30 babcp abstracts, september '13

(Abramowitz, Baucom et al. 2013; Abramowitz, Baucom et al. 2013; Batink, Peeters et al. 2013; Bergomi, Tschacher et al. 2013; Boswell, Farchione et al. 2013; Chen, Liu et al. 2013; Churchill, Moore et al. 2013; Crane and Kuyken 2013; Deacon, Kemp et al. 2013; Driessen, Van et al. 2013; Fentz, Hoffart et al. 2013; Gyani, Shafran et al. 2013; Heins, Knoop et al. 2013; Kelleher, Corcoran et al. 2013; Kmietowicz 2013; Krpan, Kross et al. 2013; Lakhan and Schofield 2013; Lucas, O'Reilly et al. 2013; MacPherson, Richmond et al. 2013; Meston, Lorenz et al. 2013; Ottaviani and Couyoumdjian 2013; Pompili, Gonda et al. 2013; Probst, Lambert et al. 2013; Przybylski and Weinstein 2013; Richards, Hill et al. 2013; Roos and Werbart 2013; Sareen, Henriksen et al. 2013; Shinohara, Honyashiki et al. 2013; Thase 2013; Wiltink, Michal et al. 2013)

Abramowitz, J. S., D. H. Baucom, et al. (2013). ***"Treating obsessive-compulsive disorder in intimate relationships: A pilot study of couple-based cognitive-behavior therapy."*** Behavior Therapy 44(3): 395-407. http://www.sciencedirect.com/science/article/pii/S0005789413000129

Although cognitive-behavioral therapy (CBT) involving exposure and response prevention (ERP) is an established treatment for obsessive-compulsive disorder (OCD), not all patients respond optimally, and some show relapse upon discontinuation. Research suggests that for OCD patients in close relationships, targeting relationship dynamics enhances the effects of CBT. In the present study, we developed and pilot tested a 16-session couple-based CBT program for patients with OCD and their romantic partners. This program included (a) partner-assisted ERP, (b) techniques targeting maladaptive relationship patterns focal to OCD (e.g., symptom accommodation), and (c) techniques targeting non OCD-related relationship stressors. OCD, related symptoms, and relationship functioning were assessed at baseline, immediately following treatment (posttest), and at 6- and 12-month follow-up. At posttest, substantial improvements in OCD symptoms, relationship functioning, and depression were observed. Improvements in OCD symptoms were maintained up to 1 year. Results are compared to findings from studies of individual CBT for OCD and discussed in terms of the importance of addressing interpersonal processes that maintain OCD symptoms. [Note, the authors also comment: *"To examine the effectiveness of couple-based CBT relative to individual CBT for OCD, we first benchmarked our results with the meta-analytic findings for individual CBT reported by Eddy et al. (2004). These authors found a mean within-group, pre-post effect size (i.e., the difference between pre and post treatment means divided by the pooled standard deviation) of d = 1.53 across 16 studies. Using Y-BOCS data from the current study and the same effect size formula, we obtained a notably larger effect size of d = 2.68 (SE = .39) ... Moreover, improvement was maintained through 1-year follow-up. In comparison with individual ERP for OCD, the long-term effects of this program were also notable. Indeed, the effect size we obtained was more than one standard deviation larger than the meta-analytic effect size reported by Eddy et al. (2004) for individual CBT (2.68 vs. 1.53)."].*

Abramowitz, J. S., D. H. Baucom, et al. (2013). ***"Enhancing exposure and response prevention for OCD: A couple-based approach."*** Behav Modif 37(2): 189-210. http://bmo.sagepub.com/content/37/2/189.abstract

The effectiveness of individual therapy by exposure and response prevention (ERP) for obsessive–compulsive disorder (OCD) is well established, yet not all patients respond well, and some show relapse on discontinuation. This article begins by providing an overview of the personal and interpersonal experiences of OCD, focusing on interpersonal processes that maintain OCD symptoms and interfere with ERP. The study then describes a couple-based treatment program that the authors have developed to enhance ERP for individuals with OCD who are in long-term relationships. This program involves psychoeducation, partner-assisted exposure therapy, couple-based interventions aimed at changing maladaptive relationship patterns regarding OCD (i.e., symptom accommodation), and general couple therapy. Three case examples are presented to illustrate the couple-based techniques used in this treatment program.

Batink, T., F. Peeters, et al. (2013). ***"How does mbct for depression work? Studying cognitive and affective mediation pathways."*** PLoS ONE 8(8): e72778. http://dx.doi.org/10.1371%2Fjournal.pone.0072778

(Free full text available) Mindfulness based cognitive therapy (MBCT) is a non-pharmacological intervention to reduce current symptoms and to prevent recurrence of major depressive disorder. At present, it is not well understood which underlying mechanisms during MBCT are associated with its efficacy. The current study (n = 130) was designed to examine the roles of mindfulness skills, rumination, worry and affect, and the interplay between those factors, in the mechanisms of change in MBCT for residual depressive symptoms. An exploratory but systematic approach was chosen using Sobel-Goodman mediation analyses to identify mediators on the pathway from MBCT to reduction in depressive symptoms. We replicated earlier findings that therapeutic effects of MBCT are mediated by changes in mindfulness skills and worry. Second, results showed that changes in momentary positive and negative affect significantly mediated the efficacy of MBCT, and also mediated the effect of worry on depressive symptoms. Third, within the group of patients with a prior history of ≤ 2 episodes of MDD, predominantly changes in cognitive and to a lesser extent affective processes mediated the effect of MBCT. However, within the group of patients with a prior history of ≥ 3 episodes of MDD, only changes in affect were significant mediators for the effect of MBCT.

Bergomi, C., W. Tschacher, et al. (2013). ***"The assessment of mindfulness with self-report measures: Existing scales and open issues."*** Mindfulness (N Y) 4(3): 191-202. http://dx.doi.org/10.1007/s12671-012-0110-9

During recent years, mindfulness-based approaches have been gaining relevance for treatment in clinical populations. Correspondingly, the empirical study of mindfulness has steadily grown; thus, the availability of valid measures of the construct is critically important. This paper gives an overview of the current status in the field of self-report assessment of mindfulness. All eight currently available and validated mindfulness scales (for adults) are evaluated, with a particular focus on their virtues and limitations and on differences among them. It will be argued that none of these scales may be a fully adequate measure of mindfulness, as each of them offers unique advantages but also disadvantages. In particular, none of them seems to provide a comprehensive assessment of all aspects of mindfulness in samples from the general population. Moreover, some scales may be particularly indicated in investigations focusing on specific populations such as clinical samples (Cognitive and Affective Mindfulness Scale, Southampton Mindfulness Questionnaire) or meditators (Freiburg Mindfulness Inventory). Three main open issues are discussed: (1) the coverage of aspects of mindfulness in questionnaires; (2) the nature of the relationships between these aspects; and (3) the validity of self-report measures of mindfulness. These issues should be considered in future developments in the self-report assessment of mindfulness.

Boswell, J. F., T. J. Farchione, et al. (2013). ***"Anxiety sensitivity and interoceptive exposure: A transdiagnostic construct and change strategy."*** Behavior Therapy 44(3): 417-431. http://www.sciencedirect.com/science/article/pii/S0005789413000191

Recent findings support the relevance of anxiety sensitivity (AS) and interoceptive exposure (IE) across emotional disorders. This study (a) evaluated levels of AS across different anxiety disorders, (b) examined change in AS over the course of

transdiagnostic psychological intervention, and its relationship with outcome, and (c) described the implementation of IE to address AS with patients with different anxiety disorders. Participants (N = 54) were patients who received treatment with the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) in two consecutive treatment trials. Participants completed a measure of AS at pre- and posttreatment, and multiple occasions during treatment. Symptom severity was assessed at pre- and posttreatment, and clinical information related to physical symptoms and IE were collected as part of routine clinical practice. Elevated AS was observed at pretreatment across diagnoses and decreases in AS were observed from pre- to posttreatment. Similar changes occurred across the diagnostic categories, notably coinciding with the introduction of IE. Change in AS was correlated with reduced symptom levels at posttreatment and 6-month follow-up. Patients with different anxiety disorders endorsed similar physical symptoms and practiced similar IE exercises with similar effects. Results provide preliminary support for the usefulness of IE as a treatment strategy across the spectrum of anxiety disorders, and additional support for the transdiagnostic relevance of AS.

Chen, J., X. Liu, et al. (2013). ***"Behavioural activation: A pilot trial of transdiagnostic treatment for excessive worry."*** Behaviour Research and Therapy 51(9): 533-539. http://www.sciencedirect.com/science/article/pii/S0005796713000983

Transdiagnostic interventions present pragmatic benefits in treatment dissemination and training of mental health professionals when faced with emotional disorders such as anxiety and depression. Excessive worry is a common feature across emotional disorders and represents an ideal candidate target for transdiagnostic intervention. The current pilot trial examined the efficacy of a behavioural activation treatment for worry (BAW) in a community population. 49 individuals experiencing excessive worry were randomised to waitlist or BAW receiving an 8 week group based intervention. Results demonstrated that BAW was successful in reducing excessive worry, depressive symptoms, cognitive avoidance, Intolerance of Uncertainty and improving problem solving orientation. Twice as many individuals showed clinically significant reductions in excessive worry after treatment compared to the waitlist control. Despite limitations to sample size and power, this study presents promising support for BAW as a practical transdiagnostic treatment for worry.

Churchill, R., T. H. Moore, et al. (2013). ***"'Third wave' cognitive and behavioural therapies versus treatment as usual for depression."*** Cochrane Database Syst Rev 10: CD008705. http://www.ncbi.nlm.nih.gov/pubmed/24142810

BACKGROUND: So-called 'third wave' cognitive and behavioural therapies represent a new generation of psychological therapies that are increasingly being used in the treatment of psychological problems. However, the effectiveness and acceptability of third-wave cognitive and behavioural therapy (CBT) approaches as treatment for acute depression remain unclear. OBJECTIVES: 1. To examine the effects of all third wave CBT approaches compared with treatment as usual/waiting list/attention placebo/psychological placebo control conditions for acute depression.2. To examine the effects of different third wave CBT approaches (ACT, compassionate mind training, functional analytic psychotherapy, dialectical behaviour therapy, MBCT, extended behavioural activation and metacognitive therapy) compared with treatment as usual/waiting list/attention placebo/psychological placebo control conditions for acute depression.3. To examine the effects of all third wave CBT approaches compared with different types of comparators (treatment as usual, no treatment, waiting list, attention placebo, psychological placebo) for acute depression. SEARCH METHODS: We searched the Cochrane Depression Anxiety and Neurosis Group Trials Specialised Register (CCDANCTR to 01/01/12), which includes relevant randomised controlled trials from The Cochrane Library (all years), EMBASE, (1974-), MEDLINE (1950-) and PsycINFO (1967-). We also searched CINAHL (May 2010) and PSYNDEX (June 2010) and reference lists of the included studies and relevant reviews for additional published and unpublished studies. An updated search of CCDANCTR restricted to search terms relevant to third wave CBT therapies was conducted in March 2013 (CCDANCTR to 01/02/13). SELECTION CRITERIA: Randomised controlled trials that compared third wave CBT therapies with control conditions for acute depression in adults. DATA COLLECTION AND ANALYSIS: Two review authors independently identified studies, assessed trial quality and extracted data. Study authors were contacted for additional information when required. We rated the quality of evidence using GRADE methods. MAIN RESULTS: Four small studies (224 participants) were included in the review. Little information was provided about the process of allocating participants to groups. None of the studies used independent outcome assessors, and evidence suggested researcher allegiance towards the active treatments. The four studies examined a diversity of third wave CBT approaches (extended behavioural activation, acceptance and commitment therapy and competitive memory training) and control conditions. None of the studies conducted follow-up assessments. The results showed a significant difference in clinical response rates in favour of third wave CBT when compared with treatment as usual (TAU) conditions (three studies, 170 participants, risk ratio (RR) 0.51, 95% confidence interval (CI) 0.27 to 0.95; very low quality). No significant difference in treatment acceptability based on dropout rates was found between third wave CBT approaches and TAU (four studies, 224 participants, RR 1.01, 95% CI 0.08 to 12.30; very low quality). Both analyses showed substantial statistical heterogeneity. AUTHORS' CONCLUSIONS: Very low quality evidence suggests that third wave CBT approaches appear to be more effective than treatment as usual in the treatment of acute depression. The very small number of available studies and the diverse types of interventions and control comparators, together with methodological limitations, limit the ability to draw any conclusions on their effect in the short term or over a longer term. The increasing popularity of third wave CBT approaches in clinical practice underscores the importance of completing further studies of third wave CBT approaches in the treatment of acute depression, on a short- and long-term basis, to provide evidence of their effectiveness to policy-makers, clinicians and users of services.

Crane, R. and W. Kuyken (2013). ***"The implementation of mindfulness-based cognitive therapy: Learning from the UK health service experience."*** Mindfulness (N Y) 4(3): 246-254. http://dx.doi.org/10.1007/s12671-012-0121-6

(Free full text available) Mindfulness-based cognitive therapy (MBCT) is an effective depression prevention programme for people with a history of recurrent depression. In the UK, the National Institute for Clinical Excellence (NICE) has suggested that MBCT is a priority for implementation. This paper explores the exchange, synthesis and application of evidence and guidance on MBCT between the academic settings generating the evidence and delivering practitioner training and the practice settings where implementation takes place. Fifty-seven participants in a workshop on MBCT implementation in the NHS were asked for their experience of facilitators and obstacles to implementation, and a UK-wide online survey of 103 MBCT teachers and stakeholders was conducted. While MBCT is starting to become available in the NHS, this is rarely part of a strategic, coherent or appropriately resourced approach. A series of structural, political cultural, educational, emotional and physical/technological obstacles and facilitators to implementation were identified. Nearly a decade since NICE first recommended MBCT, only a small number of mental health services in the UK have systematically implemented the guidance. Guiding principles for implementation are set out. We offer an implementation resource to facilitate the transfer of MBCT knowledge into action.

Deacon, B., J. J. Kemp, et al. (2013). ***"Maximizing the efficacy of interoceptive exposure by optimizing inhibitory learning: A randomized controlled trial."*** Behaviour Research and Therapy 51(9): 588-596. http://www.sciencedirect.com/science/article/pii/S0005796713001198

Cognitive-behavioral treatments for panic disorder (PD) emphasize interoceptive exposure (IE) to target anxiety sensitivity (AS) but vary considerably in its manner of delivery. This randomized controlled trial was conducted to compare the efficacy of the low-dose delivery of IE exercises often prescribed in treatment protocols to an intensive form of IE hypothesized to optimize inhibitory learning. Participants (N = 120) with elevated AS were randomly assigned to one of four single-session interventions: (a) low-dose IE as prescribed in Barlow and Craske's Panic Control Treatment, (b) low-dose IE without controlled breathing or a lengthy between-trial rest period, (c) intensive IE, or (d) expressive writing control. Compared to the other conditions, intensive IE produced significantly greater reductions in AS and fearful responding to a straw breathing task from pretreatment to posttreatment. Maintenance of gains during the follow-up period did not differ between conditions. Changes in fear toleration and negative outcome expectancies fully mediated the superior efficacy of intensive IE over low-dose IE. The two low intensity IE conditions produced particularly high rates of fear sensitization on between-trial and outcome variables. The findings suggest that the intensive delivery of IE exercises has the potential to improve the efficacy of exposure-based treatments for PD.

Driessen, E., H. L. Van, et al. (2013). ***"The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: A randomized clinical trial."*** Am J Psychiatry 170(9): 1041-1050. http://www.ncbi.nlm.nih.gov/pubmed/24030613

OBJECTIVE: The efficacy of psychodynamic therapies for depression remains open to debate because of a paucity of high-quality studies. The authors compared the efficacy of psychodynamic therapy with that of cognitive-behavioral therapy (CBT), hypothesizing nonsignificant differences and the noninferiority of psychodynamic therapy relative to CBT. METHOD: A total of 341 adults who met DSM-IV criteria for a major depressive episode and had Hamilton Depression Rating Scale (HAM-D) scores >/=14 were randomly assigned to 16 sessions of individual manualized CBT or short-term psychodynamic supportive therapy. Severely depressed patients (HAM-D score >24) also received antidepressant medication according to protocol. The primary outcome measure was posttreatment remission rate (HAM-D score </=7). Secondary outcome measures included mean posttreatment HAM-D score and patient-rated depression score and 1-year follow-up outcomes. Data were analyzed with generalized estimating equations and mixed-model analyses using intent-to-treat samples. Noninferiority margins were prespecified as an odds ratio of 0.49 for remission rates and a Cohen's d value of 0.30 for continuous outcome measures. RESULTS: No statistically significant treatment differences were found for any of the outcome measures. The average posttreatment remission rate was 22.7%. Noninferiority was shown for posttreatment HAM-D and patient-rated depression scores but could not be demonstrated for posttreatment remission rates or any of the follow-up measures. CONCLUSIONS: The findings extend the evidence base of psychodynamic therapy for depression but also indicate that time-limited treatment is insufficient for a substantial number of patients encountered in psychiatric outpatient clinics.

Fentz, H. N., A. Hoffart, et al. (2013). ***"Mechanisms of change in cognitive behaviour therapy for panic disorder: The role of panic self-efficacy and catastrophic misinterpretations."*** Behaviour Research and Therapy 51(9): 579-587. http://www.sciencedirect.com/science/article/pii/S0005796713001058

The efficacy of cognitive behavioural therapy (CBT) for panic disorder with or without agoraphobia (PD) is well-established; however, little is known about the underlying change processes of clinical improvement during therapy. According to cognitive theories, CBT for PD primarily works by changing catastrophic misinterpretations of bodily symptoms and panic attacks. However, panic self-efficacy, i.e. the perceived ability to cope with panic attacks, has also been suggested as an important change mechanism in CBT for PD. The aim of the study was to investigate if change in catastrophic misinterpretations and panic self-efficacy mediated change in the level of anxiety during the course of thirteen sessions of group CBT for PD. Forty-five participants completed weekly self-report measures of the possible cognitive mediators and the level of anxiety throughout therapy. The results indicated that within-person change in panic self-efficacy in one session, but not in catastrophic misinterpretations, predicted within-person level of anxiety symptoms the following week. However, in a reversed analysis, prior change in level of anxiety symptoms also predicted change in panic self-efficacy the following session. These results support panic self-efficacy as a mediator of change in CBT for PD, although a reciprocal causal relationship between panic self-efficacy and level of anxiety seems to be implied.

Gyani, A., R. Shafran, et al. (2013). ***"Enhancing recovery rates: Lessons from year one of IAPT."*** Behaviour Research and Therapy 51(9): 597-606. http://www.sciencedirect.com/science/article/pii/S0005796713001150

(Available in free full text) Abstract Background The English Improving Access to Psychological Therapies (IAPT) initiative aims to make evidence-based psychological therapies for depression and anxiety disorder more widely available in the National Health Service (NHS). 32 IAPT services based on a stepped care model were established in the first year of the programme. We report on the reliable recovery rates achieved by patients treated in the services and identify predictors of recovery at patient level, service level, and as a function of compliance with National Institute of Health and Care Excellence (NICE) Treatment Guidelines. Method Data from 19,395 patients who were clinical cases at intake, attended at least two sessions, had at least two outcomes scores and had completed their treatment during the period were analysed. Outcome was assessed with the patient health questionnaire depression scale (PHQ-9) and the anxiety scale (GAD-7). Results Data completeness was high for a routine cohort study. Over 91% of treated patients had paired (pre-post) outcome scores. Overall, 40.3% of patients were reliably recovered at post-treatment, 63.7% showed reliable improvement and 6.6% showed reliable deterioration. Most patients received treatments that were recommended by NICE. When a treatment not recommended by NICE was provided, recovery rates were reduced. Service characteristics that predicted higher reliable recovery rates were: high average number of therapy sessions; higher step-up rates among individuals who started with low intensity treatment; larger services; and a larger proportion of experienced staff. Conclusions Compliance with the IAPT clinical model is associated with enhanced rates of reliable recovery.

Heins, M. J., H. Knoop, et al. (2013). ***"The process of cognitive behaviour therapy for chronic fatigue syndrome: Which changes in perpetuating cognitions and behaviour are related to a reduction in fatigue?"*** Journal of Psychosomatic Research 75(3): 235-241. http://www.sciencedirect.com/science/article/pii/S0022399913002663

Abstract Objective Cognitive behaviour therapy (CBT) can significantly reduce fatigue in chronic fatigue syndrome (CFS), but little is known about the process of change taking place during CBT. Based on a recent treatment model (Wiborg et al. J Psych Res 2012), we examined how (changes in) cognitions and behaviour are related to the decrease in fatigue. Methods We included 183 patients meeting the US Centers for Disease Control criteria for CFS, aged 18 to 65 years, starting CBT. We measured fatigue and possible process variables before treatment; after 6, 12 and 18 weeks; and after treatment. Possible process variables were sense of control over fatigue, focusing on symptoms, self-reported physical functioning, perceived physical activity and objective (actigraphic) physical activity. We built multiple regression models, explaining levels of fatigue during therapy by (changes in) proposed process variables. Results We observed large individual variation in the patterns of change in fatigue and process variables during CBT for CFS. Increases in the sense of control over fatigue, perceived activity and self-reported physical functioning, and decreases in focusing on symptoms explained 20 to 46% of the variance in fatigue. An

increase in objective activity was not a process variable. Conclusion A change in cognitive factors seems to be related to the decrease in fatigue during CBT for CFS. The pattern of change varies considerably between patients, but changes in process variables and fatigue occur mostly in the same period.

Kelleher, I., P. Corcoran, et al. (2013). ***"Psychotic symptoms and population risk for suicide attempt: A prospective cohort study."*** JAMA Psychiatry 70(9): 940-948. http://dx.doi.org/10.1001/jamapsychiatry.2013.140

Importance Up to 1 million persons die by suicide annually. However, a lack of risk markers makes suicide risk assessment one of the most difficult areas of clinical practice. Objective To assess psychotic symptoms (attenuated or frank) as a clinical marker of risk for suicide attempt.Design, Setting, and Participants Prospective cohort study of 1112 school-based adolescents (aged 13-16 years), assessed at baseline and at 3 and 12 months for self-reported psychopathology, psychotic symptoms, and suicide attempts.Main Outcomes and Measures Suicide attempts at the 3- and 12-month follow-up and acute suicide attempts (defined as those occurring in the 2 weeks before an assessment). Results Of the total sample, 7% reported psychotic symptoms at baseline. Of that subsample, 7% reported a suicide attempt by the 3-month follow-up compared with 1% of the rest of the sample (odds ratio [OR], 10.01; 95% CI, 2.24-45.49), and 20% reported a suicide attempt by the 12-month follow-up compared with 2.5% of the rest of the sample (OR, 11.27; 95% CI, 4.44-28.62). Among adolescents with baseline psychopathology who reported psychotic symptoms, 14% reported a suicide attempt by 3 months (OR, 17.91; 95% CI, 3.61-88.82) and 34% reported a suicide attempt by 12 months (OR, 32.67; 95% CI, 10.42-102.41). Adolescents with psychopathology who reported psychotic symptoms had a nearly 70-fold increased odds of acute suicide attempts (OR, 67.50; 95% CI, 11.41-399.21). Differences were not explained by nonpsychotic psychiatric symptom burden, multimorbidity, or substance use. In a causative model, the population-attributable fraction of suicide attempts would be 56% to 75% for psychotic symptoms. Conclusions and Relevance Adolescents with psychopathology who report psychotic symptoms are at clinical high risk for suicide attempts. More careful clinical assessment of psychotic symptoms (attenuated or frank) in mental health services and better understanding of their pathological significance are urgently needed.

Kmietowicz, Z. (2013). ***"Evidence that exercise helps in depression is still weak, finds review."*** BMJ 347: f5585. http://www.bmj.com/content/347/bmj.f5585

An analysis of trials that looked at the effectiveness of exercise in treating depression found it to be of moderate benefit, but when the analysis was narrowed to only good quality trials it found no additional benefit in exercise. The review, from the Cochrane Library, concluded that more large trials are needed to find out whether exercise is as effective as antidepressants or psychological treatments and to pinpoint how much and what type of exercise helps people with depression. The last Cochrane review on exercise for depression, published in 2012, found only limited evidence that exercise was helpful, but the publication of several new studies meant an update was needed. The latest review analysed the results of 39 trials involving 2326 people with a diagnosis of depression. The researchers used Hedges's g method to calculate effect sizes for each trial and a random effects model risk ratio for dichotomous data to calculate a standardised mean difference (SMD) for the overall pooled effect. The researchers' review of 35 trials that compared exercise with control treatment or no treatment in 1356 people found moderate benefit in using exercise to treat depression (SMD −0.62 (95% confidence interval −0.81 to −0.42). And pooled data from eight trials involving 377 people found that exercise had a small effect on mood in the long term (SMD −0.33 (−0.63 to −0.03)). However, a separate analysis focusing on just high quality trials (six trials, 464 participants) in which the treatment allocated to the participants was adequately concealed found that the effect of exercise was not significant (SMD −0.18 (−0.47 to 0.11)). Exercise was found to be as effective as psychological therapy (seven trials, 189 people) and antidepressants (four trials, 300 people), although these few trials were small and of low quality. One very small trial (18 participants) found that exercise was more effective than bright light therapy (mean difference −6.4 (−10.20 to −2.6)). Gillian Mead, from the Centre for Clinical Brain Sciences at the University of Edinburgh and one of the review authors, said, "Our review suggested that exercise might have a moderate effect on depression. We can't tell from currently available evidence which kinds of exercise regimes are most effective or whether the benefits continue after a patient stops their exercise programme. "When we looked only at those trials that we considered to be high quality, the effect of exercise on depression was small and not statistically significant. The evidence base would be strengthened by further large scale, high quality studies."

Krpan, K. M., E. Kross, et al. (2013). ***"An everyday activity as a treatment for depression: The benefits of expressive writing for people diagnosed with major depressive disorder."*** J Affect Disord 150(3): 1148-1151. http://www.ncbi.nlm.nih.gov/pubmed/23790815

BACKGROUND: The benefits of expressive writing have been well documented among several populations, but particularly among those who report feelings of dysphoria. It is not known, however, if those diagnosed with Major Depressive Disorder (MDD) would also benefit from expressive writing. METHODS: Forty people diagnosed with current MDD by the Structured Clinical Interview for DSM-IV participated in the study. On day 1 of testing, participants completed a series of questionnaires and cognitive tasks. Participants were then randomly assigned to either an expressive writing condition in which they wrote for 20 min over three consecutive days about their deepest thoughts and feelings surrounding an emotional event (n=20), or to a control condition (n=20) in which they wrote about non-emotional daily events each day. On day 5 of testing, participants completed another series of questionnaires and cognitive measures. These measures were repeated again 4 weeks later. RESULTS: People diagnosed with MDD in the expressive writing condition showed significant decreases in depression scores (Beck Depression Inventory and Patient Health Questionnaire-9 scores) immediately after the experimental manipulation (Day 5). These benefits persisted at the 4-week follow-up. LIMITATIONS: Self-selected sample. CONCLUSIONS: This is the first study to demonstrate the efficacy of expressive writing among people formally diagnosed with current MDD. These data suggest that expressive writing may be a useful supplement to existing interventions for depression.

Lakhan, S. E. and K. L. Schofield (2013). ***"Mindfulness-based therapies in the treatment of somatization disorders: A systematic review and meta-analysis."*** PLoS ONE 8(8): e71834. http://dx.doi.org/10.1371%2Fjournal.pone.0071834

(Free full text available) Background Mindfulness-based therapy (MBT) has been used effectively to treat a variety of physical and psychological disorders, including depression, anxiety, and chronic pain. Recently, several lines of research have explored the potential for mindfulness-therapy in treating somatization disorders, including fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome. Methods Thirteen studies were identified as fulfilling the present criteria of employing randomized controlled trials to determine the efficacy of any form of MBT in treating somatization disorders. A meta-analysis of the effects of mindfulness-based therapy on pain, symptom severity, quality of life, depression, and anxiety was performed to determine the potential of this form of treatment. Findings While limited in power, the meta-analysis indicated a small to moderate positive effect of MBT (compared to wait-list or support group controls) in reducing pain (SMD = −0.21, 95% CI: −0.37, −0.03; $p<0.05$), symptom severity (SMD = −0.40, 95% CI: −0.54, −0.26; $p<0.001$), depression (SMD = −0.23, 95% CI: −0.40, −0.07, $p<0.01$), and anxiety (SMD = −0.20, 95% CI: −0.42, 0.02, $p = 0.07$) associated with somatization disorders, and improving quality of life (SMD = 0.39, 95% CI: 0.19, 0.59; $p<0.001$) in patients with this disorder. Subgroup analyses indicated that the efficacy of MBT was most consistent for irritable bowel syndrome ($p<0.001$ for pain, symptom severity, and

quality of life), and that mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MCBT) were more effective than eclectic/unspecified MBT. Conclusions Preliminary evidence suggests that MBT may be effective in treating at least some aspects of somatization disorders. Further research is warranted.

Lucas, M., E. J. O'Reilly, et al. (2013). ***"Coffee, caffeine, and risk of completed suicide: Results from three prospective cohorts of american adults."*** World J Biol Psychiatry. http://www.ncbi.nlm.nih.gov/pubmed/23819683

Objective.To evaluate the association between coffee and caffeine consumption and suicide risk in three large-scale cohorts of US men and women. Methods. We accessed data of 43,599 men enrolled in the Health Professionals Follow-up Study (HPFS, 1988-2008), 73,820 women in the Nurses' Health Study (NHS, 1992-2008), and 91,005 women in the NHS II (1993-2007). Consumption of caffeine, coffee, and decaffeinated coffee, was assessed every 4 years by validated food-frequency questionnaires. Deaths from suicide were determined by physician review of death certificates. Multivariate adjusted relative risks (RRs) were estimated with Cox proportional hazard models. Cohort specific RRs were pooled using random-effect models. Results. We documented 277 deaths from suicide. Compared to those consuming </= 1 cup/week of caffeinated coffee (< 8 oz/237 ml), the pooled multivariate RR (95% confidence interval [CI]) of suicide was 0.55 (0.38-0.78) for those consuming 2-3 cups/day and 0.47 (0.27-0.81) for those consuming >/= 4 cups/day (P trend < 0.001). The pooled multivariate RR (95% CI) for suicide was 0.75 (0.63-0.90) for each increment of 2 cups/day of caffeinated coffee and 0.77 (0.63-0.93) for each increment of 300 mg/day of caffeine. Conclusions. These results from three large cohorts support an association between caffeine consumption and lower risk of suicide.

MacPherson, H., S. Richmond, et al. (2013). ***"Acupuncture and counselling for depression in primary care: A randomised controlled trial."*** PLoS Med 10(9): e1001518. http://dx.doi.org/10.1371%2Fjournal.pmed.1001518

(Free full text downloadable) Background: Depression is a significant cause of morbidity. Many patients have communicated an interest in non-pharmacological therapies to their general practitioners. Systematic reviews of acupuncture and counselling for depression in primary care have identified limited evidence. The aim of this study was to evaluate acupuncture versus usual care and counselling versus usual care for patients who continue to experience depression in primary care. Methods and Findings: In a randomised controlled trial, 755 patients with depression (Beck Depression Inventory BDI-II score ≥20) were recruited from 27 primary care practices in the North of England. Patients were randomised to one of three arms using a ratio of 2:2:1 to acupuncture (302), counselling (302), and usual care alone (151). The primary outcome was the difference in mean Patient Health Questionnaire (PHQ-9) scores at 3 months with secondary analyses over 12 months follow-up. Analysis was by intention-to-treat. PHQ-9 data were available for 614 patients at 3 months and 572 patients at 12 months. Patients attended a mean of ten sessions for acupuncture and nine sessions for counselling. Compared to usual care, there was a statistically significant reduction in mean PHQ-9 depression scores at 3 months for acupuncture (−2.46, 95% CI −3.72 to −1.21) and counselling (−1.73, 95% CI −3.00 to −0.45), and over 12 months for acupuncture (−1.55, 95% CI −2.41 to −0.70) and counselling (−1.50, 95% CI −2.43 to −0.58). Differences between acupuncture and counselling were not significant. In terms of limitations, the trial was not designed to separate out specific from non-specific effects. No serious treatment-related adverse events were reported. Conclusions: In this randomised controlled trial of acupuncture and counselling for patients presenting with depression, after having consulted their general practitioner in primary care, both interventions were associated with significantly reduced depression at 3 months when compared to usual care alone.

Meston, C. M., T. A. Lorenz, et al. (2013). ***"Effects of expressive writing on sexual dysfunction, depression, and ptsd in women with a history of childhood sexual abuse: Results from a randomized clinical trial."*** The Journal of Sexual Medicine 10(9): 2177-2189. http://dx.doi.org/10.1111/jsm.12247

Introduction Women with a history of childhood sexual abuse (CSA) have high rates of depression, posttraumatic stress disorder, and sexual problems in adulthood. Aim We tested an expressive writing-based intervention for its effects on psychopathology, sexual function, satisfaction, and distress in women who have a history of CSA. Methods Seventy women with CSA histories completed five 30-minute sessions of expressive writing, either with a trauma focus or a sexual schema focus. Main Outcome Measures Validated self-report measures of psychopathology and sexual function were conducted at posttreatment: 2 weeks, 1 month, and 6 months. Results Women in both writing interventions exhibited improved symptoms of depression and posttraumatic stress disorder (PTSD). Women who were instructed to write about the impact of the abuse on their sexual schema were significantly more likely to recover from sexual dysfunction. Conclusions Expressive writing may improve depressive and PTSD symptoms in women with CSA histories. Sexual schema-focused expressive writing in particular appears to improve sexual problems, especially for depressed women with CSA histories. Both treatments are accessible, cost-effective, and acceptable to patients. *[Available in free full text from http://homepage.psy.utexas.edu/HomePage/Group/MestonLAB/HTML%20files/pubs.htm & see instructions at http://homepage.psy.utexas.edu/HomePage/Group/MestonLAB/HTML%20files/CSA_Prompts.htm].*

Ottaviani, C. and A. Couyoumdjian (2013). ***"Pros and cons of a wandering mind: A prospective study."*** Frontiers in Psychology 4. http://www.frontiersin.org/Journal/Abstract.aspx?s=851&name=perception_science&ART_DOI=10.3389/fpsyg.2013.00524

Mind wandering (MW) has recently been associated with both adaptive (e.g., creativity enhancement) and maladaptive (e.g., mood worsening) consequences. This study aimed at investigating whether proneness to MW was prospectively associated with negative health outcomes. At time 0, 21 women, 19 men; mean age = 24.5 (4.9) underwent a 5-min baseline electrocardiogram (ECG), a 20-min laboratory tracking task with thought probes, and personality questionnaires. At time 1 (1 year follow-up), the same participants underwent a 24-hour Ecological Momentary Assessment characterized by ambulatory ECG recording and electronic diaries. First, we examined if the likelihood of being a 'mind wanderer' was associated with specific personality dispositions. Then, we tested if the occurrence of episodes of MW in the lab would be correlated with frequency of MW in daily life. Finally, multiple regression models were used to test if MW longitudinally acted as a risk factor for health, accounting for the effects of biobehavioral variables. Among dispositional traits, the frequency of MW episodes in daily life was inversely associated with the capacity of being mindful (i.e., aware of the present moment and non-judging). There was a positive correlation between frequency of MW in the lab and in daily life, suggesting that it is a stable disposition of the individual. When differentiated from perseverative cognition (i.e., rumination and worry), MW did not predict the presence of health risk factors one year later, however, a higher occurrence of episodes of MW was associated with short-term adverse consequences, such as increased 24-hour heart rate on the same day and difficulty falling asleep the subsequent night. Present findings suggest that MW may be associated with short term 'side effects' but argue against a long term dysfunctional view of this cognitive process.

Pompili, M., X. Gonda, et al. (2013). ***"Epidemiology of suicide in bipolar disorders: A systematic review of the literature."*** Bipolar Disorders 15(5): 457-490. http://dx.doi.org/10.1111/bdi.12087

(Free full text available) Objective Suicidal behavior is a major public health problem worldwide, and its prediction and prevention represent a challenge for everyone, including clinicians. The aim of the present paper is to provide a systematic review of the existing literature on the epidemiology of completed suicides in adult patients with bipolar disorder (BD). Methods We performed a Pubmed/Medline, Scopus, PsycLit, PsycInfo, and Cochrane database search to identify all relevant papers published between 1980 and 2011. A total of 34 articles meeting our inclusion criteria were included in the present review. Results Several prospective follow-up contributions, many retrospective analyses, and a few psychological autopsy studies and review articles investigated the epidemiology of completed suicides in patients with BD. The main finding of the present review was that the risk for suicide among BD patients was up to 20–30 times greater than that for the general population. Conclusion Special attention should be given to the characteristics of suicides in patients with BD. Better insight and understanding of suicide and suicidal risk in this very disabling illness should ultimately help clinicians to adequately detect, and thus prevent, suicidal acts in patients with BD.

Probst, T., M. J. Lambert, et al. (2013). ***"Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice."*** Journal of Psychosomatic Research 75(3): 255-261. http://www.sciencedirect.com/science/article/pii/S0022399913002699

Abstract Objectives Although psychosomatic in-patient treatment is effective, 5–10% of the patients deteriorate. Providing patient progress feedback and clinical support tools to therapists improves the outcome for patients at risk of deterioration in counseling, outpatient psychotherapy, and substance abuse treatment. This study investigated the effects of feedback on psychosomatically treated in-patients at risk of treatment failure. Methods At intake, all patients of two psychosomatic clinics were randomized either into the experimental group or the treatment-as-usual control group. Both groups were tracked weekly with the "Outcome Questionnaire" (OQ-45) measuring patient progress and with the clinical support tool "Assessment of Signal Cases" (ASC). Therapists received feedback from both instruments for all their experimental group patients. "Patients at risk" were defined as patients who deviated from expected recovery curves by at least one standard deviation. Of 252 patients, 43 patients were at risk: 23 belonged to the experimental group, 20 to the control group. The feedback effect was analyzed using a level-2-model for discontinuous change, effect size (d), reliable change index (RCI), and odds ratio for reliable deterioration. Results For patients at risk, the experimental group showed an improved outcome on the OQ-45 total scale compared to the control group ($p<0.05$, $d = 0.54$). By providing feedback, the rate of reliably deteriorated patients at risk was reduced from 25.0% (control group) to 8.7% (experimental group) — odds ratio = 0.29. All reliably improved patients at risk belonged to the experimental group. Conclusion Feedback improves the outcome of patients at risk undergoing psychosomatic in-patient treatment.

Przybylski, A. K. and N. Weinstein (2013). ***"Can you connect with me now? How the presence of mobile communication technology influences face-to-face conversation quality."*** Journal of Social and Personal Relationships 30(3): 237-246. http://spr.sagepub.com/content/30/3/237.abstract

Recent advancements in communication technology have enabled billions of people to connect over great distances using mobile phones, yet little is known about how the frequent presence of these devices in social settings influences face-to-face interactions. In two experiments, we evaluated the extent to which the mere presence of mobile communication devices shape relationship quality in dyadic settings. In both, we found evidence they can have negative effects on closeness, connection, and conversation quality. These results demonstrate that the presence of mobile phones can interfere with human relationships, an effect that is most clear when individuals are discussing personally meaningful topics. *[The BPS Digest - http://bps-research-digest.blogspot.co.uk/2012/09/how-mere-presence-of-mobile-phone.html - comments: "You sit down for a chat with a new acquaintance but before you're even started they've placed their phone carefully on the table in front of them. Why? Are they waiting for a call? Do they just enjoy marvelling at its chic plastic beauty? Either way, a new study suggests this familiar habit could be interfering with our attempts to socialise. Andrew Przybylski and Netta Weinstein asked 34 pairs of strangers to spend 10 minutes chatting to each other about "an interesting event that occurred to you over the past month". The participants sat on chairs in a private booth and for half of them, close by but out of their direct line of view, a mobile phone was placed on a table-top. For the other pairs, there was a note-book in place of the phone. After they'd finished chatting, the participants answered questions about the partner they'd met. The ones who'd chatted with a phone visible nearby, as opposed to a notebook, were less positive. For example, they were less likely to agree with the statement "It is likely that my partner and I could become friends if we interacted a lot". They also reported feeling less closely related to their conversational partner. A second study with a fresh set of participants was similar, but this time some of the 34 pairs of strangers chatted about a mundane topic, whilst others chatted about "the most meaningful events of the past year." Again, some of them did this with a phone placed nearby, others with a notebook in the same position. For participants with the notebook visible nearby, having a more meaningful conversation (as opposed to a casual one) boosted their feelings of closeness and their trust in their conversational partner. But this extra intimacy was missing for the participants for whom a mobile phone was visible. When the researchers debriefed the participants afterwards they seemed to be unaware of the effects of the mobile phone, suggesting its adverse effects were at a non-conscious level. Why should the mere presence of a mobile phone interfere with feelings of social intimacy in this way? Przybylski and Weinstein can't be sure, but they think that modern mobile phones might trigger in the mind automatic thoughts about wider social networks, which has the effect of crowding out face-to-face conversations. Considered in this way, the present findings are an extension of the wider literature on what's known as non-conscious priming (for example, the presence of a brief-case makes people more competitive). A weakness of the study is that the researchers didn't compare the effects of the presence of a mobile phone against an old-fashioned land-line phone, or other forms of technology. So it's not clear how specific the effect is to mobile phones. Also, as the authors acknowledge, this is just a preliminary observation that poses all sorts of future questions requiring further research. For example, did the presence of a mobile phone alter the behaviour and conversational style of the participants, or did it merely change their perceptions of the social experience? Would the effects be the same for people who are already in a close relationship? But for now, Przybylski and Weinstein concluded: "These results indicate that mobile communication devices may, by their mere presence, paradoxically hold the potential to facilitate as well as to disrupt human bonding and intimacy."]*

Richards, D. A., J. J. Hill, et al. (2013). ***"Clinical effectiveness of collaborative care for depression in UK primary care (cadet): Cluster randomised controlled trial."*** BMJ 347: f4913. http://www.bmj.com/content/347/bmj.f4913

(Full text freely available) OBJECTIVE: To compare the clinical effectiveness of collaborative care with usual care in the management of patients with moderate to severe depression. DESIGN: Cluster randomised controlled trial. SETTING: 51 primary care practices in three primary care districts in the United Kingdom. PARTICIPANTS: 581 adults aged 18 years and older who met ICD-10 (international classification of diseases, 10th revision) criteria for a depressive episode on the revised Clinical Interview Schedule. We excluded acutely suicidal patients and those with psychosis, or with type I or type II bipolar disorder; patients whose low mood was associated with bereavement or whose primary presenting problem was alcohol or drug abuse; and patients receiving psychological treatment for their depression by specialist mental health services. We identified potentially

eligible participants by searching computerised case records in general practices for patients with depression. INTERVENTIONS: Collaborative care, including depression education, drug management, behavioural activation, relapse prevention, and primary care liaison, was delivered by care managers. Collaborative care involved six to 12 contacts with participants over 14 weeks, supervised by mental health specialists. Usual care was family doctors' standard clinical practice. MAIN OUTCOME MEASURES: Depression symptoms (patient health questionnaire 9; PHQ-9), anxiety (generalised anxiety disorder 7; GAD-7), and quality of life (short form 36 questionnaire; SF-36) at four and 12 months; satisfaction with service quality (client satisfaction questionnaire; CSQ-8) at four months. RESULTS: 276 participants were allocated to collaborative care and 305 allocated to usual care. At four months, mean depression score was 11.1 (standard deviation 7.3) for the collaborative care group and 12.7 (6.8) for the usual care group. After adjustment for baseline depression, mean depression score was 1.33 PHQ-9 points lower (95% confidence interval 0.35 to 2.31, P=0.009) in participants receiving collaborative care than in those receiving usual care at four months, and 1.36 points lower (0.07 to 2.64, P=0.04) at 12 months. Quality of mental health but not physical health was significantly better for collaborative care than for usual care at four months, but not 12 months. Anxiety did not differ between groups. Participants receiving collaborative care were significantly more satisfied with treatment than those receiving usual care. The number needed to treat for one patient to drop below the accepted diagnostic threshold for depression on the PHQ-9 was 8.4 immediately after treatment, and 6.5 at 12 months. CONCLUSIONS: Collaborative care has persistent positive effects up to 12 months after initiation of the intervention and is preferred by patients over usual care.

Roos, J. and A. Werbart (2013). ***"Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review."*** Psychotherapy Research 23(4): 394-418. http://dx.doi.org/10.1080/10503307.2013.775528

Among potential predictors of dropout, client variables are most thoroughly examined. This qualitative literature review examines the current state of knowledge about therapist, relationship and process factors influencing dropout. Databases searches identified 44 relevant studies published January 2000?June 2011. Dropout rates varied widely with a weighted rate of 35%. Fewer than half of the studies directly addressed questions of dropout rates in relation to therapist, relationship or process factors. Therapists' experience, training and skills, together with providing concrete support and being emotionally supportive, had an impact on dropout rates. Furthermore, the quality of therapeutic alliance, client dissatisfaction and pre-therapy preparation influenced dropout. To reduce dropout rates, therapists need enhanced skills in building and repairing the therapeutic relationship.

Sareen, J., C. A. Henriksen, et al. (2013). ***"Common mental disorder diagnosis and need for treatment are not the same: Findings from a population-based longitudinal survey."*** Psychological Medicine 43(09): 1941-1951. http://dx.doi.org/10.1017/S003329171200284X

Background Controversy exists regarding whether people in the community who meet criteria for a non-psychotic mental disorder diagnosis are necessarily in need of treatment. Some have argued that these individuals require treatment and that policy makers need to develop outreach programs for them, whereas others have argued that the current epidemiologic studies may be diagnosing symptoms of distress that in many cases are self-limiting and likely to remit without treatment. All prior studies that have addressed this issue have been cross-sectional. We examined the longitudinal outcomes of individuals with depressive, anxiety and substance use (DAS) disorder(s) who had not previously received any treatment. Method Data came from a nationally representative US sample. A total of 34 653 non-institutionalized adults (age ≥20 years) were interviewed at two time points, 3 years apart. DAS disorders, mental health service use and quality of life (QoL) were assessed at both time points. Results Individuals with a DAS disorder who had not previously received any treatment were significantly more likely than those who had been previously treated to have remission of their index disorder(s) without subsequent treatment, to be free of co-morbid disorder(s) and not to have attempted suicide during the 3-year follow-up period (50.7% v. 33.0% respectively, $p < 0.05$). At wave 2, multiple linear regression demonstrated that people with a remission of their baseline DAS disorder(s) had levels of functioning similar to those without a DAS disorder. Conclusions Individuals with an untreated DAS disorder at baseline have a substantial likelihood of remission without any subsequent intervention.

Shinohara, K., M. Honyashiki, et al. (2013). ***"Behavioural therapies versus other psychological therapies for depression."*** Cochrane Database Syst Rev 10: CD008696. http://www.ncbi.nlm.nih.gov/pubmed/24129886

BACKGROUND: Behavioural therapies represent one of several categories of psychological therapies that are currently used in the treatment of depression. However, the effectiveness and acceptability of behavioural therapies for depression compared with other psychological therapies remain unclear. OBJECTIVES: 1. To examine the effects of all BT approaches compared with all other psychological therapy approaches for acute depression.2. To examine the effects of different BT approaches (behavioural therapy, behavioural activation, social skills training and relaxation training) compared with all other psychological therapy approaches for acute depression.3. To examine the effects of all BT approaches compared with different psychological therapy approaches (CBT, third wave CBT, psychodynamic, humanistic and integrative psychological therapies) for acute depression. SEARCH METHODS: We searched the Cochrane Depression Anxiety and Neurosis Group Trials Specialised Register (CCDANCTR, 31/07/2013), which includes relevant randomised controlled trials from The Cochrane Library (all years), EMBASE, (1974-), MEDLINE (1950-) and PsycINFO (1967-). We also searched CINAHL (May 2010) and PSYNDEX (June 2010) and reference lists of the included studies and relevant reviews for additional published and unpublished studies. SELECTION CRITERIA: Randomised controlled trials that compared behavioural therapies with other psychological therapies for acute depression in adults. DATA COLLECTION AND ANALYSIS: Two or more review authors independently identified studies, assessed trial quality and extracted data. We contacted study authors for additional information. MAIN RESULTS: Twenty-five trials involving 955 participants compared behavioural therapies with one or more of five other major categories of psychological therapies (cognitive-behavioural, third wave cognitive-behavioural, psychodynamic, humanistic and integrative therapies). Most studies had a small sample size and were assessed as being at unclear or high risk of bias. Compared with all other psychological therapies together, behavioural therapies showed no significant difference in response rate (18 studies, 690 participants, risk ratio (RR) 0.97, 95% confidence interval (CI) 0.86 to 1.09) or in acceptability (15 studies, 495 participants, RR of total dropout rate 1.02, 95% CI 0.65 to 1.61). Similarly, in comparison with each of the other classes of psychological therapies, low-quality evidence showed better response to cognitive-behavioural therapies than to behavioural therapies (15 studies, 544 participants, RR 0.93, 95% CI 0.83 to 1.05) and low-quality evidence of better response to behavioural therapies over psychodynamic therapies (2 studies, 110 participants, RR 1.24, 95% CI 0.84 to 1.82).When compared with integrative therapies and humanistic therapies, only one study was included in each comparison, and the analysis showed no significant difference between behavioural therapies and integrative or humanistic therapies. AUTHORS' CONCLUSIONS: We found low- to moderate-quality evidence that behavioural therapies and other psychological therapies are equally effective. The current evidence base that evaluates the relative benefits and harms of behavioural therapies is very weak. This limits our confidence in both the size of the effect and its precision for our key outcomes related to response and withdrawal. Studies recruiting larger samples with improved reporting of design and fidelity to treatment would improve the quality of evidence in this review.

Thase, M. E. (2013). ***"Comparative effectiveness of psychodynamic psychotherapy and cognitive-behavioral therapy: It's about time, and what's next?"*** American Journal of Psychiatry 170(9): 953-956. http://dx.doi.org/10.1176/appi.ajp.2013.13060839

(Free full text available) Since depression is one of the world's greatest public health problems, conducting research to accurately weigh the benefits and risks of commonly used interventions should be as much a research priority as developing novel treatments or investigating mechanisms of disease pathophysiology. Psychotherapy is one of the most widely used classes of treatment, but unfortunately there is no commercial entity analogous to the pharmaceutical industry to support research and development of the current and next generations of interventions. The impact of this state of affairs is particularly evident with respect to the ability to conduct larger-scale studies of comparative treatment effectiveness, for which there are only a handful of relevant studies. Thus, although psychodynamic psychotherapy has been used to treat depressed outpatients for decades, the utility of this time-honored approach, as measured by the results of randomized controlled trials of treatment efficacy and effectiveness, has not been extensively studied. The study by Driessen et al. in this issue of the Journal is therefore noteworthy because it provides some of the strongest evidence to date that short-term psychodynamic psychotherapy is an effective treatment for major depressive disorder ... The primary finding of this trial was that psychodynamic psychotherapy was noninferior to CBT; posttreatment score remission rates were 21% (26/122) and 24% (27/111) for the psychodynamic psychotherapy and CBT groups, respectively. No significant differences were seen between treatments on any measure at any time point, and the overall pattern of results generally followed the primary outcome, namely that psychodynamic psychotherapy was not inferior to CBT. ... From another vantage point, whereas Driessen et al. demonstrated that psychodynamic psychotherapy was not inferior to CBT, they also showed that the outcomes of depressed outpatients were far from ideal, even when receiving good treatments from capable therapists. Indeed, the outcomes of both psychotherapy groups are strikingly comparable to those observed in the CBT arms included in the second level of the Sequenced Treatment Alternatives to Relieve Depression study, which likewise was an inclusive, multicenter study aimed at evaluating comparative effectiveness under real-world conditions. Since many clinicians may have already believed that the findings of Driessen et al. were true (i.e., the two therapies are comparably effective), perhaps the more important finding of this study is to underscore the harsh reality that we still need more effective treatments for major depressive disorder, and this need is as true for psychotherapy as it is for pharmacotherapy.

Wiltink, J., M. Michal, et al. (2013). ***"Associations between depression and different measures of obesity (BMI, WC, WHTR, WHR)."*** BMC Psychiatry 13(1): 223. http://www.biomedcentral.com/1471-244X/13/223

(Free full text available) BACKGROUND: Growing evidence suggests that abdominal obesity is a more important risk factor for the prognosis of cardiovascular and metabolic diseases than BMI. Somatic-affective symptoms of depression have also been linked to cardiovascular risk. The relationship between obesity and depression, however, has remained contradictory. Our aim was therefore to relate body mass index (BMI) and different measures for abdominal obesity (waist circumference, WC, waist-to-hip ratio, WHR, waist-to-height ratio, WHtR) to somatic vs. cognitive-affective symptoms of depression. METHODS: In a cross-sectional population based study, data on the first N=5000 participants enrolled in the Gutenberg Health Study (GHS) are reported. To analyze the relationship between depression and obesity, we computed linear regression models with the anthropometric measure (BMI, WC, WHR, WHtR) as the dependent variable and life style factors, cardiovascular risk factors and psychotropic medications as potential confounders of obesity/depression. RESULTS: We found that only the somatic, but not the cognitive-affective symptoms of depression are consistently positively associated with anthropometric measures of obesity. CONCLUSIONS: We could demonstrate that the somatic-affective symptoms of depression rather than the cognitive-affective symptoms are strongly related to anthropometric measures. This is also true for younger obese starting at the age of 35 years. Our results are in line with previous studies indicating that visceral adipose tissue plays a key role in the relationship between obesity, depression and cardiovascular disease.