# ***32 cbt & psychotherapy relevant abstracts november '16 newsletter***

(Abel, Hayes et al. 2016; Agnew-Blais, Polanczyk et al. 2016; Bron, Bijlenga et al. 2016; Cackowski, Neubauer et al. 2016; Connolly Gibbons, Gallop et al. 2016; Cozza, Fisher et al. 2016; Cuijpers 2016; Cuijpers, Donker et al. 2016; French, Thomas et al. 2016; Goldberg, Babins-Wagner et al. 2016; Goldberg, Hoyt et al. 2016; Hopfinger, Berking et al. 2016; Kendrick, El-Gohary et al. 2016; Kraus, Bentley et al. 2016; Kushner, Quilty et al. 2016; Kvam, Kleppe et al. 2016; Larsson, Falkenstrom et al. 2016; Newby, Twomey et al. 2016; Nissen-Lie, Goldberg et al. 2016; Richards, Ekers et al. 2016; Salcedo, Gold et al. 2016; Saxon, Barkham et al. 2016; Saxon, Firth et al. 2016; Schroder, Berger et al. 2016; Shear, Reynolds et al. 2016; Sobol-Kwapinska 2016; Spiers, Qassem et al. 2016; Staring, van den Berg et al. 2016; Stickley and Koyanagi 2016; Waller, Kaprio et al. 2016; Zanarini, Frankenburg et al. 2016; Zilcha-Mano, Muran et al. 2016)

Abel, A., A. M. Hayes, et al. (2016). ***"Sudden gains in cognitive-behavior therapy for treatment-resistant depression: Processes of change."*** J Consult Clin Psychol 84(8): 726-737. https://www.ncbi.nlm.nih.gov/pubmed/27100125

OBJECTIVE: Sudden gains were investigated in cognitive-behavioral therapy (CBT) for treatment-resistant depression (TRD). Client and therapist processes in sessions proximal to sudden gains were examined to better understand the antecedents of sudden gains and potential mechanisms linking them to outcome. METHOD: Participants were 156 adults with TRD in a randomized controlled trial of CBT as an adjunct to pharmacotherapy (Wiles et al., 2013). Depression symptoms were assessed by the Beck Depression Inventory-II at each session. In a subsample of 50 clients, audio-recordings of 125 therapy sessions were rated for hope, emotional processing, and therapist competence in case-conceptualization. RESULTS: Sudden gains were experienced by 54% of participants. Those with gains reported significantly lower depression severity at 12-month follow-up and more remission of symptoms than those without gains. Sudden gains also predicted lower depression at follow-up, beyond the slope of linear change in symptoms across treatment. Therapists demonstrated greater competence in case conceptualization with clients who reported sudden gains, and those with gains expressed more hope in sessions prior to a gain. In addition, more hope and emotional processing in the pregain sessions predicted less depression at follow-up, controlling for depression scores in the prior session. Better therapist conceptualization skills and more client hope in the baseline and pregain sessions were also associated with more emotional processing in those same sessions. CONCLUSION: This study extends the phenomenon of sudden gains in CBT for depression to a treatment-resistant population and identified important therapy processes that predicted long-term outcomes: hope and emotional processing.

Agnew-Blais, J. C., G. V. Polanczyk, et al. (2016). ***"Evaluation of the persistence, remission, and emergence of attention-deficit/hyperactivity disorder in young adulthood."*** JAMA Psychiatry 73(7): 713-720. http://dx.doi.org/10.1001/jamapsychiatry.2016.0465

Importance Attention-deficit/hyperactivity disorder (ADHD) is now recognized to occur in adulthood and is associated with a range of negative outcomes. However, less is known about the prospective course of ADHD into adulthood, the risk factors for its persistence, and the possibility of its emergence in young adulthood in nonclinical populations. Objective To investigate childhood risk factors and young adult functioning of individuals with persistent, remitted, and late-onset young adult ADHD.Design, Setting, and Participants The study sample was the Environmental Risk (E-Risk) Longitudinal Twin Study, a nationally representative birth cohort of 2232 twins born in England and Wales from January 1, 1994, to December 4, 1995. Evaluation of childhood ADHD (ages 5, 7, 10, and 12 years) included prenatal and perinatal factors, clinical characteristics, and aspects of the family environment. Among participants aged 18 years, ADHD symptoms and associated impairment, overall functioning, and other mental health disorders were examined. Data analysis was conducted from February 19 to September 10, 2015. Main Outcomes and Measures Attention-deficit/hyperactivity disorder according to DSM-IV diagnostic criteria in childhood and DSM-5 diagnostic criteria in young adulthood. Results Of 2232 participants in the E-Risk Study, 2040 were included in the present analysis. In total, 247 individuals met diagnostic criteria for childhood ADHD; of these, 54 (21.9%) also met diagnostic criteria for the disorder at age 18 years. Persistence was associated with more symptoms (odds ratio [OR], 1.11 [95% CI, 1.04-1.19]) and lower IQ (OR, 0.98 [95% CI, 0.95-1.00]). At age 18 years, individuals with persistent ADHD had more functional impairment (school/work: OR, 3.30 [95% CI, 2.18-5.00], home/with friends: OR, 6.26 [95% CI, 3.07-12.76]), generalized anxiety disorder (OR, 5.19 [95% CI, 2.01-13.38]), conduct disorder (OR, 2.03 [95% CI, 1.03-3.99]), and marijuana dependence (OR, 2.88 [95% CI, 1.07-7.71]) compared with those whose ADHD remitted. Among 166 individuals with adult ADHD, 112 (67.5%) did not meet criteria for ADHD at any assessment in childhood. Results from logistic regressions indicated that individuals with late-onset ADHD showed fewer externalizing problems (OR, 0.93 [95% CI, 0.91-0.96]) and higher IQ (OR, 1.04 [95% CI, 1.02-1.07]) in childhood compared with the persistent group. However, at age 18 years, those with late-onset ADHD demonstrated comparable ADHD symptoms and impairment as well as similarly elevated rates of mental health disorders. Conclusions and Relevance We identified heterogeneity in the DSM-5 young adult ADHD population such that this group consisted of a large, late-onset ADHD group with no childhood diagnosis, and a smaller group with persistent ADHD. The extent to which childhood-onset and late-onset adult ADHD may reflect different causes has implications for genetic studies and treatment of ADHD.

Bron, T. I., D. Bijlenga, et al. (2016). ***"Prevalence of ADHD symptoms across clinical stages of major depressive disorder."*** Journal of Affective Disorders 197: 29-35. http://www.sciencedirect.com/science/article/pii/S016503271530608X

Background Depression and ADHD often co-occur in clinical samples. Depression severity may be linked to ADHD symptomatology. We therefore assessed ADHD symptoms across clinical stages of major depressive disorder (MDD). Methods We used 4-year follow-up data of the Netherlands Study of Depression and Anxiety (September 2008 until April 2011), including healthy controls, groups with remitted and current MDD (N=2053; age range 21–69 years; 66.8% females). Probable ADHD was defined as having current ADHD symptoms on the Conners Adult ADHD Rating Scale and a positive score on childhood or early-adolescent ADHD indicators. We examined ADHD symptom rates across (i) those with and without lifetime MDD, (ii) clinical characteristics of MDD including severity, course and outcomes, (iii) clinical stages of MDD. Results (i) The prevalence of ADHD symptoms was 0.4% in healthy controls, 5.7% in remitted MDD and 22.1% in current MDD (OR=4.5; 95% CI 3.1–6.5). (ii) ADHD symptom rates and odds were significantly increased among those with more severe depression (29.4%; OR=6.8; 95% CI 2.9–16.1), chronic depression (21.8%; OR=3.8; 95% CI 2.5–5.7), earlier age of onset of depressive symptoms (9.9%; OR=1.5; 95% CI 1.0–2.3), and comorbid anxiety disorders (29.0%; OR=3.4; 95% CI 2.0–5.7). (iii) ADHD symptom rates increased across clinical stages of MDD, up to 22.5% in chronic MDD. Limitations We used self-reports on ADHD symptoms. Also, clinical staging models have not yet been validated for mental disorders. Conclusions ADHD symptoms are very common among MDD patients, especially among those in recurrent and chronic stages of MDD. Considering ADHD may be an important step forward in improving the treatment of depression.

Cackowski, S., T. Neubauer, et al. (2016). ***"The impact of posttraumatic stress disorder on the symptomatology of borderline personality disorder."*** Borderline Personality Disorder and Emotion Dysregulation 3(1): 7. http://dx.doi.org/10.1186/s40479-016-0042-4

(Available in free full text) Background Previous findings on the impact of co-occurring posttraumatic stress disorder (PTSD) in patients with borderline personality disorder (BPD) have revealed inconsistencies, which may have been related to small sample sizes or differences in the presence of childhood sexual abuse (CSA). In this study, the potentially aggravating impact of PTSD and the role of CSA were examined in a large cohort of BPD patients. Methods BPD patients with current PTSD (n = 142) were compared to BPD patients without PTSD (n = 225) regarding different BPD features such as non-suicidal self-injury. Further, we examined the potentially confounding role of CSA. Results BPD patients with PTSD showed elevated affect dysregulation, intrusions, dissociation, history of suicide attempts and self-mutilation compared to those with only BPD. The effects of PTSD on BPD patients regarding dissociation and the history of suicide attempts were at least partially related to CSA. Conclusions The additional diagnosis of PTSD in BPD patients can aggravate some, but not all BPD features. With respect to dissociation and suicide attempts, at least some of the impact seems to relate to CSA.

Connolly Gibbons, M., R. Gallop, et al. (2016). ***"Comparative effectiveness of cognitive therapy and dynamic psychotherapy for major depressive disorder in a community mental health setting: A randomized clinical noninferiority trial."*** JAMA Psychiatry 73(9): 904-911. http://dx.doi.org/10.1001/jamapsychiatry.2016.1720

Importance Dynamic psychotherapy (DT) is widely practiced in the community, but few trials have established its effectiveness for specific mental health disorders relative to control conditions or other evidence-based psychotherapies. Objective To determine whether DT is not inferior to cognitive therapy (CT) in the treatment of major depressive disorder (MDD) in a community mental health setting. Design, Setting, and Participants From October 28, 2010, to July 2, 2014, outpatients with MDD were randomized to treatment delivered by trained therapists. Twenty therapists employed at a community mental health center in Pennsylvania were trained by experts in CT or DT. A total of 237 adult outpatients with MDD seeking services at this site were randomized to 16 sessions of DT or CT delivered across 5 months. Final assessment was completed on December 9, 2014, and data were analyzed from December 10, 2014, to January 14, 2016.Interventions Short-term DT or CT. Main Outcomes and Measures Expert blind evaluations with the 17-item Hamilton Rating Scale for Depression. Results Among the 237 patients (59 men [24.9%]; 178 women [75.1%]; mean [SD] age, 36.2 [12.1] years) treated by 20 therapists (19 women and 1 man; mean [SD] age, 40.0 [14.6] years), 118 were randomized to DT and 119 to CT. A mean (SD) difference between treatments was found in the change on the Hamilton Rating Scale for Depression of 0.86 (7.73) scale points (95% CI, −0.70 to 2.42; Cohen d, 0.11), indicating that DT was statistically not inferior to CT. A statistically significant main effect was found for time ($F_{1,198} = 75.92$; $P = .001$). No statistically significant differences were found between treatments on patient ratings of treatment credibility. Dynamic psychotherapy and CT were discriminated from each other on competence in supportive techniques ($t_{120} = 2.48$; $P = .02$), competence in expressive techniques ($t_{120} = 4.78$; $P = .001$), adherence to CT techniques ($t_{115} = -7.07$; $P = .001$), and competence in CT ($t_{115} = -7.07$; $P = .001$). Conclusions and Relevance This study suggests that DT is not inferior to CT on change in depression for the treatment of MDD in a community mental health setting. The 95% CI suggests that the effects of DT are equivalent to those of CT.

Cozza, S. J., J. E. Fisher, et al. (2016). ***"Performance of DSM-5 persistent complex bereavement disorder criteria in a community sample of bereaved military family members."*** American Journal of Psychiatry 173(9): 919-929. http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2016.15111442

Objective: The purpose of this article was to examine the accuracy of DSM-5 proposed criteria for persistent complex bereavement disorder in identifying putative cases of clinically impairing grief and in excluding nonclinical cases. Performance of criteria sets for prolonged grief disorder and complicated grief were similarly assessed. Method: Participants were family members of U.S. military service members who died of any cause since September 11, 2001 (N=1,732). Putative clinical and nonclinical samples were derived from this community sample using cutoff scores from the Inventory of Complicated Grief and the Work and Social Adjustment Scale. Items from a self-report grief measure (Complicated Grief Questionnaire) were matched to DSM-5 persistent complex bereavement disorder, prolonged grief disorder, and complicated grief criteria. Endorsed items were used to identify cases. Results: Criteria sets varied in their ability to identify clinical cases. DSM-5 persistent complex bereavement disorder criteria identified 53%, prolonged grief disorder criteria identified 59%, and complicated grief criteria identified more than 90% of putative clinical cases. All criteria sets accurately excluded virtually all nonclinical grief cases and accurately excluded depression in the absence of clinical grief. Conclusions: The DSM-5 persistent complex bereavement disorder criteria accurately exclude nonclinical, normative grief, but also exclude nearly half of clinical cases, whereas complicated grief criteria exclude nonclinical cases while identifying more than 90% of clinical cases. The authors conclude that significant modification is needed to improve case identification by DSM-5 persistent complex bereavement disorder diagnostic criteria. Complicated grief criteria are superior in accurately identifying clinically impairing grief.

Cuijpers, P. (2016). ***"Are all psychotherapies equally effective in the treatment of adult depression? The lack of statistical power of comparative outcome studies."*** Evidence Based Mental Health 19(2): 39-42. http://ebmh.bmj.com/content/19/2/39.short

(Available in free full text) More than 100 comparative outcome trials, directly comparing 2 or more psychotherapies for adult depression, have been published. We first examined whether these comparative trials had sufficient statistical power to detect clinically relevant differences between therapies of d=0.24. In order to detect such an effect size, power calculations showed that a trial would need to include 548 patients. We selected 3 recent meta-analyses of psychotherapies for adult depression (cognitive behaviour therapy (CBT), interpersonal psychotherapy and non-directive counselling) and examined the number of patients included in the trials directly comparing other psychotherapies. The largest trial comparing CBT with another therapy included 178 patients, and had enough power to detect a differential effect size of only d=0.42. None of the trials in the 3 meta-analyses had enough power to detect effect sizes smaller than d=0.34, but some came close to the threshold for detecting a clinically relevant effect size of d=0.24. Meta-analyses may be able to solve the problem of the low power of individual trials. However, many of these studies have considerable risk of bias, and if we only focused on trials with low risk of bias, there would no longer be enough studies to detect clinically relevant effects. We conclude that individual trials are heavily underpowered and do not even come close to having sufficient power for detecting clinically relevant effect sizes. Despite this large number of trials, it is still not clear whether there are clinically relevant differences between these therapies.

Cuijpers, P., T. Donker, et al. (2016). ***"Interpersonal psychotherapy for mental health problems: A comprehensive meta-analysis."*** American Journal of Psychiatry 173(7): 680-687. http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2015.15091141

Objective: Interpersonal psychotherapy (IPT) has been developed for the treatment of depression but has been examined for several other mental disorders. A comprehensive meta-analysis of all randomized trials examining the effects of IPT for all mental health problems was conducted. Method: Searches in PubMed, PsycInfo, Embase, and Cochrane were conducted to identify all trials examining IPT for any mental health problem. Results: Ninety studies with 11,434 participants were included. IPT for acute-phase depression had moderate-to-large effects compared with control groups (g=0.60; 95% CI=0.45–0.75). No significant difference was found with other therapies (differential g=0.06) and pharmacotherapy (g=−0.13). Combined treatment was more effective than IPT alone (g=0.24). IPT in subthreshold depression significantly prevented the onset of major depression, and maintenance IPT significantly reduced relapse. IPT had significant effects on eating disorders, but the effects are probably slightly smaller than those of cognitive-behavioral therapy (CBT) in the acute phase of treatment. In anxiety disorders, IPT had large effects compared with control groups, and there is no evidence that IPT was less effective than CBT. There was risk of bias as defined by the Cochrane Collaboration in the majority of studies. There was little indication that the presence of bias influenced outcome. Conclusions: IPT is effective in the acute treatment of depression and may be effective in the prevention of new depressive disorders and in preventing relapse. IPT may also be effective in the treatment of eating disorders and anxiety disorders and has shown promising effects in some other mental health disorders.

French, L. R., L. Thomas, et al. (2016). ***"Individuals' long term use of cognitive behavioural skills to manage their depression: A qualitative study."*** Behav Cogn Psychother: 1-12. https://www.ncbi.nlm.nih.gov/pubmed/27629570

BACKGROUND: Cognitive Behavioural Therapy (CBT) aims to teach people skills to help them self-manage their depression. Trial evidence shows that CBT is an effective treatment for depression and individuals may experience benefits long-term. However, there is little research about individuals' continued use of CBT skills once treatment has finished. AIMS: To explore whether individuals who had attended at least 12 sessions of CBT continued to use and value the CBT skills they had learnt during therapy. METHOD: Semi-structured interviews were held with participants from the CoBalT trial who had received CBT, approximately 4 years earlier. Interviews were audio-recorded, transcribed and analysed thematically. RESULTS: 20 participants were interviewed. Analysis of the interviews suggested that individuals who viewed CBT as a learning process, at the time of treatment, recalled and used specific skills to manage their depression once treatment had finished. In contrast, individuals who viewed CBT only as an opportunity to talk about their problems did not appear to utilize any of the CBT skills they had been taught and reported struggling to manage their depression once treatment had ended. CONCLUSIONS: Our findings suggest individuals may value and use CBT skills if they engage with CBT as a learning opportunity at the time of treatment. Our findings underline the importance of the educational model in CBT and the need to emphasize this to individuals receiving treatment.

Goldberg, S. B., R. Babins-Wagner, et al. (2016). ***"Creating a climate for therapist improvement: A case study of an agency focused on outcomes and deliberate practice."*** Psychotherapy 53(3): 367-375. http://psycnet.apa.org/journals/pst/53/3/367/

Recent evidence suggests that psychotherapists may not increase in effectiveness over accrued experience in naturalistic settings, even settings that provide access to patients' outcomes. The current study examined changes in psychotherapists' effectiveness within an agency making a concerted effort to improve outcomes through the use of routine outcome monitoring coupled with ongoing consultation and the planful application of feedback including the use of deliberate practice. Data were available for 7 years of implementation from 5,128 patients seen by 153 psychotherapists. Results indicate that outcomes indeed improved across time within the agency, with increases of d = 0.035 (p = .003) per year. In contrast with previous reports, psychotherapists in the current sample showed improvements within their own caseloads across time (d = 0.034, p = .042). It did not appear that the observed agency-level improvement was due to the agency simply hiring higher-performing psychotherapists or losing lower-performing psychotherapists. Implications of these findings are discussed in relation to routine outcome monitoring, expertise in psychotherapy, and quality improvement within mental health care.

Goldberg, S. B., W. T. Hoyt, et al. (2016). ***"Unpacking the therapist effect: Impact of treatment length differs for high- and low-performing therapists."*** Psychotherapy Research: 1-13. http://www.tandfonline.com/doi/abs/10.1080/10503307.2016.1216625

Objective: Differences between therapists in their average outcomes (i.e., therapist effects) have become a topic of increasing interest in psychotherapy research in the past decade. Relatively little work, however, has moved beyond identifying the presence of significant between-therapist variability in patient outcomes. The current study sought to examine the ways in which therapist effects emerge over the course of time in psychotherapy. Method: We used a large psychotherapy data set (n=5828 patients seen by n=158 therapists for 50,048 sessions of psychotherapy) and examined whether outcomes diverge for high-performing (HP) and low-performing (LP) therapists as treatment duration increases. Results: Therapists accounted for a small but significant proportion of variance in patient outcomes that was not explained by differences between therapists' caseload characteristics. The discrepancy in outcomes between HP and LP therapists increased as treatment duration increased (interaction coefficient=0.071, p<.001). In addition, patients' trajectories of change were a function of their therapist's average outcome as well as the patient's duration of treatment (interaction coefficient=0.060, p=.040). Conclusions: Indeed, patterns of change previously described ignoring between-therapist differences (e.g., dose-effect, good-enough level model) may vary systematically when disaggregated by therapist effect.

Hopfinger, L., M. Berking, et al. (2016). ***"Emotion regulation mediates the effect of childhood trauma on depression."*** Journal of Affective Disorders 198: 189-197. http://www.sciencedirect.com/science/article/pii/S0165032715312544

Background Childhood trauma increases the risks of both depression and dysfunctional emotion regulation, which is a factor that has been strongly linked to depression. Because of these demonstrated relationships, it can be hypothesized that dysfunctional emotion regulation is a mediator of the association between childhood trauma and depression. Methods To test this hypothesis, we assessed the indirect effect of emotion regulation (Emotion Regulation Skills Questionnaire) on the relationship between childhood trauma (Childhood Trauma Questionnaire) and depression severity (24-item Hamilton Rating Scale for Depression) as well as depression lifetime persistency (i.e., lifetime percentage spent in major depressive episodes; assessed via SCID and Life Chart Interviews) in 269 patients with major depressive disorder (MDD). Results Bootstrapping-enhanced mediation analyses indicated that deficits in general emotion regulation mediated the association of childhood trauma to both depression severity and depression lifetime persistency. Further exploratory analyses indicated that specific emotion regulation skills (such as the ability to mindfully observe, accept, and tolerate undesired emotions or the willingness to voluntarily confront situations that prompt negative emotions in order to attain personally relevant goals) significantly mediated the association between childhood trauma and depression severity. Willingness to confront was a mediator for both depression outcomes (depression severity and lifetime persistency). Limitations The employed mediation analyses are cross-sectional in nature, which limits any firm conclusions regarding causality. Conclusions The findings support the assumption that a sophisticated emotion regulation may help prevent the onset or unfavorable course of depression in individuals who have experienced childhood trauma.

Kendrick, T., M. El-Gohary, et al. (2016). ***"Routine use of patient reported outcome measures (PROMS) for improving treatment of common mental health disorders in adults."*** Cochrane Database of Systematic Reviews 7: 1-106. http://dx.doi.org/10.1002/14651858.CD011119.pub2

Background: Routine outcome monitoring of common mental health disorders (CMHDs), using patient reported outcome measures (PROMs), has been promoted across primary care, psychological therapy and multidisciplinary mental health care settings, but is likely to be costly, given the high prevalence of CMHDs. There has been no systematic review of the use of PROMs in routine outcome monitoring of CMHDs across these three settings. Objectives: To assess the effects of routine measurement and feedback of the results of PROMs during the management of CMHDs in 1) improving the outcome of CMHDs; and 2) in changing the management of CMHDs. Search methods: We searched the Cochrane Depression Anxiety and Neurosis group specialised controlled trials register (CCDANCTR-Studies and CCDANCTR-References), the Oxford University PROMS Bibliography (2002-5), Ovid PsycINFO, Web of Science, The Cochrane Library, and International trial registries, initially to 30 May 2014, and updated to 18 May 2015. Selection criteria: We selected cluster and individually randomised controlled trials (RCTs) including participants with CMHDs aged 18 years and over, in which the results of PROMs were fed back to treating clinicians, or both clinicians and patients. We excluded RCTs in child and adolescent treatment settings, and those in which more than 10% of participants had diagnoses of eating disorders, psychoses, substance use disorders, learning disorders or dementia. Data collection and analysis: At least two authors independently identified eligible trials, assessed trial quality, and extracted data. We conducted meta-analysis across studies, pooling outcome measures which were sufficiently similar to each other to justify pooling. Main results: We included 17 studies involving 8787 participants: nine in multidisciplinary mental health care, six in psychological therapy settings, and two in primary care. Pooling of outcome data to provide a summary estimate of effect across studies was possible only for those studies using the compound Outcome Questionnaire (OQ-45) or Outcome Rating System (ORS) PROMs, which were all conducted in multidisciplinary mental health care or psychological therapy settings, because both primary care studies identified used single symptom outcome measures, which were not directly comparable to the OQ-45 or ORS. Meta-analysis of 12 studies including 3696 participants using these PROMs found no evidence of a difference in outcome in terms of symptoms, between feedback and no-feedback groups (standardised mean difference (SMD) -0.07, 95% confidence interval (CI) -0.16 to 0.01; P value = 0.10). The evidence for this comparison was graded as low quality however, as all included studies were considered at high risk of bias, in most cases due to inadequate blinding of assessors and significant attrition at follow-up. Quality of life was reported in only two studies, social functioning in one, and costs in none. Information on adverse events (thoughts of self-harm or suicide) was collected in one study, but differences between arms were not reported. It was not possible to pool data on changes in drug treatment or referrals as only two studies reported these. Meta-analysis of seven studies including 2608 participants found no evidence of a difference in management of CMHDs between feedback and no-feedback groups, in terms of the number of treatment sessions received (mean difference (MD) -0.02 sessions, 95% CI -0.42 to 0.39; P value = 0.93). However, the evidence for this comparison was also graded as low quality. Authors' conclusions: We found insufficient evidence to support the use of routine outcome monitoring using PROMs in the treatment of CMHDs, in terms of improving patient outcomes or in improving management. The findings are subject to considerable uncertainty however, due to the high risk of bias in the large majority of trials meeting the inclusion criteria, which means further research is very likely to have an important impact on the estimate of effect and is likely to change the estimate. More research of better quality is therefore required, particularly in primary care where most CMHDs are treated. Future research should address issues of blinding of assessors and attrition, and measure a range of relevant symptom outcomes, as well as possible harmful effects of monitoring, health-related quality of life, social functioning, and costs. Studies should include people treated with drugs as well as psychological therapies, and should follow them up for longer than six months.

Kraus, D. R., J. H. Bentley, et al. (2016). ***"Predicting therapist effectiveness from their own practice-based evidence."*** J Consult Clin Psychol 84(6): 473-483. http://psycnet.apa.org/journals/ccp/84/6/473/

OBJECTIVE: Differences between therapists (therapist effect) are often larger than differences between treatments (treatment effect) in explaining client outcomes, and thus should be considered relevant to providing optimal treatment to clients. However, research on therapist effectiveness has focused largely on global measures of distress as opposed to a multidimensional assessment, and has failed to risk-adjust for client characteristics. The purpose of this study was to examine the stability and predictive validity of therapist effectiveness across multiple outcome domains using risk-adjusted outcomes. METHOD: Initial and follow-up outcome data on the Treatment Outcome Package (Kraus, Seligman, & Jordan, 2005) were collected on 3,540 clients who were treated in naturalistic settings by a sample of 59 therapists. After risk-adjusting outcomes based on case-mix variables using random forest models, outcome data from the first 30 clients of each therapist were used to classify each therapist's effectiveness on 12 outcome domains. These results were then compared with outcome data from the therapist's next 30 clients. RESULTS: Results demonstrated that therapist effectiveness was relatively stable, although somewhat domain specific. Therapists classified as "exceptional" were significantly more likely to remain above average with future cases, suggesting that a therapist's past performance is an important predictor of their future performance. CONCLUSIONS: Clients are likely to experience differential benefit depending on the particular therapist and his or her strengths. Clinical outcomes may be improved by developing the best possible prediction model for each new client and then providing that client with referrals to therapists with well-matched strengths.

Kushner, S. C., L. C. Quilty, et al. (2016). ***"Therapeutic alliance mediates the association between personality and treatment outcome in patients with major depressive disorder."*** Journal of Affective Disorders 201: 137-144. http://www.sciencedirect.com/science/article/pii/S0165032715309162

Abstract Background Patient personality traits have been shown to influence treatment outcome in those with major depressive disorder (MDD). The trait agreeableness, which reflects an interpersonal orientation, may affect treatment outcome via its role in the formation of therapeutic alliance. No published studies have tested this hypothesis in patients with MDD. Method Participants were 209 outpatients with MDD who were treated in a randomized control trial. Mediation analyses were conducted to examine the role of therapeutic alliance in the association between pretreatment personality and the reduction of depression symptom severity during treatment. Separate models were estimated for patient- versus therapist-rated therapeutic alliance. Results We found a significant indirect effect of agreeableness on the reduction of depression severity via patient-rated therapeutic alliance. Results were replicated across two well-validated measures of depression symptom severity. Results also partially supported indirect effects for extraversion and openness. Therapist ratings of alliance did not mediate the association between personality and treatment outcomes. Limitations Patients were recruited as part of a randomized control trial, which may limit the generalizability of results to practice-based clinical settings. Due to constraints on statistical power, intervention-specific mediation results were not examined. Conclusions These results highlight the importance of personality and the role it plays in treatment process as well as outcome.

Kvam, S., C. L. Kleppe, et al. (2016). ***"Exercise as a treatment for depression: A meta-analysis."*** Journal of Affective Disorders 202: 67-86. http://www.sciencedirect.com/science/article/pii/S0165032715314221

Abstract Background This meta-analysis of randomized controlled trials (RCTs) examines the efficacy of physical exercise as treatment for unipolar depression, both as an independent intervention and as an adjunct intervention to antidepressant medication. Methods We searched PsycINFO, EMBASE, MEDLINE, CENTRAL, and Sports Discus for articles published until November 2014. Effect sizes were computed with random effects models. The main outcome was reduction in depressive symptoms or remission. Results A total of 23 RCTs and 977 participants were included. Physical exercise had a moderate to large significant effect on depression compared to control conditions (g=−0.68), but the effect was small and not significant at follow-up (g=−0.22). Exercise compared to no intervention yielded a large and significant effect size (g=−1.24), and exercise had a moderate and significant effect compared to usual care (g=−0.48). The effects of exercise when compared to psychological treatments or antidepressant medication were small and not significant (g=−0.22 and g=−0.08, respectively). Exercise as an adjunct to antidepressant medication yielded a moderate effect (g=−0.50) that trended toward significance. Limitations Use of the arms with the largest clinical effect instead of largest dose may have overestimated the effect of exercise. Conclusions Physical exercise is an effective intervention for depression. It also could be a viable adjunct treatment in combination with antidepressants.

Larsson, M. H., F. Falkenstrom, et al. (2016). ***"Alliance ruptures and repairs in psychotherapy in primary care."*** Psychother Res: 1-14. https://www.ncbi.nlm.nih.gov/pubmed/27139816

OBJECTIVE: The association between alliance level and outcome in psychotherapy has been extensively studied. One way to expand this knowledge is to study alliance patterns. The main aims of this study were to examine how frequent alliance patterns with ruptures or rupture-repair episodes were in a naturalistic sample of psychotherapies in primary care, and if three alliance patterns (a Rupture pattern, a Repair pattern, and a No Rupture pattern) were differentially associated with treatment outcome. METHOD: The psychotherapies (N = 605) included a wide range of different treatment orientations and patient diagnoses. Alliance patterns were studied at session-to-session level, using patient-rated alliance scores. Outcome data were analyzed using longitudinal multilevel modeling with a slopes-as-outcomes model. RESULTS: The Repair pattern accounted for 14.7% (n = 89) of the treatments, 10.7% (n = 65) exhibited a Rupture pattern, and 74.5% (n = 451) contained no ruptures. The Rupture pattern was associated with inferior treatment outcomes. The Repair pattern was, in longer treatments, associated with better outcomes than the No Rupture pattern. CONCLUSIONS: The results support theory about the importance of ruptures in the therapeutic alliance and suggest that identification of alliance ruptures is important in alliance-outcome research, for feedback purposes in clinical practice, and in training of therapists.

Newby, J. M., C. Twomey, et al. (2016). ***"Transdiagnostic computerised cognitive behavioural therapy for depression and anxiety: A systematic review and meta-analysis."*** Journal of Affective Disorders 199: 30-41. http://www.sciencedirect.com/science/article/pii/S0165032716300507

An increasing number of computerised transdiagnostic cognitive behavioural therapy programs (TD-cCBT) have been developed in the past decade, but there are no meta-analyses to explore the efficacy of these programs, nor moderators of the effects. The current meta-analysis focused on studies evaluating TD-cCBT interventions to examine their effects on anxiety, depression and quality of life (QOL). Results from 17 RCTs showed computerised TD-cCBT outperformed control conditions on all outcome measures at post-treatment, with large effect sizes for depression (g's=.84), and medium effect sizes for anxiety (g=.78) and QOL (g=.48). RCT quality was generally good, although heterogeneity was moderate to high. Further analyses revealed that studies comparing TD-cCBT to waitlist controls had the largest differences (g=.93) compared to active (g=.59) and usual care control groups (g=.37) on anxiety outcomes, but there was no influence of control group subtype on depression outcomes. Treatment length, symptom target (mixed versus anxiety only), treatment design (standardised versus tailored), and therapist experience (students versus qualified therapists) did not influence the results. Preliminary evidence from 4 comparisons with disorder-specific treatments suggests transdiagnostic treatments are as effective for reducing anxiety, and there may be small but superior outcomes for TD-cCBT programs for reducing depression (g=.21) and improving QOL (g=.21) compared to disorder-specific cCBT. These findings show that TD-cCBT programs are efficacious, and have comparable effects to disorder-specific cCBT programs.

Nissen-Lie, H. A., S. B. Goldberg, et al. (2016). ***"Are therapists uniformly effective across patient outcome domains? A study on therapist effectiveness in two different treatment contexts."*** Journal of Counseling Psychology 63(4): 367-378. http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/cou0000151

As established in several studies, therapists differ in effectiveness. A vital research task now is to understand what characterizes more or less effective therapists, and investigate whether this differential effectiveness systematically depends on client factors, such as the type of mental health problem. The purpose of the current study was to examine whether therapists are universally effective across patient outcome domains reflecting different areas of mental health functioning. Data were obtained from 2 sites: the Research Consortium of Counseling and Psychological Services in Higher Education (N = 5,828) in the United States and from primary and secondary care units (N = 616) in Sweden. Outcome domains were assessed via the Outcome Questionnaire-45 (Lambert et al., 2004) and the CORE-OM (Evans et al., 2002). Multilevel models with observations nested within patients were used to derive a reliable estimate for each patient's change (which we call a multilevel growth d) based on all reported assessment points. Next, 2 multilevel confirmatory factor analytic models were fit in which these effect sizes (multilevel ds) for the 3 subscales of the OQ-45 (Study 1) and 6 subscales of CORE-OM (Study 2) were indicators of 1 common latent factor at the therapist level. In both data sets, such a model, reflecting a global therapist effectiveness factor, yielded large factor loadings and excellent model fit. Results suggest that therapists effective (or ineffective) within one outcome domain are also effective within another outcome domain. Tentatively, therapist effectiveness can thus be conceived of as a global construct.

Richards, D. A., D. Ekers, et al. (2016). ***"Cost and outcome of behavioural activation versus cognitive behavioural therapy for depression (cobra): A randomised, controlled, non-inferiority trial."*** Lancet 388(10047): 871-880. https://www.ncbi.nlm.nih.gov/pubmed/27461440

BACKGROUND: Depression is a common, debilitating, and costly disorder. Many patients request psychological therapy, but the best-evidenced therapy-cognitive behavioural therapy (CBT)-is complex and costly. A simpler therapy-behavioural activation (BA)-might be as effective and cheaper than is CBT. We aimed to establish the clinical efficacy and cost-effectiveness of BA compared with CBT for adults with depression. METHODS: In this randomised, controlled, non-inferiority trial, we recruited adults aged 18 years or older meeting Diagnostic and Statistical Manual of Mental Disorders IV criteria for major depressive disorder from primary care and psychological therapy services in Devon, Durham, and Leeds (UK). We excluded people who were receiving psychological therapy, were alcohol or drug dependent, were acutely suicidal or had attempted suicide in the previous 2 months, or were cognitively impaired, or who had bipolar disorder or psychosis or psychotic symptoms. We randomly assigned participants (1:1) remotely using computer-generated allocation (minimisation used; stratified by depression severity [Patient Health Questionnaire 9 (PHQ-9) score of <19 vs >/=19], antidepressant use, and recruitment site) to BA from junior mental health workers or CBT from psychological therapists. Randomisation done at the Peninsula Clinical Trials Unit was

concealed from investigators. Treatment was given open label, but outcome assessors were masked. The primary outcome was depression symptoms according to the PHQ-9 at 12 months. We analysed all those who were randomly allocated and had complete data (modified intention to treat [mITT]) and also all those who were randomly allocated, had complete data, and received at least eight treatment sessions (per protocol [PP]). We analysed safety in the mITT population. The non-inferiority margin was 1.9 PHQ-9 points. This trial is registered with the ISCRTN registry, number ISRCTN27473954. FINDINGS: Between Sept 26, 2012, and April 3, 2014, we randomly allocated 221 (50%) participants to BA and 219 (50%) to CBT. 175 (79%) participants were assessable for the primary outcome in the mITT population in the BA group compared with 189 (86%) in the CBT group, whereas 135 (61%) were assessable in the PP population in the BA group compared with 151 (69%) in the CBT group. BA was non-inferior to CBT (mITT: CBT 8.4 PHQ-9 points [SD 7.5], BA 8.4 PHQ-9 points [7.0], mean difference 0.1 PHQ-9 points [95% CI -1.3 to 1.5], p=0.89; PP: CBT 7.9 PHQ-9 points [7.3]; BA 7.8 [6.5], mean difference 0.0 PHQ-9 points [-1.5 to 1.6], p=0.99). Two (1%) non-trial-related deaths (one [1%] multidrug toxicity in the BA group and one [1%] cancer in the CBT group) and 15 depression-related, but not treatment-related, serious adverse events (three in the BA group and 12 in the CBT group) occurred in three [2%] participants in the BA group (two [1%] patients who overdosed and one [1%] who self-harmed) and eight (4%) participants in the CBT group (seven [4%] who overdosed and one [1%] who self-harmed). INTERPRETATION: We found that BA, a simpler psychological treatment than CBT, can be delivered by junior mental health workers with less intensive and costly training, with no lesser effect than CBT. Effective psychological therapy for depression can be delivered without the need for costly and highly trained professionals.

Salcedo, S., A. K. Gold, et al. (2016). ***"Empirically supported psychosocial interventions for bipolar disorder: Current state of the research."*** Journal of Affective Disorders 201: 203-214. http://www.sciencedirect.com/science/article/pii/S0165032716303743

Abstract Objectives Bipolar disorder requires psychiatric medications, but even guideline-concordant treatment fails to bring many patients to remission or keep them euthymic. To address this gap, researchers have developed adjunctive psychotherapies. The purpose of this paper is to critically review the evidence for the efficacy of manualized psychosocial interventions for bipolar disorder. Methods We conducted a search of the literature to examine recent (2007-present), randomized controlled studies of the following psychotherapy interventions for bipolar disorder: psychoeducation (PE), cognitive behavioral therapy (CBT), interpersonal and social rhythm therapy (IPSRT), dialectical behavior therapy (DBT), mindfulness-based cognitive therapy (MBCT), and family therapies such as family focused therapy (FFT). Results All of the psychotherapy interventions appear to be effective in reducing depressive symptoms. Psychoeducation and CBT are associated with increased time to mood episode relapse or recurrence. MBCT has demonstrated a particular effectiveness in improving depressive and anxiety symptoms. Online psychotherapy interventions, programs combining one or more psychotherapy interventions, and targeted interventions centering on particular symptoms have been the focus of recent, randomized controlled studies in bipolar disorder. Conclusions Psychotherapy interventions for the treatment of bipolar disorder have substantial evidence for efficacy. The next challenge will to disseminate these psychotherapies into the community.

Saxon, D., M. Barkham, et al. (2016). ***"The contribution of therapist effects to patient dropout and deterioration in the psychological therapies."*** Clinical Psychology & Psychotherapy: n/a-n/a. http://dx.doi.org/10.1002/cpp.2028

Background: In the psychological therapies, patient outcomes are not always positive. Some patients leave therapy prematurely (dropout), while others experience deterioration in their psychological well-being. Methods: The sample for dropout comprised patients (n = 10 521) seen by 85 therapists, who attended at least the initial session of one-to-one therapy and completed a Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) at pre-treatment. The subsample for patient deterioration comprised patients (n = 6405) seen by the same 85 therapists but who attended two or more sessions, completed therapy and returned a CORE-OM at pre-treatment and post-treatment. Multilevel modelling was used to estimate the extent of therapist effects for both outcomes after controlling for patient characteristics. Results: Therapist effects accounted for 12.6% of dropout variance and 10.1% of deterioration variance. Dropout rates for therapists ranged from 1.2% to 73.2%, while rates of deterioration ranged from 0% to 15.4%. There was no significant correlation between therapist dropout rate and deterioration rate (Spearman's rho = 0.07, p = 0.52). Conclusions: The methods provide a reliable means for identifying therapists who return consistently poorer rates of patient dropout and deterioration compared with their peers. The variability between therapists and the identification of patient risk factors as significant predictors has implications for the delivery of safe psychological therapy services. Key Practitioner Message: * Therapists play an important role in contributing to patient dropout and deterioration, irrespective of case mix. * Therapist effects on patient dropout and deterioration appear to act independently. * Being unemployed as a patient was the strongest predictor of both dropout and deterioration. * Patient risk to self or others was also an important predictor.

Saxon, D., N. Firth, et al. (2016). ***"The relationship between therapist effects and therapy delivery factors: Therapy modality, dosage, and non-completion."*** Administration and Policy in Mental Health and Mental Health Services Research: 1-11. http://dx.doi.org/10.1007/s10488-016-0750-5

(Available in free full text) To consider the relationships between, therapist variability, therapy modality, therapeutic dose and therapy ending type and assess their effects on the variability of patient outcomes. Multilevel modeling was used to analyse a large sample of routinely collected data. Model residuals identified more and less effective therapists, controlling for case-mix. After controlling for case mix, 5.8 % of the variance in outcome was due to therapists. More sessions generally improved outcomes, by about half a point on the PHQ-9 for each additional session, while non-completion of therapy reduced the amount of pre-post change by six points. Therapy modality had little effect on outcome. Patient and service outcomes may be improved by greater focus on the variability between therapists and in keeping patients in therapy to completion.

Schroder, J., T. Berger, et al. (2016). ***"Internet interventions for depression: New developments."*** Dialogues Clin Neurosci 18(2): 203-212. http://www.ncbi.nlm.nih.gov/pubmed/27489460

A wide range of Internet interventions, mostly grounded in methods of cognitive behavioral therapy, have been developed and tested for several mental disorders. The evidence to date shows that these interventions are effective in reducing symptoms of depression. Metaanalyses report small-to-medium effect sizes when Internet interventions are delivered as stand-alone self-help interventions (d=0.25-0.36), and medium-to-large effect sizes when delivered as therapist-guided interventions (d=0.58-0.78), both compared with usual care. Only a minority of people suffering from depression receive adequate treatment, and Internet interventions might help bridge the large treatment gap. This review summarizes the current body of evidence and highlights pros and cons of Internet interventions. It also outlines how they could be implemented in mental health care systems and points out unresolved questions, as well as future directions, in this research field.

Shear, M., C. F. Reynolds, et al. (2016). ***"Optimizing treatment of complicated grief: A randomized clinical trial."*** JAMA Psychiatry 73(7): 685-694. http://dx.doi.org/10.1001/jamapsychiatry.2016.0892

Importance To our knowledge, this is the first placebo-controlled randomized clinical trial to evaluate the efficacy of antidepressant pharmacotherapy, with and without complicated grief psychotherapy, in the treatment of complicated grief. Objective To confirm the efficacy of a targeted complicated grief treatment (CGT), determine whether citalopram (CIT) enhances CGT outcome, and examine CIT efficacy without CGT. Design, Setting, and Participants Included in the study were 395 bereaved adults who met criteria for CG recruited from March 2010 to September 2014 from academic medical centers in Boston, Massachusetts; New York, New York; Pittsburgh, Pennsylvania; and San Diego, California. Co-occurring substance abuse, psychosis, mania, and cognitive impairment were exclusionary. Study participants were randomized using site-specific permuted blocks stratified by major depression into groups prescribed CIT (n = 101), placebo (PLA; n = 99), CGT with CIT (n = 99), and CGT with PLA (n = 96). Independent evaluators conducted monthly assessments for 20 weeks. Response rates were compared under the intention-to-treat principle, including all randomized participants in a logistic regression with inverse probability weighting.Interventions All participants received protocolized pharmacotherapy optimized by flexible dosing, psychoeducation, grief monitoring, and encouragement to engage in activities. Half were also randomized to receive manualized CGT in 16 concurrent weekly sessions. Main Outcomes and Measures Complicated grief–anchored Clinical Global Impression scale measurments every 4 weeks. Response was measured as a rating of "much improved" or "very much improved." Results Of the 395 study participants, 308 (78.0%) were female and 325 (82.3%) were white. Participants' response to CGT with PLA vs PLA (82.5% vs 54.8%; relative risk [RR], 1.51; 95% CI, 1.16-1.95; P = .002; number needed to treat [NNT], 3.6) suggested the efficacy of CGT, and the addition of CIT did not significantly improve CGT outcome (CGT with CIT vs CGT with PLA: 83.7% vs 82.5%; RR, 1.01; 95% CI, 0.88-1.17; P = .84; NNT, 84). However, depressive symptoms decreased significantly more when CIT was added to treatment (CGT with CIT vs CGT with PLA: model-based adjusted mean [standard error] difference, −2.06 [1.00]; 95% CI, −4.02 to −0.11; P = .04). By contrast, adding CGT improved CIT outcome (CIT vs CGT with CIT: 69.3% vs 83.7%; RR, 1.21; 95% CI, 1.00-1.46; P = .05; NNT, 6.9). Last, participant response to CIT was not significantly different from PLA at week 12 (45.9% vs 37.9%; RR, 1.21; 95% CI, 0.82-1.81; P = .35; NNT, 12.4) or at week 20 (69.3% vs 54.8%; RR, 1.26; 95% CI, 0.95-1.68; P = .11; NNT, 6.9). Rates of suicidal ideation diminished to a substantially greater extent among participants receiving CGT than among those who did not.Conclusions and Relevance Complicated grief treatment is the treatment of choice for CG, and the addition of CIT optimizes the treatment of co-occurring depressive symptoms.

Sobol-Kwapinska, M. (2016). ***"Calm down — it's only neuroticism. Time perspectives as moderators and mediators of the relationship between neuroticism and well-being."*** Personality and Individual Differences 94: 64-71.
http://www.sciencedirect.com/science/article/pii/S0191886916300046

Neuroticism is associated with poor well-being, and researchers search for variables that influence the relationship between these two constructs. The current study is focused on time perspective (TP) as a moderator and mediator of the link between neuroticism and selected aspects of well-being, that is, self-esteem, satisfaction with life, optimism and life engagement. The results suggest that, contrary to expectation, strong concentration on the present, perceived as an important and unique time area, by highly neurotic individuals intensifies the negative relationship between neuroticism and self-esteem, satisfaction with life and life engagement. Attention has been paid to the importance of distance to time for the well-being of people with high levels of neuroticism. Moreover, the findings provide evidence for the role of negative past TP and unbalanced TP in explaining the negative association between neuroticism and well-being.

Spiers, N., T. Qassem, et al. (2016). ***"Prevalence and treatment of common mental disorders in the English national population, 1993–2007."*** The British Journal of Psychiatry 209(2): 150-156
http://bjp.rcpsych.org/content/early/2016/05/31/bjp.bp.115.174979

Background The National Psychiatric Morbidity Surveys include English cross-sectional household samples surveyed in 1993, 2000 and 2007. Aims To evaluate frequency of common mental disorders (CMDs), service contact and treatment.MethodCommon mental disorders were identified with the Clinical Interview Schedule – Revised (CIS-R). Service contact and treatment were established in structured interviews. Results There were 8615, 6126 and 5385 participants aged 16–64. Prevalence of CMDs was consistent (1993: 14.3%; 2000: 16.0%; 2007: 16.0%), as was past-year primary care physician contact for psychological problems (1993: 11.3%; 2000: 12.0%; 2007: 11.7%). Antidepressant receipt in people with CMDs more than doubled between 1993 (5.7%) and 2000 (14.5%), with little further increase by 2007 (15.9%). Psychological treatments increased in successive surveys. Many with CMDs received no treatment. Conclusions Reduction in prevalence did not follow increased treatment uptake, and may require universal public health measures together with individual pharmacological, psychological and computer-based interventions.

Staring, A. B. P., D. P. G. van den Berg, et al. (2016). ***"Self-esteem treatment in anxiety: A randomized controlled crossover trial of eye movement desensitization and reprocessing (EMDR) versus competitive memory training (comet) in patients with anxiety disorders."*** Behaviour Research and Therapy 82: 11-20.
http://www.sciencedirect.com/science/article/pii/S0005796716300560

AbstractBackground and purpose Little is known about treating low self-esteem in anxiety disorders. This study evaluated two treatments targeting different mechanisms: (1) Eye Movement Desensitization and Reprocessing (EMDR), which aims to desensitize negative memory representations that are proposed to maintain low self-esteem; and (2) Competitive Memory Training (COMET), which aims to activate positive representations for enhancing self-esteem. Methods A Randomized Controlled Trial (RCT) was used with a crossover design. Group 1 received six sessions EMDR first and then six sessions COMET; group 2 vice versa. Assessments were made at baseline (T0), end of first treatment (T1), and end of second treatment (T2). Main outcome was self-esteem. We included 47 patients and performed Linear Mixed Models. Results COMET showed more improvements in self-esteem than EMDR: effect-sizes 1.25 versus 0.46 post-treatment. Unexpectedly, when EMDR was given first, subsequent effects of COMET were significantly reduced in comparison to COMET as the first intervention. For EMDR, sequence made no difference. Reductions in anxiety and depression were mediated by better self-esteem. Conclusions COMET was associated with significantly greater improvements in self-esteem than EMDR in patients with anxiety disorders. EMDR treatment reduced the effectiveness of subsequent COMET. Improved self-esteem mediated reductions in anxiety and depression symptoms.

Stickley, A. and A. Koyanagi (2016). ***"Loneliness, common mental disorders and suicidal behavior: Findings from a general population survey."*** Journal of Affective Disorders 197: 81-87.
http://www.sciencedirect.com/science/article/pii/S0165032715310442

Abstract Background Loneliness has been linked to an increased risk of engaging in suicidal behavior. To date, however, there has been comparatively little research on this in the general adult population, or on the role of common mental disorders (CMDs) in this association. The current study examined these associations using nationally representative data from England. Methods Data came from the Adult Psychiatric Morbidity Survey 2007. Information was obtained from 7403 household residents aged ≥16 years on perceived loneliness and lifetime and past 12-month suicide ideation and attempts. The Clinical Interview

Schedule Revised (CIS-R) was used to assess six forms of CMD. Logistic regression analysis was used to examine these associations. Results Loneliness was associated with suicidal behavior. Although adjusting for CMDs attenuated associations, higher levels of loneliness were still significantly associated with suicidal ideation and suicide attempts with odds ratios (OR) for those in the most severe loneliness category ranging from 3.45 (lifetime suicide attempt) to 17.37 (past 12-month suicide attempt). Further analyses showed that ORs for suicidal behavior were similar for individuals who were lonely without CMDs, and for those respondents with CMDs who were not lonely. Lonely individuals with CMDs had especially elevated odds for suicidal ideation. Limitations This study used cross-sectional data and a single-item measure to obtain information on loneliness. Conclusion Loneliness is associated with suicidal behavior in the general adult population. This highlights the importance of efforts to reduce loneliness in order to mitigate its harmful effects on health and well-being.

Waller, K., J. Kaprio, et al. (2016). ***"Persistent leisure-time physical activity in adulthood and use of antidepressants: A follow-up study among twins."*** Journal of Affective Disorders 200: 172-177.
http://www.sciencedirect.com/science/article/pii/S0165032716302051

Abstract Background To study whether persistent leisure-time physical activity (PA) during adulthood predicts use of antidepressants later in life. Methods The Finnish Twin Cohort comprises same-sex twin pairs born before 1958, of whom 11 325 individuals answered PA questions in 1975, 1981 and 1990 at a mean age of 44 years (range 33–60). PA volume over 15-years was used as the predictor of subsequent use of antidepressants. Antidepressant use (measured as number of purchases) for 1995–2004 were collected from the Finnish Social Insurance Institution (KELA) prescription register. Conditional logistic regression was conducted to calculate odds ratios (OR) with 95% confidence intervals (CI) for the use of antidepressants in pairs discordant for PA (642, including 164 monozygotic (MZ) pairs). Results Altogether 229 persons had used at least one prescribed antidepressant during the study period. Active co-twins had a lower risk (unadjusted OR 0.80, 95%CI 0.67–0.95) for using any amount of antidepressants than their inactive co-twins; trends being similar for DZ (0.80, 0.67–0.97) and MZ pairs (0.78, 0.51–1.17). The lowest odds ratio (0.51, 0.26–0.98) was seen among MZ pairs after adjusting for BMI, smoking and binge drinking. The point estimates were similar but non-significant for long-term antidepressant use (4+purchases equivalent to 12 months use). Limitations Self-reported physical activity and low number of discordant MZ pairs. Discussion Use of antidepressants was less common among physically active co-twins even when shared childhood experiences and genetic background were controlled for. Physical activity in midlife may therefore be important in preventing mild depression later in life.

Zanarini, M. C., F. R. Frankenburg, et al. (2016). ***"Fluidity of the subsyndromal phenomenology of borderline personality disorder over 16 years of prospective follow-up."*** American Journal of Psychiatry 173(7): 688-694.
http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2015.15081045

Objective: The purpose of this study was to determine the cumulative rates of 2- and 4-year remission, and the recurrences that follow them, of 24 symptoms of borderline personality disorder over 16 years of prospective follow-up. Method: A total of 290 inpatients meeting rigorous criteria for borderline personality disorder and 72 axis II comparison subjects were assessed during their index admission using a series of semistructured diagnostic interviews. The same instruments were readministered at eight contiguous 2-year time periods. Results: The 12 acute symptoms (e.g., self-mutilation, help-seeking suicide attempts) of borderline personality disorder were more likely to remit for a period of 2 years and for a period of 4 years than the 12 temperamental symptoms (e.g., chronic anger/frequent angry acts, intolerance of aloneness) of this disorder. They were also less likely to recur after a remission lasting 2 years or a remission lasting 4 years. Conclusions: Taken together, the symptoms of borderline personality disorder are quite fluid, with remissions and recurrences being common. However, the more clinically urgent acute symptoms of borderline personality disorder seem to have a better prognosis than the less turbulent temperamental symptoms of the disorder.

Zilcha-Mano, S., J. C. Muran, et al. (2016). ***"The relationship between alliance and outcome: Analysis of a two-person perspective on alliance and session outcome."*** J Consult Clin Psychol 84(6): 484-496.
http://psycnet.apa.org/journals/ccp/84/6/484/

OBJECTIVE: Better alliance is known to predict better psychotherapy outcomes, but the interdependent and interactive effects of both therapist- and patient-reported alliance levels have yet to be systematically investigated. METHOD: Using actor-partner interdependence model analysis the authors estimated actor, partner, and 2 types of interactive effects of alliance on session outcome in a sample of 241 patient-therapist dyads across 30 sessions of cognitive-behavioral and alliance-focused therapy. RESULTS: Findings suggest that the most robust predictors of session outcome are within-treatment changes in patient reports of the alliance, which predict both patient and therapist report on outcome. Within-treatment changes in therapist reports of the alliance, as well as differences between patients and between therapists in their average ratings of alliance levels across treatment, predict outcome as reported by the specific individual. Although alliance was found to be a significant predictor of outcome in both treatments, for therapist-reported alliance and outcome it had a stronger effect in alliance-focused therapy than in cognitive-behavioral therapy. Additionally, dyads with the highest pooled level of alliance from both partners fared best on session outcome. CONCLUSIONS: The results are consistent with a 2-person perspective on psychotherapy, demonstrating the importance of considering the interdependent and interactive nature of both patient and therapist alliance levels on session outcome.