36 action on depression abstracts, june '12

(Atlantis and Sullivan 2012; Baer, Lykins et al. 2012; Bertone-Johnson, Powers et al. 2012; Bieling, Hawley et al. 2012; Boschloo, Vogelzangs et al. 2012; Daley and Jolly 2012; Gibbons, Brown et al. 2012; Gibbons, Hur et al. 2012; Golden and Dalgleish 2012; Gruenewald, Liao et al. 2012; Gustavson, Røysamb et al. 2012; Harkness, Bagby et al. 2012; Kidger, Heron et al. 2012; Kmietowicz 2012; Korte, Bohlmeijer et al. 2012; Krusche, Cyhlarova et al. 2012; Kuster, Orth et al. 2012; Lee, Lennie et al. 2012; Leung, Gartner et al. 2012; Li, Shi et al. 2012; Ligthart, Richard et al. 2012; Lobban, Taylor et al. 2012; Melrose, Brown et al. 2012; Mohr, Ho et al. 2012; Nosarti C and et al. 2012; Rush, Wisniewski et al. 2012; Sarris, Mischoulon et al. 2012; Scott, McLaughlin et al. 2012; Sharpe, Burton et al. 2012; Sowislo and Orth 2012; Sunderland, Wong et al. 2012; Telford, McCarthy-Jones et al. 2012; von Wolff, Holzel et al. 2012; Weissman and Verdeli 2012; Wells, Fisher et al. 2012; Wu, Yeung et al. 2012)

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

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

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

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

Bertone-Johnson, E. R., S. I. Powers, et al. (2012). ***"Vitamin d supplementation and depression in the women's health initiative calcium and vitamin d trial."*** Am J Epidemiol 176(1): 1-13. http://www.ncbi.nlm.nih.gov/pubmed/22573431

While observational studies have suggested that vitamin D deficiency increases risk of depression, few clinical trials have tested whether vitamin D supplementation affects the occurrence of depression symptoms. The authors evaluated the impact of daily supplementation with 400 IU of vitamin D(3) combined with 1,000 mg of elemental calcium on measures of depression in a randomized, double-blinded US trial comprising 36,282 postmenopausal women. The Burnam scale and current use of antidepressant medication were used to assess depressive symptoms at randomization (1995-2000). Two years later, women again reported on their antidepressant use, and 2,263 completed a second Burnam scale. After 2 years, women randomized to receive vitamin D and calcium had an odds ratio for experiencing depressive symptoms (Burnam score >/=0.06) of 1.16 (95% confidence interval: 0.86, 1.56) compared with women in the placebo group. Supplementation was not associated with antidepressant use (odds ratio = 1.01, 95% confidence interval: 0.92, 1.12) or continuous depressive symptom score. Results stratified by baseline vitamin D and calcium intake, solar irradiance, and other factors were similar. The findings do not support a relation between supplementation with 400 IU/day of vitamin D(3) along with calcium and depression in older women. Additional trials testing higher doses of vitamin D are needed to determine whether this nutrient may help prevent or treat depression.

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

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

Decentering ($p < .01$) subscales of the Experiences Questionnaire and by the Toronto Mindfulness Scale. In addition, changes in Wider Experiences ($p < .05$) and Curiosity ($p < .01$) predicted lower Hamilton Rating Scale for Depression scores at 6-month follow-up. CONCLUSIONS: An increased capacity for decentering and curiosity may be fostered during MBCT and may underlie its effectiveness. With practice, patients can learn to counter habitual avoidance tendencies and to regulate dysphoric affect in ways that support recovery. [Correction Notice: An Erratum for this article was reported in Vol 80(3) of Journal of Consulting and Clinical Psychology (see record 2012-09923-001). There is an error in the sentence beginning "For TMS-C . . ." in the paragraph below Table 5.]

Boschloo, L., N. Vogelzangs, et al. (2012). ***"Alcohol use disorders and the course of depressive and anxiety disorders."*** The British Journal of Psychiatry 200(6): 476-484. http://bjp.rcpsych.org/content/200/6/476.abstract

Background: Inconsistent findings have been reported on the role of comorbid alcohol use disorders as risk factors for a persistent course of depressive and anxiety disorders. Aims: To determine whether the course of depressive and/or anxiety disorders is conditional on the type (abuse or dependence) or severity of comorbid alcohol use disorders. Method: In a large sample of participants with current depression and/or anxiety (n = 1369) we examined whether the presence and severity of DSM-IV alcohol abuse or alcohol dependence predicted the 2-year course of depressive and/or anxiety disorders. Results: The persistence of depressive and/or anxiety disorders at the 2-year follow-up was significantly higher in those with remitted or current alcohol dependence (persistence 62% and 67% respectively), but not in those with remitted or current alcohol abuse (persistence 51% and 46% respectively), compared with no lifetime alcohol use disorder (persistence 53%). Severe (meeting six or seven diagnostic criteria) but not moderate (meeting three to five criteria) current dependence was a significant predictor as 95% of those in the former group still had a depressive and/or anxiety disorder at follow-up. This association remained significant after adjustment for severity of depression and anxiety, psychosocial factors and treatment factors. Conclusions: Alcohol dependence, especially severe current dependence, is a risk factor for an unfavourable course of depressive and/or anxiety disorders, whereas alcohol abuse is not.

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

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

Gibbons, R. D., C. Brown, et al. (2012). ***"Suicidal thoughts and behavior with antidepressant treatment: Reanalysis of the randomized placebo-controlled studies of fluoxetine and venlafaxine."*** Archives of General Psychiatry 69(6): 580-587. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2048

Context The US Food and Drug Administration issued a black box warning for antidepressants and suicidal thoughts and behavior in children and young adults. Objective To determine the short-term safety of antidepressants by standard assessments of suicidal thoughts and behavior in youth, adult, and geriatric populations and the mediating effect of changes in

depressive symptoms.Data Sources All intent-to-treat person-level longitudinal data of major depressive disorder from 12 adult, 4 geriatric, and 4 youth randomized controlled trials of fluoxetine hydrochloride and 21 adult trials of venlafaxine hydrochloride. Study Selection All sponsor-conducted randomized controlled trials of fluoxetine and venlafaxine. Data Extraction The suicide items from the Children's Depression Rating Scale–Revised and the Hamilton Depression Rating Scale as well as adverse event reports of suicide attempts and suicide during active treatment were analyzed in 9185 patients (fluoxetine: 2635 adults, 960 geriatric patients, 708 youths; venlafaxine: 2421 adults with immediate-release venlafaxine and 2461 adults with extended-release venlafaxine) for a total of 53 260 person-week observations. Data Synthesis Suicidal thoughts and behavior decreased over time for adult and geriatric patients randomized to fluoxetine or venlafaxine compared with placebo, but no differences were found for youths. In adults, reduction in suicide ideation and attempts occurred through a reduction in depressive symptoms. In all age groups, severity of depression improved with medication and was significantly related to suicide ideation or behavior. Conclusions Fluoxetine and venlafaxine decreased suicidal thoughts and behavior for adult and geriatric patients. This protective effect is mediated by decreases in depressive symptoms with treatment. For youths, no significant effects of treatment on suicidal thoughts and behavior were found, although depression responded to treatment. No evidence of increased suicide risk was observed in youths receiving active medication. To our knowledge, this is the first research synthesis of suicidal thoughts and behavior in depressed patients treated with antidepressants that examined the mediating role of depressive symptoms using complete longitudinal person-level data from a large set of published and unpublished studies.

Gibbons, R. D., K. Hur, et al. (2012). ***"Benefits from antidepressants: Synthesis of 6-week patient-level outcomes from double-blind placebo-controlled randomized trials of fluoxetine and venlafaxine."*** Archives of General Psychiatry 69(6): 572-579. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2044

Context Some meta-analyses suggest that efficacy of antidepressants for major depression is overstated and limited to severe depression. Objective To determine the short-term efficacy of antidepressants for treating major depressive disorder in youth, adult, and geriatric populations. Data Sources Reanalysis of all intent-to-treat person-level longitudinal data during the first 6 weeks of treatment of major depressive disorder from 12 adult, 4 geriatric, and 4 youth randomized controlled trials of fluoxetine hydrochloride and 21 adult trials of venlafaxine hydrochloride. Study Selection All sponsor-conducted randomized controlled trials of fluoxetine and venlafaxine. Data Extraction Children's Depression Rating Scale–Revised scores (youth population), Hamilton Depression Rating Scale scores (adult and geriatric populations), and estimated response and remission rates at 6 weeks were analyzed for 2635 adults, 960 geriatric patients, and 708 youths receiving fluoxetine and for 2421 adults receiving immediate-release venlafaxine and 2461 adults receiving extended-release venlafaxine. Data Synthesis Patients in all age and drug groups had significantly greater improvement relative to control patients receiving placebo. The differential rate of improvement was largest for adults receiving fluoxetine (34.6% greater than those receiving placebo). Youths had the largest treated vs control difference in response rates (24.1%) and remission rates (30.1%), with adult differences generally in the 15.6% (remission) to 21.4% (response) range. Geriatric patients had the smallest drug-placebo differences, an 18.5% greater rate of improvement, 9.9% for response and 6.5% for remission. Immediate-release venlafaxine produced larger effects than extended-release venlafaxine. Baseline severity could not be shown to affect symptom reduction. Conclusions To our knowledge, this is the first research synthesis in this area to use complete longitudinal person-level data from a large set of published and unpublished studies. The results do not support previous findings that antidepressants show little benefit except for severe depression. The antidepressants fluoxetine and venlafaxine are efficacious for major depressive disorder in all age groups, although more so in youths and adults compared with geriatric patients. Baseline severity was not significantly related to degree of treatment advantage over placebo.

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

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

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

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

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

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

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

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

Kidger, J., J. Heron, et al. (2012). ***"Adolescent self-harm and suicidal thoughts in the alspac cohort: A self-report survey in england."*** BMC Psychiatry 12(1): 69. http://www.biomedcentral.com/1471-244X/12/69

(Free full text available) BACKGROUND: Substantial numbers of adolescents self-harm, but the majority of cases do not reach the attention of medical services, making community studies essential. The prevalence of suicidal thoughts and plans at this age, and the inter-relationships between suicidal thoughts, plans and self-harm remain largely unexplored. METHOD: Cross-sectional analysis of a postal survey of the Avon Longitudinal Study of Parents and Children (ALSPAC) birth cohort, England. Respondents (n=4810) were aged 16-17 years old. RESULTS: Of all respondents, 905 (18.8%) had ever self-harmed - one quarter of whom wanted to die in their most recent episode - 15.8% had ever thought of killing themselves, and 4.3% had ever made plans to do so. Among those who had self-harmed and wanted to die, 90.4% had ever had suicidal thoughts, compared to 37.6% of those who had self-harmed but not wanted to die, and 7.8% of those who had never self-harmed (chi-square statistic =102.3, p<0.001). Those who self-harmed with and without desire to die were also at substantially increased risk of suicidal plans (52.8% and 8.7% respectively compared to 0.7%, 2 =166.9, p<0.001). As the frequency of self-harm increased, so did the risk of suicidal thoughts and plans. CONCLUSIONS: Self-harm and suicidal thoughts are common among 16/17 year olds, and may be on the increase. Although the majority of self-harm behaviour is not accompanied by a desire to die, those who self-harm both with and without a desire to die are at greatly increased risk of suicidal thoughts and plans.

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

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

Korte, J., E. T. Bohlmeijer, et al. (2012). ***"Life review therapy for older adults with moderate depressive symptomatology: A pragmatic randomized controlled trial."*** Psychological Medicine 42(06): 1163-1173. http://dx.doi.org/10.1017/S0033291711002042

Background: Although there is substantial evidence for the efficacy of life review therapy as an early treatment of depression in later life, its effectiveness in natural settings has not been studied. The present study evaluates an intervention based on life review and narrative therapy in a large multi-site, pragmatic randomized controlled trial (RCT). Method: Life review therapy was compared with care as usual. The primary outcome was depressive symptoms; secondary outcomes were anxiety symptoms, positive mental health, quality of life, and current major depressive episode (MDE). To identify groups for whom the intervention was particularly effective, moderator analyses were carried out (on sociodemographic variables, personality traits, reminiscence functions, clinically relevant depressive and anxiety symptoms, and past MDEs). Results: Compared with care as usual (n=102), life review therapy (n=100) was effective in reducing depressive symptoms, at post-treatment (d=0.60, B=−5.3, p<0.001), at 3-month follow-up (d=0.50, B=−5.0, p<0.001) and for the intervention also at 9-month follow-up (t=5.7, p<0.001). The likelihood of a clinically significant change in depressive symptoms was significantly higher [odds ratio (OR) 3.77, p<0.001 at post-treatment; OR 3.76, p<0.001 at the 3-month follow-up]. Small significant effects were found for symptoms of anxiety and positive mental health. Moderator analyses showed only two significant moderators, the personality trait of extraversion and the reminiscence function of boredom reduction. Conclusions: This study shows the effectiveness of life review therapy as an early intervention for depression in an ecologically valid context, supporting its applicability to a broad target group. The intervention is also effective in reducing anxiety symptoms and strengthening positive mental health.

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

(Free full text available) OBJECTIVES: Stress has been shown to have a number of negative effects on health over time. Mindfulness interventions have been shown to decrease perceived stress but access to interventions is limited. Therefore, the effectiveness of an online mindfulness course for perceived stress was investigated. DESIGN: A preliminary evaluation of an online mindfulness course. PARTICIPANTS: This sample consisted of 100 self-referrals to the online course. The average age of participants was 48 years and 74% were women. INTERVENTIONS: The online programme consisted of modules taken from Mindfulness Based Stress Reduction and Mindfulness Based Cognitive Therapy and lasted for approximately 6 weeks. PRIMARY AND SECONDARY OUTCOME MEASURES: Participants completed the Perceived Stress Scale (PSS) before the course, after the course and at 1-month follow-up. Completion of formal (eg, body scan, mindful movement) and informal (eg, mindful meal, noticing) mindfulness activities was self-reported each week. RESULTS: Participation in the online mindfulness course significantly reduced perceived stress upon completion and remained stable at follow-up. The pre-post effect size was equivalent to levels found in other class-based mindfulness programmes. Furthermore, people who had higher PSS scores before the course reported engaging in significantly more mindfulness practice, which was in turn associated with greater decreases in PSS. CONCLUSIONS: Because perceived stress significantly decreased with such limited exposure to mindfulness, there are implications for the accessibility of mindfulness therapies online. Future research needs to evaluate other health outcomes for which face-to-face mindfulness therapies have been shown to help, such as anxiety and depressive symptoms.

Kuster, F., U. Orth, et al. (2012). ***"Rumination mediates the prospective effect of low self-esteem on depression: A five-wave longitudinal study."*** Pers Soc Psychol Bull 38(6): 747-759. http://www.ncbi.nlm.nih.gov/pubmed/22394574

Previous research supports the vulnerability model of low self-esteem and depression, which states that low self-esteem operates as a prospective risk factor for depression. However, it is unclear which processes mediate the effect of low self-esteem. To test for the mediating effect of rumination, the authors used longitudinal mediation models, which included exclusively prospective effects and controlled for autoregressive effects of the constructs. Data came from 663 individuals (aged 16 to 62 years), who were assessed 5 times over an 8-month period. The results indicated that low self-esteem predicted subsequent rumination, which in turn predicted subsequent depression, and that rumination partially mediated the prospective effect of low self-esteem on depression. These findings held for both men and women, and for both affective-cognitive and somatic symptoms of depression. Future studies should test for the mediating effects of additional intrapersonal and interpersonal processes.

Lee, K. S., T. A. Lennie, et al. (2012). ***"Association of physical versus affective depressive symptoms with cardiac event–free survival in patients with heart failure."*** Psychosomatic Medicine 74(5): 452-458. http://www.psychosomaticmedicine.org/content/74/5/452.abstract

Objective To determine whether physical depressive symptoms inflate the association between depressive symptoms as measured with the nine-item Patient Health Questionnaire (PHQ-9) and cardiac event–free survival in patients with heart failure (HF).Methods A total of 210 patients with HF were recruited from HF clinics affiliated with two academic medical centers. The PHQ-9 was used to assess levels of depressive symptoms. Cardiac event–free survival data (cardiac death, cardiac hospitalization, or cardiac emergency department visit) were collected for a median follow-up of 360 days. Cox proportional hazards regression analyses were performed separately for physical and affective depressive symptom dimensions of the PHQ-9 to examine predictive ability for time to the first cardiac event.Results Scores of both physical and affective depressive symptom dimensions of the PHQ-9 predicted time to the first cardiac event in separate unadjusted models. However, scores of the physical depressive symptom dimension did not predict time to the first cardiac events, whereas scores of the affective depressive symptom dimension remained as an independent predictor (hazard ratio = 1.12, 95% confidence interval = 1.03–1.22) after controlling for health status (comorbidities and the New York Heart Association functional class) and clinical and sociodemographic factors.Conclusions Affective depressive symptoms, not physical depressive symptoms, predicted time to the first cardiac event independent of health status and clinical and sociodemographic characteristics. The use of the full PHQ-9 does not inflate the relationship of depressive symptoms to cardiac event–free survival. Thus, clinicians can use the PHQ-9 to assess depressive symptoms in their patients with HF without concern that the instrument overestimates the relationship between depressive symptoms and outcomes.

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

Background Tobacco smoking and poor mental health are both prevalent and detrimental health problems in young women. The temporal relationship between the two variables is unclear. We investigated the prospective bi-directional relationship between smoking and mental health over 13 years. Method Participants were a randomly selected community sample of 10 012 young women with no experience of pregnancy, aged 18–23 years at baseline (1996) from the Australian Longitudinal Study on Women's Health. Follow-up surveys over 13 years were completed in 2000, 2003, 2006 and 2009,

allowing for five waves of data. Measures included self-reported smoking and mental health measured by the Mental Health Index from the 36-item short-form health questionnaire and the 10-item Center for Epidemiologic Studies Depression Scale. Sociodemographic control variables included marital status, education level and employment status. Results A strong cross-sectional dose–response relationship between smoking and poor mental health was found at each wave [odds ratio (OR) 1.41, 95% confidence intervals (CI) 1.17–1.70 to OR 2.27, 95% CI 1.82–2.81]. Longitudinal results showed that women who smoked had 1.21 (95% CI 1.06–1.39) to 1.62 (95% CI 1.24–2.11) times higher odds of having poor mental health at subsequent waves. Women with poor mental health had 1.12 (95% CI 1.17–1.20) to 2.11 (95% CI 1.68–2.65) times higher odds of smoking at subsequent waves. These results held after adjusting for mental health history and smoking history and sociodemographic factors. Correlation analysis and structural equation modelling results were consistent in showing that both directions of the relationship were statistically significant. Conclusions The association between poor mental health and smoking in young women appeared to be bi-directional.

Li, Y., S. Shi, et al. (2012). ***"Patterns of co-morbidity with anxiety disorders in chinese women with recurrent major depression."*** Psychological Medicine 42(06): 1239-1248. http://dx.doi.org/10.1017/S003329171100273X

Background Studies conducted in Europe and the USA have shown that co-morbidity between major depressive disorder (MDD) and anxiety disorders is associated with various MDD-related features, including clinical symptoms, degree of familial aggregation and socio-economic status. However, few studies have investigated whether these patterns of association vary across different co-morbid anxiety disorders. Here, using a large cohort of Chinese women with recurrent MDD, we examine the prevalence and associated clinical features of co-morbid anxiety disorders. Method A total of 1970 female Chinese MDD patients with or without seven co-morbid anxiety disorders [including generalized anxiety disorder (GAD), panic disorder, and five phobia subtypes] were ascertained in the CONVERGE study. Generalized linear models were used to model association between co-morbid anxiety disorders and various MDD features. Results The lifetime prevalence rate for any type of co-morbid anxiety disorder is 60.2%. Panic and social phobia significantly predict an increased family history of MDD. GAD and animal phobia predict an earlier onset of MDD and a higher number of MDD episodes, respectively. Panic and GAD predict a higher number of DSM-IV diagnostic criteria. GAD and blood-injury phobia are both significantly associated with suicidal attempt with opposite effects. All seven co-morbid anxiety disorders predict higher neuroticism. Conclusions Patterns of co-morbidity between MDD and anxiety are consistent with findings from the US and European studies; the seven co-morbid anxiety disorders are heterogeneous when tested for association with various MDD features.

Ligthart, S. A., E. Richard, et al. (2012). ***"Association of vascular factors with apathy in community-dwelling elderly individuals."*** Archives of General Psychiatry 69(6): 636-642. http://dx.doi.org/10.1001/archgenpsychiatry.2011.1858

Context Apathy in community-dwelling elderly individuals has been associated with a history of stroke and other cardiovascular disease. Objective To assess the relationship between symptoms of apathy and cardiovascular risk factors or disease (stroke or other) in a large sample of elderly people aged 70 to 78 years without depression or dementia.Design Cross-sectional data analysis within an ongoing cluster-randomized, open, multicenter trial.Setting The Netherlands, general community. Participants We studied 3534 elderly individuals without dementia who were included in the Prevention of Dementia by Intensive Vascular Care trial. Main Outcome Measures Symptoms of apathy, assessed with 3 items from the 15-item Geriatric Depression Scale, in participants with few or no depressive symptoms. Results The median age of participants was 74.3 years. Principal components analysis of the Geriatric Depression Scale confirmed a separate factor for the apathy items (Geriatric Depression Scale–3A). Two or more symptoms of apathy were present in 699 participants (19.9%), of whom 372 (53.2%) were without depressive symptoms (Geriatric Depression Scale–12D score <2). Ordinal regression analysis showed that increasing apathy in the absence of depressive symptoms was associated with a history of stroke (odds ratio, 1.79; 95% CI, 1.38-2.31) and cardiovascular disease other than stroke (1.28; 1.09-1.52). Exploratory analysis among 1889 participants free from stroke and other cardiovascular disease revealed an association between apathy score and the following cardiovascular risk factors: systolic blood pressure (P = .03), body mass index (P = .002), type 2 diabetes mellitus (P = .07), and C-reactive protein (P < .001). Conclusions Symptoms indicative of apathy are common in community-dwelling nondemented older people who are free from depression. The independent association of stroke, other cardiovascular disease, and cardiovascular risk factors with symptoms of apathy suggests a causal role of vascular factors.

Lobban, F., K. Taylor, et al. (2012). ***"Bipolar disorder is a two-edged sword: A qualitative study to understand the positive edge."*** Journal of Affective Disorders(0). http://www.sciencedirect.com/science/article/pii/S0165032712001681

Background Bipolar Disorder (BD) can have highly detrimental effects on the lives of people with the diagnosis and those who care about them. However, growing evidence suggests that aspects of bipolar experiences are also highly valued by some people. Method We aimed to understand how participants with a diagnosis of BD made sense of what they took to be positive about their bipolar experiences. Interpretative Phenomenological Analysis was used in the collection and analysis of data from 10 individuals in the UK. Results Positive aspects were numerous, highly valued and participants welcomed the opportunity to discuss them. Three important themes emerged: 1) Direct positive impact of bipolar experiences on everyday life including amplification of internal states, enhanced abilities and more intense human connectedness; 2) Lucky to be bipolar – the sense of having been given a special gift; 3) Relationship between the self and bipolar experiences. Limitations Given the small size, further research is needed to explore how widely positive aspects of BD are experienced. Conclusions These themes highlight the need to invite people to talk about the positive aspects of their bipolar experiences as well as the difficulties they face. This may help us to understand ambivalence to current treatment and to develop interventions that minimise the negative impacts, whilst recognising and potentially retaining some of the positives.

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

Overdetection and underdetection of depression and anxiety in primary care are common and may partly reflect individuals' misperceptions of the severity of symptoms they experience. Here, we explore how people's judgments about the severity of their own symptoms are influenced by their beliefs about the distribution of symptoms experienced by the rest of the population. We apply the rank-based decision by sampling cognitive model of judgment to symptom severity. The model proposes that judgments depend on the relative rank of an item within a mental sample of comparable items. It is predicted that judgments of symptom severity will be context dependent and more specifically that an individual's judgments will be invalid to the extent that the individual has inaccurate beliefs about the relevant social context. Two studies found that participants' assessments of symptom severity were rank based. Study 1 elicited participants' beliefs about the social distribution of symptoms and found that participants' judgments of whether they were depressed or anxious were mainly predicted not by their symptoms' objective severity but rather by where participants ranked the severity of their symptoms in comparison with the believed symptoms of others. Study 2 varied symptom distributions experimentally and again found relative rank effects as predicted. It is concluded that the real-world application of contextual models of judgment requires investigation of individual

differences in participants' background beliefs. *MedicalXpress - http://medicalxpress.com/news/2012-05-people-depression-anxiety.html - comments "People's judgements about whether they are depressed depend on how they believe their own suffering "ranks" in relation to the suffering of friends and family and the wider world, according to a new study. Research from the Department of Psychology at the University of Warwick finds that people make inaccurate judgements about their depression and anxiety symptoms – potentially leading to missed diagnoses as well as false positive diagnoses of mental health problems. This is of particular concern as vulnerable individuals surrounded by people with mental health problems may decide not to seek help because, compared to those around them, they perceive their suffering to be less severe than it actually is. Conversely, those surrounded by people who feel depressed very rarely may incorrectly believe that their suffering is abnormal, simply because their symptoms appear to be more severe in comparison to others. Researchers performed two experiments which found that people's judgments of whether they were depressed or anxious were not mainly predicted by their symptoms' objective severity - but by where they ranked that severity compared with their perception of others' symptoms. The UK study showed that participants' beliefs about the distribution of symptoms in the wider population varied greatly. For example ten per cent of participants thought that half the population felt depressed on at least 15 days a month, and ten per cent thought they felt so on two days or fewer a month. Ten per cent of participants thought that half the population felt anxious on at least 26 days a month, whereas ten per cent thought they felt so on seven days or fewer. Lead researcher Karen Melrose from the University of Warwick said: "It is the patient that initiates most GP consultations about depression and anxiety, so that personal decision to see a doctor is a vital factor in determining a diagnosis. "Given that fact, our study may explain why there are such high rates of under and over-detection of depression and anxiety. "Worryingly, people who could be the most vulnerable to mental health disorders – for example those from certain geographical areas of the country or demographic groups where depression and anxiety are high – could be the very ones who are at highest risk of missed diagnoses. "This research could help health professionals better target information campaigns aimed at these groups."*

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

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

Nosarti C, R. A. M. R. M. and et al. (2012). ***"Preterm birth and psychiatric disorders in young adult life."*** Archives of General Psychiatry 69(6): 610-617. http://dx.doi.org/10.1001/archgenpsychiatry.2011.1374

Context: Preterm birth, intrauterine growth restriction, and delivery-related hypoxia have been associated with schizophrenia. It is unclear whether these associations pertain to other adult-onset psychiatric disorders and whether these perinatal events are independent. Objective: To investigate the relationships among gestational age, nonoptimal fetal growth, Apgar score, and various psychiatric disorders in young adult life. Design: Historical population-based cohort study. Setting: Identification of adult-onset psychiatric admissions using data from the National Board of Health and Welfare, Stockholm, Sweden.Participants All live-born individuals registered in the nationwide Swedish Medical Birth Register between 1973 and 1985 and living in Sweden at age 16 years by December 2002 (n = 1 301 522). Main Outcome Measures: Psychiatric hospitalization with nonaffective psychosis, bipolar affective disorder, depressive disorder, eating disorder, drug dependency, or alcohol dependency, diagnosed according to the International Classification of Diseases codes for 8 through 10. Cox proportional hazards regression models were used to estimate hazard ratios and 95% CIs. Results: Preterm birth was significantly associated with increased risk of psychiatric hospitalization in adulthood (defined as ≥16 years of age) in a monotonic manner across a range of psychiatric disorders. Compared with term births (37-41 weeks), those born at 32 to 36 weeks' gestation were 1.6 (95% CI, 1.1-2.3) times more likely to have nonaffective psychosis, 1.3 (95% CI, 1.1-1.7) times more likely to have depressive disorder, and 2.7 (95% CI, 1.6-4.5) times more likely to have bipolar affective disorder. Those born at less than 32 weeks' gestation were 2.5 (95% CI, 1.0-6.0) times more likely to have nonaffective psychosis, 2.9 (95% CI, 1.8-4.6) times more likely to have depressive disorder, and 7.4 (95% CI, 2.7-20.6) times more likely to have bipolar affective disorder. Conclusions: The vulnerability for hospitalization with a range of psychiatric diagnoses may increase with younger gestational age. Similar associations were not observed for nonoptimal fetal growth and low Apgar score.

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

Background Major depressive disorder (MDD) is commonly chronic and/or recurrent. We aimed to determine whether a chronic and/or recurrent course of MDD is associated with acute and longer-term MDD treatment outcomes. Method This cohort study recruited out-patients aged 18–75 years with non-psychotic MDD from 18 primary and 23 psychiatric care clinics across the USA. Participants were grouped as: chronic (index episode >2 years) and recurrent (n=398); chronic non-recurrent (n=257); non-chronic recurrent (n=1614); and non-chronic non-recurrent (n=387). Acute treatment was up to 14 weeks of citalopram (⩽60 mg/day) with up to 12 months of follow-up treatment. The primary outcomes for this report were remission

[16-item Quick Inventory of Depressive Symptomatology – Self-Rated (QIDS-SR16) ⩽5] or response (⩾50% reduction from baseline in QIDS-SR16) and time to first relapse [first QIDS-SR16 by Interactive Voice Response (IVR) ⩾11]. Results Most participants (85%) had a chronic and/or recurrent course; 15% had both. Chronic index episode was associated with greater sociodemographic disadvantage. Recurrent course was associated with earlier age of onset and greater family histories of depression and substance abuse. Remission rates were lowest and slowest for those with chronic index episodes. For participants in remission entering follow-up, relapse was most likely for the chronic and recurrent group, and least likely for the non-chronic, non-recurrent group. For participants not in remission when entering follow-up, prior course was unrelated to relapse. Conclusions Recurrent MDD is the norm for out-patients, of whom 15% also have a chronic index episode. Chronic and recurrent course of MDD may be useful in predicting acute and long-term MDD treatment outcomes.

Sarris, J., D. Mischoulon, et al. (2012). ***"Omega-3 for bipolar disorder: Meta-analyses of use in mania and bipolar depression."*** J Clin Psychiatry 73(1): 81-86. http://www.ncbi.nlm.nih.gov/pubmed/21903025

OBJECTIVE: Studies using augmentation of pharmacotherapies with omega-3 in bipolar disorder have been conducted; however, to date a specific meta-analysis in this area has not been published. Thus, we present the significant findings from meta-analyses of omega-3 in the treatment of bipolar depression and bipolar mania. DATA SOURCES: PubMed, CINAHL, Web of Science, and Cochrane Library databases were searched for clinical trials up to September 1, 2010, using the search terms bipolar disorder OR bipolar depression OR bipolar mania OR mania OR hypomania OR cyclothymia with the search terms omega 3 OR essential fatty acids OR polyunsaturated fatty acids OR DHA OR EPA OR fish oil OR flax oil. Clinical trial registries and gray literature (published or unpublished data not readily accessible via main databases) were also searched. DATA SELECTION: The analysis included randomized controlled studies 4 weeks or longer, with a sample size > 10, written in English, using omega-3 for diagnosed bipolar depression or mania. No criteria were set for age, gender, or ethnicity. DATA EXTRACTION: A random-effects model was used. The model analyzed the standard mean difference between treatment and placebo between baseline and endpoint, combining the effect size (Hedges g) data. Funnel plot and heterogeneity analyses (I(2)) were also performed. DATA SYNTHESIS: The findings of 5 pooled datasets (n = 291) on the outcome of bipolar depression revealed a significant effect in favor of omega-3 (P = .029), with a moderate effect size of 0.34. On the outcome of mania, 5 pooled datasets (n = 291) revealed a nonsignificant effect in favor of omega-3 (P = .099), with an effect size of 0.20. Minor heterogeneity between studies on the outcome of bipolar depression was found (I(2) = 30%; P = .213), which was not present on the outcome of bipolar mania (I(2) = 0%; P = .98). Funnel plot symmetry suggested no significant likelihood of publication bias. Meta-regression analysis between sample size and effect size, however, revealed that studies with smaller sample sizes had larger effect sizes (P = .05). CONCLUSIONS: The meta-analytic findings provide strong evidence that bipolar depressive symptoms may be improved by adjunctive use of omega-3. The evidence, however, does not support its adjunctive use in attenuating mania.

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

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

Sharpe, M., C. Burton, et al. (2012). ***"Is co-morbid depression adequately treated in patients repeatedly referred to specialist medical services with symptoms of a medical condition?"*** Journal of Psychosomatic Research 72(6): 419-421. http://www.sciencedirect.com/science/article/pii/S0022399912000748

Objective Patients with a medical condition and co-morbid depression have more symptoms and use more medical services. We aimed to determine the prevalence of depression and the adequacy of its treatment in patients who had been repeatedly referred from primary to specialist medical care for the assessment of a medical condition. Methods All patients who had at least three referrals to medical and surgical specialists for an assessment of symptoms attributed to a medical condition, over a five year period from five primary care practices in Edinburgh, UK were identified using a referral database and review of records. Participants were sent a questionnaire which included the PHQ-9 depression scale and additional questions about depression during the preceding 5 years. Details of treatment for depression were obtained from primary care records. Results Questionnaires were sent to 230 patients and returned by 162 (70.4%). Forty-one (25.3%) had a PHQ-9 score of 10 or more and hence probable current depressive disorder. An additional 36 (22.2%) reported depression in the previous 5 years. Only eight (19.5%) of those reporting current depression and 20 (26%) of the 77 patients reporting previous depression had received minimally adequate treatment for it. Conclusion Whilst we know that patients with medical conditions are often depressed and that such co-morbid depression is often undertreated, we have found that it is undertreated even in patients repeatedly referred to medical specialists. Better assessment and management of depression in such patients could both improve patients' quality of life and reduce the cost of care.

Sowislo, J. F. and U. Orth (2012). ***"Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies."*** Psychol Bull. http://www.ncbi.nlm.nih.gov/pubmed/22730921

Low self-esteem and depression are strongly related, but there is not yet consistent evidence on the nature of the relation. Whereas the vulnerability model states that low self-esteem contributes to depression, the scar model states that depression erodes self-esteem. Furthermore, it is unknown whether the models are specific for depression or whether they are also valid for anxiety. We evaluated the vulnerability and scar models of low self-esteem and depression, and low self-esteem and anxiety, by meta-analyzing the available longitudinal data (covering 77 studies on depression and 18 studies on anxiety). The mean age of the samples ranged from childhood to old age. In the analyses, we used a random-effects model and examined prospective effects between the variables, controlling for prior levels of the predicted variables. For depression, the findings supported the vulnerability model: The effect of self-esteem on depression (beta = -.16) was significantly stronger than the effect of depression on self-esteem (beta = -.08). In contrast, the effects between low self-esteem and anxiety were relatively balanced: Self-esteem predicted anxiety with beta = -.10, and anxiety predicted self-esteem with beta = -.08. Moderator analyses were conducted for the effect of low self-esteem on depression; these suggested that the effect is not significantly

influenced by gender, age, measures of self-esteem and depression, or time lag between assessments. If future research supports the hypothesized causality of the vulnerability effect of low self-esteem on depression, interventions aimed at increasing self-esteem might be useful in reducing the risk of depression.

Sunderland, M., N. Wong, et al. (2012). ***"Investigating trajectories of change in psychological distress amongst patients with depression and generalised anxiety disorder treated with internet cognitive behavioural therapy."*** Behaviour Research and Therapy 50(6): 374-380. http://www.sciencedirect.com/science/article/pii/S0005796712000551

Internet based cognitive behavioural therapy (CBT) is efficacious for the treatment of anxiety and depression. The current study aimed to examine the effectiveness of internet based CBT prescribed by primary care clinicians for the treatment of depression and generalised anxiety disorder. Psychological distress data from 302 patients who completed an online CBT course for depression and 361 patients who completed an online CBT course for generalised anxiety disorder were subjected to growth mixture analysis. For both disorders psychological distress decreased across each lesson in a quadratic trend. Two classes of individuals were identified with different trajectories of change: a large group of individuals who responded well to the courses and a smaller group of individuals with a lower response. Both groups were similar with respect to socio-demographic characteristics however the Low Responders tended to have higher levels of symptom severity and psychological distress at baseline in comparison to the responders. For the majority of patients (75–80%) the internet CBT courses for depression and generalised anxiety disorder were effective. Further research is required to identify and effectively treat the smaller proportion of patients who did not improve during internet CBT.

Telford, C., S. McCarthy-Jones, et al. (2012). ***"Experience sampling methodology studies of depression: The state of the art."*** Psychological Medicine 42(06): 1119-1129. http://dx.doi.org/10.1017/S0033291711002200

Background: Experience Sampling Methodology (ESM) is ideally suited to test the predictions, and inform the development of contemporary cognitive models of depression. Yet there has been no systematic examination of ESM in depression research. Method: A search of databases (PsychARTICLES, PsycINFO, AMED, Ovid Medline and CINAHL) was conducted to identify studies published within the last 25 years investigating major depressive disorder (MDD) using ESM.ResultsAltogether, 19 studies using ESM, or comparable methodologies, with clinically depressed individuals were identified and critically reviewed. The identified studies examined six aspects of MDD: methodological issues; positive and negative affect; cortisol secretion; antidepressant treatment; work performance; genetic risk factors. Conclusions: Despite some methodological limitations of existing studies, ESM has made a significant contribution to our current understanding of depression by consolidating existing theories, uncovering new and clinically relevant findings and identifying questions for future research. This review concludes by introducing the possibility of using ESM as an intervention tool in clinical practice and proposing that ESM could be useful for furthering knowledge of the causes of MDD.

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

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

Weissman, M. and H. Verdeli (2012). ***"Interpersonal psychotherapy: Evaluation, support, triage."*** Clinical Psychology & Psychotherapy 19(2): 106-112. http://dx.doi.org/10.1002/cpp.1775

Depression is highly prevalent and debilitating among medically ill patients. As high as one third of the primary practise patients screen positive for depression symptoms and over half of the patients diagnosed with major depressive disorder are treated in primary care. However, current primary care service arrangements do not efficiently triage patients who screen positive for depression into appropriate treatments that reflect their individual needs and preferences. In this paper, we describe a tool that aims to fill the gap between screening the patients for depression and triaging them to appropriate care. This is a three-session adaptation of interpersonal psychotherapy: ipt; evaluation, support, triage (IPT-EST). We first outline IPT-EST procedures that aim to provide structure and content to primary care practitioners who identify patients with positive depression symptoms, thus assisting the practitioners to explore the patients' psychosocial triggers of depression, give basic strategies to manage these interpersonal stressors and provide decisions tools about triaging patients with severe/persistent depression into appropriate treatment. Key Practitioner Message * IPT-EST is a brief (2–3 sessions) intervention designed for primary care providers working with patients screened positive for depression. * It offers practitioners structure and content to 1) support patients during depression evaluation; 2) explore interpersonal triggers of depression symptoms; and 3) triage into appropriate services as needed.

Wells, A., P. Fisher, et al. (2012). ***"Metacognitive therapy in treatment-resistant depression: A platform trial."*** Behaviour Research and Therapy 50(6): 367-373. http://www.sciencedirect.com/science/article/pii/S0005796712000319

Patients with treatment-resistant depression received up to 8 sessions of metacognitive therapy (MCT) targeting attentional control, rumination, worry, and metacognitive beliefs. A baseline period was followed by weekly sessions with follow-up assessments at 6 and 12 months post treatment. Large and statistically significant improvements occurred in all symptom measures at post treatment and were maintained over follow-up. Two out of 3 process measures significantly improved at post treatment and all of these measures were improved at follow-up. Treatment was associated with similar response rates on the BDI and Hamilton rating scale. Using liberal criteria 80% of completers were classified as recovered at post treatment and 70% at follow-up on the BDI. In the intention to treat sample 66.6% were recovered at post treatment and 58.3% at follow-up. More stringent criteria showed 60% recovery rates at post treatment and at 12m. The results suggest that MCT could be a brief and effective treatment and they provide a precedent for more definitive randomized controlled trials.

Wu, J., A. S. Yeung, et al. (2012). ***"Acupuncture for depression: A review of clinical applications."*** Can J Psychiatry 57(7): 397-405. http://www.ncbi.nlm.nih.gov/pubmed/22762294

While increasing numbers of patients are seeking acupuncture treatment for depression in recent years, there is limited evidence of the antidepressant (AD) effectiveness of acupuncture. Given the unsatisfactory response rates of many Food and Drug Administration-approved ADs, research on acupuncture remains of potential value. Therefore, we sought to review the efficacy and safety of acupuncture treatment for depression in clinical applications. We conducted a PubMed search for publications through 2011. We assessed the adequacy of each report and abstracted information on reported effectiveness or efficacy of acupuncture as monotherapy for major depressive disorder (MDD) and as augmentation of ADs. We also examined adverse events associated with acupuncture, and evidence for acupuncture as a means of reducing side effects of ADs. Published data suggest that acupuncture, including manual-, electrical-, and laser-based, is a generally beneficial, well-tolerated, and safe monotherapy for depression. However, acupuncture augmentation in AD partial responders and nonresponders is not as well studied as monotherapy; and available studies have only investigated MDD, but not other depressive spectrum disorders. Manual acupuncture reduced side effects of ADs in MDD. We found no data on depressive recurrence rates after recovery with acupuncture treatment. Acupuncture is a potential effective monotherapy for depression, and a safe, well-tolerated augmentation in AD partial responders and nonresponders. However, the body of evidence based on well-designed studies is limited, and further investigation is called for.