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(Atlantis and Sullivan 2012; Baer, Lykins et al. 2012; Bergomi, Tschacher et al. 2012; Bieling, Hawley et al. 2012; Bryan, Corso et al. 2012; Cobham 2012; Daley and Jolly 2012; Farb, Anderson et al. 2012; Freedman, Park et al. 2012; Golden and Dalgleish 2012; Gruenewald, Liao et al. 2012; Gustavson, Røysamb et al. 2012; Harkness, Bagby et al. 2012; Kmietowicz 2012; Krusche, Cyhlarova et al. 2012; Lekes, Hope et al. 2012; Leung, Gartner et al. 2012; Manocha, Black et al. 2012; Manrique-Garcia, Zammit et al. 2012; Melrose, Brown et al. 2012; Mohr, Ho et al. 2012; Rush, Wisniewski et al. 2012; Ryan, Safran et al. 2012; Schröder, Rehfeld et al. 2012; Scott, McLaughlin et al. 2012; Sedlmeier, Eberth et al. 2012; Tamir and Mitchell 2012; von Wolff, Holzel et al. 2012; Werner-Seidler and Moulds 2012; Wiborg, Knoop et al. 2012)

Atlantis, E. and T. Sullivan (2012). ***"Bidirectional association between depression and sexual dysfunction: A systematic review and meta-analysis."*** The Journal of Sexual Medicine 9(6): 1497-1507. http://dx.doi.org/10.1111/j.1743-6109.2012.02709.x

Introduction. Depression is frequently associated with sexual dysfunction in both men and women. Aim. To examine whether depression predicts sexual dysfunction and, conversely, whether sexual dysfunction predicts depression. Method. A systematic review and meta-analysis was conducted. PubMed and EMBASE biomedical answers electronic databases were searched for relevant studies up to November 2011. Reference lists of relevant articles were hand-searched and expert opinions were sought. Studies identified for inclusion had to be prospective cohort studies in adult populations that reported an association between depression and sexual dysfunction variables. Main Outcome Measures.Odds ratios (ORs), prioritized where available, or relative risks (RRs) were pooled across studies using random-effects meta-analysis models. Results.Eight citations included for review yielded six studies on depression and risk of sexual dysfunction in 3,285 participants followed for 2–9 years, and six studies on sexual dysfunction and risk of depression in 11,171 participants followed for 1–10 years. Depression increased the risk of sexual dysfunction in pooled unadjusted (RR/OR 1.52 with 95% confidence intervals [1.02, 2.26]) and adjusted (RR/OR 1.71 [1.05, 2.78]) meta-analyses but not in the partially adjusted model (RR/OR 1.41 [0.90, 2.23]). There was significant heterogeneity between studies, but after removal of a single outlying study was diminished and the pooled partially adjusted, RR/OR increased to 1.69 (1.15, 2.47). Sexual dysfunction increased the odds of depression in the pooled unadjusted (OR 2.30 [1.74, 3.03]), adjusted (OR 3.12 [1.66, 5.85]), and partially adjusted (OR 2.71 [1.93, 3.79]) meta-analyses; heterogeneity was significant only in the adjusted model. Meta-regression analyses did not detect significant sources of heterogeneity in either examination. Conclusions.Clinicians should be aware of a bidirectional association between depression and sexual dysfunction. Patients reporting sexual dysfunction should be routinely screened for depression, whereas patients presenting with symptoms of depression should be routinely assessed for sexual dysfunction.

Baer, R. A., E. L. B. Lykins, et al. (2012). ***"Mindfulness and self-compassion as predictors of psychological wellbeing in long-term meditators and matched nonmeditators."*** Journal of Positive Psychology 7(3): 230-238. http://dx.doi.org/10.1080/17439760.2012.674548

Mindfulness training has well-documented effects on psychological health. Recent findings suggest that increases in both mindfulness and self-compassion may mediate these outcomes; however, their separate and combined effects are rarely examined in the same participants. This study investigated cross-sectional relationships between self-reported mindfulness, self-compassion, meditation experience, and psychological wellbeing in 77 experienced meditators and 75 demographically matched nonmeditators. Most mindfulness and self-compassion scores were significantly correlated with meditation experience and psychological wellbeing. Mindfulness and self-compassion accounted for significant independent variance in wellbeing. A significant relationship between meditation experience and wellbeing was completely accounted for by a combination of mindfulness and self-compassion scores. Findings suggest that both mindfulness and self-compassion skills may play important roles in the improved wellbeing associated with mindfulness training; however, longitudinal studies are needed to confirm these findings.

Bergomi, C., W. Tschacher, et al. (2012). ***"The assessment of mindfulness with self-report measures: Existing scales and open issues."*** Mindfulness (N Y): 1-12. http://dx.doi.org/10.1007/s12671-012-0110-9

During recent years, mindfulness-based approaches have been gaining relevance for treatment in clinical populations. Correspondingly, the empirical study of mindfulness has steadily grown; thus, the availability of valid measures of the construct is critically important. This paper gives an overview of the current status in the field of self-report assessment of mindfulness. All eight currently available and validated mindfulness scales (for adults) are evaluated, with a particular focus on their virtues and limitations and on differences among them. It will be argued that none of these scales may be a fully adequate measure of mindfulness, as each of them offers unique advantages but also disadvantages. In particular, none of them seems to provide a comprehensive assessment of all aspects of mindfulness in samples from the general population. Moreover, some scales may be particularly indicated in investigations focusing on specific populations such as clinical samples (Cognitive and Affective Mindfulness Scale, Southampton Mindfulness Questionnaire) or meditators (Freiburg Mindfulness Inventory). Three main open issues are discussed: (1) the coverage of aspects of mindfulness in questionnaires; (2) the nature of the relationships between these aspects; and (3) the validity of self-report measures of mindfulness. These issues should be considered in future developments in the self-report assessment of mindfulness.

Bieling, P. J., L. L. Hawley, et al. (2012). ***"Treatment-specific changes in decentering following mindfulness-based cognitive therapy versus antidepressant medication or placebo for prevention of depressive relapse."*** J Consult Clin Psychol 80(3): 365-372. http://www.ncbi.nlm.nih.gov/pubmed/22409641

OBJECTIVE: To examine whether metacognitive psychological skills, acquired in mindfulness-based cognitive therapy (MBCT), are also present in patients receiving medication treatments for prevention of depressive relapse and whether these skills mediate MBCT's effectiveness. METHOD: This study, embedded within a randomized efficacy trial of MBCT, was the first to examine changes in mindfulness and decentering during 6-8 months of antidepressant treatment and then during an 18-month maintenance phase in which patients discontinued medication and received MBCT, continued on antidepressants, or were switched to a placebo. In total, 84 patients (mean age = 44 years, 58% female) were randomized to 1 of these 3 prevention conditions. In addition to symptom variables, changes in mindfulness, rumination, and decentering were assessed during the phases of the study. RESULTS: Pharmacological treatment of acute depression was associated with reductions in scores for rumination and increased wider experiences. During the maintenance phase, only patients receiving MBCT showed significant increases in the ability to monitor and observe thoughts and feelings as measured by the Wider Experiences ($p < .01$) and Decentering ($p < .01$) subscales of the Experiences Questionnaire and by the Toronto Mindfulness Scale. In addition, changes in Wider Experiences ($p < .05$) and Curiosity ($p < .01$) predicted lower Hamilton Rating Scale for Depression scores at 6-month follow-up. CONCLUSIONS: An increased capacity for decentering and curiosity may be fostered during MBCT and may underlie

its effectiveness. With practice, patients can learn to counter habitual avoidance tendencies and to regulate dysphoric affect in ways that support recovery. [Correction Notice: An Erratum for this article was reported in Vol 80(3) of Journal of Consulting and Clinical Psychology (see record 2012-09923-001). There is an error in the sentence beginning "For TMS-C . . ." in the paragraph below Table 5.]

Bryan, C. J., M. L. Corso, et al. (2012). ***"Severity of mental health impairment and trajectories of improvement in an integrated primary care clinic."*** J Consult Clin Psychol 80(3): 396-403. http://www.ncbi.nlm.nih.gov/pubmed/22428939

OBJECTIVE: To model typical trajectories for improvement among patients treated in an integrated primary care behavioral health service, multilevel models were used to explore the relationship between baseline mental health impairment level and eventual mental health functioning across follow-up appointments. METHOD: Data from 495 primary care patients (61.1% female, 60.7% Caucasian, 37.141 +/- 12.21 years of age) who completed the Behavioral Health Measure (Kopta & Lowry, 2002) at each primary care appointment were used for the analysis. Three separate models were constructed to identify clinical improvement in terms of number of appointments attended, baseline impairment severity level, and the interaction of these 2 variables. RESULTS: The data showed that 71.5% of patients improved across appointments, 56.8% of which (40.5% of the entire sample) was clinically meaningful and reliable. Number of appointments and baseline severity of impairment significantly accounted for variability in clinical outcome, with trajectories of change varying across appointments as a function of baseline severity. Patients with more severe impairment at baseline improved faster than patients with less severe baseline impairment. CONCLUSIONS: Patients treated within an integrated primary care behavioral health service demonstrate significant improvements in clinical status, even those with the most severe levels of distress at baseline.

Cobham, V. E. (2012). ***"Do anxiety-disordered children need to come into the clinic for efficacious treatment?"*** J Consult Clin Psychol 80(3): 465-476. http://www.ncbi.nlm.nih.gov/pubmed/22545740

OBJECTIVE: This study compared 3 experimental conditions: wait-list, therapist-supported bibliotherapy, and individual therapy, in the treatment of child anxiety. METHOD: Participants were 55 children (25 girls and 30 boys), aged 7 to 14 years diagnosed with an anxiety disorder, and their parents. Families were assigned using a modified random assignment process to 1 of the 3 conditions. The intervention evaluated in the 2 active treatment conditions was a family-focused, cognitive-behavioral program. RESULTS: At posttreatment, participants in both treatment conditions had improved significantly on both diagnostic and questionnaire outcome measures compared with participants in the wait-list condition, with no differences demonstrated between the treatment conditions. Thus, at posttreatment, 0% of children in the wait-list condition were anxiety diagnosis free, compared with 95% in the therapist-supported bibliotherapy condition and 78.3% in the individual therapy condition. There was no significant difference between diagnostic status at posttreatment between the 2 treatment conditions. Participants assigned to a treatment condition were reassessed at 3-month and 6-month follow-up. Treatment gains were maintained in both conditions across the follow-up period. CONCLUSION: In light of the fact that more than 80% of anxiety-disordered children never receive treatment, these data suggest that therapist-supported bibliotherapy represents a cost-effective means of reaching a greater number of anxious children.

Daley, A. and K. Jolly (2012). ***"Exercise to treat depression."*** BMJ 344. http://www.bmj.com/content/344/bmj.e3181

Does not seem to benefit patients in clinical settings who receive good standard care. There has been considerable research interest in the effects of exercise on depression over the past three decades and many systematic reviews have reported moderate to large effect sizes, with the standardised mean difference for the most recent Cochrane review being −0.82 (95% confidence interval −1.12 to −0.51).1 2 3 A new linked trial (TREAtment of Depression with physical activity (TREAD); doi:10.1136/bmj.e2758) adds to this evidence base.4 At first glance reviews suggest that exercise is effective in the treatment of depression. However, most trials included in systematic reviews recruited small numbers of patients, had a short follow-up, and did not adequately conceal randomisation or recruited non-clinical community volunteers (or both). Volunteers are more likely to be motivated to exercise and may be less severely depressed than people identified in clinical settings. Subgroup analyses that included only the higher quality trials in the Cochrane review reduced the effect size to −0.42 (−0.88 to 0.03),1 casting doubt on the main finding. In 2009 the UK National Institute for Health and Clinical Excellence recommended that people with persistent subthreshold depressive symptoms or mild-moderate depression should be advised of the benefits of exercise,5 despite a lack of high quality evidence to support such a recommendation. The investigators in the current trial tried to remedy the methodological concerns of previous trials and answer definitively whether or not physical activity is an effective treatment in patients diagnosed with depression.4 TREAD was a large (n=361) methodologically rigorous trial that enrolled participants from primary care who presented with depression that had been confirmed by standardised clinical interview. The intervention was theory based and patient centred, and it aimed to be deliverable within the health service by physical activity facilitators, without unsustainable resource implications. TREAD compared usual care plus physical activity with usual care only and reported no significant difference in levels of depression between the groups at follow-up over one year. These negative findings contrast with more positive findings from systematic reviews but are perhaps not surprising, particularly when considered alongside the results of a more recent meta-analysis of 13 trials that had recruited only patients with clinically diagnosed depression.6 This meta-analysis reported that physical exercise showed a small effect on depression (standardised mean difference −0.40, −0.66 to −0.14). However, no significant difference was found when the analysis was restricted to trials with follow-up beyond the end of the intervention (−0.01, −0.28 to 0.26) or to the three high quality trials (−0.19, −0.70 to 0.31), which suggests that exercise may not be effective in this population in the long term. Should we therefore conclude, on the basis of recent evidence, that physical activity has no effect on depression in clinical populations?4 6 Not necessarily. In the TREAD trial, usual care could comprise antidepressants, counselling, referral to exercise on prescription schemes, or referral to secondary care mental health services. Patients in both groups therefore already received high quality care, and 57% were taking antidepressants at recruitment. It may have been difficult for the addition of a physical activity intervention to make an appreciable difference. In addition, about 25% of participants were already meeting the current UK government guidelines for physical activity at baseline (the target level for the intervention),7 and they could feasibly have already been gaining any benefits that physical activity might provide, leaving little room for the intervention to make a difference. Adherence was good, and 70% of participants received an adequate dose of the intervention, which is an achievement considering that it is difficult to motivate people who are depressed to commit to an exercise intervention.8 However, although a significant difference in physical activity between groups was reported at follow-up, this was relatively small and based on self reported data, which are prone to overestimation. The relatively severe depression of the recruited population (mean Beck depression inventory score 32 points) may have affected the levels of physical activity achieved. Limited information was available on the intensity of physical activity achieved, and this might be important because exercise may need to be performed at moderate-hard intensity for it to have a meaningful effect on depression. To date there has been insufficient research on how the intensity and overall duration of exercise affects depression; future trials should include an objective measurement of physical activity. Any future trials should also, as in the TREAD trial, measure longer term outcomes and use standardised clinical interviews to diagnose depression to ensure the usefulness of the findings in a population with clinically diagnosed depression. What should doctors advise their patients who present with depression? Within a clinical setting, for patients who are well managed on usual drugs or

psychological treatments (or both), advice and support to be physically active does not seem to offer additional benefit and should not be given as standard. Indeed, recommending exercise to very depressed patients may worsen any thoughts of "failure" if they are unable to comply with the recommendation. However, positive results from trials in volunteers suggest that patients who are motivated to exercise and seek support to do so might benefit and should be supported in achieving this behavioural change.

Farb, N. A., A. K. Anderson, et al. (2012). ***"The mindful brain and emotion regulation in mood disorders."*** Can J Psychiatry 57(2): 70-77. http://www.ncbi.nlm.nih.gov/pubmed/22340146

Mindfulness involves nonjudgmental attention to present-moment experience. In its therapeutic forms, mindfulness interventions promote increased tolerance of negative affect and improved well-being. However, the neural mechanisms underlying mindful mood regulation are poorly understood. Mindfulness training appears to enhance focused attention, supported by the anterior cingulate cortex and the lateral prefrontal cortex (PFC). In emotion regulation, these PFC changes promote the stable recruitment of a nonconceptual sensory pathway, an alternative to conventional attempts to cognitively reappraise negative emotion. In neural terms, the transition to nonconceptual awareness involves reducing evaluative processing, supported by midline structures of the PFC. Instead, attentional resources are directed toward a limbic pathway for present-moment sensory awareness, involving the thalamus, insula, and primary sensory regions. In patients with affective disorders, mindfulness training provides an alternative to cognitive efforts to control negative emotion, instead directing attention toward the transitory nature of momentary experience. Limiting cognitive elaboration in favour of momentary awareness appears to reduce automatic negative self-evaluation, increase tolerance for negative affect and pain, and help to engender self-compassion and empathy in people with chronic dysphoria.

Freedman, N. D., Y. Park, et al. (2012). ***"Association of coffee drinking with total and cause-specific mortality."*** New England Journal of Medicine 366(20): 1891-1904. http://www.nejm.org/doi/full/10.1056/NEJMoa1112010

Background: Coffee is one of the most widely consumed beverages, but the association between coffee consumption and the risk of death remains unclear. Methods: We examined the association of coffee drinking with subsequent total and cause-specific mortality among 229,119 men and 173,141 women in the National Institutes of Health–AARP Diet and Health Study who were 50 to 71 years of age at baseline. Participants with cancer, heart disease, and stroke were excluded. Coffee consumption was assessed once at baseline. Results: During 5,148,760 person-years of follow-up between 1995 and 2008, a total of 33,731 men and 18,784 women died. In age-adjusted models, the risk of death was increased among coffee drinkers. However, coffee drinkers were also more likely to smoke, and, after adjustment for tobacco-smoking status and other potential confounders, there was a significant inverse association between coffee consumption and mortality. Adjusted hazard ratios for death among men who drank coffee as compared with those who did not were as follows: 0.99 (95% confidence interval [CI], 0.95 to 1.04) for drinking less than 1 cup per day, 0.94 (95% CI, 0.90 to 0.99) for 1 cup, 0.90 (95% CI, 0.86 to 0.93) for 2 or 3 cups, 0.88 (95% CI, 0.84 to 0.93) for 4 or 5 cups, and 0.90 (95% CI, 0.85 to 0.96) for 6 or more cups of coffee per day ($P<0.001$ for trend); the respective hazard ratios among women were 1.01 (95% CI, 0.96 to 1.07), 0.95 (95% CI, 0.90 to 1.01), 0.87 (95% CI, 0.83 to 0.92), 0.84 (95% CI, 0.79 to 0.90), and 0.85 (95% CI, 0.78 to 0.93) ($P<0.001$ for trend). Inverse associations were observed for deaths due to heart disease, respiratory disease, stroke, injuries and accidents, diabetes, and infections, but not for deaths due to cancer. Results were similar in subgroups, including persons who had never smoked and persons who reported very good to excellent health at baseline. Conclusions: In this large prospective study, coffee consumption was inversely associated with total and cause-specific mortality. Whether this was a causal or associational finding cannot be determined from our data. *Note too Science Daily reported "The mechanism by which coffee protects against risk of death - if indeed the finding reflects a causal relationship - is not clear, because coffee contains more than 1,000 compounds that might potentially affect health," said lead author, Freedman. "The most studied compound is caffeine, although our findings were similar in those who reported the majority of their coffee intake to be caffeinated or decaffeinated."*

Golden, A. M. and T. Dalgleish (2012). ***"Facets of pejorative self-processing in complicated grief."*** J Consult Clin Psychol 80(3): 512-524. http://www.ncbi.nlm.nih.gov/pubmed/22329823

OBJECTIVE: Complicated grief (CG) has been proposed as a psychiatric response to bereavement distinct from established mood and anxiety disorder diagnoses. Little is known about the nature of cognitive-affective processing in CG, nor any similarities or differences compared with the processing profiles associated with other emotional disorders. Three studies therefore investigated 3 broad facets of negative self-processing associated with either elevated symptoms of, or diagnosis of, CG--namely, self-related attributions or blame, self-devaluation, and cognitions about the future self. METHOD: These self-processing domains were assessed using a variety of self-report and scenario-based measures either linked specifically to the bereavement or more general in their focus. Study 1 used a correlational design in a community bereaved sample. Study 2 employed an extreme-groups approach looking at individuals high versus low in CG symptoms, and Study 3 compared those with a CG diagnosis to healthy bereaved controls. RESULTS: The data revealed a profile of processing in CG characterized by significant relationships between CG symptoms or diagnosis and both self-devaluation and negative self-related cognitions about the future, but the data provided no support for a similar relationship with negative self-related attributions. CONCLUSIONS: These findings extend our understanding of self-related cognitive processing in CG. They also suggest that CG is characterized by a cognitive-affective processing profile that is distinct from that associated with other disorders, notably major depression, in the literature. This has potential implications for the psychological treatment of CG and for its nosological status as a post-loss syndrome distinct from depression.

Gruenewald, T. L., D. H. Liao, et al. (2012). ***"Contributing to others, contributing to oneself: Perceptions of generativity and health in later life."*** The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. http://psychsocgerontology.oxfordjournals.org/content/early/2012/03/27/geronb.gbs034.abstract

Objectives. To examine whether perceptions of generativity (a concern for establishing and guiding the next generation) predict the likelihood of increases in levels of impairment in activities of daily living (ADLs) or of dying over a 10-year period in older adults aged 60–75 from the Study of Midlife in the United States (MIDUS).Method. Perceptions of generativity and current generative contributions as well as select sociodemographic, health status, health behavior, and psychosocial factors, assessed at a baseline exam, were examined as predictors of change in ADL disability level or mortality over the 10-year period between the baseline and follow-up waves of the MIDUS Study. Results. Greater levels of generativity and generative contributions at baseline predicted lower odds of experiencing increases in ADL disability (2 or more new domains of impairment; generativity odds ratio [OR] = 0.93 and generative contributions OR = 0.87), or of dying (generativity OR = 0.94 and generative contributions OR = 0.88), over the 10-year follow-up in models adjusted for sociodemographics and baseline health and disability. Associations remained relatively unchanged with the inclusion of different sets of health behavior and psychosocial variables in analytic models. Discussion. Findings indicate that greater perceptions of generativity are associated with more favorable trajectories of physical functioning and longevity over time in older adults.

Gustavson, K., E. Røysamb, et al. (2012). ***"Longitudinal associations between relationship problems, divorce, and life satisfaction: Findings from a 15-year population-based study."*** The Journal of Positive Psychology 7(3): 188-197. http://dx.doi.org/10.1080/17439760.2012.671346

Relationship problems are negatively associated with life satisfaction. Bottom-up theories assume that relationship quality affects life satisfaction while top-down theories assume that global personality dispositions affect evaluations of relationship quality. Only bottom-up theories imply that the negative association between relationship problems and life satisfaction will be removed when the relationship is ended and that divorce thus may be a positive event for persons from troubled relationships. In this study associations between relationship problems, divorce, and life satisfaction were examined among 369 heterosexual couples. Relationship problems predicted life satisfaction 15 years later in both men and women. This association was significantly stronger among not-divorced than among divorced couples. Among couples with severe relationship problems those who divorced had higher life satisfaction at 15-year follow-up than those who remained together while the reverse was true among less troubled couples. The findings thus support bottom-up theories of life satisfaction.

Harkness, K. L., R. M. Bagby, et al. (2012). ***"Childhood maltreatment and differential treatment response and recurrence in adult major depressive disorder."*** J Consult Clin Psychol 80(3): 342-353. http://www.ncbi.nlm.nih.gov/pubmed/22428942

OBJECTIVE: A substantial number of patients with major depressive disorder (MDD) do not respond to treatment, and recurrence rates remain high. The purpose of this study was to examine a history of severe childhood abuse as a moderator of response following a 16-week acute treatment trial, and of recurrence over a 12-month follow-up. METHOD: Participants included 203 adult outpatients with MDD (129 women; age 18-60). The design was a 16-week single-center randomized, open label trial of interpersonal psychotherapy, cognitive-behavioral therapy, or antidepressant medication, with a 12-month naturalistic follow-up, conducted at a university psychiatry center in Canada. The main outcome measure was Hamilton Depression Rating Scale scores at treatment end point. Childhood maltreatment was assessed at the completion of treatment using an interview-based contextual measure of childhood physical, sexual, and emotional abuse. Multiple imputation was adopted to estimate missing values. RESULTS: Patients with severe maltreatment were significantly less likely to respond to interpersonal psychotherapy than to cognitive-behavioral therapy or medication (OR = 3.61), whereas no differences among treatments were found in those with no history of maltreatment (ORs < 1.50). Furthermore, maltreatment significantly predicted a shorter time to recurrence over follow-up across treatment conditions (OR = 3.04). These findings were replicated in the sample with complete case data. CONCLUSIONS: Patients with a history of childhood abuse may benefit more from antidepressant medication or cognitive-behavioral therapy than from interpersonal psychotherapy. However, these patients remain vulnerable to recurrence regardless of treatment modality.

Kmietowicz, Z. (2012). ***"Increasing access to psychological therapies will cost nhs nothing, says report."*** BMJ 344. http://www.bmj.com/content/344/bmj.e4250

Provision of treatment for people with mental illness in England needs to expand urgently to "remedy a gross inequality" whereby people with physical symptoms are four times as likely to get treatment as people who have mental health problems, says a report from the London School of Economics and Political Science (LSE).1 Nearly half of all ill health among people under 65 is due to mental illness, yet only a quarter of them get treatment, says the report by the Mental Health Policy Group, a team of economists, psychologists, doctors, and NHS managers convened by the economics professor Richard Layard, programme director at the LSE's Centre for Economic Performance. Investing more money in treating mental illness would cost the NHS nothing because "the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy," says the report. Treating mental health effectively can also generate large amounts of money through employment and extra tax receipts, while the costs of treating children for conduct disorder are almost certainly repaid in full through savings in criminal justice, education, and social services. In addition, the costs of psychological therapy are low and recovery rates are high. After an average of 10 sessions half the people with anxiety conditions will recover, most of them permanently, and half the patients with depression will recover—success rates that are much higher than for many physical conditions. The report puts the blame for the disparity in access to treatment for people with mental illness squarely at the feet of local commissioners. As part of the national roll-out of the six year improved access to psychological therapy (IAPT) programme, launched by the Labour government in 2008, commissioners were given £400m (€500m; $630m) in their budgets for 2011-14, but many are not using it for this purpose. By 2014 this programme should be treating 900 000 people with depression and anxiety, with 50% recovering. The service, which will provide for only 15% of estimated need nationally, should expand beyond 2014 to cover people with long term conditions and medically unexplained symptoms, the report says. The young people's IAPT will also need to continue till 2017, it says. Layard said, "If local NHS commissioners want to improve their budgets, they should all be expanding their provision of psychological therapy. It will save them so much on their physical healthcare budgets that the net cost will be little or nothing." In its mental health strategy, launched in February 2011, the government promised to put mental health on an even footing with physical health.2 But the IAPT roll-out is not included in the NHS outcomes framework for 2012-13, says the report. This needs to be remedied, as does the inadequate number of psychiatrists. In addition, the NHS Commissioning Board needs to prioritise IAPT, as does Health Education England, the body that will lead the education and training of doctors from April 2013.3 Commenting on the report, Clare Gerada, chairwoman of the Royal College of General Practitioners, said, "We live in a stressful society, and the number of patients with mental health problems presenting to GPs is on an upward spiral. GPs face tremendous challenges in caring for patients with mental health problems in primary care, and we welcome any development which will help us improve their care. "Talking therapies have the potential to transform thousands of patients' lives, and we applaud Lord Layard and his team for their efforts to extend the programme further. This would be a major step forward, not only for patients but for GPs and other health professionals working in mental health."

Krusche, A., E. Cyhlarova, et al. (2012). ***"Mindfulness online: A preliminary evaluation of the feasibility of a web-based mindfulness course and the impact on stress."*** BMJ Open 2(3). http://bmjopen.bmj.com/content/2/3/e000803.full.pdf+html

(Free full text available) OBJECTIVES: Stress has been shown to have a number of negative effects on health over time. Mindfulness interventions have been shown to decrease perceived stress but access to interventions is limited. Therefore, the effectiveness of an online mindfulness course for perceived stress was investigated. DESIGN: A preliminary evaluation of an online mindfulness course. PARTICIPANTS: This sample consisted of 100 self-referrals to the online course. The average age of participants was 48 years and 74% were women. INTERVENTIONS: The online programme consisted of modules taken from Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy and lasted for approximately 6 weeks. PRIMARY AND SECONDARY OUTCOME MEASURES: Participants completed the Perceived Stress Scale (PSS) before the course, after the course and at 1-month follow-up. Completion of formal (eg, body scan, mindful movement) and informal (eg, mindful meal, noticing) mindfulness activities was self-reported each week. RESULTS: Participation in the online mindfulness course significantly reduced perceived stress upon completion and remained stable at follow-up. The pre-post effect size was equivalent

to levels found in other class-based mindfulness programmes. Furthermore, people who had higher PSS scores before the course reported engaging in significantly more mindfulness practice, which was in turn associated with greater decreases in PSS. CONCLUSIONS: Because perceived stress significantly decreased with such limited exposure to mindfulness, there are implications for the accessibility of mindfulness therapies online. Future research needs to evaluate other health outcomes for which face-to-face mindfulness therapies have been shown to help, such as anxiety and depressive symptoms.

Lekes, N., N. H. Hope, et al. (2012). ***"Influencing value priorities and increasing well-being: The effects of reflecting on intrinsic values."*** The Journal of Positive Psychology 7(3): 249-261. http://dx.doi.org/10.1080/17439760.2012.677468

A four-week experimental study (N=113) examined the effects of reflecting on intrinsic values. In the experimental group, participants learned about the distinction between intrinsic (e.g. having close relationships) and extrinsic (e.g. being popular) values, wrote about two personal intrinsic values, and then reflected on these values weekly for four weeks. In the control group, participants completed parallel exercises related to the daily details of their lives. Results revealed that participants in the intrinsic values group experienced greater well-being immediately following the written reflection than participants in the control group. Four weeks later, the more engaged participants felt in the reflection exercises, the more they prioritized intrinsic over extrinsic values and the greater their well-being. These effects occurred only for participants in the intrinsic values condition. The implications for changing value priorities and improving well-being are discussed.

Leung, J., C. Gartner, et al. (2012). ***"A longitudinal study of the bi-directional relationship between tobacco smoking and psychological distress in a community sample of young australian women."*** Psychological Medicine 42(06): 1273-1282. http://dx.doi.org/10.1017/S0033291711002261

Background Tobacco smoking and poor mental health are both prevalent and detrimental health problems in young women. The temporal relationship between the two variables is unclear. We investigated the prospective bi-directional relationship between smoking and mental health over 13 years. Method Participants were a randomly selected community sample of 10 012 young women with no experience of pregnancy, aged 18–23 years at baseline (1996) from the Australian Longitudinal Study on Women's Health. Follow-up surveys over 13 years were completed in 2000, 2003, 2006 and 2009, allowing for five waves of data. Measures included self-reported smoking and mental health measured by the Mental Health Index from the 36-item short-form health questionnaire and the 10-item Center for Epidemiologic Studies Depression Scale. Sociodemographic control variables included marital status, education level and employment status. Results A strong cross-sectional dose–response relationship between smoking and poor mental health was found at each wave [odds ratio (OR) 1.41, 95% confidence intervals (CI) 1.17–1.70 to OR 2.27, 95% CI 1.82–2.81]. Longitudinal results showed that women who smoked had 1.21 (95% CI 1.06–1.39) to 1.62 (95% CI 1.24–2.11) times higher odds of having poor mental health at subsequent waves. Women with poor mental health had 1.12 (95% CI 1.17–1.20) to 2.11 (95% CI 1.68–2.65) times higher odds of smoking at subsequent waves. These results held after adjusting for mental health history and smoking history and sociodemographic factors. Correlation analysis and structural equation modelling results were consistent in showing that both directions of the relationship were statistically significant. Conclusions The association between poor mental health and smoking in young women appeared to be bi-directional.

Manocha, R., D. Black, et al. (2012). ***"Quality of life and functional health status of long-term meditators."*** Evidence-Based Complementary and Alternative Medicine 2012: 9. http://dx.doi.org/10.1155/2012/350674

(Free full text available): Background. There is very little data describing the long-term health impacts of meditation. Aim. To compare the quality of life and functional health of long-term meditators to that of the normative population in Australia. Method. Using the SF-36 questionnaire and a Meditation Lifestyle Survey, we sampled 343 long-term Australian Sahaja Yoga meditation practitioners and compared their scores to those of the normative Australian population. Results. Six SF-36 subscales (bodily pain, general health, mental health, role limitation—emotional, social functioning, and vitality) were significantly better in meditators compared to the national norms whereas two of the subscales (role limitation—physical, physical functioning) were not significantly different. A substantial correlation between frequency of mental silence experience and the vitality, general health, and especially mental health subscales ($P<0.005$) was found. Conclusion. Long-term practitioners of Sahaja yoga meditation experience better functional health, especially mental health, compared to the general population. A relationship between functional health, especially mental health, and the frequency of meditative experience (mental silence) exists that may be causal. Evidence for the potential role of this definition of meditation in enhancing quality of life, functional health and wellbeing is growing. Implications for primary mental health prevention are discussed. *MedicalXpress - - comments "The experience of 'mental silence' is linked with better health outcomes and greater wellbeing according to a University of Sydney study. The area of greatest difference was in mental health, where long-term meditators, with a minimum of two years of regular practice, were more than 10 percent better off than the general population. "We found that the health and wellbeing profile of people who had meditated for at least two years was significantly higher in the majority of health and wellbeing categories when compared to the Australian population," said Dr Ramesh Manocha, Senior Lecturer in the Discipline of Psychiatry, Sydney Medical School, who led the research. He worked with Professor Deborah Black and Dr Leigh Wilson from the Faculty of Health Sciences. "Most markedly there was a robust relationship between the frequency of experiencing mental silence and better mental health. This definition is based on it being the form of meditation practised for centuries." The national study is a world-first health quality-of-life survey of long-term meditators. It used the same measurement instruments as the one used by the federal government's National Health and Wellbeing Survey. More than 350 people from across Australia who have meditated for at least two years were assessed for the national study which has been published in the journal of Evidence-Based Complementary and Alternative Medicine. "We focused on the definition of meditation as mental silence and surveyed practitioners of Sahaja Yoga meditation who practise a form of meditation aimed at achieving this state rather than relaxation or mindfulness methods that are usually the focus of other forms," Dr Manocha said. The meditators were asked how often they experienced 'mental silence' for more than a few minutes at any one time. Fifty-two percent of respondents said that they experienced mental silence "several times per day or more" while 32 percent were experiencing it "once or twice per day". "Our analysis showed very little relationship at all between how often the person who meditated physically sat down to meditate and mental health scores. However the relationship was clearly apparent in relation to how often they experienced the state of mental silence. "The health advantage appears to be connected to this aspect more than any other feature of the meditation lifestyle. In other words it is quality over quantity. "While we did expect that there would be some differences between the meditators and the general population we didn't expect the findings to be so pronounced. We repeated large components of the survey several times to confirm our results and got the same outcomes." The Australian government survey give a numerical score to each facet of mental and physical health and because it has been applied as a national measure for the past 10 years in studies around the world involving millions of people. It allowed the researchers to accurately compare the health profile of the meditators surveyed with the general Australian population. The meditators were primarily non-smokers and non-drinkers, so to adjust for that potential bias the researchers also compared the meditators to those parts of the Australian population who did not drink or smoke, and achieved the same results. "This is one of the first studies to assess the long term health impacts of*

meditation on health and wellbeing. When we take the evidence of this study, along with the results of our other clinical trials, it makes a strong case for the use of meditation as a primary prevention strategy, especially in mental health," Dr Manocha said."

Manrique-Garcia, E., S. Zammit, et al. (2012). ***"Cannabis, schizophrenia and other non-affective psychoses: 35 years of follow-up of a population-based cohort."*** Psychological Medicine 42(06): 1321-1328. http://dx.doi.org/10.1017/S0033291711002078

BackgroundThere is now strong evidence that cannabis use increases the risk of psychoses including schizophrenia, but the relationship between cannabis and different psychotic disorders, as well as the mechanisms, are poorly known. We aimed to assess types of psychotic outcomes after use of cannabis in adolescence and variation in risk over time.MethodA cohort of 50 087 military conscripts with data on cannabis use in late adolescence was followed up during 35 years with regard to in-patient care for psychotic diagnoses.ResultsOdds ratios for psychotic outcomes among frequent cannabis users compared with non-users were 3.7 [95% confidence interval (CI) 2.3–5.8] for schizophrenia, 2.2 (95% CI 1.0–4.7) for brief psychosis and 2.0 (95% CI 0.8–4.7) for other non-affective psychoses. Risk of schizophrenia declined over the decades in moderate users but much less so in frequent users. The presence of a brief psychosis did not increase risk of later schizophrenia more in cannabis users compared with non-users.ConclusionsOur results confirm an increased risk of schizophrenia in a long-term perspective, although the risk declined over time in moderate users.

Melrose, K. L., G. D. A. Brown, et al. (2012). ***"Am i abnormal? Relative rank and social norm effects in judgments of anxiety and depression symptom severity."*** Journal of Behavioral Decision Making: n/a-n/a. http://dx.doi.org/10.1002/bdm.1754

Overdetection and underdetection of depression and anxiety in primary care are common and may partly reflect individuals' misperceptions of the severity of symptoms they experience. Here, we explore how people's judgments about the severity of their own symptoms are influenced by their beliefs about the distribution of symptoms experienced by the rest of the population. We apply the rank-based decision by sampling cognitive model of judgment to symptom severity. The model proposes that judgments depend on the relative rank of an item within a mental sample of comparable items. It is predicted that judgments of symptom severity will be context dependent and more specifically that an individual's judgments will be invalid to the extent that the individual has inaccurate beliefs about the relevant social context. Two studies found that participants' assessments of symptom severity were rank based. Study 1 elicited participants' beliefs about the social distribution of symptoms and found that participants' judgments of whether they were depressed or anxious were mainly predicted not by their symptoms' objective severity but rather by where participants ranked the severity of their symptoms in comparison with the believed symptoms of others. Study 2 varied symptom distributions experimentally and again found relative rank effects as predicted. It is concluded that the real-world application of contextual models of judgment requires investigation of individual differences in participants' background beliefs. *MedicalXpress - http://medicalxpress.com/news/2012-05-people-depression-anxiety.html - comments "People's judgements about whether they are depressed depend on how they believe their own suffering "ranks" in relation to the suffering of friends and family and the wider world, according to a new study. Research from the Department of Psychology at the University of Warwick finds that people make inaccurate judgements about their depression and anxiety symptoms – potentially leading to missed diagnoses as well as false positive diagnoses of mental health problems. This is of particular concern as vulnerable individuals surrounded by people with mental health problems may decide not to seek help because, compared to those around them, they perceive their suffering to be less severe than it actually is. Conversely, those surrounded by people who feel depressed very rarely may incorrectly believe that their suffering is abnormal, simply because their symptoms appear to be more severe in comparison to others. Researchers performed two experiments which found that people's judgments of whether they were depressed or anxious were not mainly predicted by their symptoms' objective severity - but by where they ranked that severity compared with their perception of others' symptoms. The UK study showed that participants' beliefs about the distribution of symptoms in the wider population varied greatly. For example ten per cent of participants thought that half the population felt depressed on at least 15 days a month, and ten per cent thought they felt so on two days or fewer a month. Ten per cent of participants thought that half the population felt anxious on at least 26 days a month, whereas ten per cent thought they felt so on seven days or fewer. Lead researcher Karen Melrose from the University of Warwick said: "It is the patient that initiates most GP consultations about depression and anxiety, so that personal decision to see a doctor is a vital factor in determining a diagnosis. "Given that fact, our study may explain why there are such high rates of under and over-detection of depression and anxiety. "Worryingly, people who could be the most vulnerable to mental health disorders – for example those from certain geographical areas of the country or demographic groups where depression and anxiety are high – could be the very ones who are at highest risk of missed diagnoses. "This research could help health professionals better target information campaigns aimed at these groups."*

Mohr, D. C., J. Ho, et al. (2012). ***"Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: A randomized trial."*** JAMA 307(21): 2278-2285. http://dx.doi.org/10.1001/jama.2012.5588

(Free full text available) Context Primary care is the most common site for the treatment of depression. Most depressed patients prefer psychotherapy over antidepressant medications, but access barriers are believed to prevent engagement in and completion of treatment. The telephone has been investigated as a treatment delivery medium to overcome access barriers, but little is known about its efficacy compared with face-to-face treatment delivery. Objective To examine whether telephone-administered cognitive behavioral therapy (T-CBT) reduces attrition and is not inferior to face-to-face CBT in treating depression among primary care patients. Design, Setting, and Participants A randomized controlled trial of 325 Chicago-area primary care patients with major depressive disorder, recruited from November 2007 to December 2010.Interventions Eighteen sessions of T-CBT or face-to-face CBT. Main Outcome Measures The primary outcome was attrition (completion vs noncompletion) at posttreatment (week 18). Secondary outcomes included masked interviewer-rated depression with the Hamilton Depression Rating Scale (Ham-D) and self-reported depression with the Patient Health Questionnaire–9 (PHQ-9). Results Significantly fewer participants discontinued T-CBT (n = 34; 20.9%) compared with face-to-face CBT (n = 53; 32.7%; P = .02). Patients showed significant improvement in depression across both treatments (P < .001). There were no significant treatment differences at posttreatment between T-CBT and face-to-face CBT on the Ham-D (P = .22) or the PHQ-9 (P = .89). The intention-to-treat posttreatment effect size on the Ham-D was d = 0.14 (90% CI, −0.05 to 0.33), and for the PHQ-9 it was d = −0.02 (90% CI, −0.20 to 0.17). Both results were within the inferiority margin of d = 0.41, indicating that T-CBT was not inferior to face-to-face CBT. Although participants remained significantly less depressed at 6-month follow-up relative to baseline (P < .001), participants receiving face-to-face CBT were significantly less depressed than those receiving T-CBT on the Ham-D (difference, 2.91; 95% CI, 1.20-4.63; P < .001) and the PHQ-9 (difference, 2.12; 95% CI, 0.68-3.56; P = .004). Conclusions Among primary care patients with depression, providing CBT over the telephone compared with face-to-face resulted in lower attrition and close to equivalent improvement in depression at posttreatment. At 6-month follow-up, patients remained less depressed relative to baseline; however, those receiving face-to-face CBT were less depressed

than those receiving T-CBT. These results indicate that T-CBT improves adherence compared with face-to-face delivery, but at the cost of some increased risk of poorer maintenance of gains after treatment cessation.

Rush, A. J., S. R. Wisniewski, et al. (2012). ***"Is prior course of illness relevant to acute or longer-term outcomes in depressed out-patients? A star*d report."*** Psychological Medicine 42(06): 1131-1149. http://dx.doi.org/10.1017/S0033291711002170

Background Major depressive disorder (MDD) is commonly chronic and/or recurrent. We aimed to determine whether a chronic and/or recurrent course of MDD is associated with acute and longer-term MDD treatment outcomes. Method This cohort study recruited out-patients aged 18–75 years with non-psychotic MDD from 18 primary and 23 psychiatric care clinics across the USA. Participants were grouped as: chronic (index episode >2 years) and recurrent (n=398); chronic non-recurrent (n=257); non-chronic recurrent (n=1614); and non-chronic non-recurrent (n=387). Acute treatment was up to 14 weeks of citalopram (⩽60 mg/day) with up to 12 months of follow-up treatment. The primary outcomes for this report were remission [16-item Quick Inventory of Depressive Symptomatology – Self-Rated (QIDS-SR16) ⩽5] or response (⩾50% reduction from baseline in QIDS-SR16) and time to first relapse [first QIDS-SR16 by Interactive Voice Response (IVR) ⩾11]. Results Most participants (85%) had a chronic and/or recurrent course; 15% had both. Chronic index episode was associated with greater sociodemographic disadvantage. Recurrent course was associated with earlier age of onset and greater family histories of depression and substance abuse. Remission rates were lowest and slowest for those with chronic index episodes. For participants in remission entering follow-up, relapse was most likely for the chronic and recurrent group, and least likely for the non-chronic, non-recurrent group. For participants not in remission when entering follow-up, prior course was unrelated to relapse. Conclusions Recurrent MDD is the norm for out-patients, of whom 15% also have a chronic index episode. Chronic and recurrent course of MDD may be useful in predicting acute and long-term MDD treatment outcomes.

Ryan, A., J. D. Safran, et al. (2012). ***"Therapist mindfulness, alliance and treatment outcome."*** Psychotherapy Research 22(3): 289-297. http://dx.doi.org/10.1080/10503307.2011.650653

Abstract The present study investigated the association between therapist dispositional mindfulness and therapist self-affiliation, the therapeutic alliance, and treatment outcome. Total therapist mindfulness was associated with therapist self-affiliation, r=.413, p<.05. Therapist mindfulness was positively correlated with therapist ratings of the working alliance, r=.456, p<.05, though only the Act with Awareness subscale showed a relationship with patient rated alliance, r=.379. Therapist mindfulness was not associated with patient rated decreases in global symptomatology, but was associated with patient rated improvements in interpersonal functioning, r=.481, p<.05. All correlations correspond to a medium effect size. The results indicate that therapist dispositional mindfulness may be an important pre-treatment variable in psychotherapy outcome.

Schröder, A., E. Rehfeld, et al. (2012). ***"Cognitive–behavioural group treatment for a range of functional somatic syndromes: Randomised trial."*** The British Journal of Psychiatry 200(6): 499-507. http://bjp.rcpsych.org/content/200/6/499.abstract

Background: Many specialty-specific functional somatic syndrome diagnoses exist to describe people who are experiencing so-called medically unexplained symptoms. Although cognitive–behavioural therapy can be effective in the management of such syndromes, it is rarely available. A cognitive–behavioural therapy suitable for group treatment of people with different functional somatic syndromes could address this problem. Aims: To test the efficacy of a cognitive–behavioural therapy (Specialised Treatment for Severe Bodily Distress Syndromes, STreSS) designed for patients with a range of severe functional somatic syndromes. Method: A randomised controlled trial (clinicaltrials.gov, NCT00132197) compared STreSS (nine 3.5 h sessions over 4 months, n = 54) with enhanced usual care (management by primary care physician or medical specialist, n = 66). The primary outcome was improvement in aggregate score on subscales of the 36-item Short Form Health Survey (physical functioning, bodily pain and vitality) at 16 months. Results: Participants receiving STreSS had a greater improvement on the primary outcome (adjusted mean difference 4.0, 95% CI 1.4–6.6, P = 0.002) and on most secondary outcomes. Conclusions: In the management of functional somatic syndromes, a cognitive–behavioural group treatment was more effective than enhanced usual care.

Scott, K. M., K. A. McLaughlin, et al. (2012). ***"Childhood maltreatment and dsm-iv adult mental disorders: Comparison of prospective and retrospective findings."*** The British Journal of Psychiatry 200(6): 469-475. http://bjp.rcpsych.org/content/200/6/469.abstract

Background: Prior research reports stronger associations between childhood maltreatment and adult psychopathology when maltreatment is assessed retrospectively compared with prospectively, casting doubt on the mental health risk conferred by maltreatment and on the validity of retrospective reports.AimsTo investigate associations of psychopathology with prospective v. retrospective maltreatment ascertainment. Method: A nationally representative sample of respondents aged 16–27 years (n = 1413) in New Zealand completed a retrospective assessment of maltreatment and DSM-IV mental disorders. Survey data were linked with a national child protection database to identify respondents with maltreatment records (prospective ascertainment). Results: Childhood maltreatment was associated with elevated odds of mood, anxiety and drug disorders (odds ratios = 2.1–4.1), with no difference in association strength between prospective and retrospective groups. Prospectively ascertained maltreatment predicted unfavourable depression course involving early onset, chronicity and impairment. Conclusions: Prospectively and retrospectively assessed maltreatment elevated the risk of psychopathology to a similar degree. Prospectively ascertained maltreatment predicted a more unfavourable depression course.

Sedlmeier, P., J. Eberth, et al. (2012). ***"The psychological effects of meditation: A meta-analysis."*** Psychol Bull. http://www.ncbi.nlm.nih.gov/pubmed/22582738

In this meta-analysis, we give a comprehensive overview of the effects of meditation on psychological variables that can be extracted from empirical studies, concentrating on the effects of meditation on nonclinical groups of adult meditators. Mostly because of methodological problems, almost (3/4) of an initially identified 595 studies had to be excluded. Most studies appear to have been conducted without sufficient theoretical background. To put the results into perspective, we briefly summarize the major theoretical approaches from both East and West. The 163 studies that allowed the calculation of effect sizes exhibited medium average effects (r = .28 for all studies and r = .27 for the n = 125 studies from reviewed journals), which cannot be explained by mere relaxation or cognitive restructuring effects. In general, results were strongest (medium to large) for changes in emotionality and relationship issues, less strong (about medium) for measures of attention, and weakest (small to medium) for more cognitive measures. However, specific findings varied across different approaches to meditation (transcendental meditation, mindfulness meditation, and other meditation techniques). Surprisingly, meditation experience only partially covaried with long-term impact on the variables examined. In general, the dependent variables used cover only some of the content areas about which predictions can be made from already existing theories about meditation; still, such predictions

lack precision at present. We conclude that to arrive at a comprehensive understanding of why and how meditation works, emphasis should be placed on the development of more precise theories and measurement devices.

Tamir, D. I. and J. P. Mitchell (2012). ***"Disclosing information about the self is intrinsically rewarding."*** Proc Natl Acad Sci U S A 109(21): 8038-8043. http://www.ncbi.nlm.nih.gov/pubmed/22566617

Humans devote 30-40% of speech output solely to informing others of their own subjective experiences. What drives this propensity for disclosure? Here, we test recent theories that individuals place high subjective value on opportunities to communicate their thoughts and feelings to others and that doing so engages neural and cognitive mechanisms associated with reward. Five studies provided support for this hypothesis. Self-disclosure was strongly associated with increased activation in brain regions that form the mesolimbic dopamine system, including the nucleus accumbens and ventral tegmental area. Moreover, individuals were willing to forgo money to disclose about the self. Two additional studies demonstrated that these effects stemmed from the independent value that individuals placed on self-referential thought and on simply sharing information with others. Together, these findings suggest that the human tendency to convey information about personal experience may arise from the intrinsic value associated with self-disclosure. *MedicalXpress - http://medicalxpress.com/news/2012-05-people-brain-scans.html - comments "Got something to report about yourself? An opinion, perhaps, or a status update? Nobody may care except you, but new brain research suggests you can make yourself feel good simply by sharing. Participants who talked about themselves showed signs of activity in the areas of the brain that are linked to value and motivation, said Diana Tamir, lead author of a study published in this week's issue of the Proceedings of the National Academy of Sciences. "This helps to explain why people so obsessively engage in this behavior. It's because it provides them with some sort of subjective value: It feels good, basically," said Tamir, a graduate student in the Social Cognitive and Affective Neuroscience Lab at Harvard University. Indeed, the researchers found that the regions of the brain that are activated by talking about oneself are also responsible for the thrills of food, sex, money and drug addiction, Tamir said. The findings are more than a scientific curiosity, Tamir said, considering how much time people spend discussing themselves. By one estimate, 30 percent to 40 percent of your speech has to do with you. "Self-disclosure is a behavior that we do all of the time, day in and day out: When you talk to people, they'll often talk about themselves," Tamir said. "On Twitter and Facebook, people are primarily posting about what they're thinking and feeling in the moment. This is one piece of evidence about why we may do that." In the study, Tamir and a colleague conducted several experiments on subjects whose brains were scanned as they were told to do various things. In one experiment, 78 participants alternately disclosed their own opinions -- about things like whether they preferred coffee or tea -- and judged the opinions of others whose photographs they looked at. In another experiment, 117 people alternately talked about their personality traits (among other things, declaring whether they're "curious" or "ambitious") and those of the U.S. president at the time, either George W. Bush or Barack Obama. The researchers found that certain parts of the brain were more active when people talked about themselves. In terms of monetary value, participants valued being able to share a thought as being worth about a penny, Tamir said: "We like to call it a penny for your thoughts." So, why did evolution encourage humans to feel good when they talk about themselves? "We're doing some tests to see what larger role this behavior may play, whether people's motivation to self-disclose changes depending on their motivations to bond with someone," Tamir said. "Some studies show that the more you self-disclose to someone, the more you like them, the more they like you. It may have something to do with forming social bonds." Paul Zak, a brain researcher and founding director of the Center for Neuroeconomics Studies at Claremont Graduate University, said the findings are "very convincing" and offer insight into human evolution. "If a social creature did not disclose information, then other creatures might stop interacting with it," he said. "Animals do this with smells and movements, and humans do this with language. This study reveals how our brain evolved to motivate sociality, which is pretty cool."*

von Wolff, A., L. Holzel, et al. (2012). ***"Combination of pharmacotherapy and psychotherapy in the treatment of chronic depression: A systematic review and meta-analysis."*** BMC Psychiatry 12(1): 61. http://www.biomedcentral.com/1471-244X/12/61

BACKGROUND:Chronic depression represents a substantial portion of depressive disorders and is associated with severe consequences. This review examined whether the combination of pharmacological treatments and psychotherapy is associated with higher effectiveness than pharmacotherapy alone via meta-analysis; and identified possible treatment effect modifiers via meta-regression-analysis. METHODS:A systematic search was conducted in the following databases: Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, ISI Web of Science, BIOSIS, PsycINFO, and CINAHL. Primary efficacy outcome was a response to treatment; primary acceptance outcome was dropping out of the study. Only randomized controlled trials were considered. RESULTS:We identified 8 studies with a total of 9 relevant comparisons. Our analysis revealed small, but statistically not significant effects of combined therapies on outcomes directly related to depression (BR=1.20) with substantial heterogeneity between studies (I^2=67%). Three treatment effect modifiers were identified: target disorders, the type of psychotherapy and the type of pharmacotherapy. Small but statistically significant effects of combined therapies on quality of life (SMD=0.18) were revealed. No differences in acceptance rates and the long-term effects between combined treatments and pure pharmacological interventions were observed. CONCLUSIONS:This systematic review could not provide clear evidence for the combination of pharmacotherapy and psychotherapy. However, due to the small amount of primary studies further research is needed for a conclusive decision.

Werner-Seidler, A. and M. L. Moulds (2012). ***"Mood repair and processing mode in depression."*** Emotion 12(3): 470-478. http://www.ncbi.nlm.nih.gov/pubmed/22023367

Recalling positive autobiographical memories is a powerful emotion regulation strategy that can be used to repair low mood and alleviate negative affect. Unlike healthy individuals, those with current or past depression do not experience an improvement in mood as a consequence of recalling positive memories. We tested whether differences in processing mode might account for this impairment. Following mood induction procedures designed to ensure equivalence of mood state, depressed (n = 35) and recovered depressed (n = 33) participants were instructed to recall a positive memory and focus on it while adopting either an abstract or a concrete mode of processing. Participants in the abstract processing condition experienced no change in mood, while those in the concrete processing condition showed improved mood after memory recall. This research illustrates that the process by which positive autobiographical memories are recalled is important in determining their emotional impact and suggests that psychological interventions for depression may be improved by explicitly targeting processing mode.

Wiborg, J. F., H. Knoop, et al. (2012). ***"Therapist effects and the dissemination of cognitive behavior therapy for chronic fatigue syndrome in community-based mental health care."*** Behaviour Research and Therapy 50(6): 393-396. http://www.sciencedirect.com/science/article/pii/S0005796712000526

Objective The purpose of the present study was to explore the role of the therapist in the dissemination of manualized cognitive behavior therapy (CBT) for chronic fatigue syndrome (CFS) outside specialized treatment settings. Method We used the routinely collected outcome data of three community-based mental health care centers (MHCs) which implemented and sustained CBT for CFS during the course of the study. Ten therapists, who all received the same training in CBT for CFS, and

103 patients with CFS were included. Results Random effects modeling revealed a significant difference in mean post-treatment fatigue between therapists. The effect of the therapist accounted for 21% of the total variance in post-treatment fatigue in our sample. This effect could be explained by the therapists' attitude toward working with evidence-based treatment manuals as well as by the MHC where CBT for CFS was delivered. Conclusion The context in which CBT for CFS is delivered may play an important role in the accomplishment of established therapy effects outside specialized treatment settings. Due to the small sample size of MHCs and the different implementation scenarios in which they were engaged, our findings should be interpreted as preliminary results which are in need for replication.