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(Chen, Papakostas et al. 2011; Tedeschini, Levkovitz et al. 2011; Uher, Mors et al. 2011; Watanabe, Furukawa et al. 2011; Anderson, Willer et al. 2012; Bauer, Ritter et al. 2012; Brown 2012; Chen and Lin 2012; Daniel and Goldston 2012; Ellis and Goldston 2012; Ellis and Patel 2012; Epperson, Steiner et al. 2012; Fisher, Moffitt et al. 2012; Gao, Li et al. 2012; Gitlin and Frye 2012; Gracious, Finucane et al. 2012; Joffe, Chang et al. 2012; Linehan, Comtois et al. 2012; Malhi, Bargh et al. 2012; Merry, Stasiak et al. 2012; Monroe and Harkness 2012; Moreno, Hasin et al. 2012; Morgan, Jorm et al. 2012; Murphy, Kapur et al. 2012; Sidi, Asmidar et al. 2012; Stanley and Brown 2012; Uher, Perlis et al. 2012; van Aalderena, Dondersa et al. 2012)

Anderson, C., R. Willer, et al. (2012). ***"The origins of deference: When do people prefer lower status?"*** J Pers Soc Psychol 102(5): 1077-1088. http://www.ncbi.nlm.nih.gov/pubmed/22369047

Although the desire for high status is considered universal, prior research suggests individuals often opt for lower status positions. Why would anyone favor a position of apparent disadvantage? In 5 studies, we found that the broad construct of status striving can be broken up into two conceptions: one based on rank, the other on respect. While individuals might universally desire high levels of respect, we find that they vary widely in the extent to which they strive for high-status rank, with many individuals opting for middle- or low-status rank. The status rank that individuals preferred depended on their self-perceived value to the group: when they believed they provided less value, they preferred lower status rank. Mediation and moderation analyses suggest that beliefs about others' expectations were the primary driver of these effects. Individuals who believed they provided little value to their group inferred that others expected them to occupy a lower status position. Individuals in turn conformed to these perceived expectations, accepting lower status rank in such settings.

Bauer, M., P. Ritter, et al. (2012). ***"Treatment options for acute depression in bipolar disorder."*** Bipolar Disorders 14: 37-50. http://dx.doi.org/10.1111/j.1399-5618.2012.00991.x

Objective: The burden of depression represents the most debilitating dimension for the majority of patients with bipolar disorder and dominates the long-term course of the illness. The purpose of this manuscript is to review the evidence base of the available treatment options for bipolar depression within two frequent clinical scenarios. Methods: The evidence is largely based on a systematic literature search and appraisal that was part of the development of the German Guideline for Bipolar Disorders. All relevant randomized controlled trials were critically evaluated. Results: Overall, the number of suitably controlled studies for the treatment of bipolar depression is relatively low. There are two common scenarios. Scenario A, if a patient with bipolar depression is currently not being treated with a mood-stabilizing agent (de novo depression, first or subsequent episode), then quetiapine or olanzapine are options, or alternatively, carbamazepine and lamotrigine can be considered. Antidepressants are an option for short-term use, but whether they are best administered as monotherapy or in combination with mood-stabilizing agents is still controversial. In practice, most clinicians use antidepressants in combination with an antimanic agent. Scenario B, if a patient is already being treated optimally with a mood-stabilizing agent (good adherence and appropriate dose) such as lithium, lamotrigine is an option. There is no evidence for additional benefit from antidepressants where a patient is already being treated with a mood stabilizer; however, in practice an antidepressant is often trialled. Efficient psychotherapy is an important part of the treatment regimen and should span all phases of the illness. Conclusions: Treatment decisions in bipolar depression involve a range of different pharmacological and non-pharmacological options. Monitoring potential unwanted effects and the appropriateness of treatment can help to effectively balance benefits and risks in individual situations. However, the quality of the assessment and reporting of risks in clinical trials need to be improved to better inform treatment decisions.

Brown, E. S. (2012). ***"An epidemiological approach to "steroid psychosis"."*** American Journal of Psychiatry 169(5): 447-449. http://dx.doi.org/10.1176/appi.ajp.2012.12020181

(Free full text available) Prescription glucocorticoids such as prednisone and methylprednisolone have been used for more than 60 years. Their immunosuppressant and anti-inflammatory properties make them useful for a variety of illnesses, including allergies, asthma, chronic obstructive pulmonary disease, arthritis, systemic lupus erythematosus (SLE), and inflammatory bowel disease, to name a few. They are also used as part of medication regimens to prevent transplant rejection. Despite their potentially lifesaving properties, glucocorticoids are associated with numerous side effects, including bone loss, glaucoma, cataracts, infection, bruising, and diabetes. With long-term use, patients taking glucocorticoids can also develop Cushingoid features, including buffalo hump, moon facies, and truncal obesity.

Chen, C.-H. and S.-K. Lin (2012). ***"Carbamazepine treatment of bipolar disorder: A retrospective evaluation of naturalistic long-term outcomes."*** BMC Psychiatry 12(1): 47. http://www.biomedcentral.com/1471-244X/12/47

(Free full text available) BACKGROUND: Carbamazepine (CBZ) has been used in the treatment of bipolar disorder, both in acute mania and maintenance therapy, since the early 1970s. Here, we report a follow-up study of CBZ-treated bipolar patients in the Taipei City Psychiatric Centre. METHODS:Bipolar patients diagnosed according to the DSM-IV system and treated with CBZ at the Taipei City Psychiatric Centre had their charts reviewed to evaluate the efficacy and side effects of this medication during an average follow-up period of 10 years. RESULTS: A total of 129 bipolar patients (45 males, mean age: 45.7 +/- 10.9 year) were included in the analysis of CBZ efficacy used alone (n = 63) or as an add-on after lithium (n = 50) or valproic acid (n = 11), or the both of them (n = 5). The mean age of disease onset was 24.6 +/- 9.5 years. The mean duration of CBZ use was 10.4 +/- 5.2 year. The mean dose used was 571.3 +/- 212.6 mg/day with a mean plasma level of 7.8 +/- 5.9 ug/mL. Mean body weight increased from 62.0 +/- 13.4 kg to 66.7 +/- 13.1 kg during treatment. The frequencies of admission per year before and after CBZ treatment were 0.33 +/- 0.46 and 0.14 +/- 0.30, respectively. The most common side effects targeted the central nervous system (24%), including dizziness, ataxia and cognitive impairment. Other common side effects were gastrointestinal disturbances (3.6%), tremor (3.6%), skin rash (2.9%), and blurred vision (2.9%). Eighty-eight patients (68.2%) were taking antipsychotics concomitantly. Ninety-six patients (74.4%) needed to use benzodiazepines concomitantly. Sixty-three (48.8%) patients had zero episodes in a 10-year follow-up period, compared to all patients having episodes prior to treatment. Using variable analysis, we found better response to CBZ in males than in females. CONCLUSIONS: CBZ is efficacious in the maintenance treatment of bipolar disorder in naturalistic clinical practice, either as monotherapy or in combination with other medications. CBZ is well tolerated by most patients in this patient group.

Chen, J. A., G. I. Papakostas, et al. (2011). ***"Association between patient beliefs regarding assigned treatment and clinical response: Reanalysis of data from the hypericum depression trial study group."*** J Clin Psychiatry 72(12): 1669-1676. http://www.ncbi.nlm.nih.gov/pubmed/22053942

OBJECTIVE: To reanalyze data from a 2002 study by the Hypericum Depression Trial Study Group to determine whether patients who believed they were receiving active therapy rather than placebo obtained greater improvement, independent of treatment. METHOD: Three hundred forty adults with major depressive disorder (according to the Structured

Clinical Interview for DSM-IV) and baseline scores of >/= 20 on the 17-item Hamilton Depression Rating Scale (HDRS-17) were randomized to Hypericum perforatum 900-1,500 mg/d, sertraline 50-100 mg/d, or placebo and were asked to guess their assigned treatment after 8 weeks. This reanalysis of data was performed from October 1, 2009, to April 15, 2011. The intent-to-treat sample included 207 subjects (mean age = 44 years) who had (1) at least 1 postbaseline visit; (2) adherence data based on serum levels of hyperforin, sertraline, and desmethylsertraline; and (3) guess data. Univariate factorial analysis of variance was used to determine whether treatment assignment affected clinical improvement according to HDRS-17 score and whether this effect was moderated by patient guess of sertraline, Hypericum, or placebo. Analysis of covariance was used to determine whether side effects mediated improvement in the context of patient guess and assigned treatment. chi(2) analyses compared response rates (>/= 50% decrease in HDRS-17 score) between the guess groups and between the treatment groups within each guess group. RESULTS: Assigned treatment had no significant effect on clinical improvement (P = .65), but patient guess was significantly associated with improvement (P < .001), and treatment and guess interacted significantly (P = .005). Among subjects who guessed placebo, clinical improvement was small and did not differ significantly across treatments. Among subjects who guessed Hypericum, improvement was large and did not differ significantly across treatments. Among subjects who guessed sertraline, those who received placebo or sertraline had large improvements, but those who received Hypericum had significantly less improvement (P < .001). Similar findings were obtained for response rates. CONCLUSIONS: Patient beliefs regarding treatment may have a stronger association with clinical outcome than the actual medication received, and the strength of this association may depend upon the particular combination of treatment guessed and treatment received.

Daniel, S. S. and D. B. Goldston (2012). ***"Hopelessness and lack of connectedness to others as risk factors for suicidal behavior across the lifespan: Implications for cognitive-behavioral treatment."*** Cognitive and Behavioral Practice 19(2): 288-300. http://www.sciencedirect.com/science/article/pii/S1077722911001039

The rates of suicide attempts and death by suicide vary considerably over the lifespan, highlighting the influence of different contextual, risk, and protective factors at different points in development (Daniel & Goldston, 2009). Hopelessness and lack of connectedness to others are two factors that have been associated with increased risk for suicidal thoughts and behaviors across the lifespan. The primary purposes of this paper are to describe how hopelessness and lack of connectedness to others may contribute to risk for suicidal behaviors, and to outline empirically supported cognitive-behavioral interventions for these difficulties at three developmental periods during which suicidal behavior is prevalent: (a) adolescence and young adulthood, (b) middle adulthood, and (c) older adulthood. This paper is not intended as an exhaustive review, but rather an overview of selected developmental issues related to hopelessness and lack of connectedness to others as risk factors for suicidal behavior. Special emphasis is given to clinical implications for cognitive-behavioral interventions, which are illustrated through case conceptualizations and examples at each developmental period.

Ellis, T. E. and D. B. Goldston (2012). ***"Working with suicidal clients: Not business as usual."*** Cognitive and Behavioral Practice 19(2): 205-208. http://www.sciencedirect.com/science/article/pii/S1077722911001428

In this introduction to a special series of articles on working with suicidal clients, we note that much of the recent growth in theory and research pertaining to suicidal individuals has been contributed by cognitive-behavioral theorists and researchers. This work has established that suicidal people manifest important cognitive vulnerabilities that can be addressed in therapeutic interventions specifically designed for them. Studies to date have produced outcomes that support this framework. We provide brief previews of the collection of articles that follow, which cover safety planning, protocols for evaluating risk, the utility of health behavior theory for informing treatment, mindfulness-based approaches for suicidality, developmental and family considerations, intensive inpatient CBT for individuals in the military, integrated interventions for substance abuse and suicidal behaviors, and coping with the impact of client suicide. We conclude that clinicians are now in a position to begin moving beyond a "therapy as usual" mindset in working with suicidal clients.

Ellis, T. E. and A. B. Patel (2012). ***"Client suicide: What now?"*** Cognitive and Behavioral Practice 19(2): 277-287. http://www.sciencedirect.com/science/article/pii/S1077722911000654

The loss of a client to suicide is a painful personal and professional experience for mental health providers. Whether trainee or experienced professional, the affected clinician often reports feeling overwhelmed and unprepared for the experience of client suicide, together with significant emotional distress and diminished work performance. In this article, we present a brief overview of the literature on the impact of client suicide and ideas for coping with the psychological and professional issues that typically arise. We also provide suggestions for managing the associated practical and administrative tasks, as well as resources for obtaining professional support and guidance in the wake of this tragic event.

Epperson, C. N., M. Steiner, et al. (2012). ***"Premenstrual dysphoric disorder: Evidence for a new category for dsm-5."*** American Journal of Psychiatry 169(5): 465-475. http://dx.doi.org/10.1176/appi.ajp.2012.11081302

Premenstrual dysphoric disorder, which affects 2%–5% of premenopausal women, was included in Appendix B of DSM-IV, "Criterion Sets and Axes Provided for Further Study." Since then, aided by the inclusion of specific and rigorous criteria in DSM-IV, there has been an explosion of research on the epidemiology, phenomenology, pathogenesis, and treatment of the disorder. In 2009, the Mood Disorders Work Group for DSM-5 convened a group of experts to examine the literature on premenstrual dysphoric disorder and provide recommendations regarding the appropriate criteria and placement for the disorder in DSM-5. Based on thorough review and lengthy discussion, the work group proposed that the information on the diagnosis, treatment, and validation of the disorder has matured sufficiently for it to qualify as a full category in DSM-5. A move to the position of category, rather than a criterion set in need of further study, will provide greater legitimacy for the disorder and encourage the growth of evidence-based research, ultimately leading to new treatments.

Fisher, H. L., T. E. Moffitt, et al. (2012). ***"Bullying victimisation and risk of self harm in early adolescence: Longitudinal cohort study."*** BMJ 344: e2683. http://www.bmj.com/content/344/bmj.e2683

OBJECTIVES: To test whether frequent bullying victimisation in childhood increases the likelihood of self harming in early adolescence, and to identify which bullied children are at highest risk of self harm. DESIGN: The Environmental Risk (E-Risk) longitudinal study of a nationally representative UK cohort of 1116 twin pairs born in 1994-95 (2232 children). SETTING: England and Wales, United Kingdom. PARTICIPANTS: Children assessed at 5, 7, 10, and 12 years of age. MAIN OUTCOME MEASURES: Relative risks of children's self harming behaviour in the six months before their 12th birthday. RESULTS: Self harm data were available for 2141 children. Among children aged 12 who had self harmed (2.9%; n=62), more than half were victims of frequent bullying (56%; n=35). Exposure to frequent bullying predicted higher rates of self harm even after children's pre-morbid emotional and behavioural problems, low IQ, and family environmental risks were taken into account (bullying victimisation reported by mother: adjusted relative risk 1.92, 95% confidence interval 1.18 to 3.12; bullying victimisation reported by child: 2.44, 1.36 to 4.40). Victimised twins were more likely to self harm than were their non-victimised twin sibling (bullying victimisation reported by mother: 13/162 v 3/162, ratio=4.3, 95% confidence interval 1.3 to 14.0; bullying victimisation reported by child: 12/144 v 7/144, ratio=1.7, 0.71 to 4.1). Compared with bullied children who did not self harm,

bullied children who self harmed were distinguished by a family history of attempted/completed suicide, concurrent mental health problems, and a history of physical maltreatment by an adult. CONCLUSIONS: Prevention of non-suicidal self injury in young adolescents should focus on helping bullied children to cope more appropriately with their distress. Programmes should target children who have additional mental health problems, have a family history of attempted/completed suicide, or have been maltreated by an adult.

Gao, J., Y. Li, et al. (2012). ***"Perceived parenting and risk for major depression in chinese women."*** Psychological Medicine 42(05): 921-930. http://dx.doi.org/10.1017/S0033291711001942

BackgroundIn Western countries, a history of major depression (MD) is associated with reports of received parenting that is low in warmth and caring and high in control and authoritarianism. Does a similar pattern exist in women in China?MethodReceived parenting was assessed by a shortened version of the Parental Bonding Instrument (PBI) in two groups of Han Chinese women: 1970 clinically ascertained cases with recurrent MD and 2597 matched controls. MD was assessed at personal interview.ResultsFactor analysis of the PBI revealed three factors for both mothers and fathers: warmth, protectiveness, and authoritarianism. Lower warmth and protectiveness and higher authoritarianism from both mother and father were significantly associated with risk for recurrent MD. Parental warmth was positively correlated with parental protectiveness and negatively correlated with parental authoritarianism. When examined together, paternal warmth was more strongly associated with lowered risk for MD than maternal warmth. Furthermore, paternal protectiveness was negatively and maternal protectiveness positively associated with risk for MD.ConclusionsAlthough the structure of received parenting is very similar in China and Western countries, the association with MD is not. High parental protectiveness is generally pathogenic in Western countries but protective in China, especially when received from the father. Our results suggest that cultural factors impact on patterns of parenting and their association with MD.

Gitlin, M. and M. A. Frye (2012). ***"Maintenance therapies in bipolar disorders."*** Bipolar Disorders 14: 51-65. http://dx.doi.org/10.1111/j.1399-5618.2012.00992.x

Objective:Bipolar disorder is an inherently recurrent disorder, requiring maintenance preventive treatments in the vast majority of patients. The authors review the data on maintenance treatments in bipolar disorder, highlighting the controlled trial literature. Methods: Literature review using PubMed, Medline, and a hand search of relevant literature. Results: Over the last decade, a number of effective maintenance treatments for bipolar disorder have been developed with an evidence base for second-generation antipsychotics and some anticonvulsants. Increasing numbers of patients, therefore, are appropriately treated with multiple medications as a maintenance regimen. For some medications, maintenance treatment has been demonstrated in randomized controlled trials for both monotherapy and in combination with other mood stabilizers. Lithium continues as our oldest well-established maintenance treatment in bipolar disorder with somewhat better efficacy in preventing mania than depression. Lamotrigine, olanzapine, and quetiapine have bimodal efficacy in preventing both mania and depression, although lamotrigine's efficacy is more robust in preventing depression and olanzapine's efficacy is greater in preventing mania. Aripiprazole, ziprasidone, and risperidone long-acting injection all prevent mania, but not depression. Less controlled investigations have suggested some evidence of maintenance mood stabilization with carbamazepine, oxcarbazepine, and adjunctive psychotherapy. Conclusions:Despite the number of agents with demonstrated efficacy as maintenance treatments in bipolar disorder, optimal treatment regimens are still a combination of evidence-based therapy in combination with individualized creative treatment algorithms.

Gracious, B., T. Finucane, et al. (2012). ***"Vitamin d deficiency and psychotic features in mentally ill adolescents: A cross-sectional study."*** BMC Psychiatry 12(1): 38. http://www.biomedcentral.com/1471-244X/12/38

(Free full text available): BACKGROUND:Vitamin D deficiency is a re-emerging epidemic, especially in minority populations. Vitamin D is crucial not only for bone health but for proper brain development and functioning. Low levels of vitamin D are associated with depression, seasonal affective disorder, and schizophrenia in adults but little is known about vitamin D and mental health in the pediatric population.METHODS:One hundred four adolescents presenting for acute mental health treatment over a 16-month period were assessed for vitamin D status and the relationship of 25-OH vitamin D levels to severity of illness, defined by presence of psychotic features.RESULTS:Vitamin D deficiency (25-OH D levels <20 ng/ml) was present in 34%; vitamin D insufficiency (25-OH D levels 20-30 ng/ml) was present in 38%, with a remaining 28% in the normal range. Adolescents with psychotic features had lower vitamin D levels (20.4 ng/ml vs. 24.7 ng/ml; p=0.04, 1 df). The association for vitamin D deficiency and psychotic features was substantial (OR 3.5; 95% CI 1.4-8.9; p <0.009). Race was independently associated with vitamin D deficiency and independently associated with psychosis for those who were Asian or biracial vs. white (OR=3.8; 95% CI 1.113.4; p<0.04). Race was no longer associated with psychosis when the results were adjusted for vitamin D level.CONCLUSIONS:Vitamin D deficiency and insufficiency are both highly prevalent in adolescents with severe mental illness. The preliminary associations between vitamin D deficiency and presence of psychotic features warrant further investigation as to whether vitamin D deficiency is a mediator of illness severity, result of illness severity, or both. Higher prevalence of vitamin D deficiency but no greater risk of psychosis in African Americans, if confirmed, may have special implications for health disparity and treatment outcome research.

Joffe, H., Y. Chang, et al. (2012). ***"Lifetime history of depression and anxiety disorders as a predictor of quality of life in midlife women in the absence of current illness episodesdepression and anxiety predict quality of life."*** Archives of General Psychiatry 69(5): 484-492. http://dx.doi.org/10.1001/archgenpsychiatry.2011.1578

Context It is unknown whether a history of depression, anxiety disorders, or comorbid depression and anxiety affects subsequent health-related quality of life (HRQOL) during midlife in women when vasomotor symptoms (VMS) and sleep disturbance commonly disrupt QOL.Objectives To evaluate whether previous affective illness is associated with low HRQOL during midlife in the absence of current illness episodes and whether low HRQOL is explained by VMS or sleep disruption.Design Longitudinal, community-based study.Setting Western Pennsylvania.Participants A total of 425 midlife women in the Study of Women's Health Across the Nation who completed the Structured Clinical Interview for DSM-IV (SCID) and the 36-Item Short Form Health Survey (SF-36) annually during 6 years of follow-up.Main Outcome Measures Scores on the SF-36 scales of social functioning (SF), role-emotional (RE), role-physical (RP), body pain (BP), and vitality.Results Ninety-seven women (22.8%) had comorbid affective illness histories, 162 (38.1%) had previous depression only, and 21 (4.9%) had previous anxiety only. Those with comorbid illness histories and depression alone were more likely to report low HRQOL on the SF, RE, RP, and BP domains (odds ratio [OR] = 2.31-3.54 and 1.59-2.28, respectively) than were women with neither disorder. After adjustment for VMS and sleep disturbance, the comorbid group continued to have low HRQOL on these domains (OR = 2.13-3.07), whereas the association was significant on SF and BP only for the depression-alone group (OR = 2.08 and 1.95, respectively). Compared with women with neither disorder, the anxiety-only group had low HRQOL on the RP domain (OR = 2.60). Sleep disturbance, but not VMS, was independently associated with low HRQOL on all the domains except RE.Conclusions A history of both depression and anxiety has the most robust negative effect on HRQOL in women during midlife, an association not explained by VMS or sleep

disturbance. For the depression-alone group, sleep disturbance may partially explain the negative impact of previous affective illness on HRQOL. Sleep disturbance remains an independent correlate of low HRQOL.

Linehan, M. M., K. A. Comtois, et al. (2012). ***"Assessing and managing risk with suicidal individuals."*** Cognitive and Behavioral Practice 19(2): 218-232. http://www.sciencedirect.com/science/article/pii/S1077722911000599

The University of Washington Risk Assessment Protocol (UWRAP) and Risk Assessment and Management Protocol (UWRAMP) have been used in numerous clinical trials treating high-risk suicidal individuals over several years. These protocols structure assessors and treatment providers to provide a thorough suicide risk assessment, review standards of care recommendations for action, and allow for subsequent documentation of information gathered and actions taken. As such, it is a resource for providers treating high-risk populations across multiple contexts (e.g., primary care, outpatient psychotherapy, emergency department). This article describes both the UWRAP and UWRAMP. Taken together, these assessment and risk management tools include (a) assessment questions for gathering information to determine the level of risk, (b) action steps that can be taken to ensure safety, and (c) a companion therapist note where providers document their assessment and actions.

Malhi, G. S., D. M. Bargh, et al. (2012). ***"Balanced efficacy, safety, and tolerability recommendations for the clinical management of bipolar disorder."*** Bipolar Disorders 14: 1-21. http://dx.doi.org/10.1111/j.1399-5618.2012.00989.x

Objective: To provide practical and clinically meaningful treatment recommendations that amalgamate clinical experience and research findings for each phase of bipolar disorder. Methods: A comprehensive search of the literature was undertaken using electronic database search engines (Medline, PubMed, Cochrane reviews) using key words (e.g., bipolar depression, mania, treatment). All relevant randomised controlled trials were examined, along with review papers, meta-analyses, and book chapters known to the authors. In addition, the recommendations from accompanying papers in this supplement have been distilled and captured in the form of summary boxes. The findings, in conjunction with the clinical experience of international researchers and clinicians who are practiced in treating mood disorders, formed the basis of the treatment recommendations within this paper. Results: Balancing clinical experience with evidence informed and lead to the development of practical clinical recommendations that emphasise the importance of safety and tolerability alongside efficacy in the clinical management of bipolar disorder. Conclusions: The current paper summarises the treatment recommendations relating to each phase of bipolar disorder while providing additional, evidence-based, practical insights. Medication-related side effects and monitoring strategies highlight the importance of safety and tolerability considerations, which, along with efficacy information, should be given equal merit.

Merry, S. N., K. Stasiak, et al. (2012). ***"The effectiveness of sparx, a computerised self help intervention for adolescents seeking help for depression: Randomised controlled non-inferiority trial."*** BMJ 344: e2598. http://www.ncbi.nlm.nih.gov/pubmed/22517917

OBJECTIVE: To evaluate whether a new computerised cognitive behavioural therapy intervention (SPARX, Smart, Positive, Active, Realistic, X-factor thoughts) could reduce depressive symptoms in help seeking adolescents as much or more than treatment as usual. DESIGN: Multicentre randomised controlled non-inferiority trial. SETTING: 24 primary healthcare sites in New Zealand (youth clinics, general practices, and school based counselling services). PARTICIPANTS: 187 adolescents aged 12-19, seeking help for depressive symptoms, with no major risk of self harm and deemed in need of treatment by their primary healthcare clinicians: 94 were allocated to SPARX and 93 to treatment as usual. INTERVENTIONS: Computerised cognitive behavioural therapy (SPARX) comprising seven modules delivered over a period of between four and seven weeks, versus treatment as usual comprising primarily face to face counselling delivered by trained counsellors and clinical psychologists. OUTCOMES: The primary outcome was the change in score on the children's depression rating scale-revised. Secondary outcomes included response and remission on the children's depression rating scale-revised, change scores on the Reynolds adolescent depression scale-second edition, the mood and feelings questionnaire, the Kazdin hopelessness scale for children, the Spence children's anxiety scale, the paediatric quality of life enjoyment and satisfaction questionnaire, and overall satisfaction with treatment ratings. RESULTS: 94 participants were allocated to SPARX (mean age 15.6 years, 62.8% female) and 93 to treatment as usual (mean age 15.6 years, 68.8% female). 170 adolescents (91%, SPARX n = 85, treatment as usual n = 85) were assessed after intervention and 168 (90%, SPARX n = 83, treatment as usual n = 85) were assessed at the three month follow-up point. Per protocol analyses (n = 143) showed that SPARX was not inferior to treatment as usual. Post-intervention, there was a mean reduction of 10.32 in SPARX and 7.59 in treatment as usual in raw scores on the children's depression rating scale-revised (between group difference 2.73, 95% confidence interval -0.31 to 5.77; P=0.079). Remission rates were significantly higher in the SPARX arm (n = 31, 43.7%) than in the treatment as usual arm (n = 19, 26.4%) (difference 17.3%, 95% confidence interval 1.6% to 31.8%; P = 0.030) and response rates did not differ significantly between the SPARX arm (66.2%, n = 47) and treatment as usual arm (58.3%, n = 42) (difference 7.9%, -7.9% to 24%; P = 0.332). All secondary measures supported non-inferiority. Intention to treat analyses confirmed these findings. Improvements were maintained at follow-up. The frequency of adverse events classified as "possibly" or "probably" related to the intervention did not differ between groups (SPARX n = 11; treatment as usual n = 11). CONCLUSIONS: SPARX is a potential alternative to usual care for adolescents presenting with depressive symptoms in primary care settings and could be used to address some of the unmet demand for treatment.

Monroe, S. M. and K. L. Harkness (2012). ***"Is depression a chronic mental illness?"*** Psychological Medicine 42(05): 899-902. http://dx.doi.org/10.1017/S0033291711002066

Over the past few decades, theory and research on depression have increasingly focused on the recurrent and chronic nature of the disorder. These recurrent and chronic forms of depression are extremely important to study, as they may account for the bulk of the burden associated with the disorder. Paradoxically, however, research focusing on depression as a recurrent condition has generally failed to reveal any useful early indicators of risk for recurrence. We suggest that this present impasse is due to the lack of recognition that depression can also be an acute, time-limited condition. We argue that individuals with acute, single lifetime episodes of depression have been systematically eclipsed from the research agenda, thereby effectively preventing the discovery of factors that may predict who, after experiencing a first lifetime episode of depression, goes on to have a recurrent or chronic clinical course. Greater awareness of the high prevalence of people with a single lifetime episode of depression, and the development of research designs that identify these individuals and allow comparisons with those who have recurrent forms of the disorder, could yield substantial gains in understanding the lifetime pathology of this devastating mental illness.

Moreno, C., D. S. Hasin, et al. (2012). ***"Depression in bipolar disorder versus major depressive disorder: Results from the national epidemiologic survey on alcohol and related conditions."*** Bipolar Disorders 14(3): 271-282. http://dx.doi.org/10.1111/j.1399-5618.2012.01009.x

Objectives: To compare the clinical features and course of major depressive episodes (MDEs) occurring in subjects with bipolar I disorder (BD-I), bipolar II disorder (BD-II), and major depressive disorder (MDD). Methods: Data were drawn from the

National Epidemiologic Survey on Alcohol and Related Conditions (2001–2002), a nationally representative face-to-face survey of more than 43000 adults in the USA, including 5695 subjects with lifetime MDD, 935 with BD-I and lifetime MDE, and 494 with BD-II and lifetime MDE. Differences on sociodemographic characteristics and clinical features, course, and treatment patterns of MDE were analyzed. Results: Most depressive symptoms, family psychiatric history, anxiety disorders, alcohol and drug use disorders, and personality disorders were more frequent—and number of depressive symptoms per MDE was higher—among subjects with BD-I, followed by BD-II, and MDD. BD-I individuals experienced a higher number of lifetime MDEs, had a poorer quality of life, and received significantly more treatment for MDE than BD-II and MDD subjects. Individuals with BD-I and BD-II experienced their first mood episode about ten years earlier than those with MDD (21.2, 20.5, and 30.4 years, respectively). Conclusions: Our results support the existence of a spectrum of severity of MDE, with highest severity for BD-I, followed by BD-II and MDD, suggesting the utility of dimensional assessments in current categorical classifications.

Morgan, A. J., A. F. Jorm, et al. (2012). ***"Email-based promotion of self-help for subthreshold depression: Mood memos randomised controlled trial."*** The British Journal of Psychiatry 200(5): 412-418. http://bjp.rcpsych.org/content/200/5/412.abstract

Background: Subthreshold depression is common, impairs functioning and increases the risk of major depression. Improving self-help coping strategies could help subthreshold depression and prevent major depression. Aims: To test the effectiveness of an automated email-based campaign promoting self-help behaviours. Method: A randomised controlled trial was conducted through the website: www.moodmemos.com. Participants received automated emails twice weekly for 6 weeks containing advice about self-help strategies. Emails containing general information about depression served as a control. The principal outcome was depression symptom level on the nine-item Patient Health Questionnaire (PHQ-9) (trial registration: ACTRN12609000925246). Results: The study recruited 1326 adults with subthreshold depression. There was a small significant difference in depression symptoms at post-intervention, favouring the active group (d = 0.17, 95% CI 0.01–0.34). There was a lower, although non-significant, risk of major depression in the active group (number needed to treat (NNT) 25, 95% CI 11 to ∞ to NNT(harm) 57). Conclusions: Emails promoting self-help strategies were beneficial. Internet delivery of self-help messages affords a low-cost, easily disseminated and highly automated approach for indicated prevention of depression.

Murphy, E., N. Kapur, et al. (2012). ***"Risk factors for repetition and suicide following self-harm in older adults: Multicentre cohort study."*** The British Journal of Psychiatry 200(5): 399-404. http://bjp.rcpsych.org/content/200/5/399.abstract

Background Older adults have elevated suicide rates. Self-harm is the most important risk factor for suicide. There are few population-based studies of self-harm in older adults. Aims To calculate self-harm rates, risk factors for repetition and rates of suicide following self-harm in adults aged 60 years and over. Method We studied a prospective, population-based self-harm cohort presenting to six general hospitals in three cities in England during 2000 to 2007. Results In total 1177 older adults presented with self-harm and 12.8% repeated self-harm within 12 months. Independent risk factors for repetition were previous self-harm, previous psychiatric treatment and age 60–74 years. Following self-harm, 1.5% died by suicide within 12 months. The risk of suicide was 67 times that of older adults in the general population. Men aged 75 years and above had the highest suicide rates. Conclusions Older adults presenting to hospital with self-harm are a high-risk group for subsequent suicide, particularly older men.

Sidi, H., D. Asmidar, et al. (2012). ***"Female sexual dysfunction in patients treated with antidepressant—comparison between escitalopram and fluoxetine."*** The Journal of Sexual Medicine 9(5): 1392-1399. http://dx.doi.org/10.1111/j.1743-6109.2011.02256.x

Introduction. Selective serotonin reuptake inhibitor is one of the most widely used antidepressant and commonly associated with female sexual dysfunction (FSD). Aims. This study compares the prevalence of FSD between patients on escitalopram and fluoxetine. The risk factors for FSD were also examined. Methods. A cross-sectional study involved 112 female depressed patients (56 each group) who were in remission (as defined in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] during the past 2 months with no significant signs or symptoms of the disturbance and Montgomery–Asberg Depression Rating Scale score of ≤10) from the psychiatric clinic in a university hospital. The rates of sexual dysfunction between the two groups were compared. Main Outcome Measures. The subjects were interviewed by using Structured Clinical Interview for DSM-IV. Sexual dysfunction was assessed with the Malay Version of the Female Sexual Function Index. Results. The prevalence of FSD was 44.6% for all patients, 55.4% for the fluoxetine group, and 33.9% for the escitalopram group. Multivariate logistic regression analysis showed no significant difference in the risk of FSD between the two groups. Moderate to high dosing was the only significant associated factor for FSD (odds ratio = 4.89, 95% confidence interval = 1.94–12.33). Conclusion. There was no significant difference in the risk of having FSD between patients treated with fluoxetine or escitalopram. Patients on higher dosage of antidepressant have higher risk of having FSD. Sidi H, Asmidar D, Hod R, and Ng CG. Female sexual dysfunction in patients treated with antidepressant—comparison between escitalopram and fluoxetine.

Stanley, B. and G. K. Brown (2012). ***"Safety planning intervention: A brief intervention to mitigate suicide risk."*** Cognitive and Behavioral Practice 19(2): 256-264. http://www.sciencedirect.com/science/article/pii/S1077722911000630

The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

Tedeschini, E., Y. Levkovitz, et al. (2011). ***"Efficacy of antidepressants for late-life depression: A meta-analysis and meta-regression of placebo-controlled randomized trials."*** J Clin Psychiatry 72(12): 1660-1668. http://www.ncbi.nlm.nih.gov/pubmed/22244025

OBJECTIVE: Late-life depression is an important public health issue, given the growing proportion of the elderly relative to the general population in the developed world. The purpose of this study was to examine the efficacy of antidepressants for

the treatment of major depressive disorder (MDD) in elderly patients. DATA SOURCES: PubMed/MEDLINE was searched for randomized, double-blind, placebo-controlled trials of antidepressants for treatment of both adult (nonelderly) MDD (patients aged < 65 years) and late-life MDD (patients aged >/= 55 years). The search was limited to articles published between January 1, 1980, and March 3, 2010 (inclusive). The year 1980 was used as a cutoff in our search to decrease diagnostic variability, since the DSM-III was introduced in 1980. Our search cross-referenced the term placebo with each of the following antidepressants: amitriptyline, nortriptyline, imipramine, desipramine, clomipramine, trimipramine, protriptyline, dothiepin, doxepin, lofepramine, amoxapine, maprotiline, amineptine, nomifensine, bupropion, phenelzine, tranylcypromine, isocarboxazid, moclobemide, brofaromine, fluoxetine, sertraline, paroxetine, citalopram, escitalopram, fluvoxamine, zimelidine, tianeptine, trazodone, nefazodone, agomelatine, venlafaxine, desvenlafaxine, duloxetine, milnacipran, reboxetine, mirtazapine, and mianserin. We also reviewed the reference lists of all studies identified through the PubMed/MEDLINE search. STUDY SELECTION: Articles were selected that reported on randomized, double-blind, placebo-controlled trials of antidepressants used as monotherapy for treatment of MDD and that met numerous a priori criteria pertaining to MDD diagnosis criteria, study duration, study design, drug formulation, original data, age thresholds, primary and secondary outcome measures, and exclusions of other disorders. Final inclusion of articles was determined by consensus between the authors. Seventy-four articles were found eligible for inclusion in our analysis (15 late-life MDD trials and 59 adult MDD trials). RESULTS: Antidepressants were found to be efficacious for late-life MDD (age 55 and older; P < .0001), although there was evidence for heterogeneity across studies (Q22 = 67.302, P < .001). However, antidepressants were not found to be efficacious in the subset of studies using age thresholds of 65 years or older (older late-life MDD) (P = .265). Finally, when we controlled for study design characteristics, antidepressant but not placebo response rates were lower among late-life MDD patients than among adult MDD patients. CONCLUSIONS: The present meta-analysis suggests that antidepressants are efficacious in late-life MDD, but significant study heterogeneity suggests that other factors may contribute to these findings. A secondary analysis raises the possibility that efficacy of these agents may be reduced in trials involving patients aged 65 years or older. Why antidepressants may be less efficacious in elderly versus younger subjects remains unclear.

Uher, R., O. Mors, et al. (2011). ***"Early and delayed onset of response to antidepressants in individual trajectories of change during treatment of major depression: A secondary analysis of data from the genome-based therapeutic drugs for depression (gendep) study."*** J Clin Psychiatry 72(11): 1478-1484. http://www.ncbi.nlm.nih.gov/pubmed/22127194

OBJECTIVE: The timing and rate of improvement after the initiation of an antidepressant has implications for establishing the mechanism of antidepressant action and for answering the clinically relevant question of how long an appropriate trial of antidepressant medication should be. We explore the individual trajectories of relative change in depression severity to establish what proportion of individuals experience early and late onset of improvement. METHOD: Longitudinal latent class analysis was applied in a secondary analysis of data obtained from the Genome-Based Therapeutic Drugs for Depression (GENDEP) study. In the GENDEP trial, conducted in 9 European academic psychiatry centers from July 2004 to June 2008, 811 treatment-seeking adult subjects with DSM-IV major depression received escitalopram or nortriptyline for 12 weeks. Montgomery-Asberg Depression Rating Scale measurements were taken weekly. The secondary analysis reported in this article was conducted in 2010. RESULTS: A model with 9 latent classes provided a good description of the individual trajectories of symptom change over time. These classes included 3 nonresponder classes, 3 classes with varying degrees of improvement concentrated in the first 3 weeks (early improvement), and 3 classes with varying degrees of improvement that was more prominent in the second 3 weeks than in the first 3 weeks (delayed improvement). More than half of the subjects who eventually reached remission showed a pattern of delayed improvement, and their eventual outcome could not be predicted from early time points. Early marked response occurred more frequently in subjects treated with nortriptyline than in those treated with escitalopram (12.9% vs 7.5%, chi(2) = 6.29, P = .01). Delayed complete remission occurred more frequently in subjects treated with escitalopram than in those treated with nortriptyline (13.6% vs 6.1%, chi(2) = 11.52, P = .0007). CONCLUSIONS: Both early and delayed improvement are common. Although early changes are maintained, the eventual outcome of 12-week antidepressant treatment can be accurately predicted only after 8 weeks.

Uher, R., R. H. Perlis, et al. (2012). ***"Depression symptom dimensions as predictors of antidepressant treatment outcome: Replicable evidence for interest-activity symptoms."*** Psychological Medicine 42(05): 967-980. http://dx.doi.org/10.1017/S0033291711001905

Background: Symptom dimensions have not yet been comprehensively tested as predictors of the substantial heterogeneity in outcomes of antidepressant treatment in major depressive disorder. Method: We tested nine symptom dimensions derived from a previously published factor analysis of depression rating scales as predictors of outcome in 811 adults with moderate to severe depression treated with flexibly dosed escitalopram or nortriptyline in Genome-based Therapeutic Drugs for Depression (GENDEP). The effects of symptom dimensions were tested in mixed-effect regression models that controlled for overall initial depression severity, age, sex and recruitment centre. Significant results were tested for replicability in 3637 adult out-patients with non-psychotic major depression treated with citalopram in level I of Sequenced Treatment Alternatives to Relieve Depression (STAR*D). Results: The interest-activity symptom dimension (reflecting low interest, reduced activity, indecisiveness and lack of enjoyment) at baseline strongly predicted poor treatment outcome in GENDEP, irrespective of overall depression severity, antidepressant type and outcome measure used. The prediction of poor treatment outcome by the interest-activity dimension was robustly replicated in STAR*D, independent of a comprehensive list of baseline covariates. Conclusions: Loss of interest, diminished activity and inability to make decisions predict poor outcome of antidepressant treatment even after adjustment for overall depression severity and other clinical covariates. The prominence of such symptoms may require additional treatment strategies and should be accounted for in future investigations of antidepressant response.

van Aalderena, J. R., A. R. T. Dondersa, et al. (2012). ***"The efficacy of mindfulness-based cognitive therapy in recurrent depressed patients with and without a current depressive episode: A randomized controlled trial."*** Psychological Medicine 42(05): 989-1001. http://dx.doi.org/10.1017/S0033291711002054

Background: The aim of this study is to examine the efficacy of mindfulness-based cognitive therapy (MBCT) in addition to treatment as usual (TAU) for recurrent depressive patients with and without a current depressive episode. Method: A randomized, controlled trial comparing MBCT+TAU (n=102) with TAU alone (n=103). The study population consisted of patients with three or more previous depressive episodes. Primary outcome measure was post-treatment depressive symptoms according to the Hamilton Rating Scale for Depression. Secondary outcome measures included the Beck Depression Inventory, rumination, worry and mindfulness skills. Group comparisons were carried out with linear mixed modelling, controlling for intra-group correlations. Additional mediation analyses were performed. Comparisons were made between patients with and without a current depressive episode. Results: Patients in the MBCT+TAU group reported less depressive symptoms, worry and rumination and increased levels of mindfulness skills compared with patients receiving TAU alone. MBCT resulted in a comparable reduction of depressive symptoms for patients with and without a current depressive episode. Additional analyses suggest that the reduction of depressive symptoms was mediated by decreased levels of rumination and worry. :

ConclusionsThe study findings suggest that MBCT is as effective for patients with recurrent depression who are currently depressed as for patients who are in remission. Directions towards a better understanding of the mechanisms of action of MBCT are given, although future research is needed to support these hypotheses.

Watanabe, N., T. A. Furukawa, et al. (2011). ***"Brief behavioral therapy for refractory insomnia in residual depression: An assessor-blind, randomized controlled trial."*** J Clin Psychiatry 72(12): 1651-1658.
http://www.ncbi.nlm.nih.gov/pubmed/21457679

OBJECTIVE: Insomnia often persists despite pharmacotherapy in depression and represents an obstacle to its full remission. This study aimed to investigate the added value of brief behavioral therapy for insomnia over treatment as usual (TAU) for residual depression and refractory insomnia. METHOD: Thirty-seven outpatients (mean age of 50.5 years) were randomly assigned to TAU alone or TAU plus brief behavioral therapy for insomnia, consisting of 4 weekly 1-hour individual sessions. The Insomnia Severity Index (ISI) scores (primary outcome), sleep parameters, and GRID-Hamilton Depression Rating Scale (GRID-HAMD) scores were assessed by blind raters and remission rates for both insomnia and depression were collected at 4- and 8-week follow-ups. The patients were recruited from February 18, 2008, to April 9, 2009. RESULTS: Brief behavioral therapy for insomnia plus TAU resulted in significantly lower ISI scores than TAU alone at 8 weeks ($P < .0005$). The sleep efficiency for the combination was also significantly better than that for TAU alone ($P = .015$). Significant differences were observed in favor of the combination group on both the total GRID-HAMD scores ($P = .013$) and the GRID-HAMD scores after removing the 3 sleep items ($P = .008$). The combination treatment produced higher rates of remission than TAU alone, both in terms of insomnia (50% vs 0%), with a number needed to treat (NNT) of 2 (95% CI, 1-4), and in terms of depression (50% vs 6%), with an NNT of 2 (95% CI, 1-5). CONCLUSIONS: In patients with residual depression and treatment refractory insomnia, adding brief behavioral therapy for insomnia to usual clinical care produced statistically significant and clinically substantive added benefits.