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(Arch, Wolitzky-Taylor et al. 2012; Bauer, Okon et al. 2012; Chapman, Mills et al. 2012; de Jong, van Sluis et al. 2012; Edmondson, Richardson et al. 2012; Evans-Lacko, Brohan et al. 2012; Gale, Batty et al. 2012; Geulayov, Gunnell et al. 2012; Gooding, Taylor et al. 2012; Hesser, Gustafsson et al. 2012; Hilvert-Bruce, Rossouw et al. 2012; Kelley, Weathers et al. 2012; Lewis, Simons et al. 2012; Lewis 2012; Lincoln, Ziegler et al. 2012; Mason and Richardson 2012; Meeus, Nijs et al. 2012; Mills, Teesson et al. 2012; Moritz, Schilling et al. 2012; Mychailyszyn, Brodman et al. 2012; Otto, Tolin et al. 2012; Reavley, Mackinnon et al. 2012; Russ, Stamatakis et al. 2012; Saxon and Barkham 2012; Smits, Julian et al. 2012; Smits, Minhajuddin et al. 2012; Wathen and MacMillan 2012; Werner and Griffin 2012; White 2012; Woltmann, Grogan-Kaylor et al. 2012)

Arch, J. J., K. B. Wolitzky-Taylor, et al. (2012). ***"Longitudinal treatment mediation of traditional cognitive behavioral therapy and acceptance and commitment therapy for anxiety disorders."*** Behaviour Research and Therapy 50(7–8): 469-478. http://www.sciencedirect.com/science/article/pii/S0005796712000769

Objective To assess the relationship between session-by-session putative mediators and treatment outcomes in traditional cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) for mixed anxiety disorders. Method Session-by-session changes in anxiety sensitivity and cognitive defusion were assessed in 67 adult outpatients randomized to CBT (n = 35) or ACT (n = 32) for a DSM-IV anxiety disorder. Results Multilevel mediation analyses revealed significant changes in the proposed mediators during both treatments (p < .001, d = .90–1.93), with ACT showing borderline greater improvements than CBT in cognitive defusion (p = .05, d = .82). Anxiety sensitivity and cognitive defusion both significantly mediated post-treatment worry; cognitive defusion more strongly predicted worry reductions in CBT than in ACT. In addition, cognitive defusion significantly mediated quality of life, behavioral avoidance, and (secondary) depression outcomes across both CBT and ACT (p < .05, R2 change = .06–.13), whereas anxiety sensitivity did not significantly mediate other outcomes. Conclusions Cognitive defusion represents an important source of therapeutic change across both CBT and ACT. The data offered little evidence for substantially distinct treatment-related mediation pathways.

Bauer, S., E. Okon, et al. (2012). ***"Technology-enhanced maintenance of treatment gains in eating disorders: Efficacy of an intervention delivered via text messaging."*** J Consult Clin Psychol 80(4): 700-706. http://www.ncbi.nlm.nih.gov/pubmed/22545736

OBJECTIVE: Given the lack of maintenance interventions for eating disorders, a program delivered via the short message service (SMS) and text messaging was developed to support patients after their discharge from inpatient treatment. METHOD: The efficacy of the intervention was studied in a randomized controlled trial. Additionally, its impact on the utilization of outpatient treatment during follow-up was investigated. One hundred sixty-five female patients with bulimia nervosa or a related eating disorder not otherwise specified were randomly assigned to a control group (treatment as usual; TAU) or an intervention group (SMS-based maintenance intervention; SMS). After hospital discharge, participants in the intervention group submitted a weekly symptom report via text message for 16 weeks and received tailored feedback. Primary outcome was the rate of partial remission 8 months after discharge from inpatient treatment. RESULTS: The difference in remission rates reached significance in the intent-to-treat analyses (SMS = 51.2%; TAU = 36.1%), chi(2)(1) = 3.81, p = .05, and approached significance in the completer analysis (SMS = 59.2%; TAU = 43.5%), chi(2)(1) = 3.44, p = .06. There were no differences in the utilization of outpatient treatment. Remission rates between the intervention and control groups were not significantly different among patients who used outpatient treatment (63.2% vs. 55.6%), chi(2)(1) = 0.44, p = .51. A significant difference was found in those who did not utilize such treatment (54.5% vs. 30.3%), chi(2)(1) = 3.97, p = .046. CONCLUSION: The aftercare intervention was efficacious in enhancing treatment outcome after discharge from inpatient treatment.

Chapman, C., K. Mills, et al. (2012). ***"Remission from post-traumatic stress disorder in the general population."*** Psychological Medicine 42(08): 1695-1703. http://dx.doi.org/10.1017/S0033291711002856

Background Few studies have focused on post-traumatic stress disorder (PTSD) remission in the population, none have modelled remission beyond age 54 years and none have explored in detail the correlates of remission from PTSD. This study examined trauma experience, symptom severity, co-morbidity, service use and time to PTSD remission in a large population sample. Method Data came from respondents (n=8841) of the 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB). A modified version of the World Health Organization's World Mental Health Composite International Diagnostic Interview (WMH-CIDI) was used to determine the presence and age of onset of DSM-IV PTSD and other mental and substance use disorders, type, age, and number of lifetime traumas, severity of re-experiencing, avoidance and hypervigilance symptoms and presence and timing of service use. Results Projected lifetime remission rate was 92% and median time to remission was 14 years. Those who experienced childhood trauma, interpersonal violence, severe symptoms or a secondary anxiety or affective disorder were less likely to remit from PTSD and reported longer median times to remission compared to those with other trauma experiences, less severe symptoms or no co-morbidity. Conclusions Although most people in the population with PTSD eventually remit, a significant minority report symptoms decades after onset. Those who experience childhood trauma or interpersonal violence should be a high priority for intervention.

de Jong, K., P. van Sluis, et al. (2012). ***"Understanding the differential impact of outcome monitoring: Therapist variables that moderate feedback effects in a randomized clinical trial."*** Psychotherapy Research 22(4): 464-474. http://dx.doi.org/10.1080/10503307.2012.673023

Providing outcome monitoring feedback to therapists seems to be a promising approach to improve outcomes in clinical practice. This study aims to examine the effect of feedback and investigate whether it is moderated by therapist characteristics. Patients (n=413) were randomly assigned to either a feedback or a no-feedback control condition. There was no significant effect of feedback in the full sample, but feedback was effective for not-on-track cases for therapists who used the feedback. Internal feedback propensity, self-efficacy, and commitment to use the feedback moderated the effects of feedback. The results demonstrate that feedback is not effective under all circumstances and therapist factors are important when implementing feedback in clinical practice.

Edmondson, D., S. Richardson, et al. (2012). ***"Posttraumatic stress disorder prevalence and risk of recurrence in acute coronary syndrome patients: A meta-analytic review."*** PLoS ONE 7(6): e38915. http://dx.doi.org/10.1371%2Fjournal.pone.0038915

(Free full text available) Background: Acute coronary syndromes (ACS; myocardial infarction or unstable angina) can induce posttraumatic stress disorder (PTSD), and ACS-induced PTSD may increase patients' risk for subsequent cardiac events and mortality. Objective: To determine the prevalence of PTSD induced by ACS and to quantify the association between ACS-induced PTSD and adverse clinical outcomes using systematic review and meta-analysis. Data Sources: Articles were identified

by searching Ovid MEDLINE, PsycINFO, and Scopus, and through manual search of reference lists. Methodology/Principal Findings: Observational cohort studies that assessed PTSD with specific reference to an ACS event at least 1 month prior. We extracted estimates of the prevalence of ACS-induced PTSD and associations with clinical outcomes, as well as study characteristics. We identified 56 potentially relevant articles, 24 of which met our criteria (N = 2383). Meta-analysis yielded an aggregated prevalence estimate of 12% (95% confidence interval [CI], 9%–16%) for clinically significant symptoms of ACS-induced PTSD in a random effects model. Individual study prevalence estimates varied widely (0%–32%), with significant heterogeneity in estimates explained by the use of a screening instrument (prevalence estimate was 16% [95% CI, 13%–20%] in 16 studies) vs a clinical diagnostic interview (prevalence estimate was 4% [95% CI, 3%–5%] in 8 studies). The aggregated point estimate for the magnitude of the relationship between ACS-induced PTSD and clinical outcomes (ie, mortality and/or ACS recurrence) across the 3 studies that met our criteria (N = 609) suggested a doubling of risk (risk ratio, 2.00; 95% CI, 1.69–2.37) in ACS patients with clinically significant PTSD symptoms relative to patients without PTSD symptoms. Conclusions/Significance: This meta-analysis suggests that clinically significant PTSD symptoms induced by ACS are moderately prevalent and are associated with increased risk for recurrent cardiac events and mortality. Further tests of the association of ACS-induced PTSD and clinical outcomes are needed.

Evans-Lacko, S., E. Brohan, et al. (2012). ***"Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries."*** Psychological Medicine 42(08): 1741-1752. http://dx.doi.org/10.1017/S0033291711002558

Background Little is known about how the views of the public are related to self-stigma among people with mental health problems. Despite increasing activity aimed at reducing mental illness stigma, there is little evidence to guide and inform specific anti-stigma campaign development and messages to be used in mass campaigns. A better understanding of the association between public knowledge, attitudes and behaviours and the internalization of stigma among people with mental health problems is needed. Method This study links two large, international datasets to explore the association between public stigma in 14 European countries (Eurobarometer survey) and individual reports of self-stigma, perceived discrimination and empowerment among persons with mental illness (n=1835) residing in those countries [the Global Alliance of Mental Illness Advocacy Networks (GAMIAN) study]. Results Individuals with mental illness living in countries with less stigmatizing attitudes, higher rates of help-seeking and treatment utilization and better perceived access to information had lower rates of self-stigma and perceived discrimination and those living in countries where the public felt more comfortable talking to people with mental illness had less self-stigma and felt more empowered. Conclusions Targeting the general public through mass anti-stigma interventions may lead to a virtuous cycle by disrupting the negative feedback engendered by public stigma, thereby reducing self-stigma among people with mental health problems. A combined approach involving knowledge, attitudes and behaviour is needed; mass interventions that facilitate disclosure and positive social contact may be the most effective. Improving availability of information about mental health issues and facilitating access to care and help-seeking also show promise with regard to stigma.

Gale, C., G. Batty, et al. (2012). ***"Association of mental disorders in early adulthood and later psychiatric hospital admissions and mortality in a cohort study of more than 1 million men."*** Archives of General Psychiatry 69(8): 823-831. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2000

Context Mental disorders have been associated with increased mortality, but the evidence is primarily based on hospital admissions for psychoses. The underlying mechanisms are unclear. Objectives To investigate whether the risks of death associated with mental disorders diagnosed in young men are similar to those associated with admission for these disorders and to examine the role of confounding or mediating factors. Design Prospective cohort study in which mental disorders were assessed by psychiatric interview during a medical examination on conscription for military service at a mean age of 18.3 years and data on psychiatric hospital admissions and mortality during a mean 22.6 years of follow-up were obtained from national registers. Setting Sweden. Participants A total of 1 095 338 men conscripted between 1969 and 1994. Main Outcome Measure All-cause mortality according to diagnoses of schizophrenia, other nonaffective psychoses, bipolar or depressive disorders, neurotic and adjustment disorders, personality disorders, and alcohol-related or other substance use disorders at conscription and on hospital admission. Results Diagnosis of mental disorder at conscription or on hospital admission was associated with increased mortality. Age-adjusted hazard ratios according to diagnoses at conscription ranged from 1.81 (95% CI, 1.54-2.10) (depressive disorders) to 5.55 (95% CI, 1.79-17.2) (bipolar disorders). The equivalent figures according to hospital diagnoses ranged from 5.46 (95% CI, 5.06-5.89) (neurotic and adjustment disorders) to 11.2 (95% CI, 10.4-12.0) (other substance use disorders) in men born from 1951 to 1958 and increased in men born later. Adjustment for early-life socioeconomic status, body mass index, and blood pressure had little effect on these associations, but they were partially attenuated by adjustment for smoking, alcohol intake, intelligence, educational level, and late-life socioeconomic status. These associations were not primarily due to deaths from suicide. Conclusion The increased risk of premature death associated with mental disorder is not confined to those whose illness is severe enough for hospitalization or those with psychotic or substance use disorders.

Geulayov, G., D. Gunnell, et al. (2012). ***"The association of parental fatal and non-fatal suicidal behaviour with offspring suicidal behaviour and depression: A systematic review and meta-analysis."*** Psychological Medicine 42(08): 1567-1580. http://dx.doi.org/10.1017/S0033291711002753

Background Children whose parents die by, or attempt, suicide are believed to be at greater risk of suicidal behaviours and affective disorders. We systematically reviewed the literature on these associations and, using meta-analysis, estimated the strength of associations as well as investigated potential effect modifiers (parental and offspring gender, offspring age). Method We comprehensively searched the literature (Medline, PsycINFO, EMBASE, Web of Science), finding 28 articles that met our inclusion criteria, 14 of which contributed to the meta-analysis. Crude odds ratio and adjusted odds ratio (aOR) were pooled using fixed-effects models. Results Controlling for relevant confounders, offspring whose parents died by suicide were more likely than offspring of two living parents to die by suicide [aOR 1.94, 95% confidence interval (CI) 1.54–2.45] but there were heterogeneous findings in the two studies investigating the impact on offspring suicide attempt (aOR 1.31, 95% CI 0.73–2.35). Children whose parents attempted suicide were at increased risk of attempted suicide (aOR 1.95, 95% CI 1.48–2.57). Limited evidence indicated that exposure to parental death by suicide is associated with subsequent risk of affective disorders. Maternal suicidal behaviour and younger age at exposure were associated with larger effect estimates but there was no evidence that the association differed in sons versus daughters. Conclusions Parental suicidal behaviour is associated with increased risk of offspring suicidal behaviour. Findings suggest that maternal suicidal behaviour is a more potent risk factor than paternal, and that children are more vulnerable than adolescents and adults. However, there is no evidence of a stronger association in either male or female offspring.

Gooding, P., P. Taylor, et al. (2012). ***"Perceived extent and effectiveness of reflection and brooding in relation to depressed mood."*** Cognitive Therapy and Research 36(4): 282-289. http://dx.doi.org/10.1007/s10608-011-9367-x

The goal of this study was to determine whether the perceived effectiveness of two components of rumination, namely reflection and brooding, would differ, and whether these perceptions would interact with the extent that reflection and brooding were personally experienced, to predict depressed mood states. Participants completed measures of depressed mood, rumination, and measures of the personal and general effectiveness of rumination. Brooding was perceived to be less personally and generally effective compared to reflection. Depressed moods were predicted by high levels of brooding irrespective of effectiveness perceptions. High levels of reflection predicted depressed mood scores when the general effectiveness of reflection was perceived to be low. From a therapeutic perspective, these results suggest that brooding should be targeted irrespective of beliefs about the effectiveness of brooding but interventions designed to attenuate reflection should do so in the context of an individual's beliefs about its general effectiveness.

Hesser, H., T. Gustafsson, et al. (2012). ***"A randomized controlled trial of internet-delivered cognitive behavior therapy and acceptance and commitment therapy in the treatment of tinnitus."*** J Consult Clin Psychol 80(4): 649-661. http://www.ncbi.nlm.nih.gov/pubmed/22250855

OBJECTIVE: Our aim in this randomized controlled trial was to investigate the effects on global tinnitus severity of 2 Internet-delivered psychological treatments, acceptance and commitment therapy (ACT) and cognitive behavior therapy (CBT), in guided self-help format. METHOD: Ninety-nine participants (mean age = 48.5 years; 43% female) who were significantly distressed by tinnitus were recruited from the community. Participants were randomly assigned to CBT (n = 32), ACT (n = 35), or a control condition (monitored Internet discussion forum; n = 32), and they were assessed with standardized self-report measures (Tinnitus Handicap Inventory; Hospital Anxiety and Depression Scale; Quality of Life Inventory; Perceived Stress Scale; Tinnitus Acceptance Questionnaire) at pre-, posttreatment (8 weeks), and 1-year follow-up. RESULTS: Mixed-effects linear regression analysis of all randomized participants showed significant effects on the primary outcome (Tinnitus Handicap Inventory) for CBT and for ACT compared with control at posttreatment (95% CI [-17.03, -2.94], d = 0.70, and 95% CI [-16.29, -2.53], d = 0.68, respectively). Within-group effects were substantial from pretreatment through 1-year-follow-up for both treatments (95% CI [-44.65, -20.45], d = 1.34), with no significant difference between treatments (95% CI [-14.87, 11.21], d = 0.16). CONCLUSIONS: Acceptance-based procedures may be a viable alternative to traditional CBT techniques in the management of tinnitus. The Internet can improve access to psychological interventions for tinnitus.

Hilvert-Bruce, Z., P. J. Rossouw, et al. (2012). ***"Adherence as a determinant of effectiveness of internet cognitive behavioural therapy for anxiety and depressive disorders."*** Behaviour Research and Therapy 50(7–8): 463-468. http://www.sciencedirect.com/science/article/pii/S0005796712000708

Since 2009, the Clinical Research Unit for Anxiety and Depression (CRUfAD) has been providing primary care clinicians with internet cognitive behaviour therapy (iCBT) courses to prescribe to patients. Although these courses have demonstrated efficacy in research trials, adherence in primary care is less than half that of the research trials. The present studies pose three questions: first, do course non-completers drop out because of lack of efficacy? Second, can changes in delivery (e.g. adding choice, reminders and financial cost) improve adherence? Last, does clinician contact improve adherence? The results showed that non-completers derive benefit before dropping out; that adding reminders, choice of course and timing, and financial cost can significantly improve adherence; and that clinician contact during the course is associated with increased adherence. It is concluded that improved adherence is an important determinant of effectiveness.

Kelley, L. P., F. W. Weathers, et al. (2012). ***"Association of life threat and betrayal with posttraumatic stress disorder symptom severity."*** Journal of Traumatic Stress 25(4): 408-415. http://dx.doi.org/10.1002/jts.21727

The Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000) emphasizes life threat as the defining feature of psychological trauma. Recent theoretical and empirical work, however, indicates the need to identify and evaluate other key aspects of trauma. Betrayal has been proposed as a pertinent, distinct, and complementary factor that can explain effects of trauma not accounted for by life threat alone. This study examined the relationship between injury, perceived life threat (PLT), and betrayal with posttraumatic stress disorder (PTSD) symptom severity. Trauma-exposed college students (N = 185) completed self-report measures of trauma exposure and PTSD, as well as items regarding life threat, betrayal, and level of medical care received. In hierarchical regressions incorporating injury, PLT, and betrayal, betrayal was associated with all PTSD symptom clusters and PTSD total severity (f2 = .08), whereas PLT was associated with hyperarousal (f2 = .05) and PTSD total (f2 = .03), and injury had no association with PTSD symptoms. In a revised model with trauma type as an additional variable, betrayal was associated with avoidance (f2 = .03), numbing (f2 = .04), and PTSD total (f2 = .03), whereas PLT was associated with reexperiencing (f2 = .04), hyperarousal (f2 = .04), and PTSD total (f2 = .03), and injury was associated with avoidance (f2 = .03). These findings support the idea that betrayal is a core dimension of psychological trauma that may play an important role in the etiology of PTSD.

Lewis, C. C., A. D. Simons, et al. (2012). ***"The role of early symptom trajectories and pretreatment variables in predicting treatment response to cognitive behavioral therapy."*** J Consult Clin Psychol 80(4): 525-534. http://www.ncbi.nlm.nih.gov/pubmed/22730951

OBJECTIVE: Research has focused on 2 different approaches to answering the question, "Which clients will respond to cognitive behavioral therapy (CBT) for depression?" One approach focuses on rates of symptom change within the 1st few weeks of treatment, whereas the 2nd approach looks to pretreatment client variables (e.g., hopelessness) to identify clients who are more or less likely to respond. The current study simultaneously examines these 2 lines of research (i.e., early symptom change and pretreatment variables) on the prediction of treatment outcome to determine the incremental utility of each potential predictor. METHOD: The sample consists of 173 clients (66.47% female, 92.49% Caucasian), 18-64 years of age (M = 27.94, SD = 11.42), receiving treatment for depression and anxiety disorders in a CBT-oriented psychology training clinic. RESULTS: The rate of change in depressive symptom severity from baseline over the 1st 5 treatment sessions significantly predicted treatment outcome. A contemplative orientation to change and medication status positively predicted early symptom change, whereas student status negatively predicted early symptom change. Higher levels of baseline anxiety, precontemplative readiness to change, and global functioning predicted lower levels of depressive symptom severity at termination. CONCLUSIONS: The findings suggest achieving rapid symptom change early in treatment may be integral to overall success. As such, therapists may wish to target factors such as readiness to change to potentially maximize rapid rate of symptom change and subsequent treatment outcome.

Lewis, G. (2012). ***"Psychological distress and death from cardiovascular disease."*** BMJ 345. http://dx.doi.org/10.1136/bmj.e5177

May be related in a dose-response manner, but it is not clear how to intervene: The association between psychiatric disorders and cardiovascular disease is often reported in observational studies, but the question of reverse causation has always loomed large. In a linked research study (doi:10.1136/bmj.e4933), Russ and colleagues investigated the association between psychological distress and death from cardiovascular disease (recorded on death certificates) by examining data on more than

60 000 people from 10 large cohort studies based on the Health Surveys for England. The authors excluded early deaths (in the first five years of follow-up) and therefore the likelihood of reverse causation. Although the possibility of confounding can never be completely excluded, after adjusting for several "lifestyle" factors and cardiovascular disease risk factors, the authors still found a dose-response association between psychological distress and death from cardiovascular disease. These findings add to evidence that suggests a causal association between psychological distress and cardiovascular disease. In the English health surveys used by Russ and colleagues, psychological distress was measured using the General Health Questionnaire (GHQ). This assessment of mental health status is widely used and shows good agreement with more detailed assessments of depression and anxiety, conditions that are best represented along a continuum of severity in population studies. No obvious point separates people who report symptoms of depression or anxiety that meet diagnostic criteria from those who report similar symptoms below the diagnostic threshold. The current study found that an increased risk of cardiovascular disease exists along the whole of this continuum in a dose-response manner. Forty per cent of the sample scored at least 1 on the GHQ, and an association with subsequent death from cardiovascular disease was seen even at these low scores. The prevalence of depression and anxiety disorders is about 7.5% in the United Kingdom. It is now clear that an association between psychological distress and cardiovascular disease exists well below the threshold that would lead to a diagnosis of depression or anxiety or require specific treatment ... It is difficult to make the leap from the current observational evidence to suggesting that reducing stressors in the environment or changing the psychological interpretation of stressors will help to prevent cardiovascular disease. But, if psychological stress and distress are causes of cardiovascular disease, what implications does this have for prevention and treatment? For those people who meet diagnostic criteria for depression and anxiety, several effective psychological and drug treatments are available. However, what should be done about the much larger numbers of people who report symptoms on the depression-anxiety continuum but do not meet diagnostic criteria? Obvious sources of stress such as workplace stress could be modified. It is also worth considering how societal stresses related to inequalities and socioeconomic status might contribute to the incidence of cardiovascular disease. However, an attempt to produce a stress-free existence seems utopian and ignores the idea of "good stress." People vary greatly in their response to stressors, and some people even seek out stressors to provide a challenge and a sense of achievement. Avoiding stressors might also lead to more anxiety in the long run. A more useful approach could be to change the psychological interpretation of stressors, because this might reduce their biological impact. Cognitive behavioural therapy is, in part, designed to help people change the way they interpret stressors and thereby reduce the impact of stress. Individual and group cognitive behavioural therapy has been shown to be an effective treatment for depression and anxiety, but not, sadly, for preserving the health of the English football team's supporters. Even if we could improve our understanding and use of cognitive theories in the population to increase resilience to stressors, there is currently no evidence that these methods can be disseminated to the population at large to help people reduce perceived stress.

Lincoln, T. M., M. Ziegler, et al. (2012). ***"Moving from efficacy to effectiveness in cognitive behavioral therapy for psychosis: A randomized clinical practice trial."*** J Consult Clin Psychol 80(4): 674-686. http://www.ncbi.nlm.nih.gov/pubmed/22663901

OBJECTIVE: Randomized controlled trials have attested the efficacy of cognitive behavioral therapy (CBT) in reducing psychotic symptoms. Now, studies are needed to investigate its effectiveness in routine clinical practice settings. METHOD: Eighty patients with schizophrenia spectrum disorders who were seeking outpatient treatment were randomized to a specialized cognitive behavioral intervention for psychosis (CBTp; n = 40) or a wait list (n = 40). The CBTp group was assessed at baseline, posttreatment, and 1-year follow-up. The wait list group was assessed at baseline, after a 4-month waiting period, at posttreatment, and after 1 year. The primary outcome measure was the Positive and Negative Syndrome Scale (PANSS). RESULTS: The CBTp group showed significant improvement over the wait list group for the total PANSS score at posttreatment-postwaiting. CBTp was also superior to the wait list group in regard to the secondary outcomes positive symptoms, general psychopathology, depression, and functioning, but not in regard to negative symptoms. The number of dropouts during the treatment phases was low (11.3%). Participants perceived the treatment as helpful (98%) and considered themselves improved (92%). Significant pre- and posttreatment effect sizes varied between 0.77 for general psychopathology and 0.38 for delusional conviction. The positive effects of treatment could be maintained at 1-year follow-up, although the number of patients who had deteriorated was higher than at postassessment. CONCLUSIONS: Large proportions of patients in clinical practice settings benefit from CBTp. The efficacy of CBTp can be generalized to clinical practice despite the differences in patients, therapists, and deliverance.

Mason, E. C. and R. Richardson (2012). ***"Treating disgust in anxiety disorders."*** Clinical Psychology: Science and Practice 19(2): 180-194. http://dx.doi.org/10.1111/j.1468-2850.2012.01282.x

There is now a significant body of work which indicates that excessive disgust responses play a crucial role in certain anxiety disorders. In addition, emerging evidence suggests that disgust may not be effectively reduced by exposure therapy. Because of this, there is a need to arm clinicians with additional therapeutic tools to target maladaptive disgust responses. This study reviews potential strategies that may be useful in reducing disgust in the context of anxiety disorders. This review is intended to provide a useful starting point to inform clinicians and suggest possible future research directions. Ultimately, by ameliorating dysfunctional and distressing emotions other than fear that are prominent in certain anxiety disorders, such as disgust, treatments for anxiety disorders may be improved.

Meeus, M., J. Nijs, et al. (2012). ***"Role of psychological aspects in both chronic pain and in daily functioning in chronic fatigue syndrome: A prospective longitudinal study."*** Clinical Rheumatology 31(6): 921-929. http://dx.doi.org/10.1007/s10067-012-1946-z

In addition to fatigue, many patients with chronic fatigue syndrome (CFS) experience chronic musculoskeletal pain. We aimed at examining the role of catastrophizing, coping, kinesiophobia, and depression in the chronic pain complaints and in the daily functioning of CFS patients. A consecutive sample of 103 CFS patients experiencing chronic widespread musculoskeletal pain completed a battery of questionnaires evaluating pain, daily functioning, and psychological characteristics (depression, kinesiophobia, pain coping, and catastrophizing). Thirty-nine patients participated in the 6–12-month follow-up, consisting of questionnaires evaluating pain and pressure pain algometry. Correlation and linear regression analyses were performed to identify predictors. The strongest correlations with pain intensity were found for catastrophizing ($r = -.462$, $p < .001$) and depression ($r = -.439$, $p < .001$). The stepwise multiple regression analysis revealed that catastrophizing was both the immediate main predictor for pain (20.2%) and the main predictor on the longer term (20.1%). The degree of depression was responsible for 10% in the observed variance of the VAS pain after 6–12 months. No significant correlation with pain thresholds could be revealed. The strongest correlations with daily functioning at baseline were found for catastrophizing ($r = .435$, $p < .001$) and depression ($r = .481$, $p < .001$). Depression was the main predictor for restrictions in daily functioning (23.1%) at baseline. Pain catastrophizing and depression were immediate and long-term main predictors for pain in patients with CFS having chronic widespread musculoskeletal pain. They were also correlated to daily functioning, with depression as the main predictor for restrictions in daily functioning at baseline.

Mills, K. L., M. Teesson, et al. (2012). ***"Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial."*** JAMA 308(7): 690-699. http://dx.doi.org/10.1001/jama.2012.9071

Context There is concern that exposure therapy, an evidence-based cognitive-behavioral treatment for posttraumatic stress disorder (PTSD), may be inappropriate because of risk of relapse for patients with co-occurring substance dependence. Objective To determine whether an integrated treatment for PTSD and substance dependence, Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE), can achieve greater reductions in PTSD and substance dependence symptom severity compared with usual treatment for substance dependence. Design, Setting, and Participants Randomized controlled trial enrolling 103 participants who met DSM-IV-TR criteria for both PTSD and substance dependence. Participants were recruited from 2007-2009 in Sydney, Australia; outcomes were assessed at 9 months postbaseline, with interim measures collected at 6 weeks and 3 months postbaseline.Interventions Participants were randomized to receive COPE plus usual treatment (n = 55) or usual treatment alone (control) (n = 48). COPE consists of 13 individual 90-minute sessions (ie, 19.5 hours) with a clinical psychologist.Main Outcome Measures Change in PTSD symptom severity as measured by the Clinician-Administered PTSD Scale (CAPS; scale range, 0-240) and change in severity of substance dependence as measured by the number of dependence criteria met according to the Composite International Diagnostic Interview version 3.0 (CIDI; range, 0-7), from baseline to 9-month follow-up. A change of 15 points on the CAPS scale and 1 dependence criterion on the CIDI were considered clinically significant. Results From baseline to 9-month follow-up, significant reductions in PTSD symptom severity were found for both the treatment group (mean difference, −38.24 [95% CI, −47.93 to −28.54]) and the control group (mean difference, −22.14 [95% CI, −30.33 to −13.95]); however, the treatment group demonstrated a significantly greater reduction in PTSD symptom severity (mean difference, −16.09 [95% CI, −29.00 to −3.19]). No significant between-group difference was found in relation to improvement in severity of substance dependence (0.43 vs 0.52; incidence rate ratio, 0.85 [95% CI, 0.60 to 1.21), nor were there any significant between-group differences in relation to changes in substance use, depression, or anxiety. Conclusion Among patients with PTSD and substance dependence, the combined use of COPE plus usual treatment, compared with usual treatment alone, resulted in improvement in PTSD symptom severity without an increase in severity of substance dependence.

Moritz, S., L. Schilling, et al. (2012). ***"A randomized controlled trial of internet-based therapy in depression."*** Behaviour Research and Therapy 50(7–8): 513-521. http://www.sciencedirect.com/science/article/pii/S0005796712000757

Depression is among the most prevalent disorders worldwide. In view of numerous treatment barriers, internet-based interventions are increasingly adopted to "treat the untreated". The present trial (registered as NCT01401296) was conducted over the internet and aimed to assess the efficacy of an online self-help program for depression (Deprexis). In random order, participants with elevated depression symptoms received program access or were allocated to a wait-list control condition. After eight weeks, participants were invited to take part in an online re-assessment. To compensate for common problems of online studies, such as low completion rates and unclear diagnostic status, reminders and incentives were used, and clinical diagnoses were externally confirmed in a subgroup of 29% of participants. Relative to the wait-list group, program users experienced significant symptom decline on the Beck Depression Inventory (BDI; primary outcome), the Dysfunctional Attitudes Scale (DAS), the Quality of Life scale (WHOQOL-BREF) and the Rosenberg Self-Esteem Scale (RSE). Compared to wait-list participants, symptom decline was especially pronounced among those with moderate symptoms at baseline as well as those not currently consulting a therapist. Completion (82%) and re-test reliability of the instruments (r = .72–.87) were good. The results of this trial suggest that online treatment can be beneficial for people with depression, particularly for those with moderate symptoms.

Mychailyszyn, M. P., D. M. Brodman, et al. (2012). ***"Cognitive-behavioral school-based interventions for anxious and depressed youth: A meta-analysis of outcomes."*** Clinical Psychology: Science and Practice 19(2): 129-153. http://dx.doi.org/10.1111/j.1468-2850.2012.01279.x

A meta-analysis of school-based interventions for anxious and depressed youth using QUORUM guidelines was conducted. Studies were located by searching electronic databases, manual effort, and contact with expert researchers. Analyses examined 63 studies with 8,225 participants receiving cognitive-behavioral therapy (CBT) and 6,986 in comparison conditions. Mean pre–post effect sizes indicate that anxiety-focused school-based CBT was moderately effective in reducing anxiety (Hedge's g = 0.501) and depression-focused school-based CBT was mildly effective in reducing depression (Hedge's g = 0.298) for youth receiving interventions as compared to those in anxiety intervention control conditions (Hedge's g = 0.193) and depression intervention controls (Hedge's g = 0.091). Predictors of outcome were explored. School-based CBT interventions for youth anxiety and for youth depression hold considerable promise, although investigation is still needed to identify features that optimize service delivery and outcome.

Otto, M. W., D. F. Tolin, et al. (2012). ***"Five sessions and counting: Considering ultra-brief treatment for panic disorder."*** Depress Anxiety 29(6): 465-470. http://www.ncbi.nlm.nih.gov/pubmed/22730311

BACKGROUND: Brief cognitive-behavioral therapy for panic disorder has the potential to lower health care costs and enhance dissemination of evidence-based interventions to clinical practice. This manuscript evaluates the utility of brief cognitive-behavioral therapy for panic disorder. METHODS: A narrative review of studies examining the efficacy of cognitive-behavioral brief treatment of panic disorder, with a specific focus on an ultra-brief, 5-session, intervention developed by our group. RESULTS: Brief cognitive-behavioral therapy for panic disorder is associated with clinically meaningful symptom improvement reflecting large effect sizes, comparable to those observed for standard protocols. CONCLUSIONS: Growing evidence encourages the further evaluation and application brief cognitive-behavioral therapy for panic disorder. Controlled trials of cognitive-behavioral therapy have established the dramatic benefit that can be offered by brief treatment (often 12-15 sessions) approaches for Axis I disorders. Yet, as the field advances and core mechanisms of change are identified, there is the potential for offering efficacy in even briefer treatment protocols. In this manuscript, we describe the elements and initial efficacy estimates, based on published studies, for an ultra-brief treatment approach for panic disorder. We also discuss the potential impact, and such brief treatment can have relative to dissemination issues and the desire for the timely end to psychological suffering.

Reavley, N. J., A. J. Mackinnon, et al. (2012). ***"Quality of information sources about mental disorders: A comparison of Wikipedia with centrally controlled web and printed sources."*** Psychological Medicine 42(08): 1753-1762. http://dx.doi.org/10.1017/S003329171100287X

Background Although mental health information on the internet is often of poor quality, relatively little is known about the quality of websites, such as Wikipedia, that involve participatory information sharing. The aim of this paper was to explore the quality of user-contributed mental health-related information on Wikipedia and compare this with centrally controlled information sources. Method Content on 10 mental health-related topics was extracted from 14 frequently accessed websites (including Wikipedia) providing information about depression and schizophrenia, Encyclopaedia Britannica, and a psychiatry

textbook. The content was rated by experts according to the following criteria: accuracy, up-to-dateness, breadth of coverage, referencing and readability. Results Ratings varied significantly between resources according to topic. Across all topics, Wikipedia was the most highly rated in all domains except readability. Conclusions The quality of information on depression and schizophrenia on Wikipedia is generally as good as, or better than, that provided by centrally controlled websites, Encyclopaedia Britannica and a psychiatry textbook.

Russ, T. C., E. Stamatakis, et al. (2012). ***"Association between psychological distress and mortality: Individual participant pooled analysis of 10 prospective cohort studies."*** BMJ 345: e4933. http://www.bmj.com/content/345/bmj.e4933

(Free full text available): OBJECTIVE: To quantify the link between lower, subclinically symptomatic, levels of psychological distress and cause-specific mortality in a large scale, population based study. DESIGN: Individual participant meta-analysis of 10 large prospective cohort studies from the Health Survey for England. Baseline psychological distress measured by the 12 item General Health Questionnaire score, and mortality from death certification. PARTICIPANTS: 68,222 people from general population samples of adults aged 35 years and over, free of cardiovascular disease and cancer, and living in private households in England at study baseline. MAIN OUTCOME MEASURES: Death from all causes (n = 8365), cardiovascular disease including cerebrovascular disease (n = 3382), all cancers (n = 2552), and deaths from external causes (n = 386). Mean follow-up was 8.2 years (standard deviation 3.5). RESULTS: We found a dose-response association between psychological distress across the full range of severity and an increased risk of mortality (age and sex adjusted hazard ratio for General Health Questionnaire scores of 1-3 v score 0: 1.20, 95% confidence interval 1.13 to 1.27; scores 4-6: 1.43, 1.31 to 1.56; and scores 7-12: 1.94, 1.66 to 2.26; P<0.001 for trend). This association remained after adjustment for somatic comorbidity plus behavioural and socioeconomic factors. A similar association was found for cardiovascular disease deaths and deaths from external causes. Cancer death was only associated with psychological distress at higher levels. CONCLUSIONS: Psychological distress is associated with increased risk of mortality from several major causes in a dose-response pattern. Risk of mortality was raised even at lower levels of distress.

Saxon, D. and M. Barkham (2012). ***"Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk."*** J Consult Clin Psychol 80(4): 535-546. http://www.ncbi.nlm.nih.gov/pubmed/22663902

OBJECTIVE: To investigate the size of therapist effects using multilevel modeling (MLM), to compare the outcomes of therapists identified as above and below average, and to consider how key variables--in particular patient severity and risk and therapist caseload--contribute to therapist variability and outcomes. METHOD: We used a large practice-based data set comprising patients referred to the U.K.'s National Health Service primary care counseling and psychological therapy services between 2000 and 2008. Patients were included if they had received >/=2 sessions of 1-to-1 therapy (including an assessment), had a planned ending to treatment, and completed the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham et al., 2001; Barkham, Mellor-Clark, Connell, & Cahill, 2006; Evans et al., 2002) at pre- and post-treatment. The study sample comprised 119 therapists and 10,786 patients, whose mean age was 42.1 years (71.5% were female). MLM, including Markov chain Monte Carlo procedures, was used to derive estimates to produce therapist effects and to analyze therapist variability. RESULTS: The model yielded a therapist effect of 6.6% for average patient severity, but it ranged from 1% to 10% as patient non-risk scores increased. Recovery rates for individual therapists ranged from 23.5% to 95.6%, and greater patient severity and greater levels of aggregated patient risk in a therapist's caseload were associated with poorer outcomes. CONCLUSIONS: The size of therapist effect was similar to those found elsewhere, but the effect was greater for more severe patients. Differences in patient outcomes between those therapists identified as above or below average were large, and greater therapist risk caseload, rather than non-risk caseload, was associated with poorer patient outcomes. [Correction Notice: An Erratum for this article was reported in Vol 80(4) of Journal of Consulting and Clinical Psychology (see record 2012-16576-001). In the article's Appendix, the symbol β in line 1 of the model should be repeated in lines 3 and 4, rather than B.]

Smits, J. A., K. Julian, et al. (2012). ***"Threat reappraisal as a mediator of symptom change in cognitive-behavioral treatment of anxiety disorders: A systematic review."*** J Consult Clin Psychol 80(4): 624-635. http://www.ncbi.nlm.nih.gov/pubmed/22686124

OBJECTIVE: Identifying mediators of therapeutic change is important to the development of interventions and augmentation strategies. Threat reappraisal is considered a key mediator underlying the effects of cognitive-behavioral therapy (CBT) for anxiety disorders. The present study systematically reviewed the evidence for the threat reappraisal mediation hypothesis. METHOD: In our review, we included studies that (a) investigated the threat reappraisal mediation hypothesis; (b) included adults with an anxiety disorder diagnosis; (c) used a longitudinal design; and (d) did not report on previously published findings (to avoid the inclusion of multiple reports of the same data). After data extraction, we made review-specific quality judgments for each study using the following a priori criteria informed by mediation theory: (a) demonstrated statistical mediation; (b) demonstrated that CBT caused threat reappraisal; (c) demonstrated that threat reappraisal caused anxiety reduction; and (d) demonstrated specificity of the threat reappraisal-anxiety reduction relation. RESULTS: Of the 2,296 studies we identified, 25 met inclusion criteria. Of these studies, 56% tested and 52% established statistical mediation, 52% tested and 28% established CBT as a cause of threat reappraisal, 28% tested and 24% established threat reappraisal as a cause of anxiety reduction, and 44% tested and 36% established specificity of the threat reappraisal-anxiety reduction relation. CONCLUSIONS: While threat reappraisal is related to anxiety symptom improvement with CBT, there are few extant studies that meet most of the criteria necessary to conclusively demonstrate that it causes symptom improvement in CBT and that it is not a proxy for other third variables. Recommendations for future research in this area are discussed.

Smits, J. A., A. Minhajuddin, et al. (2012). ***"Outcomes of acute phase cognitive therapy in outpatients with anxious versus nonanxious depression."*** Psychother Psychosom 81(3): 153-160. http://www.ncbi.nlm.nih.gov/pubmed/22398963

OBJECTIVE: Compared to nonanxious depressed patients, anxious depressed patients respond less to pharmacotherapy, prompting consideration of alternate treatments. Based on the transdiagnostic principles of cognitive therapy (CT), we predicted that anxious depressed patients would respond as well to CT as nonanxious depressed patients. METHOD: Adults (n = 523) with recurrent major depressive disorder received 12-14 weeks of CT as part of the Continuation Phase Cognitive Therapy Relapse Prevention Trial. Anxious depressed patients (n = 264; 50.4%) were compared to nonanxious depressed patients (n = 259; 49.6%) on demographic variables, initial severity, attrition, and rates and patterns of response and remission. RESULTS: Anxious depressed patients presented with greater illness severity and had significantly lower response (55.3 vs. 68.3%) and remission rates (26.9 vs. 40.2%) based on clinician-administered measures. By contrast, smaller between-group differences for attrition, and for response (59.1 vs. 64.9%) and remission (41.7 vs. 48.7%) rates on self-report measures were not significant. Further, anxious depressed patients had greater speed of improvement on self-reported anxiety symptom severity and clinician-rated depressive and anxiety symptom severity measures. CONCLUSION: Consistent with prior reports, anxious depressed patients presented with greater severity and, following CT, had lower response and remission rates on clinician-administered scales. However, anxious depressed patients improved more rapidly and response

and remission rates on self-report measures were not significantly different from nonanxious depressed patients. Our findings suggest that anxious depressed patients may simply need additional time or more CT sessions to reach outcomes fully comparable to those of less anxious patients.

Wathen, C. N. and H. L. MacMillan (2012). ***"Health care's response to women exposed to partner violence: Moving beyond universal screening."*** JAMA 308(7): 712-713. http://dx.doi.org/10.1001/jama.2012.9913

Partner violence is a serious social and health care issue that results in short- and long-term physical and psychological harm for women, their children, and their families. Consequently, an issue with which the health sector has struggled since partner violence was identified as a major public health problem in 19921 is how to best identify and respond to abused women in primary health care settings. In this issue of JAMA, the study by Klevens and colleagues2 provides important new evidence to inform recommendations for the clinical management of abused women. The results of this clinical trial should encourage shifting the focus away from universal screening (administering a standard set of questions to all patients) to case finding—identifying and providing appropriate clinical and social services to women who show signs and symptoms of abuse.

Werner, K. B. and M. G. Griffin (2012). ***"Peritraumatic and persistent dissociation as predictors of ptsd symptoms in a female cohort."*** Journal of Traumatic Stress 25(4): 401-407. http://dx.doi.org/10.1002/jts.21725

Recent research has investigated peritraumatic and persistent dissociation as a possible predictive factor for posttraumatic stress disorder (PTSD). The current study aimed to add to this literature by examining dissociative responses in female assault survivors (N = 92 at initial assessment; n = 62 at follow-up). Dissociative symptoms experienced at 3 time points were assessed: peritraumatic dissociation (PD), persistent dissociation–initial (M = 28.2 days posttrauma) and follow-up (M = 224.9 days posttrauma), as well as initial and follow-up PTSD symptoms. We hypothesized that PD and persistent dissociative symptoms would predict chronic PTSD symptoms at the follow-up assessment with initial PTSD symptoms and assault type in the model. Hierarchical regression resulted in a significant model predicting 39% of the variance in follow-up PTSD symptom scores ($p < .001$). Both peritraumatic and follow-up persistent dissociative symptoms significantly and uniquely added to the variance explained in follow-up PTSD symptom score contributing 4% ($p = .05$) and 8% ($p = .008$) of the variance, respectively. Results support the predictive value of peritraumatic and persistent dissociative symptoms, and the findings suggest that persistent dissociation may contribute to the development and continuation of PTSD symptoms. We discuss the implications for assessment and possible treatment of PTSD as well as future directions.

White, S. W. (2012). ***"Growing pains: How psychologists can help to meet the clinical needs of clients with autism spectrum disorders."*** Cognitive and Behavioral Practice 19(3): 433-436. http://www.sciencedirect.com/science/article/pii/S1077722911001398

The pervasiveness and the prevalence of the autism spectrum disorders (ASD) are now much more recognized than in years past. The treatment needs of higher functioning people with ASD unfortunately often go unmet, and there is tremendous potential for psychologists to help meet these needs. The four articles in this special series provide current, best practice reviews and recommendations for practicing psychologists who work in this area. They highlight commonalities that cut across ASD and other clinical populations, and offer considerations that are unique to working with clients who have ASD. This commentary emphasizes the need for clinicians and applied psychological scientists to consider some of these issues in their own work.

Woltmann, E., A. Grogan-Kaylor, et al. (2012). ***"Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, speciality, and behavioral health care settings: Systematic review and meta-analysis."*** Am J Psychiatry 169(8): 790-804. http://www.ncbi.nlm.nih.gov/pubmed/22772364

OBJECTIVE: Collaborative chronic care models (CCMs) improve outcome in chronic medical illnesses and depression treated in primary care settings. The effect of such models across other treatment settings and mental health conditions has not been comprehensively assessed. The authors performed a systematic review and meta-analysis to assess the comparative effectiveness of CCMs for mental health conditions across disorders and treatment settings. METHOD: Randomized controlled trials comparing CCMs with other care conditions, published or in press by August 15, 2011, were identified in a literature search and through contact with investigators. CCMs were defined a priori as interventions with at least three of the six components of the Improving Chronic Illness Care initiative (patient self-management support, clinical information systems, delivery system redesign, decision support, organizational support, and community resource linkages). Articles were included if the CCM effect on mental health symptoms or mental quality of life was reported. Data extraction included analyses of these outcomes plus social role function, physical and overall quality of life, and costs. Meta-analyses included comparisons using unadjusted continuous measures. RESULTS: Seventy-eight articles yielded 161 analyses from 57 trials (depression, N=40; bipolar disorder, N=4; anxiety disorders, N=3; multiple/other disorders, N=10). The meta-analysis indicated significant effects across disorders and care settings for depression as well as for mental and physical quality of life and social role function (Cohen's d values, 0.20-0.33). Total health care costs did not differ between CCMs and comparison models. A systematic review largely confirmed and extended these findings across conditions and outcome domains. CONCLUSIONS: CCMs can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.