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Editor-in-Chief
Volume 13, Number 4
April 2015
www.thecarlatreport.com

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Learning objectives for this issue:
1. Describe the use of computer-assisted psychotherapy.
2. Explain some of the ways psychiatrists can improve their clinical performance.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Computer-Assisted Psychotherapy: An Introduction and Road Test

There are plenty of ways that we use technology in psychiatric practice these days—including e-prescribing, electronic health records, referring patients to websites for psycho-education, etc. But when was the last time you referred a patient to their computer for psychotherapy? Well, it may be time to consider it.

First, let's define some terms. This article is not about delivering therapy remotely via Skype or other technology. That would be called "teletherapy" or "telepsychiatry," which is a well-established modality and is increasingly covered by insurance companies. Nor is this about "virtual therapy" in which your

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In Summary

- There are different models for computer-assisted psychotherapy, with some of the most researched focusing on cognitive behavioral therapy to treat depression or anxiety.
- Programs that include therapist support and involvement are more effective than stand-alone options.
- We test-drove three popular programs: MoodGYM, Beating the Blues, and Good Days Ahead.

Q&A With the Expert

Becoming a Top-Performing Clinician

Scott D. Miller, PhD

Founder and Director, International Center for Clinical Excellence

Dr. Miller has disclosed that he receives payments for licensing outcome measures for use by clinicians. Dr. Carlat has reviewed this interview and found no evidence of bias in this educational activity.

TCPR: Dr. Miller, you've devoted your professional life to researching how therapists can improve their skills. There are a lot of different types of therapy out there—do you think one form of therapy is inherently more effective than another?

Dr. Miller: Absolutely not, and that is because we are looking at the wrong variables when we are talking about psychotherapy, and in some cases actually medication treatments as well. The best predictor of treatment outcome in mental health services is not the specific technique, but rather the provider of those services. In psychotherapy, for example, who provides the treatment is between five and nine times more important than what particular treatment approach is provided (Wampold BE, Imel ZE. *The Great Psychotherapy Debate,* second edition. New York: Routledge; 2015).

TCPR: That means to me that if I'm any more or less effective than Dr. Smith down the street, it has more to do with some quality in myself rather than with the technique that I am using?

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patient uses a fancy virtual reality device, like the Oculus Rift, to simulate being in a scary situation.

In this article we'll focus on potentially game-changing technology for busy psychiatrists called computer-assisted psychotherapy (CAP). Don't have the time or the expertise to do therapy for a given patient? Are good therapists in short supply in your area? No problem—there are more and more websites offering experiences that come close to seeing a therapist. The modalities differ, but the most well-researched programs focus on cognitive behavioral therapy (CBT) for depression or anxiety disorders.

Evidence for Computer-Assisted Therapy

For a field that you may not have heard much about, you might be surprised that dozens of randomized controlled trials have already been conducted on different versions of CAP.

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Before getting into the evidence, you should know about the inherent limitations of any study attempting to assess any kind of psychotherapy (for a lively discussion of the pitfalls of these studies, see Marks IM et al, *Cogn Behav Ther* 2009;38(2):83–90). The main problem is figuring out how to create a good control group. In medication trials, the usual control groups are either placebo or an active comparator—and preferably both.

In trials of psychotherapy, there's no such thing as a true placebo control. The most common control group is the "wait-list,"—patients assigned to this group are told that their names will be put on a waiting list for treatment. Another tactic is to assign the control group to "treatment as usual" (TAU). This means telling patients to see their doctors and to follow their instructions—which might be a medication, some therapy, or nothing at all. Other studies use a bland nonspecific treatment as a control, such as relaxation practice. None of these control groups can accomplish what a placebo can accomplish—which is to measure whether the active treatment has a specific curative component, beyond nonspecific effects such as high expectations.

The best psychotherapy studies will randomly assign patients to three groups: the therapy being evaluated; another therapy already established as effective; and a no-treatment control (such as a wait-list group). But such ideal therapy studies are rare.

Another issue is that meta-analyses will tend to lump many different types of CAP together. Perhaps the most important distinction among them is how much therapeutic support patients are provided as augmentation to computer therapy.

With this in mind, let's look at a recent meta-analysis evaluating the efficacy of CAP for depression (Richards D & Richardson T, *Clin Psychol Rev* 2012;32(4):329–342). Researchers combined nearly 3,000 patients from 19 randomized controlled studies (1,553 received CAP and 1,443 were controls). Most of the programs were based on CBT. Overall, CAP worked pretty well, with an effect size of 0.56, which is considered moderate and compares well to effect sizes of medications for depression.

Drilling into this data reveals something interesting, which is that those computer programs that included therapist support were far more effective (effect size 0.78) than programs without such support (effect size 0.36). What is "therapist support?" Some programs are meant as completely stand-alone treatment, whereas others include real therapist contact and support, which might be in the form of phone calls, emails, or brief supplemental in-person sessions. Thus, it appears that CAP works best when you "prescribe" the sessions to your patient and stay involved in some way. Other programs provided "administrative support" only, such as volunteers or administrative staff helping with technical issues. These programs had an effect size of 0.58, midway between therapist support and no support. The level of support also affected dropout rates with the highest dropouts in the no-support studies (74%) and the lowest in the therapist-supported studies (28%).

Road Tests of Computer-Assisted Psychotherapy

In order to give you a better feel for what CAP is like, both for you and your patients, we chose three popular programs to review: MoodGYM, Beating the Blues, and Good Days Ahead. Why did we choose these three, as opposed to the dozens of others in this increasingly crowded field? For a somewhat arbitrary reason, which was that a recently published article described these three programs in some detail, including a synthesis of the clinical trials that have evaluated each one (Eells TD et al, *Psychotherapy* 2014;51(2):191–197). We did not attempt a comprehensive *Consumer Reports*-type review of these products. Mostly, we wanted to give you a flavor of the experience of computer-assisted therapy in order to pique your interest.

Our methodology in evaluating the programs was informal—we logged on to the sites and poked around. When asked about our symptoms, we said we were mildly depressed and that we were down on ourselves for small stuff—such as get-

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ting the car stuck in the snow.

MOODGYM

http:// moodgym.anu.edu.au

Cost: Free

How to access: Go to website and set up an account.

Efficacy evidence: MoodGYM was found to be more effective than weekly "checking in" phone calls for reducing depressive symptoms and for improving dysfunctional thinking in 525 moderately distressed individuals and effects were maintained for up to one year (Mackinnon A et al, *Br J Psychiatry* 2008;192(2):130–134).

Review: Developed by the Centre for Mental Health Research at the Australian National University, MoodGYM is the least flashy of the three programs we reviewed. It is based almost entirely on text, with a few drawings here and there, and is pretty funny. You are introduced to several prototype characters, one of whom, named "Noproblemos," exemplifies healthy cognitions. "Cyber man," on the other hand, "looks good on the outside but is a seething wreck inside." You can click on the characters' faces at various points throughout the program to learn about how distorted cognitions lead to negative emotions.

We meet these characters at various times throughout the modules and they are used to illustrate cognitive distortions—or, in MoodGYM's jargon—"warped thoughts" such as all-or-none thinking and overgeneralization. There's an initial psychoeducation component in which you get to practice identifying the character's warped thoughts, and you learn how to generate "unwarping" statements. The key mnemonic used is WUTIWUF (What you think is what you feel), and it's undeniably useful for quickly capturing the essence of CBT.

The "therapy" component is comprised of various forms and questionnaires to help you identify specific events, your warped thoughts in response, and how they lead to depression. For example, my event was, "I got my car stuck in the snow." The program guided me through the process of identifying which type of warped thought this elicited (a "should statement": "I should have prevented it"), followed by an unwarping thought: "I couldn't have prevented it, it was too icy."

Pros of MoodGYM:

- It's free.
- It uses fun and colloquial language to make the material very accessible.

Cons of MoodGYM:

- Too many quizzes to fill out—I felt too lazy to complete them, but without completing them you can't go through the rest of the program. My experience is reflected by studies of MoodGYM, one of which found that only 138 of 3,174 users (4.3%) completed all five modules (Christensen H et al, *Aust N Z J Psychiatry* 2006;40(1):59– 62).
- Too much text—which gets tedious.
- Stand-alone (no support) which could mean higher dropouts and less efficacy.

BEATING THE BLUES

http://www.beatingtheblues.co.uk

Cost: Unclear. Currently available only through certain insurance companies and institutions.

How to access: Access is easiest in the United Kingdom, where the program was developed. Access in the US is limited. The University of Pittsburgh Medical Center, along with some behavioral healthcare providers in South Carolina, Kansas, and California, offer it and a project is currently underway to pilot it within the US Department of Veterans Affairs health system.

Efficacy evidence: This is the most studied of all CAPs, with multiple demonstrations of its efficacy as compared to treatment as usual (Eells et al, *op cit*.)

Review: Beating the Blues uses a combination of audio narration, animated graphics, and videos to accomplish psychoeducation and therapy. Of the three programs we reviewed, this did the best at providing an initial overview of the program. There are eight sessions, with each session containing three to five modules. These short modules take about 15 minutes to complete, which is an advantage for those with shorter attention spans.

The program uses videos of five different characters to illustrate automatic thoughts, feelings, and various techniques to improve one's mood. As with the other programs, you are required to input your own experiences and automatic thoughts. The pacing of the program seemed well thought-out. For example, a fairly long and didactic lesson on basic CBT concepts was followed by an engaging module on pleasurable activities. This latter module guided me through steps on how to come up with mood-elevating things to do, and I could click on each of the characters to watch them describe their own anti-depressant activity, such as calling a friend.

Overall, it seemed like a very useful self-help treatment program, and I would imagine many patients benefitting.

Pros of Beating the Blues:

- Good pacing.
- Sessions can be personalized and can build from one to the next, as with standard CBT.
- Can be used with or without therapist support (report of patient progress is available to providers at end of each session).

Cons of Beating the Blues:

- Limited access in US.

GOOD DAYS AHEAD

http://bit.ly/1D61F6Q

Cost and Access: Prices are not published. For information, email Empower Interactive (the company that runs Good Days Ahead), at info@ empower-interactive.com.

Efficacy evidence: Two studies have endorsed its efficacy. It is one of few computerized treatments to be compared in a randomized trial to in-person CBT, and it proved to be just as effective for depression as traditional treatment.

Review: Good Days Ahead is a "supported" CAP, and is designed to be used as an adjunct to in-person CBT. As a clinician, you log in to your account and then you can invite patients to participate by inputting their email address. They will automatically be emailed by the system and can start participating.

There are nine lessons, and they rely

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Dr. Miller: I would say that if you are a person trying to decide whether or not to enter care or treatment that it is much better to know who you are going to see rather than what necessarily they are doing or where they were trained.

TCPR: How are different therapists different? And, more to the point, how can we improve our own skills?

Dr. Miller: There are two kinds of variability between therapists. The first is that some therapists are more consistent about delivering an effective therapy product than others. This is true in virtually all fields in healthcare, whether it's cardiology, radiology, or psychiatry. No one is equally effective with all the clients they see. Our performance might vary by type of client or by day. Some days we deliver a better performance more effectively than other days. The other difference is that some clinicians are on balance more effective than other clinicians.

TCPR: Okay, you're saying to become better practitioners we need to focus on two things. First, we need to become more consistent in what we do with patients, and second, we need to improve our skills. How do we improve our consistency with patients?

Dr. Miller: The first step is that you have to have a mechanism of tracking how well the client is doing. The research I've done has led to the development of the Outcome Rating Scale (ORS), which is a simple, well-validated tool that allows clinicians to track change in their clients.

TCPR: And for full disclosure, readers should know that you derive income from conducting training on your outcome scales, though I believe the ORS is available to any clinician as a free download?

Dr. Miller: Yes, I make my living providing training, though not exclusively about the ORS. I work with hundreds of agencies around the world, both public and private, helping them measure and improve their results. (Supportive empirical and "how to" information, as well as free copies, can be downloaded at www.whatispcoms.com.)

TCPR: Walk me through how the ORS would actually be used. How would I use that in my practice? Do I give the scale at the end of each session?

Dr. Miller: The ORS, or any similar outcome tool, is given at the beginning of each session. In essence, you are looking for the impact of your prior session's work at the beginning of the present session. That way you can either continue with more of the same or adjust the dose, type, or intensity of the therapy. You can administer the scale whether you are doing a 15-minute medication check-in or a traditional 50-minute therapy session. The scale is extremely brief. There are four questions that ask how your client has done over the past week in terms of: 1) personal well-being, 2) close interpersonal relationships, such as with family and close friends, 3) socially, such as at work and school, and 4) how they are doing overall. They rate their answers on a visual analog scale.

TCPR: And how do we interpret the results of the scale?

Dr. Miller: You add up the total score, which gives you a gross idea about whether or not this client feels like he or she is moving forward. You can then dig deeper by plotting that score against a normative trajectory based on hundreds of thousands of episodes of care and that gives the clinician an instant sense of whether the case is on track. By "on track," I mean, whether or not the client is making sufficient change to predict they will be among the successfully treated group at the end of treatment. Any deviation from the norm provides the clinician with an opportunity to change direction—adjust, modify, refer, etc. Early on, we usually recommend clinicians think about the alliance they have with the client exploring, for example, whether there's agreement on the goals for treatment. And whether the approach makes sense to them and is congruent with their values and preferences.

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>
> Scott D. Miller, PhD

TCPR: Psychiatrists are familiar with various symptom rating scales, such as the Hamilton Depression Rating Scale (HAM-D) and the Patient Health Questionnaire-9 (PHQ-9). How is the ORS different from these scales?

Dr. Miller: Both are excellent symptom scales. That said, changes in symptoms may not correlate well with clients' estimates of their own well-being. Importantly, research shows that client ratings of well-being are better predictors of seeking and staying in treatment than is their experience of or the clinician's assessment of symptoms (Duncan BL, Miller SD, Sparks JA. *The Heroic Client.* San Francisco, CA: Jossey-Bass; 2004). The HAM-D is a good example of a problem that can occur with clinician-rated measures. What happens if a clinician rates a client as improving on that tool but the client disagrees? Since dropout and disengagement are the two largest threats to treatment outcome, it makes sense to err on the side of the client.

TCPR: Does the ORS also help guide us specifically in how we might want to change what we are doing?

Dr. Miller: You raise an important question, and this is a process we call "Feedback Informed Treatment." The measure points to specific areas that may need to be explored. At the same time, it leaves the actual intervention up to the clinician and their client, merely underscoring the importance of doing something different than what has been done up to this point.

TCPR: So it is basically saying, "Look, what you're doing isn't working, so do something different," and then a good clinician does what?

Dr. Miller: A good clinician does several things. First, work at retaining the client in treatment. The risk of dropout rises as the

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amount of treatment without effect increases. We know the risk of people stopping or discontinuing their medication is huge. And so I want to make sure that people stick around long enough to either give the intervention a chance to work, or to be feel comfortable telling the clinician that the treatment is not quite helping. We now have several studies showing the routine use of the measures improves compliance with psychotropic and other drug treatments (for example, Pringle J et al, *Inov Pharm* 2011;2(1):Article 33). I suspect that most of the psychiatrists reading this have had clients come in and say, "You know, I am not really feeling much better," and the psychiatrist says, "Just stick with it for a couple of more weeks," and then, boom, it works. Now we think of the medication as the important part, but I think the psychiatrist who says, "Stick with it; it will be okay," is making it possible for this client to talk about the lack of effect, and this leads to a conversation that instills hope and enhances engagement, which may be the critical components for success.

TCPR: All right, let's say I start using the ORS. I get some feedback from my patient that the treatment isn't really going anywhere. Give me an example of the specific kinds of feedback patients will give their clinicians.

Dr. Miller: Seventy percent of the time, problems in the therapy encounter are related to misunderstanding of the client's goal. Many of our clients don't even know what their goals are when they come in, and by process of elimination we find out what they are over time. Another scale we've developed, the Session Rating Scale, cues you to have that conversation with the client.

TCPR: Okay, so I'm thinking my patient wants to sleep better, but I find out from the Session Rating Scale that I am missing the boat and that my patient has different goals.

Dr. Miller: Right, maybe they want to perform better at work. It's a reasonable thing to assume that if they slept better they'd be better performers at work. But that's only an assumption. Once you find out that your client wants to improve his ability to perform at work, you might start discussing some simple skills about assertiveness or organization, and the client begins to do better at work, which then leads him to sleep more soundly at night.

TCPR: I like this approach. But I think the typical psychiatrist might respond to this conversation by saying, "Well, I think it is pretty clear to everybody that when a patient comes in with anxiety or depression the goal is to diminish their symptoms; there is no big mystery about that, and they can tell me if they feel better. Why do I need to use a formal scale?" So are you saying that we are overestimating the accuracy of our assessment of our clients' goals?

Dr. Miller: I would say that is perfectly reasonable to practice that way if it works—if the person you are treating is getting better. But if they are not improving then it's not the best way. So, the question is not which approach is right. The question is whether or not what you are doing is working for this person in front of you. So, let me be bold. If you are so certain, why not measure and see for sure? It's simple and quick. It's the difference between taking a person's temperature by feeling their forehead and using a thermometer.

TCPR: So your plea is not to suggest specific techniques, but it's really to encourage clinicians to gain feedback from their clients so that they can alter whatever they're doing in order to make their clients better, and that may involve all kinds of different adjustments.

Dr. Miller: We say that there are three main pathways that you can take once you find out that what you are doing with an individual client isn't working. You can change the "what," the "where," or the "who." The "what" means you can change what you're doing. Here, you can be guided by conversations about the alliance: what are the person's goals and what's your role in helping them to achieve those goals. If that doesn't help, change the "where." All psychiatrists do this already: individual outpatient isn't working, so maybe we are going to add a group or refer to a short-term, intensive setting, such as partial hospitalization. Third, and last, and I know the most controversial, change the "who." You know you can't marry everyone you date, and at some point the time for learning and experimenting is over. At that point the best thing that you can do to increase the odds that this person will be helped is to get them away from you and to a different clinician.

TCPR: So far we've talked mainly about putting processes in place to consistently get feedback from our patients, which should lead to more consistently effective care. But you've also looked at the research on expertise and you've applied it to how therapists can improve their performance. What have you found?

Dr. Miller: We know that the top-performing clinicians spend three to four-and-a-half times as many hours per week than their more average counterparts outside of work engaged in deliberate practice (Chow D et al, *Psychotherapy* 2015; in press).

TCPR: "Outside of work"—meaning that just seeing patients is not the kind of "practice" that will lead us to become top performers?

Dr. Miller: Work is not practice and experience is not correlated with outcome. So unfortunately, the idea that you get better by working more is simply untrue. There is no evidence of this. In fact, if anything it is negatively correlated with performance! We end up with "delusions of certainty." The reason for this is that the most crucial elements needed for learning and growth are absent when you are in the midst of a busy day meeting with clients. These required elements include the possibility to reflect, identify small process errors, make a plan, and try again.

TCPR: Are there any specific ways that we should be accomplishing this deliberate practice?

Dr. Miller: We've looked at whether there is a specific group of activities that clinicians should engage in to improve performance. But we found that the type of activity doesn't matter. You can read a book or paper, attend a continuing education event, or listen to a podcast. What's critical is doing more of it than everybody else. Additionally, whatever you do needs to stretch you beyond your

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Research Updates IN PSYCHIATRY

DEPRESSION

Does rTMS Work as Augmentation in Patients with Resistant Depression?

Repetitive transcranial magnetic stimulation (rTMS) is approved by the US Food and Drug Administration (FDA) for treatment resistant depression (TRD), and presumably works by modulating brain circuitry (see the September 2014 issue of *TCPR* for more detail). A new meta-analysis focuses specifically on using rTMS as augmentation to antidepressants in patients with TRD.

Researchers located seven studies with a total of 279 patients with TRD. In all, 171 of these patients were assigned to rTMS plus antidepressant, while 108 received sham treatment plus antidepressant. The researchers found that 47% of rTMS patients responded (defined as a 50% improvement on the Hamilton Depression Scale) compared to only 22% of sham patients. The odds ratio was 5.12, meaning rTMS patients were about five times more likely to respond than those receiving sham treatment. The number needed to treat (NNT) was 3.4, meaning that you would have to treat 3.4 patients with rTMS for one patient to benefit more than they would have from sham.

However, the quality of most of the studies was poor, according to the authors. In particular, most studies did a poor job of ensuring that patients were truly blinded to which treatment they received. Real rTMS causes distinct vibrating sensations in the scalp, whereas sham does not. This possibility of "losing the blind" bedevils most rTMS results (Liu B et al, *BMC Psychiatry* 2014;14(1):342–350).

***TCPR's* Take:** As in most large meta-analyses of rTMS, this one appears to endorse the treatment—specifically for antidepressant augmentation in patients with TRD. But the glowing numbers are undermined by significant doubts about the integrity of the blind. These concerns continue to make us skeptical about the efficacy of rTMS—FDA approval notwithstanding.

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heavily on videos. A psychiatrist narrator introduces and discusses CBT concepts. The core of the program is a series of videos following the story of Lisa, an employed married woman with depression.

In each vignette, Lisa interacts with somebody and we observe how she responds, often with a voiceover of her thoughts. For example, she is at her desk at work, and her boss calls her and wants to meet with her about a project. We hear her internal monologue: an automatic thought that her boss is going to reprimand her for taking too long on the project. There is a cut to the narrator who discusses Lisa's reactions and uses it as a teaching opportunity to discuss the concept of automatic thoughts. This is followed by some brief quizzes to assess our understanding.

In some vignettes, there are alternate versions of the scene, with the first showing Lisa using distorted thoughts, and a second showing her successfully using CBT skills, such as developing rational thoughts. Through the different lessons we see Lisa gradually recovering from her depression.

The videos are well produced and the acting is pretty compelling. I found myself identifying with Lisa and rooting for her. As with the other programs, you are required to do assignments to identify your own automatic thoughts.

Although Good Days Ahead is not meant to be an independent therapy program, I believe it would be helpful for many patients even if not used in conjunction with therapy.

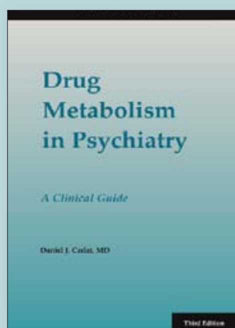
Pros of Good Days Ahead:

- Developed for those with no previous computer experience (requires minimal typing skills and is written at the ninth-grade level).
- Intended to be used with support, which usually means less drop out and better efficacy per studies.

Cons of Good Days Ahead:

- Unclear pricing and availability.

DR. CARLAT'S VERDICT: Computer-assisted psychotherapy, at least when based on cognitive behavioral therapy, shows a lot of promise. Consider adding it to your practice but learn about the various options, tinker with them, and check out accompanying clinician guides to get a sense of plusses and minuses of each.



Drug Metabolism in Psychiatry: A Clinical Guide

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. What exactly is meant by computer-assisted psychotherapy (CAP) (Learning Objective #1)?
   [ ] a) It is a way of e-prescribing medications
   [ ] b) It is a way to deliver therapy remotely, such as via Skype
   [ ] c) It uses a virtual reality device to stimulate a situation for a patient
   [ ] d) It is a way for patients to receive psychotherapy using a computer

2. The most well-researched CAP programs focus on which of the following therapies and disorders (LO #1)?
   [ ] a) Cognitive behavioral therapy for depression or anxiety disorders
   [ ] b) Family therapy for eating disorders
   [ ] c) Psychodynamic therapy for PTSD
   [ ] d) Acceptance and commitment therapy for depression

3. What is the best predictor of treatment outcome in mental health services (LO #2)?
   [ ] a) The type of psychotherapy
   [ ] b) The therapist who provides the treatment
   [ ] c) The medical school the psychiatrist attended
   [ ] d) The length of time the therapist has practiced

4. What is the first step for a therapist to improve consistency with patients (LO #2)?
   [ ] a) Keep up with current research
   [ ] b) Know what medications are most effective
   [ ] c) Have a tool that allows tracking of how well the patient or client is doing
   [ ] d) Attend training conferences

5. A new meta-analysis focused on using rTMS as augmentation to antidepressants in patients with treatment resistant depression. Researchers found rTMS (LO #3):
   [ ] a) Was more effective than sham treatment
   [ ] b) Was no different than sham treatment
   [ ] c) Resulted in no improvement on the Hamilton Depression Scale
   [ ] d) Resulted in higher ratings of depression on the Hamilton Depression Scale

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News of Note

FDA Approves Vyvanse to Treat Binge-Eating Disorder

Lisdexamfetamine (Vyvanse), a stimulant approved for treating kids and adults with ADHD, is the first drug approved by the US Food and Drug Administration (FDA) for treating adults with binge-eating disorder (BED).

The approval, which was made in January 2015, was based on two 12-week clinical studies with 724 adults with moderate to severe BED (http://1.usa.gov/1KeTiKN). In one of the studies, patients taking Vyvanse reported a decrease in binges from about five per week to about one per week, whereas patients randomly assigned to placebo went from five to two episodes per week. The percentage of patients who stopped binge eating for four weeks was about 21% in the placebo group compared to 42% in the 50 mg/day and 50% in the 70 mg/day Vyvanse groups. BED patients taking Vyvanse experienced typical stimulant side effects, such as insomnia, increased heart rate, jittery feelings, and anxiety.

BED made its formal diagnostic debut in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* in 2013. For a diagnosis of BED, a patient has to have recurring episodes (at least once a week over three months) of eating significantly more food than most others would eat, along with feelings of lack of control, shame, guilt, or embarrassment. According to the *DSM-5*, BED is different from the much more common phenomenon of overeating in that it's more severe and accompanied by significant psychological distress. Shire Pharmaceuticals, the manufacturer of Vyvanse, is estimating that there are nearly three million US adults with BED. This blockbuster drug (total sales of nearly $1.5 billion in 2014) is now poised to make even more money for its manufacturer.

In the June issue of *TCPR*, which will focus on eating disorders, we will provide an overview of Vyvanse for BED—addressing diagnostic issues, the role of medication vs. psychotherapy, and the risks of stimulant use and abuse.

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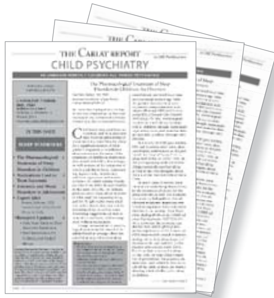

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Psychotherapy Updates

Next month in *The Carlat Psychiatry Report:* Diagnostic Testing in Psychiatry

Expert Interview
Continued from page 5

current realm of reliable performance. Approach the material with a client in mind or an error you have made. Spend some time developing a plan about what you will do differently next time. Develop a rich picture of both the process and intended outcome. You should be tired after you do it! Interestingly, if the activity is not cognitively taxing, you are not really engaged with the material, and the time spent will have little impact on performance.

TCPR: That sounds exhausting.

Dr. Miller: That's right. So I often say this is a marathon and not a sprint. Think about the deliberate practice in the same way you think about your retirement; you are investing a little bit at a time. On any given day, spend 20 or 30 concentrated minutes thinking about small improvements, such as how you open your visits with clients, and what you might do to help clients express more energy, less passivity, so that they are more actively engaged in rather than passive recipients of their treatment.

TCPR: Thank you, Dr. Miller.

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