22 depression alliance abstracts, dec '11

(Andreescu, Glick et al. 2011; Carvalho, Gawrysiak et al. 2011; Ekers, Godfrey et al. 2011; Farrer, Christensen et al. 2011; Gartlehner, Hansen et al. 2011; Hetrick, Cox et al. 2011; Hopko, Armento et al. 2011; Hughes 2011; Katon, Lyles et al. 2011; Kendall, Taylor et al. 2011; Leamy, Bird et al. 2011; Lucassen, Merry et al. 2011; Merry, Hetrick et al. 2011; Murray, Lam et al. 2011; Nusslock and Frank 2011; Posner, Brown et al. 2011; Preschl, Maercker et al. 2011; Thase, Larsen et al. 2011; Tidemalm, Runeson et al. 2011; Virtanen, Ferrie et al. 2011; Watanabe, Omori et al. 2011; Winthorst, Post et al. 2011)

Andreescu, C., R. M. Glick, et al. (2011). "Acupuncture for the treatment of major depressive disorder: a randomized controlled trial." J Clin Psychiatry **72**(8): 1129-1135. http://www.ncbi.nlm.nih.gov/pubmed/21672495.

BACKGROUND: Over 50% of patients with major depressive disorder (MDD) either do not tolerate or do not respond to antidepressant medications. Several preliminary studies have shown the benefits of acupuncture in the treatment of depression. We sought to determine whether a 2-point electroacupuncture protocol (verum acupuncture) would be beneficial for MDD, in comparison to needling at nonchannel scalp points with sham electrostimulation (control acupuncture). METHOD: Fifty-three subjects aged 18-80 years, recruited via advertisement or referral, were included in the primary analysis of our randomized controlled trial, which was conducted from March 2004 through May 2007 at UPMC Shadyside, Center for Complementary Medicine, in Pittsburgh, Pennsylvania. Inclusion criteria were mild or moderate MDD (according to the Structured Clinical Interview for DSM-IV Axis I Disorders) and a score of 14 or higher on the Hamilton Depression Rating Scale (HDRS). Exclusion criteria included severe MDD, seizure disorder or risk for seizure disorder, psychosis, bipolar disorder, chronic MDD, treatment-resistent MDD, and history of substance abuse in the prior 6 months. Patients were randomized to receive twelve 30-minute sessions of verum versus control acupuncture over 6 to 8 weeks. The HDRS was the primary outcome measure. The UKU Side Effect Rating Scale was used to assess for adverse effects. RESULTS: Twenty-eight subjects were randomized to verum electroacupuncture and 25 to control acupuncture. The 2 groups did not differ with regard to gender, age, or baseline severity of depression. Both groups improved, with mean (SD) absolute HDRS score decreases of -6.6 (5.9) in the verum group and -7.6 (6.6) in the control group, corresponding to 37.5% and 41.3% relative decreases from baseline. There were no serious adverse events associated with either intervention, and endorsement of adverse effects was similar in the 2 groups. CONCLUSIONS: We were unable to demonstrate a specific effect of electroacupuncture. Electroacupuncture and control acupuncture were equally well tolerated, and both resulted in similar absolute and relative improvement in depressive symptoms as measured by the HDRS.

Carvalho, J. P., M. J. Gawrysiak, et al. (2011). "The reward probability index: design and validation of a scale measuring access to environmental reward." Behav Ther **42**(2): 249-262. http://www.ncbi.nlm.nih.gov/pubmed/21496510.

Behavioral models of depression implicate decreased response-contingent positive reinforcement (RCPR) as critical toward the development and maintenance of depression (Lewinsohn, 1974). Given the absence of a psychometrically sound self-report measure of RCPR, the Reward Probability Index (RPI) was developed to measure access to environmental reward and to approximate actual RCPR. In Study 1 (n=269), exploratory factor analysis supported a 20-item two-factor model (Reward Probability, Environmental Suppressors) with strong internal consistency (alpha=.90). In Study 2 (n=281), confirmatory factor analysis supported this two-factor structure and convergent validity was established through strong correlations between the RPI and measures of activity, avoidance, reinforcement, and depression (r=.65 to .81). Discriminant validity was supported via smaller correlations between the RPI and measures of social support and somatic anxiety (r=-.29 to -.40). Two-week test-retest reliability was strong (r=.69). In Study 3 (n=33), controlling for depression symptoms, hierarchical regression supported the incremental validity of the RPI in predicting daily diary reports of environmental reward. The RPI represents a parsimonious, reliable, and valid measure that may facilitate understanding of the etiology of depression and its relationship to overt behaviors. (Full text downloadable from http://web.utk.edu/~jmcnulty/McNulty/Papers.html).

Ekers, D., C. Godfrey, et al. (2011). "Cost utility of behavioural activation delivered by the non-specialist." The British Journal of Psychiatry **199**(6): 510-511. http://bjp.rcpsych.org/content/199/6/510.abstract.

Behavioural activation by non-specialists appears effective in the treatment of depression. We examined incremental cost-effectiveness of behavioural activation (n = 24) v. treatment as usual (n = 23) in a randomised controlled trial. Intention-to-treat analyses indicated a quality-adjusted life-year (QALY) difference in favour of behavioural activation of 0.20 (95% CI 0.01–0.39, P = 0.042), incremental cost-effectiveness ratio of £5756 per QALY and a 97% probability that behavioural activation is more cost-effective at a threshold value of £20 000. Results are promising for dissemination of behavioural activation but require replication in a larger study.

Farrer, L., H. Christensen, et al. (2011). "Internet-based CBT for depression with and without telephone tracking in a national helpline: randomised controlled trial." PLoS One **6**(11): e28099. http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0028099.

(Free full text available) BACKGROUND: Telephone helplines are frequently and repeatedly used by individuals with chronic mental health problems and web interventions may be an effective tool for reducing depression in this population. AIM: To evaluate the effectiveness of a 6 week, web-based cognitive behaviour therapy (CBT) intervention with and without proactive weekly telephone tracking in the reduction of depression in callers to a helpline service. METHOD: 155 callers to a national helpline service with moderate to high psychological distress were recruited and randomised to receive either Internet CBT plus weekly telephone follow-up; Internet CBT only; weekly telephone follow-up only; or treatment as usual. RESULTS: Depression was lower in participants in the web intervention conditions both with and without telephone tracking compared to the treatment as usual condition both at post intervention and at 6 month follow-up. Telephone tracking provided by a lay telephone counsellor did not confer any additional advantage in terms of symptom reduction or adherence. CONCLUSIONS: A web-based CBT program is effective both with and without telephone tracking for reducing depression in callers to a national helpline.

Gartlehner, G., R. A. Hansen, et al. (2011). "Comparative Benefits and Harms of Second-Generation Antidepressants for Treating Major Depressive Disorder." Annals of Internal Medicine **155**(11): 772-785. http://www.annals.org/content/155/11/772.abstract.

Background: Second-generation antidepressants dominate the management of major depressive disorder (MDD), but evidence on the comparative benefits and harms of these agents is contradictory.Purpose: To compare the benefits and harms of second-generation antidepressants for treating MDD in adults.Data Sources: English-language studies from PubMed, Embase, the Cochrane Library, PsycINFO, and International Pharmaceutical Abstracts from 1980 to August 2011 and reference lists of pertinent review articles and gray literature.Study Selection: 2 independent reviewers identified randomized trials of at least 6 weeks' duration to evaluate efficacy and observational studies with at least 1000 participants to assess harm.Data Extraction:

Reviewers abstracted data about study design and conduct, participants, and interventions and outcomes and rated study quality. A senior reviewer checked and confirmed extracted data and quality ratings.Data Synthesis: Meta-analyses and mixed-treatment comparisons of response to treatment and weighted mean differences were conducted on specific scales to rate depression. On the basis of 234 studies, no clinically relevant differences in efficacy or effectiveness were detected for the treatment of acute, continuation, and maintenance phases of MDD. No differences in efficacy were seen in patients with accompanying symptoms or in subgroups based on age, sex, ethnicity, or comorbid conditions. Individual drugs differed in onset of action, adverse events, and some measures of health-related quality of life.Limitations: Most trials were conducted in highly selected populations. Publication bias might affect the estimates of some comparisons. Mixed-treatment comparisons cannot conclusively exclude differences in efficacy. Evidence within subgroups was limited.Conclusion: Current evidence does not warrant recommending a particular second-generation antidepressant on the basis of differences in efficacy. Differences in onset of action and adverse events may be considered when choosing a medication.Primary Funding Source: Agency for Healthcare Research and Quality.

Hetrick, S. E., G. R. Cox, et al. (2011). "Treatment-resistant depression in adolescents: is the addition of cognitive behavioral therapy of benefit?" Psychol Res Behav Manag **4**: 97-112. http://www.ncbi.nlm.nih.gov/pubmed/22114540.

BACKGROUND: Many young people with major depression fail first-line treatments. Treatment-resistant depression has various definitions in the literature but typically assumes nonresponse to medication. In young people, cognitive behavioral therapy (CBT) is the recommended first-line intervention, thus the definition of treatment resistance should be expanded. Therefore, our aim was to synthesize the existing evidence of any interventions for treatment-resistant depression, broadly defined, in children and adolescents and to investigate the effectiveness of CBT in this context. METHODS: We used Cochrane Collaboration methodology, with electronic searches of Medline, PsycINFO, Embase, and the Cochrane Depression Anxiety and Neurosis Group trials registers. Only randomized controlled trials were included, and were assessed for risk of bias. Meta-analysis was undertaken where possible and appropriate. RESULTS: Of 953 articles retrieved, four trials were eligible for inclusion. For one study, only the trial registration document was available, because the study was never completed. All other studies were well conducted with a low risk of bias, although one study had a high dropout rate. Two studies assessed the effect of adding CBT to medication. While an assertive trial of antidepressants does appear to lead to benefit, when compared with placebo, there was no significant advantage, in either study, or in a meta-analysis of data from these trials, that clearly demonstrated an additional benefit of CBT. The third trial showed little advantage of a tricyclic antidepressant over placebo in the context of an inpatient admission. CONCLUSION: Few randomized controlled trials have investigated interventions for treatment-resistant depression in young people, and results from these show modest benefit from antidepressants with no additional benefit over medication from CBT. Overall, there is a lack of evidence about effective interventions to treat young people who have failed to respond to evidence-based interventions for depression. Research in this area is urgently required.

Hopko, D. R., M. E. Armento, et al. (2011). "Brief behavioral activation and problem-solving therapy for depressed breast cancer patients: randomized trial." J Consult Clin Psychol **79**(6): 834-849. http://www.ncbi.nlm.nih.gov/pubmed/21988544.

OBJECTIVE: Major depression is the most common psychiatric disorder among breast cancer patients and is associated with substantial impairment. Although some research has explored the utility of psychotherapy with breast cancer patients, only 2 small trials have investigated the potential benefits of behavior therapy among patients with well-diagnosed depression. METHOD: In a primarily Caucasian, well-educated sample of women (age = 55.4 years, SD = 11.9) diagnosed with breast cancer and major depression (n = 80), this study was a randomized clinical trial testing the efficacy of 8 sessions of behavioral activation treatment for depression (BATD) compared to problem-solving therapy. Primary outcome measures assessed depression, environmental reward, anxiety, quality of life, social support, and medical outcomes. RESULTS: Across both treatments, results revealed strong treatment integrity, excellent patient satisfaction with treatment protocols, and low patient attrition (19%). Intent-to-treat analyses suggested both treatments were efficacious, with both evidencing significant pre-post treatment gains across all outcome measures. Across both treatments, gains were associated with strong effect sizes, and based on response and remission criteria, a reliable change index, and numbers-needed-to-treat analyses, approximately (3/4) of patients exhibited clinically significant improvement. No significant group differences were found at posttreatment. Treatment gains were maintained at 12-month follow-up, with some support for stronger maintenance of gains in the BATD group. CONCLUSIONS: BATD and problem-solving interventions represent practical interventions that may improve psychological outcomes and quality of life among depressed breast cancer patients. Study limitations and future research directions are discussed.

Hughes, C. W. (2011). "Objective assessment of suicide risk: Significant improvements in assessment, classification, and prediction." American Journal of Psychiatry **168**(12): 1233-1234. http://dx.doi.org/10.1176/appi.ajp.2011.11091362.

(Free full text editorial) Assessment of suicidal behavior and risk remains a source of apprehension for clinicians, clinical researchers, and the pharmaceutical industry. This apprehension has been exacerbated by U.S. Food and Drug Administration (FDA) “black box” warnings for antidepressants used with children and adolescents and by an increasingly litigious society. Much has been learned about risk factors and predicting suicide in the past decade, as succinctly summarized in a recent commentary by Brent (+1), who suggested that the field should be moving on to researching prevention, concomitant health risks such as substance abuse, and causal mechanisms. Even with this progress, however, dissemination of new precision measurements and training to improve suicide assessment lags behind (+2). Well-designed, precisely defined instruments for suicide assessment lessen apprehension about identifying potential suicidal behavior and increase precision in diagnosis as well as in treatment, prediction of risk, and monitoring of suicidal behavior, for clinicians, researchers, and the pharmaceutical industry (+3). In this issue, Posner et al. (+4) describe the psychometric properties of a new instrument, the Columbia–Suicide Severity Rating Scale (C-SSRS).

Katon, W., C. R. Lyles, et al. (2011). "Association of Depression With Increased Risk of Dementia in Patients With Type 2 Diabetes: The Diabetes and Aging Study." Arch Gen Psychiatry. http://www.ncbi.nlm.nih.gov/pubmed/22147809.

CONTEXT: Although depression is a risk factor for dementia in the general population, its association with dementia among patients with diabetes mellitus has not been well studied. OBJECTIVE: To determine whether comorbid depression in patients with type 2 diabetes increases the risk of development of dementia. DESIGN: The Diabetes and Aging Study was a cohort investigation that surveyed a racially/ethnically stratified random sample of patients with type 2 diabetes. SETTING: A large, integrated, nonprofit managed care setting in Northern California. PARTICIPANTS: A sample of 19 239 diabetes registry members 30 to 75 years of age. MAIN OUTCOME MEASURES: The Patient Health Questionnaire 8, International Classification of Diseases, Ninth Revision (ICD-9) diagnoses of depression, and/or antidepressant prescriptions in the 12 months prior to baseline were used to identify prevalent cases of depression. Clinically recognized dementia was identified among subjects with no prior ICD-9 Clinical Modification (ICD-9-CM) diagnoses of dementia. To exclude the possibility that depression was a prodrome of dementia, dementia diagnoses were only based on ICD-9-CM diagnoses identified in years 3 to 5 postbaseline. The risk of dementia for patients with depression and diabetes relative to patients with diabetes alone was estimated using Cox proportional

hazard regression models that adjusted for sociodemographic, clinical, and health risk factors and health use. RESULTS: During the 3- to 5-year period, 80 of 3766 patients (2.1%) with comorbid depression and diabetes (incidence rate of 5.5 per 1000 person-years) vs 158 of 15 473 patients (1.0%) with diabetes alone (incidence rate of 2.6 per 1000 person-years) had 1 or more ICD-9-CM diagnoses of dementia. Patients with comorbid depression had a 100% increased risk of dementia during the 3 to 5 years postbaseline (adjusted hazard ratio, 2.02; 95% confidence interval, 1.73-2.35). CONCLUSION: Depression in patients with diabetes was associated with a substantively increased risk for development of dementia compared with those with diabetes alone.

Kendall, T., C. Taylor, et al. (2011). "Longer term management of self harm: summary of NICE guidance." BMJ **343**. http://www.bmj.com/content/343/bmj.d7073.

Self harm is common but its prevalence may be underestimated because many studies rely on self report. In a study of 17 countries an average of 2.7% of adults reported self harm. A survey in the United Kingdom of 15-16 year olds estimated that more than 10% of girls and 3% of boys had self harmed in the previous year. Self harm and psychiatric disorder are strongly associated. Importantly, once a person has self harmed, the likelihood that he or she will die by suicide increases 50 to 100 times, with 1 in 15 dying by suicide within nine years of the index episode. The UK suicide rate is 17.5 for males and 5.2 for females per 100 000 population, which is nearly 10 times the homicide rate. Understanding and helping people who self harm is therefore likely to be an important part of an effective suicide prevention strategy. This article summarises the most recent recommendations from the National Institute for Health and Clinical Excellence (NICE) on the longer term management of self harm. This guideline is intended to complement the earlier NICE guideline on the short term management of self harm (treatment within the first 48 hours after an episode of self harm).

Leamy, M., V. Bird, et al. (2011). "Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis." British Journal of Psychiatry **199**(6): 445-452. http://bjp.rcpsych.org/content/199/6/445.abstract.

Background: No systematic review and narrative synthesis on personal recovery in mental illness has been undertaken. Aims: To synthesise published descriptions and models of personal recovery into an empirically based conceptual framework.MethodSystematic review and modified narrative synthesis. Results: Out of 5208 papers that were identified and 366 that were reviewed, a total of 97 papers were included in this review. The emergent conceptual framework consists of: (a) 13 characteristics of the recovery journey; (b) five recovery processes comprising: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME); and (c) recovery stage descriptions which mapped onto the transtheoretical model of change. Studies that focused on recovery for individuals of Black and minority ethnic (BME) origin showed a greater emphasis on spirituality and stigma and also identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery. Conclusions: The conceptual framework is a theoretically defensible and robust synthesis of people's experiences of recovery in mental illness. This provides an empirical basis for future recovery-oriented research and practice.

Lucassen, M. F., S. N. Merry, et al. (2011). "Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students." Aust N Z J Psychiatry **45**(5): 376-383. http://www.ncbi.nlm.nih.gov/pubmed/21361850.

OBJECTIVE: To describe the sexual attractions of New Zealand secondary school students and investigate the associations between sexual attraction and self-reported depression, self-harm, suicidality and help-seeking behaviour. METHOD: Multiple logistic regression was used to examine the associations between sexual attraction and depressive symptoms, suicidality, self-harming and help-seeking behaviours in a nationally representative secondary school health and well-being survey, undertaken in 2007. RESULTS: Of the students surveyed, 92% were attracted to the opposite sex, 1% to the same sex, 3% to both sexes, 2% were not sure and 2% were attracted to neither sex. Students who were attracted to the same or to both sexes consistently had higher prevalence estimates of depression ($p = < 0.0001$), suicidality ($p = < 0.0001$) and self-harming ($p = < 0.0001$). Odds ratios were highest for students who reported they were attracted to both sexes for depressive symptoms (OR 3.7, 95%CI 2.8-4.7), self-harm (OR 5.8, 95%CI 4.4-7.6) and attempted suicide (OR 7.0, 95%CI 5.2-9.4). Students not exclusively attracted to the opposite sex were more likely to report having seen a health professional for an emotional worry and were more likely to have difficulty accessing help for emotional concerns. CONCLUSIONS: The study findings highlight significant mental health disparities faced by students attracted to the same or both sexes, with those attracted to both sexes appearing particularly vulnerable. There is a vital need to ensure primary care and mental health services have the capacity and capability to screen and provide appropriate responsive care for youth who are attracted to the same or both sexes.

Merry, S. N., S. E. Hetrick, et al. (2011). "Psychological and educational interventions for preventing depression in children and adolescents." Cochrane Database Syst Rev **12**: CD003380. http://www.ncbi.nlm.nih.gov/pubmed/22161377.

BACKGROUND: Depression is common in young people, has a marked negative impact and is associated with self-harm and suicide. Preventing its onset would be an important advance in public health. OBJECTIVES: To determine whether psychological or educational interventions, or both, are effective in preventing the onset of depressive disorder in children and adolescents. SEARCH METHODS: The Cochrane Depression, Anxiety and Neurosis Review Group's trials registers (CCDANCTR) were searched at the editorial base in July 2010. Update searches of MEDLINE, EMBASE, PsycINFO and ERIC were conducted by the authors in September 2009. Conference abstracts, reference lists of included studies and reviews were searched and experts in the field contacted. SELECTION CRITERIA: Randomised controlled trials of psychological or educational prevention programmes, or both, compared with placebo, any comparison intervention, or no intervention for young people aged 5 to 19 years-old, who did not currently meet diagnostic criteria for depression or who were below the clinical range on standardised, validated, and reliable rating scales of depression, or both, were included. DATA COLLECTION AND ANALYSIS: Two authors independently assessed studies for inclusion and rated their quality. Sample sizes were adjusted to take account of cluster designs and multiple comparisons. We contacted study authors for additional information where needed. MAIN RESULTS: Fifty-three studies including 14,406 participants were included in the analysis. There were only six studies with clear allocation concealment, participants and assessors were mostly not blind to the intervention or blinding was unclear so that the overall risk of bias was moderately high. Sixteen studies including 3240 participants reported outcomes on depressive diagnosis. The risk of having a depressive disorder post-intervention was reduced immediately compared with no intervention (15 studies; 3115 participants risk difference (RD) -0.09; 95% confidence interval (CI) -0.14 to -0.05; $P<0.0003$), at three to nine months (14 studies; 1842 participants; RD -0.11; 95% CI -0.16 to -0.06) and at 12 months (10 studies; 1750 participants; RD -0.06; 95% CI -0.11 to -0.01). There was no evidence for continued efficacy at 24 months (eight studies; 2084 participant; RD -0.01; 95% CI -0.04 to 0.03) but limited evidence of efficacy at 36 months (two studies; 464 participants; RD -0.10; 95% CI -0.19 to -0.02). There was significant heterogeneity in all these findings. There was no evidence of efficacy in the few studies that compared intervention with placebo or attention controls. AUTHORS' CONCLUSIONS: There is some evidence from this review that targeted and universal depression prevention programmes may prevent the onset of depressive disorders compared with no

intervention. However, allocation concealment is unclear in most studies, and there is heterogeneity in the findings. The persistence of findings suggests that this is real and not a placebo effect.

Murray, G., R. W. Lam, et al. (2011). "Do symptoms of bipolar disorder exhibit seasonal variation? A multisite prospective investigation." Bipolar Disorders **13**(7-8): 687-695. http://dx.doi.org/10.1111/j.1399-5618.2011.00959.x.

Objectives: Evidence that symptoms of bipolar disorder (BD) vary seasonally is inconclusive. Here, a multisite prospective investigation of patients with BD was used to test the hypothesis that, on average, depressive symptoms peak in autumn/winter and hypo/manic symptoms peak in spring/summer. Secondary analyses explored gender and diagnosis [bipolar I disorder (BD-I) versus bipolar II disorder (BD-II)] effects on seasonality. Methods: A sample of 429 patients with BD (61.6% female; 56.2% BD-I) were recruited from 12 sites across Canada. Clinician-rated measures of manic [Young Mania Rating Scale (YMRS), n = 4,753 total observations] and depression symptoms [Montgomery-Åsberg Depression Rating Scale (MADRS), n = 4,691 observations] were taken at scheduled three-month visits as well as any unscheduled visits. At scheduled visits only, Hamilton Depression Rating Scale (Ham-D) assessments (n = 3,153 observations) were also made. Multi-level modeling (MLM) analyses were conducted separately for the three dependent variables and three definitions of Time: calendar month, nominal season, and harmonic analysis. Results: Primary analyses of the whole sample found that for manic symptoms (YMRS), neither calendar month nor nominal season were significant, and harmonic analyses found an unpredicted frequency two sinusoid, with peaks at 4th December and 4th June ($p < 0.018$). Secondary analyses found that this sinusoid approximately fit the YMRS data for females and those diagnosed with BD-II. For depression symptoms measured on the MADRS and Ham-D, no significant seasonal patterns were found in primary analyses of the whole sample. Secondary analyses found a significant increase in MADRS scores in November/December among females, but this pattern was not corroborated in nominal season or harmonic analyses. Conclusions: No evidence of systematic seasonal variation in symptoms was found in the sample as a whole. Primary analyses found no evidence that hypo/manic symptoms peaked in the lighter months and depressive symptoms peaked in the darker months. The present findings align with broadly negative conclusions from three earlier prospective investigations, and provide the strongest evidence to date that seasonal changes do not in fact cause coordinated variation in BD symptoms.

Nusslock, R. and E. Frank (2011). "Subthreshold bipolarity: diagnostic issues and challenges." Bipolar Disorders **13**(7-8): 587-603. http://dx.doi.org/10.1111/j.1399-5618.2011.00957.x.

Background: Research suggests that current diagnostic criteria for bipolar disorders may fail to include milder, but clinically significant, bipolar syndromes and that a substantial percentage of these conditions are diagnosed, by default, as unipolar major depression. Accordingly, a number of researchers have argued for the upcoming 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to better account for subsyndromal hypomanic presentations. Methods: The present paper is a critical review of research on subthreshold bipolarity, and an assessment of some of the challenges that researchers and clinicians might face if the DSM-5 were designed to systematically document subsyndromal hypomanic presentations. Results: Individuals with major depressive disorder (MDD) who display subsyndromal hypomanic features, not concurrent with a major depressive episode, have a more severe course compared to individuals with MDD and no hypomanic features, and more closely resemble individuals with bipolar disorder on a number of clinical validators. Conclusion: There are clinical and scientific reasons for systematically documenting subsyndromal hypomanic presentations in the assessment and diagnosis of mood disorders. However, these benefits are balanced with important challenges, including (i) the difficulty in reliably identifying subsyndromal hypomanic presentations, (ii) operationalizing subthreshold bipolarity, (iii) differentiating subthreshold bipolarity from borderline personality disorder, (iv) the risk of over-diagnosing bipolar spectrum disorders, and (v) uncertainties about optimal interventions for subthreshold bipolarity.

Posner, K., G. K. Brown, et al. (2011). "The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults." Am J Psychiatry **168**(12): 1266-1277. http://www.ncbi.nlm.nih.gov/pubmed/22193671.

OBJECTIVE: Research on suicide prevention and interventions requires a standard method for assessing both suicidal ideation and behavior to identify those at risk and to track treatment response. The Columbia-Suicide Severity Rating Scale (C-SSRS) was designed to quantify the severity of suicidal ideation and behavior. The authors examined the psychometric properties of the scale. METHOD: The C-SSRS's validity relative to other measures of suicidal ideation and behavior and the internal consistency of its intensity of ideation subscale were analyzed in three multisite studies: a treatment study of adolescent suicide attempters (N=124); a medication efficacy trial with depressed adolescents (N=312); and a study of adults presenting to an emergency department for psychiatric reasons (N=237). RESULTS: The C-SSRS demonstrated good convergent and divergent validity with other multi-informant suicidal ideation and behavior scales and had high sensitivity and specificity for suicidal behavior classifications compared with another behavior scale and an independent suicide evaluation board. Both the ideation and behavior subscales were sensitive to change over time. The intensity of ideation subscale demonstrated moderate to strong internal consistency. In the adolescent suicide attempters study, worst-point lifetime suicidal ideation on the C-SSRS predicted suicide attempts during the study, whereas the Scale for Suicide Ideation did not. Participants with the two highest levels of ideation severity (intent or intent with plan) at baseline had higher odds for attempting suicide during the study. CONCLUSIONS: These findings suggest that the C-SSRS is suitable for assessment of suicidal ideation and behavior in clinical and research settings.

Preschl, B., A. Maercker, et al. (2011). "The working alliance in a randomized controlled trial comparing online with face-to-face cognitive-behavioral therapy for depression." BMC Psychiatry **11**(1): 189. http://www.biomedcentral.com/1471-244X/11/189.

(Free full text available) BACKGROUND:Although numerous efficacy studies in recent years have found internet-based interventions for depression to be effective, there has been scant consideration of therapeutic process factors in the online setting. In face-to face therapy, the quality of the working alliance explains variance in treatment outcome. However, little is yet known about the impact of the working alliance in internet-based interventions, particularly as compared with face-to-face therapy. METHODS:This study explored the working alliance between client and therapist in the middle and at the end of a cognitive-behavioral intervention for depression. The participants were randomized to an internet-based treatment group (n = 25) or face-to-face group (n = 28). Both groups received the same cognitive behavioral therapy over an 8-week timeframe. Participants completed the Beck Depression Inventory (BDI) post-treatment and the Working Alliance Inventory at mid- and post- treatment. Therapists completed the therapist version of the Working Alliance Inventory at post-treatment. RESULTS:With the exception of therapists' ratings of the tasks subscale, which were significantly higher in the online group, the two groups' ratings of the working alliance did not differ significantly. Further, significant correlations were found between clients' ratings of the working alliance and therapy outcome at post-treatment in the online group and at both mid- and post-treatment in the face-to-face group. Correlation analysis revealed that the working alliance ratings did not significantly predict the BDI residual gain score in either group. CONCLUSIONS:Contrary to what might have been expected, the working alliance in the online group was comparable to that in the face-to-face group. However, the results showed no significant relations between the BDI residual gain score and the working alliance ratings in either group.

Thase, M. E., K. G. Larsen, et al. (2011). "Assessing the 'true' effect of active antidepressant therapy v. placebo in major depressive disorder: use of a mixture model." The British Journal of Psychiatry **199**(6): 501-507. http://bjp.rcpsych.org/content/199/6/501.abstract.

(Free full text available) Background: There is controversy about the implications of relatively small average drug–placebo differences observed in randomised controlled trials of antidepressant medications. Aims: To investigate whether efficacy is better understood as a large effect in a subgroup of patients. Method: The mixture model was used to identify patient subgroups (patients benefiting or not benefiting from treatment) to directly model the skewness of Montgomery–Åsberg Depression Rating Scale (MADRS) scores at week 8. Results: The MADRS scores improved by 15.9 points (95% CI 15.2–16.6) among patients who benefited from treatment. The proportion of patients who benefited from escitalopram and not from placebo treatment was 19.5%, corresponding to a number needed to treat of 5. Conclusions: This model gave a considerably better fit to the data than the analysis of covariance model in which all patients were assumed to benefit from treatment. The small average antidepressant–placebo difference obscures a much larger effect in a clinically meaningful subgroup of patients.

Tidemalm, D., B. Runeson, et al. (2011). "Familial clustering of suicide risk: a total population study of 11.4 million individuals." Psychological Medicine **41**(12): 2527-2534. http://dx.doi.org/10.1017/S0033291711000833.

Background: Research suggests that suicidal behaviour is aggregated in families. However, due to methodological limitations, including small sample sizes, the strength and pattern of this aggregation remains uncertain.MethodWe examined the familial clustering of completed suicide in a Swedish total population sample. We linked the Cause of Death and Multi-Generation Registers and compared suicide rates among relatives of all 83 951 suicide decedents from 1952–2003 with those among relatives of population controls. Results: Patterns of familial aggregation of suicide among relatives to suicide decedents suggested genetic influences on suicide risk; the risk among full siblings (odds ratio 3.1, 95% confidence interval 2.8–3.5, 50% genetic similarity) was higher than that for maternal half-siblings (1.7, 1.1–2.7, 25% genetic similarity), despite similar environmental exposure. Further, monozygotic twins (100% genetic similarity) had a higher risk than dizygotic twins (50% genetic similarity) and cousins (12.5% genetic similarity) had higher suicide risk than controls. Shared (familial) environmental influences were also indicated; siblings to suicide decedents had a higher risk than offspring (both 50% genetically identical but siblings having a more shared environment, 3.1, 2.8–3.5 v. 2.0, 1.9–2.2), and maternal half-siblings had a higher risk than paternal half-siblings (both 50% genetically identical but the former with a more shared environment). Although comparisons of twins and half-siblings had overlapping confidence intervals, they were supported by sensitivity analyses, also including suicide attempts. Conclusions: Familial clustering of suicide is primarily influenced by genetic and also shared environmental factors. The family history of suicide should be considered when assessing suicide risk in clinical settings or designing and administering preventive interventions.

Virtanen, M., J. E. Ferrie, et al. (2011). "Long working hours and symptoms of anxiety and depression: a 5-year follow-up of the Whitehall II study." Psychological Medicine **41**(12): 2485-2494. http://dx.doi.org/10.1017/S0033291711000171.

Background: Although long working hours are common in working populations, little is known about the effect of long working hours on mental health. Method: We examined the association between long working hours and the onset of depressive and anxiety symptoms in middle-aged employees. Participants were 2960 full-time employees aged 44 to 66 years (2248 men, 712 women) from the prospective Whitehall II cohort study of British civil servants. Working hours, anxiety and depressive symptoms, and covariates were measured at baseline (1997–1999) followed by two subsequent measurements of depressive and anxiety symptoms (2001 and 2002–2004). Results: In a prospective analysis of participants with no depressive (n=2549) or anxiety symptoms (n=2618) at baseline, Cox proportional hazard analysis adjusted for baseline covariates showed a 1.66-fold [95% confidence interval (CI) 1.06–2.61] risk of depressive symptoms and a 1.74-fold (95% CI 1.15–2.61) risk of anxiety symptoms among employees working more than 55 h/week compared with employees working 35–40 h/week. Sex-stratified analysis showed an excess risk of depression and anxiety associated with long working hours among women [hazard ratios (HRs) 2.67 (95% CI 1.07–6.68) and 2.84 (95% CI 1.27–6.34) respectively] but not men [1.30 (0.77–2.19) and 1.43 (0.89–2.30)]. Conclusions: Working long hours is a risk factor for the development of depressive and anxiety symptoms in women.

Watanabe, N., I. M. Omori, et al. (2011). "Mirtazapine versus other antidepressive agents for depression." Cochrane Database Syst Rev **12**: CD006528. http://www.ncbi.nlm.nih.gov/pubmed/22161405.

BACKGROUND: Mirtazapine has a unique mechanism of antidepressive action and is one of the commonly used antidepressants in clinical practice. OBJECTIVES: The aim of the present review was to assess the evidence on the efficacy and acceptability of mirtazapine compared with other antidepressive agents in the acute-phase treatment of major depression in adults. SEARCH METHODS: We searched the Cochrane Collaboration Depression, Anxiety and Neurosis review group's specialised register (CCDANCTR), which includes relevant randomised controlled trials from the following bibliographic databases: The Cochrane Library (all years to April 2011), EMBASE, (1980 to July 2011) MEDLINE (1950 to July 2011) and PsycINFO (1974 to July 2011). Reference lists of the reports of relevant studies were checked and experts in the field contacted. The review was not limited to English-language articles. SELECTION CRITERIA: Randomised controlled trials (RCTs) allocating participants with major depression to mirtazapine versus any other antidepressive agent. DATA COLLECTION AND ANALYSIS: Two authors independently checked eligibility and extracted data on an intention-to-treat basis. The primary outcome was response to treatment. The secondary outcomes included dropouts and individual adverse events.Meta-analyses were conducted using the random-effects model. MAIN RESULTS: A total of 29 RCTs (n = 4974), mostly following up the participants for six weeks in outpatient clinics and inadequately reporting the risk of bias, were included. In comparison with tricyclic antidepressants (10 trials, n = 1553) there was no robust evidence to detect a difference between mirtazapine and tricyclics in terms of response at two weeks (odds ratio (OR) 0.85, 95% confidence interval (CI) 0.64 to 1.13) or at the end of acute-phase treatment (at 6 to 12 weeks) (OR 0.89, 95% CI 0.72 to 1.10). In comparison with selective serotonin reuptake inhibitors (SSRIs) (12 trials, n = 2626) mirtazapine was significantly more effective at two weeks (OR 1.57, 95% CI 1.30 to 1.88) and at the end of acute-phase treatment (OR 1.19, 95% CI 1.01 to 1.39). Mirtazapine was significantly more effective than a serotonin-noradrenaline reuptake inhibitor (venlafaxine only, two trials, n = 415) at two weeks (OR 2.29, 95% CI 1.45 to 3.59) and at the end of acute-phase treatment (OR 1.53, 95% CI 1.03 to 2.25).In terms of dropouts, there was no robust evidence to detect a difference between mirtazapine and other antidepressants. Mirtazapine was more likely to cause weight gain or increased appetite and somnolence than SSRIs but less likely to cause nausea or vomiting and sexual dysfunction. AUTHORS' CONCLUSIONS: Some statistically significant and possibly clinically meaningful differences between mirtazapine and other antidepressive agents were found for the acute-phase treatment of major depression. Mirtazapine is likely to have a faster onset of action than SSRIs during the acute-phase treatment. Dropouts occur similarly in participants treated with mirtazapine and those treated with other antidepressants, although the adverse event profile of mirtazapine is unique.

Winthorst, W., W. Post, et al. (2011). "Seasonality in depressive and anxiety symptoms among primary care patients and in patients with depressive and anxiety disorders; results from the Netherlands Study of Depression and Anxiety." BMC Psychiatry **11**(1): 198. http://www.biomedcentral.com/1471-244X/11/198.

(Free full text available) BACKGROUND:Little is known about seasonality of specific depressive symptoms and anxiety symptoms in different patient populations. This study aims to assess seasonal variation of depressive and anxiety symptoms in a primary care population and across participants who were classified in diagnostic groups 1) healthy controls 2) patients with a major depressive disorder, 3) patients with any anxiety disorder and 4) patients with a major depression and any anxiety disorder. METHODS:Data were used from the Netherlands Study of Depression and Anxiety (NESDA). First, in 5549 patients from the NESDA primary care recruitment population the Kessler-10 screening questionnaire was used and data were analyzed across season in a multilevel linear model. Second, in 1090 subjects classified into four groups according to psychiatric status according to the Composite International Diagnostic Interview, overall depressive symptoms and atypical versus melancholic features were assessed with the Inventory of Depressive Symptoms. Anxiety and fear were assessed with the Beck Anxiety Inventory and the Fear questionnaire. Symptom levels across season were analyzed in a linear regression model. RESULTS:In the primary care population the severity of depressive and anxiety symptoms did not show a seasonal pattern. In the diagnostic groups healthy controls and patients with any anxiety disorder, but not patients with a major depressive disorder, showed a small rise in depressive symptoms in winter. Atypical and melancholic symptoms were both elevated in winter. No seasonal pattern for anxiety symptoms was found. There was a small gender related seasonal effect for fear symptoms. CONCLUSIONS:Seasonal differences in severity or type of depressive and anxiety symptoms, as measured with a general screening instrument and symptom questionnaires, were absent or small in effect size in a primary care population and in patient populations with a major depressive disorder and anxiety disorders.