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(Afifi, Mota et al. 2012; Beidas, Edmunds et al. 2012; Car, Gurol-Urganci et al. 2012; Cipriani, Purgato et al. 2012; Gulliver, Griffiths et al. 2012; H., V. et al. 2012; Inoue, Tanaka et al. 2012; Jakobsen, Hansen et al. 2012; Kelleher, Keeley et al. 2012; Levin 2012; Lewis 2012; McLaughlin, Nandi et al. 2012; Meyer and Hautzinger 2012; Murray and Jones 2012; Pilling and Anderson 2012; Rhebergen, Lamers et al. 2012; Rimer, Dwan et al. 2012; Seder and Oishi 2012; Sinclair 2012; Swift and Greenberg 2012; Swift, Greenberg et al. 2012; Thompson and McCabe 2012; van der Horst and Coffé 2012; Watkins, Taylor et al. 2012; Yonkers, Norwitz et al. 2012)

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

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

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

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

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

BACKGROUND: Missed appointments are a major cause of inefficiency in healthcare delivery, with substantial monetary costs for the health system, leading to delays in diagnosis and appropriate treatment. Patients' forgetfulness is one of the main reasons for missed appointments, and reminders may help alleviate this problem. Modes of communicating reminders for appointments to patients include face-to-face communication, postal messages, calls to landlines or mobile phones, and mobile phone messaging. Mobile phone messaging applications such as Short Message Service (SMS) and Multimedia Message Service (MMS) could provide an important, inexpensive delivery medium for reminders for healthcare appointments. OBJECTIVES: To assess the effects of mobile phone messaging reminders for attendance at healthcare appointments. Secondary objectives include assessment of patients' and healthcare providers' evaluation of the intervention; costs; and possible risks and harms associated with the intervention. SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (CENTRAL,The Cochrane Library 2009, Issue 2), MEDLINE (OvidSP) (January 1993 to June 2009), EMBASE (OvidSP) (January 1993 to June 2009), PsycINFO (OvidSP) (January 1993 to June 2009), CINAHL (EbscoHOST) (January 1993 to June 2009), LILACS (January 1993 to June 2009) and African Health Anthology (January 1993 to June 2009). We also reviewed grey literature (including trial registers) and reference lists of articles. SELECTION CRITERIA: We included randomised controlled trials (RCTs), quasi-randomised controlled trials (QRCTs), controlled before-after (CBA) studies, or interrupted time series (ITS) studies with at least three time points before and after the intervention. We included studies assessing mobile phone messaging as reminders for healthcare appointments. We only included studies in which it was possible to assess effects of mobile phone messaging independent of other technologies or interventions. DATA COLLECTION AND ANALYSIS: Two review authors independently assessed all studies against the inclusion criteria, with any disagreements resolved by a third review author. Study design features, characteristics of target populations, interventions and controls, and results data were extracted by two review authors and confirmed by a third author. Primary outcomes of interest were rate of attendance at healthcare appointments. We also considered health outcomes as a result of the intervention, patients' and providers' evaluation of the intervention, perceptions of safety, costs, and potential harms or adverse effects. As the intervention characteristics and outcome measures were similar across included studies, we conducted a meta-analysis to estimate an overall effect size. MAIN RESULTS: We included four randomised controlled trials involving 3547 participants. Three studies with moderate quality evidence showed that mobile text message reminders improved the rate of attendance at healthcare appointments compared to no reminders (risk ratio (RR) 1.10 (95% confidence interval (CI) 1.03 to 1.17)). One low quality study reported that mobile text message reminders with postal reminders, compared to postal reminders, improved rate of attendance at healthcare appointments (RR 1.10 (95% CI 1.02 to 1.19)). However, two studies with moderate quality of evidence showed that mobile phone text message reminders and phone call reminders had a similar impact on healthcare attendance (RR 0.99 (95% CI 0.95 to 1.03). The costs per attendance of mobile phone text message reminders were shown to be lower compared to phone call

reminders. None of the included studies reported outcomes related to harms or adverse effects of the intervention, nor health outcomes or user perception of safety related to the intervention. AUTHORS' CONCLUSIONS: There is moderate quality evidence that mobile phone text message reminders are more effective than no reminders, and low quality evidence that text message reminders with postal reminders are more effective than postal reminders alone. Further, according to the moderate quality evidence we found, mobile phone text message reminders are as effective as phone call reminders. Overall, there is limited evidence on the effects of mobile phone text message reminders for appointment attendance, and further high-quality research is required to draw more robust conclusions.

Cipriani, A., M. Purgato, et al. (2012). ***"Citalopram versus other anti-depressive agents for depression."*** Cochrane Database Syst Rev 7: CD006534. http://www.ncbi.nlm.nih.gov/pubmed/22786497

BACKGROUND: Recent US and UK clinical practice guidelines recommend that second-generation antidepressants should be considered amongst the best first-line options when drug therapy is indicated for a depressive episode. Systematic reviews have already highlighted some differences in efficacy between second-generation antidepressants. Citalopram, one of the first selective serotonin reuptake inhibitors (SSRI) introduced in the market, is one of these antidepressant drugs that clinicians use for routine depression care. OBJECTIVES: To assess the evidence for the efficacy, acceptability and tolerability of citalopram in comparison with tricyclics, heterocyclics, other SSRIs and other conventional and non-conventional antidepressants in the acute-phase treatment of major depression. SEARCH METHODS: We searched The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register and the Cochrane Central Register of Controlled Trials up to February 2012. No language restriction was applied. We contacted pharmaceutical companies and experts in this field for supplemental data. SELECTION CRITERIA: Randomised controlled trials allocating patients with major depression to citalopram versus any other antidepressants. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data. Information extracted included study characteristics, participant characteristics, intervention details and outcome measures in terms of efficacy (the number of patients who responded or remitted), patient acceptability (the number of patients who failed to complete the study) and tolerability (side-effects). MAIN RESULTS: Thirty-seven trials compared citalopram with other antidepressants (such as tricyclics, heterocyclics, SSRIs and other antidepressants, either conventional ones, such as mirtazapine, venlafaxine and reboxetine, or non-conventional, like hypericum). Citalopram was shown to be significantly less effective than escitalopram in achieving acute response (odds ratio (OR) 1.47, 95% confidence interval (CI) 1.08 to 2.02), but more effective than paroxetine (OR 0.65, 95% CI 0.44 to 0.96) and reboxetine (OR 0.63, 95% CI 0.43 to 0.91). Significantly fewer patients allocated to citalopram withdrew from trials due to adverse events compared with patients allocated to tricyclics (OR 0.54, 95% CI 0.38 to 0.78) and fewer patients allocated to citalopram reported at least one side effect than reboxetine or venlafaxine (OR 0.64, 95% CI 0.42 to 0.97 and OR 0.46, 95% CI 0.24 to 0.88, respectively). AUTHORS' CONCLUSIONS: Some statistically significant differences between citalopram and other antidepressants for the acute phase treatment of major depression were found in terms of efficacy, tolerability and acceptability. Citalopram was more efficacious than paroxetine and reboxetine and more acceptable than tricyclics, reboxetine and venlafaxine, however, it seemed to be less efficacious than escitalopram. As with most systematic reviews in psychopharmacology, the potential for overestimation of treatment effect due to sponsorship bias and publication bias should be borne in mind when interpreting review findings. Economic analyses were not reported in the included studies, however, cost effectiveness information is needed in the field of antidepressant trials.

Gulliver, A., K. Griffiths, et al. (2012). ***"A systematic review of help-seeking interventions for depression, anxiety and general psychological distress."*** BMC Psychiatry 12(1): 81. http://www.biomedcentral.com/1471-244X/12/81

BACKGROUND:Depression and anxiety are treatable disorders, yet many people do not seek professional help. Interventions designed to improve help-seeking attitudes and increase help-seeking intentions and behaviour have been evaluated in recent times. However, there have been no systematic reviews of the efficacy or effectiveness of these interventions in promoting help-seeking. Therefore, this paper reports a systematic review of published randomised controlled trials targeting help-seeking attitudes, intentions or behaviours for depression, anxiety, and general psychological distress. METHODS: Studies were identified through searches of PubMed, PsycInfo, and the Cochrane database in November 2011. Studies were included if they included a randomised controlled trial of at least one intervention targeting help-seeking for depression or anxiety or general psychological distress, and contained extractable data on help-seeking attitudes or intentions or behaviour. Studies were excluded if they focused on problems or conditions other than the target (e.g., substance use, eating disorder). RESULTS: Six published studies of randomised controlled trials investigating eight different interventions for help-seeking were identified. The majority of trials targeted young adults. Mental health literacy content was effective (d = .12 to .53) in improving help-seeking attitudes in the majority of studies at post-intervention, but had no effect on help-seeking behaviour (d = .01, .02). There was less evidence for other intervention types such as efforts to destigmatise or provide help-seeking source information. CONCLUSIONS: Mental health literacy interventions are a promising method for promoting positive help-seeking attitudes, but there is no evidence that it leads to help-seeking behaviour. Further research investigating the effects of interventions on attitudes, intentions, and behaviour is required.

H., E. M., J. V. V., et al. (2012). ***"Maternal use of selective serotonin reuptake inhibitors, fetal growth, and risk of adverse birth outcomes."*** Archives of General Psychiatry 69(7): 706-714. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2333

Context Selective serotonin reuptake inhibitors (SSRIs) are frequently prescribed to pregnant women, but knowledge about their unintended effects on child health is scarce. Objective To examine the effects of maternal SSRI use during pregnancy on fetal growth and birth outcomes. Design The study was embedded in the Generation R Study, a prospective population-based study from fetal life onward.Participants Seven thousand six hundred ninety-six pregnant women were included. Selective serotonin reuptake inhibitor use was assessed by questionnaires in each trimester and verified by pharmacy records. Using depressive symptom scores from the Brief Symptom Inventory, 7027 pregnant mothers (91.3%) had no or low depressive symptoms, 570 pregnant mothers (7.4%) had clinically relevant depressive symptoms and used no SSRIs, and 99 pregnant mothers (1.3%) used SSRIs. Main Outcome Measures Fetal ultrasonography was performed in each trimester. We determined fetal body and head growth with repeated assessments of body and head size. The birth outcomes studied were preterm birth, small for gestational age, and low birth weight. Results Fetuses from mothers with prenatal depressive symptoms showed reduced body growth (β = −4.4 g/wk; 95% CI: −6.3 to −2.4; P < .001) and head growth (β = −0.08 mm/wk; 95% CI: −0.14 to −0.03; P = .003). Mothers using SSRIs during pregnancy had fewer depressive symptoms than mothers in the clinical symptom range. Prenatal SSRI use was not associated with reduced body growth but was associated with reduced fetal head growth (β = −0.18 mm/wk; 95% CI: −0.32 to −0.07; P = .003). The SSRI-exposed children were at higher risk for preterm birth (odds ratio = 2.14; 95% CI: 1.08 to 4.25; P = .03). Conclusions Untreated maternal depression was associated with slower rates of fetal body and head growth. Pregnant mothers treated with SSRIs had fewer depressive symptoms and their fetuses had no delay in body growth but had delayed head growth and were at increased risk for preterm birth. Further research on the implications of these findings is needed.

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

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

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

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

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

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

Levin, A. (2012). ***"Late-life depression not a unified syndrome."*** Psychiatric News 47(13): 12b-18. http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1212621

When depression begins for the first time in elderly people, clinicians should take a closer look at the patient's psychiatric and general medical history. "Geriatric depression is a hypothesis, not a syndrome," George Alexopoulos, M.D., postulated at a symposium on geriatric psychiatry at APA's 2012 annual meeting in Philadelphia in May. Alexopoulos, a professor of psychiatry at Weill-Cornell Medical College in New York and founder and director of the Weill-Cornell Institute of Geriatric Psychiatry, has spent a career exploring the complexities of late-life depression. Elderly patients who present with late-onset depression exhibit a different constellation of symptoms than older people whose depression first appeared when they were young, said Alexopoulos. In general, late-onset patients appear to have higher rates of dementia, cognitive dysfunction, or structural brain abnormalities, he said. That is because when depression starts late in life, it often occurs in people with vascular disease or severe vascular risk factors, he said. Rapid changes occur once vascular disease begins, including psychomotor retardation, apathy, lack of guilt and insight, disproportionate disability, and executive dysfunction. The last of these has been the focus of much research attention, said Alexopoulos. Poor abstract thinking, difficulty planning, and perseveration leave patients messy and disorganized. "They don't get better executive function even if you treat their depression," he said. "So we have hypothesized that there is a form of depression with executive dysfunction characterized by periventricular white-matter hyperintensities." Research shows that depressed patients who remit have similar volumes of hyperintensities as controls, while nonremitters have higher volumes, suggesting a different etiology or disease course. Individuals with the s-allele of the 5-HTTLPR gene also demonstrated increased white-matter hyperintensities and poorer remission rates, leading Alexopoulos to speculate that the s-allele's influence on poor remission may be associated with microstructural lesions in the prefrontal cortex. In some ways, this syndrome resembles medial frontal lobe syndrome and has a poor response to serotonin antidepressants, he said. In addition, the cognitive control network (including the anterior cingulate

cortex and the dorsolateral prefrontal cortex) has been thought of as a structure remote from emotional events, but that may not be true, he suggested. The network is impaired in elderly patients and may cause a poor response to antidepressant drugs, although not to psychotherapy. "Depressed patients with executive dysfunction respond well to problem-solving therapy," he said. Alexopoulos suggests the following etiology for late-onset depression among the elderly: vascular changes produce repair responses and inflammation, triggering a cascade of events leading to a predisposition for depression that is expressed in frontolimbic compromise, either alone or in response to neurobiological responses associated with stress that lead to mechanisms mediating depression. With that in mind, he has tested several therapies, although so far without definitive outcomes, he said. One trial of the anti-inflammatory antibiotic minocycline in six patients who had failed at least one antidepressant had mixed results. Two showed an excellent response, three were considered "good," and one regressed. Prevention studies have proved equally ambiguous. Trials of cholinesterase inhibitors, NMDA inhibitors, and statins have yet to show benefit, he said. Taken together, the research leads Alexopoulos to state cautiously where the field stands at present and where it must go to find useful treatments. "Vascular depression is not a syndrome," he said. "It is a hypothesis about etiology and pathogenesis that has served as the conceptual basis for developing studies with testable hypotheses."

Lewis, G. (2012). ***"Authors' reply to davies and colleagues, donnelly, and pilling and anderson."*** BMJ 345. http://www.bmj.com/content/345/bmj.e4500

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

McLaughlin, K. A., A. Nandi, et al. (2012). ***"Home foreclosure and risk of psychiatric morbidity during the recent financial crisis."*** Psychological Medicine 42(07): 1441-1448. http://dx.doi.org/10.1017/S0033291711002613

Background A defining feature of the US economic downturn of 2008–2010 was the alarming rate of home foreclosure. Although a substantial number of US households have experienced foreclosure since 2008, the effects of foreclosure on mental health are unknown. We examined the effects of foreclosure on psychiatric symptomatology in a prospective, population-based community survey. Method Data were drawn from the Detroit Neighborhoods and Health Study (DNHS), waves 1 and 2 (2008–2010). A probability sample of predominantly African-American adults in Detroit, Michigan participated (n=1547). We examined the association between home foreclosure between waves 1 and 2 and increases in symptoms of DSM-IV major depression and generalized anxiety disorder (GAD). Results The most common reasons for foreclosure were an increase in monthly payments, an increase in non-medical expenses and a reduction in family income. Exposure to foreclosure between waves 1 and 2 predicted symptoms of major depression and GAD at wave 2, controlling for symptoms at wave 1. Even after adjusting for wave 1 symptoms, sociodemographics, lifetime history of psychiatric disorder at wave 1 and exposure to other financial stressors between waves 1 and 2, foreclosure was associated with an increased rate of symptoms of major depression [incidence density ratio (IDR) 2.4, 95% confidence interval (CI) 1.6–3.6] and GAD (IDR 1.9, 95% CI 1.4–2.6). Conclusions We provide the first prospective evidence linking foreclosure to the onset of mental health problems. These results, combined with the high rate of home foreclosure since 2008, suggest that the foreclosure crisis may have adverse effects on the mental health of the US population.

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

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

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

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

Pilling, S. and I. Anderson (2012). ***"Tread adds little to the evidence."*** BMJ 345. http://www.bmj.com/content/345/bmj.e4490

The TREAD trial claims that physical exercise does not improve mood. The trial, however, has serious limitations. The National Institute for Health and Clinical Excellence recommends structured group physical activity to treat subthreshold and mild-moderate depression. TREAD did not evaluate this intervention but aimed to increase physical activity, through the use of physical activity facilitators, to such a level that it improves mood. Given a 9% increase in activity in the intervention arm, the absence of improvement in mood may result from the limited change in physical activity compared with the control group (high at 43%). The average score on the Beck depression inventory at trial entry was 32.1, placing most trial participants within the moderate-severe range. Evidence suggests that moderate-severe depression is unlikely to benefit from physical activity, and that the intervention was not appropriate for most participants. In addition, 59% and 53% in the intervention and control arms, respectively, received antidepressants, which may account for a large proportion of the improvement. The authors conclude that an "increase in physical activity will not increase . . . chances of recovery from depression." This is a premature conclusion that could deprive patients of effective treatment. The findings suggest that for moderate-severe depression the combination of physical activity and antidepressants may be no more effective than antidepressants alone. For these patients, combined antidepressants and cognitive behavioural therapy would probably produce a significant improvement (recovery rates of over 50%3) compared with the 28.2% recovery rate reported in the intervention arm in TREAD. We believe the evidence still supports the use of exercise in subthreshold and mild-moderate depression; despite claims to the contrary, TREAD adds little to that evidence.

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

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

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

BACKGROUND: Depression is a common and important cause of morbidity and mortality worldwide. Depression is commonly treated with antidepressants and/or psychotherapy, but some people may prefer alternative approaches such as exercise. There are a number of theoretical reasons why exercise may improve depression. This is an update of an earlier review first published in 2009. OBJECTIVES: To determine the effectiveness of exercise in the treatment of depression. Our secondary outcomes included drop-outs from exercise and control groups, costs, quality of life and adverse events. SEARCH METHODS: We searched the Cochrane Depression, Anxiety and Neurosis (CCDAN) Review Group's Specialised Register (CCDANCTR), CENTRAL, MEDLINE, EMBASE, Sports Discus and PsycINFO for eligible studies (to February 2010). We also searched www.controlled-trials.com in November 2010. The CCDAN Group searched its Specialised Register in June 2011 and potentially eligible trials were listed as 'awaiting assessment'. SELECTION CRITERIA: Randomised controlled trials in which exercise was compared to standard treatment, no treatment or a placebo treatment in adults (aged 18 and over) with depression, as defined by trial authors. We excluded trials of postnatal depression. DATA COLLECTION AND ANALYSIS: For this update, two review authors extracted data on outcomes at the end of the trial. We used these data to calculate effect sizes for each trial using Hedges' g method and a standardised mean difference (SMD) for the overall pooled effect, using a random-effects model. Where trials used a number of different tools to assess depression, we included the main outcome measure only in the meta-analysis. We systematically extracted data on adverse effects and two authors performed the 'Risk of bias' assessments. MAIN RESULTS: Thirty-two trials (1858 participants) fulfilled our inclusion criteria, of which 30 provided data for meta-analyses. Randomisation was adequately concealed in 11 studies, 12 used intention-to-treat analyses and nine used blinded outcome assessors. For the 28 trials (1101 participants) comparing exercise with no treatment or a control intervention, at post-treatment analysis the pooled SMD was -0.67 (95% confidence interval (CI) -0.90 to -0.43), indicating a moderate clinical effect. However, when we included only the four trials (326 participants) with adequate allocation concealment, intention-to-treat analysis and blinded outcome assessment, the pooled SMD was -0.31 (95% CI -0.63 to 0.01) indicating a small effect in favour of exercise. There was no difference in drop-outs between exercise and control groups. Pooled data from the seven trials (373 participants) that provided long-term follow-up data also found a small effect in favour of exercise (SMD -0.39, 95% CI -0.69 to -0.09). Of the six trials comparing exercise with cognitive behavioural therapy (152 participants), the effect of exercise was not significantly different from that of cognitive therapy. There were insufficient data to determine risks, costs and quality of life. Five potentially eligible studies identified by the search of the CCDAN Specialised Register in 2011 are listed as 'awaiting classification' and will be included in the next update of this review. AUTHORS' CONCLUSIONS: Exercise seems to improve depressive symptoms in people with a diagnosis of depression when compared with no treatment or control intervention, however since analyses of methodologically robust trials show a much smaller effect in favour of exercise, some caution is required in interpreting these results.

Seder, J. P. and S. Oishi (2012). ***"Intensity of smiling in facebook photos predicts future life satisfaction."*** Social Psychological and Personality Science 3(4): 407-413. http://spp.sagepub.com/content/3/4/407.abstract

Does the extent to which people are smiling in their Facebook photos predict future life satisfaction? In two longitudinal studies, the authors showed that smile intensity coded from a single Facebook profile photograph from male and female participants' first semester at college was a robust predictor of self-reported life satisfaction 3.5 years later—as they were about to graduate from college. Controlling for first-semester life satisfaction, the authors also determined that smile intensity was a unique predictor of changes in life satisfaction over time. In addition, the authors demonstrated that the results were not due to extraversion or to sex differences in smile intensity. Finally, the authors showed that participants who exhibited a more intense smile in their Facebook photo had better social relationships during their first semester at college and that the association

between smile intensity and life satisfaction 3.5 years later was partially mediated by first-semester social relationships satisfaction.

Sinclair, L. (2012). ***"Bipolar disorder expert laments lithium's fading popularity "*** Psychiatric News 47(13): 11a

The search for the mechanisms of lithium response in bipolar disorder may lead directly to more personalized treatment decisions for patients. That's the hope of John Kelsoe, M.D., a professor of psychiatry with the Laboratory of Psychiatric Genomics in the Department of Psychiatry at the University of California, San Diego. Kelsoe directs the Bipolar Genome Study (BiGS), a 13-site consortium focused on identifying genes for bipolar disorder and their relationship to clinical symptoms. He also co-directs the Psychiatric GWAS Consortium for Bipolar Disorder (PGC-BD), an international collaborative effort designed to identify genes for bipolar disorder in a sample of over 10,000 patients. Kelsoe spoke at APA's 2012 annual meeting in Philadelphia in May as part of the "Research Advances in Psychiatric Pharmacogenomics" symposium, discussing his work on advances in the pharmacogenetics of lithium response in the search for a personalized treatment of bipolar disorder. "It's long been an observation that there's a subset of individuals who have a fantastic response to lithium," he said. "They are essentially cured … as long as they stay on their medication. So it's been disturbing to me to see lithium fall to the wayside as other medications have come along. I'm concerned there are lots of patients who will miss the opportunity to find out if they are one of these excellent lithium responders, because they'll never get tried on it. The clinical pitch I make is that every bipolar patient deserves a trial of lithium somewhere early in their course of illness to find out if they are in this category." Kelsoe said the individuals who are good lithium responders tend to have distinct clinical features: euphoric manias, positive family history, few comorbidities, and symptom-free intervals between episodes. "I'll make the argument that that's because they may have a somewhat different illness, with a different underlying mechanism," he said. Kelsoe credited the hypothesis to Paul Grof, M.D., Ph.D., a professor of psychiatry at the University of Toronto and director of the Mood Disorders Centre of Ottawa. "Grof asked the question almost a decade ago: If lithium response is familial … is lithium-responsive bipolar disorder a unique, distinct form of illness?" Grof and his colleagues, in the Journal of Clinical Psychiatry in 2002, compared the response to long-term lithium treatment in bipolar relatives of bipolar lithium responders with those of bipolar controls and found that the response to lithium prophylaxis clusters in families. In a study published in Pharmacogenomics in 2010, Kelsoe and his colleagues detailed possible scenarios that may describe the relationship of lithium response to the pathophysiology of bipolar disease. Movement toward a simple test for lithium response is hampered by a lack of knowledge about the drug's actual mechanism of action in the disorder. "Studies of lithium pharmacogenetics are largely in the initial trial stages," they said in the 2010 article, "but they offer great promise in improving clinical care." The group offered direction for future research, recommending approaches that use large, prospectively assessed clinical samples, genomewide measurements of genetic variation, and gene expression coupled by powerful computational approaches. "Studying pathways identified in this manner may prove more sensitive and reliable than studying isolated candidate genes," they wrote. So, for now at least, determining which patients with bipolar disorder might respond best to lithium must be done the old-fashioned way, through trial and error, but Kelsoe remains hopeful that pharmacogenomics testing will personalize the selection of mood stabilizers for bipolar disorder in the near future: "Anything that would reduce the number of medication trials, doctors, and diagnoses for these patients would be welcomed by patient and doctor alike." An abstract of "Pharmacogenetics of Lithium Response in Bipolar Disorder" is posted at www.ncbi.nlm.nih.gov/pubmed/21047205. An abstract of "Is Response to Prophylactic Lithium a Familial Trait?" is posted at www.ncbi.nlm.nih.gov/pubmed/12416605.

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

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

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

Premature termination from therapy is a significant problem frequently encountered by practicing clinicians of all types. In fact, a recent meta-analytic review (J. K. Swift & R. P. Greenberg, 2012, Premature discontinuation in adult psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology. doi:10.1037/a0028226) of 669 studies found that approximately 20% of all clients drop out of treatment prematurely, with higher rates among some types of clients and in some settings. Although this dropout rate is lower than previously estimated, a significant number of clients are still prematurely terminating, and thus further research toward a solution is warranted. Here we present a conceptualization of premature termination based on perceived and anticipated costs and benefits and review 6 practice strategies for reducing premature termination in therapy. These strategies include providing education about duration and patterns of change, providing role induction, incorporating client preferences, strengthening early hope, fostering the therapeutic alliance, and assessing and discussing treatment progress.

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

(Free full text available) BACKGROUND: Nonadherence to mental health treatment incurs clinical and economic burdens. The clinician-patient relationship presents a point of intervention. This alliance is negotiated through clinical communication. However, recent medical reviews of communication and adherence exclude studies of psychiatric patients. The following review examines the impact of clinician-patient alliance and communication on adherence in mental health and the specific mechanisms that result in patient engagement. METHODS: In December 2010, a systematic search was conducted in Pubmed, PsychInfo, Web of Science, Cochrane Library, Embase and Cinahl and yielded 6672 titles. A secondary hand search was performed in relevant journals, grey literature and reference. RESULTS: 23 studies met the inclusion criteria for the review. The methodological quality overall was moderate. 17 studies reported positive associations with adherence, only four of which

employed intervention designs. 10 studies examined the association between clinician-patient alliance and adherence. Subjective ratings of clinical communication styles and messages were assessed in 12 studies. 1 study examined the association between objectively rated communication and adherence. Meta-analysis was not possible due to heterogeneity of methods. Findings were presented as a narrative synthesis. CONCLUSIONS: Clinician-patient alliance and communication are associated with more favourable patient adherence. Further research of observer rated communication would better facilitate the application of findings in clinical practice. Establishing agreement on the tasks of treatment, utilising collaborative styles of communication and discussion of treatment specifics may be important for clinicians in promoting cooperation with regimens. These findings align with those in health communication. However, the benefits of shared decision making for adherence in mental health are less conclusive than in general medicine.

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

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

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

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

Yonkers, K. A., E. R. Norwitz, et al. (2012). ***"Depression and serotonin reuptake inhibitor treatment as risk factors for preterm birth."*** Epidemiology 23(5): 677-685. http://www.ncbi.nlm.nih.gov/pubmed/22627901

BACKGROUND: Major depressive disorder and the use of serotonin reuptake inhibitors (SRIs) in pregnancy have been associated with preterm birth. Studies that have attempted to separate effects of illness from treatment have been inconclusive. We sought to explore the separate effects of SRI use and major depressive episodes in pregnancy on risk of preterm birth. METHODS: We conducted a prospective cohort study of 2793 pregnant women, oversampled for a recent episode of major depression or use of an SRI. We extracted data on birth outcomes from hospital charts and used binary logistic regression to model preterm birth (<37 weeks' gestation). We used ordered logistic regression to model early (<34 weeks' gestation) or late (34-36 weeks) preterm birth, and we used nominal logistic regression to model preterm birth antecedents (spontaneous preterm labor/preterm premature rupture of membranes/preterm for medical indications/term). RESULTS: Use of an SRI, both with (odds ratio = 2.1 [95% confidence interval = 1.0-4.6]) and without (1.6 [1.0-2.5]) a major depressive episode, was associated with preterm birth. A major depressive episode without SRI use (1.2 [0.68-2.1]) had no clear effect on preterm birth risk. None of these exposures was associated with early preterm birth. Use of SRIs in pregnancy was associated with increases in spontaneous but not medically indicated preterm birth. CONCLUSIONS: SRI use increased risk of preterm birth. Although the effect of a major depressive episode alone was unclear, symptomatic women undergoing antidepressant treatment had elevated risk. *(And note too the apparent ineffectiveness of antidepressants at preventing the development of depression during pregnancy - http://www.ncbi.nlm.nih.gov/pubmed/21900825).*