30 babcp abstracts, july '12

(Afifi, Mota et al. 2012; Barrett, Hayney et al. 2012; Beidas, Edmunds et al. 2012; Car, Gurol-Urganci et al. 2012; Chen, Berger et al. 2012; Dunkley, Berg et al. 2012; Forman, Chapman et al. 2012; Hofmann, Asnaani et al. 2012; Inoue, Tanaka et al. 2012; Jakobsen, Hansen et al. 2012; Jazaieri, Goldin et al. 2012; Kelleher, Keeley et al. 2012; Laurens, Hobbs et al. 2012; Leander, Chartrand et al. 2012; Lewis 2012; Meuret, Wolitzky-Taylor et al. 2012; Meyer and Hautzinger 2012; Murray and Jones 2012; Peters, Williams et al. 2012; Rhebergen, Lamers et al. 2012; Richey, Keough et al. 2012; Rimer, Dwan et al. 2012; Santucci, McHugh et al. 2012; Sinclair 2012; Stel, Dijk et al. 2012; Swift and Greenberg 2012; Swift, Greenberg et al. 2012; Thompson and McCabe 2012; van der Horst and Coffé 2012; Watkins, Taylor et al. 2012)

Afifi, T. O., N. P. Mota, et al. (2012). ***"Physical punishment and mental disorders: Results from a nationally representative us sample."*** Pediatrics. http://pediatrics.aappublications.org/content/early/2012/06/27/peds.2011-2947.abstract

(Available in free full text) BACKGROUND: The use of physical punishment is controversial. Few studies have examined the relationship between physical punishment and a wide range of mental disorders in a nationally representative sample. The current research investigated the possible link between harsh physical punishment (ie, pushing, grabbing, shoving, slapping, hitting) in the absence of more severe child maltreatment (ie, physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, exposure to intimate partner violence) and Axis I and II mental disorders. METHODS: Data were from the National Epidemiologic Survey on Alcohol and Related Conditions collected between 2004 and 2005 (N = 34 653). The survey was conducted with a representative US adult population sample (aged ≥20 years). Statistical methods included logistic regression models and population-attributable fractions. RESULTS: Harsh physical punishment was associated with increased odds of mood disorders, anxiety disorders, alcohol and drug abuse/dependence, and several personality disorders after adjusting for sociodemographic variables and family history of dysfunction (adjusted odds ratio: 1.36–2.46). Approximately 2% to 5% of Axis I disorders and 4% to 7% of Axis II disorders were attributable to harsh physical punishment. CONCLUSIONS: Harsh physical punishment in the absence of child maltreatment is associated with mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders in a general population sample. These findings inform the ongoing debate around the use of physical punishment and provide evidence that harsh physical punishment independent of child maltreatment is related to mental disorders.

Barrett, B., M. S. Hayney, et al. (2012). ***"Meditation or exercise for preventing acute respiratory infection: A randomized controlled trial."*** The Annals of Family Medicine 10(4): 337-346. http://www.annfammed.org/content/10/4/337.abstract

PURPOSE This study was designed to evaluate potential preventive effects of meditation or exercise on incidence, duration, and severity of acute respiratory infection (ARI) illness. METHODS Community-recruited adults aged 50 years and older were randomized to 1 of 3 study groups: 8-week training in mindfulness meditation, matched 8-week training in moderate-intensity sustained exercise, or observational control. The primary outcome was area-under-the-curve global illness severity during a single cold and influenza season, using the Wisconsin Upper Respiratory Symptom Survey (WURSS-24) to assess severity. Health care visits and days of missed work were counted. Nasal wash collected during ARI illness was assayed for neutrophils, interleukin-8, and viral nucleic acid. RESULTS Of 154 adults randomized into the study, 149 completed the trial (82% female, 94% white, mean age 59.3 ± 6.6 years). There were 27 ARI episodes and 257 days of ARI illness in the meditation group (n = 51), 26 episodes and 241 illness days in the exercise group (n = 47), and 40 episodes and 453 days in the control group (n = 51). Mean global severity was 144 for meditation, 248 for exercise, and 358 for control. Compared with control, global severity was significantly lower for meditation (P = .004). Both global severity and total days of illness (duration) trended toward being lower for the exercise group (P=.16 and P=.032, respectively), as did illness duration for the meditation group (P=.034). Adjusting for covariates using zero-inflated multivariate regression models gave similar results. There were 67 ARI-related days of-work missed in the control group, 32 in the exercise group (P = .041), and 16 in the meditation group (P <.001). Health care visits did not differ significantly. Viruses were identified in 54% of samples from meditation, 42% from exercise, and 54% from control groups. Neutrophil count and interleukin-8 levels were similar among intervention groups. CONCLUSIONS Training in meditation or exercise may be effective in reducing ARI illness burden.

Beidas, R. S., J. M. Edmunds, et al. (2012). ***"Training and consultation to promote implementation of an empirically supported treatment: A randomized trial."*** Psychiatr Serv 63(7): 660-665. http://www.ncbi.nlm.nih.gov/pubmed/22549401

OBJECTIVE: The study evaluated the efficacy of three training modalities and the impact of ongoing consultation after training. Cognitive-behavioral therapy (CBT) for anxiety among youths, an empirically supported treatment, was used as the exemplar. Participants were randomly assigned to one of three one-day workshops to examine the efficacy of training modality: routine training (training as usual), computer training (computerized version of training as usual), and augmented training (training that emphasized active learning). After training, all participants received three months of ongoing consultation that included case consultation, didactics, and problem solving. METHODS: Participants were 115 community therapists (mean age of 35.9 years; 90% were women). Outcome measures included the Adherence and Skill Checklist, used to rate a performance-based role-play; a knowledge test; and the Training Satisfaction Rating Scale. RESULTS: All three training modalities resulted in limited gains in therapist adherence, skill, and knowledge. There was no significant effect of modality on adherence, skill, or knowledge from pretraining to posttraining. Participants were more satisfied with augmented and routine training than with computer training. Most important, number of consultation hours after training significantly predicted higher therapist adherence and skill at the three-month follow-up. CONCLUSIONS: The findings suggest that training alone did not result in therapist behavior change. The inclusion of ongoing consultation was critical to influencing therapist adherence and skill. Implications for implementation science and mental health services research are discussed.

Car, J., I. Gurol-Urganci, et al. (2012). ***"Mobile phone messaging reminders for attendance at healthcare appointments."*** Cochrane Database Syst Rev 7: CD007458. http://www.ncbi.nlm.nih.gov/pubmed/22786507

BACKGROUND: Missed appointments are a major cause of inefficiency in healthcare delivery, with substantial monetary costs for the health system, leading to delays in diagnosis and appropriate treatment. Patients' forgetfulness is one of the main reasons for missed appointments, and reminders may help alleviate this problem. Modes of communicating reminders for appointments to patients include face-to-face communication, postal messages, calls to landlines or mobile phones, and mobile phone messaging. Mobile phone messaging applications such as Short Message Service (SMS) and Multimedia Message Service (MMS) could provide an important, inexpensive delivery medium for reminders for healthcare appointments. OBJECTIVES: To assess the effects of mobile phone messaging reminders for attendance at healthcare appointments. Secondary objectives include assessment of patients' and healthcare providers' evaluation of the intervention; costs; and possible risks and harms

associated with the intervention. SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (CENTRAL,The Cochrane Library 2009, Issue 2), MEDLINE (OvidSP) (January 1993 to June 2009), EMBASE (OvidSP) (January 1993 to June 2009), PsycINFO (OvidSP) (January 1993 to June 2009), CINAHL (EbscoHOST) (January 1993 to June 2009), LILACS (January 1993 to June 2009) and African Health Anthology (January 1993 to June 2009). We also reviewed grey literature (including trial registers) and reference lists of articles. SELECTION CRITERIA: We included randomised controlled trials (RCTs), quasi-randomised controlled trials (QRCTs), controlled before-after (CBA) studies, or interrupted time series (ITS) studies with at least three time points before and after the intervention. We included studies assessing mobile phone messaging as reminders for healthcare appointments. We only included studies in which it was possible to assess effects of mobile phone messaging independent of other technologies or interventions. DATA COLLECTION AND ANALYSIS: Two review authors independently assessed all studies against the inclusion criteria, with any disagreements resolved by a third review author. Study design features, characteristics of target populations, interventions and controls, and results data were extracted by two review authors and confirmed by a third author. Primary outcomes of interest were rate of attendance at healthcare appointments. We also considered health outcomes as a result of the intervention, patients' and providers' evaluation of the intervention, perceptions of safety, costs, and potential harms or adverse effects. As the intervention characteristics and outcome measures were similar across included studies, we conducted a meta-analysis to estimate an overall effect size. MAIN RESULTS: We included four randomised controlled trials involving 3547 participants. Three studies with moderate quality evidence showed that mobile text message reminders improved the rate of attendance at healthcare appointments compared to no reminders (risk ratio (RR) 1.10 (95% confidence interval (CI) 1.03 to 1.17)). One low quality study reported that mobile text message reminders with postal reminders, compared to postal reminders, improved rate of attendance at healthcare appointments (RR 1.10 (95% CI 1.02 to 1.19)). However, two studies with moderate quality of evidence showed that mobile phone text message reminders and phone call reminders had a similar impact on healthcare attendance (RR 0.99 (95% CI 0.95 to 1.03). The costs per attendance of mobile phone text message reminders were shown to be lower compared to phone call reminders. None of the included studies reported outcomes related to harms or adverse effects of the intervention, nor health outcomes or user perception of safety related to the intervention. AUTHORS' CONCLUSIONS: There is moderate quality evidence that mobile phone text message reminders are more effective than no reminders, and low quality evidence that text message reminders with postal reminders are more effective than postal reminders alone. Further, according to the moderate quality evidence we found, mobile phone text message reminders are as effective as phone call reminders. Overall, there is limited evidence on the effects of mobile phone text message reminders for appointment attendance, and further high-quality research is required to draw more robust conclusions.

Chen, K. W., C. C. Berger, et al. (2012). ***"Meditative therapies for reducing anxiety: A systematic review and meta-analysis of randomized controlled trials."*** Depress Anxiety 29(7): 545-562. http://www.ncbi.nlm.nih.gov/pubmed/22700446

BACKGROUND: Anxiety disorders are among the most common psychiatric disorders and meditative therapies are frequently sought by patients with anxiety as a complementary therapy. Although multiple reviews exist on the general health benefits of meditation, no review has focused on the efficacy of meditation for anxiety specifically. METHODS: Major medical databases were searched thoroughly with keywords related to various types of meditation and anxiety. Over 1,000 abstracts were screened, and 200+ full articles were reviewed. Only randomized controlled trials (RCTs) were included. The Boutron (Boutron et al., 2005: J Clin Epidemiol 58:1233-1240) checklist to evaluate a report of a nonpharmaceutical trial (CLEAR-NPT) was used to assess study quality; 90% of the authors were contacted for additional information. Review Manager 5 was used for meta-analysis. RESULTS: A total of 36 RCTs were included in the meta-analysis (2,466 observations). Most RCTs were conducted among patients with anxiety as a secondary concern. The study quality ranged from 0.3 to 1.0 on the 0.0-1.0 scale (mean = 0.72). Standardized mean difference (SMD) was -0.52 in comparison with waiting-list control ($p < .001$; 25 RCTs), -0.59 in comparison with attention control ($p < .001$; seven RCTs), and -0.27 in comparison with alternative treatments ($p < .01$; 10 RCTs). Twenty-five studies reported statistically superior outcomes in the meditation group compared to control. No adverse effects were reported. CONCLUSIONS: This review demonstrates some efficacy of meditative therapies in reducing anxiety symptoms, which has important clinical implications for applying meditative techniques in treating anxiety. However, most studies measured only improvement in anxiety symptoms, but not anxiety disorders as clinically diagnosed.

Dunkley, D. M., J.-L. Berg, et al. (2012). ***"The role of perfectionism in daily self-esteem, attachment, and negative affect."*** Journal of Personality 80(3): 633-663. http://dx.doi.org/10.1111/j.1467-6494.2011.00741.x

This study of university students (64 men, 99 women) examined the role of self-critical (SC) and personal standards (PS) higher order dimensions of perfectionism in daily self-esteem, attachment, and negative affect. Participants completed questionnaires at the end of the day for 7 consecutive days. Trait and situational influences were found in the daily reports of self-esteem, attachment, and affect. In contrast to PS perfectionism, SC perfectionism was strongly related to aggregated daily reports of low self-esteem, attachment fears (fear of closeness, fear of dependency, fear of loss), and negative affect as well as instability indexes of daily self-esteem, attachment, and negative affect. Multilevel modeling indicated that both SC and PS perfectionists were emotionally reactive to decreases in self-esteem, whereas only SC perfectionists were emotionally reactive to increases in fear of closeness with others. These results demonstrate the dispositional and moderating influences of perfectionism dimensions on daily self-esteem, attachment, and negative affect.

Forman, E. M., J. E. Chapman, et al. (2012). ***"Using session-by-session measurement to compare mechanisms of action for acceptance and commitment therapy and cognitive therapy."*** Behavior Therapy 43(2): 341-354. http://www.sciencedirect.com/science/article/pii/S0005789411001122

Debate continues about the extent to which postulated mechanisms of action of cognitive behavior therapies (CBT), including standard CBT (i.e., Beckian cognitive therapy [CT]) and acceptance and commitment therapy (ACT) are supported by mediational analyses. Moreover, the distinctiveness of CT and ACT has been called into question. One contributor to ongoing uncertainty in this arena is the lack of time-varying process data. In this study, 174 patients presenting to a university clinic with anxiety or depression who had been randomly assigned to receive either ACT or CT completed an assessment of theorized mediators and outcomes before each session. Hierarchical linear modeling of session-by-session data revealed that increased utilization of cognitive and affective change strategies relative to utilization of psychological acceptance strategies mediated outcome for CT, whereas for ACT the mediation effect was in the opposite direction. Decreases in self-reported dysfunctional thinking, cognitive "defusion" (the ability to see one's thoughts as mental events rather than necessarily as representations of reality), and willingness to engage in behavioral activity despite unpleasant thoughts or emotions were equivalent mediators across treatments. These results have potential implications for the theoretical arguments behind, and distinctiveness of, CT and ACT.

Hofmann, S., A. Asnaani, et al. (2012). ***"The efficacy of cognitive behavioral therapy: A review of meta-analyses."*** Cognitive Therapy and Research: 1-14. http://dx.doi.org/10.1007/s10608-012-9476-1

Cognitive behavioral therapy (CBT) refers to a popular therapeutic approach that has been applied to a variety of problems. The goal of this review was to provide a comprehensive survey of meta-analyses examining the efficacy of CBT. We identified 269 meta-analytic studies and reviewed of those a representative sample of 106 meta-analyses examining CBT for the following problems: substance use disorder, schizophrenia and other psychotic disorders, depression and dysthymia, bipolar disorder, anxiety disorders, somatoform disorders, eating disorders, insomnia, personality disorders, anger and aggression, criminal behaviors, general stress, distress due to general medical conditions, chronic pain and fatigue, distress related to pregnancy complications and female hormonal conditions. Additional meta-analytic reviews examined the efficacy of CBT for various problems in children and elderly adults. The strongest support exists for CBT of anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress. Eleven studies compared response rates between CBT and other treatments or control conditions. CBT showed higher response rates than the comparison conditions in seven of these reviews and only one review reported that CBT had lower response rates than comparison treatments. In general, the evidence-base of CBT is very strong. However, additional research is needed to examine the efficacy of CBT for randomized-controlled studies. Moreover, except for children and elderly populations, no meta-analytic studies of CBT have been reported on specific subgroups, such as ethnic minorities and low income samples.

Inoue, T., T. Tanaka, et al. (2012). ***"Utility and limitations of PHQ-9 in a clinic specializing in psychiatric care."*** BMC Psychiatry 12(1): 73. http://www.biomedcentral.com/1471-244X/12/73

(Free full text available) BACKGROUND:The Patient Health Questionnaire-9 (PHQ-9), despite its excellent reliability and validity in primary care, has not been examined for administration to psychiatric patients. This study assesses the accuracy of PHQ-9 in screening for major depressive episode and in diagnosing major depressive episode in patients of a psychiatric specialty clinic.METHODS:We compared operational characteristics of PHQ-9 as a screening and diagnostic instrument to DSM-IV-TR diagnosis by a trained psychiatrist as a reference standard. The reference criteria were "current major depressive episode" or "current major depressive episode with major depressive disorder". PHQ-9 was used with two thresholds: diagnostic algorithm and summary scores (PHQ-9[greater than or equal to]10). The optimal cut-off points of PHQ-9 summary scores were analyzed using a receiver operational characteristics (ROC) curve.RESULTS:For "current major depressive episode", PHQ-9 showed high sensitivity and high negative predictive value at both thresholds, but its specificity and positive predictive value were low. For "current major depressive episode with major depressive disorder", PHQ-9 also showed high sensitivity and high negative predictive value at both thresholds, but the positive predictive value decreased more than that for "current major depressive episode". The ROC analysis showed the optimal cut-off score of 13/14 for "current major depressive episode".CONCLUSIONS:PHQ-9 is useful for screening, but not for diagnosis of "current major depressive episode" in a psychiatric specialty clinic.

Jakobsen, J. C., J. L. Hansen, et al. (2012). ***"Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: A systematic review of randomized clinical trials with meta-analyses and trial sequential analyses."*** Psychological Medicine 42(07): 1343-1357. http://dx.doi.org/10.1017/S0033291711002236

Background Major depressive disorder afflicts an estimated 17% of individuals during their lifetime at tremendous suffering and cost. Cognitive therapy and interpersonal psychotherapy are treatment options, but their effects have only been limitedly compared in systematic reviews. Method Using Cochrane systematic review methodology we compared the benefits and harm of cognitive therapy versus interpersonal psychotherapy for major depressive disorder. Trials were identified by searching the Cochrane Library's CENTRAL, Medline via PubMed, EMBASE, Psychlit, PsycInfo, and Science Citation Index Expanded until February 2010. Continuous outcome measures were assessed by mean difference and dichotomous outcomes by odds ratio. We conducted trial sequential analysis to control for random errors. Results We included seven trials randomizing 741 participants. All trials had high risk of bias. Meta-analysis of the four trials reporting data at cessation of treatment on the Hamilton Rating Scale for Depression showed no significant difference between the two interventions [mean difference −1.02, 95% confidence interval (CI) −2.35 to 0.32]. Meta-analysis of the five trials reporting data at cessation of treatment on the Beck Depression Inventory showed comparable results (mean difference −1.29, 95% CI −2.73 to 0.14). Trial sequential analysis indicated that more data are needed to definitively settle the question of a differential effect. None of the included trial reported on adverse events. Conclusions Randomized trials with low risk of bias and low risk of random errors are needed, although the effects of cognitive therapy and interpersonal psychotherapy do not seem to differ significantly regarding depressive symptoms. Future trials should report on adverse events.

Jazaieri, H., P. R. Goldin, et al. (2012). ***"A randomized trial of MBSR versus aerobic exercise for social anxiety disorder."*** Journal of Clinical Psychology 68(7): 715-731. http://dx.doi.org/10.1002/jclp.21863

Objective Effective treatments for social anxiety disorder (SAD) exist, but additional treatment options are needed for nonresponders as well as those who are either unable or unwilling to engage in traditional treatments. Mindfulness-based stress reduction (MBSR) is one nontraditional treatment that has demonstrated efficacy in treating other mood and anxiety disorders, and preliminary data suggest its efficacy in SAD as well. Method Fifty-six adults (52% female; 41% Caucasian; age mean [M] ± standard deviation [SD]: 32.8 ± 8.4) with SAD were randomized to MBSR or an active comparison condition, aerobic exercise (AE). At baseline and post-intervention, participants completed measures of clinical symptoms (Liebowitz Social Anxiety Scale, Social Interaction Anxiety Scale, Beck Depression Inventory-II, and Perceived Stress Scale) and subjective well-being (Rosenberg Self-Esteem Scale, Satisfaction with Life Scale, Self-Compassion Scale, and UCLA-8 Loneliness Scale). At 3 months post-intervention, a subset of these measures was readministered. For clinical significance analyses, 48 healthy adults (52.1% female; 56.3% Caucasian; age [M ± SD]: 33.9 ± 9.8) were recruited. MBSR and AE participants were also compared with a separate untreated group of 29 adults (44.8% female; 48.3% Caucasian; age [M ± SD]: 32.3 ± 9.4) with generalized SAD who completed assessments over a comparable time period with no intervening treatment. Results A 2 (Group) x 2 (Time) repeated measures analyses of variance (ANOVAs) on measures of clinical symptoms and well-being were conducted to examine pre-intervention to post-intervention and pre-intervention to 3-month follow-up. Both MBSR and AE were associated with reductions in social anxiety and depression and increases in subjective well-being, both immediately post-intervention and at 3 months post-intervention. When participants in the randomized controlled trial were compared with the untreated SAD group, participants in both interventions exhibited improvements on measures of clinical symptoms and well-being. Conclusion Nontraditional interventions such as MBSR and AE merit further exploration as alternative or complementary treatments for SAD.

Kelleher, I., H. Keeley, et al. (2012). ***"Clinicopathological significance of psychotic experiences in non-psychotic young people: Evidence from four population-based studies."*** The British Journal of Psychiatry 201(1): 26-32. http://bjp.rcpsych.org/content/201/1/26.abstract

Background Epidemiological research has shown that hallucinations and delusions, the classic symptoms of psychosis, are far more prevalent in the population than actual psychotic disorder. These symptoms are especially prevalent in childhood and adolescence. Longitudinal research has demonstrated that psychotic symptoms in adolescence increase the risk of psychotic

disorder in adulthood. There has been a lack of research, however, on the immediate clinicopathological significance of psychotic symptoms in adolescence. Aims To investigate the relationship between psychotic symptoms and non-psychotic psychopathology in community samples of adolescents in terms of prevalence, co-occurring disorders, comorbid (multiple) psychopathology and variation across early v. middle adolescence. Method Data from four population studies were used: two early adolescence studies (ages 11–13 years) and two mid-adolescence studies (ages 13–16 years). Studies 1 and 2 involved school-based surveys of 2243 children aged 11–16 years for psychotic symptoms and for emotional and behavioural symptoms of psychopathology. Studies 3 and 4 involved in-depth diagnostic interview assessments of psychotic symptoms and lifetime psychiatric disorders in community samples of 423 children aged 11–15 years. Results Younger adolescents had a higher prevalence (21–23%) of psychotic symptoms than older adolescents (7%). In both age groups the majority of adolescents who reported psychotic symptoms had at least one diagnosable non-psychotic psychiatric disorder, although associations with psychopathology increased with age: nearly 80% of the mid-adolescence sample who reported psychotic symptoms had at least one diagnosis, compared with 57% of the early adolescence sample. Adolescents who reported psychotic symptoms were at particularly high risk of having multiple co-occurring diagnoses. Conclusions Psychotic symptoms are important risk markers for a wide range of non-psychotic psychopathological disorders, in particular for severe psychopathology characterised by multiple co-occurring diagnoses. These symptoms should be carefully assessed in all patients.

Laurens, K. R., M. J. Hobbs, et al. (2012). ***"Psychotic-like experiences in a community sample of 8000 children aged 9 to 11 years: An item response theory analysis."*** Psychological Medicine 42(07): 1495-1506. http://dx.doi.org/10.1017/S0033291711002108

Background Psychotic-like experiences (PLEs) in the general population are common, particularly in childhood, and may constitute part of a spectrum of normative development. Nevertheless, these experiences confer increased risk for later psychotic disorder, and are associated with poorer health and quality of life. Method This study used factor analytic methods to determine the latent structure underlying PLEs, problem behaviours and personal competencies in the general child population, and used item response theory (IRT) to assess the psychometric properties of nine PLE items to determine which items best represented a latent psychotic-like construct (PSY). A total of 7966 children aged 9–11 years, constituting 95% of eligible children, completed self-report questionnaires. Results Almost two-thirds of the children endorsed at least one PLE item. Structural analyses identified a unidimensional construct representing psychotic-like severity in the population, the full range of which was well sampled by the nine items. This construct was discriminable from (though correlated with) latent dimensions representing internalizing and externalizing problems. Items assessing visual and auditory hallucination-like experiences provided the most information about PSY; delusion-like experiences identified children at more severe levels of the construct. Conclusions Assessing PLEs during middle childhood is feasible and supplements information concerning internalizing and externalizing problems presented by children. The hallucination-like experiences constitute appropriate items to screen the population to identify children who may require further clinical assessment or monitoring. Longitudinal follow-up of the children is required to determine sensitivity and specificity of the PLE items for later psychotic illness.

Leander, N. P., T. L. Chartrand, et al. (2012). ***"You give me the chills."*** Psychological Science 23(7): 772-779. http://pss.sagepub.com/content/23/7/772.abstract

In the research reported here, we investigated how suspicious nonverbal cues from other people can trigger feelings of physical coldness. There exist implicit standards for how much nonverbal behavioral mimicry is appropriate in various types of social interactions, and individuals may react negatively when interaction partners violate these standards. One such reaction may be feelings of physical coldness. Participants in three studies either were or were not mimicked by an experimenter in various social contexts. In Study 1, participants who interacted with an affiliative experimenter reported feeling colder if they were not mimicked than if they were, and participants who interacted with a task-oriented experimenter reported feeling colder if they were mimicked than if they were not. Studies 2 and 3 demonstrated that it was not the amount of mimicry per se that moderated felt coldness; rather, felt coldness was moderated by the inappropriateness of the mimicry given implicit standards set by individual differences (Study 2) and racial differences (Study 3). Implications for everyday subjective experience are discussed.

Lewis, G. (2012). ***"Exercise & depression: Authors' reply to Davies and colleagues, Donnelly, and Pilling and Anderson."*** BMJ 345. http://www.bmj.com/content/345/bmj.e4500

Our study compared a physical activity intervention plus usual care with usual care alone. The intervention did not improve depressive symptoms compared with usual care. As many correspondents have stated, we did not evaluate "exercise" or even "physical activity" but the effect of our intervention on depression. The headline that "exercise is no help for depression" clearly goes beyond our findings and is not the conclusion given in our paper. But we recognise that statements on the press release and in interviews might have led to different conclusions. We can conclude that our intervention should not be adopted for treating depression. We also think that advice to be physically active is unlikely to improve depressive symptoms because our more intensive facilitated intervention was ineffective. However, our intervention that encouraged choice and autonomy led to a sustained increase in self reported physical activity. Being given advice to be physically active is not the same as following that advice. Many people report that physical activity can improve their mood and a randomised controlled study provides an "average effect." We still do not know if physical activity of the "right" intensity, duration, or frequency might benefit depression. Neither do we know whether certain subgroups would benefit, or who they might be. We also found no evidence of greater effectiveness in the less severe forms of depression mentioned by the National Institute for Health and Clinical Excellence guidelines. Commentators have been interested in a range of questions, only one of which our study dealt with. For those confused by the headlines, please read our paper. There are many outstanding questions about the possible therapeutic role of physical activity in depression. However, our results are clear cut. Giving advice to be more physically active, even with the support of a facilitator, did not improve depressive symptoms.

Meuret, A. E., K. B. Wolitzky-Taylor, et al. (2012). ***"Coping skills and exposure therapy in panic disorder and agoraphobia: Latest advances and future directions."*** Behavior Therapy 43(2): 271-284. http://www.sciencedirect.com/science/article/pii/S0005789411001158

Although cognitive-behavioral treatments for panic disorder have demonstrated efficacy, a considerable number of patients terminate treatment prematurely or remain symtpomatic. Cognitive and biobehavioral coping skills are taught to improve exposure therapy outcomes but evidence for an additive effect is largely lacking. Current methodologies used to study the augmenting effects of coping skills test the degree to which the delivery of coping skills enhances outcomes. However, they do not assess the degree to which acquisition of coping skills and their application during exposure therapy augment outcomes. We examine the extant evidence on the role of traditional coping skills in augmenting exposure for panic disorder, discuss the limitations of existing research, and offer recommendations for methodological advances.

Meyer, T. D. and M. Hautzinger (2012). ***"Cognitive behaviour therapy and supportive therapy for bipolar disorders: Relapse rates for treatment period and 2-year follow-up."*** Psychological Medicine 42(07): 1429-1439. http://dx.doi.org/10.1017/S0033291711002522

Background The efficacy of adjunctive psychosocial interventions such as cognitive behaviour therapy (CBT) for bipolar disorder (BD) has been demonstrated in several uncontrolled and controlled studies. However, these studies compared CBT to either a waiting list control group, brief psycho-education or treatment as usual (TAU). Our primary aim was to determine whether CBT is superior to supportive therapy (ST) of equal intensity and frequency in preventing relapse and improving outcome at post-treatment. A secondary aim was to look at predictors of survival time. Method We conducted a randomized controlled trial (RCT) at the Department of Psychology, University of Tübingen, Germany (n=76 patients with BD). Both CBT and ST consisted of 20 sessions over 9 months. Patients were followed up for a further 24 months. Results Although changes over time were observed in some variables, they were not differentially associated with CBT or ST. CBT showed a non-significant trend for preventing any affective, specifically depressive episode during the time of therapy. Kaplan–Meier survival analyses revealed that 64.5% of patients experienced a relapse during the 33 months. The number of prior episodes, the number of therapy sessions and the type of BD predicted survival time.ConclusionsNo differences in relapse rates between treatment conditions were observed, suggesting that certain shared characteristics (e.g. information, systematic mood monitoring) might explain the effects of psychosocial treatment for BD. Our results also suggest that a higher number of prior episodes, a lower number of therapy sessions and a diagnosis of bipolar II disorder are associated with a shorter time before relapse.

Murray, G. K. and P. B. Jones (2012). ***"Psychotic symptoms in young people without psychotic illness: Mechanisms and meaning."*** The British Journal of Psychiatry 201(1): 4-6. http://bjp.rcpsych.org/content/201/1/4.abstract

Psychotic symptoms are common in the general population. There is evidence for common mechanisms underlying such symptoms in health and illness (such as the functional role of mesocorticostriatal circuitry in error-dependent learning) and differentiating factors (relating to non-psychotic features of psychotic illness and to social and emotional aspects of psychotic symptoms). Clinicians should be aware that psychotic symptoms in young people are more often associated with common mental disorders such as depression and anxiety than with severe psychotic illness.

Peters, E. R., S. L. Williams, et al. (2012). ***"It's not what you hear, it's the way you think about it: Appraisals as determinants of affect and behaviour in voice hearers."*** Psychological Medicine 42(07): 1507-1514. http://dx.doi.org/10.1017/S0033291711002650

Background Previous studies have suggested that beliefs about voices mediate the relationship between actual voice experience and behavioural and affective response. Method We investigated beliefs about voice power (omnipotence), voice intent (malevolence/benevolence) and emotional and behavioural response (resistance/engagement) using the Beliefs About Voices Questionnaire – Revised (BAVQ-R) in 46 voice hearers. Distress was assessed using a wide range of measures: voice-related distress, depression, anxiety, self-esteem and suicidal ideation. Voice topography was assessed using measures of voice severity, frequency and intensity. We predicted that beliefs about voices would show a stronger association with distress than voice topography. Results Omnipotence had the strongest associations with all measures of distress included in the study whereas malevolence was related to resistance, and benevolence to engagement. As predicted, voice severity, frequency and intensity were not related to distress once beliefs were accounted for. Conclusions These results concur with previous findings that beliefs about voice power are key determinants of distress in voice hearers, and should be targeted specifically in psychological interventions.

Rhebergen, D., F. Lamers, et al. (2012). ***"Course trajectories of unipolar depressive disorders identified by latent class growth analysis."*** Psychological Medicine 42(07): 1383-1396. http://dx.doi.org/10.1017/S0033291711002509

Background Current classification of unipolar depression reflects the idea that prognosis is essential. However, do DSM categories of major depressive disorder (MDD), dysthymic disorder (Dysth) and double depression (DD=MDD+Dysth) indeed adequately represent clinically relevant course trajectories of unipolar depression? Our aim was to test DSM categories (MDD, Dysth and DD) in comparison with empirically derived prognostic categories, using a prospectively followed cohort of depressed patients. Method A large sample (n=804) of out-patients with unipolar depression were derived from a prospective cohort study, the Netherlands Study of Depression and Anxiety (NESDA). Using latent class growth analysis (LCGA), empirically derived 2-year course trajectories were constructed. These were compared with DSM diagnoses and a wider set of putative predictors for class membership. Results Five course trajectories were identified, ranging from mild severity and rapid remission to high severity and chronic course trajectory. Contrary to expectations, more than 50% of Dysth and DD were allocated to classes with favorable course trajectories, suggesting that current DSM categories do not adequately represent course trajectories. The class with the most favorable course trajectory differed on several characteristics from other classes (younger age, more females, less childhood adversity, less somatic illnesses, lower neuroticism, higher extraversion). Older age, earlier age of onset and lower extraversion predicted poorest course trajectory. Conclusions MDD, Dysth and DD did not adequately match empirically derived course trajectories for unipolar depression. For the future classification of unipolar depression, it may be wise to retain the larger, heterogeneous category of unipolar depression, adopting cross-cutting dimensions of severity and duration to further characterize patients.

Richey, J. A., M. E. Keough, et al. (2012). ***"Attentional control moderates fearful responding to a 35% co2 challenge."*** Behavior Therapy 43(2): 285-299. http://www.sciencedirect.com/science/article/pii/S0005789411001067

Attentional control (AC) is an individual difference variable indexing the ability to voluntarily focus attention and shift attention when desired. AC is thought to impact the experience of fear by facilitating the disengagement of attention from threat and promoting the deployment of attentional resources toward regulatory or coping strategies. Whereas previous research has focused on visual threat cues, in the current study we examined whether this model also applies to interoceptive threat by evaluating the extent to which individual differences in AC moderated the relationship between trait anxiety and self-reported fear in response to a single vital capacity inhalation of a 35% CO2, 65% balanced O2 gas mixture. The sample comprised a large nonclinical group of young adults (N = 128). Results indicated that AC moderated the relationship between trait anxiety and fearful responding to the challenge. Findings suggest that AC plays a significant and clinically important role in modulating self-reported fear.

Rimer, J., K. Dwan, et al. (2012). ***"Exercise for depression."*** Cochrane Database Syst Rev 7: CD004366. http://www.ncbi.nlm.nih.gov/pubmed/22786489

BACKGROUND: Depression is a common and important cause of morbidity and mortality worldwide. Depression is commonly treated with antidepressants and/or psychotherapy, but some people may prefer alternative approaches such as exercise. There are a number of theoretical reasons why exercise may improve depression. This is an update of an earlier review first published in 2009. OBJECTIVES: To determine the effectiveness of exercise in the treatment of depression. Our secondary outcomes included drop-outs from exercise and control groups, costs, quality of life and adverse events. SEARCH METHODS: We

searched the Cochrane Depression, Anxiety and Neurosis (CCDAN) Review Group's Specialised Register (CCDANCTR), CENTRAL, MEDLINE, EMBASE, Sports Discus and PsycINFO for eligible studies (to February 2010). We also searched www.controlled-trials.com in November 2010. The CCDAN Group searched its Specialised Register in June 2011 and potentially eligible trials were listed as 'awaiting assessment'. SELECTION CRITERIA: Randomised controlled trials in which exercise was compared to standard treatment, no treatment or a placebo treatment in adults (aged 18 and over) with depression, as defined by trial authors. We excluded trials of postnatal depression. DATA COLLECTION AND ANALYSIS: For this update, two review authors extracted data on outcomes at the end of the trial. We used these data to calculate effect sizes for each trial using Hedges' g method and a standardised mean difference (SMD) for the overall pooled effect, using a random-effects model. Where trials used a number of different tools to assess depression, we included the main outcome measure only in the meta-analysis. We systematically extracted data on adverse effects and two authors performed the 'Risk of bias' assessments. MAIN RESULTS: Thirty-two trials (1858 participants) fulfilled our inclusion criteria, of which 30 provided data for meta-analyses. Randomisation was adequately concealed in 11 studies, 12 used intention-to-treat analyses and nine used blinded outcome assessors. For the 28 trials (1101 participants) comparing exercise with no treatment or a control intervention, at post-treatment analysis the pooled SMD was -0.67 (95% confidence interval (CI) -0.90 to -0.43), indicating a moderate clinical effect. However, when we included only the four trials (326 participants) with adequate allocation concealment, intention-to-treat analysis and blinded outcome assessment, the pooled SMD was -0.31 (95% CI -0.63 to 0.01) indicating a small effect in favour of exercise. There was no difference in drop-outs between exercise and control groups. Pooled data from the seven trials (373 participants) that provided long-term follow-up data also found a small effect in favour of exercise (SMD -0.39, 95% CI -0.69 to -0.09). Of the six trials comparing exercise with cognitive behavioural therapy (152 participants), the effect of exercise was not significantly different from that of cognitive therapy. There were insufficient data to determine risks, costs and quality of life. Five potentially eligible studies identified by the search of the CCDAN Specialised Register in 2011 are listed as 'awaiting classification' and will be included in the next update of this review. AUTHORS' CONCLUSIONS: Exercise seems to improve depressive symptoms in people with a diagnosis of depression when compared with no treatment or control intervention, however since analyses of methodologically robust trials show a much smaller effect in favour of exercise, some caution is required in interpreting these results.

Santucci, L. C., R. K. McHugh, et al. (2012). ***"Direct-to-consumer marketing of evidence-based psychological interventions: Introduction."*** Behavior Therapy 43(2): 231-235. http://www.sciencedirect.com/science/article/pii/S0005789411001110

The dissemination and implementation of evidence-based psychological interventions (EBPIs) to service provision settings has been a major challenge. Most efforts to disseminate and implement EBPIs have focused on clinicians and clinical systems as the consumers of these treatments and thus have targeted efforts to these groups. An alternative, complementary approach to achieve more widespread utilization of EBPIs is to disseminate directly to patients themselves. The aim of this special section is to explore several direct-to-consumer (i.e., patient) dissemination and education efforts currently underway. This manuscript highlights the rationale for direct-to-patient dissemination strategies as well as the application of marketing science to dissemination efforts. Achieving greater access to EBPIs will require the use of multiple approaches to overcome the many and varied barriers to successful dissemination and implementation.

Sinclair, L. (2012). ***"Treating social anxiety doesn't decrease alcohol consumption."*** Psychiatric News 47(13): 11b-17. http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1212619

(Free full text available) In any substance abuse treatment setting—whether inpatient or outpatient—patients frequently present with comorbid social anxiety disorder, which impedes treatment. Does the comorbid psychiatric disorder always matter in the addiction treatment setting? Does the alcohol use disorder always matter in the psychiatric treatment setting? These questions were addressed by Sarah Book, M.D., at APA's 2012 annual meeting in Philadelphia in May in the workshop "Management of Patients With Alcohol and Co-Occurring Disorders: Problems and Solutions."

Stel, M., E. v. Dijk, et al. (2012). ***"Lowering the pitch of your voice makes you feel more powerful and think more abstractly."*** Social psychological and personality science 3(4): 497-502. http://spp.sagepub.com/content/3/4/497.abstract

Voice pitch may not only influence the listeners but also the speakers themselves. Based on the theories of embodied cognition and previous research on power, we tested whether lowering their pitch leads people to feel more powerful and think more abstractly. In three experiments, participants received instructions to read a text out loud with either a lower or a higher voice than usual. Subsequently, feelings of power (Experiments 1 and 2) and abstract thinking (Experiment 3) were assessed. Participants who lowered their voice pitch perceived themselves more as possessing more powerful traits (Experiments 1 and 2) and had a higher level of abstract thinking (Experiment 3) compared to participants who raised their voice pitch.

Swift, J. K. and R. P. Greenberg (2012). ***"Premature discontinuation in adult psychotherapy: A meta-analysis."*** J Consult Clin Psychol 80(4): 547-559. http://www.ncbi.nlm.nih.gov/pubmed/22506792

Objective: Premature discontinuation from therapy is a widespread problem that impedes the delivery of otherwise effective psychological interventions. The most recent comprehensive review found an average dropout rate of 47% across 125 studies (Wierzbicki & Pekarik, 1993); however, given a number of changes in the field over the past 2 decades, an updated meta-analysis is needed to examine the current phenomenon of therapy dropout. Method: A series of meta-analyses and meta-regressions were conducted in order to identify the rate at which treatment dropout occurs and predictors of its occurrence. This review included 669 studies representing 83,834 clients. Results: Averaging across studies using a random effects model, the weighted dropout rate was 19.7%, 95% CI [18.7%, 20.7%]. Further analyses, also using random effects models, indicated that the overall dropout rate was moderated by client diagnosis and age, provider experience level, setting for the intervention, definition of dropout, type of study (efficacy vs. effectiveness), and other design variables. Dropout was not moderated by orientation of therapy, whether treatment was provided in an individual or group format, and a number of client demographic variables. Conclusions: Although premature discontinuation is occurring at a lower rate than what was estimated 20 years ago (Wierzbicki & Pekarik, 1993), it is still a significant problem, with about 1 in every 5 clients dropping out of therapy. Special efforts should be made to decrease premature discontinuation, particularly with clients who are younger, have a personality or eating disorder diagnosis, and are seen by trainee clinicians.

Swift, J. K., R. P. Greenberg, et al. (2012). ***"Practice recommendations for reducing premature termination in therapy."*** Professional Psychology: Research and Practice 43(4): 379-387. doi: 10.1037/a0028291

Premature termination from therapy is a significant problem frequently encountered by practicing clinicians of all types. In fact, a recent meta-analytic review (J. K. Swift & R. P. Greenberg, 2012, Premature discontinuation in adult psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology. doi:10.1037/a0028226) of 669 studies found that approximately 20% of all clients drop out of treatment prematurely, with higher rates among some types of clients and in some settings. Although this dropout rate is lower than previously estimated, a significant number of clients are still prematurely terminating,

and thus further research toward a solution is warranted. Here we present a conceptualization of premature termination based on perceived and anticipated costs and benefits and review 6 practice strategies for reducing premature termination in therapy. These strategies include providing education about duration and patterns of change, providing role induction, incorporating client preferences, strengthening early hope, fostering the therapeutic alliance, and assessing and discussing treatment progress.

Thompson, L. and R. McCabe (2012). ***"The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review."*** BMC Psychiatry 12(1): 87. http://www.biomedcentral.com/1471-244X/12/87

(Free full text available) BACKGROUND: Nonadherence to mental health treatment incurs clinical and economic burdens. The clinician-patient relationship presents a point of intervention. This alliance is negotiated through clinical communication. However, recent medical reviews of communication and adherence exclude studies of psychiatric patients. The following review examines the impact of clinician-patient alliance and communication on adherence in mental health and the specific mechanisms that result in patient engagement. METHODS: In December 2010, a systematic search was conducted in Pubmed, PsychInfo, Web of Science, Cochrane Library, Embase and Cinahl and yielded 6672 titles. A secondary hand search was performed in relevant journals, grey literature and reference. RESULTS: 23 studies met the inclusion criteria for the review. The methodological quality overall was moderate. 17 studies reported positive associations with adherence, only four of which employed intervention designs. 10 studies examined the association between clinician-patient alliance and adherence. Subjective ratings of clinical communication styles and messages were assessed in 12 studies. 1 study examined the association between objectively rated communication and adherence. Meta-analysis was not possible due to heterogeneity of methods. Findings were presented as a narrative synthesis. CONCLUSIONS: Clinician-patient alliance and communication are associated with more favourable patient adherence. Further research of observer rated communication would better facilitate the application of findings in clinical practice. Establishing agreement on the tasks of treatment, utilising collaborative styles of communication and discussion of treatment specifics may be important for clinicians in promoting cooperation with regimens. These findings align with those in health communication. However, the benefits of shared decision making for adherence in mental health are less conclusive than in general medicine.

van der Horst, M. and H. Coffé (2012). ***"How friendship network characteristics influence subjective well-being."*** Social Indicators Research 107(3): 509-529. http://dx.doi.org/10.1007/s11205-011-9861-2

(Available in free full text) This article explores how friendship network characteristics influence subjective well-being (SWB). Using data from the 2003 General Social Survey of Canada, three components of the friendship network are differentiated: number of friends, frequency of contact, and heterogeneity of friends. We argue that these characteristics shape SWB through the benefits they bring. Benefits considered are more social trust, less stress, better health, and more social support. Results confirm that higher frequency of contacts and higher number of friends, as well as lower heterogeneity of the friendship network are related to more social trust, less stress, and a better health. Frequency of contact and number of friends, as well as more heterogeneity of the friendship network increase the chance of receiving help from friends. With the exception of receiving help from friends, these benefits are in turn related to higher levels of SWB. Only the frequency of meeting friends face-to-face has a remaining positive direct influence on SWB.

Watkins, E. R., R. S. Taylor, et al. (2012). ***"Guided self-help concreteness training as an intervention for major depression in primary care: A phase ii randomized controlled trial."*** Psychological Medicine 42(07): 1359-1371. http://dx.doi.org/10.1017/S0033291711002480

Background The development of widely accessible, effective psychological interventions for depression is a priority. This randomized trial provides the first controlled data on an innovative cognitive bias modification (CBM) training guided self-help intervention for depression. Method One hundred and twenty-one consecutively recruited participants meeting criteria for current major depression were randomly allocated to treatment as usual (TAU) or to TAU plus concreteness training (CNT) guided self-help or to TAU plus relaxation training (RT) guided self-help. CNT involved repeated practice at mental exercises designed to switch patients from an unhelpful abstract thinking habit to a helpful concrete thinking habit, thereby targeting depressogenic cognitive processes (rumination, overgeneralization). Results The addition of CNT to TAU significantly improved depressive symptoms at post-treatment [mean difference on the Hamilton Rating Scale for Depression (HAMD) 4.28, 95% confidence interval (CI) 1.29–7.26], 3- and 6-month follow-ups, and for rumination and overgeneralization post-treatment. There was no difference in the reduction of symptoms between CNT and RT (mean difference on the HAMD 1.98, 95% CI −1.14 to 5.11), although CNT significantly reduced rumination and overgeneralization relative to RT post-treatment, suggesting a specific benefit on these cognitive processes. Conclusions This study provides preliminary evidence that CNT guided self-help may be a useful addition to TAU in treating major depression in primary care, although the effect was not significantly different from an existing active treatment (RT) matched for structural and common factors. Because of its relative brevity and distinct format, it may have value as an additional innovative approach to increase the accessibility of treatment choices for depression.