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(Vohringer and Ghaemi 2011; Zisook, Lesser et al. 2011; Andreescu and Lenze 2012; Coryell, Fiedorowicz et al. 2012; Cosco, Doyle et al. 2012; Coyne and van Sonderen 2012; Cuijpers, Beekman et al. 2012; Davis, Pilkinton et al. 2012; Eisenberger 2012; Gebauer, Sedikides et al. 2012; Gibbons, Hur et al. 2012; Goldberg and Huxley 2012; Hamad, Helsel et al. 2012; Holtermann, Hansen et al. 2012; Hunnicutt-Ferguson, Hoxha et al. 2012; Huntley, Araya et al. 2012; Ingleby, McKee et al. 2012; Kasen, Wickramaratne et al. 2012; Manea, Gilbody et al. 2012; Michels 2012; Mok, Kapur et al. 2012; Palmsten, Setoguchi et al. 2012; Sánchez-Villegas, Toledo et al. 2012; Stone, Whitham et al. 2012; Turner, Knoepflmacher et al. 2012; Webb, Kontopantelis et al. 2012; Wilcox, Kuramoto et al. 2012; Zisook, Corruble et al. 2012)

Andreescu, C. and E. J. Lenze (2012). "Comorbid anxiety and depression: bête noire or quick fix?" The British Journal of Psychiatry **200**(3): 179-181. http://bjp.rcpsych.org/content/200/3/179.abstract.

The common territory shared by anxiety and depression has always been a contentious subject. Research in favour of anxious depression as a potentially treatment-relevant subtype has been limited by diagnostic dilemmas and crude measurement. The most recent evidence from genetics, neuropeptide systems and functional neuroimaging suggests a valid diagnostic construct.

Coryell, W., J. G. Fiedorowicz, et al. (2012). "Effects of anxiety on the long-term course of depressive disorders." British Journal of Psychiatry **200**(3): 210-215. http://bjp.rcpsych.org/content/200/3/210.abstract.

Background: It is well established that the presence of prominent anxiety within depressive episodes portends poorer outcomes. Important questions remain as to which anxiety features are important to outcome and how sustained their prognostic effects are over time. Aims: To examine the relative prognostic importance of specific anxiety features and to determine whether their effects persist over decades and apply to both unipolar and bipolar conditions. Method: Participants with unipolar (n = 476) or bipolar (n = 335) depressive disorders were intensively followed for a mean of 16.7 years (s.d. = 8.5). Results: The number and severity of anxiety symptoms, but not the presence of pre-existing anxiety disorders, showed a robust and continuous relationship to the subsequent time spent in depressive episodes in both unipolar and bipolar depressive disorder. The strength of this relationship changed little over five successive 5-year periods. Conclusions: The severity of current anxiety symptoms within depressive episodes correlates strongly with the persistence of subsequent depressive symptoms and this relationship is stable over decades.

Cosco, T. D., F. Doyle, et al. (2012). "Latent structure of the Hospital Anxiety And Depression Scale: A 10-year systematic review." Journal of Psychosomatic Research **72**(3): 180-184. http://www.sciencedirect.com/science/article/pii/S0022399911001942.

Objective To systematically review the latent structure of the Hospital Anxiety and Depression Scale (HADS). Methods A systematic review of the literature was conducted across Medline, ISI Web of Knowledge, CINAHL, PsycInfo and EmBase databases spanning articles published between May 2000 and May 2010. Studies conducting latent variable analysis of the HADS were included. Results Twenty-five of the 50 reviewed studies revealed a two-factor structure, the most commonly found HADS structure. Additionally, five studies revealed unidimensional, 17 studies revealed three-factor, and two studies revealed four-factor structures. One study provided equal support for two- and three-factor structures. Different latent variable analysis methods revealed correspondingly different structures: exploratory factor analysis studies revealed primarily two-factor structures, confirmatory factor analysis studies revealed primarily three-factor structures, and item response theory studies revealed primarily unidimensional structures. Conclusion The heterogeneous results of the current review suggest that the latent structure of the HADS is unclear, and dependent on statistical methods invoked. While the HADS has been shown to be an effective measure of emotional distress, its inability to consistently differentiate between the constructs of anxiety and depression means that its use needs to be targeted to more general measurement of distress.

Coyne, J. C. and E. van Sonderen (2012). "No further research needed: Abandoning the Hospital and Anxiety Depression Scale (HADS)." Journal of Psychosomatic Research **72**(3): 173-174. http://www.sciencedirect.com/science/article/pii/S0022399911003059.

Cosco and colleagues [this issue] provide a well done and transparently reported systematic review of the Hospital Anxiety and Depression Scale (HADS) literature of the past decade. They conclude that the underlying structure of the HADS is inconsistent across samples and highly dependent on the statistical methods used to establish that structure. The implication is that the HADS is not a dependable means of differentiating anxiety and depression for the purposes of assessing the absolute or relative levels of these variables. These results can also go far in explaining the confusing difficulties that have arisen in research concerning use of the HADS as the first stage of two-stage screening procedures of depression and anxiety disorders or case identification procedures ... There are abundant reasons why the field should move on, leave the HADS literature behind, and select any of a number of alternative instruments in its place. Tradition and the HADS still being the most widely used screening and assessment instrument with medically ill patients are insufficient reasons to continue to recommend it.

Cuijpers, P., A. T. F. Beekman, et al. (2012). "Preventing depression." JAMA: The Journal of the American Medical Association **307**(10): 1033-1034. http://jama.ama-assn.org/content/307/10/1033.short.

Depressive disorders erode quality of life, productivity in the workplace, and fulfillment of social and familial roles. In today's knowledge- and service-driven economies, the population's mental capital (ie, cognitive, emotional, and social skills resources required for role functioning) becomes both more valuable and more vulnerable to the effects of depression. Depressive disorders, severe mental illnesses that should not be confused with normal mood variations, are part of a vicious circle of poverty, discrimination, and poor mental health in middle- and low-income countries. These realities also have major economic ramifications: treatment costs of depression are soaring but are only a fragment of the costs of reduced productivity due to depression. More than half of those with depression develop a recurrent or chronic disorder after a first depressive episode and are likely to spend more than 20% of their lifetime in a depressed condition.

Davis, L. L., P. Pilkinton, et al. (2012). "Effect of concurrent substance use disorder on the effectiveness of single and combination antidepressant medications for the treatment of major depression: an exploratory analysis of a single-blind randomized trial." Depress Anxiety **29**(2): 111-122. http://www.ncbi.nlm.nih.gov/pubmed/22495941.

BACKGROUND: The co-occurrence of substance use disorder (SUD) and major depressive disorder (MDD) is common and is often thought to impair response to antidepressant therapy. These patients are often excluded from clinical trials, resulting in a significant knowledge gap regarding optimal pharmacotherapy for the treatment of MDD with concurrent SUD. METHODS: In the Combining Medications to Enhance Depression Outcomes study, 665 adult outpatients with chronic and/or

recurrent MDD were prospectively treated with either escitalopram monotherapy (escitalopram and placebo) or an antidepressant combination (venalfaxine-XR and mirtazapine or escitalopram and bupropion-SR). Participants with MDD and concurrent SUD (13.1%) were compared to those without SUD (86.9%) on sociodemographic and clinical characteristics at baseline and treatment response at 12- and 28-week endpoints. RESULTS: The participants with MDD and SUD were more likely to be male and have current suicidal thoughts/plans, and had a greater lifetime severity and number of suicide attempts, and a higher number of concurrent Axis I disorders, particularly concurrent anxiety disorders. There were no significant differences between the MDD with or without SUD groups in terms of dose, time in treatment, response or remission at week 12 and 28. Furthermore, no significant differences in response or remission rates were noted between groups on the basis of the presence or absence of SUD and treatment assignment. CONCLUSIONS: Although significant baseline sociodemographic and clinical differences exist, patients with MDD and concurrent SUD are as likely to respond and remit to a single or combination antidepressant treatment as those presenting without SUD.

Eisenberger, N. I. (2012). "Broken hearts and broken bones." Current Directions in Psychological Science **21**(1): 42-47. http://cdp.sagepub.com/content/21/1/42.abstract.

Although it is common to describe experiences of social rejection or loss with words typically reserved for physical pain, the idea that these social experiences might actually be experienced as painful seems more far-fetched. However, accumulating evidence demonstrates that social pain—the painful feelings following social rejection or loss—may rely on pain-related neural circuitry. Here, I summarize a program of research that has explored whether social pain relies on pain-related neural regions, as well as some of the expected consequences of a physical–social pain overlap. I also discuss the implications of these findings for our understanding of social pain.

Gebauer, J. E., C. Sedikides, et al. (2012). "Religiosity, social self-esteem, and psychological adjustment." Psychological Science **23**(2): 158-160. http://pss.sagepub.com/content/23/2/158.short.

The 'Greater Good' centre - http://greatergood.berkeley.edu/article/research_digest/religion_and_resilience - report on this study: "Are religious people happier than non-believers? Not necessarily, according to this study. Through an online dating site (eDarling), researchers collected data on roughly 188,000 adults across several countries. They found that religious people are better adjusted psychologically and more comfortable in social situations—but only when they live in a country that places greater value on being religious. In cultures that don't value religiosity, non-believers enjoyed the same psychological benefits as believers. In other words, the benefits of being religious are related to the values that a society places on religion."

Gibbons, R. D., K. Hur, et al. (2012). "Benefits from antidepressants: Synthesis of 6-week patient-level outcomes from double-blind placebo-controlled randomized trials of fluoxetine and venlafaxine." Arch Gen Psychiatry: archgenpsychiatry.2011.2044. http://archpsyc.ama-assn.org/cgi/content/abstract/archgenpsychiatry.2011.2044v1.

Context Some meta-analyses suggest that efficacy of antidepressants for major depression is overstated and limited to severe depression. Objective To determine the short-term efficacy of antidepressants for treating major depressive disorder in youth, adult, and geriatric populations. Data Sources Reanalysis of all intent-to-treat person-level longitudinal data during the first 6 weeks of treatment of major depressive disorder from 12 adult, 4 geriatric, and 4 youth randomized controlled trials of fluoxetine hydrochloride and 21 adult trials of venlafaxine hydrochloride. Study Selection All sponsor-conducted randomized controlled trials of fluoxetine and venlafaxine. Data Extraction Children's Depression Rating Scale-Revised scores (youth population), Hamilton Depression Rating Scale scores (adult and geriatric populations), and estimated response and remission rates at 6 weeks were analyzed for 2635 adults, 960 geriatric patients, and 708 youths receiving fluoxetine and for 2421 adults receiving immediate-release venlafaxine and 2461 adults receiving extended-release venlafaxine. Data Synthesis Patients in all age and drug groups had significantly greater improvement relative to control patients receiving placebo. The differential rate of improvement was largest for adults receiving fluoxetine (34.6% greater than those receiving placebo). Youths had the largest treated vs control difference in response rates (24.1%) and remission rates (30.1%), with adult differences generally in the 15.6% (remission) to 21.4% (response) range. Geriatric patients had the smallest drug-placebo differences, an 18.5% greater rate of improvement, 9.9% for response and 6.5% for remission. Immediate-release venlafaxine produced larger effects than extended-release venlafaxine. Baseline severity could not be shown to affect symptom reduction. Conclusions To our knowledge, this is the first research synthesis in this area to use complete longitudinal person-level data from a large set of published and unpublished studies. The results do not support previous findings that antidepressants show little benefit except for severe depression. The antidepressants fluoxetine and venlafaxine are efficacious for major depressive disorder in all age groups, although more so in youths and adults compared with geriatric patients. Baseline severity was not significantly related to degree of treatment advantage over placebo.

Goldberg, D. and P. Huxley (2012). "At least 25% with a mental health problem is a conservative estimate." BMJ **344**. http://www.bmj.com/content/344/bmj.e1776.

There are enormous problems in deciding what counts as a mental disorder, but most epidemiologists use an official classification such as the international classification of diseases. We were responsible for providing evidence that the one year prevalence of mental disorders in community samples is about 250/1000. We obtained this figure by combining figures for cross sectional prevalence with admittedly speculative estimates of annual inceptions, so that a cross sectional rate of 180/1000 was inflated by assuming that about a third of that number would develop a new episode during the next year. Even at that time, we had excellent evidence that most episodes are of short duration (fewer than three months). Since then, surveys have asked people to remember their health over the previous year. By 2002 it was shown that survey results were yielding slight underestimates: the rate for the UK was then revised upwards to 270/1000, also taking into account rates reported by the Office for National Statistics. These rates did not include severe mental disorders, such as schizophrenia, bipolar disorder, or dementia, and neither did they include alcohol and drug dependence. These are annual rates, not lifetime rates—the concept of lifetime prevalence is necessary for studies of the genetics of mental disorders, but it is a highly questionable concept where common mental disorders are concerned. This is because it assumes that people not only can, but will, reveal information about minor disorders that occurred many years ago that they might have forgotten or suppressed. For this reason, we have never quoted figures for lifetime rates. However, for those who like to think in these terms, "at least 25%" is almost certainly a conservative estimate.

Hamad, G. G., J. C. Helsel, et al. (2012). "The effect of gastric bypass on the pharmacokinetics of serotonin reuptake inhibitors." Am J Psychiatry **169**(3): 256-263. http://www.ncbi.nlm.nih.gov/pubmed/22407114.

OBJECTIVE: Morbidly obese patients frequently present with mood and anxiety disorders, which are often treated with serotonin reuptake inhibitors (SRIs). Having observed that patients treated with SRIs frequently relapse after Roux-en-Y gastric bypass surgery, the authors sought to assess whether SRI bioavailability is reduced postoperatively. METHOD: Twelve gastric bypass candidates treated with an SRI for primary mood or anxiety disorders were studied prospectively. Timed blood samples for SRI plasma levels were drawn for pharmacokinetic studies before surgery and 1, 6, and 12 months afterward. Maximum

concentration, time to maximum concentration, and area under the concentration/time curve (AUC) were determined. RESULTS: In eight of the 12 patients, AUC values 1 month after surgery dropped to an average of 54% (SD=18) of preoperative levels (range=36%-80%); in six of these patients, AUC values returned to baseline levels (or greater) by 6 months. Four patients had an exacerbation of depressive symptoms, which resolved by 12 months in three of them. Three of the four patients had a reduced AUC level at 1 month and either gained weight or failed to lose weight between 6 and 12 months. Normalization of the AUC was associated with improvement in symptom scores. CONCLUSIONS: Patients taking SRIs in this study were at risk for reduced drug bioavailability 1 month after Roux-en-Y gastric bypass. The authors recommend close psychiatric monitoring after surgery.

Holtermann, A., J. V. Hansen, et al. (2012). "The health paradox of occupational and leisure-time physical activity." British Journal of Sports Medicine **46**(4): 291-295. http://bjsm.bmj.com/content/46/4/291.abstract.

Background Occupational and leisure-time physical activity are considered to provide similar health benefits. The authors tested this hypothesis.Methods A representative sample of Danish employees (n=7144, 52% females) reported levels of occupational and leisure-time physical activity in 2005. Long-term sickness absence (LTSA) spells of ≥3 consecutive weeks were retrieved from a social-transfer payment register from 2005 to 2007.Results 341 men and 620 females experienced a spell of LTSA during the period. Cox analyses adjusted for age, gender, smoking, alcohol, body mass index, chronic disease, social support from immediate superior, emotional demands, social class and occupational or leisure-time physical activity showed a decreased risk for LTSA among workers with moderate (HR 0.85, CI 0.72 to 1.01) and high (HR 0.77, CI 0.62 to 0.95) leisure-time physical activity in reference to those with low leisure-time physical activity. In contrast, an increased risk for LTSA was shown among workers with moderate (HR 1.59, CI 1.35 to 1.88) and high (HR 1.84, CI 1.55 to 2.18) occupational physical activity referencing those with low occupational physical activity.Conclusion The hypothesis was rejected. In a dose–response manner, occupational physical activity increased the risk for LTSA, while leisure-time physical activity decreased the risk for LTSA. The findings indicate opposing effects of occupational and leisure-time physical activity on global health.

Hunnicutt-Ferguson, K., D. Hoxha, et al. (2012). "Exploring sudden gains in behavioral activation therapy for major depressive disorder." Behaviour Research and Therapy **50**(3): 223-230. http://www.sciencedirect.com/science/article/pii/S0005796712000174.

Understanding the onset and course of sudden gains in treatment provides clinical information to the patient and clinician, and encourages clinicians to strive for these sudden clinical gains with their patients. This study characterizes the occurrence of sudden gains with Behavioral Activation (BA; Martell, Addis, & Jacobson, 2001), and the extent to which pre-treatment dysfunctional depressive thinking predicts sudden gains during treatment. We enrolled a sample of adults (n = 42) between ages 18–65 diagnosed with primary Major Depressive Disorder. All participants completed a 16-week course of BA, with clinical and self-report assessments at pre-, mid- and post-treatment. Results indicated that sudden gain and non-sudden gain participants showed differential improvement across treatment. No significant effects emerged for the dysfunctional cognitive style as a predictor of sudden gain status. Sudden gains may result from interaction of non-specific factors with the BA techniques implemented during early phases of therapy.

Huntley, A. L., R. Araya, et al. (2012). "Group psychological therapies for depression in the community: systematic review and meta-analysis." British Journal of Psychiatry **200**(3): 184-190. http://bjp.rcpsych.org/content/200/3/184.abstract.

Background: Psychological therapies have been shown to be effective in the treatment of depression. However, evidence is focused on individually delivered therapies, with less evidence for group-based therapies. Aims: To conduct a systematic review and meta-analysis of the efficacy of group-based psychological therapies for depression in primary care and the community. Method: We searched MEDLINE, Embase, PsycINFO, the Cochrane Central Register of Controlled Trials and the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group database from inception to July 2010. The Cochrane risk of bias methodology was applied. Results: Twenty-three studies were included. The majority showed considerable risk of bias. Analysis of group cognitive–behavioural therapy (CBT) v. usual care alone (14 studies) showed a significant effect in favour of group CBT immediately post-treatment (standardised mean difference (SMD) −0.55 (95% CI −0.78 to −0.32)). There was some evidence of benefit being maintained at short-term (SMD = −0.47 (95% CI −1.06 to 0.12)) and medium- to long-term follow-up (SMD = −0.47 (95% CI − 0.87 to −0.08)). Studies of group CBT v. individually delivered CBT therapy (7 studies) showed a moderate treatment effect in favour of individually delivered CBT immediately post-treatment (SMD = 0.38 (95% CI 0.09–0.66)) but no evidence of difference at short- or medium- to long-term follow-up. Four studies described comparisons for three other types of group psychological therapies. Conclusions: Group CBT confers benefit for individuals who are clinically depressed over that of usual care alone. Individually delivered CBT is more effective than group CBT immediately following treatment but after 3 months there is no evidence of difference. The quality of evidence is poor. Evidence about group psychological therapies not based on CBT is particularly limited.

Ingleby, D., M. McKee, et al. (2012). "How the NHS measures up to other health systems." BMJ **344**. http://www.bmj.com/content/344/bmj.e1079.

Debate about how to improve the NHS has been handicapped by a lack of suitable comparative data about the functioning of other health systems. David Ingleby and colleagues examine two recent reports by the Commonwealth Fund: The government's plans for reorganising the English National Health Service have sparked heated discussions about the performance of the UK health system in comparison with that of other countries. Politicians favouring reform have emphasised real and perceived shortcomings of the NHS, while opponents have lauded its successes. Objective data have been sadly lacking in much of this debate. Arbitrary examples of good or bad performance from the UK and various other countries have been thrown back and forth, often using totally incommensurable data. Two new publications from the Commonwealth Fund, a New York based health policy institute, shed some much needed light on these questions. We analyse the data and discuss the strengths and weaknesses of the NHS in the light of current proposals for reform ... key conclusions: The NHS outperforms other high income countries on many measures despite spending much less than most of them. It enjoys the highest levels of public confidence and satisfaction of all the countries studied. The effects of increased investment and policy improvements over the past decade are clearly visible ... The results reported here do not support complacency about the current performance of the health system in the UK. They show that, like all health systems, it has its strengths and weaknesses. They do, however, cast serious doubt on any claim that there is widespread popular support for radical reform. Improvements are needed, but continuation and expansion of the measures already set in motion—more of the same—seems to be a better formula than totally rebuilding a system that, by international standards, already works remarkably well.

Kasen, S., P. Wickramaratne, et al. (2012). "Religiosity and resilience in persons at high risk for major depression." Psychological Medicine **42**(03): 509-519. http://dx.doi.org/10.1017/S0033291711001516.

Background: Few studies have examined religiosity as a protective factor using a longitudinal design to predict resilience in persons at high risk for major depressive disorder (MDD). Method: High-risk offspring selected for having a

depressed parent and control offspring of non-depressed parents were evaluated for psychiatric disorders in childhood/adolescence and at 10-year and 20-year follow-ups. Religious/spiritual importance, services attendance and negative life events (NLEs) were assessed at the 10-year follow-up. Models tested differences in relationships between religiosity/spirituality and subsequent disorders among offspring based on parent depression status, history of prior MDD and level of NLE exposure. Resilience was defined as lower odds for disorders with greater religiosity/spirituality in higher-risk versus lower-risk offspring. Results: Increased attendance was associated with significantly reduced odds for mood disorder (by 43%) and any psychiatric disorder (by 53%) in all offspring; however, odds were significantly lower in offspring of non-depressed parents than in offspring of depressed parents. In analyses confined to offspring of depressed parents, those with high and those with average/low NLE exposure were compared: increased attendance was associated with significantly reduced odds for MDD, mood disorder and any psychiatric disorder (by 76, 69 and 64% respectively) and increased importance was associated with significantly reduced odds for mood disorder (by 74%) only in offspring of depressed parents with high NLE exposure. Moreover, those associations differed significantly between offspring of depressed parents with high NLE exposure and offspring of depressed parents with average/low NLE exposure. Conclusions: Greater religiosity may contribute to development of resilience in certain high-risk individuals.

Manea, L., S. Gilbody, et al. (2012). "Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): a meta-analysis." CMAJ **184**(3): E191-196. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3281183/?tool=pubmed.

(Free full text available) BACKGROUND: The brief Patient Health Questionnaire (PHQ-9) is commonly used to screen for depression with 10 often recommended as the cut-off score. We summarized the psychometric properties of the PHQ-9 across a range of studies and cut-off scores to select the optimal cut-off for detecting depression. METHODS: We searched Embase, MEDLINE and PsycINFO from 1999 to August 2010 for studies that reported the diagnostic accuracy of PHQ-9 to diagnose major depressive disorders. We calculated summary sensitivity, specificity, likelihood ratios and diagnostic odds ratios for detecting major depressive disorder at different cut-off scores and in different settings. We used random-effects bivariate meta-analysis at cutoff points between 7 and 15 to produce summary receiver operating characteristic curves. RESULTS: We identified 18 validation studies (n = 7180) conducted in various clinical settings. Eleven studies provided details about the diagnostic properties of the questionnaire at more than one cut-off score (including 10), four studies reported a cut-off score of 10, and three studies reported cut-off scores other than 10. The pooled specificity results ranged from 0.73 (95% confidence interval [CI] 0.63-0.82) for a cut-off score of 7 to 0.96 (95% CI 0.94-0.97) for a cut-off score of 15. There was major variability in sensitivity for cut-off scores between 7 and 15. There were no substantial differences in the pooled sensitivity and specificity for a range of cut-off scores (8-11). INTERPRETATION: The PHQ-9 was found to have acceptable diagnostic properties for detecting major depressive disorder for cut-off scores between 8 and 11. Authors of future validation studies should consistently report the outcomes for different cut-off scores.

Michels, R. (2012). "Diagnosing personality disorders." Am J Psychiatry **169**(3): 241-243. http://ajp.psychiatryonline.org/article.aspx?articleid=1028573.

(Available in free full text) In the past, one might have argued that the differential diagnosis of specific personality disorders made little difference, that it wasn't a useful clinical guide for individual patients. However, research has demonstrated differences in clinical course and prognosis among the several personality disorders, and the separate categories have been useful to the growing body of research on therapeutics. As we move toward DSM-5, it is clear that the clinical and research communities view personality disorders differently. The clinical community wants a system that is practical and workable in the real world and that focuses on the essence of each category. The research community wants to capture as much information as possible and to emphasize precise boundaries of categories rather than reifying core syndromes that may have more to do with tradition or theory than with patients. In this issue of the Journal, Westen et al. enter the fray with the goal of "bridging" science and practice. They claim that they are developing a "taxonomy" (the term Linnaeus introduced for classifying living things according to their natural relationships). DSM is more modest, claiming only to be a "nosology" (a classification of diseases). In fact, "nomenclature" (a system of names) might be even more appropriate. Westen and colleagues' important study is the most recent in a 15-year program of research that has established their position as an exemplar representing one important position in the dialogue of personality disorder diagnosis. Westen et al. argue that personality disorders are primarily clinical concepts. The individual disorders are syndromes—clusters of meaningfully related characteristics that are recognized as syndromic entities, not as collections of independent phenomena. In explaining the concept, the authors use the metaphor of face recognition; it is relatively easy when we see a whole face but much more difficult if we are presented with an assortment of eyebrows, noses, chins, eyes, and mouths. Westen et al. have developed prototypic descriptions of eight personality disorders, two of "neurotic styles," and one of personality health ... The gap between researcher and practitioner in personality disorders may be fundamental—the diagnoses are used for different purposes. Westen et al. have provided a state-of-the-art strategy for constructing categories that reflect how clinicians think and that clinicians will find friendly to use. The architects of DSM-5 will have to decide how it should resolve the tensions between the clinical and research communities and their different goals in using the nosology.

Mok, P. L. H., N. Kapur, et al. (2012). "Trends in national suicide rates for Scotland and for England & Wales, 1960–2008." The British Journal of Psychiatry **200**(3): 245-251. http://bjp.rcpsych.org/content/200/3/245.abstract.

Background: Suicide rates in Scotland have increased markedly relative to those in England in recent decades. Aims: To compare changing patterns of suicide risk in Scotland with those in England & Wales, 1960–2008. Method: For Scotland and for England & Wales separately, we obtained national data on suicide counts and population estimates. Gender-specific, directly age-standardised rates were calculated. Results: We identified three distinct temporal phases: 1960–1967, when suicide rates in England & Wales were initially higher than in Scotland, but then converged; 1968–1991, when male suicide rates in Scotland rose slightly faster than in England & Wales; and 1992–2008, when there was a marked divergence in national trends. Much of the recent divergence in rates is attributable to the rise in suicide among young men and deaths by hanging in Scotland. Introduction of the `undetermined intent' category in 1968 had a significant impact on suicide statistics across Great Britain, but especially so in Scotland. Conclusions: Differences in temporal patterns in suicide risk between the countries are complex. Reversal of the divergent trends may require a change in the perception of hanging as a `painless' method of suicide.

Palmsten, K., S. Setoguchi, et al. (2012). "Elevated Risk of Preeclampsia in Pregnant Women With Depression: Depression or Antidepressants?" American Journal of Epidemiology. http://aje.oxfordjournals.org/content/early/2012/03/22/aje.kwr394.abstract.

A previous study suggested an increased risk of preeclampsia among women treated with selective serotonin reuptake inhibitors (SSRIs). Using population-based health-care utilization databases from British Columbia (1997–2006), the authors conducted a study of 69,448 pregnancies in women with depression. They compared risk of preeclampsia in women using SSRIs, serotonin-norepinephrine reuptake inhibitors (SNRIs), or tricyclic antidepressants (TCAs) between gestational weeks 10 and 20 with risk in depressed women not using antidepressants. Among prepregnancy antidepressant users, the authors

compared the risk in women who continued antidepressants between gestational weeks 10 and 24 with the risk in those who discontinued. Relative risks and 95% confidence intervals were estimated. The risk of preeclampsia in depressed women not treated with antidepressants (2.4%) was similar to that in women without depression (2.3%). Compared with women with untreated depression, women treated with SSRI, SNRI, and TCA monotherapy had adjusted relative risks of 1.22 (95% confidence interval (CI): 0.97, 1.54), 1.95 (95% CI: 1.25, 3.03), and 3.23 (95% CI: 1.87, 5.59), respectively. Within prepregnancy antidepressant users, the relative risk for preeclampsia among continuers compared with discontinuers was 1.32 (95% CI: 0.95, 1.84) for SSRI, 3.43 (95% CI: 1.77, 6.65) for SNRI, and 3.26 (95% CI: 1.04, 10.24) for TCA monotherapy. Study results suggest that women who use antidepressants during pregnancy, especially SNRIs and TCAs, have an elevated risk of preeclampsia. These associations may reflect drug effects or more severe depression.

Sánchez-Villegas, A., E. Toledo, et al. (2012). "Fast-food and commercial baked goods consumption and the risk of depression." Public Health Nutrition **15**(03): 424-432. http://dx.doi.org/10.1017/S1368980011001856.

Objective: Whereas the relationship between some components of diet, such as n-3 fatty acids and B-vitamins, and depression risk has been extensively studied, the role of fast-food or processed pastries consumption has received little attention. Design: Consumption of fast food (hamburgers, sausages, pizza) and processed pastries (muffins, doughnuts, croissants) was assessed at baseline through a validated semi-quantitative FFQ. Participants were classified as incident cases of depression if they reported a physician diagnosis of depression or the use of antidepressant medication in at least one of the follow-up questionnaires. Cox regression models were fit to assess the relationship between consumption of fast food and commercial baked goods and the incidence of depression. Setting: The SUN (Seguimiento Universidad de Navarra – University of Navarra Follow-up) Project, Spain. Subjects: Participants (n 8964) from a Spanish cohort.ResultsAfter a median follow-up of 6·2 years, 493 cases of depression were reported. A higher risk of depression was associated with consumption of fast food (fifth (Q5) v. first quintile (Q1): hazard ratio (HR) = 1·36; 95 % CI 1·02, 1·81; P trend = 0·003). The results did not change after adjustment for the consumption of other food items. No linear relationship was found between the consumption of commercial baked goods and depression. Participants belonging to consumption quintiles Q2–Q5 showed an increased risk of depression compared with those belonging to the lowest level of consumption (Q1; HR = 1·38; 95 % CI 1·06, 1·80). Conclusions: Fast-food and commercial baked goods consumption may have a detrimental effect on depression risk. *Deborah Brauser of Medscape - http://www.medscape.com/psychiatry - commented on 25 April: "Eating too much junk food may increase risk for depression, a large study suggests. In a cohort study of almost 9000 adults in Spain, those who consistently consumed "fast food," such as hamburgers and pizza, were 40% more likely to develop depression than the participants who consumed little to none of these types of food. In addition, investigators found that the depression risk rose steadily as more fast food was consumed. Participants who often ate commercial baked goods, such as croissants and doughnuts, were also at significant risk of developing this disorder. "We were not surprised with the results. Several studies have analyzed the association between fast food and commercial bakery consumption and physical diseases, such as obesity or coronary heart disease," Almudena Sánchez-Villegas, PhD, from the Department of Clinical Sciences at the University of Las Palmas de Gran Canaria and the Department of Preventive Medicine and Public Health at the University of Navarra in Pamplona, Spain, told Medscape Medical News. Dr. Almudena Sánchez-Villegas "With these results, a relatively new line of research is open. Limiting trans fatty acids content in several foods, avoiding the consumption of fast food and bakery, and increasing the consumption of other products such as vegetables, legumes, and fruits should be a primary goal for clinicians and public health makers," she added. The study is published in the March issue of Public Health Nutrition. Croissants, Doughnuts, and Muffins, Oh My! According to the investigators, depression affects around 121 million people throughout the world. Although "little is known about the role of diet in the development of depressive disorders," past studies have suggested that olive oil, B vitamins, and omega-3 fatty acids may play a preventative role, write the researchers. As reported by Medscape Medical News, Dr. Sánchez-Villegas and colleagues published a study last year in PLoS One that linked consumption of trans unsaturated fatty acids (TFA) to a significantly increased risk for depression. For the current study, they sought to specifically examine the role that consumption of fast food and processed food may play in the development of this disorder. The researchers examined data on 8964 adults from the Seguimiento Universidad de Navarra (SUN) Project, an ongoing diet and lifestyle tracking study that started in 1999. None of the SUN participants had been diagnosed with depression or had taken antidepressants before the start of the study. Exposures and outcomes were gathered through surveys mailed out biennially to the participants. A food frequency questionnaire was used to assess dietary intake. Fast food consumption was defined as total consumption of hamburgers, pizza, and hot dogs/sausages. Commercial baked goods consumption was defined as total consumption of croissants, doughnuts, and muffins. Incident depression and/or self-reported physician-made diagnosis of depression, antidepressant use, and demographic and lifestyle data were recorded on other questionnaires. Curb the Junk Food: Results showed that 493 of the participants were diagnosed with depression after a median follow-up of 6.2 years. Those who were found to have the highest levels of consumption of fast food showed a significantly higher risk of developing depression compared with those who had the lowest levels of consumption (adjusted hazard ratio [HR], 1.40; 95% confidence interval [CI], 1.05 - 1.86; P = .01). "Moreover, a significant dose-response relationship was found (P for trend = .001)," report the researchers. However, the researchers note that even small quantities of fast food were linked to a significantly higher risk for depression. Participants who often consumed commercial baked goods were also at increased risk of developing this disorder (adjusted HR, 1.43; 95% CI, 1.06 - 1.93). The investigators also found that the study participants with the highest consumption of fast food and of commercial baked goods were more likely to be single, less active, smoke, work more than 45 hours per week, and eat less fruits, vegetables, nuts, fish, and/or olive oil. "Although more studies are necessary, the intake of this type of food should be controlled because of its implications on both health (obesity, cardiovascular disease) and mental well-being," said Dr. Sánchez-Villegas. The researchers add that the legally permitted content of TFA in these foods "should be reviewed." "This Spanish team conducted very good, quality research and took considerable care to consider multiple possible causes of confounding, such as other factors that may explain both dietary habits and risk for depression," Felice Jacka, PhD, research fellow at Deakin University in Melbourne, Australia, told Medscape Medical News. "For example, they take into account many variables that may be proxies of health consciousness or overall health lifestyle, such as the use of seat belts, frequency of medical and dental checkups, and drunk driving, as well as marital status, smoking, alcohol consumption, and intake of nutrient-dense foods. The study sample is also large and well described, and the prospective cohort design affords the potential for investigating cause-effect relationships," she added. Dr. Jacka noted that the results support a previous study that she and her colleagues published recently in the American Journal of Psychiatry, which showed that women who consumed a diet higher in unhealthy and processed food were likely to be depressed. In a study published in the Australian and New Zealand Journal of Psychiatry, they reported the same results in a cohort of adolescents. The results of the current study "are also concordant with the two prospective studies in this field, in both adults and adolescents, reporting that unhealthy diets are associated with an increased risk for mental health problems over time," she reported. She added that although this study was rigorously conducted and is methodologically sound, "it is perhaps a shame that [it] does not have data on diagnoses of depression ascertained via clinical assessments. However, this is rare in large epidemiological studies, and the measures they have used have been shown to be valid." Dr. Jacka noted that because diet and mental health research is relatively new, it is often uncommon for clinicians to consider diet as an intervention target in clinical care. "However, this study adds to the rapidly growing and highly consistent body of literature*

suggesting that depression is another common, noncommunicable illness with a significant lifestyle component," she said. "As such, it is prudent for clinicians to assess and address the dietary as well as exercise habits of their patients, in addition to pharmacological and other established treatments."

Stone, K., E. A. Whitham, et al. (2012). "A comparison of psychiatry and internal medicine: a bibliometric study." Acad Psychiatry **36**(2): 129-132. http://www.ncbi.nlm.nih.gov/pubmed/22532204.

OBJECTIVE: Psychiatric education needs to expose students to a broad range of topics. One resource for psychiatric education, both during initial training and in later continuing medical education, is the scientific literature, as published in psychiatric journals. The authors assessed current research trends in psychiatric journals, as compared with internal-medicine counterparts and examined their relevance to psychiatric education. METHODS: The authors classified abstracts and original articles as biological or non-biological, based on methodology, from 2008 in Archives of General Psychiatry and The American Journal of Psychiatry, as compared with The Archives of Internal Medicine and Annals of Internal Medicine. RESULTS: Biological and non-biological studies were similarly frequent in psychiatric journals (48.2% and 51.8%, respectively). Internal-medicine journals had a non-biological and epidemiological predominance (22.2% biological, 77.8% non-biological: epidemiological, 59.9%; reviews, 21.4%; clinical, 13.2%; other, 5.4%). CONCLUSION: Psychiatric journals publish more biological studies than internal-medicine journals. This tendency may influence psychiatric education and practice in a biological direction, with less attention to psychosocial or clinical approaches to psychiatry.

Turner, E. H., D. Knoepflmacher, et al. (2012). "Publication Bias in Antipsychotic Trials: An Analysis of Efficacy Comparing the Published Literature to the US Food and Drug Administration Database." PLoS Med **9**(3): e1001189. http://dx.doi.org/10.1371%2Fjournal.pmed.1001189.

Background: Publication bias compromises the validity of evidence-based medicine, yet a growing body of research shows that this problem is widespread. Efficacy data from drug regulatory agencies, e.g., the US Food and Drug Administration (FDA), can serve as a benchmark or control against which data in journal articles can be checked. Thus one may determine whether publication bias is present and quantify the extent to which it inflates apparent drug efficacy. Methods and Findings: FDA Drug Approval Packages for eight second-generation antipsychotics—aripiprazole, iloperidone, olanzapine, paliperidone, quetiapine, risperidone, risperidone long-acting injection (risperidone LAI), and ziprasidone—were used to identify a cohort of 24 FDA-registered premarketing trials. The results of these trials according to the FDA were compared with the results conveyed in corresponding journal articles. The relationship between study outcome and publication status was examined, and effect sizes derived from the two data sources were compared. Among the 24 FDA-registered trials, four (17%) were unpublished. Of these, three failed to show that the study drug had a statistical advantage over placebo, and one showed the study drug was statistically inferior to the active comparator. Among the 20 published trials, the five that were not positive, according to the FDA, showed some evidence of outcome reporting bias. However, the association between trial outcome and publication status did not reach statistical significance. Further, the apparent increase in the effect size point estimate due to publication bias was modest (8%) and not statistically significant. On the other hand, the effect size for unpublished trials (0.23, 95% confidence interval 0.07 to 0.39) was less than half that for the published trials (0.47, 95% confidence interval 0.40 to 0.54), a difference that was significant. Conclusions: The magnitude of publication bias found for antipsychotics was less than that found previously for antidepressants, possibly because antipsychotics demonstrate superiority to placebo more consistently. Without increased access to regulatory agency data, publication bias will continue to blur distinctions between effective and ineffective drugs.

Vohringer, P. A. and S. N. Ghaemi (2011). "Solving the antidepressant efficacy question: effect sizes in major depressive disorder." Clin Ther **33**(12): B49-61. http://www.ncbi.nlm.nih.gov/pubmed/22136980.

BACKGROUND: Numerous reviews and meta-analyses of the antidepressant literature in major depressive disorders (MDD), both acute and maintenance, have been published, some claiming that antidepressants are mostly ineffective and others that they are mostly effective, in either acute or maintenance treatment. OBJECTIVE: The aims of this study were to review and critique the latest and most notable antidepressant MDD studies and to conduct our own reanalysis of the US Food and Drug Administration database studies specifically analyzed by Kirsch et al. METHODS: We gathered effect estimates of each MDD study. In our reanalysis of the acute depression studies, we corrected analyses for a statistical floor effect so that relative (instead of absolute) effect size differences were calculated. We also critiqued a recent meta-analysis of the maintenance treatment literature. RESULTS: Our reanalysis showed that antidepressant benefit is seen not only in severe depression but also in moderate depression and confirmed a lack of benefit for antidepressants over placebo in mild depression. Relative antidepressant versus placebo benefit increased linearly from 5% in mild depression to 12% in moderate depression to 16% in severe depression. The claim that antidepressants are completely ineffective, or even harmful, in maintenance treatment studies involves unawareness of the enriched design effect, which, in that analysis, was used to analyze placebo efficacy. The same problem exists for the standard interpretation of those studies, although they do not prove antidepressant efficacy either, since they are biased in favor of antidepressants. CONCLUSIONS: In sum, we conclude that antidepressants are effective in acute depressive episodes that are moderate to severe but are not effective in mild depression. Except for the mildest depressive episodes, correction for the statistical floor effect proves that antidepressants are effective acutely. These considerations only apply to acute depression, however. For maintenance, the long-term efficacy of antidepressants is unproven, but the data do not support the conclusion that they are harmful.

Webb, R. T., E. Kontopantelis, et al. (2012). "Suicide Risk in Primary Care Patients With Major Physical Diseases: A Case-Control Study." Arch Gen Psychiatry **69**(3): 256-264. http://archpsyc.ama-assn.org/cgi/content/abstract/69/3/256.

Context Most previous studies have examined suicide risk in relation to a single physical disease. Objectives To estimate relative risk across a range of physical diseases, to assess the confounding effect of clinical depression and effect modification by sex and age, and to examine physical illness multimorbidity. Design Nested case-control study. Setting Family practices (n = 593) registered with the General Practice Research Database from January 1, 2001, through December 31, 2008. The case-control data were drawn from approximately 10.6 million complete patient records, pertaining to approximately 8% of the total population of the United Kingdom, with complete linkage to national mortality records. Participants A total of 873 adult suicide cases and 17 460 living controls matched on age and sex were studied. The reference group for relative risk estimation consisted of people without any of the specific physical illnesses examined. Main Outcome Measures Suicide and open verdicts. Results Among all patients, coronary heart disease, stroke, chronic obstructive pulmonary disease, and osteoporosis were linked with elevated suicide risk, and, with the exception of osteoporosis, the increase was explained by clinical depression. The only significantly elevated risk in men was with osteoporosis. Female effect sizes were greater, with 2- or 3-fold higher risk found among women diagnosed as having cancer, coronary heart disease, stroke, chronic obstructive pulmonary disease, and osteoporosis. In women with cancer and coronary heart disease, a significant elevation persisted after adjustment for depression. Overall, heightened risk was confined to physically ill women younger than 50 years and to older women with multiple physical diseases. Conclusions Our findings indicate that clinical depression is a strong confounder of increased suicide

risk among physically ill people. They also demonstrate an independent elevation in risk linked with certain diagnoses, particularly among women. Health care professionals working across all medical specialties should be vigilant for signs of undetected psychological symptoms.

Wilcox, H. C., S. J. Kuramoto, et al. (2012). "The interaction of parental history of suicidal behavior and exposure to adoptive parents' psychiatric disorders on adoptee suicide attempt hospitalizations." Am J Psychiatry **169**(3): 309-315. http://ajp.psychiatryonline.org/article.aspx?articleid=1028563.

OBJECTIVE: The authors examined the risk of suicide attempt or other psychiatric hospitalization among adoptees whose biological parents died from or were hospitalized for suicidal behavior (BPSB) relative to adoptees whose biological parents had a psychiatric hospitalization but never for suicide attempt (BPPH). The authors examined whether risk was moderated by having an adoptive parent who had a psychiatric hospitalization during the adoptee's childhood or adolescence. METHOD: This retrospective cohort study used national longitudinal population-based Swedish registry data from 1973 to 2003 to identify 2,516 adoptees with BPSB and 5,875 adoptees with BPPH. Cox regression models compared the risk for suicide attempt and other psychiatric hospitalization in the two groups. RESULTS: The interaction of BPSB with adoptive mothers' psychiatric hospitalization while the adoptee was younger than 18 years old increased the risk for an adoptee's suicide attempt. Neither BPSB nor psychiatric hospitalization among adoptive mothers alone placed adoptees at greater risk for suicide attempt hospitalizations. The interaction results were specific to adoptee suicide attempt. CONCLUSIONS: Exposure to the hospitalization of an adoptive mother because of a psychiatric disorder amplified an adoptee's risk for suicide attempt hospitalization among those adoptees at high genetic risk of suicide or suicide attempt. These results imply that suicide attempts among those at biological risk might be prevented with the early recognition and care of parental psychiatric illness.

Zisook, S., E. Corruble, et al. (2012). "The bereavement exclusion and dsm-5." Depress Anxiety **29**(5): 425-443. http://www.ncbi.nlm.nih.gov/pubmed/22495967.

BACKGROUND: Pre-DSM-III (where DSM is Diagnostic and Statistical Manual), a series of studies demonstrated that major depressive syndromes were common after bereavement and that these syndromes often were transient, not requiring treatment. Largely on the basis of these studies, a decision was made to exclude the diagnosis of a major depressive episode (MDE) if symptoms could be "better accounted for by bereavement than by MDE" unless symptoms were severe and very impairing. Thus, since the publication of DSM-III in 1980, the official position of American Psychiatry has been that recent bereavement may be an exclusion criterion for the diagnosis of an MDE. This review article attempts to answer the question, "Does the best available research favor continuing the 'bereavement exclusion' (BE) in DSM-5?" We have previously discussed the proposal by the DSM-5 Mood Disorders Work Group to remove the BE from DSM-5. METHODS: Prior reviews have evaluated the validity of the BE based on studies published through 2006. The current review adds research studies published since 2006 and critically examines arguments for and against retaining the BE in DSM-5. RESULTS: The preponderance of data suggests that bereavement-related depression is not different from MDE that presents in any other context; it is equally genetically influenced, most likely to occur in individuals with past personal and family histories of MDE, has similar personality characteristics and patterns of comorbidity, is as likely to be chronic and/or recurrent, and responds to antidepressant medications. CONCLUSIONS: We conclude that the BE should not be retained in DSM-5.

Zisook, S., I. M. Lesser, et al. (2011). "Effect of antidepressant medication treatment on suicidal ideation and behavior in a randomized trial: an exploratory report from the Combining Medications to Enhance Depression Outcomes Study." J Clin Psychiatry **72**(10): 1322-1332. http://www.ncbi.nlm.nih.gov/pubmed/22075098.

OBJECTIVE: To explore relationships between baseline sociodemographic and clinical features and baseline suicidal ideation, and treatment effects on suicidal ideation and behavior, in depressed outpatients. METHOD: From March 2008 to September 2009, the Combining Medications to Enhance Depression Outcomes study, a single-blind, 7-month randomized trial, enrolled outpatients with nonpsychotic chronic and/or recurrent major depressive disorder (DSM-IV-TR criteria) in primary and psychiatric care (N = 665). Participants received escitalopram plus placebo, bupropion sustained release (SR) plus escitalopram, or venlafaxine extended release (XR) plus mirtazapine. The primary outcome measure for this report is presence of suicidal ideation assessed by the Concise Health Risk Tracking Self-Report, which measures suicidal ideation and behaviors over the last 24 hours. Sociodemographic and clinical features were compared in those with versus without baseline ideation. At 4, 12, and 28 weeks, treatment effects on suicidality were assessed, and unadjusted and adjusted outcomes were compared among those with and without baseline ideation using linear, logistic, ordinal logistic, and negative binomial regression models. RESULTS: Baseline suicidal ideation was associated with greater depressive severity, childhood neglect, childhood abuse, early major depressive disorder onset, greater psychiatric comorbidity, and worse functioning and quality of life. After adjustment for treatment, gender, age at first depressive episode, obsessive-compulsive symptoms, and depressive severity, depressive symptom outcomes did not differ between ideation groups at 12 or 28 weeks or between treatments. Overall, 79% of participants with baseline suicidal ideation had none at week 4, 83% had none at week 12, and 86% had none at week 28. All treatments reduced ideation, with bupropion-SR plus escitalopram the most effective at week 12 ($P < .01$). In participants without baseline ideation, emergent ideation did not differ between treatments: 2.5% had ideation at 4 weeks, 1.3% had ideation at 12 weeks, and only 1.7% had ideation at 28 weeks. Four patients (all receiving venlafaxine-XR plus mirtazapine) attempted suicide ($P = .0162$). CONCLUSION: Baseline ideation did not affect depressive symptom outcome. Bupropion-SR plus escitalopram most effectively reduced ideation. Ideation emergence was uncommon. Venlafaxine-XR plus mirtazapine may pose a higher risk of suicide attempts.