# ***30 babcp abstracts, july/august '13***

(Arnow, Steidtmann et al. 2013; Bell, Marcus et al. 2013; Benros, Waltoft et al. 2013; Bryant, O'Donnell et al. 2013; Craske 2013; Cuijpers, Huibers et al. 2013; Cuijpers, Sijbrandij et al. 2013; Drake, Csipke et al. 2013; Glenn, Golinelli et al. 2013; Heins, Knoop et al. 2013; Kaplan and Harvey 2013; Kleiman and Rule 2013; Kossowsky, Pfaltz et al. 2013; Kross, Verduyn et al. 2013; Leichsenring, Salzer et al. 2013; Limb 2013; Moradveisi, Huibers et al. 2013; Morriss, Kapur et al. 2013; Ost 2013; Pietrzak, Kinley et al. 2013; Pineda and Dadds 2013; Sasso and Strunk 2013; Seery, Leo et al. 2013; Spijker, van Straten et al. 2013; Stringaris, Maughan et al. 2013; Sutin, Terracciano et al. 2013; Sveen, Berg-Nielsen et al. 2013; Vittengl, Clark et al. 2013; Whiteford, Degenhardt et al. 2013; Whiteford, Harris et al. 2013)

Arnow, B. A., D. Steidtmann, et al. (2013). ***"The relationship between the therapeutic alliance and treatment outcome in two distinct psychotherapies for chronic depression."*** J Consult Clin Psychol 81(4): 627-638. http://www.ncbi.nlm.nih.gov/pubmed/23339536

OBJECTIVE: This study tested whether the quality of the patient-rated working alliance, measured early in treatment, predicted subsequent symptom reduction in chronically depressed patients. Secondarily, the study assessed whether the relationship between early alliance and response to treatment differed between patients receiving cognitive behavioral analysis system of psychotherapy (CBASP) vs. brief supportive psychotherapy (BSP). METHOD: 395 adults (57% female; Mage = 46; 91% Caucasian) who met criteria for chronic depression and did not fully remit during a 12-week algorithm-based, open-label pharmacotherapy trial were randomized to receive either 16-20 sessions of CBASP or BSP in addition to continued, algorithm-based antidepressant medication. Of these, 224 patients completed the Working Alliance Inventory-Short Form at Weeks 2 or 4 of treatment. Blind raters assessed depressive symptoms at 2-week intervals across treatment using the Hamilton Rating Scale for Depression. Linear mixed models tested the association between early alliance and subsequent symptom ratings while accounting for early symptom change. RESULTS: A more positive early working alliance was associated with lower subsequent symptom ratings in both the CBASP and BSP, $F(1, 1236) = 62.48$, $p < .001$. In addition, the interaction between alliance and psychotherapy type was significant, such that alliance quality was more strongly associated with symptom ratings among those in the CBASP treatment group, $F(1, 1234) = 8.31$, $p = .004$. CONCLUSIONS: The results support the role of the therapeutic alliance as a predictor of outcome across dissimilar treatments for chronic depression. Contrary to expectations, the therapeutic alliance was more strongly related to outcome in CBASP, the more directive of the 2 therapies.

Bell, E. C., D. K. Marcus, et al. (2013). ***"Are the parts as good as the whole? A meta-analysis of component treatment studies."*** J Consult Clin Psychol 81(4): 722-736. http://www.ncbi.nlm.nih.gov/pubmed/23688145

OBJECTIVE: Component studies compare standard treatments to treatments with added components or dismantled components. A previous meta-analysis (Ahn & Wampold, 2001) failed to find any differences in outcome between treatments with more components and those with fewer components, leading the authors to conclude that common factors and not specific ingredients account for therapeutic change. METHOD: The current random effects model meta-analysis of psychotherapy component studies conducted between 1980 and 2010 included more than 3 times as many studies as Ahn and Wampold's (2001) meta-analysis ($k = 66$). Unlike the previous meta-analysis, this study conducted separate meta-analyses for additive and dismantling studies and also examined treatment outcomes at follow-up. RESULTS: For the dismantling studies, there were no significant differences between the full treatments and the dismantled treatments. For the additive studies, the treatment with the added component yielded a small, but significant, effect at completion ($d = 0.14$) and a slightly larger effect at follow-up ($d = 0.28$), but only for the specific problems that were targeted for treatment. Despite the diversity of populations studied, problems treated, and treatments examined, there was little heterogeneity among the results of these studies. CONCLUSION: These findings suggest that added specific ingredients may contribute modestly to treatment outcomes.

Benros, M. E., B. L. Waltoft, et al. (2013). ***"Autoimmune diseases and severe infections as risk factors for mood disorders: A nationwide study."*** JAMA Psychiatry 70(8): 812-820. http://dx.doi.org/10.1001/jamapsychiatry.2013.1111

Importance Mood disorders frequently co-occur with medical diseases that involve inflammatory pathophysiologic mechanisms. Immune responses can affect the brain and might increase the risk of mood disorders, but longitudinal studies of comorbidity are lacking. Objective To estimate the effect of autoimmune diseases and infections on the risk of developing mood disorders. Design Nationwide, population-based, prospective cohort study with 78 million person-years of follow-up. Data were analyzed with survival analysis techniques and adjusted for calendar year, age, and sex.Setting Individual data drawn from Danish longitudinal registers.Participants A total of 3.56 million people born between 1945 and 1996 were followed up from January 1, 1977, through December 31, 2010, with 91 637 people having hospital contacts for mood disorders. Main Outcomes and Measures The risk of a first lifetime diagnosis of mood disorder assigned by a psychiatrist in a hospital, outpatient clinic, or emergency department setting. Incidence rate ratios (IRRs) and accompanying 95% CIs are used as measures of relative risk. Results A prior hospital contact because of autoimmune disease increased the risk of a subsequent mood disorder diagnosis by 45% (IRR, 1.45; 95% CI, 1.39-1.52). Any history of hospitalization for infection increased the risk of later mood disorders by 62% (IRR, 1.62; 95% CI, 1.60-1.64). The 2 risk factors interacted in synergy and increased the risk of subsequent mood disorders even further (IRR, 2.35; 95% CI, 2.25-2.46). The number of infections and autoimmune diseases increased the risk of mood disorders in a dose-response relationship. Approximately one-third (32%) of the participants diagnosed as having a mood disorder had a previous hospital contact because of an infection, whereas 5% had a previous hospital contact because of an autoimmune disease. Conclusions and Relevance Autoimmune diseases and infections are risk factors for subsequent mood disorder diagnosis. These associations seem compatible with an immunologic hypothesis for the development of mood disorders in subgroups of patients.

Bryant, R. A., M. L. O'Donnell, et al. (2013). ***"A multisite analysis of the fluctuating course of posttraumatic stress disorder."*** JAMA Psychiatry 70(8): 839-846. http://dx.doi.org/10.1001/jamapsychiatry.2013.1137

Importance Delayed-onset posttraumatic stress disorder (PTSD) accounts for approximately 25% of PTSD cases. Current models do not adequately explain the delayed increases in PTSD symptoms after trauma exposure. Objective To test the roles of initial psychiatric reactions, mild traumatic brain injury (MTBI), and ongoing stressors on delayed-onset PTSD. Design, Setting, and Participants In this prospective cohort study, patients were selected from recent admissions to 4 major trauma hospitals across Australia. A total of 1084 traumatically injured patients were assessed during hospital admission from April 1, 2004, through February 28, 2006, and 785 (72.4%) were followed up at 3, 12, and 24 months after injury. Main Outcome and Measure Severity of PTSD was determined at each assessment with the Clinician-Administered PTSD Scale. Results Of those who met PTSD criteria at 24 months, 44.1% reported no PTSD at 3 months and 55.9% had subsyndromal or full PTSD. In those who displayed subsyndromal or full PTSD at 3 months, PTSD severity at 24 months was predicted by prior psychiatric disorder, initial PTSD symptom severity, and type of injury. In those who displayed no PTSD at 3 months, PTSD

severity at 24 months was predicted by initial PTSD symptom severity, MTBI, length of hospitalization, and the number of stressful events experienced between 3 and 24 months. Conclusions and Relevance These data highlight the complex trajectories of PTSD symptoms over time. This study also points to the roles of ongoing stress and MTBI in delayed cases of PTSD and suggests the potential of ongoing stress to compound initial stress reactions and lead to a delayed increase in PTSD symptom severity. This study also provides initial evidence that MTBI increases the risk of delayed PTSD symptoms, particularly in those with no acute symptoms.

Craske, M. (2013). ***New ways to optimise exposure therapy for anxiety disorders***. BABCP 41st Annual Conference. Imperial College, London.

This presentation will address the augmentation of emotion regulation during exposure therapy for anxiety disorders, using strategies that target the function rather than the content of cognition. Affect labelling, a simple process that involves linguistic processing of emotional responses, activates neural regions that serve to down-regulate the amygdala. Affect labelling is a form of inhibitory regulation of emotion. Individual with anxiety disorders show deficits in such inhibitory regulation. Thus, in training affect labelling may be particularly beneficial as individuals with anxiety disorders undergo exposure to fear producing stimuli. In clinical translation of this work, we have demonstrated the value of affect labelling as compared to cognitive reappraisal during exposure to phobic stimuli. This presentation will cover the basic science of affect labelling and the clinical translation to exposure therapy, in terms of outcomes and mechanisms. Further, the overlap between affect labelling and acceptance-based approaches, and out latest findings regarding acceptance based approaches to exposure therapy, will be presented.

Cuijpers, P., M. Huibers, et al. (2013). ***"How much psychotherapy is needed to treat depression? A metaregression analysis."*** J Affect Disord 149(1-3): 1-13. http://www.ncbi.nlm.nih.gov/pubmed/23528438

BACKGROUND: Although psychotherapies are effective in the treatment of adult depression it is not clear how this treatment effect is related to amount, frequency and intensity of therapy. METHODS: To fill this gap in knowledge, the present metaregression analysis examined the association between the effects of psychotherapy for adult depression and several indicators of amount, frequency and intensity of therapy. The analysis included 70 studies (92 comparisons) with 5403 patients, in which individual psychotherapy was compared with a control group (e.g. waiting list, care-as-usual). RESULTS: There was only a small association between number of therapy sessions and effect size, and this association was no longer significant when the analysis adjusted for other characteristics of the studies. The multivariable analyses also found no significant association with the total contact time or duration of the therapy. However, there was a strong association between number of sessions per week and effect size. An increase from one to two sessions per week increased the effect size with g=0.45, while keeping the total number of treatment sessions constant. DISCUSSION: More research is needed to establish the robustness of this finding. Based on these findings, it may be advisable to concentrate psychotherapy sessions within a brief time frame.

Cuijpers, P., M. Sijbrandij, et al. (2013). ***"The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: A meta-analysis of direct comparisons."*** World Psychiatry 12(2): 137-148. http://www.ncbi.nlm.nih.gov/pubmed/23737423

Although psychotherapy and antidepressant medication are efficacious in the treatment of depressive and anxiety disorders, it is not known whether they are equally efficacious for all types of disorders, and whether all types of psychotherapy and antidepressants are equally efficacious for each disorder. We conducted a meta-analysis of studies in which psychotherapy and antidepressant medication were directly compared in the treatment of depressive and anxiety disorders. Systematic searches in bibliographical databases resulted in 67 randomized trials, including 5,993 patients that met inclusion criteria, 40 studies focusing on depressive disorders and 27 focusing on anxiety disorders. The overall effect size indicating the difference between psychotherapy and pharmacotherapy after treatment in all disorders was g=0.02 (95% CI: -0.07 to 0.10), which was not statistically significant. Pharmacotherapy was significantly more efficacious than psychotherapy in dysthymia (g=0.30), and psychotherapy was significantly more efficacious than pharmacotherapy in obsessive-compulsive disorder (g=0.64). Furthermore, pharmacotherapy was significantly more efficacious than non-directive counseling (g=0.33), and psychotherapy was significantly more efficacious than pharmacotherapy with tricyclic antidepressants (g=0.21). These results remained significant when we controlled for other characteristics of the studies in multivariate meta-regression analysis, except for the differential effects in dysthymia, which were no longer statistically significant.

Drake, G., E. Csipke, et al. (2013). ***"Assessing your mood online: Acceptability and use of moodscope."*** Psychological Medicine 43(07): 1455-1464. http://dx.doi.org/10.1017/S0033291712002280

Background Moodscope is an entirely service-user-developed online mood-tracking and feedback tool with built-in social support, designed to stabilize and improve mood. Many free internet tools are available with no assessment of acceptability, validity or usefulness. This study provides an exemplar for future assessments. Method A mixed-methods approach was used. Participants with mild to moderate low mood used the tool for 3 months. Correlations between weekly assessments using the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Assessment (GAD-7) with daily Moodscope scores were examined to provide validity data. After 3 months, focus groups and questionnaires assessed use and usability of the tool. Results Moodscope scores were correlated significantly with scores on the PHQ-9 and the GAD-7 for all weeks, suggesting a valid measure of mood. Low rates of use, particularly toward the end of the trial, demonstrate potential problems relating to ongoing motivation. Questionnaire data indicated that the tool was easy to learn and use, but there were concerns about the mood adjectives, site layout and the buddy system. Participants in the focus groups found the tool acceptable overall, but felt clarification of the role and target group was required. Conclusions With appropriate adjustments, Moodscope could be a useful tool for clinicians as a way of initially identifying patterns and influences on mood in individuals experiencing low mood. For those who benefit from ongoing mood tracking and the social support provided by the buddy system, Moodscope could be an ongoing adjunct to therapy.

Glenn, D., D. Golinelli, et al. (2013). ***"Who gets the most out of cognitive behavioral therapy for anxiety disorders? The role of treatment dose and patient engagement."*** J Consult Clin Psychol 81(4): 639-649. http://www.ncbi.nlm.nih.gov/pubmed/23750465

OBJECTIVE: The present study explored treatment dose and patient engagement as predictors of treatment outcome in cognitive behavioral therapy (CBT) for anxiety disorders. METHOD: Measures of high versus low treatment dose and high versus low patient engagement in CBT were compared as predictors of 12- and 18-month outcomes for patients being treated for anxiety disorders with CBT (with or without concurrent pharmacotherapy) in primary care settings as part of a randomized controlled effectiveness trial of the Coordinated Anxiety Learning and Management (CALM) intervention. Measures of dose (attendance, exposure completion) and engagement in CBT (homework adherence, commitment) were collected throughout treatment, and blinded follow-up phone assessments of outcome measures (12-item Brief Symptom Inventory, Patient Health Questionnaire 8, Sheehan Disability Scale) were completed at 12 and 18 months. Propensity score weighting controlled for

baseline differences in demographics and symptom severity between patients with high and low dose and engagement. These analyses included the 439 patients who selected CBT as treatment modality. RESULTS: Completing exposures, having high attendance, and being more adherent to completing homework predicted better outcomes across all measures at 12 and 18 months, and high CBT commitment predicted better outcomes on all measures at 18 months. CONCLUSIONS: This study found that higher treatment dose and patient engagement in CBT for anxiety disorders were stable and robust predictors of greater reductions in anxiety symptoms, depression symptoms, and functional disability.

Heins, M. J., H. Knoop, et al. (2013). ***"The role of the therapeutic relationship in cognitive behaviour therapy for chronic fatigue syndrome."*** Behaviour Research and Therapy 51(7): 368-376. http://www.sciencedirect.com/science/article/pii/S0005796713000338

Cognitive behaviour therapy (CBT) for chronic fatigue syndrome (CFS) can reduce fatigue and impairment. Recently, it was found that changes in fatigue-perpetuating factors, i.e. focusing on symptoms, control over fatigue, perceived activity and physical functioning, are associated with and explain up to half of the variance in fatigue during CBT for CFS. The therapy relationship, e.g. outcome expectations and working alliance, may also contribute to treatment outcome. We aimed to examine the role of the therapy relationship in CBT and determine whether it exerts its effect independently of changes in fatigue-perpetuating factors. We used a cohort of 217 CFS patients in which the pattern of change in fatigue-perpetuating factors was examined previously. Fatigue, therapy relationship and fatigue-perpetuating factors were measured at the start of therapy, three times during CBT and at the end of therapy. Baseline outcome expectations and agreement about the content of therapy predicted post therapy fatigue. A large part of the variance in post-treatment fatigue (25%) was jointly explained by outcome expectations, working alliance and changes in fatigue-perpetuating factors. From this, we conclude that positive outcome expectations and task agreement seem to facilitate changes in fatigue-perpetuating factors during CBT for CFS. It is therefore important to establish a positive therapy relationship early in therapy.

Kaplan, K. A. and A. G. Harvey (2013). ***"Behavioral treatment of insomnia in bipolar disorder."*** Am J Psychiatry 170(7): 716-720. http://ajp.psychiatryonline.org/article.aspx?articleid=1700614

Sleep disturbance is common in bipolar disorder. Stimulus control and sleep restriction are powerful, clinically useful behavioral interventions for insomnia, typically delivered as part of cognitive-behavioral therapy for insomnia (CBT-I). Both involve short-term sleep deprivation. The potential for manic or hypomanic symptoms to emerge after sleep deprivation in bipolar disorder raises questions about the appropriateness of these methods for treating insomnia. In a series of patients with bipolar disorder who underwent behavioral treatment for insomnia, the authors found that regularizing bedtimes and rise times was often sufficient to bring about improvements in sleep. Two patients in a total group of 15 patients reported mild increases in hypomanic symptoms the week following instruction on stimulus control. Total sleep time did not change for these individuals. Two of five patients who underwent sleep restriction reported mild hypomania that was unrelated to weekly sleep duration. Sleep restriction and stimulus control appear to be safe and efficacious procedures for treating insomnia in patients with bipolar disorder. Practitioners should encourage regularity in bedtimes and rise times as a first step in treatment, and carefully monitor changes in mood and daytime sleepiness throughout the intervention.

Kleiman, S. and N. O. Rule (2013). ***"Detecting suicidality from facial appearance."*** Social psychological and personality science 4(4): 453-460. http://spp.sagepub.com/content/4/4/453.abstract

Suicide is a pervasive problem worldwide. In this investigation, we show that individuals can perceive suicidality from facial appearance with accuracy that is significantly greater than chance guessing. Inferences of expected or obvious cues, such as how depressed a person seems, did not lead to accurate judgments. Rather, perceptions of how impulsive an individual appears differentiated suicide victims from living controls. Teasing apart various forms of impulsivity revealed that perceptions of impulsive aggression, distinct from other forms of impulsive behavior (e.g., impulsive buying), distinguished suicide victims from controls. Finally, experienced mental health clinicians did not perform significantly better than laypersons at judging suicidality. Facial appearance may therefore hold cues to suicidality, expanding what is known about the expression and perception of social cues from the face and providing new insights into the relationship between mental health and nonverbal cues.

Kossowsky, J., M. C. Pfaltz, et al. (2013). ***"The separation anxiety hypothesis of panic disorder revisited: A meta-analysis."*** Am J Psychiatry 170(7): 768-781. http://www.ncbi.nlm.nih.gov/pubmed/23680783

OBJECTIVE Evidence suggests that childhood separation anxiety disorder may be associated with a heightened risk for the development of other disorders in adulthood. The authors conducted a meta-analysis to examine the relationship between childhood separation anxiety disorder and future psychopathology. METHOD PubMed, PsycINFO, and Embase were searched for studies published through December 2011. Case-control, prospective, and retrospective cohort studies comparing children with and without separation anxiety disorder with regard to future panic disorder, major depressive disorder, any anxiety disorder, and substance use disorders were included in the analysis. Effects were summarized as pooled odds ratios in a random-effects model. RESULTS Twenty-five studies met all inclusion criteria (14,855 participants). A meta-analysis of 20 studies indicated that children with separation anxiety disorder were more likely to develop panic disorder later on (odds ratio=3.45; 95% CI=2.37-5.03). Five studies suggested that a childhood diagnosis of separation anxiety disorder increases the risk of future anxiety (odds ratio=2.19; 95% CI=1.40-3.42). After adjusting for publication bias, the results of 14 studies indicated that childhood separation anxiety disorder does not increase the risk of future depression (odds ratio=1.06; 95% CI=0.78-1.45). Five studies indicated that childhood separation anxiety disorder does not increase the risk of substance use disorders (odds ratio=1.27; 95% CI=0.80-2.03). Of the subgroup analyses performed, differences in comparison groups and sample type significantly affected odds ratio sizes. CONCLUSIONS A childhood diagnosis of separation anxiety disorder significantly increases the risk of panic disorder and any anxiety disorder. These results support a developmental psychopathology conceptualization of anxiety disorders.

Kross, E., P. Verduyn, et al. (2013). ***"Facebook use predicts declines in subjective well-being in young adults."*** PLoS One 8(8): e69841. http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0069841

(Freely available in full text) Over 500 million people interact daily with Facebook. Yet, whether Facebook use influences subjective well-being over time is unknown. We addressed this issue using experience-sampling, the most reliable method for measuring in-vivo behavior and psychological experience. We text-messaged people five times per day for two-weeks to examine how Facebook use influences the two components of subjective well-being: how people feel moment-to-moment and how satisfied they are with their lives. Our results indicate that Facebook use predicts negative shifts on both of these variables over time. The more people used Facebook at one time point, the worse they felt the next time we text-messaged them; the more they used Facebook over two-weeks, the more their life satisfaction levels declined over time. Interacting with other people "directly" did not predict these negative outcomes. They were also not moderated by the size of people's Facebook networks, their perceived supportiveness, motivation for using Facebook, gender, loneliness, self-esteem, or

depression. On the surface, Facebook provides an invaluable resource for fulfilling the basic human need for social connection. Rather than enhancing well-being, however, these findings suggest that Facebook may undermine it.

Leichsenring, F., S. Salzer, et al. (2013). ***"Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicenter randomized controlled trial."*** Am J Psychiatry 170(7): 759-767. http://www.ncbi.nlm.nih.gov/pubmed/23680854

OBJECTIVE Various approaches to cognitive-behavioral therapy (CBT) have been shown to be effective for social anxiety disorder. For psychodynamic therapy, evidence for efficacy in this disorder is scant. The authors tested the efficacy of psychodynamic therapy and CBT in social anxiety disorder in a multicenter randomized controlled trial. METHOD In an outpatient setting, 495 patients with social anxiety disorder were randomly assigned to manual-guided CBT (N=209), manual-guided psychodynamic therapy (N=207), or a waiting list condition (N=79). Assessments were made at baseline and at end of treatment. Primary outcome measures were rates of remission and response, based on the Liebowitz Social Anxiety Scale applied by raters blind to group assignment. Several secondary measures were assessed as well. RESULTS Remission rates in the CBT, psychodynamic therapy, and waiting list groups were 36%, 26%, and 9%, respectively. Response rates were 60%, 52%, and 15%, respectively. CBT and psychodynamic therapy were significantly superior to waiting list for both remission and response. CBT was significantly superior to psychodynamic therapy for remission but not for response. Between-group effect sizes for remission and response were small. Secondary outcome measures showed significant differences in favor of CBT for measures of social phobia and interpersonal problems, but not for depression. CONCLUSIONS CBT and psychodynamic therapy were both efficacious in treating social anxiety disorder, but there were significant differences in favor of CBT. For CBT, the response rate was comparable to rates reported in Swedish and German studies in recent years. For psychodynamic therapy, the response rate was comparable to rates reported for pharmacotherapy and cognitive-behavioral group therapy.

Limb, M. (2013). ***"Free online professional counselling service for children and teenagers with mental health problems is launched."*** BMJ 347. http://www.bmj.com/content/347/bmj.f4420

A new UK charity has launched an initiative to help children and teenagers with mental health problems, warning that "appalling" service cutbacks are depriving them of adequate support. MindFull said that 11-17 year olds would be able to receive free online professional counselling, self help advice, and support in schools from trained peer mentors. It said that an estimated 850 000 young people had a diagnosable mental health problem, equal to three children in every classroom, but almost 75% received no treatment. One in five children, MindFull said, had had symptoms of depression, and almost a third of all children (32%) had thought about or attempted suicide before they were 16. The new programme, which is part of the Beat Bullying (BB) group of charities, is designed to help young people at an early stage to talk about their concerns, including many who may not have had any contact with mental health or wellbeing services before. For more information, see www.mindfull.org

Moradveisi, L., M. J. H. Huibers, et al. (2013). ***"The influence of comorbid personality disorder on the effects of behavioural activation vs. antidepressant medication for major depressive disorder: Results from a randomized trial in iran."*** Behaviour Research and Therapy 51(8): 499-506. http://www.sciencedirect.com/science/article/pii/S0005796713000946

There is a disagreement about the impact of personality disorder (PD) on treatment outcome for patients with major depressive disorder (MDD). 100 out-patients with MDD were randomized to 16 sessions of behavioural activation (BA) (n = 50) or antidepressant medication (ADM) (n = 50) in Iran. Main outcome was depression severity, measured with the Beck Depression Inventory (BDI-II) and the Hamilton Rating Scale for Depression (HRSD), and assessed at 0, 4, 13 and 49 weeks. Participants with comorbid PDs had higher scores on BDI and HRSD at baseline and throughout the study than participants without comorbid PD. Patients with and without comorbid personality pathology responded equally to treatment on the short- and the long-term. Overall, BA was better in reducing symptoms in patients but this effect was not influenced by comorbid PD. Similar effects were found for a dimensional PD-measure. Only cluster-C PD-traits turned out to be associated with overall depression severity. Cluster-A PD-traits predicted poorer long-term treatment response to ADM and BA, but only on the BDI, not on the HRSD. No effects of cluster-B PD-traits were found. However, PD was associated with higher dropout. The general conclusion is that comorbid PD pathology, especially from cluster-C, is associated with higher depression severity, but not with less response to treatment. Comorbid PD did predict increased chance of dropout.

Morriss, R., N. Kapur, et al. (2013). ***"Assessing risk of suicide or self harm in adults."*** BMJ 347. http://www.bmj.com/content/347/bmj.f4572

*This review discusses how general practitioners and non-psychiatric specialists can assess suicide risk and self harm.* A middle aged man presents to his general practitioner having just lost his job. He seems to be low in mood and asks for something to help him to "pick myself up." He is reluctant to talk. Meanwhile, a teenage girl presents to the local emergency department having made a third drug overdose in the past two months. In both situations the attending doctor wants to know what factors would suggest that the person was more likely or less likely to be at risk of suicide or repeat self harm. The clinical problem: Suicide is one of the top three causes of death in people aged 10-44 years throughout the world. In the UK, suicide rates fell from a peak in the 1980s in men and women, but they have started to rise again in the past few years (11.8 per 100 000 in 2011) (www.ons.gov.uk/ons/dcp171778_295718.pdf), with the highest rates in men aged 30-59 years. Self harm is defined here as any act of self poisoning or self injury irrespective of motivation1 but generally excludes habitual behaviours such as hair pulling and the consequences of excessive consumption of alcohol or drugs. Self harm is one of the five leading causes of hospital admission2 and is associated with a significantly increased risk of subsequent death, much of it by suicide. Methods: Data on the assessment of suicide risk and self harm have been compiled primarily from recent systematic reviews of risk factors for guidelines developed by the National Institute for Health and Care Excellence (NICE),4 a review of 15 years of findings from the UK National Confidential Inquiry into Suicide,5 a systematic review of risk factors for suicide in people with depression,6 and a Medline search on risk factors for suicide in non-depressed groups and for repetition of self harm (updating the NICE review). These data have limitations—for example, many of the risk factors in the general population are common in clinical patients (such as unemployment, living alone, alcohol misuse). This article will concentrate on the general clinical assessment of suicide and self harm. How to assess suicide risk: NICE recommended that none of the current simple risk measurement tools or checklists should be used in isolation to determine treatment decisions (because of their poor predictive ability), and a comprehensive clinical interview should be the main basis of assessment.4 We suggest that assessments by non-specialists could follow a structured pattern as described below, paying attention to risk factors but more importantly creating a coherent narrative summary of the risk that informs further action or referral. Who to assess: The non-mental health specialist should ask about suicide and self harm in people with established risk factors such as any history of mental disorder or self harm and those with current heightened emotional distress, depressive symptoms, unpredictable behaviour (especially if it is impulsive and associated with irritability or violence8), or an unstable social situation. Sometimes significant suicide risk can be ruled out quickly, or the need for specialist involvement is immediately obvious, but otherwise the clinician should carry out a

more thorough clinical assessment to formulate a plan.9 When accurate information cannot be obtained from the patient directly, information from others can be sought, but clinicians should be mindful of confidentiality.4 Situations may arise where patients are reluctant to engage in assessments, but their level of risk remains unclear. Specialist advice is needed when this occurs.

Ost, L. G. (2013). ***One-session treatment, ACT, and implementation of research findings in clinical practice***. BABCP 41st Annual Conference. Imperial College, London.

One-session treatment (OST) has become the treatment-of-choice for specific phobias. OST will be described together with a meta-analysis of 30 efficacy studies. Acceptance and Commitment Therapy (ACT) is part of the so called Third wave of Behaviour Therapy and the keynote presents an updated meta-analysis of 50 RCTs showing an overall effect size of 0.53. When applying the criteria of the APA Task Force (1995, 1998) for evidence-based treatment ACT was not well-established for any psychiatric or somatic disorder. It was probably efficacious for OCD, Mixed anxiety, Pain, and Tinnitus. Finally, the keynote reviews effectiveness research of CBT for both children/adolescents and adults. A total of 243 studies show that CBT in clinical routine care yields approximately the same within-group effect sizes as efficacy studies for all adult disorders and all but one disorder for children. In conduct disorder effectiveness studies actually yielded significantly higher effect size than efficacy studies. The conclusion is that CBT works in clinical settings.

Pietrzak, R. H., J. Kinley, et al. (2013). ***"Subsyndromal depression in the United States: Prevalence, course, and risk for incident psychiatric outcomes."*** Psychological Medicine 43(07): 1401-1414. http://dx.doi.org/10.1017/S0033291712002309

Background Subsyndromal depression (SD) may increase risk for incident major depressive and other disorders, as well as suicidality. However, little is known about the prevalence, course, and correlates of SD in the US general adult population. Method Structured diagnostic interviews were conducted to assess DSM-IV Axis I and II disorders in a nationally representative sample of 34 653 US adults who were interviewed at two time-points 3 years apart. Results A total of 11.6% of US adults met study criteria for lifetime SD at Wave 1. The majority (9.3%) had <5 total symptoms required for a diagnosis of major depression; the remainder (2.3%) reported ≥5 symptoms required for a diagnosis of major depression, but denied clinically significant distress or functional impairment. SD at Wave 1 was associated with increased likelihood of developing incident major depression [odds ratios (ORs) 1.72–2.05], as well as dysthymia, social phobia, and generalized anxiety disorder (GAD) at Wave 2 (ORs 1.41–2.92). Among respondents with SD at Wave 1, Cluster A and B personality disorders, and worse mental health status were associated with increased likelihood of developing incident major depression at Wave 2. Conclusions SD is prevalent in the US population, and associated with elevated rates of Axis I and II psychopathology, increased psychosocial disability, and risk for incident major depression, dysthymia, social phobia, and GAD. These results underscore the importance of a dimensional conceptualization of depressive symptoms, as SD may serve as an early prognostic indicator of incident major depression and related disorders, and could help identify individuals who may benefit from preventive interventions.

Pineda, J. and M. R. Dadds (2013). ***"Family intervention for adolescents with suicidal behavior: A randomized controlled trial and mediation analysis."*** Journal of the American Academy of Child & Adolescent Psychiatry 52(8): 851-862. http://www.sciencedirect.com/science/article/pii/S0890856713003420

Objective Family processes are a risk factor for suicide but few studies target this domain. We evaluated the effectiveness of a family intervention, the Resourceful Adolescent Parent Program (RAP-P) in reducing adolescent suicidal behavior and associated psychiatric symptoms. Method A preliminary randomized controlled trial compared RAP-P plus Routine Care (RC) to RC only, in an outpatient psychiatric clinic for N = 48 suicidal adolescents and their parents. Key outcome measures of adolescent suicidality, psychiatric disability, and family functioning were completed at pre-treatment, 3-month, and 6-month follow-up. Results RAP-P was associated with high recruitment and retention, greater improvement in family functioning, and greater reductions in adolescents' suicidal behavior and psychiatric disability, compared to RC alone. Benefits were maintained at follow-up with a strong overall effect size. Changes in adolescent's suicidality were largely mediated by changes in family functioning. Conclusion The study provides preliminary evidence for the use of family-focused treatments for adolescent suicidal behavior in outpatient settings. Clinical trial registration information–Family intervention for adolescents with suicidal behaviour: A randomized controlled trial and mediation analysis; http://anzctr.org/; ACTRN12613000668707.

Sasso, K. E. and D. R. Strunk (2013). ***"Thin slice ratings of client characteristics in intake assessments: Predicting symptom change and dropout in cognitive therapy for depression."*** Behaviour Research and Therapy 51(8): 443-450. http://www.sciencedirect.com/science/article/pii/S0005796713000740

Thin slice ratings of personality have been shown to predict a number of outcomes, but have yet to be examined in the context of psychotherapy. In a sample of 66 clients participating in cognitive therapy for depression, we examined the predictive utility of thin slice rated pre-treatment client traits. On the basis of short video clip excerpts (i.e., thin slices) of intake assessments, trained observers rated clients on personality characteristics and specific personality disorder (PD) traits. Clients' therapy interest and neuroticism predicted lower odds of dropout. Ratings of extraversion predicted greater symptom change across treatment; ratings of clients' Avoidant and Schizoid PD traits predicted less marked symptom improvement. Ratings of agreeableness and likeability also predicted greater symptom change, but these relations were only significant in one of two analytic approaches used. Evidence for the predictive validity of thin slice ratings was generally stronger than that observed for self-reported PD traits and PD status. Moreover, these self-report and diagnostic assessments failed to account for the thin slice-outcome relations identified. Findings support the clinical utility of quick, thin slice impressions of clients, as these ratings could be used to identify clients with a high risk of dropout or poor treatment outcome.

Seery, M. D., R. J. Leo, et al. (2013). ***"An upside to adversity?: Moderate cumulative lifetime adversity is associated with resilient responses in the face of controlled stressors."*** Psychological Science 24(7): 1181-1189. http://pss.sagepub.com/content/24/7/1181.abstract

Despite common findings suggesting that lack of negative life events should be optimal, recent work has revealed a curvilinear pattern, such that some cumulative lifetime adversity is instead associated with optimal well-being. This work, however, is limited in that responses to specific stressors as they occurred were not assessed, thereby precluding investigation of resilience. The current research addressed this critical gap by directly testing the relationship between adversity history and resilience to stressors. Specifically, we used a multimethod approach across two studies to assess responses to controlled laboratory stressors (respectively requiring passive endurance and active instrumental performance). Results revealed hypothesized U-shaped relationships: Relative to a history of either no adversity or nonextreme high adversity, a moderate number of adverse life events was associated with less negative responses to pain and more positive psychophysiological responses while taking a test. These results provide novel evidence in support of adversity-derived propensity for resilience that generalizes across stressors.

Spijker, J., A. van Straten, et al. (2013). ***"Psychotherapy, antidepressants, and their combination for chronic major depressive disorder: A systematic review."*** Can J Psychiatry 58(7): 386-392. http://www.ncbi.nlm.nih.gov/pubmed/23870720

OBJECTIVE: Recommendations for treatment of chronic major depressive disorder (cMDD) are mostly based on clinical experiences and on the literature on treatment-resistant depression (TRD) but not on a systematic review of the literature. METHOD: We conducted a systematic review of 10 randomized controlled trials (RCTs), with 17 comparisons between antidepressants (ADs), psychotherapy, or the combination of both interventions. RESULTS: The best evidence is for the combination of psychotherapy and ADs, and especially for the combination of the cognitive behavourial analysis system of psychotherapy and ADs. Evidence is very weak for both ADs alone and psychotherapy alone. Assessment of TRD was mostly absent in the studies. CONCLUSION: The best treatment for cMDD is a combination of psychotherapy and ADs. However, there is a lack of well-performed RCTs in both ADs and psychotherapy and their combination for cMDD. Therefore, the conclusions are preliminary.

Stringaris, A., B. Maughan, et al. (2013). ***"Irritable mood as a symptom of depression in youth: Prevalence, developmental, and clinical correlates in the Great Smoky Mountains study."*** Journal of the American Academy of Child & Adolescent Psychiatry 52(8): 831-840. http://www.sciencedirect.com/science/article/pii/S0890856713003444

(Available in free full text) Objective DSM-IV grants episodic irritability an equal status to low mood as a cardinal criterion for the diagnosis of depression in youth, yet not in adults; however, evidence for irritability as a major criterion of depression in youth is lacking. This article examines the prevalence, developmental characteristics, associations with psychopathology, and longitudinal stability of irritable mood in childhood and adolescent depression. Method Data from the prospective population-based Great Smoky Mountains Study (N = 1,420) were used. We divided observations on 9- to 16-year-olds who met criteria for a diagnosis of depression into 3 groups: those with depressed mood and no irritability, those with irritability and no depressed mood, and those with both depressed and irritable mood. We compared these groups using robust regression models on adolescent characteristics and early adult (ages 19–21 years) depression outcomes. Results Depressed mood was the most common cardinal mood in youth meeting criteria for depression (58.7%), followed by the co-occurrence of depressed and irritable mood (35.6%); irritable mood alone was rare (5.7%). Youth with depressed and irritable mood were similar in age and developmental stage to those with depression, but had significantly higher rates of disruptive disorders. The co-occurrence of depressed and irritable mood was associated with higher risk for comorbid conduct disorder in girls (gender-by-group interaction, $F1,132 = 4.66$, $p = .03$). Conclusions Our study findings do not support the use of irritability as a cardinal mood criterion for depression. However, the occurrence of irritability in youth depression is associated with increased risk of disruptive behaviors, especially in girls.

Sutin, A. R., A. Terracciano, et al. (2013). ***"The trajectory of depressive symptoms across the adult life span."*** JAMA Psychiatry 70(8): 803-811. http://dx.doi.org/10.1001/jamapsychiatry.2013.193

Importance Long-term longitudinal studies are needed to delineate the trajectory of depressive symptoms across adulthood and to individuate factors that may contribute to increases in depressive symptoms in older adulthood.Objectives To estimate the trajectory of depressive symptoms across the adult life span; to test whether this trajectory varies by demographic factors (sex, ethnicity, and educational level) and antidepressant medication use; and to test whether disease burden, functional limitations, and proximity to death explain the increase in depressive symptoms in old age. Design Longitudinal study.Setting Community.Participants The study included 2320 participants (47.0% female; mean [SD] age at baseline, 58.1 [17.0] years; range, 19-95 years) from the Baltimore Longitudinal Study of Aging.Main Outcomes and Measures Estimated trajectory of depressive symptoms modeled from 10 982 assessments (mean [SD] assessments per participant, 4.7 [3.6]; range, 1-21) based on the Center for Epidemiologic Studies Depression scale and 3 subscales (depressed affect, somatic complaints, and interpersonal problems). The linear ($\gamma 10 = 0.52$; $P < .01$) and quadratic ($\gamma 20 = 0.43$; $P < .01$) terms were significant. The subscales followed a similar pattern. Women reported more depressed affect at younger ages, but an interaction with age suggested that this gap disappeared in old age. Accounting for comorbidity, functional limitations, and impending death slightly reduced but did not eliminate the uptick in depressive symptoms in old age.Conclusions and Relevance Symptoms of depression follow a U-shaped pattern across adulthood. Older adults experience an increase in distress that is not due solely to declines in physical health or approaching death.

Sveen, T. H., T. S. Berg-Nielsen, et al. (2013). ***"Detecting psychiatric disorders in preschoolers: Screening with the strengths and difficulties questionnaire."*** Journal of the American Academy of Child & Adolescent Psychiatry 52(7): 728-736. http://www.sciencedirect.com/science/article/pii/S0890856713002566

Objective To examine screening efficiency for preschool psychopathology by comparing the Strengths and Difficulties Questionnaire findings against diagnostic information, and to determine the added value of impact scores and teacher information. Method Using a 2-phase sampling design, a population-based sample of 845 children 4 years of age was recruited from community health check-ups in Trondheim, Norway, screen score stratified and oversampled for high screening scores. Blinded to screen ratings, DSM-IV diagnoses were assigned using the Preschool Age Psychiatric Assessment interview, against which the Strengths and Difficulties Questionnaire scores were compared through receiver operating characteristic analysis. Results Emotional and behavioral disorders were identified through parent ratings with a specificity of 88.8% (range, 87.0%–90.6%) and a sensitivity of 65.1% (range, 51.6–78.6%). The negative predictive value was 97.9% (range, 96.8%–98.9%), whereas the positive predictive value was 24.2% (range, 18.0%–30.3%) at a prevalence of 5.2%. Parental ratings identified more behavioral disorders (79.3%) than emotional disorders (59.2%). Screening for any disorder was somewhat less efficient: specificity, 88.9% (range, 87.0%–90.7%); sensitivity, 54.2% (range, 41.8%–66.6%); negative predictive value, 96.4% (range, 95.0%–97.8%); and positive predictive value, 25.9% (range, 19.6%–32.2%) at a prevalence of 6.7%. The area under the curve (AUC) value was 0.83 (range, 0.76–0.90) for emotional and behavioral disorders and 0.76 (range, 0.68–0.83) for any disorder. The prediction accuracy was not improved by impact scores or teacher information. Conclusions The results indicate that preschoolers' emotional and behavioral disorders can be screened with the same efficiency as those of older children and adults. Other disorders were identified to a lesser extent. Further research should explore the potential of preschool screening to improve early detection and subsequent intervention.

Vittengl, J. R., L. A. Clark, et al. (2013). ***"Nomothetic and idiographic symptom change trajectories in acute-phase cognitive therapy for recurrent depression."*** J Consult Clin Psychol 81(4): 615-626. http://www.ncbi.nlm.nih.gov/pubmed/23627652

OBJECTIVE: We tested nomothetic and idiographic convergence and change in 3 symptom measures during acute-phase cognitive therapy (CT) for depression and compared outcomes among patients showing different change patterns. METHOD: Outpatients (N = 362; 69% women; 85% White; age M = 43 years) with recurrent major depressive disorder according to criteria in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; American Psychiatric Association, 2000) completed the Hamilton Rating Scale for Depression (Hamilton, 1960), Beck Depression Inventory (Beck,

Ward, Mendelson, Mock, & Erbaugh, 1961), and Inventory for Depressive Symptomatology-Self-Report (Rush, Gullion, Basco, Jarrett, & Trivedi, 1996) on 14 occasions as well as pre/post-CT measures of social-interpersonal functioning and negative cognitive content. RESULTS: The 3 symptom measures marked the same severity and change constructs, and we offer improved formulas for intermeasure score conversions via their common factor. Pre/post-CT symptom reductions were large (ds = 1.71-1.92), and nomothetic symptom curves were log-linear (larger improvements earlier and smaller improvements later in CT). Nonetheless, only 30% of individual patients showed clear log-linear changes, whereas other patients showed linear (e.g., steady decreases; 20%), 1-step (e.g., a quick drop; 16%), and unclassified (34%) patterns. Log-linear, linear, and 1-step patients were generally similar to one another and superior to unclassified patients post-CT in symptom levels, response and stable remission rates, social-interpersonal functioning, and cognitive content (median d = 0.69). CONCLUSIONS: Reaching a low-symptom "destination" at the end of CT via any coherent "path" is more important in the short term than which path patients take. We discuss implications for theories of change, clinical monitoring of individuals' progress in CT, and the need to investigate long-term outcomes of patients with differing patterns of symptom change.

Whiteford, H. A., L. Degenhardt, et al. (2013). ***"Global burden of disease attributable to mental and substance use disorders: Findings from the global burden of disease study 2010."*** The Lancet(0). http://www.sciencedirect.com/science/article/pii/S0140673613616116

Background We used data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) to estimate the burden of disease attributable to mental and substance use disorders in terms of disability-adjusted life years (DALYs), years of life lost to premature mortality (YLLs), and years lived with disability (YLDs). Methods For each of the 20 mental and substance use disorders included in GBD 2010, we systematically reviewed epidemiological data and used a Bayesian meta-regression tool, DisMod-MR, to model prevalence by age, sex, country, region, and year. We obtained disability weights from representative community surveys and an internet-based survey to calculate YLDs. We calculated premature mortality as YLLs from cause of death estimates for 1980–2010 for 20 age groups, both sexes, and 187 countries. We derived DALYs from the sum of YLDs and YLLs. We adjusted burden estimates for comorbidity and present them with 95% uncertainty intervals. Findings In 2010, mental and substance use disorders accounted for 183·9 million DALYs (95% UI 153·5 million–216·7 million), or 7·4% (6·2–8·6) of all DALYs worldwide. Such disorders accounted for 8·6 million YLLs (6·5 million–12·1 million; 0·5% [0·4–0·7] of all YLLs) and 175·3 million YLDs (144·5 million–207·8 million; 22·9% [18·6–27·2] of all YLDs). Mental and substance use disorders were the leading cause of YLDs worldwide. Depressive disorders accounted for 40·5% (31·7–49·2) of DALYs caused by mental and substance use disorders, with anxiety disorders accounting for 14·6% (11·2–18·4), illicit drug use disorders for 10·9% (8·9–13·2), alcohol use disorders for 9·6% (7·7–11·8), schizophrenia for 7·4% (5·0–9·8), bipolar disorder for 7·0% (4·4–10·3), pervasive developmental disorders for 4·2% (3·2–5·3), childhood behavioural disorders for 3·4% (2·2–4·7), and eating disorders for 1·2% (0·9–1·5). DALYs varied by age and sex, with the highest proportion of total DALYs occurring in people aged 10–29 years. The burden of mental and substance use disorders increased by 37·6% between 1990 and 2010, which for most disorders was driven by population growth and ageing. Interpretation Despite the apparently small contribution of YLLs—with deaths in people with mental disorders coded to the physical cause of death and suicide coded to the category of injuries under self-harm—our findings show the striking and growing challenge that these disorders pose for health systems in developed and developing regions. In view of the magnitude of their contribution, improvement in population health is only possible if countries make the prevention and treatment of mental and substance use disorders a public health priority.

Whiteford, H. A., M. G. Harris, et al. (2013). ***"Estimating remission from untreated major depression: A systematic review and meta-analysis."*** Psychological Medicine 43(08): 1569-1585. http://dx.doi.org/10.1017/S0033291712001717

Background Few studies have examined spontaneous remission from major depression. This study investigated the proportion of prevalent cases of untreated major depression that will remit without treatment in a year, and whether remission rates vary by disorder severity. Method Wait-list controlled trials and observational cohort studies published up to 2010 with data describing remission from untreated depression at > or = 2-year follow-up were identified. Remission was defined as rescinded diagnoses or below threshold scores on standardized symptom measures. Nineteen studies were included in a regression model predicting the probability of 12-month remission from untreated depression, using logit transformed remission proportion as the dependent variable. Covariates included age, gender, study type and diagnostic measure. Results Wait-listed compared to primary-care samples, studies with longer follow-up duration and older adult compared to adult samples were associated with lower probability of remission. Child and adolescent samples were associated with higher probability of remission. Based on adult samples recruited from primary-care settings, the model estimated that 23% of prevalent cases of untreated depression will remit within 3 months, 32% within 6 months and 53% within 12 months. Conclusions It is undesirable to expect 100% treatment coverage for depression, given many will remit before access to services is feasible. Data were drawn from consenting wait-list and primary-care samples, which potentially over-represented mild-to-moderate cases of depression. Considering reported rates of spontaneous remission, a short untreated period seems defensible for this subpopulation, where judged appropriate by the clinician. Conclusions may not apply to individuals with more severe depression.