# ***29 action on depression abstracts, july/august '13***

(Arnow, Steidtmann et al. 2013; Benros, Waltoft et al. 2013; Butterworth, Leach et al. 2013; Cuijpers, Huibers et al. 2013; Cuijpers, Sijbrandij et al. 2013; Day, McGrath et al. 2013; Drake, Csipke et al. 2013; Kaplan and Harvey 2013; Kapur, Gunnell et al. 2013; Kleiman and Rule 2013; Kornstein, Toups et al. 2013; Kuyken, Weare et al. 2013; Limb 2013; Meijer, Conradi et al. 2013; Merrill, Lyon et al. 2013; Morriss, Kapur et al. 2013; Oosterbaan, Verbraak et al. 2013; Parboosing, Bao et al. 2013; Pietrzak, Kinley et al. 2013; Pineda and Dadds 2013; Sasso and Strunk 2013; Schulte-van Maaren, Carlier et al. 2013; Stringaris, Maughan et al. 2013; Sutin, Terracciano et al. 2013; Sveen, Berg-Nielsen et al. 2013; Vasey, Harbaugh 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.

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.

Butterworth, P., L. S. Leach, et al. (2013). ***"Common mental disorders, unemployment and psychosocial job quality: Is a poor job better than no job at all?"*** Psychological Medicine 43(08): 1763-1772. http://dx.doi.org/10.1017/S0033291712002577

Background Employment is associated with health benefits over unemployment, but the psychosocial characteristics of work also influence health. There has, however, been little research contrasting the prevalence of psychiatric disorders among people who are unemployed with those in jobs of differing psychosocial quality. Method Analysis of data from the English Adult Psychiatric Morbidity Survey (APMS) considered the prevalence of common mental disorders (CMDs) among 2603 respondents aged between 21 and 54 years who were either (i) employed or (ii) unemployed and looking for work at the time of interview in 2007. Quality of work was assessed by the number of adverse psychosocial job conditions reported (low control, high demands, insecurity and low job esteem). Results The prevalence of CMDs was similar for those respondents who were unemployed and those in the poorest quality jobs. This pattern remained after controlling for relevant demographic and socio-economic covariates. Conclusions Although employment is thought to promote mental health and well-being, work of poor psychosocial quality is not associated with any better mental health than unemployment. Policy efforts to improve community mental health should consider psychosocial job quality in conjunction with efforts to increase employment rates.

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.

Day, V., P. J. McGrath, et al. (2013). ***"Internet-based guided self-help for university students with anxiety, depression and stress: A randomized controlled clinical trial."*** Behaviour Research and Therapy 51(7): 344-351. http://www.sciencedirect.com/science/article/pii/S000579671300051X

Anxiety, depression and stress, often co-occurring, are the psychological problems for which university students most often seek help. Moreover there are many distressed students who cannot, or choose not to, access professional help. The present study evaluated the efficacy of an internet-based guided self-help program for moderate anxiety, depression and stress. The program was based on standard cognitive behavior therapy principles and included 5 core modules, some of which involved options for focusing on anxiety and/or depression and/or stress. Trained student coaches provided encouragement and advice about using the program via e-mail or brief weekly phone calls. Sixty-six distressed university students were randomly assigned to either Immediate Access or a 6-week Delayed Access condition. Sixty-one percent of Immediate Access participants completed all 5 core modules, and 80% of all participants completed the second assessment. On the Depression, Anxiety and Stress Scales-21, Immediate Access participants reported significantly greater reductions in depression ( η p 2 =. 07), anxiety ( η p 2 =. 08) and stress ( η p 2 =. 12) in comparison to participants waiting to do the program, and these improvements were maintained at a six month follow-up. The results suggest that the provision of individually-adaptable, internet-based, self-help programs can reduce psychological distress in university students.

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.

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.

Kapur, N., D. Gunnell, et al. (2013). ***"Messages from Manchester: Pilot randomised controlled trial following self-harm."*** The British Journal of Psychiatry 203(1): 73-74. http://bjp.rcpsych.org/content/203/1/73.abstract

Studies of therapeutic contact following self-harm have had mixed results. We carried out a pilot randomised controlled trial comparing an intervention (information leaflet listing sources of help, two telephone calls soon after presentation and a series of letters over 12 months) to usual treatment alone in 66 adults presenting with self-harm to two hospitals. We found that our methodology was feasible, recruitment was challenging and repeat self-harm was more common in those who received the intervention (12-month repetition rate 34.4% v. 12.5%).

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.

Kornstein, S. G., M. Toups, et al. (2013). ***"Do menopausal status and use of hormone therapy affect antidepressant treatment response? Findings from the sequenced treatment alternatives to relieve depression (STAR*D) study."*** J Womens Health (Larchmt) 22(2): 121-131. http://www.ncbi.nlm.nih.gov/pubmed/23398127

BACKGROUND: Menopausal status and use of hormonal contraception or menopausal hormone therapy (HT) may affect treatment response to selective serotonin reuptake inhibitors (SSRIs). This report evaluates whether menopausal status and use of hormonal contraceptives or menopausal HT affect outcome in women treated with citalopram. METHODS: In the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, 896 premenopausal and 544 postmenopausal women were treated with citalopram for 12-14 weeks. Baseline demographic and clinical characteristics were used in adjusted analysis of the effect of menopausal status and use of hormonal contraceptives or menopausal HT on outcomes. Remission was defined as final Hamilton Rating Scale for Depression-17 (HRSD(17)) </=7 or Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR(16)) score </=5 and response as >/=50% decrease from the baseline QIDS-SR(16) score. RESULTS: Premenopausal and postmenopausal women differed in multiple clinical and demographic baseline variables but did not differ in response or remission rates. Premenopausal women taking hormonal contraceptives had significantly greater unadjusted remission rates on the HRSD(17) and the QIDS-SR(16) than women not taking contraception. Response and remission rates were not different between postmenopausal women taking vs. not taking HT. Adjusted results showed no significant difference in any outcome measure across menopause status in women who were not taking contraception/HT. There were no significant differences in adjusted results across HT status in premenopausal or postmenopausal women. CONCLUSIONS: In this study, citalopram treatment outcome was not affected by menopausal status. Hormonal contraceptives and HT also did not affect probability of good outcome.

Kuyken, W., K. Weare, et al. (2013). ***"Effectiveness of the mindfulness in schools programme: Non-randomised controlled feasibility study."*** The British Journal of Psychiatry 203(2): 126-131. http://bjp.rcpsych.org/content/203/2/126.abstract

Background Mindfulness-based approaches for adults are effective at enhancing mental health, but few controlled trials have evaluated their effectiveness among young people. Aims To assess the acceptability and efficacy of a schools-based universal mindfulness intervention to enhance mental health and well-being. Method A total of 522 young people aged 12-16 in 12 secondary schools either participated in the Mindfulness in Schools Programme (intervention) or took part in the usual school curriculum (control). Results Rates of acceptability were high. Relative to the controls, and after adjusting for baseline imbalances, children who participated in the intervention reported fewer depressive symptoms post-treatment (P = 0.004) and at follow-up (P = 0.005) and lower stress (P = 0.05) and greater well-being (P = 0.05) at follow-up. The degree to which students in the intervention group practised the mindfulness skills was associated with better well-being (P<0.001) and less stress (P = 0.03) at 3-month follow-up. Conclusions The findings provide promising evidence of the programme's acceptability and efficacy.

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

Meijer, A., H. J. Conradi, et al. (2013). ***"Adjusted prognostic association of depression following myocardial infarction with mortality and cardiovascular events: Individual patient data meta-analysis."*** The British Journal of Psychiatry 203(2): 90-102. http://bjp.rcpsych.org/content/203/2/90.abstract

Background The association between depression after myocardial infarction and increased risk of mortality and cardiac morbidity may be due to cardiac disease severity. Aims To combine original data from studies on the association between post-infarction depression and prognosis into one database, and to investigate to what extent such depression predicts prognosis independently of disease severity. Method An individual patient data meta-analysis of studies was conducted using multilevel, multivariable Cox regression analyses. Results Sixteen studies participated, creating a database of 10 175 post-infarction cases. Hazard ratios for post-infarction depression were 1.32 (95% CI 1.26-1.38, P<0.001) for all-cause mortality and 1.19 (95% CI 1.14-1.24, P<0.001) for cardiovascular events. Hazard ratios adjusted for disease severity were attenuated by 28% and 25% respectively. Conclusions The association between depression following myocardial infarction and prognosis is attenuated after adjustment for cardiac disease severity. Still, depression remains independently associated with prognosis, with a 22% increased risk of all-cause mortality and a 13% increased risk of cardiovascular events per standard deviation in depression z-score.

Merrill, R., J. Lyon, et al. (2013). ***"Tardive and spontaneous dyskinesia incidence in the general population."*** BMC Psychiatry 13(1): 152. http://www.biomedcentral.com/1471-244X/13/152

BACKGROUND:To identify the incidence rate of spontaneous dyskinesia (SD) and tardive dyskinesia (TD) in a general population and to examine the association between dykinesia and potential risk factors (exposure to metoclopramide [MCP], antipsychotic drugs, and history of diabetes and psychoses). METHODS:A retrospective cohort study was conducted for the years 2001 through 2010, based on medical claims data from the Deseret Mutual Benefit Administrators (DMBA). RESULTS:Thirty-four cases of TD and 229 cases of SD were identified. The incidence rate of TD among persons previously prescribed an antipsychotic or metoclopramide (MCP) (per 1,000) was 4.6 (1.6-7.7) for those with antipsychotic drug use only,

8.5 (4.8-12.2) for those with MCP use only, and 15.0 (2.0-28.1) for those with both antipsychotic and MCP use. In the general population, the incidence rate (per 100,000 person-years) of TD was 4.3 and of probable SD was 28.7. The incidence rates of TD and SD increased with age and were greater for females. Those with diabetes or psychoses had almost a 3-fold greater risk of TD than those without either of these diseases. Persons with schizophrenia had 31.2 times increased risk of TD than those without the disease. Positive associations also existed between the selected diseases and the incidence rate of probable SD, with persons with schizophrenia having 4.4 times greater risk of SD than those without the disease. CONCLUSIONS:SD and TD are rare in this general population. Diabetes, psychoses, and especially schizophrenia are positively associated with SD and TD. A higher proportion of those with SD present with spasm of the eyelid muscles (blepharospasm) compared more with the TD cases who present more with orofacial muscular problems.

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.

Oosterbaan, D. B., M. J. P. M. Verbraak, et al. (2013). ***"Collaborative stepped care v. Care as usual for common mental disorders: 8-month, cluster randomised controlled trial."*** The British Journal of Psychiatry 203(2): 132-139. http://bjp.rcpsych.org/content/203/2/132.abstract

Background Thus far collaborative stepped care (CSC) studies have not incorporated self-help as a first step. Aims To evaluate the effectiveness of CSC in the treatment of common mental disorders. Method An 8-month cluster randomised controlled trial comparing CSC to care as usual (CAU) (Dutch Trial Register identifier NTR1224). The CSC consisted of a stepped care approach guided by a psychiatric nurse in primary care with the addition of antidepressants dependent on the severity of the disorder, followed by cognitive-behavioural therapy in mental healthcare. Results Twenty general practitioners (GPs) and 8 psychiatric nurses were randomised to provide CSC or CAU. The GPs recruited 163 patients of whom 85% completed the post-test measurements. At 4-month mid-test CSC was superior to CAU: 74.7% (n = 68) v. 50.8% (n = 31) responders (P = 0.003). At 8-month post-test and 12-month follow-up no significant differences were found as the patients in the CAU group improved as well. Conclusions Treatment within a CSC model resulted in an earlier treatment response compared with CAU.

Parboosing, R., Y. Bao, et al. (2013). ***"Gestational influenza and bipolar disorder in adult offspring."*** JAMA Psychiatry 70(7): 677-685. http://dx.doi.org/10.1001/jamapsychiatry.2013.896

Importance Gestational influenza has been associated previously with schizophrenia in offspring, but the relationship between this exposure and bipolar disorder (BD) is unclear. The identification of gestational influenza as a risk factor for BD may have potential for preventive approaches.Objective To test the hypothesis that maternal influenza during pregnancy is related to BD among offspring. Design Nested case-control study of a population-based birth cohort from the Child Health and Development Study (CHDS). From January 1, 1959, through December 31, 1966, the CHDS recruited nearly all pregnant women receiving obstetric care from the Kaiser Permanente Medical Care Plan, Northern California Region (KPNC). Data on treated maternal influenza from the CHDS were used. Potential cases with BD from the cohort were identified by database linkages of identifiers among the CHDS, Kaiser Permanente database, and a large county health care database; by a mailed questionnaire to the CHDS cohort with subsequent interviews; and from an earlier psychiatric follow-up study on this birth cohort. Setting The CHDS, Kaiser Permanente, and county health care databases. Participants Cases of BD (n = 92) confirmed by structured research interviews and consensus diagnosis among the 214 subjects (48% of those ascertained) who participated and control subjects (n = 722) matched on date of birth, sex, and membership in KPNC or residence in Alameda County.Exposures Influenza.Main Outcome and Measures Bipolar I or II disorder, BD not otherwise specified, or BD with psychotic features. Results We found a significant, nearly 4-fold increase in the risk of BD (odds ratio, 3.82 [95% CI, 1.58-9.24; P = .003]) after exposure to maternal influenza at any time during pregnancy. The findings were not confounded by maternal age, race, educational level, gestational age at birth, and maternal psychiatric disorders. Conclusions and Relevance Maternal influenza may be a risk factor for BD. Although replication is required, the findings suggest that prevention of maternal influenza during pregnancy may reduce the risk of BD.

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.

Schulte-van Maaren, Y. W., I. V. Carlier, et al. (2013). ***"Reference values for major depression questionnaires: The Leiden routine outcome monitoring study."*** J Affect Disord 149(1-3): 342-349. http://www.ncbi.nlm.nih.gov/pubmed/23541841

BACKGROUND: The Beck Depression Inventory-II (BDI-II), the Inventory of Depressive Symptoms (self-report) (IDS-SR) and the Montgomery-Asberg Depression Rating Scale (MADRS) are questionnaires that assess symptom severity in patients with a depressive disorder, often part of Routine Outcome Monitoring (ROM). We aimed to generate reference values for both "healthy" and "clinically depressed" populations. METHODS: We included 1295 subjects from the general population (ROM reference-group) recruited through general practitioners, and 4627 psychiatric outpatients diagnosed with Major Depressive Disorder (MDD) or dysthymia (ROM patient-group). The outermost 5% of observations were used to define limits for one-sided reference intervals (95th percentiles; P95). Receiver Operating Characteristics (ROC) analyses were used to yield alternative cut-off values. Internal consistency was assessed. RESULTS: The mean age was 40.3yr (SD=12.6) and 39.3 (SD=12.3) for the ROM reference and patient-groups, respectively, and 62.8% versus 61.0% were female. Cut-off (P95) values differed for women and men, being respectively 15 and 12 for the BDI-II, 23 and 18 for the IDS-SR, and 12.5 and 9 for the MADRS. ROC analyses yielded almost equal reference values. The discriminative power of the BDI-II, IDS-SR and MADRS scores was very high. Internal consistency was excellent for total scores and satisfactory for all subscales, except for the IDS-SR subscale Atypical Characteristics. LIMITATIONS: Substantial non-response and limited generalizability. CONCLUSIONS: For the BDI-II, IDS-SR and MADRS a comprehensive set of reference values were provided. Reference values were higher in women than in men, implying the use of sex-specific cut-off values. Either instrument can be offered to every patient with MAS disorders to make responsible decisions about continuing, changing or terminating therapy.

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.

Vasey, M. W., C. N. Harbaugh, et al. (2013). ***"Dimensions of temperament and depressive symptoms: Replicating a three-way interaction."*** Journal of Research in Personality 47(6): 908-921. http://www.sciencedirect.com/science/article/pii/S0092656613001207

High negative emotionality (NE), low positive emotionality (PE), and low self-regulatory capacity (i.e., effortful control or EC) are related to depressive symptoms and furthermore, may moderate one another’s relations to such symptoms. Indeed, preliminary evidence suggests they may operate in a three-way interaction (Dinovo & Vasey, 2011), but the replicability of that finding remains unknown. Therefore, we tested this NE × PE × EC interaction in association with depressive symptoms in 5 independent samples. This interaction was significant in 4 of the 5 samples and a combined sample and approached significance in the fifth sample. In contrast, the NE × PE × EC interaction was unrelated to general anxious symptoms and thus may be specific to symptoms of depression. Implications, directions for future research, and limitations are discussed.

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 ⩽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.