NHS Education for Scotland

The Matrix Evidence Tables

ADULT MENTAL HEALTH

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The Scottish Government

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PANIC DISORDER WITH/WITHOUT AGORAPHOBIA **UPDATED 2014**

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
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 [1]
		Low	Online self-help CBT Programme for Prevention of Panic Disorder	B [7]
		Low	Brief Exposure Instruction (therapist-delivered)	B [19]
Mild	**Primary Care**	**Low**	Minimal Therapy Contact CBT (4-6 hours) with:	
			▪ Bibliotherapy	A [5, 13]
			▪ Internet-delivery	A [3, 4, 9, 10, 18]
Moderate	**Primary Care**	**Low**	Therapist-supported CBT (6-12 hours) augmented by CBT self-help	
			a) Bibliotherapy	A [5, 11, 16]
			b) Computer-Assisted (e.g. FearFighter)	A [8, 14]
			c) Internet-delivered CBT with therapist contact (up to six hours)	A [4, 9, 10, 18]
			d) Group CBT (8-18 hours)	A [11, 17, 20]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe	**Primary Care/ Secondary Care**	**High**	Individual Therapist-Directed CBT (16-20 sessions) with supplementary written material CBT with medication more effective than medication alone. Some evidence of trend for CBT plus antidepressants to have slightly greater effect in acute phase compared with CBT alone, but difference not maintained at 6-24 months follow-up	A [2, 6, 12, 13, 15]
Chronic or Treatment Resistant	**Secondary Care/Specialist Service; In-Patient Care**	**High**	Individual Therapist-Directed CBT (up to 20 sessions)	C
Moderate to Severe, following positive response to CBT	**Primary Care/ Secondary Care**	**High**	Maintenance-CBT following CBT ▪ Reduced chance of relapse ▪ Reduced work and social impairment	A [21]

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SOCIAL ANXIETY / SOCIAL PHOBIA

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**Primary Care, Voluntary settings**	**Low**	Guided self-help (bibliotherapy or internet-based)	A [1, 2]
Moderate to Severe	**Primary Care, Voluntary settings**	**High**	Individual or group CBT (Clark/Wells or Heimberg models, including Exposure, and Cognitive restructuring or social skills training)	A [3, 4, 5, 6, 7, 10, 11, 12]
		High	Interpersonal Therapy	B [8, 11]
		High	Short-term Psychodynamic (focused on social anxiety)	B [9, 10]
		High	Humanistic-Person-Centred-Experiential (focused on social anxiety)	C [13]
Avoidant PD	**Primary Care/ Secondary Care**	**High**	CBT (20 sessions)	A [9]

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GENERALISED ANXIETY DISORDER

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**Primary care**	**Low**	Multi-modal CBT	A [2]
		Low	Guided self-help	B [3, 6]
		Low	Large group psychoeducation	B [8]
		Low	Brief counselling	C
Moderate to Severe	**Primary Care/ Secondary Care**	**High**	CBT (8-16 sessions over 10 weeks – 6 months)	A [1, 5, 9]
Severe and Chronic	**Secondary Care**	**High**	CBT (20 sessions over 6 months) delivered to a specialist treatment protocol for GAD	B [4, 5]

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OBSESSIVE COMPULSIVE DISORDER

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**Primary Care**	**Low**	CBT including Exposure and Response Prevention (ERP) (c) with less than 10 therapist hours which should consist of: ▪ Individual contact supported by self-help materials ▪ Brief individual telephone contact. ▪ Group sessions but with more than 10 hours of therapy (b)	B [1, 2, 3, 7, 8]
Moderate	**Secondary Care**	**High**	CBT/ERP*. More than 10 hours of therapist guided ERP including sessions in the most salient environment, i.e. public toilets, home	A [1, 3, 4, 5, 7, 8]
Severe	**Secondary Care**	**High**	CBT/ERP. More than 20 hours of therapist guided ERP including sessions in the most salient environment, i.e. public toilets, home. augmented with anti-obsessional medication	A [1, 3, 4, 5]
Extreme	**Specialist Services**	**High**	CBT/ERP. More than 20 hours of therapist guided ERP including sessions in the most salient environment, i.e. public toilets, home. augmented with anti-obsessional medication plus anti-psychotic	B [1, 6]

NOTES:

a) The use of the Yale Brown Obsessive Compulsive Scale (Y-BOCS) is recommended to establish severity[7, 9]

Y-BOCS Ranges:	Mild 8-15	Moderate 16-23	Severe 24-31	Extreme 32-40

b) Some individuals (15-20%) may have obsessions around the themes of blasphemy, sexual taboos, or violence that preclude group work at even mild levels of severity

c) Like other exposure therapies this should combine *in vivo* and imaginal exposure. The most common problem is not ensuring the person understands and complies with response prevention

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PSYCHOSIS (INCLUDING THOSE DIAGNOSED WITH SCHIZOPHRENIA)

UPDATED 2014

PREVENTING PSYCHOSIS

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate / Severe	**Primary / Secondary Care**	**High Intensity / specialist interventions**	Cognitive Behaviour Therapy [1]	A [1 - 4]
		High Intensity / specialist interventions	Family Intervention [2]	A [1]

[1] CBT should be delivered on a one-to-one basis over at least 16 planned sessions and follow a treatment manual so that:(a) people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning (b) the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms and (c) also include at least one of the following components: people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms, promoting alternative ways of coping with the target symptom, reducing distress or improving functioning.

[2] Family intervention should include (a) the person with psychosis or schizophrenia if practical (b) be carried out for between 3 months and 1 year (c) include at least 10 planned sessions (d) take account of the whole family's preference for either single-family intervention or multi-family group intervention (e) take account of the relationship between the main carer and the person with psychosis or schizophrenia and (f) have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work

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FIRST EPISODE PSYCHOSIS, SUBSEQUENT EPISODES AND PROMOTING RECOVERY

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe	**Secondary Care**	**High Intensity / specialist interventions**	Cognitive Behaviour Therapy	A [1, 5 - 10]
		High Intensity / specialist interventions	Family Intervention	A [1, 5, 11, 12]
	Rehabilitation	**High Intensity / specialist interventions**	Cognitive Remediation Therapy	A [5, 13]
	Secondary Care	**High Intensity / specialist interventions**	Metacognitive Therapy	B [14]
		High Intensity / specialist interventions	Mindfulness	B [15 - 27]
		Low intensity	Early Signs Monitoring	A [28 - 30]

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BIPOLAR DISORDER

UPDATED 2014

PRIMARY OUTCOME – PREVENTION OF RELAPSE

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe and Enduring	**Secondary Care**	**High**	Caregiver group psychoeducation and family psychoeducation for Prevention of Relapse in depression and/or mania	A [6, 7]
		High	Group psychoeducation for Prevention of Relapse in depression and/or mania	A [2, 3, 8]

OTHER OUTCOMES

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe and Enduring	**Secondary Care**	**High**	Functional remediation for improvement in functional outcomes	A [11]
		High	Group psychoeducation and family psychoeducation for improved medication adherence	A [10, 6]
		High	Interpersonal and Social Rhythm Therapy (IPSRT) for regularity of social rhythm	A [4]
		High	Cognitive behavioural therapy for improved social functioning	B [1, 5, 8, 9]

There is no evidence that care management, integrated group therapy or mindfulness-based cognitive therapy is effective in the prevention of relapse (Beynon et al. 2008; Reinares et al. 2014). In relation to CBT, there is no strong evidence to suggest that CBT is effective in the prevention of relapse. Scott et al. (2006), however, found that CBT may be effective in the prevention of relapse for patients with less than 12 episodes.

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NON PSYCHOTIC AFFECTIVE DISORDERS IN THE PERINATAL PERIOD

UPDATED 2014

GOOD PRACTICE FOR PSYCHOLOGICAL THERAPIES FOR NON-PSYCHOTIC AFFECTIVE DISORDERS IN THE PERINATAL PERIOD SHOULD INCLUDE:

- Given the importance of early intervention in the maternity context, services delivering psychological therapies should prioritise early response to pregnant and postnatal women
- An understanding of the perinatal context and its influence on non-psychotic affective disorders.
- Knowledge of the additional clinical features and risk factors associated with perinatal disorders and in particular the distinction between an ongoing mental health problem that has been exacerbated by pregnancy and/or childbirth, a new onset mental health problem and an emerging psychotic illness and its associated high risk status.
- Knowledge of the developmental needs of the infant.
- Linking into the routine clinical network around the woman at this time and the regional specialist perinatal service as required.
- Consideration should be given to patient preferences regarding intervention in terms of type and whether this is group or individual based
- Practitioners having an awareness of how perinatal mental illness impacts on all members of the family and in particular partners who may show symptoms of co-morbidity.
- Psychological therapy practitioners having the knowledge and ability to refer and/or include other perinatal mental health support e.g Home Start, Infant Massage etc

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
***Mild**	**Low Intensity**	**Low**	Psychoeducational groups with partner involvement	A [3]
Moderate	**Primary Care**	**Low**	CBT / IPT / person centred therapy	A [4,5,6,7,8,9,10]
Moderate / Severe	**Specialist/ Highly Specialist**	**High**	CBT/IPT	B [4,5,6,7,8,9,10]

*There is some evidence to support proactive home visits focussed on parenting or peer to peer telephone support in women showing signs of depression or anxiety.[1, 2]

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DEPRESSION

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild/Moderate	**Primary Care/ Voluntary Setting**	**Low**	Behavioural Activation	A [1, 6]
		Low	Computerised CBT within the context of guided self-help (CCBT)	A [1, 4, 5]
		Low	Guided self-help based on CBT or behavioural principles	A [1, 2, 3]
		Low	Multi modal CBT	A [7]
		Low	Problem solving therapy	B [1, 11]
		High	CBT	A [1, 8,10]
		High	IPT	A [1, 9]
		High	Non-directive counseling	B [15]
		High	Process-experiential psychotherapy	B [13,14]
		High	Short-term psychodynamic psychotherapy	B [1, 10]
Relapsing	**Primary Care/ Secondary Care**	**High**	Mindfulness based cognitive therapy (MBCT) in a group setting may be considered as a treatment option to reduce relapse in patients with depression who have had three or more episodes	B [1, 12]
Chronic	**Secondary Care**	**Highly Specialist**	Cognitive Behavioural Analysis of Systems Psychotherapy (CBASP)	B [16]
Severe	**Secondary Care**	**Highly Specialist**	For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).	B [3]

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BORDERLINE PERSONALITY DISORDER

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe	**Secondary/ Specialist Outpatient**	**High**	CBT for personality disorders Individual therapy (30 sessions over one year)	A [2]
		High	Dialectical Behaviour Therapy (DBT) Involves group + individual therapy + telephone support (Several times per week over one year)	A [1, 9]
		High	General Psychiatric management (APA style) or Generic Structured Clinical Care (minimum of 12 months and up to 18 months (52 to 140 sessions)	A [8, 9, 10]
		High	Mentalization-based therapy (MBT) individual + group + psychiatric review, drug treatment, crisis contact and plans, telephone contact, written information (18 months, 140 sessions)	A [8]
		High	Schema Focused CBT Twice weekly over three years	A [3]
		High	STEPPS -Systems Training for Emotional Predictability and Problem Solving (CBT approach) 20 group sessions group + usual treatment	A [6]
		High	Transference-focused psychotherapy (twice weekly sessions plus weekly supportive treatment over one year)	A [4]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe	**Secondary/ Specialist Partial Day Hospital**	**High Multi-modal**	Mentalization based Day Hospital [Several times per week over three years]	A [5]

There is evidence that "General Psychiatric Management" [McMain et al., 2009][9] and "Structured Clinical Management" [Bateman & Fonagy, 2009][8] are as effective as DBT or MBT. Please note that this is not the same as treatment as usual but is a structured clinical program.

The competences for Generic Structured Clinical Care are delineated in the UCL, CORE website.
[**www.ucl.ac.uk/clinicalpsychology/CORE/competence_mentalillness.html** OR **www.ucl.ac.uk/CORE/**]

Lessons learned from the evaluation of pilot services in England suggests that due to the complexity of personality disorder most services should offer more than one type of intervention [Crawford et al, 2007][7].

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ALCOHOL PROBLEMS

UPDATED 2011

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Prevention and Early Intervention (Hazardous and Harmful Drinking)	**Primary Care / Non-Specialist** **Health Setting including Antenatal Care, Minor Injury Unit, A&E**	**Low Intensity**	Simple brief interventions – one session lasting 5-15 minutes	A [1]
Mild to Moderate (Harmful Drinking and Mild Dependence) No response to extended Brief Intervention	**Non Specialist with training / Specialist practitioner**	**Low Intensity**	Extended Brief Interventions and Motivational Enhancement Therapy (one 20-30 minute session. Further 3-4 sessions if required).	B [2, 3, 4]
		Low Intensity	Motivational Interviewing/ MI Assessment.	A [1, 2, 3, 5]
	Secondary Care / Specialist Alcohol Treatment	**Low Intensity**	Cognitive Behaviour Therapy and Behavioural Therapies (e.g. Behavioural Self Control Training and Community Reinforcement Approach), Social Network and Environment Based Therapies	B [2, 3, 4, 5]
		Low Intensity	Coping and Social Skills Training to Prevent Relapse	B [2, 3, 4]
		High Intensity	Behavioural Couples Therapy	B [2, 3, 4, 5]
	Mutual Self Help Groups	**Low Intensity**	Alcoholic Anonymous, SMART Recovery or involvement in another mutual self-help group	B [1, 2, 3, 5]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate to Severe Alcohol Dependence	**Secondary Care / Specialist Alcohol Treatment, including residential settings**		Motivational Interviewing / MI Assessment	A [1, 2, 3, 5]
	Psychological Interventions integrated with detoxification and pharmacotherapy	**Low Intensity**	Cognitive Behaviour Therapy and Behavioural Therapies (e.g. Behavioural Self Control Training and Community Reinforcement Approach), and Social Network and Environment Based Therapies	B [2, 3, 4, 5]
			Coping and Social Skills Training to Prevent Relapse	B [2, 3, 4]
		High Intensity	Behavioural Couples Therapy	B [2, 3, 4, 5]
	Mutual Self-Help Group	**Low Intensity**	Alcoholic Anonymous, SMART Recovery or involvement in another mutual self-help group	B [2, 3, 5]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Highly Complex and/or Enduring Problems Co-occurring alcohol, drug, psychological, medical, and social problems are common, creating highly complex clinical pictures. Potential complex needs that may impact treatment can be found in Appendix 6 of the review of effective matched/stepped care services referenced on page 29 of the Matrix	**Specialist Alcohol Treatment or in partnership with other specialist health care programmes**	**Highly Specialist Psychological Therapies and Interventions**	As per the Matrix Intensity definitions (p. 31), these are "...highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models."	Essential to consider the evidence based treatment recommendations from the identified co-occurring or psychological, medical and social problems, taking into account the variation from the studied populations, and use scientist-practitioner principles to assess effectiveness of the individualised care plan.

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Alcohol Misuse disorders are frequently found co-occurring with other mental health conditions. A full assessment of all of the mental health needs is essential in the planning of the delivery of appropriate psychological therapies. The Matrix is designed as a guide to the evidence-based interventions specific to mental health needs. Where multiple mental health needs are present, an informed formulation is essential in identifying the combination of interventions appropriate for an individual. A review of the research literature on psychological interventions for comorbid substance misuse and mental health disorders emphasises the importance of utilising integrated models of treatment to address complex, co-occurring needs, as opposed to providing sequential interventions for each disorder individually.

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SUBSTANCE USE

UPDATED 2011

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild Cannabis, stimulants, and/ or people misusing opiates and not in formal treatment.	**Opportunistic contact with people not in formal drug treatment, including harm reduction, primary or secondary care settings, occupational health, or tertiary education.**	**Low**	Opportunistic Brief Intervention focused on motivation.	A [1]
Mild to Moderate Opiate and stimulant misuse	**Primary Care/ Secondary Care**	**Low Intensity**	Motivational Interviewing	A [2, 3]
	Secondary care	**Low Intensity**	Contingency Management	A [1, 2, 3]
Stimulant and cannabis misuse	**Secondary care**	**Low Intensity**	CBT based relapse prevention	A [2] (and [1] for just Cannabis)
	Mutual Self Help Groups	**Low Intensity**	Alcoholic Anonymous, SMART Recovery or involvement in another mutual self-help group	A [1]
Opiate (Abstinent or stable maintenance), stimulant or cannabis misuse with comorbid anxiety and/or depression	**Primary Care / Secondary Care**	**High Intensity**	Cognitive Behavioural Therapy	A [1, 3]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Benzodiazepines With Panic Disorder	**Primary Care / Secondary Care**	**Specialist Psychological Therapy**	Group Cognitive Behavioural Therapy and Gradual Tapering	A [2]
Benzodiazepines	**Primary Care / Secondary Care**	**Specialist Psychological Therapy**	Cognitive Behavioural Therapy	B [2]
Opiates and stimulant misuse	**Shared care or specialist drug treatment**	**High Intensity**	Behavioural Couples Therapy	A [1, 2, 3]
Moderate to Severe People in methadone maintenance treatment programmes	**Shared care or specialist drug treatment**	**Low Intensity**	Contingency Management	A [1, 2]
Opiate and Stimulant misuse	**Specialist drug treatment**	**Low Intensity**	Contingency Management	A [1, 2]
Opiate and Stimulant misuse	**Shared care or specialist drug treatment**	**High Intensity**	Behavioural Couples Therapy	A [1, 2]
Opiate, stimulants and poly-substance misuse	**Shared care or specialist drug treatment**	**Low Intensity**	Community Reinforcement Approaches	A [2]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Opiate (Abstinent or stable maintenance), stimulant or cannabis misuse with comorbid anxiety and/or depression	**Shared care or specialist drug treatment**	**High Intensity**	Cognitive Behavioural Therapy	A [1]
Benzodiazepines With Panic Disorder	**Primary Care / Secondary Care**	**Specialist Psychological Therapy**	Group Cognitive Behavioural Therapy and Gradual Tapering	A [2]
Benzodiazepines	**Primary Care / Secondary Care**	**Specialist Psychological Therapy**	Cognitive Behavioural Therapy	B [2]
Opiates and stimulant misuse	**Shared care or specialist drug treatment**	**High Intensity**	Behavioural Couples Therapy	A [1, 2, 3]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Highly Complex and/or Enduring Problems Co-occurring drug, alcohol, psychological, medical, and social problems are common, creating highly complex clinical pictures. Potential complex needs that may impact treatment can be found in Appendix 6 of the review of effective matched/stepped care services referenced on page 29 of the Matrix.	**Specialist Alcohol Treatment or in partnership with other specialist health care programmes**	**Highly Specialist Psychological Therapies and Interventions**	As per the Matrix Intensity definitions (p. 31), these are "... highly specialist, individually tailored interventions based on case formulations drawn from a range of psychological models."	Essential to consider the evidence based treatment recommendations from the identified co-occurring or psychological, medical and social problems, taking into account the variation from the studied populations, and use scientist-practitioner principles to assess effectiveness of the individualised care plan.

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Substance Misuse disorders are frequently found co-occurring with other mental health conditions. A full assessment of all of the mental health needs is essential in the planning of the delivery of appropriate psychological therapies. The Matrix is designed as a guide to the evidence-based interventions specific to mental health needs. Where multiple mental health needs are present, an informed formulation is essential in identifying the combination of interventions appropriate for an individual. A review of the research literature on psychological interventions for comorbid substance misuse and mental health disorders emphasises the importance of utilising integrated models of treatment to address complex, co-occurring needs, as opposed to providing sequential interventions for each disorder individually.

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EATING DISORDERS

UPDATED 2014

ANOREXIA NERVOSA

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**GP/Primary Care**	**Low**	Advice about the help and support available such as self-help groups and internet resources	C [18]
		Low	Medication should not be used as the sole or primary treatment for anorexia nervosa	C [17]
Moderate to Severe	**Secondary Care/ Specialist**	**High**	Family interventions	C [18]
		High	A choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas. CBT, Interpersonal Psychotherapy (IPT), Psychodynamic Therapy, Cognitive Analytic Therapy (CAT), Motivational Enhancement Therapy	C [18]

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BULIMIA NERVOSA AND BINGE EATING DISORDER

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Subclinical/Mild	**Primary Care**	**Low**	Evidence-based self-help programme	B [6, 17, 20*, 22]
		Low	Guided CBT self-help	B [13]
Moderate	**Secondary Care**	**Low**	Evidence-based self-help programme	B [6, 4, 17, 20*, 23]
		Low	Guided CBT self-help	B [13]
		High	CBT 16 to 20 sessions over 4 to 5 months.	A [1, 7, 8, 9*, 14*, 15, 17, 21, 23]
		High	Interpersonal Psychotherapy (IPT). 8 to 12 months to achieve same results as CBT	B [13, 7, 17]

* Evidence from adolescent studies and adolescent recommendations.

**Eating Disorders (NOS) should be treated using recommendations for disorder it most closely resembles.

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INSOMNIA

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Chronic primary insomnia	**Primary/ Specialist Health Settings**	*****Low (4-10 sessions)**	CBT (individual or small group)	*A [1-14]
		*****Low (4-10 sessions)**	Best validated / most efficacy data for Sleep Restriction Stimulus Control Progressive Relaxation Paradoxical Intention components	**A[12-14]
Chronic insomnia associated with medical or psychiatric illness	**Specialist Health Settings**	*****Low (4-10 sessions)**	CBT	***A [2, 3, 10, 18, 19]
Insomnia in older adults	**Primary/ Specialist Health Settings**	*****Low (4-10 sessions)**	CBT	****A[2, 3, 7, 11, 15, 16]
Chronic insomnia (unselective) clinical effectiveness studies	**Primary Care**	*****Low (4-10 sessions)**	CBT (delivered by trained nurses)	A [17, 20, 21]

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Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Chronic insomnia	**Primary/ Specialist Health Settings**	*****Low (4-10 sessions)**	These are therapeutic components with as yet unproven efficacy (from high quality RCTs)	B/C [2-3]
		*****Low (4-10 sessions)**	Multicomponent Cognitive Therapy	B [21]
		*****Low (4-10 sessions)**	Mindfulness Training	B [24, 26]
		*****Low (4-10 sessions)**	Self-Help	*B [27]
		*****Low (4-10 sessions)**	Intensive Sleep-Retraining	C [22]
		*****Low (4-10 sessions)**	Imagery Training	C [25]

* Meta-analytic studies and systematic reviews

** As concluded in practice parameter statements although strongest evidence indicates effectiveness of CBT rather than any singular interventions

*** Most encouraging in the context of insomnia associated with cancer care, pain and depression

****Treatment is equally efficacious in older adults

*****4 biweekly individual sessions is the least 'dose' so far found to be effective[28]

Other Evidence:

There is currently sufficient evidence against using Sleep Hygiene as a singular intervention

There is currently sufficient evidence against using Psychoeducation as a singular intervention

There is currently no evidence of the effectiveness of any psychological or behavioural intervention for acute insomnia

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TRAUMA

UPDATED 2011

THE PREVENTION AND TREATMENT OF PTSD

THE CONSEQUENCES TO THE INDIVIDUAL OF EXPOSURE TO PSYCHOLOGICALLY TRAUMATIC EVENTS VARY WIDELY.

In many cases there will be no adverse impact on their wellbeing. In others it may cause or contribute towards 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. A different pattern and range of symptoms is usually seen in those exposed to prolonged and repetitive trauma, often in childhood (so- called type 2, or complex trauma) compared with those exposed to a single (Type 1) traumatic event.

It is now recognised that PTSD is only one possible psychiatric outcome following Type 1 trauma exposure. The development of depressive and anxiety disorders is probably more common. Where there has been exposure to Type 2 trauma, the evidence suggests that mood, psychotic, substance misuse and personality disorders are all more likely to develop.

This section will focus on the prevention and treatment of PTSD, where there is a reasonable evidence base, and the management of complex trauma, where the evidence for effective treatments is much sparser.

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PREVENTING POST TRAUMATIC STRESS DISORDER

IN RECENT YEARS, EARLY PSYCHOLOGICAL INTERVENTIONS, SUCH AS PSYCHOLOGICAL 'DEBRIEFING' HAVE BEEN INCREASINGLY USED FOLLOWING PSYCHOLOGICAL TRAUMA.

Debriefing has two principal intentions. The first is to reduce the psychological distress that is found after traumatic incidents. The second is to prevent the development of psychiatric disorder, usually PTSD. Rose et al's [1] updated review of single session psychological 'debriefing' identified twelve published trials. [2-13]

There is no evidence that debriefing reduces the risk of developing PTSD. Two trials with the longest follow-up both reported adverse effects, in that debriefing appears to increase long-term traumatic distress.

There is also no evidence that debriefing has any effect on any other psychological outcome including depression, anxiety or general functioning.

At present the routine use of single session individual debriefing in the aftermath of individual trauma is not recommended.

However, preliminary information suggests that delivering more formalised interventions, such as brief trauma focussed CBT, over a number of sessions and aimed at those with overt distress (such as Acute Stress Disorder) may be worthwhile. Treatment should be targeted at symptomatic patients and not those who are asymptomatic. Rose et al identified four such published trials of trauma focussed CBT type interventions. [14-17]

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PREVENTING POST TRAUMATIC STRESS DISORDER

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**Primary Care**	**Low**	Trauma Focussed CBT (4-5 sessions): aimed at those with overt distress	B [14-17]

Routine 'debriefing' **not recommended**. Could increase long-term traumatic distress.

TREATING POST TRAUMATIC STRESS DISORDER

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	**Primary Care**	**Low**	Watchful Waiting with Follow-up in One Month	C [18,23]
Moderate to Severe	**Secondary Care**	**High**	Trauma-Focused CBT (8-12 Sessions)	A [18,19,20,24]
	Secondary Care	**High**	EMDR (8-12 Sessions)	A [18,21,22]
Severe & Chronic	**Secondary Care / Specialist Trauma Service**	**High**	Alternative Form of Trauma-Focused Treatment (e.g. try EDMR if no response to Trauma-Focused CBT)	C [18,25]

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TREATMENT OF COMPLEX TRAUMATIC STRESS DISORDERS

COURTOIS & FORD [26] HAVE DEFINED COMPLEX PSYCHOLOGICAL TRAUMA AS "INVOLVING TRAUMATIC STRESSORS THAT [1] ARE REPETITIVE OR PROLONGED; [2] INVOLVE DIRECT HARM AND/OR NEGLECT AND ABANDONMENT BY CAREGIVERS OR OSTENSIBLY RESPONSIBLE ADULTS; [3] OCCUR AT DEVELOPMENTALLY VULNERABLE TIMES IN THE VICTIM'S LIFE, SUCH AS EARLY CHILDHOOD; AND [4] 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. Effects may include affect deregulation and impaired self-concept , dissociation, somatic dysregulation , and disorganized attachment patterns leading to inter and intra-personal difficulties in adult life [27, 28]. These are in addition to DSM- IV PTSD symptoms of re-experiencing of the traumatic events, avoidance of the reminders and hyperarousal.

Courtois and Ford [26] have concluded that there is limited treatment outcome research on complex traumatic stress and further research in the area is required. This is in part because it is a heterogeneous condition and most outcome studies in the area of psychological trauma have screened out patients with complex trauma.

There is therefore insufficient high quality evidence available to allow the development of evidence-based recommendations. However, expert opinion can give some insights into current best practice. It is widely thought that a phased based intervention programme is indicated. The 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. When this has been achieved the treatment can move on to the processing of traumatic memories using CBT or EMDR. Finally the patient can be helped to reintegrate with others in their life.

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TREATMENT OF COMPLEX TRAUMATIC STRESS DISORDERS

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate to Severe	**Specialist Trauma Service**	**High**	Phased Based Intervention Programme **Phase 1 Safety and Stabilisation** Establish therapeutic alliance Training in affect regulation Education about trauma and its impacts **Phase 2 Processing of traumatic memories** Narrative reconstruction of memories with careful use of CBT interventions including exposure where appropriate **Phase 3 Reintegration** The continued development of trustworthy relationships. Work on intimacy, sexual functioning, parenting etc Duration of treatment 16-30 sessions. For some treatment may be much longer.	C [26, 29]

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SELF-HARM AND SUICIDAL BEHAVIOUR

IT IS RECOGNISED THAT SELF-HARM IS NOT A DIAGNOSIS, AND CO-EXISTS WITH OTHER ISSUES SUCH AS DEPRESSION, BORDERLINE PERSONALITY DISORDER (BPD), SUBSTANCE MISUSE, OBSESSIVE-COMPULSIVE DISORDERS AND EATING DISORDERS.

However, there is a body of literature around self-harm and suicidal behaviour, and the table below has been derived from this evidence base.

The definition of self-harm adopted by the SIGN guideline is "intentional self-poisoning or injury, irrespective of the apparent purpose of the act".

Self-harm includes poisoning, asphyxiation, cutting, burning and other self-inflicted injuries.

Self-harm is more common in young people with the incidence peaking between the 15 and 19 years of age in females and 20 and 24 years in males. Self-harm is also more common among people who are socioeconomically disadvantaged and who are single or divorced, live alone, are single parents or have a severe lack of social support (Meltzer et al., 2002).

Papers cited in The Matrix include participants who had a suicidal act or act of self-harm. Within the table the participants are categorised as 'repeaters' (having more than one episode of self-harm or suicidal behaviour), or 'any suicidal behaviour' (which included those with only one episode and participants from papers where no distinction was made)

The primary outcome of interest was repetition: what effect did interventions have on rates of repetition of self harm? Although the majority of papers addressed this issue, there were a minority that did not. With these papers, the secondary outcome of interest were rates of depression, hopelessness, problem solving, global functioning etc.

All but one of the studies included were RCTs, with the exception of Salkovskis, who employed a controlled design.

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(In this literature search, many interventions were found for self harm in those with borderline personality disorder. These are not included in the self harm matrix as specific interventions for BPD can be found in the BPD matrix section.)

Recommendations

Interventions receiving A or A/B ratings are CBT, manualised psychodynamic interpersonal therapy, problem solving/problem oriented therapy and brief intervention and follow-up contact. Those interventions receiving a C recommendation are developmental group psychotherapy, manual assisted CBT, a letter on how to access help, a telephone reminder of how to access help, a post card augmented with self-help recommendations and post cards with reminders on how to access help (also known as crisis cards and green cards).

No interventions received a B rating.

The recommendations from The Matrix are consistent with those from the NICE guidelines, where it is stated that self-harm is not a medical diagnosis but a heterogeneous set of behaviours, which can have different meanings in different contexts. Therefore there is no 'one size fits all' intervention for self harm and interventions should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements (NICE 2004).

THE RECOMMENDATIONS FROM THE MATRIX ARE CONSISTENT WITH THOSE FROM THE NICE GUIDELINES

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Those with repeat suicidal behaviour (repeaters) or Any suicidal behaviour (including only one)	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Any suicidal behaviour	**Primary**	**Low**	Brief intervention and follow-up contact	A [12]
	Primary	**Low**	Manualised psychodynamic interpersonal therapy	A [13]
	Primary	**Low**	Problem solving/problem oriented therapy	A/B [15, 18, 20, 25]
	Primary	**Low**	Telephone reminder of how to access help	C [8, 27]
	Primary/ secondary	**Low**	Green card / postcard / crisis card	C [2, 6, 7, 14, 21]
	Secondary	**High**	CBT	A [3, 24]
Repeaters	**Secondary**	**Low**	Problem solving/problem oriented therapy	A/B [23]
	Secondary	**Low**	Post card (augmented with self-help recommendations)	C [22]
	Secondary	**Specialist**	Manual assisted CBT	* A/C [5, 11, 26]

* A/C Brief cognitive behaviour therapy (MACT) was of limited efficacy in reducing self-harm repetition (hence C recommendation), but the findings taken in conjunction with the economic evaluation (Byford et al. 2003) indicated superiority of MACT over TAU in terms of cost and effectiveness combined.

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Some studies looked at specific interventions and found no differences in self-harm or repetition rates. These interventions are therefore not recommended. These are listed below.

Hospital admission/token allowing hospital admission 10, 30

Social work intervention (adolescents) 4

Domiciliary/outpatient visits 1, 16, 17, 29, 31

In patient treatment 19, 28

Aftercare service 9

(This is not to suggest that these interventions are always inappropriate. There may be compelling reasons for inpatient admission or social work intervention in a particular case for a range of reasons. It simply means that the intervention does not affect the likelihood that the person will self-harm at some point in the future)

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REFERENCE SECTION

PANIC DISORDER WITH / WITHOUT AGORAPHOBIA

1. Baillie, A.J. and Rapee, R.M. (2001) *Brief stepped intervention for panic attacks.* Unpublished PhD Thesis. Macquarie University, Sydney.
2. Butler, A.C., Chapman, J.E., Forman, E.M. and Beck, A.T. (2006) the empirical status of cognitive behavioural therapy: a review of meta-analyses. *Clinical Psychology Review*, 26, 17-31.
3. Carlbring, P., Bohman, S., Brunt, S., Buhrman, M. et al (2006) Remote treatment of panic disorder: a randomised trial of internet- based cognitive behaviour therapy supplemented with telephone calls. *American Journal of Psychiatry*, 163, 2119-2125
4. Carlbring, P., Nilsson-Ihrfelt, Waara, J., Kollenstam, C., et al (2005) Treatment of panic disorder: live therapy vs. self-help via the Internet. *Behaviour Research and Therapy*, 43, 1321-1333
5. Gould, R.A. and Clum,G.A. (1993) A meta-analysis of self-help treatment approaches. *Clinical Psychology Review*, 13, 169-186
6. Gould, R.A., Otto, M.H., (1995) A meta-analysis of treatment outcome for panic disorder. *Clinical Psychology Review*, 15 (8), 819-844
7. Kenardy, J., McCafferty, K. and Rosa, V. (2003) Internet-delivered indicated prevention for anxiety disorders: a randomised controlled trial. *Behavioural and Cognitive Therapy*, 31, 279-289
8. Kenardy, J., Dow, M.G.T., Johnston, D.W., Newman, M.G., Thomson, A., and 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
9. Kiropoulos, L.A. Klein, B., Austin, D.W., Gilson, K., Pier, C., Mitchell, J. and Ciechomski, L.(in press) Is internet-based CBT for panic disorder and agoraphobia as effective as face-to-face CBT? *Journal of Anxiety Disorders* doi:10.1016/j.janxdis.2008.01.008
10. Klein, B., Richards, J.C. and Austin, D.W. (2006) Efficacy of internet therapy for panic disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 37, 213-238
11. Lidren, D.M., Watkins, P.L., Gould, R.A., Clum, G.A., Asterino, M., and Tulloch, H.L. (1994) A comparison of bibliography and group therapy in the treatment of panic disorder. *Journal of Consulting and Clinical Psychology*, 62 (4), 865-869

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PANIC DISORDER WITH / WITHOUT AGORAPHOBIA

1. Mitte, K. (2005) A meta-analysis of the efficacy of psycho-and pharmacotherapy in panic disorder with and without agoraphobia. *Journal of Affective Disorder*, 88, 27-45
2. 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
3. National Institute for Health and Clinical Excellence (N.I.C.E.) (2006) Technology Appraisal 97 Computerised cognitive behaviour therapy for depression and anxiety: *Review of Technology Appraisal 51* (**www.nice.org.uk/nicemedia/pdf/TA097guidance.pdf**)
4. Oei, TPS, 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
5. Power, K.G., Sharp, D.M., Swanson, V. and 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
6. Sharp, D.M., Power, K.G., and 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
7. Spek,V.,Cuijpers,P. Nyklíček,I., Riper, H., Keyzer,J. and Pop,V. (2007) Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychological Medicine*, 37, 319-328
8. Swinson, R.P., Soulios,C., Cox,B.J. and Kuch,K. (1992) Brief treatment of emergency room patients with panic attacks. *American Journal of Psychiatry*, 149, 944-946
9. Telch, M.J., Lucas, J.A., Schmidt, N.B., Hanna, H.H., Jaimez, T.L. and Lucas, R.A., (1993) Group cognitive behavioural treatment of panic disorder. *Behaviour Research and Therapy*, 31, 279-287
10. 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

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SOCIAL ANXIETY / SOCIAL PHOBIA

1. Carlbring, P., Gunnarsdottir, M., Hedensjo, 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.
2. Andersson, G., Carlbring, P., Holmström, A., et al (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, 677–686.
3. National Collaborating Centre for Mental Health (2013). *Social anxiety disorder: Recognition, assessment and treatment* [National Clinical Guideline Number 159]. London: National Institute for Clinical Excellence.
4. Lambert, M.J., & Ogles, B.M. (2004) The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Bergin & Garfield's Handbook of psychotherapy and behavior change* (5th ed.) (pp. 139-193), New York: Wiley.
5. Ponniah, K., & Hollon, S.D. (2008) Empirically supported psychological interventions for social phobia in adults: a qualitative review of randomized controlled trials. *Psychological Medicine*, 38, 3-14.
6. Stravynski, *A. Fearing Others: The nature and treatment of social phobia*. Cambridge, UK: Cambridge University Press.
7. Cottraux, J., Note, I., Albuisson, 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
8. Joshua D. Lipsitz, Ph.D., John C. Markowitz, M.D., Sabrina Cherry, M.D., and Abby J. Fyer, M.D. (1999) Open Trial of Interpersonal Psychotherapy for the Treatment of Social Phobia, *American Journal of Psychiatry*, 156:1814-1816
9. Emmelkamp, P.M.G., Benner, A., Kuipers, A., Fiertag., G., et al (2006) Comparison of brief and dynamic and cognitive-behavioural therapies in avoidant personality disorder. *British Journal of Psychiatry*, 189, 60-64

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SOCIAL ANXIETY / SOCIAL PHOBIA

1. Leichsenring F, Salzer S, Beutel ME, Herpertz S, Hiller W, Hoyer J, Huesing J, Joraschky P, Nolting B, Poehlmann K, Ritter V, Stangier U, Strauss B, Stuhldreher N, Tefikow S, Teismann T, Willutzki U, Wiltink J, & Leibing E. (2013). Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: a multicenter randomized controlled trial. *American Journal of Psychiatry*, 170:759-67. doi: 10.1176/appi.ajp.2013.12081125.

2. Stangier U, Schramm E, Heidenreich T, Berger M, Clark DM. Cognitive therapy vs interpersonal psychotherapy in social anxiety disorder: A randomized controlled trial. *Archives of General Psychiatry*. 2011;68:692–700.

3. 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*, Early Online Publication, 26 September 2014. doi:10.1016/S2215-0366(14)70329-3

4. Elliott, R. (2013). Person-Centered-Experiential Psychotherapy for Anxiety Difficulties: Theory, Research and Practice. *Person-Centered and Experiential Psychotherapies*, 12, 14-30. DOI:10.1080/14779757.2013.767750

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GENERALISED ANXIETY DISORDER

1. Ballenger, J., Davidson, J., Lecrubier, Y., Nutt, D., et al. (2001) Consensus statement on generalised anxiety disorder from the international consensus group on depression and anxiety. *Journal of Clinical Psychiatry*, 11:53-58.
2. 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
3. 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(3):267-273.
4. Durham, R., Fisher, P., Dow, M., Sharp, D., et al. (2004) Cognitive behaviour therapy for good and poor prognosis generalized anxiety disorder: a clinical effectiveness study. *Clinical Psychology and Psychotherapy*, 11:145-157.
5. Fisher, P.L. (2006) The efficacy of psychological treatments for generalised anxiety disorder. In: Davey GCL, Wells A, editors. *Worry and its psychological disorders: theory, assessment and treatment*: John Wiley & Sons, Ltd; 359-378.
6. NICE. (2014) *Anxiety Disorders* (guidance.nice.org.uk/qs53)
7. NICE. (2006) Computerised cognitive behavior therapy for depression and anxiety: *Review of Technology appraisal 51*: National Institute for Health & Clinical Excellence.
8. White, J. (1998) 'Stress control' large group therapy for generalised anxiety disorder: two year follow-up. *Behavioural & Cognitive Psychotherapy*, 26:237-245.
9. Power KG, Simpson RJ, Swanson V, Wallace LA et al (1990) A controlled comparison of cognitive behaviour therapy, diazepam and placebo, alone and in combination, for the treatment of generalised anxiety disorder. *Journal of Anxiety Disorders*, 4, 267 – 292.

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OBSESSIVE COMPULSIVE DISORDER

1. NICE (2006) *Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*, **http://www.nice.org.uk/nicemedia/pdf/cg031fullguideline.pdf**
2. Mataix-Cols, D. & Marks, I. M. (2006) Self-help with minimalist therapist contact for obsessive-compulsive disorder: a review. *EuropeanPsychiatry,*21,75-80
3. Abramowitz, J.S. (2006) The Psychological Treatment of Obsessive-Compulsive Disorder. *Canadian Journal of Psychiatry*, 51 (7), 407-416
4. Foa, E.B., Liebowitz, M.R., Kozak, M.J, Davies, S., Campeas, R., Franklin, M.E., Huppert, J.D., Kjernisted, K., Rowan, V., Schmidt, A.B., Simpson, H.B. & Tu, X. (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
5. Roth, A, & Fonagy, P. (2006). What Works for Whom. 198-215. The Guilford Press. New York
6. Abramowitz, J.S., Foa, E.B., & Franklin, M.E., (2003) Exposure and Ritual Prevention for Obsessive-Compulsive Disorder: Effects of Intensive versus Twice Weekly Sessions. *The Journal of Consulting and Clinical Psychology*, 71. 394-398
7. Koran, L.M. & Simpson, H.B. (2013) Guideline Watch: Practice Guideline for the Treatment of Patients with Obsessive Compulsive Disorder. (American Psychiatric Association 2007). **http://psychiatryonline.org/content.aspx?bookid=28&sectionid=40634994**
8. NICE (2013) *Obsessive-compulsive disorder: Evidence update 47, A summary of selected new evidence relevant to NICE clinical guideline 31 'Obsessive-compulsive disorder and body dysmorphic disorder* (2005) **http://www.evidence.nhs.uk/evidence-update-47**
9. Goodman W.K, Price L.H, Rasmussen S.A, Mazure C, Fleischmann R.L., Hill C.L., Heninger G.R., Charney D.S., (1989) The Yale–Brown Obsessive–Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatry*;46:1006–1011

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PSYCHOSIS (INCLUDING THOSE DIAGNOSED WITH SCHIZOPHRENIA)

1. National Institute for Health and Care Excellence. *Psychosis and schizophrenia: treatment and management.* (Clinical guideline 178.) 2014. **http://guidance.nice.org.uk/CG178**
2. Hutton, P. & Taylor, P.J. (2014) Cognitive behavioural Therapy for psychosis prevention: a systematic review and meta-analysis. *Psychological Medicine*, 44, 449-468.
3. Stafford M.R., Jackson, H., Mayo-Wilson, E., Morrison, A.P. & Kendall, T. (2013) Early intervention to prevent psychosis: systematic review and meta-analysis. *British Medical Journal*, 346:f185
4. Van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D., Yung, A.R., McGorry, P. & Cuipers, P. (2013) Preventing the first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12 months and longer term follow-ups. *Schizophrenia Research*, 149, 56-62.
5. Scottish Intercollegiate Guidelines Network (2014) *Management of Schizophrenia: A National Clinical Guideline*. Edinburgh: SIGN; 2013. (SIGN publication no. 131). [March 2013].
6. Turner, D.T., van der Gaag, M., Karyotaki, E., & Cuipers, P. (2014) Psychological interventions for psychosis: a meta-analysis of comparative outcome studies. *American Journal of Psychiatry*, 171, 523-538.
7. Jauhar, S., McKenna, P.J., Radua, J., Fung, E., Salvador, R. & Laws, K.R. (2014) Cogitive behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *British Journal of Psychiatry*, 204, 20-29.
8. 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. *Schizophrenia Research,* 156 (1), 30–37.
9. Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J., & Kuipers, E. (2010) Early intervention services, cognitive behavioural therapy and family intervention in early psychosis: systematic review. *British Journal of Psychiatry*, 197, 350-356.
10. Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008) Cognitive behaviour therapy for schizophrenia: effect sizes, clinical models and methodological rigour. *Schizophrenia Bulletin*, 34, 523-527.

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PSYCHOSIS (INCLUDING THOSE DIAGNOSED WITH SCHIZOPHRENIA)

1. Alvarez-Jiminez, M., Parker, A.G., Hetrick, S.E., McGorry, P.D. & Gleeson, J.F. (2011) Preventing the second episode: a systematic review and meta-analysis of psychosocial and pharmacological trials in first episode psychosis. *Schizophrenia Bulletic*. 37, 619-630.
2. Pharoah, F., Mari, J.J., Rathbone, J., & Wong, W. (2010) *Family intervention for schizophrenia*. Cochrane Schizophrenia Group. DOI: 10.1002/14651858. CD000088.pub3
3. Wykes T., Huddy, V., Cellard, C., McGurk, S.R. & Czobor, P. (2011) A meta-analysis of cognitive remediation for schizophrenia: methodology and effect sizes. *American Journal of Psychiatry*, 168, 472-285.
4. Moritz, S., Andreou, C., Schneider, B.C., Wittekind, C.E., Mahesh, M., Balzan, R.P. & Woodward, T.S. (2014) Sowing the seeds of doubt: a narrative review on metacognitive training in schizophrenia. *Clinical Psychology Review*, 34, 358-366.
5. Khoury, B., Lecomte, T., Gaudiano, B.A. et al. (2013). Mindfulness interventions for psychosis: A meta-analysis. *Schizophrenia Research*, 150, 176–184.
6. Bach, P. & Hayes, S.C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 70 (5), 1129–1139.
7. Bach, P., Hayes, S.C. & Gallop, R. (2012). Long-term effects of brief acceptance and commitment therapy for psychosis. *Behavior Modification*, 36 (2), 165–181.
8. Braehler, C., Gumley, A., Harper, J., Wallace, S., Norris, J., & Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, 52 (2), 199–214.
9. Chadwick, P., Hughes, S., Russell, D., Russell, I. & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy*, 37 (4), 403-412.
10. Chien, W.T. & Lee, I.Y.M. (2013). The mindfulness-based psychoeducation program for Chinese patients with schizophrenia. *Psychiatric Services*, 64 (4), 375-379.

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1. Chien, W.T. & Thompson, D.R. (2014). *Effects of a mindfulness-based psychoeducation programme for Chinese patients with schizophrenia: 2-year follow-up*. *In Press*.
2. Gaudiano, B.A. & Herbert, J.D. (2006). Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy: pilot results. *Behaviour Research and Therapy*, 44, 415–437.
3. Langer, A.I., Cangas, A.J., Salcedo, E. et al.(2011). Applying mindfulness therapy in a group of psychotic individuals: a controlled study. *Behavioural and Cognitive Psychotherapy*, 40 (1), 105-109.
4. Perich, T., Manicavasagar, V., Mitchell, P.B., Ball, J.B. & Hadzi-Pavlovic, D. (2013). A randomized controlled trial of mindfulness-based cognitive therapy for bipolar disorder. *Acta Psychiatrica Scandinavcica*, 127, 333–343.
5. Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliff, K., Larner, C., Thomas, N., Castle, D., Mullen, P. & Copolov, D. (2012). A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. *Behaviour Research and Therapy*, 50, 110–121.
6. Van Dijk, S., Jeffrey, J. & Katz, M.R. (2013). A randomized, controlled, pilot study of dialectical behavior therapy skills in a psychoeducational group for individuals with bipolar disorder. *Journal of Affective Disorders*, 145, 386–393.
7. White, R., Gumley, A., McTaggart, J., Rattrie, L., McConville, D., Cleare, S. & Mitchell, G. (2011). A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. *Behaviour Research and Therapy*, 49, 901-907.
8. Eisner, E., Drake, R., Barrowclough, C. (2013) Assessing early signs of relapse in psychosis: Review and future directions. *Clinical Psychology Review*, 33, 637-653.
9. 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.
10. 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.

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BIPOLAR DISORDER

1. Beynon, S., Soares-Weiser, K., Woolacott, N., Duffy, D., & Geddes, J. R. (2008). Psychosocial interventions for the prevention of relapse in bipolar disorder: systematic review of controlled trials. *The British Journal of Psychiatry*, *192*, 5-11.
2. Castle, D., White, C., Chamberlain, J., Berk, M., Lauder, S., Murray. G., Schweitzer, I., Piterman, L., & Gilbert, M. (2010). Group-based psychosocial intervention for bipolar disorder: randomised controlled trial. *The British Journal of Psychiatry*, *196*, 383-388.
3. Colom, F., Vieta, E., Sanchez-Moreno, J., Palimino-Otiniano, R., Reinares, M., Goikolea, J. M., Benabarre, A., & Martinez-Aran, A. (2009). Group psychoeducation for stabilised bipolar disorders: 5-year outcomes of a randomised clinical trial. *The British Journal of Psychiatry*, *194*, 260-265.
4. Frank, E., Kupfer, D. J., Thase, M. E., Mallinger, A. G., Swartz, H. A., Fagiolini, A. M., Grochocinski, V., Houck, P., Scott, J., Thompson, W., & Monk, T. (2005). Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. *Archives of General Psychiatry, 62*, 996-1004.
5. Lam, D. H., Hayward, P., Watkins, E., Wright, W., & Sham, P. (2005). Outcome of a two-year follow-up of a cognitive therapy of relapse prevention in bipolar disorder. *American Journal of Psychiatry, 162*, 324-329.
6. Miklowitz, D. J., George, E., Richards, J., Simoneau, T. L., & Suddath, R. (2003). A randomised study of family-focused psycho-education and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, *60*, 904-912.
7. Reinares, M., Colom, F., Sanchez-Moreno, J., Torrent, C., Martinez-Aran, A., Comes, M., Goikolea, J. M., Benabarre, A., Salamero, M., & Vieta, E. (2008). Impact of caregiver group psychoeducation on the course and outcome of bipolar patients in remission: a randomized controlled trial. *Bipolar Disorder*, *10*, 511-519.
8. Reinares, M., Sanchez-Moreno, J., & Fountoulakis, N. (2014). Psychosocial interventions in bipolar disorder: What, for whom, and when. *Journal of Affective Disorders*, http://dx.doi.org/10.1016/j.jad.2013.12.017
9. Scott, J., Paykel, E., Morriss, R., Bentall, R., Kinderman, P., Johnson, T., Abbott, R., & Hayhurst, H. (2006). Cognitive-behavioural therapy for severe and recurrent bipolar disorders: randomised controlled trial. *British Journal of Psychiatry*, *188*, 313-320.

BIPOLAR DISORDER

1. Simon, G. E., Ludman, E. J., Unutzer, J., Bauer, M. S., Operskalski, B., & Rutter, C. (2005). Randomised trial of a population-based care program for people with bipolar disorder. *Psychological Medicine*, *35*, 13-24.

2. 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.

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NON PSYCHOTIC AFFECTIVE DISORDERS IN THE PERINATAL PERIOD

SUPPORTIVE THERAPIES

1. Shaw E, Levitt C, Wong S, Kaczorowski J, Group. MUPR.Systematic review of the literature on postpartum care:effectiveness of postpartum support to improve maternal parenting, mental health, quality of life, and physical health. *Birth 2006*;33(3):210-20.

2. Dennis CL, Kingston D. A systematic review of telephone support for women during pregnancy and the early postpartum period. *J Obstet Gynecol Neonatal Nurs 2008*;37(3):301-14.

COUPLE INTERVENTIONS

3. Misri S, Kostaras X, Fox D, Kostaras D. The impact of partner support in the treatment of postpartum depression. *Can J Psychiatry 2000*;45(6):554-8.

PSYCHOLOGICAL THERAPIES

4. Bledsoe SE, Grote NK. Treating Depression During Pregnancy and the Postpartum: A Preliminary Meta-Analysis. *Res Soc Work Pract 2006*;16(2):109-20.

5. Cuijpers P, Brannmark JG, Van Straten A. Psychological treatment of postpartum depression: A meta-analysis. J *Clin Psychol 2008*;64(1):103-18.

6. Leis JA, Mendelson T, Tandon SD, Perry DF. A systematic review of home-based interventions to prevent and treat postpartum depression. *Arch Womens Ment Health 2009*;12(1):3-13.

7. 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*;338(7689):276-9.

8. Holden, J.M., Sagovsky, R., & Cox, J.L. (1989). Counselling in a general practice setting: Controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal*, 298, 223-226.

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NON PSYCHOTIC AFFECTIVE DISORDERS IN THE PERINATAL PERIOD

1. Wickberg, B., & Hwang, C. P. (1996). Counselling of postnatal depression: A controlled study on a population based Swedish sample.Journal of Affective Disorders, 39, 209-216.

2. Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003).Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression.British Journal of Psychiatry,182, 412-419 .

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DEPRESSION

1. Scottish Intercollegiate Guidelines Network (SIGN) *Non-pharmaceutical management of depression.* Edinburgh: SIGN; 2010.(SIGN publication no. 114) [cited 10 June 2010] Available from url: **http://www.sign.ac.uk**

2. 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.

1. 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**

2. Kaltenthaler E, Brazier J, De Nigris E, Tumur I, Ferriter M, Beverley C, et al. Computerised cognitive behaviour therapy for depression and anxiety update: a systematic review and economic evaluation. *Health Technology Assessment 2006*;10(33):1-168

3. Christensen H, Griffiths KM, Jorm AF. Delivering interventions for depression by using the internet: Randomised controlled trial. BMJ: *British Medical Journal 2004*;328(7434):265-9.

4. Cuijpers P, van Straten A, Warmerdam L. Behavioral activation treatments of depression: A meta-analysis. *Clinical Psychology Review 2007*;27(3):318-26.

5. 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

6. Churchill R, Hunot V, Corney R, Knapp M, McGuire H, Tylee A, et al. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment 2001*;5(35):1-173

7. de Mello MF, 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.

8. Leichsenring F. Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: a meta-analytic approach. *Clin Psychol Rev 2001*;21(3):401-19.

DEPRESSION

1. Cuijpers P, van Straten A, Warmerdam L. Problem solving therapies for depression: A meta-analysis. *European Psychiatry 2007*;22(1):9-15.
2. Coelho H.F., Canter P.H., Ernst E., Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research. *Journal of Consulting and Clinical Psychology*. 2007;75(6):1000-5.
3. Greenberg, L.S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research*, 8, 210-224.
4. Watson, J.C., Gordon, L.B., Stermac, L., Kalogerakos, F., Steckley, P. (2003). Comparing the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, 71, 773-781.
5. King, M., Marston, L. & Bower, P. (2013). Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: a randomized control trial. *Psychological Medicine*. Available on CJO 2013 doi:10.1017/S0033291713002377
6. Keller, M. B., McCullough, J. P., Klein, D. N., et al (2000)A Comparison of Nefazodone, the Cognitive Behavioral-Analysis System of Psychotherapy, and Their Combination for the Treatment of Chronic Depression. *New England Journal of Medicine*, 342, 1462-1470.

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BORDERLINE PERSONALITY DISORDER

1. Linehan M.M, Armstrong H, Suarez A, Allmon D, Heard HL.(1991) Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 48, 1060–1064.
2. 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
3. Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, Kremers I, Nadort M, Arntz, A. (2006) Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry*, 63, 649–658
4. Clarkin J.F., Levy K.N., Lenzenweger M.F., Kernberg O.F. (2007) Evaluating three treatments for borderline personality disorder: a multiwave study. *American Journal of Psychiatry*, 164, 922–928
5. Bateman A, Fonagy P (1999) The effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry*, 156, 1563–1569
6. Blum N, St. John D, Pfohl B, Stuart S, McCormick B, Allen J, Arndt S, Black D (2008) Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder: A Randomized Controlled Trial and 1-Year Follow-Up. *American Journal of Psychiatry*, 165, 468–478
7. Crawford, M & Rutter, D (2007) Lessons learned from an evaluation of dedicated community based services for people with personality disorder. *Mental Health Review Journal*, 12, 55-61.
8. Bateman A., Fonagy P (2009) Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder. *American Journal of Psychiatry*, 166, 1355–1364.

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BORDERLINE PERSONALITY DISORDER

1. McMain S.F., Links P.S., Gnam W.H., Guimond T., Cardish R.J., Korman L., et al. (2009) A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry*, 166, 1365–74.

2. Generic Structured Clinical Care are delineated in the University College London UCL, CORE website [**www.ucl.ac.uk/clinicalpsychology/CORE/competence_mentalillness.html** OR **www.ucl.ac.uk/CORE/**]

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ALCOHOL PROBLEMS

1. Scottish Intercollegiate Guidelines Network. (2003). *The Management of Harmful Drinking and Alcohol Dependence in Primary Care: SIGN Guideline 74.* Edinburgh: SIGN.
2. Slattery, J., Chick, J., Cochrane, M., Craig, J., Godfrey, C., Kohli, H., et al. (2003). *Prevention of Relapse in Alcohol Dependence. Health Technology Assessment Report 3*. Glasgow: Health Technology Board for Scotland.
3. Raistrick, D., Heather, N. & Godfrey, C. (2006). *Review of the effectiveness of treatment for alcohol problems*. National Treatment Agency: NHS England.
4. Miller, W. R., Wilbourne, P. D. & Hetema, J. E. (2003). What Works? A Summary of Alcohol Treatment OutcomeResearch. In R. K. Hester & W. R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches: Effective Alternatives,* (3rd edition), (pp. 13–63). Boston, MA: Allyn and Bacon.
5. National Institute for Health and Clinical Excellence. (2011). *Alcohol-use disorders Diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical Guideline 115*. NICE: London.

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SUBSTANCE USE

1. National Institute for Health and Clinical Excellence. (2007). *Drug Misuse: Psychosocial Intervention. Clinical Guideline 51*, NICE: London.
2. National Treatment Agency for Substance Misuse. (2005). *The Effectiveness of Psychological Therapies on Drug Misusing Clients.* London: NTA.
3. Pilling, S., Hesketh, K. & Mitcheson, L. (2010). *Psychosocial Interventions for Drug Misuse: A framework and toolkit for implementing NICE-recommended treatment interventions.*

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EATING DISORDERS

1. Agras, W.S., Walsh, B.T., Fairburn, C.G., Wilson, G.T., Kraemer, H.C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry*, 57, 459-466.
2. American Psychiatric Association (2000). Practice guidelines for the treatment of patients with eating disorders. *The American Journal of Psychiatry,* 157 (1), 1-39.
3. American Psychiatric Association Guidelines (2006). Practice guidelines for the treatment of patients with psychiatric disorders compendium. *American Psychiatric Publications*, 1097-1222.
4. Bailer, U., de Zwaan, M., Leisch, F., Strnad, A., Lennkh-Wolfsberg, C., El-Giamal, N., Hornik, K., Kasper, S. (2004). Guided self-help versus cognitive-behavioural group therapy in the treatment of bulimia nervosa. *International Journal of Eating Disorders*, 35, 522-537
5. Bell, L., Clare, L., Thorn, E. (2001). Service Guidelines for people with eating disorders. DCP Occasional paper No.3. The British Psychological Society.
6. Carter, J.C., Olmsted, M.P., Kaplan, A.S., McCabe, R.E., Mills, J.S., Aimé, A. (2003). Self-Help for Bulimia Nervosa: A Randomised Controlled Trial. *American Journal of Psychiatry*, 160, 973-978.
7. Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., Burton, J., Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry,* 48, 463-469.
8. Fairburn, C. G., Marcus, M. D., Wilson, G. T. (1993). Cognitive-behavioural therapy for binge eating and bulimia nervosa: A Comprehensive treatment Manual; in Fairburn, CG and Wilson, GT(eds) *Binge Eating: Nature assessment and Treatment*. New York, Guilford Press, 1993, 361-404
9. Fairburn, C.G., Kirk, J., O'Connor, M., Cooper, P.J. (1986). *A comparison of two psychological treatments for bulimia nervosa*.
10. *Behaviour Research and Therapy*, 24 (6), 629-643.

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EATING DISORDERS

1. Hoek, H. (1995) *Distribution of Eating Disorders, In Eating Disorders and Obesity*, Eds: Brownell and Fairburn: Chapter 41: p233-237. Guilford Press, New York.
2. Hoek, H., van Hoeken, D. (2003) Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders*, 34:383-396
3. Hsu, L. K. G. (1990). *Eating Disorders*. London: Guilford.
4. Le Grange, D., Crosby, R.D., Rathouz,P. J., Leventhal, B.L. (2007). A Randomised Controlled Comparison of Family-Based Treatment and Supportive Psychotherapy for Adolescent Bulimia Nervosa. *Archives of General Psychiatry*, 64 (9), 1049-1056.
5. LeGrange, D., Schmidt, U. (2005). The treatment of adolescents with bulimia nervosa. *Journal of Mental Health*, 14 (6), 587-597.
6. Lewandowski, L. M., Gebing, T. A., Anthony, J. L., O'Brien, W. H. (1997). Meta-analysis of cognitive-behavioural treatment studies for bulimia. *Clinical Psychology Review*, 17, 703-718.
7. Mitchell, J. E., Pyle, R. L., Eckert, E. D., Hatsukami, D., Pomeroy, C., Zimmerman, R. (1990). A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa. *Archives of General Psychiatry*, 47, 149-157.
8. National Institute for Clinical Excellence (NICE). (2004). *Eating Disorders*. London: NICE; Clinical Guideline 9. (1.3.2.3)
9. NHS Quality Improvement Scotland (QIS). (2006). *Eating Disorders in Scotland: Recommendations for Management and Treatment*. Scotland: NHS. www.nhshealthyquality.org
10. Rossi, G., Balottin, U., Rossi, M., Chiappedi, M., Fazzi, E., Lanzi, G. (2007). Pharmacologic treatment of anorexia nervosa: a retrospective study in preadolescents and adolescents. *Clinical Paediatrics*, 46 (9), 806-811.
11. Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., Winn, S., Robinson, P., Murphy, R., Keville, S., Johnson-Sabine, E., Jenkins, M., Frost, S., Dodge, L., Berelowitz, M., Eisler, I. (2007). A randomised controlled trial of family therapy and cognitive behaviour therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry*, 164 (4), 591-598.

EATING DISORDERS

1. Shapiro, J., Berkman, N., Brownley, K., Sedway, J., Lohr, K., Bulik, C. (2007). Bulimia nervosa treatment: a systematic review of randomised controlled trials. *International Journal of Eating Disorders*, 40, 321-336.
2. Sysko, B., Walsh, T. (2008). A critical evaluation of the efficacy of self-help interventions for the treatment of bulimia nervosa and binge-eating disorder. *International Journal of Eating Disorders*, 41, 97-112.
3. Whittal, M.L, Agras, W.S., Gould, R.A. (1990). Bulimia nervosa: a meta-analysis of psychosocial and psychopharmacological treatments. *Behaviour Therapy*, 30, 117-135.

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INSOMNIA

1. Morin, C.M., Culbert, J.P., Schwartz, M.S. (1994) Non-pharmacological interventions for insomnia: a meta-analysis of treatment efficacy. *American Journal of Psychiatry* 151, 1172-1180
2. Murtagh, D.R., Greenwood, K.M., (1995) Identifying effective psychological treatments for insomnia: a meta-analysis. *Journal of Consulting and Clinical Psychology* 63, 79-89
3. Pallesen, S., Nordhus, I. H., Kvale, G. (1998) Nonpharmacological interventions for insomnia in older adults: A meta-analysis of treatment efficacy. *Psychotherapy*, 35, 472–482.
4. Morin CM, Hauri PJ, Espie CA, Spielman A, Buysse DJ, Bootzin RR. (1999) Nonpharmacologic treatment of insomnia: an American Academy of Sleep Medicine Review. *Sleep 22*, 1134-56
5. Smith MT, Perlis, ML, Park A, Giles DE, Pennington JA, Buysse, DJ. (2002) Behavioral treatment vs pharmacotherapy for Insomnia - A comparative meta-analyses. *American Journal of Psychiatry* 159, 5-11
6. Montgomery, P., & Dennis, J. (2003). *Cognitive behavioral interventions for sleep problems in adults aged 60*. Cochrane Database Syst Rev (1): CD003161
7. Irwin MR, Cole JC, Nicassio PM (2006) Comparative Meta-Analysis of Behavioral Interventions for Insomnia and Their Efficacy in Middle-Aged Adults and in Older Adults 55+ Years of Age. *Health Psychology*. 25, 3-14
8. Morin, C.M., Bootzin, R.R., Buysse, D.J., Edinger, J.D., Espie, C.A. & Lichstein, K.L. (2006) Psychological and behavioural treatment of insomnia. Update of the recent evidence (1998-2004) prepared by a Task Force of the American Academy of Sleep Medicine. *Sleep 29*, 1398-1414
9. Wang MY, Wang SY, Tsai PS. (2005). Cognitive behavioural therapy for primary insomnia: A systematic review. *Journal of Advanced Nursing*, 50 (5), 553-564.
10. Smith MT, Huang MI, Manber R. (2005). Cognitive behaviour therapy for chronic insomnia occurring within the context of medical and psychiatric disorders. *Clinical Psychology Reviews*, 25, 559-592.

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INSOMNIA

1. Montgomery P, Dennis J. (2008). *Cognitive behavioural interventions for sleep problems in adults aged 60+ (Review)*. The Cochrane Library, Issue 3. Art. No. CD003161.

2. Chesson AL, McDowell Anderson W, Littner M, Davila D, Hartse K, Johnson S, Wise M, Rafecas J. (1999). Practice parameters for the nonpharmacologic treatment of chronic insomnia. *SLEEP*, 22 (8), 1128-1133.

3. Morgenthaler T, Kramer M, Alessi C, Friedman L, Boehlecke B, Brown T, Coleman J, Kapur V, Lee-Chiong T, Owens J, Pancer J, Swick T. (2006). Practice parameters for the psychological and behavioural treatment of insomnia: An update. An American Academy of Sleep Medicine report. *SLEEP*, 29 (11), 1415-1419.

4. Okajima, I., Komada, Y., & Inoue, Y. (2011). A meta-analysis on the treatment effectiveness of cognitive behavioral therapy for primary insomnia. *Sleep and Biological Rhythms*, *9*(1), 24-34.

5. Soeffng JP, Lichstein KL, Nau SD, McCrea CS, Wilson NM, Aguillard RN, Lester KW, Bush AJ. (2008). Psychological treatment of insomnia in hypnotic-dependant older adults. *Sleep Medicine*, 9, 165-171.

6. Germain A, Moul DE, Franzen PL, Miewald JM, Reynolds CF 3rd, Monk TH, Buysse DJ. (2006). Effects of a brief behavioural treatment for late-life insomnia: Preliminary findings. *Journal of Clinical Sleep Medicine*, 2 (4), 403-406.

7. Espie CA, MacMahon KM, Kelly HL, Broomfield NM, Douglas NJ, Engleman HM, McKinstry B, Morin CM, Walker A, Wilson P. (2007). Randomized clinical effectiveness trial of nurse-administered small-group cognitive behaviour therapy for persistent insomnia in general practice. *SLEEP*, 30 (5), 574-584.

8. Espie, CA, Fleming, L, Cassidy, J, Samuel, L, Taylor. LM, White, CA, Douglas, NJ, Engleman, HM, Kelly, H-L, Paul. J. (2008). Randomized Controlled Clinical Effectiveness Trial of Cognitive Behavior Therapy Compared With Treatment As Usual for Persistent Insomnia in Patients With Cancer. *Journal of Clinical Oncology*, 26(8), 4651-4658.

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INSOMNIA

1. Manber, R, Edinger, JD, Gress, JL, Pedro-Salcedo, MGS, Kuo, TF, Kalista, T. (2008). Cognitive Behavioral Therapy for Insomnia Enhances Depression Outcome in Patients with Comorbid Major Depressive Disorder and Insomnia. *SLEEP*, 31(4), 489-495.
2. Espie, CA, Inglis, S, Tessier, S, Harvey, L. (2001). The clinical effectiveness of cognitive behaviour therapy for chronic insomnia: implementation and evaluation of a sleep clinic in general medical practice. *Behaviour Research and Therapy,*39, 45–60.
3. Espie, CA, Inglis, S, Harvey, L. (2001). Predicting clinically significant response to cognitive behaviour therapy (CBT) for chronic insomnia in general medical practice: Analyses of outcome data at 12 months posttreatment. *Journal of Consulting and Clinical Psychology* 69, 58-66
4. Harris J, Lack L, Wright H, Gradisar M, Brooks A. (2007). Intensive sleep retraining treatment for chronic primary insomnia: A preliminary investigation. *Journal of Sleep Research*, 16, 276-284.
5. Harvey AG, Sharpley AL, Ree MJ, Stinson K, Clark DM. (2007). An open trial of cognitive therapy for chronic insomnia. *Behaviour Research and Therapy*, 45, 2491-2501.
6. Yook K, Lee SH, Ryu M, Kim KH, Choi TK, Suh SY, Kim YW, Kim B, Kim MY, Kim MJ. (2008). Usefulness of mindfulness-based cognitive therapy for treating insomnia in patients with anxiety disorders. *Journal of Nervous and Mental Disease*, 196 (6), 501-503.
7. Rosen RC, Lewin DS, Goldberg L, Woolfolk RL. Psychophysiological insomnia: combined effects of pharmacotherapy and relaxation- based treatments. *Sleep Medicine 1*, 279-88
8. Ong JC, Shapiro SL, Manber R. (2008). Combining mindfulness meditation with cognitive-behaviour therapy for insomnia: A treatment-development study. *Behavior Therapy*, 39, 171-182.
9. van Straten, A., & Cuijpers, P. (2009). Self-help therapy for insomnia: a meta-analysis. *Sleep Medicine Reviews*, *13*(1), 61-71.
10. Edinger JD, Wohlgemuth WK, Radtke RA, Coffman CJ, Carney CE. Dose-response effects of cognitive behavioural insomnia therapy: A randomized clinical trial. *SLEEP*, 30 (2), 203-212.

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TRAUMA

1. Rose, S.C., Bisson, J., Churchill, R., Wessely, S. *Psychological debriefing for presenting post traumatic stress disorder (PTSD)* (Review) The Cochrane Library 2009, Issue 1, 1-45
2. Bisson, J., Jenkins, P., Alexander, J., Bannister, C. Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry 1997*; 171: 78-81
3. Bordow, S., Porritt, D. An experimental evaluation of crisis intervention. *Social Science and Medicine* 1979; 13A(3):251-6
4. Bunn, B., Clarke, A. Crisis intervention: an experimental study of the effects of a brief period of counselling on the anxiety of relatives of seriously injured or ill hospital patients. *British Journal of Medical Psychology* 1979; 52(2):191-5
5. Campfield, K.M., Hills, A.M.,. Effect of timing of critical incident stress debriefing (CISD) on post-traumatic symptoms. *Journal of Traumatic Stress* 2001;14(2);327-40
6. Conlon, L., Faby, T., Conroy, R. PTSD in ambulant RTA victims; prevalence, predictors and a randomised controlled trial of psychological debriefing in prophylaxis. *Journal of Pschomatic Research* 1999; 46(1):37-44
7. Hobbs, M., Mayou, R., Harrison, B., Worlock, P. A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *BMJ* 1996;313(7070):1438-9
8. Lavender, T.,Walkinshaw, S.A. Can midwives reduce postpartum psychological morbidity? A randomised trial. *Birth* 1998; 25(4):215-9
9. Lee, C., Slade, P., Lygo, V. The influence of psychological debriefing on emotional adaptation in women following early miscarriage: a preliminary study. *British Journal of Medical Psychology* 1996;69(1):47-58
10. Priest, S.R., Henderson, J., Evans, S.F., Hagan, R. Stress debriefing after childbirth: randomised controlled trial. *MJA* 1003;178:542-545

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TRAUMA

1. Rose, S., Brewin, C.R., Andrews, B., Kirk, M. A randomised controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine* 1999;29(4);793-9

2. Small, R., Lumley, J., Donohue, L., Potter, A., Walderstrom, U. Midwife-led debriefing to reduce maternal depression following operative birth; a randomised controlled trial. BMJ 2000; 321, 7268:1043-7

3. Hobbs, G., Adshead, G. Preventative psychological intervention for road crash victims. In: Mitchell M editor(s). The aftermath of road accidents; Psychological, social and legal perspectives. London: Routledge, 1997;159-71

4. Andre, C., Lelord, F., Legeron, P., Reignier, A., Delattre, A. Controlled study of outcome after 6 months to early intervention of bus driver victims of aggression. Encephale 1997;23(1);65-71

5. Bisson, J., Shepherd, J., Joy, D., Probert, R. *Randomised controlled trial of a brief psychological intervention to prevent post traumatic stress disorder.* Submitted

6. Bryant, R., Harvey, A., Dang, S., Sackville, T., Basten, C. Treatment of acute stress disorder; a comparison of cognitive behaviour therapy and supportive counselling. *Journal of Counselling and Clinical Psychology* 1998;66(5);862-6

7. Foa, E., Heart-Ikeda, D., Perry, K. Evaluation of a brief cognitive-behavioural program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology* 1995; 63(6);948-55

8. NICE Post-Traumatic Stress Disorder.*The Management of PTSD in Adults and Children in Primary and Secondary Care*. National Institutes for Health and Clinical Excellence; 2005.

9. Blanchard, E.B., Wickling, E. J., Devineni, T. et al. A Controlled Evaluation of Cognitive Behavioural Therapy for Post-Traumatic Stress in Motor Vehicle Accident Survivors. *Behaviour Research and Therapy* 2003; 41, 79-96.

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TRAUMA

1. Marks, I., Lovell, K., Noshirvani, H. et al Treatment of Post-Traumatic Stress Disorder by Exposure and/or Cognitive Restructuring: A Controlled Study. *Archives of General Psychiatry* 1998; 55, 317-325.
2. Power, K., McGoldrick, T., Brown, K., et al. A Controlled Comparison of Eye Movement Desensitisation and Reprocessing Versus Exposure Plus Cognitive Restructuring Versus Waiting List Control in the Treatment of Post-Traumatic Stress Disorder. *Clinical Psychology and Psychotherapy* 2002; 9, 299-318.
3. Taylor, S., Thordarson, D.S., Maxfield, L., et al. Comparative Efficiency, Speed, and Adverse Effects of Three PTSD Treatments: Exposure Therapy, EDMR and Relaxation Training. *Journal of Consulting and Clinical Psychology* 2003; 71, 330-338.
4. Bryant, R.A. Early Predictors of Post-Traumatic Stress Disorder. *Biological Psychiatry* 2003, 53, 789-759.
5. Foa, E.,B., Rothbaum, B., O., Riggs, D., et al. Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioural procedures and counselling. *Journal of Consulting and Clinical Psychology*, 1991; 59, 715-723.
6. McDonagh, A., Friedman, M., McHugo, G., et al. Randomized Trial of Cognitive Behavioral Therapy for Chronic Posttraumatic Stress Disorder in Adult Female Survivors of Childhood sexual Abuse. *Journal of Consulting and Clinical Psychology* 2005; 73, 515-524.
7. Courtois, C. A., & Ford, J. D. T*reating complex traumatic stress disorders: An evidenced-based guide*. New York: Guilford Press, 2009.
8. DePrince, A. P., & Freyd, J. J. 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, 2007.
9. Kessler, R., C., McLaughlin, K., A., Green, J., G., et al. Childhood adversities and adult psychopathology in the WHO Mental Health Surveys. *British Journal Of Psychiatry* 2010; 197, 378-385.
10. Cloitre, M., Koenen, K.C., Cohen, L.R., Hyemee, H. Skills Training in Affective and Interpersonal Regulation followed by Exposure: A Phase-Based Treatment for PTSD Related to Childhood Abuse. *Journal of Consulting and Clinical Psychology* 2002; 70, 1067-1074

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SELF HARM AND SUICIDE

1. Allard, R., Marshall, M., Plante, M.C. (1992). Intensive follow up does not decrease the risk of repeat suicide attempts. *Suicide and Life Threatening Behaviour*, 22, 303-314.
2. Beautrais, A., Gibb, S., Faulkner, A., Fergusson, D., Mulder, R. (2010). Postcard intervention for repeat self harm: randomized controlled trial. *The British Journal of Psychiatry*, 197, 55-60.
3. Brown, G., Ten Have, T., Henriques, G., Xie, S., Hollander, J., Beck, A. (2005). Cognitive therapy for the prevention of suicide attempts. *American Medical Association*, 294, 563-570.
4. Byford, S., Harrington, R., Torgerson, D., Kerfoot, M., Dyer, E., Harrington, V., McNiven, F. (1999). Cost effectiveness analysis of a home based social work intervention for children and adolescents. *British Journal of Psychiatry*, 174, 56-62.
5. Byford, S., Knapp, M., Greenshields, J., Ukoumunne, O.C., Jones, V., Thompson, S., Tyrer, P., Schmidt, U., Davidson, K. (2003). Cost effectiveness of brief cognitive behavior therapy versus treatment as usual in recurrent deliberate self harm: a decision making approach. *Psychological Medicine,* 33, 977-986.
6. Carter, G., Clover, K., Whyte, I., Dawson, A., D'este, C. (2005). Postcards from the Edge: randomized controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *British Medical Journal,* 331, 805-810.
7. Carter, G., Clover, K., Whyte, I., Dawson, A., D'este, C. (2007). Postcards from the Edge: 24 month outcomes of a randomized controlled trial for hospital treated self poisoning. *British Journal of Psychiatry*, 191, 548-553.
8. Cedereke,, M., Monti, K., Ojehagen. (2002). Telephone contact with patients in the year after a suicide attempt: does it affect treatment attendance and outcome? A randomized controlled study. *European Psychiatry*, 17, 82-91.
9. Chowdhury, N., Hicks, R.C., Kreitman, N. (1973). Evaluation of an aftercare service for parasuicide (attempted suicide) patients. *Social Psychiatry*, 8, 67-81. this is not in the table yet

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SELF HARM AND SUICIDE

1. Cotgrove, A., Zirinsky, L., Black, D., Weston, D. (1995). Secondary prevention of attempted suicide in adolescence. *Journal of Adolescence*, 18, 569-577.
2. Evans, K., Tyrere, P., Catalan, J., Schmidt, U., Davidson, K., Dent, J., Tata, P., Thornton, S., Barber, J., Thompson, S. (1999). Manual assisted cognitive behaviour therapy (MACT): a randomized controlled trial of a brief intervention with bibliotherapy in the treatment of recurrent deliberate self harm. *Psychological Medicine*, 29, 19-25.
3. Fleischmann, A., Bertolote, J., Wasserman, D., De Leo, D., Bolhari, J., Botega, N.,Thanh, H. (2008). Effectiveness of a brief intervention and contact for suicide attempters: a randomised controlled trial in 5 countries. *Bulletin of the World Health Organisation*, 86, 703-709.
4. Guthrie, E., Kapur, N., Mackway Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Francis, F., Tomenson, B. et al. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. *British Medical Journal*, 323, 1-5.
5. Hassanian-Moghaddam, H., Sarjami, S., Kolahi, A., Carter, G. (2011). Postcards in persia: randomised controlled trial to reduce suicidal behaviours 12 months after hospital treated self poisoning. *British Journal of Psychiatry*, 198, 309-316.
6. Hatcher, S., Sharon, C., Parag, V., Collins, N. (2011). Problem solving therapy for people with self harm: zelen randomised controlled trial. *The British Journal of Psychiatry*, 199, 310-316.
7. Hawton, K., Bancroft, J., Catalan, J., Kingston, B., Stedeford, A., Welch, N. (1981). Domiciliary and out-patient treatment of self-poisoning patients by medical and non-medical staff. *Psychological Medicine,* 11, 169-177.
8. Hawton, K., McKeown, S., Day, A., Martin, P., O'Connor, M., Yule, J. (1987). Evaluation of out patient counseling compared with general practitioner care following overdoses. *Psychological Medicine*, 17, 751-761.
9. Hvid, M., Vanborg, K., Sorensen, J.S., Nielsen, I., Stenborg, J., Wang, A. (2011). Preventing repetition of attempted suicide – II. The Amager Project, a randomized controlled trial. *Informa Healthcare*, 65:292–298.

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SELF HARM AND SUICIDE

1. Liberman, R.P., Eckman, T. (1981). Behaviour therapy vs insight oriented therapy for repeated suicide attempters. *Archives of General Psychiatry*, 38, 1126-1130.
2. McLeavy, B. (1994). Interpersonal problem solving skills training in the treatment of self poisoning patients. *Suicide and Life Threatening Behaviour*, 4, 382-394.
3. Morgan, H.G., Jones., E.M., Owen, J.H. (1993). Secondary prevention of non fatal deliberate self harm. *British Journal of Psychiatry*, 163, 111-112.
4. Robinson, J., Yeun, H.P., Gook, S., Hughes, A., Cosgrave, E., Killackey, E., Baker, K., Jorm, A., McGorry, P., Yung, A. (2012). Can receipt of a regular postcard reduce suicide related behaviour in young help seekers? A randomised controlled trial. *Early Intervention in Psychiatry* (in press).
5. Salvoskis, P., Atha, C., Storer, D. (1990). Cognitive behavioural problem solving in the treatment of patients who repeatedly attempt suicide a controlled trial. *British Journal of Psychiatry*, 157, 871-876.
6. Tarrier, N., Taylor, K., Gooding, P. (2008). Cognitive-Behavioural Interventions to Reduce Suicide Behavior: A Systematic Review and Meta-Analysis. *Behaviour Modification*, 32, 77-108.
7. Townsend, E., Hawton, K., Altman, D.G, et al. The efficacy of problemsolving treatments after deliberate selfharm: metaanalysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine*, 31, 979–988.
8. Tyrer, P., Thompson, S., Schmidt, U. (2003). Manual assisted cognitive behaviour therapy is as effective as treatment as usual for deliberate self harm, but is more cost effective. *Psychological Medicine*, 33, 977-986.
9. Vaiva, G., Ducrocq, F., Meyer, P., Mathieu, D., Philippe, A., Libersa, C., Goudemand, M. (2006). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomised controlled study. *British Medical Journal*, 332, 1241-1247.
10. Van Der Sande, R., Van Rooijen, L., Buskens, E., Allart, E., Hawton, K., Van Der Graaf, Y., Van Engeland, H. (1996). Intensive in-patient and community intervention versus routine are after attempted suicide. *The British Journal of Psychiatry*, 171, 35-41.

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1. Van Heeringen, C., Jannes, S., Buylaert, W., Hendrick, H., De Bacquer, D., Van Remoortel, J. (1995). The management of non compliance with referral to out-patients after care among attempted suicide patients: a controlled intervention study. *Psychological Medicine*, 25, 962-970.
2. Waterhouse, J., Platt, S. (1990). General hospital admission in the management of parasuicide. *British Journal of Psychiatry*, 156, 236-242.
3. Welu. T.C. (1977). A Follow-up Program for Suicide Attempters: Evaluation of Effectiveness. *The American Association for Suicidology*, 7, 17-30.

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