survey study. *European Journal of Psychotraumatology*, 10 (1).
4. International Trauma Consortium. (2020) International Trauma Questionnaire Child and Adolescent Version (ITQ-CA). <https://www.traumameasuresglobal.com/itqca> (Accessed 30 April 2021).
5. Kazlauskas, E., Zelviene, P., Daniunaite, I., Hyland, P., Kvedaraite, M., Shevlin, M., Cloitre, M. (2020) The structure of ICD-11 PTSD and Complex PTSD in adolescents exposed to potentially traumatic experiences. *Journal of Affective Disorders*, 265, 169-174.
6. American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders*. 5th ed. Washington: APA.
7. Sachser, C., Berliner, L., Holt, T., Jensen, T.K., Jungbluth, N., Risch, E., Rosner, R., Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS) *Journal of Affective Disorders*, 210, 189-195.
8. Nixon, R. D. V., Sterk, J., & Pearce, A. (2012) A randomized trial of cognitive behaviour therapy and cognitive therapy for children with posttraumatic stress disorder following single-incident trauma. *Journal of Abnormal Child Psychology*, 20, 327-337.
9. Nixon, R. D. V., Sterk, J., Pearce, A., & Weber, N. (2017) A randomized trial of cognitive behavior therapy and cognitive therapy for children with posttraumatic stress disorder following single-incident trauma: Predictors and outcome at 1-year follow-up. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9, 471-478.
10. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2015) *What Works For Whom? A Critical Review of Treatments for Children and Adolescents*. New York: The Guildford Press.
11. Chowdhury, U., & Pancha, A. (2011) Post-traumatic stress disorder in children and adolescents. *Community Practitioner: The Journal of the Community Practitioners' & Health Visitors' Association*, 84(12), 33-35.
12. Cobham, V. E., McDermott, B., Haslam, D., & Sanders, M. R. (2016) The role of parents, parenting and the family environment in Children's post-disaster mental health. *Current Psychiatry Reports*, 18(6), 53.
13. Quackley, S., Reynolds, S., Coker, S. The effects of cues on young children's abilities to discriminate among thoughts, feelings and behaviours. *Behaviour Research and Therapy*. 2004 42 (3): 343-56.
14. Greenwald R. (1999) *Eye Movement Desensitization Reprocessing (EMDR) in Child and Adolescent Psychotherapy*. Northvale NJ: Jason Aronson Inc. Publishers.

15. Improvement Cymru. Matrics Plant Wales. Available from: <https://phw.nhs.wales/services-and-teams/improvement-cymru/news-and-publications/publications/matrics-plant/> (Accessed 30 June 2021).
16. National Institute for Clinical Excellence (2018) Post-traumatic stress disorder (update): Guideline consultation. London: NICE.
17. Stallard P, Velleman R, Salter E, Howse I, Yule W, Taylor G. (2006) A randomised controlled trial to determine the effectiveness of an early psychological intervention with children involved in road traffic accidents. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 47, 127–134.
18. Zehnder, D., Meuli, M., Landolt, M.A. (2010) Effectiveness of a single-session early psychological intervention for children after road traffic accidents: a randomised controlled trial. *Child and Adolescent Psychiatry and Mental Health*, 4, 7.
19. Berkowitz, S., Stover C. S., Marans, S. R. (2011) The child and family traumatic stress intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*, 52, 676-685.
20. Kassam-Adams, N., Marsac, M.L., Kohser, K.L., Kenardy, J., March, S., Winston, F. K. (2016) Pilot randomized controlled trial of a novel web-based intervention to prevent posttraumatic stress in children following medical events. *Journal of Pediatric Psychology*, 41, 138-148.
21. Perry, B & Dobson, C.L. (2013) The Neurosequential Model of Therapeutics. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents*. Edited by Julian D. Ford J.D & Courtois C.A. (Eds), pp249-260 Guilford Press.
22. Lewey, J.H., Smith, C.L., Burcham, B., Saunders, N.L., Elfallal, D., O'Toole, S.K. (2018) Comparing the Effectiveness of EMDR and TF-CBT for Children and Adolescents: a Meta-Analysis. *Journal of Child and Adolescent Trauma*, 11, 457-472.
23. Wilker, S., Catani, C., Wittmann, J., et al. (2020) The efficacy of Narrative Exposure Therapy for Children (KIDNET) as a treatment for traumatized young refugees versus treatment as usual: study protocol for a multi-center randomized controlled trial (YOURTREAT). *Trials*, 21, 185.
24. Ford, J., Mahoney, K., Russo, E. (2001) TARGET and FREEDOM (for children). Farmington: University of Connecticut Health Centre.
25. International Society for Traumatic Stress Studies (ISTSS). Position paper on complex PTSD in children and adolescents. ISTSS; 2018. Available from: [https://istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-\(Child_Adol\)_FNL.pdf.aspx](https://istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-(Child_Adol)_FNL.pdf.aspx) (Accessed 30 April 2021).
26. Cohen, J.A., Deblinger, E., Mannarino, A.P., Steer, R. (2004) A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Association of Child & Adolescent Psychiatry*, 43, 393–402.

27. Dalgleish, T., Goodall, B., Chadwick, I., Werner-Seidler, A., McKinnon, A., Morant, N., Meiser-Stedman, R. (2015) Trauma-focused cognitive behaviour therapy versus treatment as usual for post-traumatic stress disorder (PTSD) in young children aged 3 to 8 years: A randomised controlled trial. *Trials*, 16, 116.
28. de Roos, C., Greenwald, R., den Hollander-Gijsman, M., Noorthoorn, E., van Buuren, S., de Jongh, A. (2011) A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster exposed children. *European Journal of Psychotraumatology*, 2, 5694.
29. de Roos, C., van der Oord, S., Zijlstra, B., Lucassen, S., Perrin, S., Emmelkamp, P., de Jongh, A. (2017) 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. *Journal of Child Psychology and Psychiatry*, 58, 1219–1228.
30. Diehle, J., Opmeer, B.C., Boer, F., Mannarino, A.P., Lindauer, R.J.L. (2015) Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry*, 24, 227–236.
31. Meiser-Stedman R, Smith P, McKinnon A, et al. (2017) Cognitive therapy as an early treatment for post-traumatic stress disorder in children and adolescents: a randomized controlled trial addressing preliminary efficacy and mechanisms of action. *Journal of Child Psychology and Psychiatry*, 58, 623–33.
32. Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., Clark, D.M. (2007) Cognitive behavior therapy for PTSD in children and adolescents: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1051–1061.
33. Gilboa-Schechtman, E., Foa, E.B., Shafran, N., et al. (2010) Prolonged exposure versus dynamic therapy for adolescent PTSD: a pilot randomized controlled trial [published correction appears in *Journal of the American Academy of Child and Adolescent Psychiatry*. 2016, 55, 920]. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49, 1034–1042.
34. Foa, E.B., McLean, C.P., Capaldi, S., Rosenfield, D. (2013) Prolonged exposure vs supportive counseling for sexual abuse-related PTSD in adolescent girls: a randomized clinical trial. *JAMA*, 310, 2650–7.
35. Rosner, R., Rimane, E., Frick, U., Gutermann, J., Hagl, M., Renneberg, B., et al. (2019) Effect of developmentally adapted cognitive processing therapy for youth with symptoms of posttraumatic stress disorder after childhood sexual and physical abuse: a randomized clinical trial. *JAMA Psychiatry*, 76, 484–91. PTSD in Adults (2021)

PTSD in Adults (2021)

The consequences to the individual of exposure to psychologically traumatic events vary widely. For most people there will be no lasting adverse impact on wellbeing. In others it may cause, or contribute to, a range of psychological disorders as well as social and physical problems. The nature and timing of the traumatic exposure may, in part, determine the individual's response to it. Psychological disorders caused, or contributed to, by exposure to traumatic events include PTSD, complex PTSD, depressive disorders, anxiety disorders, substance use disorders, somatic symptom disorders, psychosis and personality disorders. Over 50% of people with PTSD will experience at least one comorbid psychological disorder¹.

Mental health clinicians should routinely explore for trauma history as part of their assessment and consider trauma history in their formulation of a service user's difficulties. A full and comprehensive assessment of mental health needs, undertaken by an individual who has the skills required to do so, is vital in order to determine the nature of an individual's difficulties and needs, an assessment of risk and the co-production of an appropriate management plan.

Preventing PTSD

Currently, there is insufficient evidence to support any single universal intervention (one provided to everyone exposed) to prevent PTSD in the immediate aftermath of a traumatic event². The National Institute for Health and Care Excellence recommends against psychological debriefing but the current evidence for this is not considered strong enough for Matrics Cymru to specifically recommend against its delivery. There is evidence that single session individual debriefing may cause harm to some people³; whilst this is not the case for group debriefing, overall there is insufficient evidence to recommend any form of psychological debriefing. It is, therefore, recommended that people involved in traumatic events are offered practical, pragmatic support in an empathic manner.

There is some level B evidence for universal interventions such as single session EMDR, brief dyadic therapy and a self-guided internet-based intervention², but the level of efficacy of these interventions is unknown and further evidence would be required before such interventions can be recommended for inclusion in the Matrics Cymru PTSD Prevention Table.

There is better, albeit still limited, evidence for interventions that aim to prevent PTSD by treating early symptoms of PTSD or acute stress disorder. Stepped/Collaborative care involves screening and direct assessment, followed by the provision of flexible and modular interventions (psychological, pharmacological and/or case management) based on an individual's needs⁴.

All people presenting with symptoms within the first few months of traumatic events should be offered an assessment of mental health needs prior to being offered an intervention. A period of "watchful waiting" may be appropriate to see if symptoms naturally improve. All decisions should be co-produced with the affected individual.

Prevention (1-3 Months Post Trauma)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
All levels	Parts 1 & 2	High	Individual CBT with a trauma focus for acute stress disorder and PTSD symptoms	A	Medium
All levels	Parts 1 & 2	High	Stepped/Collaborative care	A	Low
All levels	Parts 1 & 2	High	EMDR for PTSD symptoms	B	Medium

Treating PTSD

There is much better evidence for the treatment of PTSD than its prevention, in terms of both strength of evidence and efficacy⁵. It can be argued that detecting and treating PTSD as early as possible is likely to represent a more clinically and cost-effective use of available resources/services than focusing on prevention. That said, the most effective interventions for the prevention of PTSD are also the most effective interventions for its treatment.

There are a wide range of different interventions that now have enough evidence to be included in the Matrics Cymru Tables with A or B level evidence⁵. In order to be consistent with the aim of Matrics Cymru to focus on interventions with the highest levels of efficacy and the strongest levels of evidence, only those psychological interventions with A strength evidence of a medium or high level of efficacy have been included. There are a number of psychological treatments with lower strength evidence of efficacy that are not included in the Table, such as couples CBT⁶ with a trauma focus and reconsolidation of traumatic memories⁷.

As highlighted by the Table, five specific individual face to face therapies with a trauma focus have the highest levels of efficacy. Other psychological therapies with a trauma focus, namely narrative exposure therapy and group CBT with a trauma focus, have demonstrated a lower level of efficacy but may still have a role in the treatment of people with PTSD⁵. The same is true for non-trauma-focused CBT and present centred therapy, non-trauma-focused psychological therapies with medium levels of efficacy⁵, especially for people with PTSD who are in unstable situations (e.g., ongoing domestic

violence) that mean trauma-focused work is inappropriate, people with PTSD who do not want to engage in trauma-focused work and those who are unable to tolerate it.

There is also strong evidence of medium efficacy for guided internet-based CBT with a trauma focus for people with mild to moderate PTSD⁸. This provides a flexible, cost-effective alternative approach that has the potential to increase choice for people with PTSD and be provided primarily in Part 1 services as part of a stepped/stratified approach to the treatment of PTSD.

The recommended therapies listed in the Table are indicated for people with PTSD as opposed to complex PTSD, which is now formally recognised as a parallel diagnosis to PTSD in the ICD-11 classification system⁹. With the exception of guided internet-based CBT with a trauma focus, the listed therapies have been shown to be helpful to some people with more complex presentations of PTSD^{10,11}. Given the current absence of a formal evidence base for the treatment of complex PTSD¹², the Table should help inform possible treatment approaches for complex PTSD. It is particularly important to consider the need for stabilisation work before recommending delivery of a trauma-focused intervention to someone with complex PTSD. Some people with PTSD may also benefit from emotional stabilisation work before trauma-focused treatment. This and additional considerations, also applies to people with PTSD with significant comorbidity. For example, in the case of comorbid PTSD and substance use disorder, although there is evidence that some individuals may benefit from trauma-focused work, stabilisation of substance use is often required before trauma-focused treatment is likely to be optimally beneficial. It is important to note that the evidence the tables is based on is primarily drawn from studies of working age adults and it is unclear how applicable the evidence is to other groups, for example, older people and people with learning disabilities.

Treatment

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence	Level of Efficacy/Effect
All levels	Part 1 & 2	High	Cognitive processing therapy, cognitive therapy, EMDR*, individual CBT with a trauma focus (undifferentiated), prolonged exposure	A	High
All levels	Part 1 & 2	High	CBT without a trauma focus, group CBT with a trauma focus, narrative exposure therapy, present centred therapy	A	Medium
Mild to moderate	Part 1	High	Guided internet-based CBT with a trauma focus	A	Medium

* NICE recommend EMDR only after a non-combat-related trauma. A marked difference in response to EMDR in adults exposed to combat-related trauma compared to non-combat-related trauma is not supported by practice-based evidence, but more work is needed and it is important that practitioners and people with PTSD are aware that the current, albeit limited, research evidence suggests that EMDR is not effective for combat-related trauma.

References

1. Brady, K.T., Killeen, T.K., Brewerton, T., Lucerini, S. (2000) Comorbidity of psychiatric disorders and posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 61, 7, 22-32.
2. Bisson, J.I., Astill Wright, L., Jones, K.A., Lewis, C., Phelps, A.J., Sijbrandij, M., Varker, T., Roberts, N.P. (2021) Preventing the onset of post traumatic stress disorder. *Clinical Psychology Review*, 86, 102004. DOI: 10.1016/j.cpr.2021.102004.
3. Rose, S. C., Bisson, J., Churchill, R., Wessely, S. (2009) Psychological debriefing for presenting post traumatic stress disorder (PTSD) (Review) *The Cochrane Library*, 2009, Issue 1, 1-45.

4. Roberts, N.P., Kitchiner, N.J., Kenardy, J., Lewis, C.E., Bisson, J.I. (2019) Early psychological intervention following recent trauma: A systematic review and meta-analysis. *European Journal of Psychotraumatology* 10 (1), 1695486.
5. Lewis, C., Roberts, N.P., Andrew, M., Starling, E., Bisson, J.I. (2020) Psychological therapies for post-traumatic stress disorder in adults: systematic review and meta-analysis, *European Journal of Psychotraumatology*, 11:1, 1729633.
6. Monson, C., Fredman, S., Macdonald, A., Pukay Martin, N., Resick, P., Schnurr, P. (2012) Effect of cognitive-behavioral couple therapy for PTSD: a randomized controlled trial. *JAMA*, 308, 700-9.
7. Tylee, D.S., Gray, R., Glatt, S.J., Bourke, F. (2017) Evaluation of the reconsolidation of traumatic memories protocol for the treatment of PTSD: a randomized, wait-list-controlled trial. *Journal of Military, Veteran and Family Health*, 3, 21-33.
8. Lewis, C., Roberts, N., Simon, N., Bethell, A., Bisson, J. (2019) Internet-delivered cognitive behavioural therapy for post-traumatic stress disorder: systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 140, 508-521.
9. World Health Organisation. International Classification of Diseases 11th Revision. WHO; 2018. Available from: <https://icd.who.int> <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559> (Accessed 23 April 2021).
10. Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Shevlin, M., Hyland, P., et al. (2019) Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. *Psychological Medicine*, 49, 1761-75.
11. Coventry, P.A., Meader, N., Melton, H., Temple, M., Dale, H., Wright, K., et al. (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. *PLoS Medicine*. 2020; 17(8):e1003262.
12. International Society for Traumatic Stress Studies (ISTSS). Position paper on complex PTSD in adults. ISTSS; 2018. Available from: [https://istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-\(Adults\)_FNL.pdf.aspx](https://istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_CPTSD-Position-Paper-(Adults)_FNL.pdf.aspx) (Accessed 23 April 2021).

Complex Traumatic Stress Disorders (Type 2 Trauma) 2017

Courtois and Ford (1) have defined complex psychological trauma as “involving traumatic stressors that (i) are repetitive or prolonged; (ii) involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; (iii) occur at developmentally vulnerable times in the victim's life, such as early childhood and (iv) have great potential to compromise severely a child's development”. Traumatic experiences early in childhood have been particularly associated with poor mental health in adulthood. Repeated exposure to interpersonal stressors in adulthood such as domestic violence, torture, sex trafficking and other forms of organised violence are also associated with complex psychological trauma responses (2). Effects may include affect deregulation and impaired self-concept, dissociation, somatic dysregulation and disorganised attachment patterns leading to interpersonal and intra-personal difficulties in adult life (3, 4). These are in addition to DSMV PTSD symptoms of re-experiencing of the traumatic events, avoidance of the reminders, negative alterations in cognitions and mood and hyper arousal. There is limited treatment outcome research on interventions for complex traumatic stress and further research in the area is required (1). The expert consensus task force established by the International Society for Traumatic Stress Studies identified nine RCTs in which complex trauma symptoms were the target of treatment in individuals with complex trauma resulting from childhood physical and/or sexual abuse (2). The models evaluated in these studies were all based on phase based programmes. Although evidence is limited, it is widely thought that a phase based intervention approach is indicated for treatment of complex traumatic stress disorders. A prolonged assessment and formulation process is essential initially along with the development of the therapeutic relationship. It is also recommended that interventions that specifically target problem areas such as affect deregulation, dissociation and somatic dysregulation are addressed first, with an initial focus on safety, emotion regulation and patient education. Medication can sometimes aid the stabilisation process. When sufficient sense of safety and stabilisation has been achieved, the treatment can move on to the processing of traumatic memories using CBT or EMDR. Some service users will choose not to undertake this phase and careful consideration of the pros and cons of undertaking processing is needed before this begins. Finally the patient can be helped to reintegrate with others in their life.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate - Severe	Specialist trauma service	High	<p>Phase based intervention programme: 16-30 sessions (some treatment may be much longer)</p> <p>Phase 1 - Safety and stabilisation</p> <p>Establish therapeutic alliance. Training in affect regulation. Education about trauma and its impacts</p> <p>Phase 2 - Processing of traumatic memories narrative reconstruction of memories with careful use of CBT interventions and/or EMDR, including exposure where appropriate</p> <p>Phase 3 - Reintegration</p> <p>The continued development of trustworthy relationships. Work on intimacy, sexual functioning, parenting etc.</p>	<p>A^{18,19}</p> <p>C^{14,15}</p> <p>C^{14,15}</p>

References

1. Courtois, C. A., & Ford, J. D. (Eds.). (2009) Treating complex traumatic stress disorders: An evidence-based guide (pp. 82-104). New York, NY: Guilford Press.
2. Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011) Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, 24(6), 615-627.
3. DePrince, A.P., & Freyd, J. J. (2007) Trauma-induced dissociation. In M. J. Friedman, T M. Keane & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 135-150). New York: Guilford Press
4. Kessler, R., C., McLaughlin, K., A., Green, J., G., et al. (2010) Childhood adversities and adult psychopathology in the WHO Mental Health Surveys. *British Journal of Psychiatry*, 197, 378-385.

Schizophrenia/Psychosis (2017)

Psychosis is a term used to represent a range of major mental health problems, of which the commonest is schizophrenia and which includes schizoaffective disorder, schizophreniform disorder, delusional disorder and non-affective psychoses¹. These conditions comprise a cluster of signs and symptoms which reflect changes in perception, mood, behaviour, thinking and speech. There is considerable overlap with other conditions and this gives rise to diagnostic uncertainty and a lack of predictive utility². The causes of these conditions remain uncertain, although an integrated socio-developmental-cognitive model is favoured³.

The onset of the condition is characterised by a prodromal phase typified by a dysphoric state with attenuated or brief psychotic symptoms⁴. Approximately a fifth of those at high risk will transition to psychosis within the first year⁵, giving rise to a predicted rate for Wales of around three hundred new presentations a year, of which 80% will be between the ages of 16 and 25⁶. Outcome in schizophrenia is variable, with symptomatic relapse within the first year post diagnosis ranging from 30% to 60%. Only between 17% and 40% of those diagnosed reach fully symptomatic recovery at seven years post diagnosis (with the variation representing different treatment regimes^{7,8}). The societal and personal costs of schizophrenia and psychosis are high, with low rates of employment, social participation, lower life expectancy and longer years lived with disability, victimisation and suicide⁹⁻¹⁴.

Treatments for schizophrenia and psychosis have been the subject of considerable empirical study, which is summarised through the various iterations of the UK guidelines published by NICE¹⁵ and SIGN¹⁶. These broad guidelines include psychological and psychosocial therapies that target physical health and behaviour change, symptoms, recovery, social functioning and occupation. Psychological therapies should be seen in the context of overall approaches to health gain and social participation. Despite a recent update, the NICE recommendations addressing psychological and psychosocial therapies date back to 2009¹⁷ and since then there have been a number additional trials and meta-analysis¹⁸⁻³⁰ which report on additional studies and the risk of bias and its influence on effect size^{31,32}.

Reviews of CBT for negative and positive symptoms report small to moderate effect sizes for hallucinations and very small effect sizes for delusions. When the risk of study bias is accounted for, the effect size falls to very small or no effect depending on the intervention and its target symptom^{16,18-20,23,24}. A large pragmatic trial of arts therapy (MATISSE) did not support the previous NICE recommendation for arts therapy for negative symptoms^{16,18}. Also, supportive therapy and befriending are unlikely to be superior to treatment as usual^{24,25}. Finally, whilst cognitive remediation therapy demonstrates improvements in cognition, these are unlikely to be transferred into improved functioning outside of a rehabilitation framework^{28,29}.

In spite of this, there are positive outcomes for the use for family intervention and CBT for people at risk of psychosis or in the early stages of the condition^{22,33}. Family intervention is likely to reduce relapse rates and may reduce family burden across all phases of the condition^{15,34,35}. Social skills training²⁴ and group psychotherapies may improve negative symptoms and social functioning³⁰. PTSD, anxiety and depression are prevalent in schizophrenia and psychosis and therapies targeting these should be offered^{15,36,37}. There is also emerging evidence (with a risk of bias) of the benefits

of offering low intensity interventions targeting distress, worry and sleep which although have a small to moderate effect size, may be cost effective if delivered at scale^{33,38-42}.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Ultra-high risk of psychosis (attenuated or brief limited/ intermittent psychotic symptoms)	Secondary care	High	Family intervention CBT for psychosis	A ^{15,34,35} A ²²
		Low	Worry-reduction and sleep improvement CBT; progressive relaxation	A ^{38,39,42}

First episode psychosis, relapse or persistent symptoms in psychosis	Secondary care	High	<p>Family intervention for reducing relapse and family burden</p> <p>NICE recommended treatments for associated problems such as depression and PTSD</p> <p>Reasoning and rehabilitation programmes for verbal aggression and problem-solving in offenders with psychosis</p> <p>Cognitive remediation within a rehabilitation programme for social functioning and cognitive functioning¥</p> <p>Formulation based cognitive behaviour therapy for positive symptoms (greater effect for voices compared to delusions) ¥</p> <p>For negative symptoms social skills training ¥, and group psychotherapy ¥*</p> <p>Group art psychotherapy</p> <p>Music therapy</p>	<p>A^{15,34,35}</p> <p>A^{15,36,37}</p> <p>A⁴³</p> <p>A²⁸</p> <p>A^{19,20,24}</p> <p>A^{24,30}</p> <p>B^{46,49}</p> <p>A^{47,48}</p>
		Low	<p>Mindfulness for positive and negative symptoms¥</p> <p>Worry-reduction and sleep improvement cognitive behaviour therapy; progressive relaxation; relapse prevention training; yoga and distraction techniques</p> <p>Early signs of monitoring</p>	<p>A⁴⁵ C⁴⁴</p> <p>A³⁸⁻⁴²</p> <p>A^{50,51,52}</p>

‡ Interventions with small or very small effect sizes.

* The benefits appear equal across psychotherapies and attributable to nonspecific effects for which non-psychotherapeutic groups may be equally effective i.e., discussion or support groups.

References

1. American Psychiatric Association. (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM-V). 5th ed, (American Psychiatric Association).
2. Keshavan, M. S., Nasrallah, H. A. & Tandon, R. (2011) Schizophrenia, 'Just the Facts' 6. Moving ahead with the schizophrenia concept: From the elephant to the mouse. *Schizophr. Res.* 127, 3–13.
3. Howes, O. D. & Murray, R. M. (2014) Schizophrenia: an integrated sociodevelopmental-cognitive model. *The Lancet* 383, 1677–1687.
4. McGlashan, T. H. (2003) Commentary: Progress, Issues, and Implications of Prodromal Research: An Inside View. *Schizophr. Bull.* 29, 851–858 .10.1001/archgenpsychiatry.2011.1472.
5. Kirkbride, J. (2013) Predicted first episode psychosis, England & Wales, per annum. *PsyMaptic* at <<http://www.psymaptic.org/prediction/psychosis-incidence-map/>>
6. Leucht, S. et al. (2012) Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. *The Lancet* 379, 2063–2071.
7. Wunderink, L., Nieboer, R. M., Wiersma, D., Sytema, S. & Nienhuis, F. J. (2013) Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-term Follow-up of a 2-Year Randomized Clinical Trial. *JAMA Psychiatry* 70, 913.
8. Andrew, A., Knapp, M., McCrone, P., Parsonage, M. & Trachtenberg, M. (2012) Effective Interventions in Schizophrenia: The economic case. (Rethink).
9. Knapp, M., Mangalore, R. & Simon, J. (2004) The global costs of schizophrenia. *Schizophr. Bull.* 30, 279–93.
10. Thornicroft, G. et al. (2004) The personal impact of schizophrenia in Europe. *Schizophr. Res.* 69, 125–32.
11. Brown, S., Kim, M., Mitchell, C. & Inskip, H. (2010) Twenty-five year mortality of a community cohort with schizophrenia. *Br. J. Psychiatry* 196, 116–121.

12. Maniglio, R. (2009) Severe mental illness and criminal victimization: a systematic review. *Acta Psychiatr. Scand.* 119, 180–191.
13. Fazel, S., Wolf, A., Palm, C. & Lichtenstein, P. (2014) Violent crime, suicide, and premature mortality in patients with schizophrenia and related disorders: a 38-year total population study in Sweden. *Lancet Psychiatry* 1, 44–54.
14. NICE (2014) Psychosis and schizophrenia in adults: treatment and management (CG178).
15. SIGN (2013) SIGN 131: Management of schizophrenia.
16. NICE (2009) Schizophrenia (CG82): Core interventions in the treatment and management of schizophrenia in primary and secondary care (update).
17. Crawford, M. J. et al. (2012) Group art therapy as an adjunctive treatment for people with schizophrenia: multicentre pragmatic randomised trial. *BMJ* 344, e846–e846.
18. Jauhar, S. et al. (2014) Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br. J. Psychiatry* 204, 20–29.
19. van der Gaag, M., Valmaggia, L. R. & Smit, F. (2014) The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *Schizophr. Res.* doi:10.1016/j.schres.2014.03.016
20. Morrison, A. P. et al. (2014) Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial. *Lancet* doi:10.1016/S0140-6736(13)62246-1
21. Stafford, M. R., Jackson, H., Mayo-Wilson, E., Morrison, A. P. & Kendall, T. (2013) Early interventions to prevent psychosis: systematic review and meta-analysis. *BMJ* 346, f185–f185.
22. Burns, A. M. N., Erickson, D. H. & Brenner, C. A. Cognitive Behavioral Therapy for Medication Resistant Psychosis: A Meta-Analytic Review. *Psychiatr. Serv.* (2014). doi:10.1176/appi.ps.201300213
23. Turner, D. T., van der Gaag, M., Karyotaki, E. & Cuijpers, P. Psychological Interventions for Psychosis: A Meta-Analysis of Comparative Outcome Studies. *Am. J. Psychiatry* (2014). doi:http://dx.doi.org/10.1176/appi.ajp.2013.13081159
24. Buckley, L. A., Maayan, N., Soares-Weiser, K. & Adams, C. E. in *Cochrane Database of Systematic Reviews* (ed. The Cochrane Collaboration) (John Wiley & Sons, Ltd, 2015). at <http://doi.wiley.com/10.1002/14651858.CD004716.pub4>
25. Morriss, R., Vinjamuri, I., Faizal, M. A., Bolton, C. A. & McCarthy, J. P. in *Cochrane Database of Systematic Reviews* (ed. The Cochrane Collaboration) (John Wiley & Sons, Ltd, 2013). at <http://doi.wiley.com/10.1002/14651858.CD005147.pub2>

-
26. Jones, C., Hacker, D., Cormac, I., Meaden, A. & Irving, C. B. in *Cochrane Database of Systematic Reviews* (ed. The Cochrane Collaboration) (John Wiley & Sons, Ltd, 2012). at <<http://doi.wiley.com/10.1002/14651858.CD008712.pub2>>
 27. Wykes, T., Huddy, V., Cellard, C., McGurk, S. R. & Czobor, P. A (2011) Meta-Analysis of Cognitive Remediation for Schizophrenia: Methodology and Effect Sizes. *Am. J. Psychiatry* 168, 472–485.
 28. Revell, E. R., Neill, J. C., Harte, M., Khan, Z. & Drake, R. J. (2015) A systematic review and meta-analysis of cognitive remediation in early schizophrenia. *Schizophr. Res.* 168, 213–222.
 29. Orfanos, S., Banks, C. & Priebe, S. (2015) Are Group Psychotherapeutic Treatments Effective for Patients with Schizophrenia? A Systematic Review and Meta-Analysis. *Psychother. Psychosom.* 84, 241–249.
 30. Guyatt, G. H. et al. (2008) What is 'quality of evidence' and why is it important to clinicians? *BMJ* 336, 995–998.
 31. Munder, T., Brüttsch, O., Leonhart, R., Gerger, H. & Barth, J. (2013) Researcher allegiance in psychotherapy outcome research: An overview of reviews. *Clin. Psychol. Rev.* 33, 501–511.
 32. Morrison, A. P. et al. (2012) Early detection and intervention evaluation for people at risk of psychosis: multisite randomised controlled trial. *BMJ* 344, e2233–e2233.
 33. NICE (2013) Psychosis and schizophrenia in children and young people: Recognition and management (CG155).
 34. Pharoah, F., Mari, J. J., Rathbone, J. & Wong, W. in *Cochrane Database of Systematic Reviews* (ed. The Cochrane Collaboration) (John Wiley & Sons, Ltd, 2010). at <<http://doi.wiley.com/10.1002/14651858.CD000088.pub3>>
 35. NICE. Depression in Adults (update). Depression: the treatment and management of depression in adults (CG 90). (National Institute for Health and Clinical Excellence, 2009).
 36. van den Berg, D. P. G. et al. (2015) Prolonged Exposure vs Eye Movement Desensitization and Reprocessing vs Waiting List for Posttraumatic Stress Disorder in Patients With a Psychotic Disorder: A Randomized Clinical Trial. *JAMA Psychiatry* 72, 259.
 37. Freeman, D. et al. (2015) Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): a parallel, single-blind, randomised controlled trial with a mediation analysis. *Lancet Psychiatry* 2, 305–313.
 38. Freeman, D. et al. (2015) Efficacy of cognitive behavioural therapy for sleep improvement in patients with persistent delusions and hallucinations (BEST): a prospective, assessor-blind, randomised controlled pilot trial. *Lancet Psychiatry* 2, 975–983.
 39. Broderick, J., Knowles, A., Chadwick, J. & Vancampfort, D. in *Cochrane Database of Systematic Reviews* (ed. The Cochrane Collaboration) (John Wiley & Sons, Ltd, 2015). at <<http://doi.wiley.com/10.1002/14651858.CD010554.pub2>>
-

-
40. Crawford-Walker, C. J., King, A. & Chan, S. Distraction techniques for schizophrenia. (John Wiley & Sons, Ltd, 2005). at <<http://doi.wiley.com/10.1002/14651858.CD004717.pub2>>
 41. Vancampfort, D. et al. (2013) Progressive muscle relaxation in persons with schizophrenia: a systematic review of randomized controlled trials. *Clin. Rehabil.* 27, 291–298.
 42. Boxer, P. (2013) Reasoning and rehabilitation cognitive skills programme reduces verbal aggression in violent offenders with psychotic disorders. *Evid. Based Ment. Health* 16, 48–48.
 43. Chadwick, P. (2014) Mindfulness for psychosis. *Br. J. Psychiatry* 204, 333–334.
 44. Khoury, B., Lecomte, T., Gaudiano, B. A. & Paquin, K. (2013) Mindfulness interventions for psychosis: A meta-analysis. *Schizophr. Res.* 150, 176–184.
 45. Montag, C. et al. (2014) A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: feasibility, impact on symptoms and mentalising capacity. *PLOS One*, 9(1), 1-11.
 46. Carr, C., Odell-Miller, H. & Priebe, S. (2013) A systematic review of music therapy practice and outcomes with acute adult psychiatric inpatients. *PLOS One*, 8 (8).
 47. Mossler, K. et al. (2011) Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Systematic Reviews*, 2011, (12).
 48. Crawford, M.J., et al. (2012) Group art therapy as an adjunctive treatment for people with schizophrenia: multicentre pragmatic randomised trial. *British Medical Journal*, 344.
 49. Eisner, E., Drake, R., Barrowclough, C. (2013) Assessing early signs of relapse in psychosis: Review and future directions. *Clinical Psychology Review*, 33, 637-653.
 50. Morriss R, Vinjamuri I, Faizal MA, Bolton CA, McCarthy JP. Training to recognise the early signs of recurrence in schizophrenia. *Cochrane Database of Systematic Reviews* 2013, Issue 2. Art. No.: CD005147. DOI: 10.1002/14651858.CD005147.pub2.
 51. Alvarez-Jiminez, M., Priede, A., Hetrick, S.E., Bendall, S., Killackey, E., Parker, A.G., McGorry, P., & Gleeson, J.F. (2012) Risk factors for relapse following treatment for first episode psychosis: A systematic review and meta-analysis of longitudinal studies. *Schiz Res*, 139, 116-128.
-

Social Anxiety Disorder (2017)

The Social Phobia Inventory (SPIN) (8) assesses severity of social phobia and the Work and Social Adjustment Scale (WSAS) (20) can help to assess the impact of social phobia on functioning.

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild (SPIN>19 indicates social anxiety)	Primary care	Low	Book prescription using books based on CBT for social anxiety Guided self-help based on CBT for social anxiety	A ^{5,12,18,21,24} A ^{1,2,3,4,15,17,18,21,25,26,27,28,29,30}
Moderate – Severe (SPIN>30 indicates moderate social anxiety; SPIN>40 indicates severe social anxiety)	Secondary care	High	14-16 sessions disorder-specific CBT for social phobia N.B. Group CBT is so much less effective than individual CBT that it is not clinically or cost-effective Interpersonal psychotherapy (IPT) Psychodynamic therapy	A ^{6,7,9,10,11,13,14,16,17,19,21,22,23} A ³¹ A ³²
Social anxiety disorder with avoidant personality disorder	Secondary care	High	14-16 sessions disorder-specific CBT for social phobia delivered by therapists competent in the disorder-specific model	A ⁷

There is no Cochrane Review for social anxiety disorder. There have been two recent and significant meta-analyses, one commissioned by The National Collaborating Centre for Mental Health (NCCMH) and published in 2013 (21) and one by Mayo-Wilson et al. published in The Lancet in 2014 (19). The recommendations in the table above are largely based on these two reviews. Individual CBT is the only psychological treatment that is better than a placebo control (19) and therefore no others are included in this evidence table.

References

1. Andersson, G., Carlbring, P., Holmström, A., Sparthán, E., Furmark, T., Nilsson-Ihrfelt, E., & Ekselius, L. (2006) Internet-based self-help with therapist feedback and in vivo group exposure for social phobia: a randomized controlled trial. *Journal of consulting and clinical psychology*, 74(4), 677.
2. Andrews, G., Davies, M., & Titov, N. (2011) Effectiveness randomized controlled trial of face to face versus Internet cognitive behaviour therapy for social phobia. *Australian and New Zealand Journal of Psychiatry*, 45(4), 337-340.
3. Berger, T., Hohl, E., & Caspar, F. (2009) Internet-based treatment for social phobia: a randomized controlled trial. *Journal of Clinical Psychology*, 65, 1021-1035.
4. Carlbring, P., Gunnarsdottir, M., Hedensjö, L., Andersson, G., Ekselius, L. & Furmark, T. (2007) Treatment of social phobia: randomized trial of internet-delivered cognitive-behavioural therapy with telephone support. *British Journal of Psychiatry*, 190, 123-128.
5. Chung, Y. S., Kwon, J. H. (2008) The efficacy of bibliotherapy for social phobia. *Brief Treatment and Crisis Intervention*, 8, 390-401.
6. Clark, D. M., Ehlers, A., McManus, F., Hackmann, A., Fennell, M., Campbell, H., & Louis, B. (2003) Cognitive therapy versus fluoxetine in generalized social phobia: a randomized placebo-controlled trial. *Journal of consulting and clinical psychology*, 71(6), 1058.
7. Clark, D. M., Ehlers, A., Hackmann, A., McManus, F., Fennell, M., Grey, N., ... & Wild, J. (2006) Cognitive therapy versus exposure and applied relaxation in social phobia: A randomized controlled trial. *Journal of consulting and clinical psychology*, 74(3), 568.
8. Connor, K. M., Davidson, J. R., Churchill, L. E., Sherwood, A., Foa, E., & Weisler, R. H. (2000) Psychometric properties of the Social Phobia Inventory (SPIN): new self-rating scale. *British Journal of Psychiatry*, 176, 379-386.
9. Cottraux, J., Note, I., Albuissou, E., Yao, S. N., Note, B., Mollard, E., Bonasse, F., Jalenques, I., Guérin, J., & Coudert, A. J. (2000). Cognitive behavior therapy versus supportive therapy in social phobia: A randomized controlled trial. *Psychotherapy and Psychosomatics*, 69, 137-146
10. Ehlers, A., Bisson, J., Clark, D. M., Creamer, M., Pilling, S., Richards, D., Schnurr, P. P., Turner, S., & Yule, W. (2010) Do all psychological treatments really work the same in posttraumatic stress disorder? *Clinical Psychology Review*, 30, 269-276.
11. Emmelkamp, P. M., Benner, A., Kuipers, A., Feiertag, G. A., Koster, H. C., & van Apeldoorn, F. J. (2006) Comparison of brief dynamic and cognitive-behavioural therapies in avoidant personality disorder. *The British journal of psychiatry*, 189(1), 60-64.
12. Furmark, T., Carlbring, P., Hedman, E., Sonnenstein, A., Clevberger, P., Bohman, B., ... & Andersson, G. (2009). Guided and unguided self-help for social anxiety disorder: randomised controlled trial. *The British Journal of Psychiatry*, 195(5), 440-447.

13. Ginzburg, D.M., Bohn, C., Höfling, V., Weck, F., Clark, D. M. Stangier, U. (2012) Treatment specific competence predicts outcome in cognitive therapy for social anxiety disorder. *Behaviour Research and Therapy*, 50, 747-752.
14. Goldin, P. R., Jazaieri, H., Ziv, M., Kraemer, H., Heimberg, R., Gross, J. (2013) Changes in positive self-views mediate the effect of cognitive-behavioral therapy for social anxiety disorder. *Clinical Psychological Science*, 1, 301-310.
15. Hedman, E., Andersson, E., Ljotsson, B., Andersson, G., Ruck, C., & Lindefors, N. (2011a) Cost effectiveness of internet-based cognitive behavior therapy vs. cognitive behavioral group therapy for social anxiety disorder: results from a randomized controlled trial. *Behaviour Research and Therapy*, 49, 729-736.
16. Herbert, J. D., Rheingold, A. A., Gaudiano, B. A., & Myers, V. H. (2004) Standard versus extended cognitive behavior therapy for social anxiety disorder: a randomized-controlled trial. *Behavioural and Cognitive Psychotherapy*, 32, 131-147.
17. Ledley, D. R., Heimberg, R. G., Hope, D. A., Hayes, S. A., Zaider, T. I., Van Dyke, M., ... & Fresco, D. M. (2009) Efficacy of a manualized and workbook-driven individual treatment for social anxiety disorder. *Behavior Therapy*, 40(4), 414-424.
18. Lewis, C., Pearce, J., & Bisson, J. I. (2012) Efficacy, cost-effectiveness and acceptability of self-help interventions for anxiety disorders: systematic review. *British Journal of Psychiatry*, 200, 15-21
19. Mayo-Wilson, E., Dias, S., Mavranezouli, I., Kew, K., Clark, D.M., Ades, A.E., & Pilling, S. (2014) Psychological and pharmacological interventions for social anxiety disorder in adults: a systematic review and network meta-analysis. *The Lancet Psychiatry*, 1, 368-376.
20. Mundt, J. M., Marks, I. M., Shear, M. K., & Greist, J.M. (2002) The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *British Journal of Psychiatry*, 180, 461-464.
21. National Collaborating Centre for Mental Health (2013) Social Anxiety Disorder: Recognition, Assessment and Treatment. The British Psychological Society & The Royal College of Psychiatrists.
22. Oosterbaan, D. B., van Balkom, A. J. L. M., Spinhoven, P., van Oppen, P., & van Dyck, R. (2001) Cognitive therapy versus moclobemide in social phobia: a controlled study. *Journal of Clinical Psychology and Psychotherapy*, 35, 889-900.
23. Prasko, J. K. (2003) Pharmacotherapy and/or cognitive-behavioral therapy in the treatment of social phobia: control study with two year follow up. *Ceska a Slovenska Psychiatrie*, 99, 106-108.
24. Rapee, R. M., Abbott, M. J., Baillie, A. J., Gaston, J. E. (2007) Treatment of social phobia through pure self-help and therapist-augmented self-help. *British Journal of Psychiatry*, 191, 246-252.

25. Stott, R., Wild, J., Grey, N., Liness, S., Warnock-Parkes, E., Commins, S., Readings, J., Bremner, G., Woodward, E., Ehlers, A., & Clark, D. M. (2013) Internet-delivered therapy for social anxiety disorder. *Behavioural and Cognitive Psychotherapy*, 41, 383-397.
26. Titov, N., Andrews, G., Choi, I., Schwencke, G., & Mahoney, A. (2008a) Shyness 3: randomized controlled trial of guided versus unguided Internet-based CBT for social phobia. *Australian and New Zealand Journal of Psychiatry*, 42(12), 1030-1040.
27. Titov, N., Andrews, G., & Schwencke, G. (2008b) Shyness 2: treating social phobia online: replication and extension. *Australian and New Zealand Journal of Psychiatry*, 42(7), 595-605.
28. Titov, N., Andrews, G., Schwencke, G., Drobny, J., & Einstein, D. (2008c) Shyness 1: distance treatment of social phobia over the Internet. *Australian and New Zealand Journal of Psychiatry*, 42(7), 585-594.
29. Titov, N., Andrews, G., Choi, I., Schwencke, G., & Johnston, L. (2009a) Randomized controlled trial of web-based treatment of social phobia without clinician guidance. *Australian and New Zealand Journal of Psychiatry*, 43(10), 913-919.
30. Titov, N., Andrews, G., Johnston, L., Schwencke, G., & Choi, I. (2009) Shyness programme: longer term benefits, cost-effectiveness, and acceptability. *Australian and New Zealand Journal of Psychiatry*, 43(1), 36-44.
31. Stangier, U. et al. (2011) Cognitive Therapy versus Interpersonal Psychotherapy in social anxiety disorder: a randomized controlled trial. *Archives of General Psychiatry*, 68, 692-700.
32. Liechsenring, F. et al. (2013) Psychodynamic therapy and cognitive-behavioural therapy in social anxiety disorder: a multicenter randomized controlled trial. *American Journal of Psychiatry*, 170, 759-767

Specific Phobias (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	Group treatment based on BT principles Exposure-based therapy (BT) Manualised self-guided therapy based on behaviour therapy (BT) principles Supportive counselling	A ^{1,6} A ^{4,5} B ² B ⁴
Moderate – Severe	Primary care	High	Disorder specific CBT EMDR Emotion freedom technique (EFT)	A ^{5,9,10} B ³ B ⁷

Mild

Manualised self-guided therapy has been tested with spider phobics, using a specific handout for use with spider phobia (2).

Group treatment has again been tested in a number of small trials (1, 6). Groups of 3/4 are recommended and format varies. Basing this on exposure treatments appears to be the most effective.

Supportive counselling (based on a dynamic and non-directive approach) has been tested and gained significant results in one trial (4). The caution here is that many of the candidates could also have achieved forms of exposure during the treatment process.

Moderate/Severe

Most presentations to services for specific phobias are likely to fall into this category, due to the impact on their social functioning leading the person to seek treatment. Within this category, exposure based models for treatment have been the most tested and with significant outcomes.

Variations on the method of administration are noted. Ost's well studied 3 hour sessions appear to have a wide evidence base. His development of the applied tension technique (8) has also been tested with good results and would be recommended for use as an adjunct with exposure for certain presentations of blood/injury phobia.

Cognitive restructuring within a CT or CBT format has also been tested with good outcomes, particularly with claustrophobia. The results vary, with one study suggesting no further impact beyond those of the exposure based model (9, 10).

EMDR has been tested in case studies, one uncontrolled study and one controlled study (3). The results of the latter were not significant. This form of treatment could be considered if there is a traumatic event associated with the phobia's development, or the phobia is difficult to confront (e.g., flying, wasps, thunderstorms). There is a suggestion though, that other forms of imaginal exposure may perform just as well. EFT has been tested in one small RCT (7) with significant outcomes controlled against a breathing technique. Although based on contested theoretical principles, this alone should not necessarily warrant its exclusion. Virtual reality guided phobia treatment has been well studied with some good outcomes. It does not appear in this guidance though, as the protocol is likely to be expensive compared to other treatments.

References

1. Ost, L-G. (1996) One session group treatment of spider phobia. *Behaviour Research and Therapy*, 34, 707-715.
2. Hellstrom, K., Ost, L-G. (1995) One session therapist directed exposure vs two forms of manual directed self-exposure in the treatment of spider phobia. *Behaviour Research and Therapy*, 33, 959-965.
3. DeJongh, A., Ten, Broeke, E., Renssen, M. R. (1999) Treatment of specific phobias with EMDR: Protocol, Empirical Status and Conceptual issues. *Journal of Anxiety Disorders*, 13, 69-85.
4. Choy, Y., Fyer, A. J., Lipsitz, J. D. (2006) Treatment of specific phobia in adults. *Clinical Psychology Review*, 27, 266-286.
5. Wolitzky-Taylor, K. B., Horowitz, J. D., Powers, M. B., Telch, M. J. (2008) Psychological approaches in the treatment of specific phobias: A meta-analysis. *Clinical Psychology Review*, 28, 1021-1037.
6. Ost, L-G., Ferebee, I., Furmark, T. (1997) One-session group therapy of spider phobia: direct versus indirect treatments. *Behaviour, Research and Therapy*, 35, 721-732.
7. Wells, S., Polglase, K., Andrews, H. B., Carrington, P., Baker, A. H. (2003) Evaluation of a meridian-based intervention, Emotional Freedom Technique, for reducing specific phobias of small animals. *Journal of Clinical Psychology*, 59, 943-966

8. Ost, L-G., Sterner, U., Fellenius, J. (1989) Applied tension, applied relaxation and the combination in the treatment of blood phobia. Behaviour Research and Therapy, 27, 407-422.
9. Booth, R., Rachman, S. (1992) The reduction of claustrophobia. Behaviour, Research and Therapy, 30, 207-221.
10. Koch, E. L., Spates, C. R., Himle, J. A. (2004) Comparison of behavioural and cognitive-behavioural one session exposure treatments for small animal phobias. Behaviour, Research and Therapy, 42, 1483-1504.

Substance Misuse (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Opportunistic contact	Low	Opportunistic brief intervention (motivationally based)	A ^{1,2}
Mild-Moderate Cannabis with comorbid anxiety and/or depression Stimulants with comorbid anxiety and/or Benzodiazepines with panic disorder	Primary/Secondary care	High	CBT Group CBT + gradual tapering (10 weeks)	A ^{1,2} A ^{1,2}
Moderate – Severe	Community/Inpatient/ Residential/Criminal Justice	High	Contingency management Behavioural couples therapy	A ^{1,2} A ^{1,2}
Moderate – Severe Stimulants with comorbid anxiety and/or depression	Primary care/Community	High	CBT	A ^{1,2}

Individuals with comorbid drug and/or alcohol misuse are often excluded from studies evaluating interventions for PTSD. There is some evidence to suggest that they can benefit from TFCBT but there is also increased risk of disengagement from treatment. There is a consensus that drug/alcohol misuse should be stabilised before trauma-focused treatment is offered.

References

1. National Institute for Health and Clinical Excellence (NICE) (2007) Drug Misuse: Psychosocial Intervention. (CG51). London: NICE.
2. National Treatment Agency for Substance Misuse (NTA) (2005) The Effectiveness of Psychological Therapies on Drug Misusing Clients, London: NTA.
3. Roberts, N. P., Roberts, P. A., Jones, N., & Bisson, J. I. (2015) Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: A systematic review and meta-analysis. *Clinical psychology review*, 38, 25-38.

Psychological therapies with older adults

In the developed and developing world, the older adult population is growing rapidly. Half the total population of the UK is currently aged 50 or older and the number of people aged 60+ outnumbers those aged 18 and under. In Wales, the population aged 65+ is predicted to rise by almost 40 percent over the next 20 years, with one in four people expected to be aged 65+ by the year 2036.

A multitude of social, demographic, psychological and biological factors contribute to a person's mental health and emotional wellbeing; almost all of which are particularly pertinent amongst older adults. These include factors such as poverty, social isolation, loss of independence and loneliness. Older adults are more likely to experience events such as bereavements or physical disability. As such, older adults often present with psychological difficulties and comorbid physical health problems.

However, there are a number of myths about ageing that have contributed to the perception that psychotherapy with older adults may be less effective, including the notion that it's too late for older people to change, that older people don't want psychotherapy, or that depression is to be expected in later life. In fact, there is a lot of empirical evidence to suggest that older adults can and often do, benefit from psychological therapies. Furthermore, treatment outcomes for older adults have been found to be comparable with those of younger adults (Cuijpers et al., 2009).

The following tables summarise the current evidence for the effectiveness of psychological therapies in later life across a variety of mental health problems. However, it is important to remember that many of those therapeutic approaches and interventions recommended for adults of working age (see evidence tables for Mental Health Service for Adults) still benefit adults aged 65 and over, especially given that research in the field of older adults is significantly lagging behind that focused upon adults of working age.

Anxiety disorders in later life (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	CBT ACT	A ^{6,7} B ⁸
Moderate to severe	Secondary or tertiary care	High	CBT ACT	A ^{1,2,3,5} A ¹
Chronic/Complex with evidence of executive impairment	Psychological therapy services with highly specialist practitioners	High	CBT (adapted for older people with anxiety and executive dysfunction using specialist protocol)	B ⁴
Comorbid anxiety and depression	Part 1, Community, Part 2, care homes, day hospitals, in-patient units	High	Group CBT	A ⁹

References

1. Arch, J.J., Eifert, G.H., Davies, C., Plumb Vilardaga, J.C., Rose, R.D. & Craske, M.G. (2012) Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology*, 80, 750–765.
2. Barrowclough, C., et al. (2001) A randomized trial of the effectiveness of cognitive-behavioural therapy and supportive counselling for anxiety symptoms in older adults. *Journal of Consulting and Clinical Psychology*, 69, 756-762.
3. Hendriks, G. J., et al. (2008) Cognitive-behavioural therapy for late-life anxiety disorders: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 117, 403-411.
4. Mohlman, J. & Gorman, J.M. (2005) The role of executive functioning in CBT: A pilot study with anxious older adults. *Behaviour Research and Therapy*, 43, 447-465.
5. Schuurmans, J., et al. (2006) A randomized, controlled trial of the effectiveness of cognitive-behavioral therapy and sertraline versus a waitlist control group for anxiety disorders in older adults. *The American Journal of Geriatric Psychiatry*, 14, 255-263.

-
6. Stanley, M. A., et al. (2001) Assessing older adults with generalized anxiety: a replication and extension. *Behaviour Research and Therapy*, 39, 221-235.
 7. Stanley, M. A., et al. (2009) Cognitive behavior therapy for generalized anxiety disorder among older adults in primary care: a randomized clinical trial. *JAMA*, 301, 1460-1467.
 8. Wetherell, J. L., et al. (2011) Acceptance and commitment therapy for generalized anxiety disorder in older adults: A preliminary report. *Behaviour Therapy*, 42, 127-134.
 9. Wurthrich, V.M. & Rapee, R.R. (2013) Randomised controlled trial of group cognitive behavioural therapy for comorbid anxiety and depression in older adults. *Behaviour Research and Therapy*, 51, 779-786.

Depression in later life (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Primary care	Low	Bibliotherapy	A ¹⁷
			Reminiscence therapy	A ^{2,3,12,25}
			Life review therapy	A ^{2,3}
			Counselling	C ¹⁷
Mild to severe	All	Low	Positive psychology interventions	A ¹⁹
Moderate	Primary and secondary care	Low-High	Problem-solving therapy	A ¹¹
			Individual CBT	A ^{6,9,11,12,18,21}
			Group-based CBT	A ^{8,22}
			Psychodynamic therapy	A ^{6,23}
			IPT maintenance post-recovery	A ^{14,15}
			Behaviour therapy	A ¹⁶
Severe	Primary and secondary care	High	Individual CBT	A ¹¹
Chronic or treatment resistant	Secondary care/Highly specialised specialist service; in-patient care	High	Individual CBT	C ²¹
Prevention of relapse in recurrent depression	Primary/Secondary care	High	Mindfulness-based CT	C ^{5,20}

Depression with anxiety	All	Low	Group CBT	A ²⁴
		High	CAT	C ⁷

References

1. Arean, P. A., Perri, M. G., Nezu, A. M., Schein, R.L., Frima, C. & Joseph, T.X. (1993) Comparative effectiveness of social problem-solving therapy and reminiscence therapy as treatments for depression in older adults. *Journal of Consulting & Clinical Psychology*, 61, 1003-1010.
2. Bohlmeijer, E., Roemer, M., Cuijpers, P. & Smit, F. (2007) The effects of reminiscence on psychological well-being in older adults: A meta-analysis. *Ageing & Mental Health*, 11291-300. ** (read – A, B, C, if a change life review therapy bit above).
3. Bohlmeijer, E., Smit, F., & Cuijpers, P. (2003) Effects of reminiscence and life review on late-life depression: A meta-analysis. *International Journal of Geriatric Psychiatry*, 18, 1088-1094.
4. Boiler, L., et al. (2013) Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC Public Health*, 119.
5. Foulk, M.A., Ingersoll-Dayton, B., Kavanagh, J., Robinson, E. & Kales, H.C. (2014) Mindfulness-based cognitive therapy with older adults: an exploratory study. *Journal of Gerontological Social Work*, 57 (5), 498-520.
6. Gallagher-Thompson, D., Hanley-Peterson, P. & Thompson, L.W. (1990) Maintenance of gains versus relapse following brief psychotherapy for depression. *Journal of Consulting and Clinical Psychology*, 58, 371-374.
7. Hepple, J. & Sutton, L (2004) *Cognitive Analytic Therapy and Later Life: New Perspective on Old Age*, Brunner-Routledge: Hove.
8. Krishna, M., Jauhari, A., Lepping, P., Turner, J., Crossley, D., Krishnamoorthy, A. (2011) Is group psychotherapy effective in older adults with depression? A systematic review. *International Journal of Geriatric Psychiatry*, 26, 331-340.
9. Laidlaw, K, Davidson, K.M., Toner, H.L., Jackson, G., et al. (2008) A Randomised Controlled Trial of Cognitive Behaviour Therapy versus Treatment as Usual in the Treatment of Mild to Moderate Late Life Depression. *International Journal of Geriatric Psychiatry*, 23, 843-850.
10. Layous, K., et al. (2011) Delivering Happiness: Translating Positive Psychology Intervention Research for Treating Major and Minor Depressive Disorders. *The Journal of Alternative and Complementary Medicine*, 17, 675-683. Later life?
11. Pinquart, M. Duberstein, P.R., Lyness, J.M. (2006) Treatments for later-life depressive conditions: A meta-analytic comparison of pharmacotherapy and psychotherapy. *American Journal of Psychiatry*, 163, 1493-1501.

12. Pinquart, M., Duberstein, P. R. & Lyness, J. M. (2007) Effects of psychotherapy and other behavioral interventions on clinically depressed older adults: A meta-analysis. *Ageing & Mental Health*, 11, 645-657.
13. Pot, A. M., Bohlmeijer, E. T., Onrust, S., Melenhorst, A.-S., Veerbeek, M. & DeVries, W. (2010) The impact of life review on depression in older adults: a randomized controlled trial. *International Psychogeriatrics*, 22, 572-581.
14. Reynolds, C.F., III, Frank, E., Perel, J.M., Imber, S.D., Cornes, C., Miller, M.D., et al. (1999) Nortriptyline and Interpersonal Psychotherapy as Maintenance Therapies for Recurrent Major Depression: A Randomized Controlled Trial in Patients Older Than 59 Years. *Journal of the American Medical Association*, 281, 39-45.
15. Reynolds, C.F., III, Dew, M.A., Pollock, B.G., Mulsant, B.H., Frank, E., Miller, M.D., et al. (2006) Maintenance Treatment of Major Depression in Old Age. *The New England Journal of Medicine*, 354, 1130-1138.
16. Samad, Z, Brealy, S. & Gilbody, S. (2011) The effectiveness of behavioural therapy for the treatment of depression in older adults: A meta-analysis. *International Journal of Geriatric Psychiatry*, 26, published online in Wiley online library.
17. Scogin, F. & McElreath, L. (1994) Efficacy of psychosocial treatments for geriatric depression: A quantitative review. *Journal of Consulting and Clinical Psychology*, 62, 69-74.
18. Serfaty, M., Haworth, D., Blanchard, M., Buszewicz, M., Murad, S & King, M. (2009) Clinical effectiveness of individual cognitive behavioural therapy for depressed older people in primary care. *Archives of General Psychiatry*, 66, 1332-1340.
19. Sin, N. L. & Lyubomirsky. (2009) Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology*, 65, 467-487.
20. Smith, A., Graham, L. & Senthinathan, S. (2007) Mindfulness-based cognitive therapy for recurring depression in older people: A qualitative study. *Ageing and Mental Health*, 11, 346-357.
21. Thompson, L.W., Coon, D.W., Gallagher-Thompson, D. G., Sommer, B. R. & Koin, D. (2001) Comparison of Desipramine and Cognitive Behavioral Therapy in the treatment of elderly outpatients with mild-to-moderate depression. *American Journal of Geriatric Psychiatry*, 9, 225-240.
22. Wilkinson, P., Alder, N., Juszczak, E., Matthews, H., Merritt, C., Montgomery, H., Howard, R., MacDonald, A. & Jacoby, R. (2009) A pilot randomised controlled trial of a brief cognitive behavioural group intervention to reduce recurrence rates in late life depression. *International Journal of Geriatric Psychiatry*, 24, 68-75.
23. Wilson, K., Mottram, P.G., Vassilas, CA. (2008) Psychotherapeutic treatments for older depressed people. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD004853.DOI: 10.1002/14651858.CD0044853.pub2.

24. Wurthrich, V. M. & Rapee, R. R. (2013) Randomised controlled trial of group cognitive behavioural therapy for comorbid anxiety and depression in older adults. *Behaviour Research and Therapy*, 51, 779-786.
25. Zhang, S. J., Hwu, Y. J., Wu, P. I., & Chang, C. W. (2015) The Effects of Reminiscence Therapy on Depression, Self-Esteem and Life Satisfaction on Institutionalized Older Adults: A Meta-Analysis. *Journal of Nursing & Healthcare Research*, 11. (** severity)

Personality disorder in later life (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate	Secondary care	High	DBT	B ²
			CAT	C ¹

References

1. Hepple, J. & Sutton, L. (2004) *Cognitive Analytic Therapy and Later Life: New Perspective on Old Age*, Brunner-Routledge: Hove.
2. Lynch, T., et al. (2007) Treatment of older adults with co-morbid personality disorder and depression: A dialectical behaviour therapy approach. *International Journal of Geriatric Psychiatry*, 22, 131-43.

Severe and enduring conditions (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Moderate	Secondary care	High	Group-based CBT for older adults with bipolar disorder	C ³
			Cognitive behavioural social skills training for psychosis	B ^{1,2,4}
			Family intervention in psychosis	B ⁵

References

1. Granholm, E., et al. (2005) A randomized controlled trial of cognitive behavioural social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162, 520-529.
2. Granholm, E., et al. (2007) Randomized controlled trial of cognitive behavioural social skills training for older people with schizophrenia: 12 month follow-up. *The Journal of Clinical Psychiatry*, 68, 730-737.
3. Nguyen, T., et al. (2006) Response to group-based cognitive behavioural therapy for older adults with bipolar disorder. *Clinical Gerontologist*, 30, 103-110.
4. Patterson, T. L., et al. (2006) Functional adaption skills training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders. *Schizophrenia Research*, 86, 291-299.
5. Pharoah, F., et al. (2010) Family intervention in schizophrenia: international review. *The Cochrane Library*, issue 12.

Dementia

In Wales, one in 16 people aged 65+ and one in six aged 80+ are affected by dementia. There are currently over 40,000 people in Wales living with dementia and this is set to rise by 30 per cent over the next 10 years. However, despite this, there is very little research exploring the efficacy of psychological therapies for this service user group. The following tables summarise the research in this area to date.

Depression and anxiety in the person with dementia and their caregivers (2017)

Level of Severity	Level of Service	Intensity of Intervention	What intervention?	Level of Evidence
Moderate	Secondary care/Specialist protocol	High	Behaviour therapy	B ^{3,8}
			CBT (person with dementia)	C ^{2,5,6,7,9}
	Secondary care/Community	High	CBT (depression and distress in caregivers)	A ^{1,3,4}

References

1. Gallagher-Thompson, D., Steffen, A. (1994) Comparative effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. *Journal of consulting and Clinical Psychology*, 62, 543-549.
2. Kraus, C.A., Seignourel, P. Balasubramanyam, V., Snow, L., Wilson, N.L. Kunik, M. E., Schulz, P. E., & Stanley, M. (2008) Cognitive behavioural treatment for anxiety in patients with dementia: Two case studies. *Journal of Psychiatric Practice*, 14, 185-192
3. Logsdon, R., McCurry, S. & Teri, L. (2007) Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and Aging*, 22, 28-36.
4. Losada, A., Marquez-Gonzalez, M., Romero-Moreno, R. (2011) Mechanisms of action of a psychological intervention for dementia caregivers: effects of behavioural activation and modification of dysfunctional thoughts, *International Journal of Geriatric Psychiatry*. 26(11):1119-27.
5. Orgeta, V., Qazi, A., Spector, A. E. & Orrell, M. (2014) Psychological treatments for depression and anxiety in dementia and mild cognitive impairment. *The Cochrane Library*.

-
6. Scholey & Woods, R. T. (2001) A series of cognitive therapy interventions with people experiencing both dementia and depression. *Clinical Psychology & Psychotherapy*, 10, 175-185.
 7. Spector, A., Charlesworth, G., King, M., Lattimer, M., Sadek, S., Marstn, L., Rehill, A., Hoe, J., Qazi, A., Knapp, M. & Orrell, M. (2015) Cognitive-behavioural therapy for anxiety in dementia: pilot randomised controlled trial. *British Journal of Psychiatry*, 206(6), 509-16.
 8. Teri, L., Logsdon, R. G., Uomoto, J., & McCury, S. M. (1997) Behavioral treatment of depression in dementia patients: A controlled clinical trial. *Journal of Gerontology: Psychological Sciences*, 52B, 159-166.
 9. Wetherall, J, L., Stoddard, J.A. white, K.S., Kornblith, S., Nguyen, H., Andreescu, C., Zisock, S. & Lenze, E. J. (2011) Augmenting antidepressant medication with modular CBT for geriatric generalized anxiety disorder: A pilot study. *International Journal of Geriatric Psychiatry*, 26, published online in Wiley online library.

Cognition (and quality of life) (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild/Moderate	Secondary care/Specialist	High/Specialist	Cognitive rehabilitation	A ^{1,2}
		Low	Cognitive stimulation therapy (improves cognition and quality of life)	A ^{1,2,3}
Mild/Moderate	All tiers of care including voluntary settings	Low	Maintenance CST	A ⁴

References

1. Clare, L., Linden, D. E., Woods, R. T., Whitaker, R., Evans, S. J., Parkinson, C. H., & Rugg, M. D. (2010) Goal-oriented cognitive rehabilitation for people with early-stage Alzheimer disease: a single-blind randomized controlled trial of clinical efficacy. *The American journal of geriatric psychiatry*, 18(10), 928-939.
2. Bahar-Fuchs, A., Clare, L. & Woods, B. (2013) Cognitive training and cognitive rehabilitation for mild to moderate Alzheimer's disease and vascular dementia. *Cochrane Database Syst Rev*, 6.
3. Aguirre, E., Woods, R. T., Spector, A. & Orrell, M. (2013) Cognitive stimulation for dementia: a systematic review of the evidence of effectiveness from randomised controlled trials. *Ageing research reviews*, 12(1), 253-262.
4. Orrell, M., Aguirre, E., Spector, A., Hoare, Z., Woods, R. T., Streeter, A., & Russell, I. (2014) Maintenance cognitive stimulation therapy for dementia: single-blind, multicentre, pragmatic randomised controlled trial. *The British Journal of Psychiatry*, 204(6), 454-461.

Living well with dementia (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild	Part 1 – Early stage dementia	Low	Pre-assessment and post-diagnostic counselling	C ^{4,7}
		High	Post-diagnostic groups	C ^{2,4,7,12,16}
		High	Creative arts therapies	C ¹
Mild/Moderate	All – Early stage dementia	Low	Peer support	B ^{5,6}
Mild/Moderate	All	Low	Life story work	C ^{8,9,14}
	Secondary/Care home/Day hospital	Low	Reminiscence therapy for mood, including personalised activity	A ^{13,15}
	All	High	Narrative therapy	C ^{10,11}
Moderate/Severe	Secondary care/Specialised	High	Reminiscence therapy for mood and some cognitive abilities	A ³

References

1. Beard, R. L. (2011) Art therapies and dementia care: A systematic review. *Dementia*, 1471301211421090.
2. Cheston, R. & Howells, L. (2015) A feasibility study of translating “Living Well with Dementia” groups into a Primary Care Improving Access to Psychological Therapy Service (innovative practice). *Dementia*, 1471301215582104.
3. Cotelli, M., Manenti, R. & Zanetti, O. (2012) Reminiscence Therapy in Dementia: A Review. *Maturitas*, 72(3), 203-205.
4. Guss, R., Middleton, J., Beanland, T., Slade, L., Moniz-Cook, E., Watts, S. & Bone, A. (2014) Clinical Psychology in the Early Stage Dementia Care Pathway.
5. Keyes, S. E. et al. (2014) “We’re all thrown in the same boat...”: A qualitative analysis of peer support in dementia care. *Dementia*, 1471301214529575.

-
6. Logsdon, R. G., Pike, K. C., McCurry, S. M., Hunter, P., Maher, J., Snyder, L. & Teri, L. (2010) Early-stage memory loss support groups: outcomes from a randomized controlled clinical trial. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 65(6), 691-697.
 7. Manthorpe, J., & Moniz-Cook, E. (Eds.). (2008) *Early Psychosocial Interventions in Dementia*. Jessica Kingsley Publishers.
 8. Moos, I., & Björn, A. (2006) Use of the life story in the institutional care of people with dementia: a review of intervention studies. *Ageing and Society*, 26(03), 431-454.
 9. McKeown, J., Clarke, A. & Repper, J. (2006) Life story work in health and social care: systematic literature review. *Journal of advanced nursing*, 55(2), 237-247.
 10. Offord, R. & Field, E. (2013) Why practitioners working in dementia should be thinking in narratives. *FPOP Newsletter*, 122, 12-17.
 11. Offord, R. & Field, E. (2014) Using Narrative Therapy with people with dementia. *FPOP Newsletter*, 128, 32-35.
 12. Snow, K. (2010) Moving forward: Post-diagnostic groups for people with a mild dementia. *Faculty for the Psychology of Older people newsletter*, 111, 59-63.
 13. Testad, I., Corbett, A., Aarsland, D., Lexow, K.O., Fossey, J., Woods, B. & Ballard, C. (2014) The Value of Personalised Psychosocial Interventions to Address Behavioral and Psychological Symptoms in People with Dementia Living in Care Home Settings: A Systematic Review. *International Psychogeriatrics*. 26(7), 1083-1098.
 14. Thompson, R. (2011) Using life story work to enhance care: Rachel Thompson describes how staff can be supported to implement and sustain biographical approaches with clients. *Nursing older people*, 23(8), 16-21.
 15. Woods, B., Spector, A.E., Jones, C.A., Orrell, M. & Davies, S.P. (2005) Reminiscence therapy for dementia (Review). *Cochrane Database of Systematic Reviews*, 2005(2).
 16. Yale, R. (1995) *Developing Support Groups for Individuals with Early-Stage Alzheimer's Disease: Planning, Implementation. Evaluation*. Health Professions Press, Baltimore, MD.

Insomnia (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild-Severe	Secondary care/Specialist	High/Specialist	Psychological therapy for insomnia in dementia (multi-component caregiver intervention, including daytime activity, sleep hygiene and light exposure)	A ¹⁻⁴

References

1. Brown, C.A., Berry, R., Tan, M.C., et al. (2011) A critique of the evidence base for non-pharmacological sleep interventions for persons with dementia. *Dementia* 12(2), 210-237.
2. Guarnieri, B., Musicco, M., Caffarra, P., et al. (2014) Recommendations of the Sleep Study Group of the Italian Dementia Research Association (SINDem) on clinical assessment and management of sleep disorders in individuals with mild cognitive impairment and dementia: a clinical review. *Neurological Sciences*, 35, 1329–1348.
3. McCurry, S.M., Gibbons, L.E., Logsdon, R.G., et al. (2005) Nighttime Insomnia Treatment and Education for Alzheimer's Disease: A Randomized Controlled Trial. *Journal of the American Geriatrics Society*, 53(5), 793-802.
4. Salami, O., Lyketsos, C. & Rao, V. (2011) Treatment of sleep disturbance in Alzheimer's dementia. *International Journal of Geriatric Psychiatry*, 26, 771-782.

Stress and distress in dementia

The term stress and distress in dementia is increasingly being used in place of other terms such as challenging behaviour or behaviour that challenges in the literature and amongst those working in older adults' services.

The majority of people living with dementia are likely to experience stress and distress at some point during their illness. National policy and guidance make it clear that many of the behaviours identified as challenging should not be treated as if they are an inevitable consequence of dementia, but instead be recognised as symptoms of human distress, disorientation and misperception. As such, National Clinical Guidelines (NICE 42) recommend psychosocial and behavioural interventions as a first line treatment for stress and distress in dementia; that is, prior to the administration of psychotropic drugs. They recommend that any intervention should be tailored to the individual and be based upon a comprehensive assessment that takes into consideration the person with dementia's preferences, skills and abilities.

Despite this, there is still very little empirical research exploring the effectiveness of non-pharmacological approaches to stress and distress in dementia; however, it is generally agreed that individualised formulation-led interventions that focus upon meeting the specific needs of the individual with dementia are most appropriate (James, 2011; BPS, 2013).

Psychological approaches in response to stress and distress in dementia (2017)

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Level of Evidence
Mild – Severe	Nursing home	Low	Enhanced psychosocial care (to reduce use of neuroleptic medication)	A ³
Mild – Severe	Secondary care	Low	Psychoeducation for caregivers	B ⁵
Mild – Severe	Community	Low	Multiple component interventions - For caregivers	A ^{1,2,6,7} A ^{2,5}

Moderate – Severe	Community/Secondary care	High	Behavioural management training to reduce caregivers stress and distress Behaviour management to reduce depression in person with dementia	A ⁸ B ⁹
-------------------	--------------------------	------	---	--------------------------------------

References

1. Ballard, C., Brown, R., Fossey, J., Douglas, S., Bradley, P., Hancock, J. & Lindesay, J. (2009) Brief psychosocial therapy for the treatment of agitation in Alzheimer disease (the CALM-AD trial). *The American journal of geriatric psychiatry*, 17(9), 726-733.
2. Brodaty, H., Arasaratnam, C. (2012) Meta-analysis of Nonpharmacological interventions of neuropsychiatric symptoms of dementia, *American Journal of Psychiatry*, 169, 946-953.
3. Fossey, J., Ballard, C., Juszczak, E., James, I., Alder, N., Jacoby, R. & Howard, R. (2006) Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster randomised trial, *British Medical Journal*, 332(7544), 756-761.
4. Livingston, G., Barber, J., Rapaport, P., Knapp, M., Griffin, M., King, D., Livingston, D., Mummery, C., Walker, Z. et al (2013) Clinical effectiveness of a manual based coping strategy programme (START, STrategies for RelaTives) in promoting the mental health of carers of family members with dementia: pragmatic randomised controlled trial. *British Medical Journal*, 347:f6276.
5. Livingstone, G., Johnston, K., Katona, C., Paton, J. & Lyketsos, C. (2005) Systematic review of psychological approaches to the management of neuropsychiatric symptoms of dementia, *American Journal of Psychiatry*, 162(11), 1996-2021.
6. Livingston, G., Kelly, L., Lewis-Holmes, E., et al. (2014) Non-pharmacological interventions for agitation in dementia: systematic review of randomised controlled trials. *Br J Psychiatry*; 205(6):436-42
7. NICE (2006) Dementia: Supporting people with dementia and their carers in health and social care. NICE Clinical Guideline 42.
8. Selwood, A, Johnston, K., Katona, C., Lyketsos, C. & Livingston, G. (2007) Systematic review of the effect of psychological interventions on family caregivers of people with dementia. *Journal of Affective Disorders*, 101, 75-89.
9. Teri, L., Logsdon, R. G., Uomoto, J. & McCury, S. M. (1997) Behavioral treatment of depression in dementia patients: A controlled clinical trial. *Journal of Gerontology: Psychological Sciences*, 52B, 159-166.

Specific interventions in response to stress and distress (2017)

Level of Severity	Level of Service	Intensity of Intervention	What intervention?	Level of Evidence
Mild to severe	All	High	Music therapy	C ^{1,7,13,15}
Moderate/Severe	Secondary care	Low	Environmental adaptation	B ^{4,13,14}
		Low	Doll therapy with clear ethical guidelines	B ^{10,11}
			Increasing occupation/stimulation (e.g., music therapy and activities)	A ⁸
			Stimulated presence therapy (SPT): important to assess suitability for therapy and monitor closely	B ^{3,16}
			Social contact – real or simulated, including animal assisted therapy	B ^{2,9,16}
			Validation therapy	C ¹²

References

1. Aldridge, D. (Ed.) (2000) Music therapy in Dementia Care. London: Jessica Kingsley Publishers.
2. Bernabei, V., De Ronchi, D., La Ferla, T., Moretti, F., Tonelli, L. & Ferrari, B. (2013) Animal-assisted interventions for elderly patients affected by dementia or psychiatric disorders: A review. *Journal of Psychiatry Research*, 47(7), 762-773.
3. Cheston, R., Thorne, K., Whitby, P. & Peak, J. (2007) Simulated presence therapy, attachment and separation amongst people with dementia. *Dementia*, 6, 442-449.
4. Day, K., Carreon, D. & Stump, C. (2000) The therapeutic design of environments for people with dementia. *Gerontologist*, 40(4), 397-416.

5. Filan, S. L. & Llewellyn-Jones, R. H. (2006) Animal-assisted therapy for dementia: a review of the literature. *International Psychogeriatrics*, 18(4), 597-612.
6. Guss, R., Middleton, J., Beanland, T., Slade, L., Moniz-Cook, E., Watts, S. & Bone, A. (2014) A guide to psychosocial interventions in early stages of dementia. Leicester: The British Psychological Society.
7. Hsu, M. H., Flowerdew, R., Parker, M., Fachner, J. & Odell-Miller, H. (2015) Individual music therapy for managing neuropsychiatric symptoms for people with dementia and their carers: a cluster randomised controlled feasibility study. *BMC geriatrics*, 15(1), 1.
8. Livingston, G., Kelly, L., Lewis-Holmes, E., et al. (2014) Non-pharmacological interventions for agitation in dementia: systematic review of randomised controlled trials. *Br J Psychiatry*; 205(6):436-42.
9. Low, L. F., Brodaty, H., Goodenough, B., Spitzer, P., Bell, J. P., Fleming, R. & Chenoweth, L. (2013) The Sydney Multisite Intervention of LaughterBosses and ElderClowns (SMILE) study: cluster randomised trial of humour therapy in nursing homes. *BMJ open*, 3(1), e002072.
10. MacKenzie, L., James, I.A., Morse, R., Mukaetova-Ladinska, E. & Reichelt, F.K. (2006) A pilot study on the use of dolls for people with dementia, *Age and Aging*, 35(4), 441-443.
11. Mitchell, G., O'Donnell, H. (2013) The therapeutic use of doll therapy in dementia, *British Journal of Nursing*, 22(6), 329-334.
12. Neal, M. & Barton Wright, P. (2003) Validation therapy for dementia, *Cochrane Database of Systematic Review*, Issue 4.
13. NICE (2006) Dementia: Supporting people with dementia and their carers in health and social care. NICE Clinical Guideline 42.
14. SIGN (2006) Management of patients with dementia. A national clinical guideline, Scottish Intercollegiate Guidelines Network.
15. Vink, A. C., Bruinsma, M. S. & Scholten, R. J. (2003) Music therapy for people with dementia. The Cochrane Library.
16. Zettler, J. (2008) Effectiveness of simulated presence therapy for individuals with dementia: A systematic review and meta-analysis, *Aging and Mental Health*, 12(6), 779-785.