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Evidence-Based Happenings

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What We Mean by “Evidence”

What exactly is an “evidence-based practice?” A simple answer is that an evidence-based practice is a treatment that has been shown to be effective in reducing symptoms and improving functioning. What do we mean, however, by “shown?” **What qualifies as an “evidence-based treatment?”**

Evidence-based treatments are divided into the following 4 broad categories based on the level of evidence supporting the treatment:

1. Well-Established Treatments. These treatments have the strongest evidence that suggest they work. To reach this category, at least two randomized controlled trials (RCTs) must show the treatment is effective. A RCT is a controlled experiment in which two or more treatments are studied with patients assigned to treat-

ments in a random order. To be “Well-Established,” at least one of the RCTs must be conducted by researchers who are different and independent from the researchers who conducted the other RCTs.

2. Probably Efficacious. These treatments have a “modest” level of evidence to suggest they work. At least two research studies suggest that treatments in this category are effective; however, these studies are either not RCTs, or the RCTs are all performed by one research group and haven’t be independently evaluated.

3. Possibly Efficacious. These treatments are supported by at least one well-designed study, but either there are too few studies or the studies are not high enough quality to be considered Probably Efficacious. To be in

this category, however, no study can show that the treatment does *not* work.

4. Experimental. These treatments have not been evaluated with any well-designed research study; they may be effective, may not be effective, or may actually make things worse.

At ABBHH, we use these categories to help us decide which treatments to provide to our patients. For example, Cognitive-Behavior Therapy (CBT) has been shown to be a Well-Established treatment for depression. Consequently, it is no surprise that CBT is the backbone of our psychosocial treatment programs. In the next edition of Evidence-Based Happenings, we’ll discuss how you can use these categories to decide what treatments are best to select for your patients.

Latest Evidence-Based News @ ABBHH

- Drs. Kumar, Raza, D’Agostino, and Chadha, and Washburn will be presenting a poster at the American Academy of Child & Adolescent Psychiatry on a Continuing Medical Education program to improve the diagnosis of pediatric bipolar disorder at ABBHH. For more information see: <http://aacap.confex.com/aacap/2009/webprogram/Paper11314.html>
- Simon Jencius from the OCD program recently co-authored a paper in the journal *Drug and Alcohol Dependence*. Simon’s paper was titled “Effectiveness of very low-cost contingency management in a community adolescent treatment program” and was published in the June edition. Congratulations, Simon!
- Drs. Aldridge, Juzwin, Styer, and Washburn presented a talk, *A Clinical Typology of Non-Suicidal Self-Injury*, at the International Society for the Study of Self-Injury in Stony Brook, New York. They also presented two posters.
- ABBHH & Northwestern University will be co-hosting the 2010 conference of the International Society for the Study of Self-Injury next June. More details to follow in future editions of *Evidence-Based Happenings*!

Is a Single Gene Responsible for Depression?

For many years, research has suggested that the Serotonin Transporter Gene (5-HTTLPR) plays a critical role in the development of major depression. Many have assumed that this gene, especially when combined with a person's experience of stressful life events, increase risk for major depression. A current study, however, suggests this may not be the case. Using a meta-analytic approach, in which the results of 14 studies involving over 14,000 subjects were analyzed, did **not** increase or decrease risk for developing major depression. This finding was true regardless of the experience of stressful life events, and was true for both men and women. It is likely that the complex disorder of major depression will not be linked solely with one gene; instead, many genes and combinations of genes are likely to be associated with many different type of depression. "To say someone is depressed is almost like saying someone has a fever," said a co-author of the study, Dr. Merikangas. "It is a very nonspecific disorder. Individuals with depression become depressed via many different pathways. Until we understand more about subgroups of depression, along with their biological underpinnings, it's going to be very hard to identify genetic variants that play a role."

Risch, et al., (2009). *JAMA*, 301(23), 2462-2471



Chronic PTSD Associated with Neuropsych Deficits in Iraq War Veterans

For veterans returning from war, a recent study found chronic PTSD symptoms were associated with worse performance on attention tasks. These findings support a stress sensitization model of PTSD, in which exposure to stress changes neurotransmitter and neurohormonal responses that either cause or worsen PTSD symptoms, which then result in overreactivity of the nervous system. Of note, immediate or acute PTSD symptoms did not worsen neuropsychological performance; indeed, response time *improved* with higher levels of combat intensity.

Marx, et al., (2009). *Archives of General Psychiatry*, 66(9), 996-1004.

Sudden Death & Stimulants

A case-control study of mortality data of 7-19 year olds from 1985-1996 found 1.8% of unexplained deaths were among youths taking stimulants (methylphenidate). The authors compared this rate to youths who died from a motor vehicle accident, and found only 0.4% of these youths were taking stimulants. Although sudden, unexplained death is a rare, this study presents troubling findings that it may be associated with stimulant use.

Gould, et al. (2009), *American Journal of Psychiatry*, 166(9), 992-1001.



Multifamily Psychoeducational Therapy for Mood Disorders

Multifamily psychoeducational therapy is an adjunctive treatment that combines psychoeducation, family systems interventions, and cognitive behavioral techniques to reduce symptoms of depression and mania in children. A recent randomized controlled trial found that this 8-session adjunctive treatment significantly improved mood symptom severity over a wait-list control group at a 1-year follow-up. Some evidence suggests that the impact of the intervention

Fristad et al. (2009), *Archives of General Psychiatry*, 66(9), 1013-1021



Negative Affect & Relapse

An examination of Project MATCH data, a large intervention study of alcohol abuse, found a connection between negative affect and alcohol relapse. Specifically, increased depressive symptoms and anger expression over time increased risk for relapse after treatment. Of interest, heavier and more frequent alcohol use also increased risk for higher and increased negative affect over time. In other words, the association between negative affect and alcohol abuse was reciprocal; these each affected the other! Negative affect and alcohol abuse may result in a self-sustaining feedback loop that makes intervention even more complicated. The findings suggest it is critical to monitor negative affect both after treatment, and after a relapse.

Witkiewitz, et al. (2009), *Journal of Consulting & Clinical Psychology*, 77(4), 633-644.