

02.15 Newsletter



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EDITORIAL

Dear colleagues,

The IFP board is glad to send you our latest Newsletter.

The present issue first presents a report on new developments in Internet-based treatments by Drs. Berger, Krieger, and Caspar from the University of Bern. Research on Internet-based treatments has grown rapidly over the recent years and evidence is growing that some forms of Internet interventions often result in similar outcomes as conventional face-to-face psychotherapy. Internet-based interventions have several advantages and disadvantages. Main advantages include: easy accessibility, easy use independent of time and place at a self-determined pace, high level of anonymity and privacy which is for many persons with a mental disorder an attractive feature due to their fear of stigmatization and low cost of delivery to large populations. A common concern is the confidentiality of communications and client records. Another concern relates to how therapists deal with crisis and what to do when patients do not apply the treatment in an appropriate fashion. Most of these concerns can be adequately addressed. Since Internet-based treatments generally require limited resources once they are built and can quite easily be disseminated, research on Internet interventions growing very fast and may represent an hot issue for the future research as well as a great innovation for the present and future clinical practice. The possibility of providing affordable therapy to individuals with a foreign language without costly interpreters, as needed in face-to-face therapy, might be added: an issue of high relevance given the immense stream of refugees into Europe, of which a high percentage is traumatized.

Then, you can find an interesting report on routine outcome monitoring and benchmarking in the Netherlands by Prof.

Edwin de Beurs from Leiden University. In 2011, Nationwide Routine Outcome Monitoring (ROM) was implemented in the Netherlands aiming at enhancing the effectiveness and efficiency of mental health care. At set time points, session by session, or after 6 or 12 weeks of treatment, self-report instruments are completed by the patients. In this framework, ROM provides feedback to the therapist and patient on progress during treatment. It is too early to fully evaluate this new approach but encouraging is that professionals expressed satisfaction with regained ownership of ROM.

Finally, we present abstracts of some recently published papers that are interesting from both a scientific and a clinical point of view. We hope they will help you keep updated on new developments.

The IFP board wishes all of you pleasant reading,

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New developments in Internet-based treatments

Thomas Berger, Tobias Krieger & Franz Caspar, University of Bern

“Internet therapy can’t work, because a patient can’t have a therapeutic relationship with a computer!”, “An already socially isolated patient who spends additional time at his computer will turn out to be even more isolated”, “Internet therapy is dangerous because it steals us patients”, etc.: Many prejudices or at best half-justified assumptions stand in the way of an even broader use of Internet-based treatments. Yes, in face-to-face therapies, the relationship is important, but in many therapies the relationship is not too good. It may be better to have a relationship limited to the alliance aspect, with a strong belief that the program is adapted to ones need that can be trusted and will help at the end, than struggling with a difficult relationship. Good Internet programs for social phobia support the patient in doing exercises in the real world. We get access to new groups of patients, and there are many Internet therapy patients who tried with face-to-face therapy, were disappointed, and would not try another face-to-face therapy. Even if Internet therapy should be limited in some aspects, it may be superior to face-to-face psychotherapy in other aspects. It may be argued back and forth, but what do the data actually say?

Research on Internet-based treatments has grown rapidly over the recent years and evidence is growing that some forms of Internet interventions often result in similar outcomes as conventional face-to-face psychotherapy (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). Internet-based interventions have several advantages and disadvantages. Main advantages include: easy accessibility, easy use independent of time and place at a self-determined pace, high level of anonymity and privacy which is for many persons with a mental disorder an attractive feature due to their fear of stigmatization and low cost of delivery to large populations. Moreover, such interventions may also help to bridge waiting times for face-to-face treatments and to ensure lasting change. However, there are also risks and challenges associated with Internet interventions. A common concern is the confidentiality of communications and client records. Another concern relates to how therapists deal with crisis, e.g., when a client becomes suicidal. Still another risk is that patients do not apply the treatment in an appropriate fashion and/or not

appropriately diagnosed when they start working with an Internet-based program. Most of these concerns can be adequately addressed, e.g., by using data encryption solutions, excluding suicidal patients, developing emergency plans with patients, including diagnostic interviews and monitoring patients. However, specific measures have to be considered and taken.

There are various forms of Internet interventions. A common distinction relates to the intensity and amount of therapist contact and support provided during treatment. There are (a) *self-guided programs* that only use the Internet to provide information and that do not include any contact with a clinician during treatment, (b) *guided self-help approaches*, in which the presentation of a self-help program is combined with minimal but regular therapist contact (often via secured e-mail), and (c) *Internet-based psychotherapies* such as e-mail, chat or videoconferencing therapies, in which the Internet is only used as a communication medium between the therapist and the patient.

While there are not many controlled trials on e-mail-, chat- or videoconferencing therapies (e.g., Kessler et al., 2009; Vernmark et al., 2010), the number of studies on Internet-based self-help interventions is exceeding one hundred (Hedman, Ljotsson, & Lindefors, 2012). Many of the studies evaluated *guided* self-help treatments, which require considerably less therapist time than face-to-face psychotherapy, because the main component of the intervention is a web-based self-help program. Most of these programs are based on cognitive behavior therapy, though there are recent studies following other approaches such as psychodynamic therapy (Andersson et al., 2012). The efficacy of guided self-help interventions has been demonstrated for a variety of mental disorders (e.g., anxiety disorders, depression) and health concerns associated with bodily symptoms (e.g., tinnitus, sexual dysfunction; Hedman et al., 2012). Evidence consistently suggests that guided Internet interventions provide equivalent outcomes compared to face-to-face psychotherapy (Andersson et al., 2014). Moreover, data from several effectiveness studies show that these interventions seem to work just as well in routine clinical practice as in research studies (Andersson & Hedman, 2013).

An important discussion concerns the role of the therapist in Internet-based self-help treatments. Evidence from meta-analyses (Richardson, Richards, & Barkham, 2010; Spek et al., 2007) suggests a superiority of guided versus unguided self-help interventions, i.e., interventions that do not include an interaction with a therapist. The main problems of unguided self-help programs are the usually rather low adherence to treatment, i.e., patients do not use the program as they should, and the high drop-out rates. However, in studies on unguided treatments in which contact with a clinician was established before the treatment started there was no difference between the guided and unguided format (e.g., Berger et al., 2011).

Taken together, there is now extensive evidence that Internet interventions work and the field is therefore in the process of moving on from a legitimization phase (i.e., do these treatments work?) to new areas and research phases. In general, the new developments and questions for future research in Internet-based treatments can be roughly summarized by means of the following points:

1. *Blending online and face-to-face treatments*: Most of the research on Internet interventions has focused on interventions completely delivered via Internet. Less is known about blended treatments in which Internet interventions and regular face-to-face therapy sessions are combined (cf. Krieger et al., 2014). Recent research projects such as the large-scale European project E-COMPARED (www.ecompared.eu) have just begun to investigate the clinical and cost-effectiveness of blended treatments. There are some promising initial findings on blended treatment formats. For instance, Ly et al. (2015) compared a ten session face-to-face behavioral activation treatment for depression with a four session face-to-face treatment combined with the use of a smartphone app devoted to behavioral activation. The shorter, less (therapist) time consuming blended treatment was found to be just as effective as the ten session treatment. Thus, the use of a smartphone app allowed for six fewer sessions without any loss of effect (Ly et al., 2015).

2. *Advancing the implementation in routine care*: As mentioned above, there are already some studies showing that Internet interventions also work in routine clinical practice (Andersson & Hedman, 2013). However, the process of dissemination and implementing Internet interventions into routine mental health care just recently started. Internet interventions are now being tested in various mental health care settings. According to

Emmelkamp et al. (2014) promising areas are (a) indicated prevention (e.g., because of the low cost of delivery to large populations), (b) primary care (e.g., Internet interventions could be a good alternative treatment to antidepressant medication in patients with mild to moderate depression), (c) specialized mental health care (e.g., for patients waiting for treatment, as an adjunct to face-to-face sessions or as a relapse prevention intervention), (d) general medical settings (i.e., for patients with comorbid mental and somatic disorders), (e) other settings (e.g., occupational or school settings), and (f) independent e-mental-health services (i.e., services organized outside the traditional mental health care systems; e.g., virtual clinics).

3. *Increasing adherence*: Another question for future research is related to the fact that unguided interventions usually lead to more dropout and lower effects. Reasons for non-adherence should be better understood in order to decrease attrition rates in self-help guided treatments. It is not obvious that self-guided interventions cannot become as effective as guided treatments. For instance, recent studies suggest that the adherence and the effectiveness of unsupported interventions can be enhanced with automatic reminders (Titov et al., 2013). Moreover, the use of mobile phones to support traditional unguided interventions may result in decreased attrition and increased outcomes.

4. *Making it transdiagnostic*: Another recent development are Internet interventions that address the high comorbidity of mental disorders with transdiagnostic and tailored approaches (Berger, Boettcher, & Caspar, 2014; Titov, Andrews, Johnston, Robinson, & Spence, 2010). In tailored treatments, a number of treatment modules are prescribed according to the symptom profile of a patient (e.g., a patient suffering from depression, social anxiety disorders and sleep problems receives treatment modules targeting all these disorders/problems). The main benefit of such tailored treatments in comparison with standardized disorder-specific interventions is that they address comorbid and overlapping symptoms and thus a broader range of patients resulting in fewer individuals who need to be excluded from treatment because they do or do not fulfill the criteria of a single specific diagnosis. Moreover, tailored treatments can also account for preferences of patients by providing free choice of treatment modules (Andersson, Estling, Jakobsson, Cuijpers, & Carlbring, 2011). Future research should investigate how tailoring should best be made.

5. *Investigating the “for whom” and the “why”*: Finally, more studies on predictors, moderators and mediators of

treatment outcome are needed. As in traditional face-to-face therapies, we do not know yet much about for whom and how Internet interventions work. So far, attempts to find predictors of outcome have been modestly successful. Some of our research indicates that early process predictors (i.e., variables assessed in an early phase of an online intervention) are possibly more promising than socio-demographic variables such as age, gender or education level. In one of our studies, the correlation between the activity of the participants in the program during the first week of treatment (measured by the number of mouse clicks) and treatment outcome was surprisingly high (Berger et al., 2011). This finding is promising because program usage, which can easily be monitored in Internet interventions, could be used to inform therapeutic decisions early in the treatment process (including the decision to recommend face-to-face therapy or a blended format). With regard to research on mechanisms of change, it may be an advantage that studies on Internet interventions tend to be faster to conduct than studies on face-to-face treatments. As a consequence, series of dismantling trials could provide insight into core effective "ingredients" of psychological online treatments in a reasonable time.

Since Internet-based treatments generally require limited resources once they are built and can quite easily be disseminated, research on Internet interventions is a very fast growing and therefore exciting field. However, this also means that when you read these lines some of the findings cited above could already be obsolete. Nevertheless, as you can see in this short summary a lot of questions remain unanswered and as usual in research the more answers you seem to have found the more questions arise and thereby determine new research venues: Development at its best, Internet-based treatments are no exception here.

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Routine Outcome Monitoring and Benchmarking in the Netherlands

Edwin de Beurs, Leiden University

In 2011, two measures have been introduced in the Netherlands, both aimed at enhancing the effectiveness and efficiency of mental health care. Firstly, nationwide Routine Outcome Monitoring (ROM) was implemented. At set time points, session by session, or after 6 or 12 weeks of treatment, self-report instruments (i.e., symptom checklists) are completed by the patients (de Beurs et al., 2011). Thus, ROM provides feedback to the therapist and patient on progress during treatment. It has been demonstrated repeatedly, that ROM may diminish drop-out, improve outcome, and shorten psychotherapy (Lambert, 2007). Dropout is diminished because potentially unsuccessful treatments are earlier detected and appropriate action can be taken by the therapist before the patient decides unilaterally to discontinue therapy. ROM stimulates that the therapist and patient set a shared and explicit goal (i.e., waning of symptomatology or improvement of functioning). Treatment outcome is enhanced because keeping track of progress will motivate the patient and augments treatment. Moreover, periodically assessing what has been gained by therapy creates evaluation points to decide whether the treatment should be continued. Without clear goal setting and evaluation of the progress toward those goals, therapy may linger on for much longer than necessary.

Since 2006, Dutch health care is organized as a regulated competition system. Insurers compete on the nominal premium for a basic benefit package. Providers compete because insurers are allowed to contract them selectively and purchase health care based on price and quality. Thus, an urgent need emerged for information regarding the quality of care and, in our field, for the quality of psychotherapy. In Dutch mental health care, for practical purposes quality was equated with outcome. ROM was used to obtain aggregated data to inform patients, insurers and mental health care providers on the performance of providers. The monitoring of the quality of mental health care was called benchmarking. A nonprofit foundation was set up in the Netherlands (i.e., Foundation for Benchmarking Mental Health Care or SBG www.sbggz.nl) to serve as an independent third party to collect mental health care outcomes, aggregate results and share this information between treatment providers, health care insurers and

patients. The data of ROM are gathered and used in an aggregated form for benchmarking. Since 2011, it became mandatory for all Dutch mental health providers to provide pre-to-posttest outcome data of completed treatments to SBG. Currently, over 200 institutes submit their data on a monthly basis.

For benchmarking, we have divided the mental health care field in subdomains by age (i.e., youth, adults, and elderly patients), by treatment aim (i.e., cure for common- and care for severe mental disorders) and by problem area (i.e., for substance-related disorders a separate domain was made). Within these subdomains, various outcome domains have been selected: symptom severity, functioning, quality of life and patient experience (Consumer Quality Index or CQ-i; Delnoij et al., 2006). The data are predominantly patient-based (i.e., self-report instruments, such as the Brief Symptom Inventory - Derogatis, 1975 or the Outcome Questionnaire-45 - Lambert, Gregersen, & Burlingame, 2004), with the exception of the domain of care for severe mental disorders, where outcome is established with a clinician rating on the HoNOS (Wing et al., 1998). As various self-report and rating scales are used, raw scores are converted into total standardized T-scores (de Beurs, 2010) and treatment gains are calculated as pre-post difference scores (Delta T). The average delta T procured by providers in care trajectories are presented through web-based software (i.e., external benchmarking). To homogenize results, this software allows for selecting subgroups of patients. For instance, the average treatment outcome of all male patients, aged 31 – 50, suffering from social phobia, can be displayed. Furthermore, providers can be compared, but also results can be displayed for subunits (e.g., the outpatient clinic for depression of a provider). The latter allows for internal quality management or internal benchmarking within providers.

Submission of outcome data has increased each year with an extra 10% and in 2015 over 200 institutes send data on 80% of all remunerated treatments to SBG and 50% or these have a pre- and posttest assessment. The other 50% have missing data, mostly because no posttest was available. Of the 20% of remaining treatments half stem from small institutes, who need more time to organize submission of data to SBG; the other half are treatments

completed by therapist working in private practice. Submission of their data is planned for in 2016.

For treatments concluded in 2014, the country-wide average pre-to-post-gain for treatment of common mental disorders (predominantly depression and anxiety disorders) was $\Delta T = 7.2$ ($SD = 9.6$), which corresponds to $ES = 0.72$. For severe mental disorders gains are lower: $\Delta T = 5.7$ ($SD = 10.2$). With the method proposed by Jacobson and Truax (1991), ΔT can also be converted to denote outcome in terms of recovered (37%), improved (23%), unchanged (33) or deteriorated (7%) patients. With depression or anxiety treatments there was quite some variation among treatment providers, some attaining a ΔT for their organization of 14.0, while others do not exceed a ΔT of 5.0. In terms of clinical significant change, results ranged from 42% to 17% for recovered patients and 3% to 11% for deteriorated patients (de Beurs et al., 2015). However, as these results are not case-mix corrected (Iezzoni, 2013), differences between providers do not necessarily reflect variation in quality but may also be due to differences in patients populations. A first pilot of case-mix adjustment revealed that pretest severity level is by far the most important predictor of treatment gain. Demographic and clinical patient factors, added little predictive value to the case-mix correction model.

Pitfalls of the present research include that combining ROM and benchmarking met with firm resistance from some professionals in the field deemed the initiative a misguided one-size-fits-all approach and warned for the risk that insurers will misuse outcome data to prematurely judge treatment providers on their outcomes (Delespaul, 2015; van Os et al., 2012). Indeed, differences among providers in the patients populations they typically cater, complicates a fair comparison and may result in comparing apples and oranges. More work needs to be done to develop case-mix correction models for the various care domains. Furthermore, among professionals inherent motivation for ROM dwindled when it became obligatory and ROM-response rates were examined by insurers and used in their yearly contract negotiations. On the other hand, there were also proponents of the development among providers, who seized the opportunity to demonstrate their superior results. Implementation are, however, needed. The top-down approach to implementing ROM (i.e., insurers reinforced providers to implement ROM with financial incentives or penalties) is supplemented with a bottom-up approach with so-called "breakthrough quality improvement collaborative"

projects (Schouten, Hulscher, van Everdingen, Huijsman, & Grol, 2008). It is too early to fully evaluate this new approach but encouraging is that professionals expressed satisfaction with regained ownership of ROM.

The proof of the pudding is in the eating: therapists who gain experience with ROM are usually enthusiastic about documented proof of the progress of their patients (Lambert, 2007) and the opportunities ROM generates for shared decision making (Schauer, Everett, del Vecchio, & Anderson, 2007). However, the main question at the bottom line is: will patients benefit from ROM with more rapid recovery, better lasting results, and less drop-out? Will benchmarking result in increased efficiency and a better sustainable mental health care? Several randomized controlled trial are planned for to evaluate the added value of ROM to the treatment process, to optimize ROM approaches (Lambert, 2007; Miller, Duncan, Sorrell, & Brown, 2005) and to investigate whether quality improvement through benchmarking is feasible in mental health care.

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Interesting recent papers on psychotherapy

Internet-Based Self-Help for Trichotillomania: A Randomized Controlled Study Comparing Decoupling and Progressive Muscle Relaxation.

Weidt S, Klaghofer R, Kuenburg A, Bruehl AB, Delsignore A, Moritz S, Rufer M.

Psychother Psychosom. 2015;84(6):359-67. doi: 10.1159/000431290.

BACKGROUND: Trichotillomania (TTM) is characterized by recurrent hair-pulling that results in substantial hair loss. A previous pilot study demonstrated that the online self-help intervention 'decoupling' (DC) might be effective at reducing hair-pulling symptoms, with a stronger effect than progressive muscle relaxation (PMR). We aimed to extend these findings using a more robust randomized clinical trial design, including diagnostic interviews by phone, a 6-month follow-up and e-mail support. **METHODS:** One hundred five adults with TTM were recruited online and randomly allocated to either DC (n = 55) or PMR (n = 50). The intervention lasted 4 weeks, with severity of TTM assessed at 3 time points (before intervention, immediately after intervention and at the 6-month follow-up) using the Massachusetts General Hospital Hair-Pulling Scale (MGH-HPS). Both intention-to-treat and completer analyses were conducted. **RESULTS:** Intention-to-treat analysis demonstrated highly significant and comparable symptom reductions (MGH-HPS) in both the DC and PMR groups ($p < 0.001$, partial $\eta^2 = 0.31$) that persisted through 6 months of follow-up. Participants' subjective appraisals favoured DC in some areas (e.g. greater satisfaction with DC than PMR). Completer analyses demonstrated the same pattern as the intention-to-treat analyses. **CONCLUSIONS:** Despite subjective appraisals in favour of DC, symptom reduction was comparable in the two groups. While the results suggest that even short Internet-based interventions like DC and PMR potentially help individuals with TTM, a partial effect of unspecific factors, like regression towards the mean, cannot be ruled out. Therefore, longitudinal studies with non-treated controls are warranted.

Training Substance Use Disorder Counselors in Cognitive Behavioral Therapy for Depression: Development and Initial Exploration of an Online Training Program.

Curran GM, Woo SM, Hepner KA, Lai WP, Kramer TL, Drummond KL, Weingardt K.

J Subst Abuse Treat. 2015 Nov;58:33-42. doi: 10.1016/j.jsat.2015.05.008.

INTRODUCTION: Evidence based psychotherapies (EBPs) remain underutilized. Models for EBP training and implementation that are cost-effective, minimally disruptive, and sufficiently flexible are needed. Internet-based technology is a promising platform, but questions remain about how this technology can address the barriers to implementation. We developed and examined the implementation of an online training for the Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT) intervention—a manualized, sixteen-session group depression treatment for individuals with substance use disorders (SUDs). We explored the feasibility of replacing in-person BRIGHT training with a self-paced, online training. **METHODS:** A highly partnered and iterative process was followed to translate the written BRIGHT manual and associated didactic training materials into a media rich, interactive, and detailed (12-16h) online training. Subsequently, 8 volunteer counselors across 7 Veterans' Affairs SUD programs completed the training. Semi-structured interviews focused on the counselors' experiences and their plans for implementing BRIGHT groups. A template approach, using a mixture of deductive and inductive coding, was used for data analyses. **FINDINGS:** The most important barrier to completing training was a lack of protected time. Most counselors were not afforded protected time and reported a sometimes frustrating and fragmented training experience. Many used personal time at work and at home to complete the work. Facilitators to completing the training included positive reactions/attitudes towards the training modules, supervisor support, counselor dedication, and strong beliefs supporting providing services for depression. Many counselors were also concerned about the feasibility of fitting 16 group sessions (2h each) into their program's clinical schedule, but many had devised potential solutions or "work-arounds" to accommodate or approximate the recommended treatment

course (e.g., using lunch times, reducing some content/exercises). **CONCLUSION:** This work contributes to the literature on implementation of complex EBPs and addresses the strengths and limitations of web-based technologies in supporting the implementation of EBPs.

Randomized Controlled Trial of SuperBetter, a Smartphone-Based/Internet-Based Self-Help Tool to Reduce Depressive Symptoms.

Roepke AM, Jaffee SR, Riffle OM, McGonigal J, Broome R, Maxwell B.

Games Health J. 2015 Jun;4(3):235-46. doi: 10.1089/g4h.2014.0046.

OBJECTIVE: Technological advances have sparked the development of computer- and smartphone-based self-help programs for depressed people, but these programs' efficacy is uncertain. This randomized controlled trial evaluated an intervention called SuperBetter (SB), which is accessed via smartphone and/or the SB Web site. **MATERIALS AND METHODS:** Online, we recruited 283 adult iPhone® (Apple, Cupertino, CA) users with significant depression symptoms according to the Center for Epidemiological Studies Depression questionnaire (CES-D). They were randomly assigned to one of three conditions: (a) a version of SB using cognitive-behavioral therapy and positive psychotherapy strategies to target depression (CBT-PPT SB); (b) a general SB version focused on self-esteem and acceptance (General SB); or (c) a waiting list control group (WL). The two SB groups were instructed to use SB for 10 minutes daily for 1 month. All participants completed psychological distress and well-being measures online every 2 weeks through follow-up. An intent-to-treat analysis was conducted using hierarchical linear modeling. **RESULTS:** As hypothesized, SB participants achieved greater reductions in CES-D scores than WL participants by posttest (Cohen's $d=0.67$) and by follow-up ($d=1.05$). Contrary to prediction, CBT-PPT SB did not perform better than General SB; both versions of SB were more effective than the WL control. Differences between SB versions favored General SB but were not statistically significant. **CONCLUSIONS:** These large effect sizes should be interpreted cautiously in light of high attrition rates and the motivated, self-selected sample. Nonetheless, smartphone-based/Internet-based self-help may play an important role in treating depression.

Guided internet cognitive behavioral therapy for insomnia compared to a control treatment - A randomized trial.

Kaldo V, Jernelöv S, Blom K, Ljótsson B, Brodin M, Jörgensen M, Kraepelien M, Rück C, Lindefors N.

Behav Res Ther. 2015 Aug;71:90-100. doi: 10.1016/j.brat.2015.06.001. Epub 2015 Jun 3.

AIM: To evaluate if internet-delivered Cognitive Behavioral Therapy for insomnia (ICBT-i) with brief therapist support outperforms an active control treatment. **METHOD:** Adults diagnosed with insomnia were recruited via media ($n = 148$) and randomized to either eight weeks of ICBT-i or an active internet-based control treatment. Primary outcome was the insomnia severity index (ISI) assessed before and after treatment, with follow-ups after 6 and 12 months. Secondary outcomes were use of sleep medication, sleep parameters (sleep diary), perceived stress, and a screening of negative treatment effects. Hierarchical Linear Mixed Models were used for intent-to-treat analyses and handling of missing data. **RESULTS:** ICBT-i was significantly more effective than the control treatment in reducing ISI (Cohen's $d = 0.85$), sleep medication, sleep efficiency, sleep latency, and sleep quality at post-treatment. The positive effects were sustained. However, after 12 months the difference was no longer significant due to a continuous decrease in ISI among controls, possibly due to their significantly higher utilization of insomnia relevant care after treatment. Forty-six negative effects were reported but did not differ between interventions. **CONCLUSIONS:** Supported ICBT-i is more effective than an active control treatment in reducing insomnia severity and treatment gains remain stable one year after treatment.

Internet-vs. group-delivered cognitive behavior therapy for insomnia: A randomized controlled non-inferiority trial.

Blom K, Tarkian Tillgren H, Wiklund T, Danlycke E, Forssén M, Söderström A, Johansson R, Hesser H, Jernelöv S, Lindefors N, Andersson G, Kaldo V.

Behav Res Ther. 2015 Jul;70:47-55. doi: 10.1016/j.brat.2015.05.002.

The aim of this study was to compare guided Internet-delivered to group-delivered cognitive behavioral therapy (CBT) for insomnia. We conducted an 8-week randomized controlled non-inferiority trial with 6-months follow-up.

Participants were forty-eight adults with insomnia, recruited via media. Interventions were guided Internet-delivered CBT (ICBT) and group-delivered CBT (GCBT) for insomnia. Primary outcome measure was the Insomnia Severity Index (ISI), secondary outcome measures were sleep diary data, depressive symptoms, response- and remission rates. Both treatment groups showed significant improvements and large effect sizes for ISI (Within Cohen's d: ICBT post = 1.8, 6-months follow-up = 2.1; GCBT post = 2.1, 6-months follow-up = 2.2). Confidence interval of the difference between groups post-treatment and at FU6 indicated non-inferiority of ICBT compared to GCBT. At post-treatment, two thirds of patients in both groups were considered responders (ISI-reduction > 7p). Using diagnostic criteria, 63% (ICBT) and 75% (GCBT) were in remission. Sleep diary data showed moderate to large effect sizes. We conclude that both guided Internet-CBT and group-CBT in this study were efficacious with regard to insomnia severity, sleep parameters and depressive symptoms. The results are in line with previous research, and strengthen the evidence for guided Internet-CBT for insomnia.

Internet and computer-based cognitive behavioral therapy for anxiety and depression in youth: a meta-analysis of randomized controlled outcome trials.

Ebert DD, Zarski AC, Christensen H, Stikkelbroek Y, Cuijpers P, Berking M, Riper H.
 PLoS One. 2015 Mar 18;10(3):e0119895. doi:
 10.1371/journal.pone.0119895. eCollection 2015.

BACKGROUND: Anxiety and depression in children and adolescents are undertreated. Computer- and Internet-based cognitive behavioral treatments (cCBT) may be an attractive treatment alternative to regular face-to-face treatment. This meta-analysis aims to evaluate whether cCBT is effective for treating symptoms of anxiety and depression in youth. **METHODS AND FINDINGS:** We conducted systematic searches in bibliographical databases (Pubmed, Cochrane controlled trial register, PsychInfo) up to December 4, 2013. Only randomized controlled trials in which a computer-, Internet- or mobile-based cognitive behavioral intervention targeting either depression, anxiety or both in children or adolescents up to the age of 25 were compared to a control condition were selected. We employed a random-effects pooling model in overall effect analyses and a mixed effect model for sub-group analyses. Searches resulted in identifying 13 randomized trials,

including 796 children and adolescents that met inclusion criteria. Seven studies were directed at treating anxiety, four studies at depression, and two were of a transdiagnostic nature, targeting both anxiety and depression. The overall mean effect size (Hedges' g) of cCBT on symptoms of anxiety or depression at post-test was $g=0.72$ (95% CI: 0.55-0.90, numbers needed to be treated (NNT)=2.56). Heterogeneity was low ($I^2=20.14\%$, 95% CI: 0-58%). The superiority of cCBT over controls was evident for interventions targeting anxiety ($g=0.68$; 95% CI: 0.45-0.92; $p < .001$; NNT=2.70) and for interventions targeting depression ($g=0.76$; 95% CI: 0.41-0.12; $p < .001$; NNT=2.44) as well as for transdiagnostic interventions ($g=0.94$; 95% CI: 0.23-2.66; $p < .001$; NNT=2.60). **CONCLUSIONS:** Results provide evidence for the efficacy of cCBT in the treatment of anxiety and depressive symptoms in youth. Hence, such interventions may be a promising treatment alternative when evidence based face-to-face treatment is not feasible. Future studies should examine long-term effects of treatments and should focus on obtaining patient-level data from existing studies, to perform an individual patient data meta-analysis.

Internet-assisted delivery of cognitive behavioural therapy (CBT) for childhood anxiety: systematic review and meta-analysis.

Rooksby M, Elouafkaoui P, Humphris G, Clarkson J, Freeman R.
 J Anxiety Disord. 2015 Jan;29:83-92. doi:
 10.1016/j.janxdis.2014.11.006.

AIM: To conduct a systematic review and meta-analysis of the literature to assess efficacy of internet-delivered cognitive behavioural therapy (CBT) for child anxiety disorder. **METHOD:** A systematic search of 7 electronic databases was conducted to assess CBT intervention for children with anxiety problems with remote delivery either entirely or partly via technology. Six articles reporting 7 studies were included. **RESULTS:** The findings together suggested that CBT programmes involving computerised elements were well received by children and their families, and its efficacy was almost as favourable as clinic-based CBT. The mixture of children and adolescents included the studies, diverse range of programmes, and lack of consistency between study designs made it difficult to identify key elements of these programmes or draw conclusions on the treatment efficacy. **CONCLUSIONS:**

Analysis supports online delivery for wider access of this evidence-based therapy. Areas in need of improvement for this new method are indicated.

Cognitive behaviour therapy via the internet for depression: a useful strategy to reduce suicidal ideation.

Mewton L, Andrews G.

J Affect Disord. 2015 Jan 1;170:78-84. doi: 10.1016/j.jad.2014.08.038.

BACKGROUND: Depression is a major risk factor for suicide. Given the strong association between depression and suicide, treatment for depression should be a fundamental component of suicide prevention. Currently it is not. This study aims to demonstrate the usefulness of internet-delivered cognitive behavioural therapy (iCBT) for depression as a means of reducing suicide ideation. **METHODS:** The sample comprised 484 patients who were prescribed iCBT for depression by their primary care physician. The outcomes of interest were major depression, as indexed by the PHQ-8, and suicidal ideation as measured by question 9 of the PHQ-9. Marginal models were used to appropriately analyse available data without biasing parameter estimates. **RESULTS:** Following iCBT for depression, suicidal ideation and depression decreased in parallel over time. The prevalence of suicidal ideation reduced from 50% at baseline to 27% after treatment, whilst the prevalence of major depression reduced from 70% to 30%. Depression scores and suicidal ideation decreased after treatment regardless of demographic or clinical variables of interest. **LIMITATIONS:** This is a naturalistic study; randomisation and scientific control were not possible. **CONCLUSIONS:** The current study demonstrates the usefulness of iCBT for depression as a means of reducing suicidal ideation which can be implemented on a large scale without enacting major structural change at the societal level. These findings need to be replicated in randomised controlled trials.

Internet-based guided self-help intervention for chronic pain based on Acceptance and Commitment Therapy: a randomized controlled trial.

Trompetter HR, Bohlmeijer ET, Veehof MM, Schreurs KM. J Behav Med. 2015 Feb;38(1):66-80. doi: 10.1007/s10865-014-9579-0.

Acceptance-based psychological interventions can potentially minimize the burden of chronic pain. This randomized controlled trial evaluated an internet-delivered, guided self-help intervention based on Acceptance and Commitment Therapy (ACT). A total of 238 chronic pain sufferers from the general population were randomly allocated to either ACT (n = 82), an internet-based control condition Expressive Writing (n = 79) or a waiting list condition (n = 77). Participants completed measures at baseline, posttreatment (3 months) and at a 3-month follow-up. At follow-up, ACT participants had improved in pain interference in daily life (primary outcome) compared to participants in Expressive Writing (Cohen's d = .47), but not compared to waiting list participants (p value = .11). Those who adhered to the ACT-intervention (48%) did improve significantly compared to waiting list participants (d = .49). ACT-participants also showed superior improvement on depression, pain intensity, psychological inflexibility and pain catastrophizing (d: .28-.60). Significant clinical improvement was present. Especially, 28% of ACT-participants showed general clinically relevant improvement in pain interference, as well as in pain intensity and depression (vs. Expressive Writing and waiting list 5%). Given these findings, internet-based ACT programs may be a promising treatment modality for chronic pain.

Defining early positive response to psychotherapy: An empirical comparison between clinically significant change criteria and growth mixture modeling.

Rubel J, Lutz W, Kopta SM, Köck K, Minami T, Zimmermann D, Saunders SM.

Psychol Assess. 2015 Jun;27(2):478-88. doi: 10.1037/pas0000060.

Several different approaches have been applied to identify early positive change in response to psychotherapy so as to predict later treatment outcome and length as well as use this information for outcome monitoring and treatment planning. In this study, simple methods based on clinically significant change criteria and computationally demanding

growth mixture modeling (GMM) are compared with regard to their overlap and uniqueness as well as their characteristics in terms of initial impairment, therapy outcome, and treatment length. The GMM approach identified a highly specific subgroup of early improving patients. These patients were characterized by higher

average intake impairments and higher pre- to posttreatment score differences. Although being more specific for the prediction of treatment success, GMM was much less sensitive than clinically significant and reliable change criteria. There were no differences between the groups with regard to treatment length. Because each of the approaches had specific advantages, results suggest a combination of both methods for practical use in routine outcome monitoring and treatment planning.

Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go?

Lutz W, De Jong K, Rubel J.

Psychother Res. 2015 Sep 16:1-8.

In the last 15 years feedback interventions have had a significant impact on the field of psychotherapy research and have demonstrated their potential to enhance treatment outcomes, especially for patients with an increased risk of treatment failure. This article serves as an introduction to the special issue on "Patient-focused and feedback research in psychotherapy: Where are we and where do we want to go?" Current investigations on feedback research are concerned with potential moderators and mediators of these effects, as well as the design and the implementation of feedback into routine care. This introduction summarizes the current state of feedback research and provides an overview of the three main research topics in this issue: (1) How to implement feedback systems into routine practice and how do therapist and patient attitudes influence its effects?, (2) How to design feedback reports and decision support tools?, and (3) What are the reasons for patients to become at risk of treatment failure and how should therapists intervene with these patients? We believe that the studies included in this special issue reflect the current state of feedback research and provide promising pathways for future endeavors that will enhance our understanding of feedback effects.

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Congress Calendar

Please send announcements of your congresses!

The 47th International Meeting of the Society for Psychotherapy Research (SPR)

June 22 – June 25, 2016

Location: Jerusalem, Israel

The 8th European Conference on Positive Psychology

June 28 - July 1, 2016

Location: Paris, France

www.ecpp2016.com

The 24th World Congress on Psychosomatic Medicine (ICPM)

September 13 – September 16, 2017

Location: Bei Jing, China

www.icpm2017.com

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