30 babcp abstracts, january '13

(Chalder, Wiles et al. 2012; Cox, Callahan et al. 2012; Cox, Fisher et al. 2012; Flückiger, Grosse Holtforth et al. 2012; Kelleher, Lynch et al. 2012; Kleiman and Rule 2012; Koestner, Powers et al. 2012; Mikula, Riederer et al. 2012; Nissen-Lie, Monsen et al. 2012; Owen, Reese et al. 2012; Rothbaum, Kearns et al. 2012; Sturt, Ali et al. 2012; van der Gaag, Nieman et al. 2012; Wiles, Haase et al. 2012; Adam, Meinlschmidt et al. 2013; Burns, H et al. 2013; Del Re, Fluckiger et al. 2013; Dunn, Callahan et al. 2013; Fairburn, Cooper et al. 2013; Fjorback, Arendt et al. 2013; Fluckiger, Grosse Holtforth et al. 2013; Hardeveld, Spijker et al. 2013; Latimer, Meade et al. 2013; Mahaffey, Wheaton et al. 2013; McGowan and Behar 2013; O'Donnell, Varker et al. 2013; Radhakrishnan, Hammond et al. 2013; Sanchez-Villegas and Martinez-Gonzalez 2013; Stafford, Jackson et al. 2013; Vinson, Turner et al. 2013; Williams, Wilson et al. 2013)

Adam, Y., G. Meinlschmidt, et al. (2013). ***"Associations between mental disorders and the common cold in adults: A population-based cross-sectional study."*** Journal of Psychosomatic Research 74(1): 69-73. http://www.sciencedirect.com/science/article/pii/S0022399912002188

Objective To investigate the association between specific mental disorders and the common cold. Methods Negative binomial regression analyses were applied to examine cross-sectional associations of a broad range of mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) employing the standardized Munich Composite International Diagnostic Interview, with the self-reported number of occurrences of the common cold during the past 12 months in a representative population sample of 4022 German adults aged 18–65 years. Results After adjustment for covariates including age, gender, and marital and socioeconomic status, having any 12-month DSM-IV mental disorder (incidence rate ratio [IRR] = 1.44, 95% confidence interval [CI] = 1.29–1.60), any substance abuse or dependence (IRR = 1.32, 95% CI = 1.14–1.52), possible psychotic disorder (IRR = 1.43, 95% CI = 1.09–1.87), any mood disorder (IRR = 1.35, 95% CI = 1.16–1.56), any anxiety disorder (IRR = 1.40, 95% CI = 1.23–1.59), or any somatoform disorder (IRR = 1.38, 95% CI = 1.18–1.62) was shown to be positively associated with the number of occurrences of a cold during the past 12 months. Conclusion The presence of a DSM-IV mental disorder was associated with a 44% higher risk of having experienced a cold in the past 12 months. Further studies are needed to explore potential common risk factors for incidence of mental disorders and the common cold, since the pathway connecting them has not been fully determined.

Burns, A., O. M. H, et al. (2013). ***"A pilot randomised controlled trial of cognitive behavioural therapy for antenatal depression."*** BMC Psychiatry 13(1): 33. http://www.ncbi.nlm.nih.gov/pubmed/23339584

ABSTRACT: BACKGROUND: Few trials have evaluated the effectiveness of psychological treatment in improving depression by the end of pregnancy. This is the first pilot randomised controlled trial (RCT) of individual cognitive behavioural therapy (CBT) looking at treating depression by the end of pregnancy. Our aim was to assess the feasibility of delivering a CBT intervention modified for antenatal depression during pregnancy. METHODS: Women in North Bristol, UK between 8--18 weeks pregnant were recruited through routine contact with midwives and randomised to receive up to 12 sessions of individual CBT in addition to usual care or to continue with usual care only. Women were eligible for randomisation if they screened positive on a 3-question depression screen used routinely by midwives and met ICD-10 criteria for depression assessed using the clinical interview schedule -- revised version (CIS-R). Two CBT therapists delivered the intervention. Follow-up was at 15 and 33 weeks post-randomisation when assessments of mental health were made using measure which included the CIS-R. RESULTS: Of the 50 women assessed for the trial, 36 met ICD-10 depression criteria and were randomised: 18 to the intervention and 18 to usual care. Thirteen of the 18 (72%) women who were allocated to receive the intervention completed 9 or more sessions of CBT before the end of pregnancy. Follow-up rates at 15 and 33 weeks post-randomisation were higher in the group who received the intervention (89% vs. 72% at 15 weeks and 89% vs. 61% at 33 weeks post-randomisation). At 15 weeks post-randomisation (the end of pregnancy), there were more women in the intervention group (11/16; 68.7%) who recovered (i.e. no longer met ICD-10 criteria for depression), than those receiving only usual care (5/13; 38.5%). CONCLUSIONS: This pilot trial shows the feasibility of conducting a large RCT to assess the effectiveness of CBT for treating antenatal depression before the end of pregnancy. The intervention could be delivered during the antenatal period and there was some evidence to suggest that it could be effective.Trial registration: ISRCTN44902048.

Chalder, M., N. J. Wiles, et al. (2012). ***"A pragmatic randomised controlled trial to evaluate the cost-effectiveness of a physical activity intervention as a treatment for depression: The treating depression with physical activity (TREAD) trial."*** Health Technol Assess 16(10): 1-164, iii-iv. http://www.ncbi.nlm.nih.gov/pubmed/22398106

OBJECTIVE: The TREAting Depression with physical activity (TREAD) study investigated the cost-effectiveness of a physical activity intervention, in addition to usual general practitioner care, as a treatment for people with depression. DESIGN: An individually randomised, pragmatic, multicentre randomised controlled trial with follow-up at 4, 8 and 12 months. A subset of participants took part in a qualitative study that investigated the acceptability and perceived benefits of the intervention. SETTING: General practices in the Bristol and Exeter areas. PARTICIPANTS: Aged 18-69 years with an International Statistical Classification of Diseases and Related Health Problems, 10th Edition (ICD-10) diagnosis of depression and scoring >/= 14 on the Beck Depression Inventory (BDI). Those who were unable to complete self-administered questionnaires in English, with medical contraindications to physical activity or with psychosis, bipolar disorder or serious drug abuse were excluded. INTERVENTIONS: We devised an intervention designed to encourage choice and autonomy in the adoption of physical activity. It consisted of up to three face-to-face and ten telephone contacts delivered by a trained physical activity facilitator over an 8-month period. MAIN OUTCOME MEASURES: The primary outcome was the BDI score measured at 4 months. Secondary outcomes included depressive symptoms over the 12 months and quality of life, antidepressant use and level of physical activity. RESULTS: The study recruited 361 patients, with 182 randomised to the intervention arm and 179 to the usual care arm; there was 80% retention at the 4-month follow-up. The intervention group had a slightly lower BDI score at 4 months [-0.54, 95% confidence interval (CI) -3.06 to 1.99] but there was no evidence that the intervention improved outcome for depression. Neither was there any evidence to suggest a difference in the prescription of or self-reported use of antidepressants. However, the amount of physical activity undertaken by those who had received the intervention was increased (odds ratio 2.3, 95% CI 1.3 to 3.9) and was sustained beyond the end of the intervention. From a health-care perspective, the intervention group was more costly than the usual care group, with the cost of the intervention pound220 per person on average. It is therefore extremely unlikely that the intervention is cost-effective as a treatment for depression using current willingness-to-pay thresholds. CONCLUSIONS: This physical activity intervention is very unlikely to lead to any clinical benefit in terms of depressive symptoms or to be a cost-effective treatment for depression. Previous research has reported some benefit and there are three possible reasons for this discrepancy: first, even though the intervention increased self-reported physical activity, the increase in activity was not sufficiently large to lead to a measurable influence; second, only more vigorous activity might be of benefit; and third, previous studies had recruited individuals with a pre-existing commitment to physical activity. Future research is needed to identify and

explain the mechanisms by which depression might be effectively treated, including, in particular, specific guidance on the optimum type, intensity and duration of physical activity required to produce a therapeutic effect. TRIAL REGISTRATION: Current Controlled Trials ISRCTN16900744. FUNDING: This project was funded by the NIHR Health Technology Assessment programme and will be published in full in Health Technology Assessment; Vol. 16, No. 10. See the HTA programme website for further project information.

Cox, G. R., P. Callahan, et al. (2012). ***"Psychological therapies versus antidepressant medication, alone and in combination for depression in children and adolescents."*** Cochrane Database Syst Rev 11: CD008324. http://www.ncbi.nlm.nih.gov/pubmed/23152255

BACKGROUND: Depressive disorders are common in children and adolescents and, if left untreated, are likely to recur in adulthood. Depression is highly debilitating, affecting psychosocial, family and academic functioning. OBJECTIVES: To evaluate the effectiveness of psychological therapies and antidepressant medication, alone and in combination, for the treatment of depressive disorder in children and adolescents. We have examined clinical outcomes including remission, clinician and self reported depression measures, and suicide-related outcomes. SEARCH METHODS: We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialised Register (CCDANCTR) to 11 November 2011. This register contains reports of relevant randomised controlled trials (RCTs) from the Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE (1950 to date), EMBASE (1974 to date), and PsycINFO (1967 to date). SELECTION CRITERIA: RCTs were eligible for inclusion if they compared i) any psychological therapy with any antidepressant medication, or ii) a combination of psychological therapy and antidepressant medication with a psychological therapy alone, or an antidepressant medication alone, or iii) a combination of psychological therapy and antidepressant medication with a placebo or 'treatment as usual', or (iv) a combination of psychological therapy and antidepressant medication with a psychological therapy or antidepressant medication plus a placebo.We included studies if they involved participants aged between 6 and 18 years, diagnosed by a clinician as having Major Depressive Disorder (MDD) based on Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD) criteria. DATA COLLECTION AND ANALYSIS: Two review authors independently selected studies, extracted data and assessed the quality of the studies. We applied a random-effects meta-analysis, using the odds ratio (OR) to describe dichotomous outcomes, mean difference (MD) to describe continuous outcomes when the same measures were used, and standard mean difference (SMD) when outcomes were measured on different scales. MAIN RESULTS: We included ten studies, involving 1235 participants in this review. Studies recruited participants with different severities of disorder and with a variety of comorbid disorders, including anxiety and substance use disorder, therefore limiting the comparability of the results. Regarding the risk of bias in studies, half the studies had adequate allocation concealment (there was insufficient information to determine allocation concealment in the remainder), outcome assessors were blind to the participants' intervention in six studies, and in general, studies reported on incomplete data analysis methods, mainly using intention-to-treat (ITT) analyses. For the majority of outcomes there were no statistically significant differences between the interventions compared. There was limited evidence (based on two studies involving 220 participants) that antidepressant medication was more effective than psychotherapy on measures of clinician defined remission immediately post-intervention (odds ratio (OR) 0.52, 95% confidence interval (CI) 0.27 to 0.98), with 67.8% of participants in the medication group and 53.7% in the psychotherapy group rated as being in remission. There was limited evidence (based on three studies involving 378 participants) that combination therapy was more effective than antidepressant medication alone in achieving higher remission from a depressive episode immediately post-intervention (OR 1.56, 95% CI 0.98 to 2.47), with 65.9% of participants treated with combination therapy and 57.8% of participants treated with medication, rated as being in remission. There was no evidence to suggest that combination therapy was more effective than psychological therapy alone, based on clinician rated remission immediately post-intervention (OR 1.82, 95% CI 0.38 to 8.68). Suicide-related Serious Adverse Events (SAEs) were reported in various ways across studies and could not be combined in meta-analyses. However suicidal ideation specifically was generally measured and reported using standardised assessment tools suitable for meta-analysis. In one study involving 188 participants, rates of suicidal ideation were significantly higher in the antidepressant medication group (18.6%) compared with the psychological therapy group (5.4%) (OR 0.26, 95% CI 0.09 to 0.72) and this effect appeared to remain at six to nine months (OR 1.27, 95% CI 0.68 to 2.36), with 13.6% of participants in the medication group and 3.9% of participants in the psychological therapy group reporting suicidal ideation. It was unclear what the effect of combination therapy was compared with either antidepressant medication alone or psychological therapy alone on rates of suicidal ideation. The impact of any of the assigned treatment packages on drop out was also mostly unclear across the various comparisons in the review.Limited data and conflicting results based on other outcome measures make it difficult to draw conclusions regarding the effectiveness of any specific intervention based on these outcomes. AUTHORS' CONCLUSIONS: There is very limited evidence upon which to base conclusions about the relative effectiveness of psychological interventions, antidepressant medication and a combination of these interventions. On the basis of the available evidence, the effectiveness of these interventions for treating depressive disorders in children and adolescents cannot be established. Further appropriately powered RCTs are required.

Cox, G. R., C. A. Fisher, et al. (2012). ***"Interventions for preventing relapse and recurrence of a depressive disorder in children and adolescents."*** Cochrane Database Syst Rev 11: CD007504. http://www.ncbi.nlm.nih.gov/pubmed/23152246

BACKGROUND: Depressive disorders often begin during childhood or adolescence. There is a growing body of evidence supporting effective treatments during the acute phase of a depressive disorder. However, little is known about treatments for preventing relapse or recurrence of depression once an individual has achieved remission or recovery from their symptoms. OBJECTIVES: To determine the efficacy of early interventions, including psychological and pharmacological interventions, to prevent relapse or recurrence of depressive disorders in children and adolescents. SEARCH METHODS: We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialised Register (CCDANCTR) (to 1 June 2011). The CCDANCTR contains reports of relevant randomised controlled trials from The Cochrane Library (all years), EMBASE (1974 to date), MEDLINE (1950 to date) and PsycINFO (1967 to date). In addition we handsearched the references of all included studies and review articles. SELECTION CRITERIA: Randomised controlled trials using a psychological or pharmacological intervention, with the aim of preventing relapse or recurrence from an episode of major depressive disorder (MDD) or dysthymic disorder (DD) in children and adolescents were included. Participants were required to have been diagnosed with MDD or DD according to DSM or ICD criteria, using a standardised and validated assessment tool. DATA COLLECTION AND ANALYSIS: Two review authors independently assessed all trials for inclusion in the review, extracted trial and outcome data, and assessed trial quality. Results for dichotomous outcomes are expressed as odds ratio and continuous measures as mean difference or standardised mean difference. We combined results using random-effects meta-analyses, with 95% confidence intervals. We contacted lead authors of included trials and requested additional data where possible. MAIN RESULTS: Nine trials with 882 participants were included in the review. In five trials the outcome assessors were blind to the participants' intervention condition and in the remainder of trials it was unclear. In the majority of trials, participants were either not blind to their intervention condition, or it was unclear whether they were or not. Allocation concealment was also unclear in the majority of trials. Although all trials treated participants in an outpatient setting, the designs implemented in trials was diverse, which limits the generalisability of the results. Three trials indicated participants treated with antidepressant medication had lower relapse-recurrence rates (40.9%)

compared to those treated with placebo (66.6%) during a relapse prevention phase (odds ratio (OR) 0.34; 95% confidence interval (CI) 0.18 to 0.64, P = 0.02). One trial that compared a combination of psychological therapy and medication to medication alone favoured a combination approach over medication alone, however this result did not reach statistical significance (OR 0.26; 95% CI 0.06 to 1.15). The majority of trials that involved antidepressant medication reported adverse events including suicide-related behaviours. However, there were not enough data to show which treatment approach results in the most favourable adverse event profile. AUTHORS' CONCLUSIONS: Currently, there is little evidence to conclude which type of treatment approach is most effective in preventing relapse or recurrence of depressive episodes in children and adolescents. Limited trials found that antidepressant medication reduces the chance of relapse-recurrence in the future, however, there is considerable diversity in the design of trials, making it difficult to compare outcomes across studies. Some of the research involving psychological therapies is encouraging, however at present more trials with larger sample sizes need to be conducted in order to explore this treatment approach further.

Del Re, A. C., C. Fluckiger, et al. (2013). ***"Monitoring mindfulness practice quality: An important consideration in mindfulness practice."*** Psychother Research 23(1): 54-66. http://www.ncbi.nlm.nih.gov/pubmed/23046287

Abstract Mindfulness-Based Stress Reduction (MBSR) is an experientially based group intervention empirically supported to reduce psychological symptomology. Although MBSR has shown to be an effective intervention, little is known about which facets of the intervention are important in producing positive outcomes. This study tested several aspects of mindfulness practice (total practice duration, practice frequency and practice quality) with the primary focus being on validating (i.e., predictive and convergent validity) a new measure of mindfulness practice quality (PQ-M). The PQ-M fit a two-factor solution via a Maximum Likelihood Exploratory Factor Analysis (n=99). Using longitudinal multilevel modeling on a smaller subsample (n=19), preliminary support was found for changes in practice quality over the course of the MBSR intervention. Further, change in practice quality was associated with improvements in psychological symptoms. While this study was exploratory, these findings suggest that practice quality is a relevant factor to promote positive outcomes and may guide mindfulness instructors in providing highly tailored interventions.

Dunn, R., J. L. Callahan, et al. (2013). ***"Effects of pre-session centering for therapists on session presence and effectiveness."*** Psychotherapy Research 23(1): 78-85. http://dx.doi.org/10.1080/10503307.2012.731713

The present study tested whether engaging in a mindfulness centering exercise 5 minutes before a session could have a positive impact on therapy, in particular on the therapists' ability to remain present in session and on session outcomes. Results indicated that therapists perceived themselves as being more present in session when they prepared for their sessions by engaging in a mindfulness centering exercises (d=.45), while clients perceived their therapists as being highly present regardless of whether their therapist completed the mindfulness centering exercise. Clients did, however, perceive the sessions as being more effective when their therapists engaged in the mindfulness centering exercise prior to the start of the session (d=.52).

Fairburn, C. G., Z. Cooper, et al. (2013). ***"Enhanced cognitive behaviour therapy for adults with anorexia nervosa: A UK-Italy study."*** Behaviour Research and Therapy 51(1): R2-R8. http://www.sciencedirect.com/science/article/pii/S0005796712001544

(Free full text available) Anorexia nervosa is difficult to treat and no treatment is supported by robust evidence. As it is uncommon, it has been recommended that new treatments should undergo extensive preliminary testing before being evaluated in randomized controlled trials. The aim of the present study was to establish the immediate and longer-term outcome following "enhanced" cognitive behaviour therapy (CBT-E). Ninety-nine adult patients with marked anorexia nervosa (body mass index ≤ 17.5) were recruited from consecutive referrals to clinics in the UK and Italy. Each was offered 40 sessions of CBT-E over 40 weeks with no concurrent treatment. Sixty-four percent of the patients were able to complete this outpatient treatment and in these patients there was a substantial increase in weight (7.47 kg, SD 4.93) and BMI (2.77, SD 1.81). Eating disorder features also improved markedly. Over the 60-week follow-up period there was little deterioration despite minimal additional treatment. These findings provide strong preliminary support for this use of CBT-E and justify its further evaluation in randomized controlled trials. As CBT-E has already been established as a treatment for bulimia nervosa and eating disorder not otherwise specified, the findings also confirm that CBT-E is transdiagnostic in its scope.

Fjorback, L. O., M. Arendt, et al. (2013). ***"Mindfulness therapy for somatization disorder and functional somatic syndromes - randomized trial with one-year follow-up."*** Journal of Psychosomatic Research 74(1): 31-40. http://www.sciencedirect.com/science/article/pii/S0022399912002449

Objective To conduct a feasibility and efficacy trial of mindfulness therapy in somatization disorder and functional somatic syndromes such as fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome, defined as bodily distress syndrome (BDS). Methods We randomized 119 patients to either mindfulness therapy (mindfulness-based stress reduction and some cognitive behavioral therapy elements for BDS) or to enhanced treatment as usual (2-hour specialist medical care and brief cognitive behavioral therapy for BDS). The primary outcome measure was change in physical health (SF-36 Physical Component Summary) from baseline to 15-month follow-up. Results The study is negative as we could not demonstrate a different development over time for the two groups ($F(3,2674) = 1.51$, $P = .21$). However, in the mindfulness therapy group, improvement was obtained toward the end of treatment and it remained present at the 15-month follow-up, whereas the enhanced treatment as usual group achieved no significant change until 15-month follow-up. The change scores averaged half a standard deviation which amounts to a clinically significant change, 29% changed more than 1 standard deviation. Significant between-group differences were observed at treatment cessation. Conclusion Mindfulness therapy is a feasible and acceptable treatment. The study showed that mindfulness therapy was comparable to enhanced treatment as usual in improving quality of life and symptoms. Nevertheless, considering the more rapid improvement following mindfulness, mindfulness therapy may be a potentially useful intervention in BDS patients. Clinically important changes that seem to be comparable to a CBT treatment approach were obtained. Further research is needed to replicate or even expand these findings.

Fluckiger, C., M. Grosse Holtforth, et al. (2013). ***"Is the relation between early post-session reports and treatment outcome an epiphenomenon of intake distress and early response? A multi-predictor analysis in outpatient psychotherapy."*** Psychother Res 23(1): 1-13. http://www.ncbi.nlm.nih.gov/pubmed/22708616

Abstract The early phase of psychotherapy has been regarded as a sensitive period in the unfolding of psychotherapy leading to positive outcomes. However, there is disagreement about the degree to which early (especially relationship-related) session experiences predict outcome over and above initial levels of distress and early response to treatment. The goal of the present study was to simultaneously examine outcome at post treatment as a function of (a) intake symptom and interpersonal distress as well as early change in well-being and symptoms, (b) the patient's early session-experiences, (c) the therapist's early session-experiences/interventions, and (d) their interactions. The data of 430 psychotherapy completers treated by 151 therapists were analyzed using hierarchical linear models. Results indicate that early positive intra- and interpersonal session

experiences as reported by patients and therapists after the sessions explained 58% of variance of a composite outcome measure, taking intake distress and early response into account. All predictors (other than problem-activating therapists' interventions) contributed to later treatment outcomes if entered as single predictors. However, the multi-predictor analyses indicated that interpersonal distress at intake as well as the early interpersonal session experiences by patients and therapists remained robust predictors of outcome. The findings underscore that early in therapy therapists (and their supervisors) need to understand and monitor multiple interconnected components simultaneously.

Hardeveld, F., J. Spijker, et al. (2013). ***"Recurrence of major depressive disorder and its predictors in the general population: Results from the netherlands mental health survey and incidence study (NEMESIS)."*** Psychological Medicine 43(01): 39-48. http://dx.doi.org/10.1017/S0033291712002395

Background Knowledge of the risk of recurrence after recovery from major depressive disorder (MDD) in the general population is scarce. Method Data were derived from 687 subjects in the general population with a lifetime DSM-III-R diagnosis of MDD but without a current major depressive episode (MDE) or dysthymia. Participants had to be at least 6 months in remission, and were recruited from The Netherlands Mental Health Survey and Incidence Study (NEMESIS), using the Composite International Diagnostic Interview (CIDI). Recency and severity of the last MDE were assessed retrospectively at baseline. Recurrence of MDD was measured prospectively during the 3-year follow-up. Kaplan–Meier survival curves were used to measure time to recurrence. Determinants of time to recurrence were analyzed using proportional hazard models. Results The estimated cumulative recurrence of MDD was 13.2% at 5 years, 23.2% at 10 years and 42.0% at 20 years. In bivariate analysis, the following variables predicted a shorter time to recurrence: younger age, younger age of onset, higher number of previous episodes, a severe last depressive episode, negative youth experiences, ongoing difficulties before recurrence and high neuroticism. Multivariably, younger age, a higher number of previous episodes, a severe last depressive episode, negative youth experiences and ongoing difficulties remained significant. Conclusions In this community sample, the long-term risk of recurrence was high, but lower than that found in clinical samples. Subjects who had had an MDE had a long-term vulnerability for recurrence. Factors predicting recurrence included illness- and stress-related factors.

Kelleher, I., F. Lynch, et al. (2012). ***"Psychotic symptoms in adolescence index risk for suicidal behavior: Findings from 2 population-based case-control clinical interview studies."*** Archives of General Psychiatry 69(12): 1277-1283. http://dx.doi.org/10.1001/archgenpsychiatry.2012.164

Context Recent evidence from both clinical and population research has pointed to psychotic symptoms as potentially important markers of risk for suicidal behavior. However, to our knowledge, there have been no epidemiological studies to date that have reported data on psychotic symptoms and suicidality in individuals who have been clinically assessed for suicidal behavior. Objectives To explore associations between psychotic symptoms in nonpsychotic adolescents and risk for suicidal behavior in (1) the general population, (2) adolescents with psychiatric disorder, and (3) adolescents with suicidal ideation. Design Two independently conducted case-control clinical interview studies.Setting Population-based studies in Ireland. Participants Study 1 included 212 adolescents aged 11 to 13 years. Study 2 included 211 adolescents aged 13 to 15 years. Participants were recruited from schools. Main Outcome Measures Suicidal behavior and psychotic symptoms, assessed by semi-structured diagnostic clinical interview. Results Psychotic symptoms were associated with a 10-fold increased odds of any suicidal behavior (ideation, plans, or acts) in both the early and middle adolescence studies (odds ratio [OR], 10.23; 95% CI, 3.25-32.26; P<.001 and OR, 10.5; 95% CI, 3.14-35.17; P<.001, respectively). Adolescents with depressive disorders who also experienced psychotic symptoms were at a nearly 14-fold increased odds of more severe suicidal behavior (suicide plans and suicide acts) compared with adolescents with depressive disorders who did not experience psychotic symptoms (OR, 13.7; 95% CI, 2.1-89.6). Among all adolescents with suicidal ideation, those who also reported psychotic symptoms had a nearly 20-fold increased odds of suicide plans and suicide acts compared with adolescents with suicidal ideation who did not report psychotic symptoms (OR, 19.6; 95% CI, 1.8-216.1).Conclusions Psychotic symptoms are strongly associated with increased risk for suicidal behavior in the general adolescent population and in adolescents with (nonpsychotic) psychiatric disorder. In both studies, an absolute majority of adolescents with more severe suicidal behavior (suicidal plans and acts) reported psychotic symptoms when directly questioned about this as part of a psychiatric interview. Assessment of psychotic symptoms should form a key part of suicide risk assessment.

Kleiman, S. and N. O. Rule (2012). ***"Detecting suicidality from facial appearance."*** Social psychological and personality science. http://spp.sagepub.com/content/early/2012/11/15/1948550612466115.abstract

Suicide is a pervasive problem worldwide. In this investigation, we show that individuals can perceive suicidality from facial appearance with accuracy that is significantly greater than chance guessing. Inferences of expected or obvious cues, such as how depressed a person seems, did not lead to accurate judgments. Rather, perceptions of how impulsive an individual appears differentiated suicide victims from living controls. Teasing apart various forms of impulsivity revealed that perceptions of impulsive aggression, distinct from other forms of impulsive behavior (e.g., impulsive buying), distinguished suicide victims from controls. Finally, experienced mental health clinicians did not perform significantly better than laypersons at judging suicidality. Facial appearance may therefore hold cues to suicidality, expanding what is known about the expression and perception of social cues from the face and providing new insights into the relationship between mental health and nonverbal cues.

Koestner, R., T. A. Powers, et al. (2012). ***"Distinguishing autonomous and directive forms of goal support: Their effects on goal progress, relationship quality, and subjective well-being."*** Pers Soc Psychol Bull 38(12): 1609-1620. http://www.ncbi.nlm.nih.gov/pubmed/22930370

Three studies examined the relations of autonomy support and directive support to goal progress over 3 months. Autonomy support was defined in terms of empathic perspective-taking, whereas directive support was defined in terms of the provision of positive guidance. Results from Study 1 revealed that autonomy support between romantic partners was significantly positively related to goal progress over 3 months, and that the beneficial effect of autonomy support was mediated by enhanced autonomous goal motivation. Study 2 involved female friend dyads and extended the goal progress results to include both self-reports and reports by peers. Study 3 showed that autonomy support similarly promoted progress at vicarious goals. Across three studies, autonomy support was also significantly associated with improved relationship quality and subjective well-being. Directive support was marginally associated with better goal progress across the three studies and unrelated to relationship quality or well-being.

Latimer, S., T. Meade, et al. (2013). ***"Measuring engagement in deliberate self-harm behaviours: Psychometric evaluation of six scales."*** BMC Psychiatry 13(1): 4. http://www.biomedcentral.com/1471-244X/13/4

(Free full text available) BACKGROUND:Engagement in Deliberate Self-Harm (DSH) is commonly measured by behavioural scales comprised of specific methods of self-harm. However, there is a scarcity of information about the degree to which the methods relate to the same DSH construct although such scales are routinely used to provide a DSH total score. This

study addresses the shortfall by evaluating the dimensionality of six commonly used behavioural measures of DSH.METHODS:The DSH measures were Self-Injury Questionnaire Treatment Related (SIQTR), Self-Injurious Thoughts and Behaviors Interview (SITBI), Deliberate Self-Harm Inventory (DSHI), Inventory of Statements About Self-Injury (ISAS), Self-Harm Information Form (SHIF) and Self-Harm Inventory (SHI). The behavioural scales contained in each measure were administered to 568 young Australians aged 18 to 30 years (62% university students, 21% mental health patients, and 17% community members). Scale quality was examined against the stringent standards for unidimensional measurement provided by the Rasch model.RESULTS:According to the stringent post-hoc tests provided by the Rasch measurement model, there is support for the unidimensionality of the items contained within each of the scales. All six scales contained items with differential item functioning, four scales contained items with local response dependency, and one item was grossly misfitting (due to a lack of discrimination).CONCLUSIONS:This study supports the use of behavioural scales to measure a DSH construct, justifies the summing of items to form a total DSH score, informs the hierarchy of DSH methods in each scale, and extends the previous evidence for reliability and external validity (as provided by test developers) to a more complete account of scale quality. Given the overall adequacy of all six scales, clinicians and researchers are recommended to select the scale that best matches their adopted definition of DSH.

Mahaffey, B. L., M. G. Wheaton, et al. (2013). ***"The contribution of experiential avoidance and social cognitions in the prediction of social anxiety."*** Behavioural and Cognitive Psychotherapy 41(01): 52-65. http://dx.doi.org/10.1017/S1352465812000367

Background: Cognitive models propose that social anxiety arises from specific dysfunctional cognitions about the likelihood and severity of embarrassment. Relational frame theory (RFT), on the other hand, posits that social anxiety arises from the unwillingness to endure unpleasant internal experiences (i.e. experiential avoidance [EA]). Although cognitive models have garnered empirical support, it may be that newer models such as RFT can improve our ability to predict and treat social anxiety. Aims: We aimed to elucidate the relationship between dysfunctional cognitions and EA, as well as their independent and relative contributions to the prediction of social anxiety symptoms. We hypothesized that dysfunctional cognitions and EA would each be associated with social anxiety, as well as with each other. We also predicted that both EA and dysfunctional cognitions would remain independent predictors of social anxiety symptoms after controlling for each other and general distress. Method: Undergraduates high (n = 173) and low (n = 233) in social anxiety completed measures of social anxiety, dysfunctional cognitions, EA, and general distress. The overall sample was 66.3% female; mean age = 20.01 years (SD = 2.06). Results: Correlational analyses revealed that EA, dysfunctional cognitions, and social anxiety symptoms were moderately correlated with one another. Additionally, hierarchical regression analyses revealed that dysfunctional cognitions predicted social anxiety symptoms even after controlling for EA; the reverse was not found. Conclusions: Results suggest that EA and social anxiety specific cognitive distortions overlap to a moderate extent. EA does not add to the prediction of social anxiety symptoms above and beyond dysfunctional cognitions. Additional theoretical and treatment implications of the results are discussed.

McGowan, S. K. and E. Behar (2013). ***"A preliminary investigation of stimulus control training for worry: Effects on anxiety and insomnia."*** Behav Modif 37(1): 90-112. http://bmo.sagepub.com/content/37/1/90.abstract

For individuals with generalized anxiety disorder, worry becomes associated with numerous aspects of life (e.g., time of day, specific stimuli, environmental cues) and is thus under poor discriminative stimulus control (SC). In addition, excessive worry is associated with anxiety, depressed mood, and sleep difficulties. This investigation sought to provide preliminary evidence for the efficacy of SC procedures in reducing anxiety-, mood-, and sleep-related symptoms. A total of 53 participants with high trait worry were randomly assigned to receive 2 weeks of either SC training (consisting of a 30-min time- and place-restricted worry period each day) or a control condition called focused worry (FW; consisting of instructions to not avoid naturally occurring worry so that worry and anxiety would not paradoxically increase). At post-training, SC was superior to FW in producing reductions on measures of worry, anxiety, negative affect, and insomnia, but not on measures of depression or positive affect. Moreover, SC was superior to FW in producing clinically significant change on measures of worry and anxiety. Results provide preliminary support for the use of SC training techniques in larger treatment packages for individuals who experience high levels of worry.

Mikula, G., B. Riederer, et al. (2012). ***"Perceived justice in the division of domestic labor: Actor and partner effects."*** Personal Relationships 19(4): 680-695. http://dx.doi.org/10.1111/j.1475-6811.2011.01385.x

This study analyzed the division of domestic labor as a relational phenomenon. Using structural equation modeling with data of dual-earner couples from Austria, Germany, and Switzerland (N = 389), actor and partner effects of perceived distributive and procedural justice in the division on relationship satisfaction were investigated. Experience of relationship conflict was considered as possible mediator between perceived justice and relationship satisfaction. Results with actor effects indicate that perceived justice is relevant only to wives' but not to husbands' relationship satisfaction. Results with partner effects, however, show that wives' perceived justice is associated with husbands' relationship satisfaction through the relationship conflict experienced by husbands. Altogether, this study illustrates the importance of considering the relational character of the division of domestic labor.

Nissen-Lie, H. A., J. T. Monsen, et al. (2012). ***"Psychotherapists' self-reports of their interpersonal functioning and difficulties in practice as predictors of patient outcome."*** Psychotherapy Research 23(1): 86-104. http://dx.doi.org/10.1080/10503307.2012.735775

The need for psychotherapy research to understand the therapist effect has been emphasized in several studies. In a large naturalistic study (255 patients, 70 therapists), this topic was addressed using therapists' self-assessed difficulties in practice and interpersonal functioning in therapeutic work as predictors of patient outcome in three conventional outcome measures. Three-level growth curve analyses were employed to assess whether the therapist characteristics, measured by the Development of Psychotherapists Common Core Questionnaire (Orlinsky & Ronnestad, 2005), predicted the level of and change in patient symptom distress (SCL-90R), interpersonal problems (IIP-64), and observer-rated global functioning (GAF). Preliminary estimates of therapist effects in patient change indicated that 4% of change in general symptom distress (GSI), almost 21% of change in IIP global scores, and 28% of growth in GAF could be attributed to therapist differences. The results also demonstrated that certain therapist self-perceptions were clearly related to patient outcome. For example, therapists' scores on a type of difficulty in practice called 'Professional self-doubt' (PSD) (denoting doubt about one's professional efficacy) were positively associated with change in IIP global scores. It is suggested that therapists' self-reported functioning can be of value in understanding how individual therapists contribute to therapeutic change although their influence is not necessarily exerted in expected directions.

O'Donnell, M. L., T. Varker, et al. (2013). ***"Exploration of delayed-onset posttraumatic stress disorder after severe injury."*** Psychosomatic Medicine 75(1): 68-75. http://www.psychosomaticmedicine.org/content/75/1/68.abstract

Objective The first aim of this work was to conduct a rigorous longitudinal study to identify rates of delayed-onset posttraumatic stress disorder (PTSD) in a sample of patients with severe injury. The second aim was to determine what variables differentiated delayed-onset PTSD from chronic PTSD. Methods Randomly selected patients with injury who were admitted to four hospitals around Australia were recruited to the study (N = 834) and assessed in the acute care hospital, at 3 months, and at 12 months. A structured clinical interview was used to assess PTSD at each time point. Results Seventy-three patients (9%; n = 73) had PTSD at 12 months. Of these, 39 (53%) were classified as having delayed-onset PTSD. Furthermore, 22 (56%) patients with delayed-onset PTSD had minimal PTSD symptoms at 3 months (i.e., they did not have partial/subsyndromal PTSD at 3 months). The variables that differentiated delayed-onset PTSD from chronic PTSD were greater injury severity (odds ratio [OR] = 1.13; 95% confidence interval [CI] = 1.02–1.26), lower anxiety severity at 3 months (OR = 0.73; 95% CI = 0.61–0.87), and greater pain severity at 3 months (OR = 1.39; 95% CI = 1.06–1.84). Conclusions Delayed-onset PTSD occurred frequently in this sample. Approximately half of the patients with delayed-onset PTSD had minimal PTSD symptoms at 3 months; therefore, their delayed-onset PTSD could not be accounted for by a small number of fluctuating symptoms. As we move toward DSM-V, it is important that research continues to explore the factors that underpin the development of delayed-onset PTSD.

Owen, J., R. J. Reese, et al. (2012). ***"Alliance in action: A new measure of clients' perceptions of therapists' alliance activity."*** Psychotherapy Research 23(1): 67-77. http://dx.doi.org/10.1080/10503307.2012.731088

We developed a new measure, Alliance in Action (AiA), which assesses clients' perceptions of therapist behavior related to fostering and maintaining the alliance. Clients (N=170) were treated by 42 therapists. All clients were currently in therapy. The results of a factor analysis revealed four subscales to the AiA, which reflected clients' perceptions of their therapists' behavior to monitor the therapeutic relationship, the goals for therapy, and progress towards client goals. A fourth subscale emerged that reflected clients' perceptions of therapist avoidance of eliciting feedback. The AiA subscales demonstrated alphas above .70 and they were associated with client-rated alliance and session outcomes in univariate correlation tests. In multilevel models, three of the four subscales were associated with alliance and session outcomes. The AiA may be helpful in understanding how the therapeutic alliance functions in therapy.

Radhakrishnan, M., G. Hammond, et al. (2013). ***"Cost of improving access to psychological therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected primary care trusts in the East of England region."*** Behaviour Research and Therapy 51(1): 37-45.
http://www.sciencedirect.com/science/article/pii/S0005796712001556

(Free full text available) Recent literature on Improving Access to Psychological Therapies (IAPT) has reported on improvements in clinical outcomes, changes in employment status and the concept of recovery attributable to IAPT treatment, but not on the costs of the programme. This article reports the costs associated with a single session, completed course of treatment and recovery for four treatment courses (i.e., remaining in low or high intensity treatment, stepping up or down) in IAPT services in 5 East of England region Primary Care Trusts. Costs were estimated using treatment activity data and gross financial information, along with assumptions about how these financial data could be broken down. The estimated average cost of a high intensity session was £177 and the average cost for a low intensity session was £99. The average cost of treatment was £493 (low intensity), £1416 (high intensity), £699 (stepped down), £1514 (stepped up) and £877 (All). The cost per recovered patient was £1043 (low intensity), £2895 (high intensity), £1653 (stepped down), £2914 (stepped up) and £1766 (All). Sensitivity analysis revealed that the costs are sensitive to cost ratio assumptions, indicating that inaccurate ratios are likely to influence overall estimates. Results indicate the cost per session exceeds previously reported estimates, but cost of treatment is only marginally higher. The current cost estimates are supportive of the originally proposed IAPT model on cost-benefit grounds. The study also provides a framework to estimate costs using financial data, especially when programmes have block contract arrangements. Replication and additional analyses along with evidence-based discussion regarding alternative, cost-effective methods of intervention is recommended.

Rothbaum, B. O., M. C. Kearns, et al. (2012). ***"Early intervention may prevent the development of posttraumatic stress disorder: A randomized pilot civilian study with modified prolonged exposure."*** Biol Psychiatry 72(11): 957-963.
http://www.ncbi.nlm.nih.gov/pubmed/22766415

BACKGROUND: Posttraumatic stress disorder (PTSD) is a major public health concern with long-term sequelae. There are no accepted interventions delivered in the immediate aftermath of trauma. This study tested an early intervention aimed at modifying the memory to prevent the development of PTSD before memory consolidation. METHODS: Patients (n = 137) were randomly assigned to receive three sessions of an early intervention beginning in the emergency department compared with an assessment only control group. Posttraumatic stress reactions (PTSR) were assessed at 4 and 12 weeks postinjury and depression at baseline and week 4. The intervention consisted of modified prolonged exposure including imaginal exposure to the trauma memory, processing of traumatic material, and in vivo and imaginal exposure homework. RESULTS: Patients were assessed an average of 11.79 hours posttrauma. Intervention participants reported significantly lower PTSR than the assessment group at 4 weeks postinjury, $p < .01$, and at 12 weeks postinjury, $p < .05$, and significantly lower depressive symptoms at week 4 than the assessment group, $p < .05$. In a subgroup analysis, the intervention was the most effective at reducing PTSD in rape victims at week 4 ($p = .004$) and week 12 ($p = .05$). CONCLUSIONS: These findings suggest that the modified prolonged exposure intervention initiated within hours of the trauma in the emergency department is successful at reducing PTSR and depression symptoms 1 and 3 months after trauma exposure and is safe and feasible. This is the first behavioral intervention delivered immediately posttrauma that has been shown to be effective at reducing PTSR.

Sanchez-Villegas, A. and M. Martinez-Gonzalez (2013). ***"Diet, a new target to prevent depression?"*** BMC Medicine 11(1): 3.
http://www.biomedcentral.com/1741-7015/11/3

(Available in free full text): BACKGROUND: Research on the role of diet in the prevention of depression is scarce. Some evidence suggests that depression shares common mechanisms with cardiovascular disease. DISCUSSION: Before considering the role of diet in the prevention of depression, several points need to be considered. First, in general, evidence has been found for the effects of isolated nutrients or foods, and not for dietary patterns. Second, most previous studies have a cross-sectional design. Third, information is generally collected though questionnaires, increasing the risk of misclassification bias. Fourth, adequate control of confounding factors in observational studies is mandatory. SUMMARY: Only a few cohort studies have analyzed the relationship between overall dietary patterns, such as the Mediterranean diet, and primary prevention of depression. They have found similar results to those obtained for the role of this dietary pattern in cardiovascular disease. To confirm the findings obtained in these initial cohort studies, we need further observational longitudinal studies with improved methodology, as well as large randomized primary prevention trials, with interventions based on changes in the overall food pattern, that include participants at high risk of mental disorders.

Stafford, M. R., H. Jackson, et al. (2013). ***"Early interventions to prevent psychosis: Systematic review and meta-analysis."*** BMJ 346: f185. http://www.bmj.com/content/346/bmj.f185

OBJECTIVE: To determine whether any psychological, pharmacological, or nutritional interventions can prevent or delay transition to psychotic disorders for people at high risk. DESIGN: Systematic review and meta-analysis. DATA SOURCES: Embase, Medline, PreMedline, PsycINFO, and CENTRAL were searched to November 2011 without restriction to publication status. REVIEW METHODS: Randomised trials comparing any psychological, pharmacological, nutritional, or combined intervention with usual services or another treatment. Studies of participants with a formal diagnosis of schizophrenia or bipolar disorder were excluded. Studies were assessed for bias, and relevant limitations were considered in summarising the results. RESULTS: 11 trials including 1246 participants and eight comparisons were included. Median sample size of included trials was 81 (range 51-288). Meta-analyses were performed for transition to psychosis, symptoms of psychosis, depression, and mania; quality of life; weight; and discontinuation of treatment. Evidence of moderate quality showed an effect for cognitive behavioural therapy on reducing transition to psychosis at 12 months (risk ratio 0.54 (95% confidence interval 0.34 to 0.86); risk difference -0.07 (-0.14 to -0.01). Very low quality evidence for omega-3 fatty acids and low to very low quality evidence for integrated psychotherapy also indicated that these interventions were associated with reductions in transition to psychosis at 12 months. CONCLUSIONS: Although evidence of benefits for any specific intervention is not conclusive, these findings suggest that it might be possible to delay or prevent transition to psychosis. Further research should be undertaken to establish conclusively the potential for benefit of psychological interventions in the treatment of people at high risk of psychosis.

Sturt, J., S. Ali, et al. (2012). ***"Neurolinguistic programming: A systematic review of the effects on health outcomes."*** Br J Gen Pract 62(604): e757-764. http://www.ncbi.nlm.nih.gov/pubmed/23211179

BACKGROUND: Neurolinguistic programming (NLP) in health care has captured the interest of doctors, healthcare professionals, and managers. AIM: To evaluate the effects of NLP on health-related outcomes. DESIGN AND SETTING: Systematic review of experimental studies. METHOD: The following data sources were searched: MEDLINE, PsycINFO, ASSIA, AMED, CINAHL, Web of Knowledge, CENTRAL, NLP specialist databases, reference lists, review articles, and NLP professional associations, training providers, and research groups. RESULTS: Searches revealed 1459 titles from which 10 experimental studies were included. Five studies were randomised controlled trials (RCTs) and five were pre-post studies. Targeted health conditions were anxiety disorders, weight maintenance, morning sickness, substance misuse, and claustrophobia during MRI scanning. NLP interventions were mainly delivered across 4-20 sessions although three were single session. Eighteen outcomes were reported and the RCT sample sizes ranged from 22 to 106. Four RCTs reported no significant between group differences with the fifth finding in favour of the NLP arm ($F = 8.114$, $P<0.001$). Three RCTs and five pre-post studies reported within group improvements. Risk of bias across all studies was high or uncertain. CONCLUSION: There is little evidence that NLP interventions improve health-related outcomes. This conclusion reflects the limited quantity and quality of NLP research, rather than robust evidence of no effect. There is currently insufficient evidence to support the allocation of NHS resources to NLP activities outside of research purposes.

van der Gaag, M., D. H. Nieman, et al. (2012). ***"Cognitive behavioral therapy for subjects at ultrahigh risk for developing psychosis: A randomized controlled clinical trial."*** Schizophr Bull 38(6): 1180-1188. http://www.ncbi.nlm.nih.gov/pubmed/22941746

BACKGROUND: Evidence for the effectiveness of treatments for subjects at ultrahigh risk (UHR) for developing psychosis remains inconclusive. OBJECTIVE: A new cognitive behavioral intervention specifically targeted at cognitive biases (ie, Cognitive Behavioral Therapy [CBT] for UHR patients plus treatment as usual [TAU] called CBTuhr) is compared with TAU in a group of young help-seeking UHR subjects. METHODS: A total of 201 patients were recruited at 4 sites and randomized. In most cases, CBTuhr was an add-on therapy because most people were seeking help for a comorbid disorder. The CBT was provided for 6 months, and the follow-up period was 18 months. RESULTS: In the CBTuhr condition, 10 patients transitioned to psychosis compared with 22 in the TAU condition ($chi(2)$ $(1) = 5.575$, $P = .03$). The number needed to treat (NNT) was 9 (95% confidence interval [CI]: 4.7-89.9). At 18-month follow-up the CBTuhr group was significantly more often remitted from an at-risk mental state, with a NNT of 7 (95% CI: 3.7-71.2). Intention-to-treat analysis, including 5 violations against exclusion criteria, showed a statistical tendency ($chi(2)$ $(1) = 3.338$, $P = .06$). CONCLUSIONS: Compared with TAU, this new CBT (focusing on normalization and awareness of cognitive biases) showed a favorable effect on the transition to psychosis and reduction of subclinical psychotic symptoms in subjects at UHR to develop psychosis.

Vinson, D. C., B. J. Turner, et al. (2013). ***"Clinician suspicion of an alcohol problem: An observational study from the aafp national research network."*** The Annals of Family Medicine 11(1): 53-59. http://www.annfammed.org/content/11/1/53.abstract

PURPOSE In clinical practice, detection of alcohol problems often relies on clinician suspicion instead of using a screening instrument. We assessed the sensitivity, specificity, and predictive values of clinician suspicion compared with screening-detected alcohol problems in patients. METHODS We undertook a cross-sectional study of 94 primary care clinicians' office visits. Brief questionnaires were completed separately after a visit by both clinicians and eligible patients. The patient's anonymous exit questionnaire screened for hazardous drinking based on the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) and for harmful drinking (alcohol abuse or dependence) based on 2 questions from the Diagnostic and Statistical Manual of Mental Disorders. After the visit, clinicians responded to the question, "Does this patient have problems with alcohol?" with answer options including "yes, hazardous drinking" and "yes, alcohol abuse or dependence." Analyses assessed the associations between patients' responses to screening questions and clinician's suspicions. RESULTS Of 2,518 patients with an office visit, 2,173 were eligible, and 1,699 (78%) completed the exit questionnaire. One hundred seventy-one (10.1%) patients had a positive screening test for hazardous drinking (an AUDIT-C score of 5 or greater) and 64 (3.8%) for harmful drinking. Clinicians suspected alcohol problems in 81 patients (hazardous drinking in 37, harmful drinking in 40, and both in 4). The sensitivity of clinician suspicion of either hazardous or harmful drinking was 27% and the specificity was 98%. Positive and negative predictive values were 62% and 92%, respectively. CONCLUSION Clinician suspicion of alcohol problems had poor sensitivity but high specificity for identifying patients who had a positive screening test for alcohol problems. These data support the routine use of a screening tool to supplement clinicians' suspicions, which already provide reasonable positive predictive value. *(Although incorporating routine screening into primary care is not easy, there are ways to make it simpler, according to the authors. "To increase the feasibility of screening for alcohol problems in practice, a validated single screening question can be used. For example, for the question, 'When was the last time you had more than X drinks in one day?' where X is 4 for women and 5 for men, an answer of any time in the past 3 months was 86% sensitive and 86% specific in detecting alcohol problems compared with a structured, researcher-administered interview.")*

Wiles, N. J., A. M. Haase, et al. (2012). ***"Physical activity and depression in adolescents: Cross-sectional findings from the alspac cohort."*** Soc Psychiatry Psychiatr Epidemiol 47(7): 1023-1033. http://www.ncbi.nlm.nih.gov/pubmed/21826444

PURPOSE: Few studies have examined the association between physical activity (PA), measured objectively, and adolescent depressive symptoms. The aim of this study was to determine whether there is an association between objective measures of PA (total PA and time spent in moderate and vigorous PA (MVPA)) and adolescent depressive symptoms. METHODS: Data on 2,951 adolescents participating in ALSPAC were used. Depressive symptoms were measured using the self-report Mood and Feelings Questionnaire (MFQ) (short version). Measures of PA were based on accelerometry. The association between PA and MFQ scores was modelled using ordinal regression. RESULTS: Adolescents who were more physically active (total PA or minutes of MVPA) had a reduced odds of depressive symptoms [OR(adj) total PA (tertiles): medium 0.82 (95% CI: 0.69, 0.97); high 0.69 (95% CI: 0.57, 0.83)]; OR(adj) per 15 min MVPA: 0.92 (95% CI: 0.86, 0.98). In a multivariable model including both total PA and the percentage of time spent in MVPA, total PA was associated with depressive symptoms (OR(adj) total PA (tertiles): medium 0.82 (95% CI: 0.70, 0.98); high 0.70 (95% CI: 0.58, 0.85) but the percentage of time spent in MVPA was not independently associated with depressive symptoms [OR(adj) MVPA (tertiles) medium 1.05 (95% CI: 0.88, 1.24), high 0.91 (95% CI: 0.77, 1.09)]. CONCLUSIONS: The total amount of PA undertaken was associated with adolescent depressive symptoms, but the amount of time spent in MVPA, once total PA was accounted for, was not. If confirmed in longitudinal studies and randomised controlled trials, this would have important implications for public health messages.

Williams, C., P. Wilson, et al. (2013). ***"Guided self-help cognitive behavioural therapy for depression in primary care: A randomised controlled trial."*** PLoS One 8(1): e52735. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3543408/

(Free full text available) BACKGROUND: Access to Cognitive behavioural therapy (CBT) for depression is limited. One solution is CBT self-help books. Trial Objectives: To assess the impact of a guided self-help CBT book (GSH-CBT) on mood, compared to treatment as usual (TAU). Hypotheses:GSH-CBT will have improved mood and knowledge of the causes and treatment of depression compared to the control receiving TAUGuided self-help will be acceptable to patients and staff. METHODS AND FINDINGS: Participants: Adults attending seven general practices in Glasgow, UK with a BDI-II score of >/=14. 141 randomised to GSH-CBT and 140 to TAU. Interventions: RCT comparing 'Overcoming Depression: A Five Areas Approach' book plus 3-4 short face to face support appointments totalling up to 2 hours of guided support, compared with general practitioner TAU. Primary outcome: The BDI (II) score at 4 months. Numbers analysed: 281 at baseline, 203 at 4 months (primary outcome), 117 at 12 months. Outcome: Mean BDI-II scores were lower in the GSH-CBT group at 4 months by 5.3 points (2.6 to 7.9, p<0.001). At 4 and 12 months there were also significantly higher proportions of participants achieving a 50% reduction in BDI-II in the GSH-CBT arm. The mean support was 2 sessions with 42.7 minutes for session 1, 41.4 minutes for session 2 and 40.2 minutes of support for session 3. Adverse effects/Harms: Significantly less deterioration in mood in GSH-CBT (2.0% compared to 9.8% in the TAU group for BDI-II category change). LIMITATIONS: Weaknesses: Our follow-up rate of 72.2% at 4 months is better than predicted but is poorer at 12 months (41.6%). In the GSH-CBT arm, around 50% of people attended 2 or fewer sessions. 22% failed to take up treatment. CONCLUSIONS: GSH-CBT is substantially more effective than TAU.