25 depression-relevant abstracts october '14 newsletter

(Abbass, Kisely et al. 2014; Bedson, Bell et al. 2014; Bergink and Kushner 2014; Beute and de Kort 2014; Callan, Kay et al. 2014; Clements, Castro et al. 2014; Cooney, Dwan et al. 2014; Costello 2014; Cuijpers 2014; Diav-Citrin, Shechtman et al. 2014; Diedrich, Grant et al. 2014; Graham and Crown 2014; Hollon, DeRubeis et al. 2014; King, Marston et al. 2014; Lilienfeld, Ritschel et al. 2014; Limb 2014; Luby, Gaffrey et al. 2014; Marwaha, He et al. 2014; Petersen, Evans et al. 2014; Peterson-Post, Rhoades et al. 2014; Richardson, Ludman et al. 2014; Saint Onge, Krueger et al. 2014; Swartz and Swanson 2014; Takizawa, Maughan et al. 2014; van der Noordt, IJzelenberg et al. 2014)

Abbass, A. A., S. R. Kisely, et al. (2014). ***"Short-term psychodynamic psychotherapies for common mental disorders."*** Cochrane Database Syst Rev 7: CD004687. http://www.ncbi.nlm.nih.gov/pubmed/24984083

BACKGROUND: Since the mid-1970s, short-term psychodynamic psychotherapies (STPP) for a broad range of psychological and somatic disorders have been developed and studied. Early published meta-analyses of STPP, using different methods and samples, have yielded conflicting results, although some meta-analyses have consistently supported an empirical basis for STPP. This is an update of a review that was last updated in 2006. OBJECTIVES: To evaluate the efficacy of STPP for adults with common mental disorders compared with wait-list controls, treatments as usual and minimal contact controls in randomised controlled trials (RCTs). To specify the differential effects of STPP for people with different disorders (e.g. depressive disorders, anxiety disorders, somatoform disorders, mixed disorders and personality disorder) and treatment characteristics (e.g. manualised versus non-manualised therapies). SEARCH METHODS: The Cochrane Depression, Anxiety and Neurosis Group's Specialised Register (CCDANCTR) was searched to February 2014, this register includes relevant randomised controlled trials from The Cochrane Library (all years), EMBASE (1974-), MEDLINE (1950-) and PsycINFO (1967-). We also conducted searches on CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, DARE and Biological Abstracts (all years to July 2012) and all relevant studies (identified to 2012) were fully incorporated in this review update. We checked references from papers retrieved. We contacted a large group of psychodynamic researchers in an attempt to find new studies. SELECTION CRITERIA: We included all RCTs of adults with common mental disorders, in which a brief psychodynamic therapy lasting 40 or fewer hours in total was provided in individual format. DATA COLLECTION AND ANALYSIS: Eight review authors working in pairs evaluated studies. We selected studies only if pairs of review authors agreed that the studies met inclusion criteria. We consulted a third review author if two review authors could not reach consensus. Two review authors collected data and entered it into Review Manager software. Two review authors assessed and scored risk of bias. We assessed publication bias using a funnel plot. Two review authors conducted and reviewed subgroup analyses. MAIN RESULTS: We included 33 studies of STPP involving 2173 randomised participants with common mental disorders. Studies were of diverse conditions in which problems with emotional regulation were purported to play a causative role albeit through a range of symptom presentations. These studies evaluated STPP for this review's primary outcomes (general, somatic, anxiety and depressive symptom reduction), as well as interpersonal problems and social adjustment. Except for somatic measures in the short-term, all outcome categories suggested significantly greater improvement in the treatment versus the control groups in the short-term and medium-term. Effect sizes increased in long-term follow-up, but some of these effects did not reach statistical significance. A relatively small number of studies (N < 20) contributed data for the outcome categories. There was also significant heterogeneity between studies in most categories, possibly due to observed differences between manualised versus non-manualised treatments, short versus longer treatments, studies with observer-rated versus self report outcomes, and studies employing different treatment models. AUTHORS' CONCLUSIONS: There has been further study of STPP and it continues to show promise, with modest to large gains for a wide variety of people. However, given the limited data, loss of significance in some measures at long-term follow-up and heterogeneity between studies, these findings should be interpreted with caution. Furthermore, variability in treatment delivery and treatment quality may limit the reliability of estimates of effect for STPP. Larger studies of higher quality and with specific diagnoses are warranted.

Bedson, E., D. Bell, et al. (2014). ***"Folate augmentation of treatment - evaluation for depression (folated): Randomised trial and economic evaluation."*** Health Technol Assess 18(48). http://journalslibrary.nihr.ac.uk/hta/hta18480

Background: Folate deficiency is associated with depression. Despite the biological plausibility of a causal link, the evidence that adding folate enhances antidepressant treatment is weak. Folate deficiency is associated with depression. Despite the biological plausibility of a causal link, the evidence that adding folate enhances antidepressant treatment is weak. Objectives: (1) Estimate the clinical effectiveness and cost-effectiveness of folic acid as adjunct to antidepressant medication (ADM). (2) Explore whether baseline folate and homocysteine predict response to treatment. (3) Investigate whether response to treatment depends on genetic polymorphisms related to folate metabolism. (1) Estimate the clinical effectiveness and cost-effectiveness of folic acid as adjunct to antidepressant medication (ADM). (2) Explore whether baseline folate and homocysteine predict response to treatment. (3) Investigate whether response to treatment depends on genetic polymorphisms related to folate metabolism. Design: FolATED (Folate Augmentation of Treatment - Evaluation for Depression) was a double-blind and placebo-controlled, but otherwise pragmatic, randomised trial including cost-utility analysis. To yield 80% power of detecting standardised difference on the Beck Depression Inventory version 2 (BDI-II) of 0.3 between groups (a 'small' effect), FolATED trialists sought to analyse 358 participants. To allow for an estimated loss of 21% of participants over three time points, we planned to randomise 453. FolATED (Folate Augmentation of Treatment - Evaluation for Depression) was a double-blind and placebo-controlled, but otherwise pragmatic, randomised trial including cost-utility analysis. To yield 80% power of detecting standardised difference on the Beck Depression Inventory version 2 (BDI-II) of 0.3 between groups (a 'small' effect), FolATED trialists sought to analyse 358 participants. To allow for an estimated loss of 21% of participants over three time points, we planned to randomise 453. Settings: Clinical - Three centres in Wales - North East Wales, North West Wales and Swansea. Trial management - North Wales Organisation for Randomised Trials in Health in Bangor University. Biochemical analysis - University Hospital of Wales, Cardiff. Genetic analysis - University of Liverpool. Clinical - Three centres in Wales - North East Wales, North West Wales and Swansea. Trial management - North Wales Organisation for Randomised Trials in Health in Bangor University. Biochemical analysis - University Hospital of Wales, Cardiff. Genetic analysis - University of Liverpool. Participants: Four hundred and seventy-five adult patients presenting to primary or secondary care with confirmed moderate to severe depression for which they were taking or about to start ADM, and able to consent and complete assessments, but not (1) folate deficient, vitamin B12 deficient, or taking folic acid or anticonvulsants; (2) misusing drugs or alcohol, or suffering from psychosis, bipolar disorder, malignancy or other unstable or terminal illness; (3) (planning to become) pregnant; or (4) participating in other clinical research. Four hundred and seventy-five adult patients presenting to primary or secondary care with confirmed moderate to severe depression for which they were taking or about to start ADM, and able to consent and complete assessments, but not (1) folate deficient, vitamin B12 deficient, or taking folic acid or anticonvulsants; (2) misusing drugs or alcohol, or suffering from

psychosis, bipolar disorder, malignancy or other unstable or terminal illness; (3) (planning to become) pregnant; or (4) participating in other clinical research. Interventions: Once a day for 12 weeks experimental participants added 5 mg of folic acid to their ADM, and control participants added an indistinguishable placebo. All participants followed pragmatic management plans initiated by a trial psychiatrist and maintained by their general medical practitioners. Once a day for 12 weeks experimental participants added 5 mg of folic acid to their ADM, and ontrol participants added an indistinguishable placebo. All participants followed pragmatic management plans initiated by a trial psychiatrist and maintained by their general medical practitioners. Main outcome measures: Assessed at baseline, and 4, 12 and 25 weeks thereafter, and analysed by 'area under curve' (main); by analysis of covariance at each time point (secondary); and by multi-level repeated measures (sensitivity analysis): Mental health - BDI-II (primary), Clinical Global Impression (CGI), Montgomery-Åsberg Depression Rating Scale (MADRS), UKU side effects scale, and Mini International Neuropsychiatric Interview (MINI) suicidality subscale; General health - UK 12-item Short Form Health Survey (SF-12), European Quality of Life scale - 5 Dimensions (EQ-5D); Biochemistry - serum folate, B12, homocysteine; Adherence - Morisky Questionnaire; Economics - resource use. Assessed at baseline, and 4, 12 and 25 weeks thereafter, and analysed by 'area under curve' (main); by analysis of covariance at each time point (secondary); and by multi-level repeated measures (sensitivity analysis): Mental health - BDI-II (primary), Clinical Global Impression (CGI), Montgomery-Åsberg Depression Rating Scale (MADRS), UKU side effects scale, and Mini International Neuropsychiatric Interview (MINI) suicidality subscale; General health - UK 12-item Short Form Health Survey (SF-12), European Quality of Life scale - 5 Dimensions (EQ-5D); Biochemistry - serum folate, B12, homocysteine; Adherence - Morisky Questionnaire; Economics - resource use. Results: Folic acid did not significantly improve any of these measures. For example it gained a mean of just 2.9 quality-adjusted life-days [95% confidence interval (CI) from -12.7 to 7.0 days] and saved a mean of just £48 (95% CI from -£292 to £389). In contrast it significantly reduced mental health scores on the SF-12 by 3.0% (95% CI from -5.2% to -0.8%). Folic acid did not significantly improve any of these measures. For example it gained a mean of just 2.9 quality-adjusted life-days [95% confidence interval (CI) from -12.7 to 7.0 days] and saved a mean of just £48 (95% CI from -£292 to £389). In contrast it significantly reduced mental health scores on the SF-12 by 3.0% (95% CI from -5.2% to -0.8%). Conclusions: The FolATED trial generated no evidence that folic acid was clinically effective or cost-effective in augmenting ADM. This negative finding is consistent with improving understanding of the one-carbon folate pathway suggesting that methylfolate is a better candidate for augmenting ADM. Hence the findings of FolATED undermine treatment guidelines that advocate folic acid for treating depression, and suggest future trials of methylfolate to augment ADM. The FolATED trial generated no evidence that folic acid was clinically effective or cost-effective in augmenting ADM. This negative finding is consistent with improving understanding of the one-carbon folate pathway suggesting that methylfolate is a better candidate for augmenting ADM. Hence the findings of FolATED undermine treatment guidelines that advocate folic acid for treating depression, and suggest future trials of methylfolate to augment ADM. Trial registration: Current Controlled Trials ISRCTN37558856. Current Controlled Trials ISRCTN37558856. Funding: This project was funded by the NIHR Health Technology Assessment programme and will be published in full in Health Technology Assessment; Vol. 18, No. 48. See the HTA programme website for further project information. This project was funded by the NIHR Health Technology Assessment programme and will be published in full in Health Technology Assessment; Vol. 18, No. 48. See the HTA programme website for further project information.

Bergink, V. and S. A. Kushner (2014). ***"Lithium during pregnancy."*** American Journal of Psychiatry 171(7): 712-715. http://dx.doi.org/10.1176/appi.ajp.2014.14030409

(Freely available online) Lithium therapy is widely recommended as a first-line treatment for bipolar disorder, with demonstrated efficacy in both depression and mania, as well as in reducing the risk of suicide (1). During pregnancy, lithium is well established as an effective mood stabilizer and protective for women at high risk of relapse during the postpartum period (2–4). Among all mood stabilizers, lithium has the largest evidence base for efficacy in the peripartum period. During pregnancy, the benefits of medication need to be carefully weighed against risks for the mother, for the fetus, and of neonatal complications, as well as risks during breast-feeding. Accordingly, significant efforts have been made to define these risks for all medications available to pregnant women, including psychopharmacological medications. For example, both valproate and carbamazepine have been clearly associated with congenital abnormalities (5). In contrast, the data regarding lithium have proven more difficult to interpret. Some studies have reported higher incidences of cardiotoxicity and Ebstein's anomaly in children born to women taking lithium during pregnancy, whereas this association was not observed in other studies (6–10). In 2012, McKnight et al. (11) reported the outcome of a meta-analysis, which concluded that the odds of lithium exposure in cases of Ebstein's anomaly were not significantly elevated. Specifically, they stated: "The evidence that exposure to lithium is teratogenic is quite weak, and our findings accord with the notion that the risk has been overestimated" (11). Importantly, however, the authors also cautioned that the strength of their conclusion was limited by the small number of cases and that further studies with larger numbers of cases would be needed to establish this result more definitively. It is against the backdrop of this unresolved issue of paramount importance to peripartum mental health care that Diav-Citrin et al. (12), in this issue of the Journal, have now provided novel data from a prospective cohort study of lithium use during pregnancy. Pregnant women who contacted the Israeli Teratology Information Service were enrolled over a 6-year period. In total, 183 lithium-exposed pregnancies were included and prospectively followed during pregnancy and the postpartum period. The majority of patients had bipolar disorder or mania (67.4%), while the remaining patients were diagnosed with either unipolar depression or a primary psychotic disorder. Of these 183 patients, 121 women also used concurrent psychiatric medication. In the same time period, 72 disease-matched pregnant women were enrolled. These women with bipolar disorder were either untreated during pregnancy or taking antipsychotics and/or antidepressants. An additional comparison group consisted of 748 nonteratogenic-exposed pregnancies.

Beute, F. and Y. A. W. de Kort (2014). ***"Salutogenic effects of the environment: Review of health protective effects of nature and daylight."*** Applied Psychology: Health and Well-Being 6(1): 67-95. http://dx.doi.org/10.1111/aphw.12019

Both nature and daylight have been found to positively influence health. These findings were, however, found in two separate research domains. This paper presents an overview of effects found for daylight and nature on health and the health-related concepts stress, mood, and executive functioning and self-regulation. Because of the overlap in effects found and the co-occurrence of both phenomena, the paper points to the need to consider daylight factors when investigating effects of nature and vice versa. Furthermore, the existence of possibly shared underlying mechanisms is discussed and the need to unify the research paradigms and dependent variables used between the two research fields. Last, in view of the beneficial effects of both phenomena on health, our objective is to raise awareness amongst the general public, designers, and health practitioners to use these naturally available phenomena to their full potential.

Callan, M. J., A. C. Kay, et al. (2014). ***"Making sense of misfortune: Deservingness, self-esteem, and patterns of self-defeat."*** Journal of Personality and Social Psychology 107(1): 142-162. http://psycnet.apa.org/journals/psp/107/1/142.html

(Free full text available) Drawing on theorizing and research suggesting that people are motivated to view their world as an orderly and predictable place in which people get what they deserve, the authors proposed that (a) random and uncontrollable bad outcomes will lower self-esteem and (b) this, in turn, will lead to the adoption of self-defeating beliefs and

behaviors. Four experiments demonstrated that participants who experienced or recalled bad (vs. good) breaks devalued their self-esteem (Studies 1a and 1b), and that decrements in self-esteem (whether arrived at through misfortune or failure experience) increase beliefs about deserving bad outcomes (Studies 1a, 1b, 2a, 2b). Five studies (Studies 3–7) extended these findings by showing that this, in turn, can engender a wide array of self-defeating beliefs and behaviors, including claimed self-handicapping ahead of an ability test (Study 3), the preference for others to view the self less favorably (Studies 4–5), chronic self-handicapping and thoughts of physical self-harm (Study 6), and choosing to receive negative feedback during an ability test (Study 7). The current findings highlight the important role that concerns about deservingness play in the link between lower self-esteem and patterns of self-defeating beliefs and behaviors. The theoretical and practical implications of these findings are discussed.

Clements, C. C., V. M. Castro, et al. (2014). ***"Prenatal antidepressant exposure is associated with risk for attention-deficit hyperactivity disorder but not autism spectrum disorder in a large health system."*** Mol Psychiatry. http://dx.doi.org/10.1038/mp.2014.90

Previous studies suggested that risk for Autism Spectrum Disorder (ASD) may be increased in children exposed to antidepressants during the prenatal period. The disease specificity of this risk has not been addressed and the possibility of confounding has not been excluded. Children with ASD or attention-deficit hyperactivity disorder (ADHD) delivered in a large New England health-care system were identified from electronic health records (EHR), and each diagnostic group was matched 1:3 with children without ASD or ADHD. All children were linked with maternal health data using birth certificates and EHRs to determine prenatal medication exposures. Multiple logistic regression was used to examine association between prenatal antidepressant exposures and ASD or ADHD risk. A total of 1377 children diagnosed with ASD and 2243 with ADHD were matched with healthy controls. In models adjusted for sociodemographic features, antidepressant exposure prior to and during pregnancy was associated with ASD risk, but risk associated with exposure during pregnancy was no longer significant after controlling for maternal major depression (odds ratio (OR) 1.10 (0.70-1.70)). Conversely, antidepressant exposure during but not prior to pregnancy was associated with ADHD risk, even after adjustment for maternal depression (OR 1.81 (1.22-2.70)). These results suggest that the risk of autism observed with prenatal antidepressant exposure is likely confounded by severity of maternal illness, but further indicate that such exposure may still be associated with ADHD risk. This risk, modest in absolute terms, may still be a result of residual confounding and must be balanced against the substantial consequences of untreated maternal depression.

Cooney, G., K. Dwan, et al. (2014). ***"Exercise for depression."*** JAMA 311(23): 2432-2433. http://dx.doi.org/10.1001/jama.2014.4930

Clinical Question: Is exercise an effective treatment for depression? Bottom Line: Exercise is associated with a greater reduction in depression symptoms compared with no treatment, placebo, or active control interventions, such as relaxation or meditation. However, analysis of high-quality studies alone suggests only small benefits.

Costello, E. J. (2014). ***"Adult outcomes of childhood bullying victimization."*** American Journal of Psychiatry 171(7): 709-711. http://dx.doi.org/10.1176/appi.ajp.2014.14040466

In "Tom Brown's School Days" (1) the evil bully Henry Flashman roasts young Tom Brown in front of the great fire in the Rugby school common room until Tom's trousers are seared onto his thighs. Flashman is soon expelled from Rugby—but for drunkenness, not for bullying. He goes on to become Sir Harry Paget Flashman, VC, KCB, KCIE, an "illustrious Victorian soldier" (according to Wikipedia) and the hero of a dozen novels. Thomas Hughes, the early Victorian author of the Tom Brown stories, has Tom go to Oxford, fall in love, and come to no harm from his experiences at Flashman's hands. In this, Hughes's attitude is one held by most parents and teachers until quite recently. As part of the process of growing up to be "a brave, helpful, truth-telling Englishman, and a gentleman" (p. 69), being bullied is inevitable if not actually a good thing. The Arseneault group (Takizawa et al. [2]) brings this Victorian view of bullying up to date. They use data from a 50-year-old study to document the adult consequences of being bullied as a child. Parents of a representative birth cohort of British children born in 1958, interviewed when their child was 7 years old, and again at 11, reported whether their child was bullied by other children never, sometimes, or frequently. After adequate controls for attrition and potential confounds, answers to this single question predicted many kinds of poor biopsychosocial functioning decades later: psychological distress at ages 23 and 50, depression at age 45, poor physical health at ages 23 and 50, and poorer cognitive function at age 50. It is worth noting that these are the ages at which these variables were measured; absence of effects at other ages means that variables were not measured, not that the results were nonsignificant. So bullying predicts poorer functioning up to 40 years later. But how much does this matter in real-world terms? The authors have tested this by comparing the effects of bullying to those of other childhood problems known to bode ill for adult functioning: placement in public or substitute care; unattractive physical appearance; and being in the worst quartile on a scale of poor parenting, physical or sexual abuse, poverty, and parental mental illness or drug problems. The risk of problems in adulthood that were created by bullying was of the same magnitude in each case. Furthermore, the outcomes remained significant after controlling for a wide range of correlated risks.

Cuijpers, P. (2014). ***"Combined pharmacotherapy and psychotherapy in the treatment of mild to moderate major depression?"*** JAMA Psychiatry 71(7): 747-748. http://dx.doi.org/10.1001/jamapsychiatry.2014.277

Treatment guidelines for major depressive disorders suggest that combined treatment of pharmacotherapy and psychotherapy may be helpful in the acute phase of severe major depression. However, combined treatment is not strongly recommended in mild to moderate depression. In these cases, either pharmacotherapy or psychotherapy can be used, depending on the preference of the patient, the treatment history, and other clinical factors. However, is this recommendation still supported by the current state of knowledge? In this Viewpoint, I will discuss recent evidence suggesting that combined treatment could be a first-line treatment in the acute phase of mild to moderate depressive disorders and whether this evidence is strong enough to reconsider the recommendations in treatment guidelines.

Diav-Citrin, O., S. Shechtman, et al. (2014). ***"Pregnancy outcome following in utero exposure to lithium: A prospective, comparative, observational study."*** Am J Psychiatry 171(7): 785-794. http://ajp.psychiatryonline.org/article.aspx?articleid=1866346

OBJECTIVE: The authors conducted a prospective, comparative observational study to evaluate the risk of major anomalies following exposure to lithium during pregnancy. METHOD: A total of 183 lithium-exposed pregnancies of women who contacted the Israeli Teratology Information Service were followed up (90.2% in the first trimester) and compared with 72 disease-matched and 748 nonteratogenic-exposed pregnancies. RESULTS: There were significantly more miscarriages (adjusted odds ratio=1.94, 95% CI=1.08-3.48) and elective terminations of pregnancy (17/183 [9.3%] compared with 15/748 [2.0%]) in the lithium-exposed group compared with the nonteratogenic exposure group. The rate of major congenital anomalies after exclusion of genetic or cytogenetic anomalies was not significantly different between the three groups (lithium-exposed in the first trimester: 8/123 [6.5%]; bipolar: 2/61 [3.3%]; nonteratogenic: 19/711 [2.7%]). Cardiovascular anomalies occurred more

frequently in the lithium group exposed during the first trimester when compared with the nonteratogenic exposure group (5/123 [4.1%] compared with 4/711 [0.6%]) but not after excluding anomalies that spontaneously resolved (3/123 [2.4%] compared with 2/711 [0.3%]). Ebstein's anomaly was diagnosed in one lithium-exposed fetus and in two retrospective lithium cases that were not included because contact with the information service was made after the prenatal diagnosis by ultrasound. The rate of noncardiovascular anomalies was not significantly different between the groups. The rate of preterm deliveries was higher in the lithium group compared with the nonteratogenic exposure group (18/131 [13.7%] compared with 41/683 [6.0%]). CONCLUSIONS: Lithium treatment in pregnancy is associated with a higher rate of cardiovascular anomalies. Women who are treated with lithium during organogenesis should undergo fetal echocardiography and level-2 ultrasound.

Diedrich, A., M. Grant, et al. (2014). ***"Self-compassion as an emotion regulation strategy in major depressive disorder."*** Behaviour Research and Therapy 58(0): 43-51. http://www.sciencedirect.com/science/article/pii/S0005796714000758

Cognitive reappraisal and acceptance are two presumably adaptive emotion regulation strategies in depression. More recently, self-compassion has been discussed as another potentially effective strategy for coping with depression. In the present study, we compared the effectiveness of self-compassion with a waiting condition, reappraisal, and acceptance in a clinically depressed sample, and tested the hypothesis that the intensity of depressed mood would moderate the differential efficacy of these strategies. In an experimental design, we induced depressed mood at four points in time in 48 participants meeting criteria for major depressive disorder. After each mood induction, participants were instructed to wait, reappraise the situation, accept their negative emotions, or employ self-compassion to regulate their depressed mood. Self-ratings of depressed mood were assessed before and after each mood induction and regulation phase. Results showed that the reduction of depressed mood was significantly greater in the self-compassion condition than in the waiting condition. No significant differences were observed between the self-compassion and the reappraisal condition, and between the self-compassion and the acceptance condition in patients' mood ratings. However, the intensity of self-rated depressed mood at baseline was found to moderate the comparative effectiveness of self-compassion and reappraisal with a trend of self-compassion being more effective than reappraisal in high depressed mood at baseline. These findings support the use of self-compassion as another adaptive emotion regulation strategy for patients with major depressive disorder, especially for those suffering from high levels of depressed mood.

Graham, C. and S. Crown (2014). ***"Religion and well-being around the world: Social purpose, social time, or social insurance?"*** International Journal Of Wellbeing 4(1): 1-27. http://www.internationaljournalofwellbeing.org/index.php/ijow/article/view/258

A number of studies find that religious people are happier than non-religious ones. Yet a number of fundamental questions about that relationship remain unanswered. A critical one is the direction of causality: does religion make people happier or are happier people more likely to have faith in something that is beyond their control? We posit that the relationship between religion and wellbeing is mediated by factors ranging from intrinsic purpose, to its social aspects, to its role as an insurance mechanism for people who face great adversity. We explore a number of related questions, using world-wide data from the Gallup World Poll. As these data are cross-section data, we cannot establish causality; we do, however, explore: how or if the relationship between religion and wellbeing varies across the two distinct wellbeing dimensions (hedonic and evaluative); how social externalities mediate the relationship; how the relationship changes as countries and people within them become more prosperous and acquire greater means and agency; and how the relationship between religion and wellbeing varies depending on where respondents are in the wellbeing distribution. We find that the positive relation between religion and evaluative wellbeing is more important for respondents with lower levels of agency, while the positive relation with hedonic wellbeing holds across the board. The social dimension of religion is most important for the least social respondents, while the religiosity component of religion is most important for the happiest respondents, regardless of religious affiliation or service attendance. As such, it seems that the happiest are most likely to seek social purpose in religion, the poorest are most likely to seek social insurance in religion, and the least social are the most likely to seek social time in religion.

Hollon, S. D., R. J. DeRubeis, et al. (2014). ***"Effect of cognitive therapy with antidepressant medications vs antidepressants alone on the rate of recovery in major depressive disorder: A randomized clinical trial."*** JAMA Psychiatry. http://dx.doi.org/10.1001/jamapsychiatry.2014.1054

Importance Antidepressant medication (ADM) is efficacious in the treatment of depression, but not all patients achieve remission and fewer still achieve recovery with ADM alone.Objective To determine the effects of combining cognitive therapy (CT) with ADM vs ADM alone on remission and recovery in major depressive disorder (MDD).Design, Setting, and Participants A total of 452 adult outpatients with chronic or recurrent MDD participated in a trial conducted in research clinics at 3 university medical centers in the United States. The patients were randomly assigned to ADM treatment alone or CT combined with ADM treatment. Treatment was continued for up to 42 months until recovery was achieved.Interventions Antidepressant medication with or without CT.Main Outcomes and Measures Blind evaluations of recovery with a modified version of the 17-item Hamilton Rating Scale for Depression and the Longitudinal Interval Follow-up Evaluation.Results Combined treatment enhanced the rate of recovery vs treatment with ADM alone (72.6% vs 62.5%; $t451 = 2.45$; $P = .01$; hazard ratio [HR], 1.33; 95% CI, 1.06-1.68; number needed to treat [NNT], 10; 95% CI, 5-72). This effect was conditioned on interactions with severity ($t451 = 1.97$; $P = .05$; NNT, 5) and chronicity ($\chi 2 = 7.46$; $P = .02$; NNT, 6) such that the advantage for combined treatment was limited to patients with severe, nonchronic MDD (81.3% vs 51.7%; $n = 146$; $t145 = 3.96$; $P = .001$; HR, 2.34; 95% CI, 1.54-3.57; NNT, 3; 95% CI, 2-5). Fewer patients dropped out of combined treatment vs ADM treatment alone (18.9% vs 26.8%; $t451 = -2.04$; $P = .04$; HR, 0.66; 95% CI, 0.45-0.98). Remission rates did not differ significantly either as a main effect of treatment or as an interaction with severity or chronicity. Patients with comorbid Axis II disorders took longer to recover than did patients without comorbid Axis II disorders regardless of the condition ($P = .01$). Patients who received combined treatment reported fewer serious adverse events than did patients who received ADMs alone (49 vs 71; $P = .02$), largely because they experienced less time in an MDD episode.Conclusions and Relevance Cognitive therapy combined with ADM treatment enhances the rates of recovery from MDD relative to ADMs alone, with the effect limited to patients with severe, nonchronic depression.Trial Registration clinicaltrials.gov Identifier: NCT00057577

King, M., L. Marston, et al. (2014). ***"Comparison of non-directive counselling and cognitive behaviour therapy for patients presenting in general practice with an ICD-10 depressive episode: A randomized control trial."*** Psychological Medicine 44(09): 1835-1844. http://dx.doi.org/10.1017/S0033291713002377

Background Most evidence in the UK on the effectiveness of brief therapy for depression concerns cognitive behaviour therapy (CBT). In a trial published in 2000, we showed that non-directive counselling and CBT were equally effective in general practice for patients with depression and mixed anxiety and depression. Our results were criticized for including patients not meeting diagnostic criteria for a depressive disorder. In this reanalysis we aimed to compare the effectiveness of the two

therapies for patients with an ICD-10 depressive episode. Method Patients with an ICD-10 depressive episode or mixed anxiety and depression were randomized to counselling, CBT or usual general practitioner (GP) care. Counsellors provided nondirective, interpersonal counselling following a manual that we developed based on the work of Carl Rogers. Cognitive behaviour therapists provided CBT also guided by a manual. Modelling was carried out using generalized estimating equations with the multiply imputed datasets. Outcomes were mean scores on the Beck Depression Inventory, Brief Symptom Inventory, and Social Adjustment Scale at 4 and 12 months. Results A total of 134 participants were randomized to CBT, 126 to counselling and 67 to usual GP care. We undertook (1) an interaction analysis using all 316 patients who were assigned a diagnosis and (2) a head-to-head comparison using only those 130 (41%) participants who had an ICD-10 depressive episode at baseline. CBT and counselling were both superior to GP care at 4 months but not at 12 months. There was no difference in the effectiveness of the two psychological therapies. Conclusions We recommend that national clinical guidelines take our findings into consideration in recommending effective alternatives to CBT.

Lilienfeld, S. O., L. A. Ritschel, et al. (2014). ***"Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness."*** Perspectives on Psychological Science 9(4): 355-387. http://pps.sagepub.com/content/9/4/355.abstract

The past 40 years have generated numerous insights regarding errors in human reasoning. Arguably, clinical practice is the domain of applied psychology in which acknowledging and mitigating these errors is most crucial. We address one such set of errors here, namely, the tendency of some psychologists and other mental health professionals to assume that they can rely on informal clinical observations to infer whether treatments are effective. We delineate four broad, underlying cognitive impediments to accurately evaluating improvement in psychotherapy—naive realism, confirmation bias, illusory causation, and the illusion of control. We then describe 26 causes of spurious therapeutic effectiveness (CSTEs), organized into a taxonomy of three overarching categories: (a) the perception of client change in its actual absence, (b) misinterpretations of actual client change stemming from extratherapeutic factors, and (c) misinterpretations of actual client change stemming from nonspecific treatment factors. These inferential errors can lead clinicians, clients, and researchers to misperceive useless or even harmful psychotherapies as effective. We (a) examine how methodological safeguards help to control for different CSTEs, (b) delineate fruitful directions for research on CSTEs, and (c) consider the implications of CSTEs for everyday clinical practice. An enhanced appreciation of the inferential problems posed by CSTEs may narrow the science–practice gap and foster a heightened appreciation of the need for the methodological safeguards afforded by evidence-based practice.

Limb, M. (2014). ***Three in four cancer patients with depression are not getting adequate treatment, studies find***.

Major depression in patients with cancer is often "missed" or "overlooked" such that nearly three quarters are not receiving adequate treatment, research has found. Many of these patients would benefit from a new integrated treatment programme found to be "strikingly" more effective than current care at reducing depression and improving the quality of life, the researchers said. The research findings were contained in three papers, funded by Cancer Research UK and the Scottish government and published simultaneously across three Lancet journals on 28 August (the Lancet, Lancet Psychiatry, and Lancet Oncology) ... 1.) Walker J, Hansen C, Martin P, Symeonides S, Ramesseur R, Murray G, et al. Prevalence, associations and adequacy of treatment of major depression in patients with cancer: a cross sectional analysis of routinely collected data. Lancet Psychiatry 28 August 2014. http://dx.doi.org/10.1016/S2215-0366(14)70313-X. 2.) Sharpe M, Walker J, Hansen C, Martin P, Symeonides S. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Ocology-2): a multicentre randomised controlled effectiveness trial. Lancet 28 August 2014. http://dx.doi.org/10.1016/S0140-6736(14)61231-9. 3.) Walker J, Hansen C, Martin P, Symeonides S, Gourley C, Wall L, et al. Integrated collaborative care for major depression comorbid with a poor prognosis cancer (SMaRT Oncology-3): a multicentre randomised controlled trial in patients with lung cancer. Lancet Oncol2014;15:1168-76.

Luby, J. L., M. S. Gaffrey, et al. (2014). ***"Trajectories of preschool disorders to full DSM depression at school age and early adolescence: Continuity of preschool depression."*** Am J Psychiatry 171(7): 768-776. http://www.ncbi.nlm.nih.gov/pubmed/24700355

OBJECTIVE: Preschool-onset depression, a developmentally adapted form of depression arising between ages 3 and 6, has demonstrated numerous validated features, including characteristic alterations in stress reactivity and brain function. This syndrome is characterized by subthreshold DSM criteria for major depressive disorder, raising questions about its clinical significance. To clarify the utility and public health significance of the preschool-onset depression construct, the authors investigated diagnostic outcomes of preschool children at school age and in adolescence. METHOD: In a longitudinal prospective study of preschool children, the authors assessed the likelihood of meeting full criteria for major depressive disorder at age 6 or later as a function of preschool depression, other preschool axis I disorders, maternal history of depression, nonsupportive parenting, and traumatic life events. RESULTS: Preschool-onset depression emerged as a robust predictor of major depressive disorder in later childhood even after accounting for the effect of maternal history of depression and other risk factors. Preschool-onset conduct disorder also predicted major depression in later childhood, but this association was partially mediated by nonsupportive parenting, reducing by 21% the effect of preschool conduct disorder in predicting major depression. CONCLUSIONS: Study findings provide evidence that this preschool depressive syndrome is a robust risk factor for developing full criteria for major depression in later childhood, over and above other established risk factors. The results suggest that attention to preschool depression and conduct disorder in addition to maternal history of depression and exposure to trauma may be important in identifying young children at highest risk for later major depression and applying early interventions.

Marwaha, S., Z. He, et al. (2014). ***"How is affective instability defined and measured? A systematic review."*** Psychological Medicine 44(09): 1793-1808. http://dx.doi.org/10.1017/S0033291713002407

Background Affective instability (AI) is poorly defined but considered clinically important. The aim of this study was to examine definitions and measures of AI employed in clinical populations. Method This study was a systematic review using the PRISMA guidelines. MEDLINE, Embase, PsycINFO, PsycArticles and Web of Science databases were searched. Also five journals were hand searched. Primary empirical studies involving randomized controlled trials (RCTs), non-RCTs, controlled before and after, and observational investigations were included. Studies were selected, data extracted and quality appraised. A narrative synthesis was completed. Results A total of 11 443 abstracts were screened and 37 studies selected for final analysis on the basis that they provided a definition and measure of AI. Numbers of definitions for each of the terms employed in included studies were: AI (n = 7), affective lability (n = 6), affective dysregulation (n = 1), emotional dysregulation (n = 4), emotion regulation (n = 2), emotional lability (n = 1), mood instability (n = 2), mood lability (n = 1) and mood swings (n = 1); however, these concepts showed considerable overlap in features. A total of 24 distinct measures were identified that could be categorized as primarily measuring one of four facets of AI (oscillation, intensity, ability to regulate and affect change triggered by environment) or as measuring general emotional regulation. Conclusions A clearer definition of AI is required. We propose AI be defined as 'rapid oscillations of intense affect, with a difficulty in regulating these oscillations or their behavioural consequences'.

No single measure comprehensively assesses AI and a combination of current measures is required for assessment. A new short measure of AI that is reliable and validated against external criteria is needed.

Petersen, I., S. Evans, et al. (2014). ***"Prenatal exposure to selective serotonin reuptake inhibitors and autistic symptoms in young children: Another red herring?"*** The British Journal of Psychiatry 205(2): 105-106. http://bjp.rcpsych.org/content/205/2/105.abstract

(Available in free full text) In this issue, El Marroun et al suggest an association between prenatal selective serotonin reuptake inhibitor (SSRI) exposure and autistic traits in children, as well as an association with prenatal depressive symptoms. However, SSRIs may be mere markers of severity of underlying illnesses and it may be premature to reach such conclusions about effects of treatment. Studies like this raise concerns as this may fuel further anxiety and guilt among women who are faced with depression in pregnancy and possibly leave some women without treatment.

Peterson-Post, K. M., G. K. Rhoades, et al. (2014). ***"Perceived criticism and marital adjustment predict depressive symptoms in a community sample."*** Behavior Therapy 45(4): 564-575. http://www.sciencedirect.com/science/article/pii/S0005789414000513

Depressive symptoms are related to a host of negative individual and family outcomes; therefore, it is important to establish risk factors for depressive symptoms to design prevention efforts. Following studies in the marital and psychiatric literatures regarding marital factors associated with depression, we tested two potential predictors of depressive symptoms: marital adjustment and perceived spousal criticism. We assessed 249 spouses from 132 married couples from the community during their first year of marriage and at three time points over the next 10 years. Initial marital adjustment significantly predicted depressive symptoms for husbands and wives at all follow-ups. Further, perceived criticism significantly predicted depressive symptoms at the 5- and 10-year follow-ups. However, at the 1-year follow-up, this association was significant for men but not for women. Finally, a model where the contributions of marital adjustment and perceived criticism were tested together suggested that both play independent roles in predicting future depressive symptoms. These findings highlight the potential importance of increasing marital adjustment and reducing perceived criticism at the outset of marriage as a way to reduce depressive symptoms during the course of marriage.

Richardson, L. P., E. Ludman, et al. (2014). ***"Collaborative care for adolescents with depression in primary care: A randomized clinical trial."*** JAMA 312(8): 809-816. http://dx.doi.org/10.1001/jama.2014.9259

Importance Up to 20% of adolescents experience an episode of major depression by age 18 years yet few receive evidence-based treatments for their depression. Objective To determine whether a collaborative care intervention for adolescents with depression improves depressive outcomes compared with usual care. Design Randomized trial with blinded outcome assessment conducted between April 2010 and April 2013. Setting Nine primary care clinics in the Group Health system in Washington State.Participants Adolescents (aged 13-17 years) who screened positive for depression (Patient Health Questionnaire 9-item [PHQ-9] score ≥10) on 2 occasions or who screened positive and met criteria for major depression, spoke English, and had telephone access were recruited. Exclusions included alcohol/drug misuse, suicidal plan or recent attempt, bipolar disorder, developmental delay, and seeing a psychiatrist.Interventions Twelve-month collaborative care intervention including an initial in-person engagement session and regular follow-up by master's-level clinicians. Usual care control youth received depression screening results and could access mental health services through Group Health. Main Outcomes and Measures The primary outcome was change in depressive symptoms on a modified version of the Child Depression Rating Scale–Revised (CDRS-R; score range, 14-94) from baseline to 12 months. Secondary outcomes included change in Columbia Impairment Scale score (CIS), depression response (≥50% decrease on the CDRS-R), and remission (PHQ-9 score < 5).Results Intervention youth (n = 50), compared with those randomized to receive usual care (n = 51), had greater decreases in CDRS-R scores such that by 12 months intervention youth had a mean score of 27.5 (95% CI, 23.8-31.1) compared with 34.6 (95% CI, 30.6-38.6) in control youth (overall intervention effect: $F_{2,747.3} = 7.24$, $P < .001$). Both intervention and control youth experienced improvement on the CIS with no significant differences between groups. At 12 months, intervention youth were more likely than control youth to achieve depression response (67.6% vs 38.6%, OR = 3.3, 95% CI, 1.4-8.2; P = .009) and remission (50.4% vs 20.7%, OR = 3.9, 95% CI, 1.5-10.6; P = .007). Conclusions and Relevance Among adolescents with depression seen in primary care, a collaborative care intervention resulted in greater improvement in depressive symptoms at 12 months than usual care. These findings suggest that mental health services for adolescents with depression can be integrated into primary care. Trial Registration clinicaltrials.gov Identifier: NCT01140464

Saint Onge, J. M., P. M. Krueger, et al. (2014). ***"The relationship between major depression and nonsuicide mortality for U.S. Adults: The importance of health behaviors."*** The Journals of Gerontology Series B: Psychological Sciences and Social Sciences 69(4): 622-632. http://psychsocgerontology.oxfordjournals.org/content/69/4/622.abstract

Objectives. We aim to elucidate the role of health behaviors and health conditions in the association between depression and mortality. First, we examine the relationship between major depression and nonsuicide mortality among U.S. adults aged 50 and older. Second, we examine the relationship between major depression and cardiovascular disease and cancer, by baseline disease status. Third, we examine the role of health behaviors as potential mediators of the association between major depression and cause-specific mortality.Methods. We use data from the 1999 National Health Interview Study linked to the 2006 National Death Index (N = 11,369; M age = 65, deaths = 2,162) and Cox proportional hazards models to describe the relationships among major depression, health behaviors (alcohol use, cigarette smoking, physical activity), and nonsuicide mortality. We examine cause-specific mortality (cardiovascular and cancer) by baseline disease status.Results. Major depression remains associated with a 43% increase in the risk of death over the follow-up period, after we account for sociodemographic characteristics, health behaviors, and health conditions. Major depression is associated with 2.68 times the risk of cardiovascular disease mortality among those who did not have cardiovascular disease at baseline and 1.82 times for those with baseline cardiovascular disease. Health behaviors reduce the hazard ratio by 17% for all nonsuicide mortality, 3% for cardiovascular disease mortality, and 12% for cancer mortality.Discussion. Our results provide evidence of the important role of health behaviors and health conditions in the depression–mortality relationship and highlight the importance of identifying risk factors for depression among aging adults.

Swartz, H. A. and J. Swanson (2014). ***"Psychotherapy for bipolar disorder in adults: A review of the evidence."*** FOCUS 12: 251-266. http://focus.psychiatryonline.org/article.aspx?articleid=1892872

Although pharmacotherapy is the mainstay of treatment for bipolar disorder, medication offers only partial relief for patients. Treatment with pharmacologic interventions alone is associated with disappointingly low rates of remission, high rates of recurrence, residual symptoms, and psychosocial impairment. Bipolar-specific therapy is increasingly recommended as an essential component of illness management. This review summarizes the available data on psychotherapy for adults with bipolar disorder. We conducted a search of the literature for outcome studies published between 1995 and 2013 and identified 35

reports of 28 randomized controlled trials testing individual or group psychosocial interventions for adults with bipolar disorder. These reports include systematic trials investigating the efficacy and effectiveness of individual psychoeducation, group psychoeducation, individual cognitive-behavioral therapy, group cognitive-behavioral therapy, family therapy, interpersonal and social rhythm therapy, and integrated care management. The evidence demonstrates that bipolar disorder-specific psychotherapies, when added to medication for the treatment of bipolar disorder, consistently show advantages over medication alone on measures of symptom burden and risk of relapse. Whether delivered in a group or individual format, those who receive bipolar disorder-specific psychotherapy fare better than those who do not. Psychotherapeutic strategies common to most bipolar disorder-specific interventions are identified.

Takizawa, R., B. Maughan, et al. (2014). ***"Adult health outcomes of childhood bullying victimization: Evidence from a five-decade longitudinal british birth cohort."*** American Journal of Psychiatry 171(7): 777-784. http://dx.doi.org/10.1176/appi.ajp.2014.13101401

Objective The authors examined midlife outcomes of childhood bullying victimization. Method Data were from the British National Child Development Study, a 50-year prospective cohort of births in 1 week in 1958. The authors conducted ordinal logistic and linear regressions on data from 7,771 participants whose parents reported bullying exposure at ages 7 and 11 years, and who participated in follow-up assessments between ages 23 and 50 years. Outcomes included suicidality and diagnoses of depression, anxiety disorders, and alcohol dependence at age 45; psychological distress and general health at ages 23 and 50; and cognitive functioning, socioeconomic status, social relationships, and well-being at age 50. Results Participants who were bullied in childhood had increased levels of psychological distress at ages 23 and 50. Victims of frequent bullying had higher rates of depression (odds ratio=1.95, 95% CI=1.27–2.99), anxiety disorders (odds ratio=1.65, 95% CI=1.25–2.18), and suicidality (odds ratio=2.21, 95% CI=1.47–3.31) than their nonvictimized peers. The effects were similar to those of being placed in public or substitute care and an index of multiple childhood adversities, and the effects remained significant after controlling for known correlates of bullying victimization. Childhood bullying victimization was associated with a lack of social relationships, economic hardship, and poor perceived quality of life at age 50. Conclusions Children who are bullied—and especially those who are frequently bullied—continue to be at risk for a wide range of poor social, health, and economic outcomes nearly four decades after exposure. Interventions need to reduce bullying exposure in childhood and minimize long-term effects on victims' well-being; such interventions should cast light on causal processes.

van der Noordt, M., H. IJzelenberg, et al. (2014). ***"Health effects of employment: A systematic review of prospective studies."*** Occupational and Environmental Medicine 71(10): 730-736. http://oem.bmj.com/content/71/10/730.abstract

Objectives The purpose of this review was to systematically summarise the literature on the health effects of employment. Methods A search for prospective studies investigating the effect of employment on health was executed in several electronic databases, and references of selected publications were checked. Subsequently, the methodological quality of each study was assessed by predefined criteria. To draw conclusions about the health effect of employment, a best evidence synthesis was used, and if possible, data were pooled. Results 33 prospective studies were included, of which 23 were of high quality. Strong evidence was found for a protective effect of employment on depression and general mental health. Pooled effect sizes showed favourable effects on depression (OR=0.52; 95% CI 0.33 to 0.83) and psychological distress (OR=0.79; 95% CI 0.72 to 0.86). Insufficient evidence was found for general health, physical health and mortality due to lack of studies or inconsistent findings. Conclusions This systematic review indicates that employment is beneficial for health, particularly for depression and general mental health. There is a need for more research on the effects of employment on specific physical health effects and mortality to fill the knowledge gaps.