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(Bergen-Cico and Cheon 2013; Chiesa and Serretti 2013; Chiesa, Serretti et al. 2013; Copeland, Wolke et al. 2013; Davey, Sired et al. 2013; English and John 2013; Fortney, Pyne et al. 2013; Gellis and Park 2013; Germain 2013; Greenberg and Meiran 2013; Hunter and Chilcot 2013; Jonas, Cusack et al. 2013; King, Erickson et al. 2013; Koerner, Antony et al. 2013; Kupfer, Kuhl et al. 2013; Landolt, Schnyder et al. 2013; Luby 2013; Malooly, Genet et al. 2013; McHugh, Reynolds et al. 2013; Milosevic and Radomsky 2013; Pearson, Fernyhough et al. 2013; Rakel, Mundt et al. 2013; Rethorst, Sunderajan et al. 2013; Schröder, Heider et al. 2013; Sherman, Hartson et al. 2013; Simon and Ludman 2013; So, Yamaguchi et al. 2013; Stillmaker and Kasser 2013; Van Dijk, Seger-Guttmann et al. 2013; Wolgast, Lundh et al. 2013)

Bergen-Cico, D. and S. Cheon (2013). ***"The mediating effects of mindfulness and self-compassion on trait anxiety."*** Mindfulness (N Y): 1-15. http://dx.doi.org/10.1007/s12671-013-0205-y

Research has found meditation to be associated with improved mental health; however, less is known about how these positive outcomes develop. To better understand the operant effects of meditation on mental health, this study is set forth to examine the potential mediating effects of commonly measured constructs of mindfulness and self-compassion on trait anxiety, a personality trait prevalent in many psychiatric conditions. This longitudinal study uses a meditation treatment (n = 108) and comparative control (n = 94) designed to examine relational changes in mindfulness, self-compassion, and trait anxiety data collected in three waves: (a) baseline, (b) mid-program, and (c) post-program. Structural equation modeling (SEM) revealed significant increases in mindfulness and self-compassion scores among the treatment cohort and cross-lagged regression models that revealed significant reductions in trait anxiety were mediated by preceding increases in mindfulness. SEM model testing found that increases in mindfulness precipitate increases in self-compassion, but neither self-compassion nor anxiety mediated mindfulness. Whereas both self-compassion and mindfulness were associated with reductions in anxiety, the cultivation of mindfulness had the most robust mediating effect on reductions in trait anxiety. These finding reinforce previous studies that have suggested that increases in mindfulness skills may mediate the effects of meditation on mental health outcomes. Among the strengths of the current study are the longitudinal three waves of data, including mid-program data that enables cross-lagged regression. The cross-lagged models indicate the temporal ordering of changes and reveal mindfulness as the key mediating variable preceding substantive changes in self-compassion and trait anxiety.

Chiesa, A. and A. Serretti (2013). ***"Are mindfulness-based interventions effective for substance use disorders? A systematic review of the evidence."*** Subst Use Misuse. http://www.ncbi.nlm.nih.gov/pubmed/23461667

Mindfulness-based interventions (MBIs) are increasingly suggested as therapeutic approaches for effecting substance use and misuse (SUM). The aim of this article is to review current evidence on the therapeutic efficacy of MBIs for SUM. A literature search was undertaken using four electronic databases and references of retrieved articles. The search included articles written in English published up to December 2011. Quality of included trials was assessed. In total, 24 studies were included, three of which were based on secondary analyses of previously investigated samples. Current evidence suggests that MBIs can reduce the consumption of several substances including alcohol, cocaine, amphetamines, marijuana, cigarettes, and opiates to a significantly greater extent than waitlist controls, non-specific educational support groups, and some specific control groups. Some preliminary evidence also suggests that MBIs are associated with a reduction in craving as well as increased mindfulness. The limited generalizability of the reviewed findings is noted (i.e., small sample size, lack of methodological details, and the lack of consistently replicated findings). More rigorous and larger randomized controlled studies are warranted.

Chiesa, A., A. Serretti, et al. (2013). ***"Mindfulness: Top-down or bottom-up emotion regulation strategy?"*** Clin Psychol Rev 33(1): 82-96. http://www.ncbi.nlm.nih.gov/pubmed/23142788

The beneficial clinical effects of mindfulness practices are receiving increasing support from empirical studies. However, the functional neural mechanisms underlying these benefits have not been thoroughly investigated. Some authors suggest that mindfulness should be described as a 'top-down' emotion regulation strategy, while others suggest that mindfulness should be described as a 'bottom-up' emotion regulation strategy. Current discrepancies might derive from the many different descriptions and applications of mindfulness. The present review aims to discuss current descriptions of mindfulness and the relationship existing between mindfulness practice and most commonly investigated emotion regulation strategies. Recent results from functional neuro-imaging studies investigating mindfulness training within the context of emotion regulation are presented. We suggest that mindfulness training is associated with 'top-down' emotion regulation in short-term practitioners and with 'bottom-up' emotion regulation in long-term practitioners. Limitations of current evidence and suggestions for future research on this topic are discussed.

Copeland, W. E., D. Wolke, et al. (2013). ***"Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence."*** JAMA Psychiatry 70(4): 419-426. http://dx.doi.org/10.1001/jamapsychiatry.2013.504

Importance Both bullies and victims of bullying are at risk for psychiatric problems in childhood, but it is unclear if this elevated risk extends into early adulthood. Objective To test whether bullying and/or being bullied in childhood predicts psychiatric problems and suicidality in young adulthood after accounting for childhood psychiatric problems and family hardships.Design Prospective, population-based study. Setting Community sample from 11 counties in Western North Carolina.Participants A total of 1420 participants who had being bullied and bullying assessed 4 to 6 times between the ages of 9 and 16 years. Participants were categorized as bullies only, victims only, bullies and victims (hereafter referred to as bullies/victims), or neither. Main Outcome Measure Psychiatric outcomes, which included depression, anxiety, antisocial personality disorder, substance use disorders, and suicidality (including recurrent thoughts of death, suicidal ideation, or a suicide attempt), were assessed in young adulthood (19, 21, and 24-26 years) by use of structured diagnostic interviews. Results Victims and bullies/victims had elevated rates of young adult psychiatric disorders, but also elevated rates of childhood psychiatric disorders and family hardships. After controlling for childhood psychiatric problems or family hardships, we found that victims continued to have a higher prevalence of agoraphobia (odds ratio [OR], 4.6 [95% CI, 1.7-12.5]; P < .01), generalized anxiety (OR, 2.7 [95% CI, 1.1-6.3]; P < .001), and panic disorder (OR, 3.1 [95% CI, 1.5-6.5]; P < .01) and that bullies/victims were at increased risk of young adult depression (OR, 4.8 [95% CI, 1.2-19.4]; P < .05), panic disorder (OR, 14.5 [95% CI, 5.7-36.6]; P < .001), agoraphobia (females only; OR, 26.7 [95% CI, 4.3-52.5]; P < .001), and suicidality (males only; OR, 18.5 [95% CI, 6.2-55.1]; P < .001). Bullies were at risk for antisocial personality disorder only (OR, 4.1 [95% CI, 1.1-15.8]; P < .04). Conclusions and Relevance The effects of being bullied are direct, pleiotropic, and long-lasting, with the worst effects for those who are both victims and bullies.

Davey, G. L., R. Sired, et al. (2013). ***"The role of facial feedback in the modulation of clinically-relevant ambiguity resolution."*** Cognitive Therapy and Research 37(2): 284-295. http://dx.doi.org/10.1007/s10608-012-9480-5

Two experiments investigated the effect of facial expressions on clinically-relevant ambiguity resolution in a nonclinical sample. Experiment 1 investigated the effect of negative facial feedback (frowning) on a basic threat-interpretation bias procedure using a homophone spelling task and found that participants in a frowning condition interpreted significantly more threat/neutral homophones as threats than did participants in a neutral control condition. Experiment 2 investigated how frowning affected interpretation of bodily sensations. The findings indicated that participants in the frowning condition generated fewer positive consequences for bodily sensation scenarios and also rated the imagined bodily sensations as more negative and more of a cause for health concern. These effects could not simply be explained by differences in self-reported mood or by demand characteristics. These findings suggest that facial expressions have a moderating effect on the cognitive processes that contribute to clinically-relevant ambiguity resolution, and this has implications for clinical interventions.

English, T. and O. P. John (2013). ***"Understanding the social effects of emotion regulation: The mediating role of authenticity for individual differences in suppression."*** Emotion 13(2): 314-329. http://www.ncbi.nlm.nih.gov/pubmed/23046456

Individuals differ in the strategies they use to regulate their emotions (e.g., suppression, reappraisal), and these regulatory strategies can differentially influence social outcomes. However, the mechanisms underlying these social effects remain to be specified. We examined one potential mediator that arises directly from emotion-regulatory effort (expression of positive emotion), and another mediator that does not involve emotion processes per se, but instead results from the link between regulation and self-processes (subjective inauthenticity). Across three studies, only inauthenticity mediated the link between habitual use of suppression and poor social functioning (lower relationship satisfaction, lower social support). These findings replicated across individuals socialized in Western and East Asian cultural contexts, younger and older adults, when predicting social functioning concurrently and a decade later, and even when broader adjustment was controlled. Thus, the social costs of suppression do not seem to be due to reduced positive emotion expression but rather the incongruence between inner-self and outer-behavior. Reappraisal was not consistently related to social functioning. Implications of these findings for emotion processes, self processes, and interpersonal relationships are discussed.

Fortney, J. C., J. M. Pyne, et al. (2013). ***"Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: A pragmatic randomized comparative effectiveness trial."*** Am J Psychiatry 170(4): 414-425. http://ajp.psychiatryonline.org/article.aspx?articleid=1654939

OBJECTIVE: Practice-based collaborative care is a complex evidence-based practice that is difficult to implement in smaller primary care practices that lack on-site mental health staff. Telemedicine-based collaborative care virtually co-locates and integrates mental health providers into primary care settings. The objective of this multisite randomized pragmatic comparative effectiveness trial was to compare the outcomes of patients assigned to practice-based and telemedicine-based collaborative care. METHOD: From 2007 to 2009, patients at federally qualified health centers serving medically underserved populations were screened for depression, and 364 patients who screened positive were enrolled and followed for 18 months. Those assigned to practice-based collaborative care received evidence-based care from an on-site primary care provider and a nurse care manager. Those assigned to telemedicine-based collaborative care received evidence-based care from an on-site primary care provider and an off-site team: a nurse care manager and a pharmacist by telephone, and a psychologist and a psychiatrist via videoconferencing. The primary clinical outcome measures were treatment response, remission, and change in depression severity. RESULTS: Significant group main effects were observed for both response (odds ratio=7.74, 95% CI=3.94-15.20) and remission (odds ratio=12.69, 95% CI=4.81-33.46), and a significant overall group-by-time interaction effect was observed for depression severity on the Hopkins Symptom Checklist, with greater reductions in severity over time for patients in the telemedicine-based group. Improvements in outcomes appeared to be attributable to higher fidelity to the collaborative care evidence base in the telemedicine-based group. CONCLUSIONS: Contracting with an off-site telemedicine-based collaborative care team can yield better outcomes than implementing practice-based collaborative care with locally available staff.

Gellis, L. and A. Park (2013). ***"Nighttime thought control strategies and insomnia severity."*** Cognitive Therapy and Research 37(2): 383-389. http://dx.doi.org/10.1007/s10608-012-9479-y

Strategies used to control unwanted thoughts during the evening have been shown to be significantly associated with insomnia, a common problem associated with numerous negative consequences. This study examined whether nighttime thought control strategies would predict insomnia severity among 460 college students (mean age = 18.8, 61 % female, and 72 % Caucasian) after accounting for well-established risk factors for the disorder such as anxiety, depression, sleep hygiene, and nighttime pain. The Insomnia Severity Index was used to measure insomnia severity and the Thought Control Questionnaire Insomnia-Revised was used to measure nighttime thought management strategies. Results from a hierarchical multiple linear regression showed that the strategy of cognitive distraction (attempts to withdraw from unwanted thoughts or think about more pleasant content) was negatively associated with insomnia severity and the strategy of aggressive suppression (the use of critical and punishing self thought) was positively associated with insomnia severity after accounting for other risk factors. These findings add to the growing literature highlighting arousing pre-sleep cognitions as a correlate of insomnia. These findings also add to emerging literature showing the ability to cognitively distract from the arousing thought as a correlate of good sleep.

Germain, A. (2013). ***"Sleep disturbances as the hallmark of PTSD: Where are we now?"*** Am J Psychiatry 170(4): 372-382. http://ajp.psychiatryonline.org/article.aspx?articleid=1478352

The hypothesis that rapid eye movement (REM) sleep disturbances are the hallmark of posttraumatic stress disorder (PTSD), proposed by Ross and colleagues in 1989, has stimulated a wealth of clinical, preclinical, and animal studies on the role of sleep in the pathophysiology of PTSD. The present review revisits this influential hypothesis in light of clinical and experimental findings that have since accumulated. Polysomnographic studies conducted in adults with PTSD have yielded mixed findings regarding REM sleep disturbances, and they generally suggest modest and nonspecific sleep disruptions. Prospective and treatment studies have provided more robust evidence for the relationship between sleep disturbances and psychiatric outcomes and symptoms. Experimental animal and human studies that have probed the relationship between REM sleep and fear responses, as well as studies focused more broadly on sleep-dependent affective and memory processes, also provide strong support for the hypothesis that sleep plays an important role in PTSD-relevant processes. Overall, the literature suggests that disturbed REM or non-REM sleep can contribute to maladaptive stress and trauma responses and may constitute a modifiable risk factor for poor psychiatric outcomes. Clinicians need to consider that the chronic sleep disruption associated with nightmares may affect the efficacy of first-line PTSD treatments, but targeted sleep treatments may accelerate recovery from PTSD. The field is ripe for prospective and longitudinal studies in high-risk groups to clarify how changes in sleep physiology and neurobiology contribute to increased risk of poor psychiatric outcomes.

Greenberg, J. and N. Meiran (2013). ***"Is mindfulness meditation associated with "feeling less?"."*** Mindfulness (N Y): 1-6. http://dx.doi.org/10.1007/s12671-013-0201-2

Following previous research which has suggested that mindfulness meditators are less affected by emotional stimuli, the current study examined the hypothesis that mindfulness meditation is associated with decreased emotional engagement, by inducing moods and asking participants to generate as many autobiographical memories opposite in valence as possible. Experienced mindfulness meditators took twice as long as non-meditators to generate the first opposite mood memory yet generated the same total number of memories as non-meditators. Contrary to the initial hypothesis, results indicate that mindfulness may be associated with increased emotional engagement, increased contact with emotions, and rapid recovery from the emotional experience. The effect of mindfulness on implicit and explicit aspects of emotion is discussed, as well as potential implications for treatment of related disorders.

Hunter, M. S. and J. Chilcot (2013). ***"Testing a cognitive model of menopausal hot flushes and night sweats."*** Journal of Psychosomatic Research 74(4): 307-312. http://www.sciencedirect.com/science/article/pii/S0022399912003388

AbstractObjective Hot flushes and night sweats (HFNS) are commonly experienced by women during the menopause transition and are particularly problematic for approximately 25% having negative impact on their quality of life. We previously developed a cognitive model of HFNS, which outlines potential predictors of HFNS. This study aims to test the model by investigating the relationships between personality characteristics, perceived stress, mood, HFNS beliefs and subjective and physiological measures of menopausal HFNS. Methods 140 women (menopause transition or postmenopausal) who were experiencing at least 10 HFNS per week for at least a month, completed assessment interviews, including questionnaires assessing optimism, somatic amplification, perceived stress, depressed mood, anxiety, HFNS beliefs and HFNS frequency, problem-rating and 24-hour sternal skin conductance monitoring. Structural equation models (SEM) were used to investigate the optimum predictive model for HFNS Frequency and HFNS Problem-Rating. Results On average 63 HFNS per week and moderately problematic HFNS were reported. The physiological measure of HFNS frequency was not associated with socio-demographic variables, personality or mood. The final SEM explained 53.2% of the variance in problem rating. Stress, anxiety and somatic amplification predicted HFNS problem rating but only via their impact on HFNS beliefs; HFNS frequency, smoking and alcohol intake also predicted HFNS problem rating. Conclusions Findings support the influence of psychological factors on experience of HFNS at the level of symptom perception and cognitive appraisal of HFNS.

Jonas, D. E., K. Cusack, et al. (2013). ***"Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). Comparative effectiveness review no. 92. ."*** AHRQ Comparative Effectiveness Reviews. Publication No. 13-EHC011-EF: 1-760. www.effectivehealthcare.ahrq.gov/reports/final.cfm

(Full 760 page report freely downloadable) Objectives. To assess efficacy, comparative effectiveness, and harms of ps ychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). Data sources. MEDLINE®, Cochrane Library, PILOTS, International Pharmaceutical Abstracts, CINAHL®, PsycINFO®, Web of Science, Embase, U.S. Food and Drug Administration Web site, and reference lists of published literature (January 1980–May 2012). Review methods. Two investigators independently selected, extracted data from, and rated risk of bias of relevant trials. We conducted quantitative analyses using random-effects models to estimate pooled effects. To estimate medications' comparative effectiveness, we conducted a network meta-analysis using Bayesian methods. We graded strength of evidence (SOE) based on established guidance. Results. We included 92 trials of patients, generally with severe PTSD and mean age of 30s to 40s. High SOE supports efficacy of exposure therapy for improving PTSD symptoms (Cohen's d -1.27; 95% confidence interval, -1.54 to -1.00); number needed to treat (NNT) to achieve loss of diagnosis was 2 (moderate SOE). Evidence also supports efficacy of cognitive processing therapy (CPT), cognitive therapy (CT), cognitive behavioral therapy (CBT)-mixed therapies, eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy for improving PTSD symptoms and/or achieving loss of diagnosis (moderate SOE). Effect sizes for reducing PTSD symptoms were large (e.g., 28.9- to 32.2-poi nt reduction in Clinician-Administered PTSD Scale [CAPS]; Cohen's d ~ -1.0 or more compared with controls); NNTs were ≤ 4 to achieve loss of diagnosis for CPT, CT, CBT-mixed, and EMDR. Evidence supports the efficacy of fluoxetine, paroxetine, sertraline, topiramate, and venlafaxine for improving PTSD symptoms (moderate SOE); effect sizes were small or medium (e.g., 4.9- to 15.5-point reduction in CAPS compared with placebo). Evidence for paroxetine and venlafaxine also supports their efficacy for inducing remission (NNTs ~8; moderate SOE). Evidence supports paroxetine's efficacy for improving depression symptoms and functional impairment (moderate SOE) and venlafaxine's efficacy for improving depression symptoms, quality of life, and functional impairment (moderate SOE). Risperidone may help PTSD symptoms (low SOE). Network meta-analysis of 28 trials (4,817 subjects) found paroxetine and topiramate to be more effective than most medications for reducing PTSD symptoms, but analysis was based largely on indirect evidence and limited to one outcome measure (low SOE). We found i nsufficient head-to-head evidence comparing efficacious treatments; insufficient evidence to verify whether any treatment approaches were more effective for victims of particular trauma types or to determine comparative risks of adverse effects.

King, A. P., T. M. Erickson, et al. (2013). ***"A pilot study of group mindfulness-based cognitive therapy (mbct) for combat veterans with posttraumatic stress disorder (PTSD)."*** Depression and Anxiety: n/a-n/a. http://dx.doi.org/10.1002/da.22104

Background "Mindfulness-based" interventions show promise for stress reduction in general medical conditions, and initial evidence suggests that they are accepted in trauma-exposed individuals. Mindfulness-based cognitive therapy (MBCT) shows substantial efficacy for prevention of depression relapse, but it has been less studied in anxiety disorders. This study investigated the feasibility, acceptability, and clinical outcomes of an MBCT group intervention adapted for combat posttraumatic stress disorder (PTSD). Methods Consecutive patients seeking treatment for chronic PTSD at a VA outpatient clinic were enrolled in 8-week MBCT groups, modified for PTSD (four groups, n = 20) or brief treatment-as-usual (TAU) comparison group interventions (three groups, n = 17). Pre and posttherapy psychological assessments with clinician administered PTSD scale (CAPS) were performed with all patients, and self-report measures (PTSD diagnostic scale, PDS, and posttraumatic cognitions inventory, PTCI) were administered in the MBCT group. Results Intent to treat analyses showed significant improvement in PTSD (CAPS ($t(19) = 4.8$, $P < .001$)) in the MBCT condition but not the TAU conditions, and a significant Condition × Time interaction ($F[1,35] = 16.4$, $P < .005$). MBCT completers (n = 15, 75%) showed good compliance with assigned homework exercises, and significant and clinically meaningful improvement in PTSD symptom severity on posttreatment assessment in CAPS and PDS (particularly in avoidance/numbing symptoms), and reduced PTSD-relevant cognitions in PTCI (self blame). Conclusions These data suggest group MBCT as an acceptable brief intervention/adjunctive therapy for combat PTSD, with potential for reducing avoidance symptom cluster and PTSD cognitions. Further studies are needed to examine efficacy in a randomized controlled design and to identify factors influencing acceptability and efficacy.

Koerner, N., M. Antony, et al. (2013). ***"Changes in beliefs about the social competence of self and others following group cognitive-behavioral treatment."*** Cognitive Therapy and Research 37(2): 256-265. http://dx.doi.org/10.1007/s10608-012-9472-5

The current study examined changes in social anxiety thoughts and beliefs following cognitive-behavioral treatment (CBT). Participants (N = 77) were adults with a principal diagnosis of SAD who received 12, 2-h sessions of group CBT at a

hospital-based outpatient anxiety disorders clinic. There were significant decreases from pretreatment to posttreatment in social anxiety symptoms and in symptoms of depression, nonspecific anxiety and tension, as well as significant improvements in social anxiety beliefs, as assessed via the Social Thoughts and Beliefs Scale (STABS; Turner et al., Psychol Assess 15:384–391, 2003). Change in social anxiety beliefs made a significant contribution to the prediction of social anxiety symptoms at posttreatment over and above pretreatment social anxiety symptoms and changes in depression, nonspecific anxiety and tension. A positive change in the belief that others are more socially-competent emerged as a significant unique predictor of social anxiety symptoms at posttreatment. The findings demonstrate that the STABS is sensitive to cognitive-behavioral treatment. The findings also suggest that social comparison processes in particular are a key aspect of improvement in social anxiety symptoms. This is an important direction for future research.

Kupfer, D. J., E. A. Kuhl, et al. (2013). ***"DSM-5 - the future arrived."*** JAMA 309(16): 1691-1692. http://dx.doi.org/10.1001/jama.2013.2298

(Free full text available) Readers will recognize a few notable differences from DSM-IV. One distinction is DSM-5 's emphasis on numerous issues important to diagnosis and clinical care, including the influence of development, gender, and culture on the presentation of disorders. This is present in select diagnostic criteria, in text, or in both, which include variations of symptom presentations, risk factors, course, comorbidities, or other clinically useful information that might vary depending on a patient's gender, age, or cultural background. Another distinct feature is ensuring greater harmony between this North American classification system and the International Classification of Diseases (ICD) system. For example, the chapter structure of DSM now begins with those in which neurodevelopmental influences produce early-onset disorders in childhood. This restructuring brings greater alignment of DSM-5 to the structuring of disorders in the future ICD-11 but also reflects the manual's developmental emphasis, rather than the previous edition's sequestering of all childhood disorders to a separate chapter. A similar approach to harmonizing with the ICD was taken to promote a more conceptual relationship between DSM-5 and classifications in other areas of medicine, such as the classification of sleep disorders.

Landolt, M. A., U. Schnyder, et al. (2013). ***"Trauma exposure and posttraumatic stress disorder in adolescents: A national survey in Switzerland."*** Journal of Traumatic Stress 26(2): 209-216. http://dx.doi.org/10.1002/jts.21794

There are a limited number of epidemiological studies that have focused on trauma exposure and prevalence of posttraumatic stress disorder (PTSD) in representative general population samples of adolescents, especially outside of the United States. We therefore aimed to assess the lifetime prevalence of traumatic events (TEs) and current prevalence of PTSD, and to examine demographic risk factors for TEs and PTSD in a representative sample of adolescents. Data were collected by a school survey among a sample of 6,787 9th-grade students in Switzerland. Roughly 56% of the adolescents (females 56.6%; males 55.7%) reported having experienced at least 1 TE. Non-Swiss nationality (OR = 1.80), not living with both biological parents (OR = 1.64), and lower parental education (OR = 1.18) were associated with a higher risk of trauma exposure. The current prevalence of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) criteria was 4.2% (females 6.2%; males 2.4%). Female gender (OR = 2.70), not living with both biological parents (OR = 1.47), lower parental education (OR = 1.51), and exposure to multiple TEs (OR = 9.56) were significant risk factors for PTSD. Results suggest considerably high rates of TEs and PTSD among adolescents. Intervention efforts must be intensified to reduce trauma exposure and treat PTSD.

Luby, J. L. (2013). ***"Treatment of anxiety and depression in the preschool period."*** Journal of the American Academy of Child & Adolescent Psychiatry 52(4): 346-358. http://www.sciencedirect.com/science/article/pii/S0890856713000737

Objective Empirical studies have established that clinical anxiety and depressive disorders may arise in preschool children as young as 3.0 years. Because empirical studies validating and characterizing these disorders in preschoolers are relatively recent, less work has been done on the development and testing of age-appropriate treatments. Method A comprehensive literature search yielded several small randomized controlled trials of psychotherapeutic treatments for preschool anxiety and depression. The literature also contained case series of behavioral and psychopharmacologic interventions for specific anxiety disorders. However, to date, no large-scale randomized controlled trials of treatment for any anxiety or depressive disorder specifically targeting preschool populations have been published. Results Several age-adapted forms of cognitive-behavioral therapy have been developed and preliminarily tested in small randomized controlled trials and appear promising for different forms of preschool anxiety disorders. Notably, these adaptations centrally involve primary caregivers and use age-adjusted methodology such as cartoon-based materials and co-constructed drawing or narratives. Modified forms of Parent Child Interaction Therapy have been tested and appear promising for anxiety and depression. Although preventive interventions that target parenting have shown significant promise in anxiety, these methods have not been explored in early childhood depression. Studies of the impact of parental treatment on infants suggest that direct treatment of the youngest children may be necessary to affect long-term change. Conclusions Recommendations are made for the clinical treatment of these disorders when psychotherapy is the first line of intervention.

Malooly, A. M., J. J. Genet, et al. (2013). ***"Individual differences in reappraisal effectiveness: The role of affective flexibility."*** Emotion 13(2): 302-313. http://www.ncbi.nlm.nih.gov/pubmed/23163706

The present study examined the relation between a specific type of executive control and cognitive emotion regulation. The authors propose that successful reappraisal is related to "affective flexibility": The ability to flexibly attend to and disengage from emotional aspects of a situation or a stimulus. A new affective task-switching paradigm that required participants to shift between categorizing positive and negative affective pictures according to emotional or nonemotional features was used to assess individual differences in affective flexibility. The results showed that greater affective flexibility (less switch costs) predicted the ability to use reappraisal to down-regulate emotions in response to a sad film clip. In particular, more efficient shifts toward the neutral aspects of negative pictures and toward the emotional aspects of positive pictures were found to predict reappraisal ability. The results imply that executive control of emotional material is a capacity that is closely associated with effective reappraisal.

McHugh, R. K., E. K. Reynolds, et al. (2013). ***"An examination of the association of distress intolerance and emotion regulation with avoidance."*** Cognitive Therapy and Research 37(2): 363-367. http://dx.doi.org/10.1007/s10608-012-9463-6

Distress intolerance is an important motivator of maladaptive avoidance-based coping strategies. The selection of such avoidance behaviors is also influenced by one’s access to alternative emotion regulatory strategies. However, little research has examined the relative contributions of these vulnerability factors to avoidance. This study examined whether distress intolerance and access to emotion regulation strategies were uniquely (additively or interactively) associated with self-reported avoidance. Two samples — an unselected sample (n = 300) and a clinical sample (n = 100) — comprised of patients seeking treatment for unipolar mood and/or anxiety disorders were administered measures of distress intolerance, emotion regulation, and avoidance. Results of linear regression analyses indicated that distress intolerance and access to emotion regulation strategies were

uniquely and additively associated with avoidance. Implications for the prevention and treatment of psychological disorders are discussed.

Milosevic, I. and A. S. Radomsky (2013). ***"Incorporating the judicious use of safety behavior into exposure-based treatments for anxiety disorders: A study of treatment acceptability."*** Journal of Cognitive Psychotherapy 27(2): 155-174. http://www.ingentaconnect.com/content/springer/jcogp/2013/00000027/00000002/art00006 http://dx.doi.org/10.1891/0889-8391.27.2.155

This analog study investigated treatment acceptability and preference as a function of safety behavior use (judicious vs. discouraged) and treatment rationale (cognitive vs. extinction). Thirty-two clinically anxious participants and 437 undergraduate students provided ratings of acceptability and adherence, as well as preference ranks for four written vignettes describing a course of cognitive-behavioral therapy (CBT) for fear or anxiety. Treatment descriptions promoting judicious safety behavior use received significantly higher acceptability and adherence ratings compared to those discouraging its use. Descriptions that presented a cognitively based rationale, compared to an extinction-based rationale, were also rated as both significantly more acceptable and easier to adhere to. The highest preference rank was for treatment that included judicious safety behavior use, conveyed via a cognitive rationale. A similar pattern of results was observed in both participant groups. These findings suggest that the judicious incorporation of safety behavior into CBT has the potential to reduce treatment refusal and dropout. Results are discussed in terms of their implications for cognitive-behavioral and exposure-based treatments.

Pearson, R. M., C. Fernyhough, et al. (2013). ***"Association between maternal depressogenic cognitive style during pregnancy and offspring cognitive style 18 years later."*** Am J Psychiatry 170(4): 434-441. http://ajp.psychiatryonline.org/article.aspx?articleid=1557657

OBJECTIVE: Understanding the origins of negative cognitive style could provide a means to prevent adult depression. Cognitive style is an important target for intervention because although it is not possible to remove the stress and adversities in people's lives, it may be possible to modify interpretation of such adversities through cognitive style. Children may develop a negative cognitive style through modeling the style of their mothers. However, findings have been inconsistent on the association. The authors tested the hypothesis that there is an independent association between maternal and offspring depressogenic cognitive style. METHOD: Data from over 4,000 mothers and children from the Avon Longitudinal Study of Parents and Children cohort study in the United Kingdom were used to investigate the association between maternal depressogenic cognitive style before the offspring's birth and the offspring's depressogenic cognitive style at age 18. RESULTS: A positive association was observed between maternal and offspring cognitive styles: a one-standard-deviation increase in maternal depressogenic cognitive style score during pregnancy was significantly associated with a mean increase of 0.1 standard deviations in offspring depressogenic cognitive style score at age 18. This effect remained after adjusting for maternal and offspring depression and explained 21% of the association between maternal and offspring depression. CONCLUSIONS: Although the mechanisms remain to be elucidated, the findings are consistent with the idea that a mother's cognitive style (irrespective of her depression status) influences that of her child. This suggests that interventions to improve a mother's cognitive style could help prevent her offspring from developing depression during adulthood.

Rakel, D., M. Mundt, et al. (2013). ***"Value associated with mindfulness meditation and moderate exercise intervention in acute respiratory infection: The MEPARI study."*** Fam Pract. http://www.ncbi.nlm.nih.gov/pubmed/23515373

BACKGROUND AND OBJECTIVES:Acute respiratory infection (ARI) is among the most common, debilitating and expensive human illnesses. The purpose of this study was to assess ARI-related costs and determine if mindfulness meditation or exercise can add value. METHODS: One hundred and fifty-four adults >/=50 years from Madison, WI for the 2009-10 cold/flu season were randomized to (i) wait-list control (ii) meditation or (iii) moderate intensity exercise. ARI-related costs were assessed through self-reported medication use, number of missed work days and medical visits. Costs per subject were based on cost of generic medications, missed work days ($126.20) and clinic visits ($78.70). Monte Carlo bootstrap methods evaluated reduced costs of ARI episodes. RESULTS: The total cost per subject for the control group was $214 (95% CI: $105-$358), exercise $136 (95% CI: $64-$232) and meditation $65 (95% CI: $34-$104). The majority of cost savings was through a reduction in missed days of work. Exercise had the highest medication costs at $16.60 compared with $5.90 for meditation (P = 0.004) and $7.20 for control (P = 0.046). Combining these cost benefits with the improved outcomes in incidence, duration and severity seen with the Meditation or Exercise for Preventing Acute Respiratory Infection study, meditation and exercise add value for ARI. Compared with control, meditation had the greatest cost benefit. This savings is offset by the cost of the intervention ($450/subject) that would negate the short-term but perhaps not long-term savings. CONCLUSIONS: Meditation and exercise add value to ARI-associated health-related costs with improved outcomes. Further research is needed to confirm results and inform policies on adding value to medical spending.

Rethorst, C. D., P. Sunderajan, et al. (2013). ***"Does exercise improve self-reported sleep quality in non-remitted major depressive disorder?"*** Psychological Medicine 43(04): 699-709. http://dx.doi.org/10.1017/S0033291712001675

Background Sleep disturbances are persistent residual symptoms following remission of major depressive disorder (MDD) and are associated with an increased risk of MDD recurrence. The purpose of the current study was to examine the effect of exercise augmentation on self-reported sleep quality in participants with non-remitted MDD. Method Participants were randomized to receive selective serotonin reuptake inhibitor (SSRI) augmentation with one of two doses of exercise: 16 kilocalories per kilogram of body weight per week (KKW) or 4 KKW for 12 weeks. Depressive symptoms were assessed using the clinician-rated Inventory of Depressive Symptomatology (IDS-C). The four sleep-related items on the IDS-C (Sleep Onset Insomnia, Mid-Nocturnal Insomnia, Early Morning Insomnia, and Hypersomnia) were used to assess self-reported sleep quality. Results Significant decreases in total insomnia ($p < 0.0001$) were observed, along with decreases in sleep onset, mid-nocturnal and early-morning insomnia (p's <0.002). Hypersomnia did not change significantly ($p = 0.38$). Changes in total, mid-nocturnal and early-morning insomnia were independent of changes in depressive symptoms. Higher baseline hypersomnia predicted a greater decrease in depression severity following exercise treatment ($p = 0.0057$). No significant moderating effect of any baseline sleep on change in depression severity was observed. There were no significant differences between exercise treatment groups on total insomnia or any individual sleep item. Conclusions Exercise augmentation resulted in improvements in self-reported sleep quality in patients with non-remitted MDD. Given the prevalence of insomnia as a residual symptom following MDD treatment and the associated risk of MDD recurrence, exercise augmentation may have an important role in the treatment of MDD.

Schröder, A., J. Heider, et al. (2013). ***"Cognitive behavioral therapy versus progressive muscle relaxation training for multiple somatoform symptoms: Results of a randomized controlled trial."*** Cognitive Therapy and Research 37(2): 296-306. http://dx.doi.org/10.1007/s10608-012-9474-3

Although unexplained multiple symptoms and somatoform disorders are a highly prevalent condition in primary practice, few randomized controlled trials of cognitive behavioral therapy (CBT) have been conducted. Moreover, most of these

trials have used only the usual medical treatment or wait list control groups. The present study included 134 outpatients showing at least two medically unexplained symptoms. They were randomly assigned to eight weekly group sessions of either CBT or progressive muscle relaxation (PMR) or wait list control and were assessed before and after treatment as well as 6 months after the end of treatment. The number and intensity of somatoform symptoms were the primary outcome measures; depression, anxiety and physical and mental health constituted the secondary outcome measures. CBT showed small effects (Cohen's d = 0.44) for the treatment of somatoform disorders. Benefits of the treatment were sustained over 6 months of follow-up. However, no differential effects of CBT and PMR were found. In conclusion, both CBT and PMR appear to be effective treatments for multiple somatoform symptoms.

Sherman, D. K., K. A. Hartson, et al. (2013). ***"Deflecting the trajectory and changing the narrative: How self-affirmation affects academic performance and motivation under identity threat."*** J Pers Soc Psychol 104(4): 591-618. http://www.ncbi.nlm.nih.gov/pubmed/23397969

To the extent that stereotype and identity threat undermine academic performance, social psychological interventions that lessen threat could buffer threatened students and improve performance. Two studies, each featuring a longitudinal field experiment in a mixed-ethnicity middle school, examined whether a values affirmation writing exercise could attenuate the achievement gap between Latino American and European American students. In Study 1, students completed multiple self-affirmation (or control) activities as part of their regular class assignments. Latino American students, the identity threatened group, earned higher grades in the affirmation than control condition, whereas White students were unaffected. The effects persisted 3 years and, for many students, continued into high school by lifting their performance trajectory. Study 2 featured daily diaries to examine how the affirmation affected psychology under identity threat, with the expectation that it would shape students' narratives of their ongoing academic experience. By conferring a big-picture focus, affirmation was expected to broaden construals, prevent daily adversity from being experienced as identity threat, and insulate academic motivation from identity threat. Indeed, affirmed Latino American students not only earned higher grades than nonaffirmed Latino American students but also construed events at a more abstract than concrete level and were less likely to have their daily feelings of academic fit and motivation undermined by identity threat. Discussion centers on how social-psychological processes propagate themselves over time and how timely interventions targeting these processes can promote well-being and achievement.

Simon, G. E. and E. J. Ludman (2013). ***"Should mental health interventions be locally grown or factory-farmed?"*** Am J Psychiatry 170(4): 362-365. http://ajp.psychiatryonline.org/article.aspx?articleid=1674553

(Free full text available) In this issue, Fortney and colleagues open the next phase of research regarding organized depression care programs. The effectiveness of these collaborative care programs is now well established. Essential ingredients include outreach and support by a care manager as well as specialty supervision or consultation for patients who do not respond to standard treatment. Such programs were initially developed in settings where care managers and consulting specialists were locally available. Fortney et al. compared two strategies for providing these services in settings lacking local mental health resources. Five federally qualified health centers were randomly assigned to implement depression care management using either local primary care staff (with no specific supervision or quality control) or centralized care managers supported by an off-site consulting specialist. Patients in clinics using the centralized approach were approximately three times as likely to experience significant improvement or to achieve remission of depression. Fidelity to the care management protocol (goal setting, encouragement of positive activities, and systematic assessment of treatment adherence and outcomes) was markedly higher for the centralized program. Antidepressant treatment did not differ between the two groups, suggesting that benefits of the centralized program were due to the psychosocial aspects of care management, including both nonspecific support and specific behavior-change interventions. This finding has important implications for the implementation of organized depression care programs. Care management or collaborative care programs can certainly work in settings lacking on-site or local mental health providers. In fact, the benefits of organized depression care programs are greatest where existing care is minimal. But the Fortney et al. trial suggests that organized depression care programs in resource-poor settings are more likely to work if care management is centralized, care managers are employed full-time in this capacity, and care is supervised by off-site specialists. While one trial involving five clinics and a few care managers does not definitively settle this question, the only high-quality evidence available strongly favors the centralized approach. More important, these findings raise broader questions regarding the implementation of other empirically supported mental health treatments. Efforts to disseminate these complex interventions have typically focused on training and supervision to improve services delivered by local community therapists. The Fortney et al. trial suggests the possibility of an alternative approach: delivering empirically supported treatments from a central location using dedicated clinicians. To traditionally minded clinicians, centralized or "factory farmed" psychosocial treatments would seem oxymoronic. But this question should be settled by evidence rather than tradition ... We have limited data directly comparing the fidelity or quality of locally produced (and more variable) psychosocial interventions to that of centrally produced (and more uniform) treatments. The Fortney et al. trial addresses this question directly. Care managers with the same background and training delivered the same intervention through either a centralized or a localized model. The centralized model was clearly superior—in quality of the service delivered, patients' perceptions of helpfulness, and patients' clinical outcomes. Any benefit of local relationships with patients or providers was outweighed by the higher quality of the centralized program. This finding in favor of centralization and standardization might not apply to treatments that are more intensive and complex, such as true psychotherapy. We can certainly point to evidence that centralized psychotherapy programs have clinical benefit. But we have no high-quality evidence directly comparing the effectiveness of centralized and locally provided psychotherapy. We hope that Fortney and colleagues' provocative findings will provoke direct comparisons of centralized and locally produced approaches for a wider range of psychosocial or psychological treatments. Healthy competition between centralized and localized options might improve them both—or lead to some optimal compromise. Mental health services delivered over a distance could develop a personal touch, and locally grown services could learn to systematically measure outcomes, monitor fidelity, and improve consistency. After all, modern statistics and experimental design began with traditional farmers trying to improve their harvests.

So, M., S. Yamaguchi, et al. (2013). ***"Is computerised CBT really helpful for adult depression? - a meta-analytic re-evaluation of ccbt for adult depression in terms of clinical implementation and methodological validity."*** BMC Psychiatry 13(1): 113. http://www.biomedcentral.com/1471-244X/13/113

(Free full text available) BACKGROUND:Depression is a major cause of disability worldwide, and computerised cognitive behavioural therapy (CCBT) is expected to be a more augmentative and efficient treatment. According to previous meta-analyses of CCBT, there is a need for a meta-analytic revaluation of the short-term effectiveness of this therapy and for an evaluation of its long-term effects, functional improvement and dropout. METHODS: Five databases were used (MEDLINE, PsycINFO, EMBASE, CENTRAL and CiNii). We included all RCTs with proper concealment and blinding of outcome assessment for the clinical effectiveness of CCBT in adults (aged 18 and over) with depression. Using Cohen's method, the standard mean difference (SMD) for the overall pooled effects across the included studies was estimated with a random effect model. The main outcome measure and the relative risk of dropout were included in the meta-analysis. RESULTS: Fourteen trials met the

inclusion criteria, and sixteen comparisons from these were used for the largest meta-analysis ever. All research used appropriate random sequence generation and Intention-to-Treat analyses (ITT), and employed self-reported measures as the primary outcome. For the sixteen comparisons (2807 participants) comparing CCBT and control conditions, the pooled SMD was 0.48 [95% IC 0.63 to 0.33], suggesting similar effect to the past reviews. Also, there was no significant clinical effect at long follow-up and no improvement of function found. Furthermore, a significantly higher drop-out rate was found for CCBT than for controls. When including studies without BDI as a rating scale and with only modern imputation as sensitivity analysis, the pooled SMD remained significant despite the reduction from a moderate to a small effect. Significant publication bias was found in a funnel plot and on two tests (Begg's p=0.09; Egger's p=0.01). Using a trim and fill analysis, the SMD was 0.32 [95% CI 0.49 to 0.16]. CONCLUSION:Despite a short-term reduction in depression at post-treatment, the effect at long follow-up and the function improvement were not significant, with significantly high drop-out. Considering the risk of bias, our meta-analysis implied that the clinical usefulness of current CCBT for adult depression may need to be re-considered downwards in terms of practical implementation and methodological validity.

Stillmaker, J. and T. Kasser (2013). ***"Instruction in problem-solving skills increases the hedonic balance of highly neurotic individuals."*** Cognitive Therapy and Research 37(2): 380-382. http://dx.doi.org/10.1007/s10608-012-9466-3

Neuroticism is associated with ineffective coping strategies and experiencing substantial negative affect, but prior research has not examined whether teaching problem-solving skills can help neurotic individuals improve their emotional experience. 214 college students were screened for neuroticism and 30 participants who scored in the top two deciles of neuroticism were randomly assigned to a no-treatment control group or to an intervention group that received three lessons based on a problem-solving curriculum (Nezu et al. in Solving life's problems: a 5-step guide to enhanced well-being. Springer, New York, 2007). Hedonic balance (i.e., positive minus negative affect) was measured before the intervention and again approximately 4 days and approximately 11 weeks after the intervention ended. Analyses revealed that the intervention group showed an increase in hedonic balance over time, whereas the control group showed no changes; improvements in hedonic balance were correlated with improvements in problem-solving strategies. Thus, it appears that teaching problem-solving can improve the emotional experience of neurotic individuals.

Van Dijk, D., T. Seger-Guttmann, et al. (2013). ***"Life-threatening event reduces subjective well-being through activating avoidance motivation: A longitudinal study."*** Emotion 13(2): 216-225. http://www.ncbi.nlm.nih.gov/pubmed/23046459

Drawing on the approach-avoidance theory, we have examined the role of avoidance motivation in explaining the negative effects of a life-threatening event on subjective well-being (SWB). Residents of the south of Israel were surveyed during heavy missile attacks in January 2009 (T1; n = 283), and again after 6 months (T2; n = 212) and 1 year (T3; n = 154). During the missile attacks, we also surveyed a group from the center of the country (T1; n = 102), not exposed to the attacks. The results indicate that avoidance motivation was activated by the life threat and further mediated its detrimental influence on SWB measures (positive/negative affects, anxiety, and subjective health). Moreover, within the southern sample, the drop in avoidance motivation over time mediated the parallel drop in SWB. In contrast to avoidance motivation, approach motivation remained stable over time and was related to positive emotions. The role of avoidance and approach motivations in life-threatening situations is further discussed.

Wolgast, M., L.-G. Lundh, et al. (2013). ***"Cognitive restructuring and acceptance: An empirically grounded conceptual analysis."*** Cognitive Therapy and Research 37(2): 340-351. http://dx.doi.org/10.1007/s10608-012-9477-0

The study explores the constructs of cognitive restructuring and acceptance using items from well-established measures of the respective constructs in order to determine what subcategories or conceptual nuances that could be empirically detected, and examines these factors' relationship to each other and to positive and negative emotionality, quality of life and clinical status. The design of the study is cross-sectional and uses data from both a clinical (N = 172) and a non-clinical sample (N = 638). Exploratory and confirmatory factor analysis were used to identify and validate first order factors related to cognitive restructuring and acceptance, and regression analyses were used to determine the relationship between the identified factors and the criterion variables. In sum, the findings from the study indicate that acceptance and cognitive restructuring should not be regarded as unitary and non-related constructs, but rather as partly overlapping general dimensions of emotion regulation consisting of several sub constructs or conceptual nuances with somewhat different psychological functions and properties. The results are interpreted and discussed in relation to the ongoing discussion within clinical psychology concerning the concepts and processes related to cognitive restructuring and acceptance.