Summary of the evidence base for psychological interventions in the treatment of mental disorders in young people

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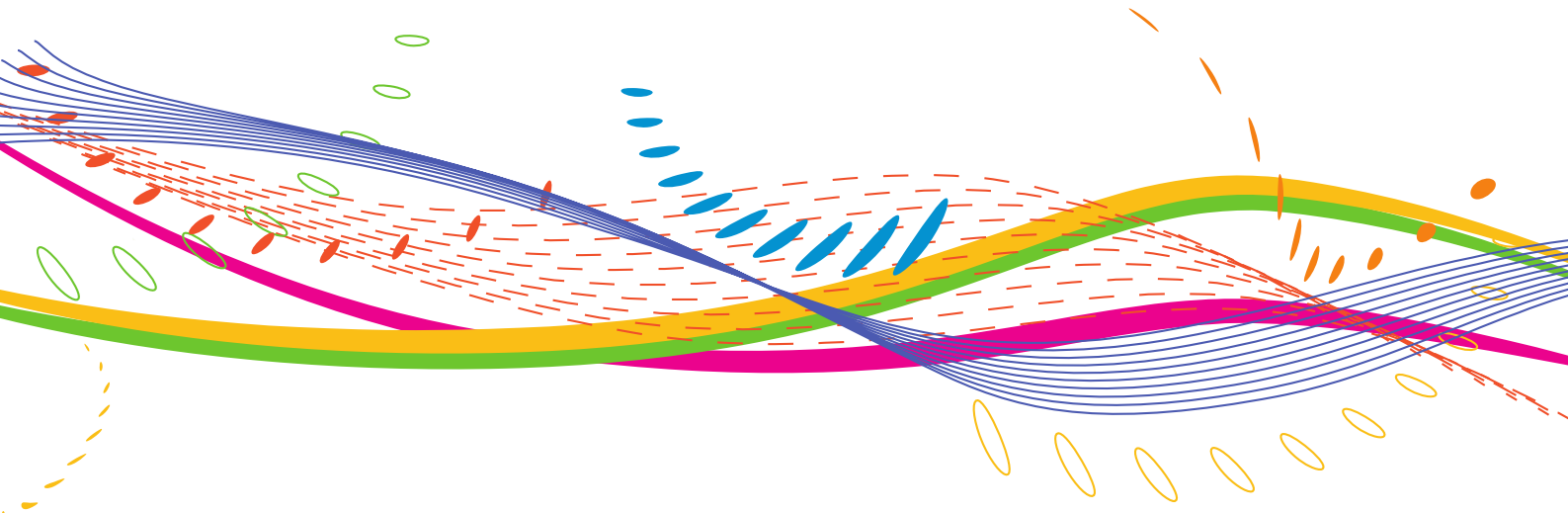

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Introduction

This document summarises the evidence-based interventions for psychological interventions in the treatment of mental disorders in young people aged 12-25 years.

In this summary document, the term “young people” is used to refer to guidelines/trials related to children, adolescents, and/or young adults. For a more detailed description of the population each recommendation is directed towards, please refer the additional Excel spread sheet “Evidence for Training Providers YMH”.

For a brief description of psychological interventions mentioned below, please refer to Appendix 1: Brief Description of Interventions.

Evidence for the treatment of disorders

Disorders are presented in the following order:

- Anxiety disorders
- Eating disorders
- Mood disorders
- Personality disorders
- Psychotic disorders
- Substance use disorders
- Self harm and suicide

Anxiety disorders

ANXIETY DISORDERS (IN GENERAL)

CBT (in particular, **exposure-based CBT**) has received the most empirical support for the treatment of anxiety disorders in young people (1,2). There is evidence for the effectiveness of group, individual, and family/parental formats.

ANXIETY-RELATED SCHOOL REFUSAL

Individual exposure-based CBT combined with parents and teacher training is recommended for young people with anxiety-related school refusal (1).

GENERALISED ANXIETY DISORDER (GAD)

There is currently limited research on the treatment of GAD in young people.

In the adult literature, low-intensity psychological interventions are first-line intervention for people with GAD whose symptoms have not improved after education and active monitoring (3). These include **individual non-facilitated Self-help, individual Guided Self-help, and Psychoeducational groups** (3). For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to low-intensity psychological interventions, **CBT** (3,4) and **applied relaxation** (3) are strongly recommended treatment options. There is also some evidence for the use of **computer-aided psychological therapy** (4) and **Psychodynamic Psychotherapy** (4) in the treatment of adults with GAD.

OBSESSIVE COMPULSIVE DISORDER

CBT (with a particular focus on **Exposure and Response Prevention**) (5-9) is the first-line treatment for mild to moderate cases of OCD in young people and support has been found for group, individual, and family-based formats. For moderate to severe OCD, medication is indicated in addition to **CBT**.

For young people with OCD with mild functional impairment, **Guided Self-help** (6) may be considered in conjunction with support and information for the family or carers.

PANIC DISORDER AND AGORAPHOBIA

There is some evidence for the use of **Introceptive Exposure** (1) for the treatment of young people with panic disorder, though this is based on one low-quality study.

In the adult literature, **CBT** (3,4) and **Self-help** (3) are strongly recommended for the treatment of panic disorder and agoraphobia. There is also good evidence for **Behaviour Therapy/Exposure Therapy** (4) and **Computer-aided Psychological Therapy** (4), and some evidence for **Virtual reality exposure therapy** (4) and **Psychodynamic Psychotherapy** (4).

POST-TRAUMATIC STRESS DISORDER (PTSD)

Manual-based, developmentally appropriate, **individual Trauma-focused CBT** (TF-CBT) (10-12) has received the most empirical support for the treatment of childhood PTSD and should be considered first-line treatment for young people with PTSD. While individual interventions should be considered in preference to group interventions, there is also evidence supporting **group-based formats of TF-CBT** for young people with PTSD (10,11). The best-researched group CBT protocol for childhood PTSD is **Cognitive Behavioural Intervention for Trauma in Schools** (CBITS) (10). For children exposed to the same traumatic event and who are presenting with symptoms of PTSD, **school-based TF-CBT** aimed at reducing symptoms of PTSD should be considered (11).

There is also some evidence for the use of **Child-parent Psychotherapy** (10) with children with PTSD, and **Trauma-focused Individual Psychoanalytic Psychotherapy** (10) with young people who have been sexually abused.

In the adult literature, **Eye Movement Desensitization and Reprocessing** (EMDR) (10-12) is strongly recommended for the treatment of PTSD. While there have been some studies of EMDR with young people with PTSD, these studies have had serious methodological shortcomings (10).

SOCIAL ANXIETY DISORDER/SOCIAL PHOBIA (SAD)

Individual or group CBT with a focus on social anxiety (13) is strongly recommended for young people with SAD. There is also evidence to support the use of **Group CBT with social skills training** (1) for young people with SAD.

In the adult literature, **CBT** (4) has the best evidence base, followed by **Behaviour therapy/Exposure therapy** (4) and **Computer-aided Psychological Therapy** (4). There is some evidence for the use of **Psychodynamic Psychotherapy** (4) for adults with SAD.

SPECIFIC PHOBIA

There is currently no treatment guidelines or systematic reviews of the treatment of specific phobia in young people.

In the adult literature, **CBT** (4), **Behaviour Therapy/Exposure Therapy** (4), and **Virtual Reality Exposure Therapy** (4) all have a strong evidence base to support their use in the treatment of specific phobias. There is good evidence for the use of **Computer-aided Psychological Therapy (**4) with specific phobias, and some evidence for **Applied Muscle Tension** (4) in the treatment of blood and injury phobia.

Anxiety disorders references

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2. James, A. C. J., Georgina; Cowdrey, Felicity A.; Soler, Angela; Choke, Aislinn (2013). "Cognitive behavioural therapy for anxiety disorders in children and adolescents." The Cochrane Database Of Systematic Reviews 6: CD004690.

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5. Geller, D. A., & March, J. (2012). Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *Focus*, *10*(3), 360-373.

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8. Sanchez-Meca, J. R.-A., Ana I.; Iniesta-Sepulveda, Marina; Rosa-Alcazar, Angel (2014). "Differential efficacy of cognitive-behavioral therapy and pharmacological treatments for pediatric obsessive-compulsive disorder: a meta-analysis." Journal Of Anxiety Disorders 28(1): 31-44.

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11. Australia Centre for Posttraumatic Mental Health (2013). Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. ACPMH, Melbourne, Victoria

12. NICE (2005) The management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26. Available at http://guidance.nice.org.uk/CG26 [NICE guideline]

13. NICE (2013) Social anxiety disorder: recognition, assessment and treatment. NICE clinical guideline 159. Available at http://guidance.nice.org.uk/CG159 [NICE guideline]

Eating disorders

ANOREXIA NERVOSA

Family Therapy (1-4) has the largest evidence base in the treatment of young people with Anorexia Nervosa and **Family-based Therapy** (also known as the Maudsley Approach) (1,2) in particular is strongly recommended as first-line treatment. When Family Therapy is inappropriate or not suitable, there is some evidence to support the use of individual therapies such as **Adolescent-focused Therapy** (1,2), **eating-disorder specific CBT** (2), and **Ego-oriented Individual Therapy** (2) in the treatment of older adolescents with Anorexia Nervosa. There is also promising preliminary findings for the use of **Motivational Interviewing** (4) to enhance motivation at the start of treatment for young adults with Anorexia Nervosa.

BULIMIA NERVOSA

Family Therapy (1,4) is also recommended for the treatment of young people with Bulimia Nervosa. **CBT** (1) and **CBT for bulimia nervosa** (CBT-BN) (3) may be appropriate for use with adolescents with this disorder, but must be adapted as needed to suit their age, circumstances and level of development, and include the family as appropriate.

In the adult literature, **individual and group CBT** (particularly enhanced cognitive therapy, **CBT-E**) (2,4) is considered first-line treatment for Bulimia Nervosa. **Individual and group IPT** (1,4) is recommended for adults who do not respond to CBT. **Self-help programs** (included **Guided Self-help**) have also been shown to be effective in the treatment of Bulimia Nervosa (4).

BINGE EATING DISORDER (BED)

There is currently no treatment guidelines or systematic reviews of the treatment of BED in young people.

In the adult literature, **CBT** is considered first-line treatment for BED (2,4). While the best evidence is for **individual CBT and CBT for binge eating disorder** (CBT-BED)(2), there are also strong recommendations for **group CBT** (4), **CBT adapted for internet delivery** (2), and in **guided self-help** form (2,4). **Individual** (1) or **group IPT** (4) may be considered as an alternative to CBT. Preliminary studies suggest that **IPT** may be useful for adolescents with BED, but these trials are of low-quality (1). **Group Dialectical Behaviour Therapy** (DBT) specifically designed for BED (4) has showed short-term effectiveness in adults and may be considered as a treatment option for young people with BED.

Eating disorders references

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2. Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., ... & Ward, W. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of Psychiatry, 48(11), 977-1008.

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Mood disorders

DEPRESSION

For young people with **mild or subclinical depressive symptoms**, there are strong recommendations for the short-term provision of **individual Supportive Therapy** (1,2), **Guided Self-Help** (1), and **CBT (group and individual** formats) (1,3). There is also evidence for the provision of **Case Management** or **Psychoeducation** for young people with mild or brief depression, with mild psychosocial impairment, and in the absence of clinically significant sucidality or psychosis (3).

For young people with **moderate to severe depression**, **Psychoeducation** (2) should be provided to the individual and their family members as a minimum standard. **Individual CBT** (1-3) and **IPT** (1-3) are strongly recommended as first-line treatment options, and should be provided over a minimum of three to six months. **Family Therapy** (1) and **Psychodynamic Psychotherapy** (1) should also be offered.

For young people with **treatment-resistant depression** (unresponsive to combination treatment with a specific psychological therapy and fluoxetine), **Systemic Family Therapy** (1) and **Individual Child Psychotherapy** (1) are strongly recommended treatment options.

BIPOLAR DISORDER

There is some evidence that a **Multi-family Psychoeducational Intervention or Family-focused Therapy**, when provided in addition to treatment as usual (including psychopharmacology), could improve mood symptoms and prevent a conversion to Bipolar Disorder in young people **at-risk** of developing the disorder (4).

Individual CBT (5) and **IPT** (5) are strongly recommended in the treatment of young people with **Bipolar Depression**. In the event the young person does not respond, or has a limited response to CBT or IPT, **family psychological intervention** should be considered (5).

Currently, there is limited information available on evidence-based psychological treatment for young people with **Bipolar Disorder.** Preliminary findings suggest that **child- and family focused CBT** (6) and **Family-focused Therapy** (modified for adolescents) (6) may be important components of a comprehensive treatment plan for early-onset Bipolar Disorder, but these recommendations are based on low-quality evidence.

Based on extrapolation of treatment guidelines for adults with Bipolar Disorder, preliminary studies in adolescents, as well as clinical consensus of therapy with young people with Bipolar Disorder, **Psychoeducation** (6,7), **CBT** (6,7), and **IPT** (7) are recommended in conjunction with medication. There is also some evidence for the use of **Group Therapy** (7) in conjunction with medication in the treatment of adults with Bipolar Disorder. The emphasis of this approach should be on adherence and 'here and now' interpersonal issues, lithium monitoring and problem-solving.

Mood disorders references

1. NICE (2015) Depression in Children and Young People: Identification and Management in Primary, Community and Secondary Care . NICE clinical guideline 28. Available at http://guidance.nice.org.uk/CG28 [NICE guideline]

2. Birmaher, B., Brent, D., & AACAP Work Group on Quality Issues. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 46(11), 1503-1526.

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Personality disorders

BORDERLINE PERSONALITY DISORDER (BPD)

Cognitive Analytic Therapy (CAT) (1), **Emotion regulation training** (1), and **manual-based team care** (1) are evidence-based recommendations for the treatment of BPD or clinically significant features of BPD in adolescents.

In adult women with BPD, a comprehensive, manual-based **DBT** program (1,2) is recommended for the reduction of self-harm, anger, anxiety, or depression.

ANTISOCIAL PERSONALITY DISORDER/CONDUCT DISORDER

Multisystemic Therapy (3) and **Functional Family Therapy** (3) are strongly recommended for adolescents with conduct disorders. **Group CBT** (3) is strongly recommended for young offenders with a history of offending behaviour, and who are in institutional care.

Personality disorders references

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3. NICE (2013) Antisocial personality disorder Treatment, management and prevention . NICE clinical guideline 77. Available at http://guidance.nice.org.uk/cg77 [NICE guideline]

Psychotic Disorders

PRODROME

While early psychosis treatment guidelines recommend **CBT** as having a good evidence base as a stand-alone treatment in the pre-onset phase (1), more recent publications (2-5) have been slightly more cautious in their recommendations due to inconsistent findings. **Individual CBT, with or without family intervention** (2-5), could be considered for young people during the ultra high risk/prodromal stage, and may be beneficial in delaying or preventing onset of psychosis in clinical high-risk individuals in the short-term.

FIRST-EPISODE PSYCHOSIS (FEP)

Individual CBT is the psychological treatment that has been found to have the most immediate benefit during the acute phase for young people with FEP (1). It is strongly recommended that in conjunction with antipsychotic medication, **individual CBT** should be combined with **family intervention** for FEP (1,5,6), with relapse prevention being the focus of treatment. There is a good evidence base supporting the use of the **LifeSPAN program**, a specific **CBT intervention targeting suicidality** in FEP (1).

Cognitive Remediation (including **Cognitive Enhancement Therapy**) (7), **Integrated Specialist Services** (1), **Supportive Therapy** (1), **Befriending** (1), **specialist vocational and educational services** (such as **Individual Placement and Support**) (1), and **Psychoeducation** (1) all have a good evidence base in the treatment of FEP.

SCHIZOPHRENIA

Individual CBT with family intervention (5) is strongly recommended for the acute exacerbation or recurrence of psychosis or schizophrenia in children and young people. **Psychoeducation** for the individual and their family (8), **Cognitive Remediation** (8), and **Skills Training** (8) are also recommended for the treatment of schizophrenia in children and young people. **Group Arts Therapies** (including **dance movement, drama, music or art therapy**) (5) could be considered for this population as there is some evidence for its effectiveness in the alleviation of negative symptoms.

Psychotic Disorders references

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2. Okuzawa, N., Kline, E., Fuertes, J., Negi, S., Reeves, G., Himelhoch, S., & Schiffman, J. (2014). Psychotherapy for adolescents and young adults at high risk for psychosis: a systematic review. *Early intervention in psychiatry*, *8*(4), 307-322.

3. Tiffin, P. A., & Welsh, P. (2013). Practitioner Review: Schizophrenia spectrum disorders and the at‐ risk mental state for psychosis in children and adolescents–evidence‐ based management approaches. Journal of Child Psychology and Psychiatry, 54(11), 1155-1175.

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Substance use disorders

AT-RISK OF SUBSTANCE MISUSE

It is strongly recommended that children who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse are offered **group-based Behavioural Therapy** (1), while vulnerable and disadvantaged young people assessed to be at high risk of substance misuse are offered a **Family-based programme** (1).

ALCOHOL MISUSE

Individual CBT (2) is strongly recommended for young people with alcohol misuse. While **extended brief interventions** based on the principles and practice of **Motivational Interviewing** (3) are also strongly recommended for young people aged 16-17 years, there is some evidence to suggest that this treatment approach has adverse outcomes for individuals under the age of 16 years. For young people with alcohol misuse and with significant comorbidities and/or limited social support, **Multicomponent programs** such as **Multidimensional Family Therapy, brief Strategic Family Therapy, Functional Family Therapy or Multi-systemic Therapy** are strongly recommended (3).

In the adult literature, **Motivational Interviewing** (3), **CBT/Behavioural Therapies** (3), **Behavioural Couple's Therapy** (3), and **social network and environment-based therapies** (3) are all strongly recommended treatment options for alcohol misuse.

SUBSTANCE MISUSE

It is strongly recommended that vulnerable and disadvantaged young people who are problematic substance misusers are offered one or more **Motivational Interviews** (1). **Family therapy** (including **Functional Family Therapy, Multidimensional Family Therapy, Family Support Network, and Multi-systemic Therapy**) (4) is the treatment with the strongest evidence of comparative effectiveness in helping young people reduce their substance use.

Extrapolating from the evidence of effective drug treatment for young adults, young people under 18 years who have significant substance misuse problems may benefit from **brief Psychosocial Interventions** (5) and **Structured treatment** (5) by specialist young people's substance misuse treatment services. This would normally comprise **specific harm reduction interventions and psychosocial treatments (motivational therapies, CBT, and family based supports and treatment)** (5).

Substance use disorders references

1. NICE (2007). Substance misuse interventions for vulnerable under 25s . NICE Public health guideline 4 . Available at http://guidance.nice.org.uk/PH4 [NICE guideline]

2. NICE (2010). Alcohol-use disorders: prevention. NICE Public health guideline 24 . Available at http://guidance.nice.org.uk/PH24 [NICE guideline]

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Suicide and Self-Harm

There is currently a lack of good-quality evidence on the treatment of suicide and self-harm in young people. Preliminary findings suggest that **Multi-systemic therapy** (1,2), **CBT interventions that integrate a problem-solving component** (3), and **CBT for deliberate self-harm** (developed to specifically identify and modify the mechanisms that maintain the deliberate self-harm) may be beneficial for young people who engage in self-harm. **DBT adapted for adolescents** (DBT-A) (3) has been found to reduce symptoms of depression and suicidal ideation among young people with features of BPD, but there is no evidence to suggest that it is effective at reducing self-harm behaviours. Therefore, while **DBT-A** is a promising intervention, empirical support for the application of DBT with young people who self-harm remains limited.

In the adult literature, **DBT** (1,4) has a good evidence base and has been found to be an effective form of treatment for self-harm and suicidal self-injury among adults with BPD. There is also some evidence to support the use of **Brief Interpersonal Psychodynamic Therapy** (4) with adults who self-harm, and a **Psychoanalytically informed partial hospitalisation program** (4) for adults with BPD who self-harm.

Suicide and Self-Harm references

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Appendix 1: Brief Description of Interventions

Adolescent-Focused Therapy: (a modification of EOIT) is a psycho-dynamically informed individual, adolescent psychotherapy focusing on issues of adolescent development including autonomy, self-efficacy, individuation, assertiveness and psychological barriers to eating.

Applied Relaxation: therapy that involves the use of relaxation techniques, such as progressive muscle relaxation combined with breathing techniques.

Arts Therapy (including dance movement, drama, music or group art therapy): a form of treatment that encourages the person to express their feelings using art materials, such as paints, chalk or pencils. In art therapy, the person works with a therapist, who combines other techniques with drawing, painting or other types of art work, and often focuses on the emotional qualities of the different art materials.

Applied Muscle Tension: people who have strong anxiety reactions to blood or injuries often show a unique response, where their blood pressure initially rises, then drops dramatically. When the blood pressure drops, these people sometimes faint. Applied muscle tension teaches people to raise their blood pressure by tensing their muscles when they are around blood or injuries to prevent this response.

Befriending: an intervention that allows for social contact but not emotional support, with a focus on 'pleasant chat' about neutral topics (used as a control condition in some studies)

Behavioural Couple's Therapy: designed for married or cohabiting individuals seeking help for alcoholism or drug abuse. BCT sees the substance abusing patient together with the spouse or live-in partner. Its purposes are to build support for abstinence and to improve relationship functioning. BCT promotes abstinence with a "recovery contract" that involves both members of the couple in a daily ritual to reward abstinence. BCT improves the relationship with techniques for increasing positive activities and improving communication.

Case Management: developed out of the deinstitutionalisation movement, which led to an associated increase in the need for community resources to assist people with psychiatric illness. Case management in general aims to assist clients navigate the complex elements of psychiatric care. This extends beyond 'formal' psychiatric treatment to other needs, such as accommodation, food, and employment, physical treatment, and broader needs, including family and social relationships, leisure activities, and spiritual needs

Cognitive and Behavioural Therapy (CBT; includes Behaviour Therapy): a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. The therapist helps individuals identify unhelpful thoughts, emotions and behaviours. CBT has two aspects: behaviour therapy and cognitive therapy. Behaviour therapy is based on the theory that behaviour is learned and therefore can be changed. Examples of behavioural techniques include exposure, activity scheduling, relaxation, and behaviour modification. Cognitive therapy is based on the theory that distressing emotions and maladaptive behaviours are the result of faulty patterns of thinking. Therefore, therapeutic interventions, such as cognitive restructuring and self-instructional training are aimed at replacing such dysfunctional thoughts with more helpful cognitions, which leads to an alleviation of problem thoughts, emotions and behaviour.

> **Cognitive Behaviour Therapy for binge eating disorder** (CBT-BED): a slightly adapted version of CBT-BN. See *Cognitive behaviour therapy for bulimia nervosa.*
>
> **Cognitive Behaviour Therapy for bulimia nervosa** (CBT-BN): primarily concerned with the processes which maintain bulimia nervosa, such as a dysfunctional system for evaluating self-worth. Focus of treatment should not solely be on patients' binge eating, despite the fact that binge eating is often their primary (and sometimes only) complaint. Rather, it suggests that to achieve a full and lasting response, these patients' dietary restraint also needs to be addressed, as does their response to adverse mood states and their over-evaluation of eating, shape and weight and their control. A range of cognitive behavioural procedures are used with its cornerstone being a specific sequence of cognitive behavioural tasks and "experiments" set within the context of a personalised version of the cognitive behavioural theory of maintenance.

Enhanced Cognitive Behaviour Therapy (CBT-E): based on a transdiagnostic perspective of eating disorders, It is a fixed length , consisting of 20 sessions over 20 weeks, and is delivered in 4 defined stages. The strategy underpinning CBT-E is to construct a formulation of the processes that are maintaining the person's psychopathology and use this to identify the features that need to be targeted in treatment

Trauma-Focused Cognitive Behaviour Therapy (TF-CBT): a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a structured, components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings, and behaviors related traumatic life events; and enhance safety, growth, parenting skills, and family communication.

Computer-Aided Psychological Therapy (CAP): consists of structured sessions of cognitive behaviour therapy or behaviour therapy delivered through a computer, usually over the internet. An individual works through the program on their own. CAP can be used with or without support from a professional, though most programs involve some form of support. Therapists may offer support via telephone, email, text, or instant messaging, to help the person successfully apply what they are learning to their life. A number of different programs can be accessed via www.mindspot.org.au.

Child-Parent Psychotherapy: is a relationship-based treatment model for young children (infants to age 7 years) who have experienced family trauma such as domestic violence. This treatment model includes elements of psychodynamic, cognitive behavioral, social learning, and attachment treatments.

Cognitive Enhancement Therapy: see *Cognitive Remediation*

Cognitive Remediation (including Cognitive Enhancement Therapy): specifically addresses cognitive deficits often seen in psychotic disorders by teaching information processing strategies through guided exercises

Cognitive Analytic Therapy (CAT): Therapy that helps with the recognition of unhelpful behaviour patterns and their origins (i.e. thinking about how they began), and to develop new and more helpful strategies in order to cope better.

Dialectical Behavior Therapy (DBT): designed to serve five functions: enhance capabilities, increase motivation, enhance generalisation to the natural environment, structure the environment, and enhance therapist capabilities and motivation to treat effectively. The overall goal is the reduction of ineffective action tendencies linked with deregulated emotions. It is delivered in four modes of therapy. The first mode involves a traditional didactic relationship with the therapist. The second mode is skills training, which involves teaching the four basic DBT skills of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Skills generalisation is the third mode of therapy in which the focus is on helping the individual integrate the skills learnt into real-life situations. The fourth mode of therapy employed is team consultation, which is designed to support therapists working with difficult clients.

Dialectical Behavioral Therapy for Adolescents (DBT-A): adaptation of DBT for suicidal adolescents with borderline personality traits. Uses DBT strategies of keeping patients committed to treatment and focuses on reducing both suicidal and quality of life interfering behaviors. DBT-A is a manualized, 16-week behavioral treatment, that includes concurrent individual therapy once a week, family therapy as needed and a multifamily skills training group in an outpatient setting.

Ego-Oriented Individual Therapy (EOIT): a psycho-dynamically informed individual, adolescent psychotherapy focusing on issues of adolescent development including autonomy, self-efficacy, individuation, assertiveness and psychological barriers to eating.

Emotion Regulation Training (ERT): relatively brief group training for adolescents suffering from two or more BPD criteria. An adaptation of the Systems Training for Emotional Predictability and Problem Solving (STEPPS), with elements of the skills training of DBT and CBT. Problems with emotion regulation (more specifically mood instability) and the development of a more internal locus of control were chosen as the primary goals of this treatment. Compared with the STEPPS program, the treatment length and the sessions are shortened. Emotion regulation skills are taught in an early stage to meet the wish for perceptible change in the short term. The language is simplified and the examples are made age-specific. Two sessions on 'knowing yourself' are added to fit to the developmental stage of self-exploration

Eye Movement Desensitization and Reprocessing (EMDR): developed to treat symptoms resulting from disturbing or traumatic experiences. It involves recalling these life experiences for short periods (15-30 seconds)

while also moving the eyes back and forth. Sometimes another task, such as hand tapping or listening to tones, is used instead of eye movements.

Exposure and Response Prevention: see *Exposure Therapy*

Exposure Therapy (includes Exposure and Response Prevention, Interoceptive Exposure, Virtual reality exposure therapy): therapy that involves being exposed, in a structured and planned manner, to the things that cause feelings of anxiety (i.e. feelings of worry, stress, fear or discomfort).

Family-Focused Therapy: see *Family Therapy and Family-based interventions*

Family Therapy and Family-based interventions (includes Systemic Family Therapy, Multi-family Psychoeducational Intervention, Family-focused Therapy, family psychological intervention, Multidimensional Family Therapy, Strategic Family Therapy, Functional Family Therapy and Multisystemic Therapy): may be defined as any psychotherapeutic endeavor that explicitly focuses on altering interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family. There are several family-oriented treatment traditions including psychoeducational, behavioural, object relations (psychodynamic), systemic, structural, post-Milan, solution-focused, and narrative therapies.

Functional Family Therapy: see *Family Therapy and Family-based interventions*

Guided Self-Help: see *Self-Help*

Individual Placement and Support: see *Specialist vocational and educational services*

Integrated Specialist Services (Integrated treatment): the collaborative provision of biological and psychological interventions, along with assertive case management and other psychosocial interventions (such as vocational or group interventions).

Interpersonal Psychotherapy (IPT): a brief, structured approach that addresses interpersonal issues. The underlying assumption of IPT is that mental health problems and interpersonal problems are interrelated. The goal of IPT is to help clients understand how these problems, operating in their current life situation, lead them to become distressed, and put them at risk of mental health problems. Specific interpersonal problems, as conceptualised in IPT, include interpersonal disputes, role transitions, grief, and interpersonal deficits. IPT explores individuals' perceptions and expectations of relationships, and aims to improve communication and interpersonal skills.

Interoceptive Exposure: involves the controlled exposure to physiological symptoms that are cognitively misinterpreted, in order to demonstrate to the patient that these symptoms are tolerable and not the harbingers of medical disaster. see *Exposure Therapy.*

Motivational Interviewing (MI): often provided as an adjunct to CBT, motivational interviewing is a directive, person-centred counselling style that aims to enhance motivation for change in individuals who are either ambivalent about, or reluctant to, change. The examination and resolution of ambivalence is its central purpose, and discrepancies between the person's current behaviour and their goals are highlighted as a vehicle to trigger behaviour change. Through therapy using MI techniques, individuals are helped to identify their intrinsic motivation to support change.

Multidimensional Family Therapy: see *Family Therapy and Family-based interventions*

Multi-family Psychoeducational Intervention: see *Family Therapy and Family-based interventions*

Multisystemic Therapy: see *Family Therapy and Family-based interventions*

Non-Facilitated Self-Help: see *Self-Help*

Psychodynamic Psychotherapy: focuses on the unconscious patterns in the mind and the roles these play in psychological problems. Unconscious patterns include thoughts and feelings of which a person is not aware. Short-term psychodynamic psychotherapy usually takes about 20- 30 weeks. Long-term psychodynamic psychotherapy can take more than a year and, in some cases, it takes many years. Psychoanalysis is a type of long-term psychodynamic psychotherapy. In psychoanalysis, the client may lie on a couch and talk about whatever is going through their mind. However, most often in psychodynamic psychotherapy the client and therapist sit and talk to each other face to face, in a similar way to other types of psychological therapy.

Psychoeducation: not a type of therapy but rather, a specific form of education. Psychoeducation involves the provision and explanation of information to clients about what is widely known about characteristics of their diagnosis. Individuals often require specific information about their diagnosis, such as the meaning of specific

symptoms and what is known about the causes, effects, and implications of the problem. Information is also provided about medications, prognosis, and alleviating and aggravating factors. Information is also provided about early signs of relapse and how they can be actively monitored and effectively managed. Individuals are helped to understand their disorder to enhance their therapy and assist them to live more productive and fulfilled lives.

Self-Help (includes Guided Self-Help, non-facilitated Self-help, Bibliotherapy): used as both an adjunct to traditional therapy or as a standalone treatment. Most self-help programs are based on CBT principles and typically combine psychoeducation with skills training, including homework tasks. In self-help programs individuals read books or use computer programs to help them overcome psychosocial problems. Some self-help programs include brief contact with a therapist (guided self-help) whereas others do not (pure self-help).

Specialist Vocational and Educational Services (specifically **Individual Placement and Support**): Community-based service open to any person with mental illness who chooses to look for work or education, so that acceptance into the program is not determined by measures of work readiness or illness variables. The IPS program is integrated with the mental health treatment team, rather than constituting a separate vocational rehabilitation service. Focused on competitive employment or education rather than sheltered or transitional employment, and potential jobs are chosen based on consumer preference. The support provided in the program continues after employment is gained, rather than termination at a set point, as needed by the individual

Social Network and Environment-Based Therapies: use the individual's social environment as a way to help achieve abstinence or controlled drinking. These therapies include Social behaviour and network therapy (SBNT) and the community reinforcement approach. SBNT comprises a range of cognitive and behavioural strategies to help clients build social networks supportive of change which involve the patient and members of the patient's networks (for example, friends and family). The integration of these strategies has the aim of helping the patient to build ‘positive social support for a change in drinking’.

Social Skills Training: training that involves learning how to interact in social situations (e.g. meeting new people, talking in a group) with the help of a therapist that is usually a treatment for social anxiety.

Strategic Family Therapy: see *Family Therapy and Family-based interventions*

Supportive Therapy: a type of psychological therapy that aims to help a person to function better by providing personal support. In general, the therapist does not ask the person to change; rather they act as a support, allowing the person to refect on their life situation in an environment where they are accepted.

Systemic Family Therapy: see *Family Therapy and Family-based interventions*

Trauma-Focused Psychoanalytic Psychotherapy: see *Psychodynamic Psychotherapy*

Virtual Reality Exposure Therapy: see *Exposure Therapy*. Exposure can be carried out in different ways, such as in real life or using imagery. Another way is using virtual reality, where the person is exposed to a computer-generated environment. Virtual reality exposure therapy is mainly used in the treatment of phobias. However, it has been used with some other types of anxiety too. This treatment is provided by practitioners with specialist equipment.

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