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(Bergomi, Tschacher et al. 2013; Burnett 2013; Cohen, Greenberg et al. 2013; Fledderus, Bohlmeijer et al. 2013; Fraley, Roisman et al. 2013; Galanter 2013; Gellis, Arigo et al. 2013; Gloria, Faulk et al. 2013; Hipol and Deacon 2013; Hundt, Mignogna et al. 2013; IsHak, Greenberg et al. 2013; Kellett, Purdie et al. 2013; Kocalevent, Hinz et al. 2013; Ma-Kellams and Blascovich 2013; Macatee and Cougle 2013; McKay and Whiteside 2013; Mckenzie and Carter 2013; Mukuria, Brazier et al. 2013; Nock, Green et al. 2013; Norton and Gino 2013; Ravitz, Lancee et al. 2013; RCP 2013; Sauer, Walach et al. 2013; Schare and Wyatt 2013; Sonuga-Barke, Brandeis et al. 2013; Thornicroft, Farrelly et al. 2013; Trépanier, Fernet et al. 2013; Usmani, Chai-Coetzer et al. 2013; Weiner and McKay 2013; Weiss, Hope et al. 2013)

Bergomi, C., W. Tschacher, et al. (2013). ***"Measuring mindfulness: First steps towards the development of a comprehensive mindfulness scale."*** Mindfulness (N Y) 4(1): 18-32. http://dx.doi.org/10.1007/s12671-012-0102-9

The present study describes the development of and results obtained from the first version of a new mindfulness scale: the Comprehensive Inventory of Mindfulness Experiences beta (CHIME-β). The aim of the present analysis was to investigate two relevant open questions in mindfulness assessment: (1) the coverage of aspects of mindfulness and (2) the type of interrelationships among these aspects. A review of the aspects of mindfulness assessed by eight currently available mindfulness questionnaires led to the identification of nine aspects of mindfulness. The CHIME-β was constructed in order to cover each of these aspects in a balanced way. Initially, principal component and confirmatory factor analyses, as well as reliability and validity analyses, were performed in the entire sample (n = 313) of individuals from the general population and mindfulness-based stress reduction (MBSR) groups. The factor structure that emerged from this analysis was further investigated in meditation-trained individuals (n = 144) who had just completed an MBSR intervention. Results suggested a four-factor structure underlying the nine aspects proposed. The relationship between these mindfulness factors appears to be influenced by the degree of meditation experience. In fact, the mindfulness factors showed a greater interconnectedness among mediation-trained participants. Finally, data suggest that a non-avoidant stance plays a central role in mindfulness, while the capacity to put inner experiences into words may be related to mindfulness rather than a component of the construct.

Burnett, D. (2013). ***Nothing personal: The questionable Myers-Briggs test***. Guardian. http://www.guardian.co.uk/science/brain-flapping/2013/mar/19/myers-briggs-test-unscientific

(Free full text available) Burnett writes "I was recently reviewing some psychological lectures for my real job. One of these was on personality tests. The speaker mentioned the Myers-Briggs test, explaining that, while well known (I personally know it from a Dilbert cartoon) the Myers-Briggs test isn't recognised as being scientifically valid so is largely ignored by the field of psychology. I tweeted this fact, thinking it would be of passing interest to a few people. I was unprepared for the intensity of the replies I got. I learned several things that day. 1. The Myers-Briggs Type Indicator (MBTI) is used by countless organisations and industries, although one of the few areas that doesn't use it is psychology, which says a lot. 2. Many people who have encountered the MBTI in the workplace really don't have a lot of positive things to say about it. 3. For some organisations, use of the MBTI seemingly crosses the line into full-blown ideology. So how did something that apparently lacks scientific credibility become such a popular and accepted tool?"

Cohen, R. M., J. M. Greenberg, et al. (2013). ***"Incorporating multidimensional patient-reported outcomes of symptom severity, functioning, and quality of life in the individual burden of illness index for depression to measure treatment impact and recovery in MDD."*** JAMA Psychiatry 70(3): 343-350. http://dx.doi.org/10.1001/jamapsychiatry.2013.286

Context The National Institute of Mental Health Affective Disorders Workgroup identified the assessment of an individual's burden of illness as an important need. The Individual Burden of Illness Index for Depression (IBI-D) metric was developed to meet this need.Objective To assess the use of the IBI-D for multidimensional assessment of treatment efficacy for depressed patients. Design, Setting, and Patients Complete data on depressive symptom severity, functioning, and quality of life (QOL) from depressed patients (N = 2280) at entry and exit of level 1 of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study (12-week citalopram treatment) were used as the basis for calculating IBI-D and self-rating scale changes. Results Principal component analysis of patient responses at the end of level 1 of STAR*D yielded a single principal component, IBI-D, with a nearly identical eigenvector to that previously reported. While changes in symptom severity (Quick Inventory of Depressive Symptomatology–Self Report) accounted for only 50% of the variance in changes in QOL (Quality of Life Enjoyment and Satisfaction Questionnaire–Short Form) and 47% of the variance in changes in functioning (Work and Social Adjustment Scale), changes in IBI-D captured 83% of the variance in changes in QOL and 80% in functioning, while also capturing 79% of the variance in change in symptom severity (Quick Inventory of Depressive Symptomatology–Self Report). Most importantly, the changes in IBI-D of the 36.6% of remitters who had abnormal QOL and/or functioning (mean [SD], 2.98 [0.35]) were significantly less than the changes in IBI-D of those who reported normal QOL and functioning (IBI-D = 1.97; t = 32.6; P < 10−8) with an effect size of a Cohen d of 2.58. In contrast, differences in symptom severity, while significant, had a Cohen d of only 0.78. Conclusions Remission in depressed patients, as defined by a reduction in symptom severity, does not denote normal QOL or functioning. By incorporating multidimensional patient-reported outcomes, the IBI-D provides a single measure that adequately captures the full burden of illness in depression both prior to and following treatment; therefore, it offers a more accurate metric of recovery.

Fledderus, M., E. T. Bohlmeijer, et al. (2013). ***"The role of psychological flexibility in a self-help acceptance and commitment therapy intervention for psychological distress in a randomized controlled trial."*** Behaviour Research and Therapy 51(3): 142-151. http://www.sciencedirect.com/science/article/pii/S0005796712001787

This study examined the role of psychological flexibility, as a risk factor and as a process of change, in a self-help Acceptance and Commitment Therapy (ACT) intervention for adults with mild to moderate depression and anxiety. Participants were randomized to the self-help programme with e-mail support (n = 250), or to a waiting list control group (n = 126). All participants completed measures before and after the intervention to assess depression, anxiety and psychological flexibility. Participants in the experimental condition also completed these measures during the intervention (after three and six weeks) and at a three-month follow-up. With multilevel modelling, it was shown that the effects of the intervention on psychological distress were stronger for participants with higher levels of psychological flexibility. Furthermore, our study showed that improved psychological flexibility mediated the effects of the ACT intervention. With a cross-lagged panel design, it was shown that especially improvements in psychological flexibility in the last three sessions of the intervention were important for further reductions in anxiety. To conclude, our study showed the importance of targeting psychological flexibility during an ACT intervention for a reduction in depressive and anxiety symptoms.

Fraley, R. C., G. I. Roisman, et al. (2013). ***"Interpersonal and genetic origins of adult attachment styles: A longitudinal study from infancy to early adulthood."*** J Pers Soc Psychol 104(5): 817-838. http://www.ncbi.nlm.nih.gov/pubmed/23397970

One of the assumptions of attachment theory is that individual differences in adult attachment styles emerge from individuals' developmental histories. To examine this assumption empirically, the authors report data from an age 18 follow-up (Booth-LaForce & Roisman, 2012) of the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development, a longitudinal investigation that tracked a cohort of children and their parents from birth to age 15. Analyses indicate that individual differences in adult attachment can be traced to variations in the quality of individuals' caregiving environments, their emerging social competence, and the quality of their best friendship. Analyses also indicate that assessments of temperament and most of the specific genetic polymorphisms thus far examined in the literature on genetic correlates of attachment styles are essentially uncorrelated with adult attachment, with the exception of a polymorphism in the serotonin receptor gene (HTR2A rs6313), which modestly predicted higher attachment anxiety and which revealed a Gene x Environment interaction such that changes in maternal sensitivity across time predicted attachment-related avoidance. The implications of these data for contemporary perspectives and debates concerning adult attachment theory are discussed.

Galanter, C. A. (2013). ***"Limited support for the efficacy of nonpharmacological treatments for the core symptoms of ADHD."*** American Journal of Psychiatry 170(3): 241-244. http://dx.doi.org/10.1176/appi.ajp.2012.12121561

(Free full text available) Attention deficit hyperactivity disorder (ADHD) is a common disorder affecting 7%–9% of children and adolescents. ADHD can be associated with significant morbidity, including school failure, difficulties with peer relationships, and family conflict. A majority of youths with ADHD also have co-occurring psychiatric disorders, the most common being oppositional defiant disorder, anxiety disorders, and learning disabilities, which lead to further impairment and which affect treatment choices. Treatment for ADHD should start with a comprehensive assessment and treatment plan that may include a multimodal, multidisciplinary approach. Stimulant medication is the first-line treatment for uncomplicated ADHD because of its demonstrated efficacy. However, families often have concerns about starting and continuing with medication (5). One recent study that used data from a Medicaid managed behavioral health system found that 45% of children with newly diagnosed ADHD did not begin with medication treatment. The article by Sonuga-Barke et al. in this issue provides clinicians with information on the efficacy of nonpharmacological treatments to help them make evidence-based recommendations to families.

Gellis, L. A., D. Arigo, et al. (2013). ***"Cognitive refocusing treatment for insomnia: A randomized controlled trial in university students."*** Behavior Therapy 44(1): 100-110. http://www.sciencedirect.com/science/article/pii/S0005789412000883

(Free full text available) This investigation assessed the efficacy of a technique specifically designed to change the style and content of presleep thoughts in order to reduce nighttime cognitive arousal and decrease insomnia severity. This investigation, termed "cognitive refocusing treatment for insomnia" (CRT-I), previously improved sleep in a small sample of veterans with primary insomnia. In this investigation, university students with poor sleep were randomly assigned to attend either one session of CRT-I and sleep hygiene education (SH: n = 27) or one session of only SH (n = 24). Insomnia severity (assessed by the Insomnia Severity Index) and nighttime arousal (assessed by the Pre-Sleep Arousal Scale) were measured at baseline and 1 month posttreatment. A significant Group × Time interaction for insomnia severity suggested more improved sleep over time for those receiving CRT-I + SH. A trend for a Group × Time interaction showed decreased cognitive arousal over time among those receiving CRT-I. These findings provide preliminary support for the efficacy of CRT-I for insomnia treatment among college students. Continued study of CRT-I in a community-based sample appears warranted.

Gloria, C. T., K. E. Faulk, et al. (2013). ***"Positive affectivity predicts successful and unsuccessful adaptation to stress."*** Motivation and Emotion 37(1): 185-193. http://dx.doi.org/10.1007/s11031-012-9291-8

This study examined adaptation to work stress among public school teachers (n = 267). Regression analyses tested whether positive affect predicted successful and unsuccessful adaptation to stress (viz., resilience and burnout, respectively) after controlling for demographic characteristics and work stress. Positive affect was largely correlated with resilience ($r = .65$, $p < .001$) and burnout ($r = -.57$, $p < .001$). The regression of resilience showed that positive affect had a direct effect ($\beta = .66$, $p < .001$) and the total model explained 44 % of the variance (R 2 Change = 37 %). In the regression of burnout, positive affect also had a direct effect ($\beta = -.41$, $p < .001$) and the total model explained 52 % of the variance (R 2 Change = 14 %). Further analyses found no significant interaction between work stress and positive affect, but revealed that positive affect completely mediated the effect of work stress on resilience. Results provide support for the broaden-and-build theory of positive emotions, particularly the theory's building and undoing effects.

Hipol, L. J. and B. J. Deacon (2013). ***"Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists."*** Behav Modif 37(2): 170-188. http://bmo.sagepub.com/content/37/2/170.abstract

Despite the well-established effectiveness of exposure-based cognitive-behavioral therapy (CBT) in the treatment of anxiety disorders, therapists have been slow to adopt CBT into their clinical practice. The present study was conducted to examine the utilization of psychotherapy techniques for anxiety disorders among community practitioners in a rural setting in order to determine the current status of the dissemination of CBT. A sample of 51 licensed psychotherapists from various mental health professions was recruited from online practice listings in the state of Wyoming. Participants completed a survey assessing their use of various psychotherapy techniques in the past 12 months for clients with obsessive-compulsive disorder, post-traumatic stress disorder, panic disorder, and social phobia. Nearly all psychotherapists reported providing CBT, and techniques such as cognitive restructuring, arousal-reduction strategies, and mindfulness were used by the vast majority of respondents. Therapist-assisted exposure was rarely utilized, and providers who delivered exposure therapy often did so alongside other techniques of questionable compatibility with this approach. Non-evidence-based techniques were frequently used, particularly by self-proclaimed anxiety specialists. Our findings highlight the successes and failures of efforts to disseminate exposure-based CBT to community practitioners. Implications for clinical training and practice are discussed.

Hundt, N. E., J. Mignogna, et al. (2013). ***"The relationship between use of CBT skills and depression treatment outcome: A theoretical and methodological review of the literature."*** Behavior Therapy 44(1): 12-26. http://www.sciencedirect.com/science/article/pii/S0005789412001177

(Free full text available) Cognitive and behavioral therapies emphasize the importance of skill acquisition and use, and these skills are proposed to mediate treatment outcomes. Despite its theoretical importance, research on skill use as a mechanism of change in CBT and its measurement is still in its infancy. A search of online databases was conducted to identify and review the literature testing the meditational effect of CBT skills on treating depression in adults. Additionally, we reviewed the various methods to assess a patient's use of CBT skills. We identified 13 studies examining the frequency of CBT skill use and 11 studies examining the quality of CBT skill use. While the literature provides preliminary evidence for the mediational role

of CBT skill use frequency and quality on depression treatment outcomes, methodological limitations in much of the existing literature prevent firm conclusions about the role of skills use on treatment outcomes.

IsHak, W. W., J. M. Greenberg, et al. (2013). ***"Development and validation of the individual burden of illness index for major depressive disorder (IBI-D)."*** Adm Policy Ment Health 40(2): 76-86. http://www.ncbi.nlm.nih.gov/pubmed/21969214

This study aims at developing a single numerical measure that represents a depressed patient's individual burden of illness. An exploratory study examined depressed outpatients (n = 317) followed by a hypothesis confirmatory study using the NIMH STAR*D trial (n = 2,967). Eigenvalues/eigenvectors were obtained from the Principal Component Analyses of patient-reported measures of symptom severity, functioning, and quality of life. The study shows that a single principal component labeled as the Individual Burden of Illness Index for Depression (IBI-D) accounts for the vast majority of the variance contained in these three measures providing a numerical z score for clinicians and investigators to determine an individual's burden of illness, relative to other depressed patients.

Kellett, S., F. Purdie, et al. (2013). ***"Predicting return to work from health related welfare following low intensity cognitive behaviour therapy."*** Behaviour Research and Therapy 51(3): 134-141. http://www.sciencedirect.com/science/article/pii/S0005796712001891

The aim of this study was to identify predictors of return to work in the short and long term following condition management cognitive-behavioural therapy (CM-CBT). All participants (N = 3794) were disability welfare claimants, unemployed due to the presence of a physical or mental health condition. CM-CBT consisted of a seven session group cognitive-behavioural psychoeducational programme, with participants followed-up at 3 and 12–30 months. The primary employment outcome measure was a categorical measure of either returned to work, made progress towards work or remained on welfare. Results index an incremental progress and return to work rate, increasing from 34.41% at short-term follow-up to 53.07% at long-term follow-up. Clinically, 17.40% were classed as recovered following CM-CBT. Reliable psychological change during CM-CBT predicted successful return to work and remaining on welfare was associated with psychological regression over time. The results are discussed in terms of identified methodological weaknesses and the potential of CBT in enabling return to work for the health related unemployed.

Kocalevent, R.-D., A. Hinz, et al. (2013). ***"Standardization of a screening instrument (PHQ-15) for somatization syndromes in the general population."*** BMC Psychiatry 13(1): 91. http://www.biomedcentral.com/1471-244X/13/91

(Free full text available) BACKGROUND:The PHQ-15 is widely used as an open access screening instrument for somatization syndromes in different health care settings, thus far, normative data from the general population are not available. The objectives of the study were to generate normative data and to further investigate the construct validity of the PHQ-15 in the general population. METHODS: Nationally representative face-to face household surveys were conducted in Germany between 2003 and 2008 (n=5,031). The survey questionnaires included, the 15-item somatization module from the Patient Health Questionnaire (PHQ-15), the 9-item depression module (PHQ-9), the Satisfaction With Life Scale (SWLS), the SF-12 for the measurement of health related quality of life, and demographic characteristics. RESULTS: Normative data for the PHQ-15 were generated for both genders and different age levels including 5031 subjects (53.6% female) with a mean age (SD) of 48.9 (18.1) years. Somatization syndromes occured in 9.3% of the general population. Women had significantly higher mean (SD) scores compared with men [4.3 (4.1) vs. 3.4 (4.0)]. Intercorrelations with somatization were highest with depression, followed by the physical component summary scale of health related quality of life. CONCLUSIONS: The normative data provide a framework for the interpretation and comparisons of somatization syndromes with other populations. Evidence supports reliability and validity of the PHQ-15 as a measure of somatization syndromes in the general population.

Ma-Kellams, C. and J. Blascovich (2013). ***"Does "science" make you moral? The effects of priming science on moral judgments and behavior."*** PLoS ONE 8(3): e57989. http://dx.doi.org/10.1371%2Fjournal.pone.0057989

(Free full text available) Background: Previous work has noted that science stands as an ideological force insofar as the answers it offers to a variety of fundamental questions and concerns; as such, those who pursue scientific inquiry have been shown to be concerned with the moral and social ramifications of their scientific endeavors. No studies to date have directly investigated the links between exposure to science and moral or prosocial behaviors. Methodology/Principal Findings: Across four studies, both naturalistic measures of science exposure and experimental primes of science led to increased adherence to moral norms and more morally normative behaviors across domains. Study 1 (n = 36) tested the natural correlation between exposure to science and likelihood of enforcing moral norms. Studies 2 (n = 49), 3 (n = 52), and 4 (n = 43) manipulated thoughts about science and examined the causal impact of such thoughts on imagined and actual moral behavior. Across studies, thinking about science had a moralizing effect on a broad array of domains, including interpersonal violations (Studies 1, 2), prosocial intentions (Study 3), and economic exploitation (Study 4). Conclusions/Significance: These studies demonstrated the morally normative effects of lay notions of science. Thinking about science leads individuals to endorse more stringent moral norms and exhibit more morally normative behavior. These studies are the first of their kind to systematically and empirically test the relationship between science and morality. The present findings speak to this question and elucidate the value-laden outcomes of the notion of science.

Macatee, R. J. and J. R. Cougle (2013). ***"The roles of emotional reactivity and tolerance in generalized, social, and health anxiety: A multimethod exploration."*** Behavior Therapy 44(1): 39-50. http://www.sciencedirect.com/science/article/pii/S0005789412000834

(Free full text available) Emotion regulation difficulties have been implicated in the maintenance of many anxiety disorders. However, existing research has relied mostly on self-report measures of emotion regulation or one type of mood induction. The present study examined the relationships between anxiety symptoms and emotional reactivity and tolerance using multiple assessment methodologies. Participants (N = 122) completed measures of generalized, social, and health anxiety symptoms and reported tolerance of and reactivity to negative emotions (sadness, fear, anger, disgust) elicited by 4 film clips. Participants also completed a mirror-tracing persistence task, a behavioral measure of distress tolerance. Social anxiety symptoms predicted unique variance in tolerance of film-elicited emotions, whereas generalized anxiety symptoms predicted unique variance in total peak reactivity to film-elicited emotions. Health anxiety was not related to tolerance or peak reactivity, but it was predictive of greater anxiety following the mirror-tracing task. The results of this study suggest heightened emotional reactivity is a salient feature of generalized anxiety symptoms, whereas emotional tolerance is more strongly related to social anxiety symptoms. The unique association between health anxiety and anxious response to the distress tolerance task represents a novel finding that warrants further investigation.

McKay, D. and S. P. H. Whiteside (2013). ***"Introduction to the special issue: New methods in exposure therapy."*** Behav Modif 37(2): 163-169. http://bmo.sagepub.com/content/37/2/163.abstract

Exposure-based interventions have been shown to significantly reduce anxiety and avoidance. The efficacy of the approach is robust, and recent efforts have been made to expand the use of exposure as well as identify more effective ways to implement the procedure. This article introduces the special issue devoted to recent novel approaches to the dissemination and implementation of exposure.

Mckenzie, S. K. and K. Carter (2013). ***"Does transition into parenthood lead to changes in mental health? Findings from three waves of a population based panel study."*** J Epidemiol Community Health 67(4): 339-345. http://jech.bmj.com/content/67/4/339.abstract

Background Longitudinal studies specifically looking at the transition into parenthood and changes in mental health in the general population are scarce. This study aimed to investigate the impact of transition into parenthood on mental health and psychological distress using longitudinal survey data.Methods The analysis used three waves from the longitudinal Survey of Family, Income and Employment. Parenthood was classified as first time parent (first and only child <12 months at interview date), subsequent parent (child <12 months and other children in the family), existing parent (no children <12 months but other existing children in the family) and not a parent. We used fixed effects generalised linear modelling, controlling for all time-invariant and time-varying sources of confounding in a sample of 6670 adults within families.Results After adjusting for confounding from time-varying partner status, area deprivation, labour force status and household income, those who became first time parents reported an increase in mental health (β 1.22, 95% CI −0.06 to 2.50; mean=83.8, SD=14.1) and a decrease in psychological distress (β −0.70 95% CI −1.10 to −0.29; mean=13.4, SD=5.0). Subsequent parents reported a decrease in psychological distress (β −0.60 95% CI −0.95 to −0.24).Conclusions Our findings suggest that a transition into parenthood for the first time leads to changes in mental health and psychological distress. Understanding the relationship between becoming a parent and mental health outcomes is important given that parental mental health is integral to effective parenting.

Mukuria, C., J. Brazier, et al. (2013). ***"Cost-effectiveness of an improving access to psychological therapies service."*** The British Journal of Psychiatry 202(3): 220-227. http://bjp.rcpsych.org/content/202/3/220.abstract

Background Effective psychological therapies have been recommended for common mental health problems, such as depression and anxiety, but provision has been poor. Improving Access to Psychological Therapies (IAPT) may provide a cost-effective solution to this problem. Aims To determine the cost-effectiveness of IAPT at the Doncaster demonstration site (2007–2009). Method An economic evaluation comparing costs and health outcomes for patients at the IAPT demonstration site with those for comparator sites, including a separate assessment of lost productivity. Sensitivity analyses were undertaken.ResultsThe IAPT site had higher service costs and was associated with small additional gains in quality-adjusted life-years (QALYs) compared with its comparator sites, resulting in a cost per QALY gained of £29 500 using the Short Form (SF-6D). Sensitivity analysis using predicted EQ-5D scores lowered this to £16 857. Costs per reliable and clinically significant (RCS) improvement were £9440 per participant. Conclusions Improving Access to Psychological Therapies provided a service that was probably cost-effective within the usual National Institute for Health and Clinical Excellence (NICE) threshold range of £20 000–30 000, but there was considerable uncertainty surrounding the costs and outcome differences.

Nock, M. K., J. Green, et al. (2013). ***"Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: Results from the national comorbidity survey replication adolescent supplement."*** JAMA Psychiatry 70(3): 300-310. http://dx.doi.org/10.1001/2013.jamapsychiatry.55

Context Although suicide is the third leading cause of death among US adolescents, little is known about the prevalence, correlates, or treatment of its immediate precursors, adolescent suicidal behaviors (ie, suicide ideation, plans, and attempts).Objectives To estimate the lifetime prevalence of suicidal behaviors among US adolescents and the associations of retrospectively reported, temporally primary DSM-IV disorders with the subsequent onset of suicidal behaviors.Design Dual-frame national sample of adolescents from the National Comorbidity Survey Replication Adolescent Supplement.Setting Face-to-face household interviews with adolescents and questionnaires for parents.Participants A total of 6483 adolescents 13 to 18 years of age and their parents.Main Outcome Measures Lifetime suicide ideation, plans, and attempts.Results The estimated lifetime prevalences of suicide ideation, plans, and attempts among the respondents are 12.1%, 4.0%, and 4.1%, respectively. The vast majority of adolescents with these behaviors meet lifetime criteria for at least one DSM-IV mental disorder assessed in the survey. Most temporally primary (based on retrospective age-of-onset reports) fear/anger, distress, disruptive behavior, and substance disorders significantly predict elevated odds of subsequent suicidal behaviors in bivariate models. The most consistently significant associations of these disorders are with suicide ideation, although a number of disorders are also predictors of plans and both planned and unplanned attempts among ideators. Most suicidal adolescents (>80%) receive some form of mental health treatment. In most cases (>55%), treatment starts prior to onset of suicidal behaviors but fails to prevent these behaviors from occurring.Conclusions Suicidal behaviors are common among US adolescents, with rates that approach those of adults. The vast majority of youth with suicidal behaviors have preexisting mental disorders. The disorders most powerfully predicting ideation, though, are different from those most powerfully predicting conditional transitions from ideation to plans and attempts. These differences suggest that distinct prediction and prevention strategies are needed for ideation, plans among ideators, planned attempts, and unplanned attempts.

Norton, M. I. and F. Gino (2013). ***"Rituals alleviate grieving for loved ones, lovers, and lotteries."*** J Exp Psychol Gen. http://www.ncbi.nlm.nih.gov/pubmed/23398180

Three experiments explored the impact of mourning rituals - after losses of loved ones, lovers, and lotteries - on mitigating grief. Participants who were directed to reflect on past rituals or who were assigned to complete novel rituals after experiencing losses reported lower levels of grief. Increased feelings of control after rituals mediated the link between use of rituals and reduced grief after losses, and the benefits of rituals accrued not only to individuals who professed a belief in rituals' effectiveness but also to those who did not. Although the specific rituals in which people engage after losses vary widely by culture and religion-and among our participants - our results suggest a common psychological mechanism underlying their effectiveness: regained feelings of control. *(The BPS Research Digest - http://www.bps-research-digest.blogspot.co.uk/2013/03/rituals-bring-comfort-even-for-non.html - comments "People around the world often perform rituals as a way to cope with sad events. The rules can be contradictory - for instance, Tibetan Buddhists think it's disrespectful to cry near the deceased, while Catholic Latinos believe the opposite. Beneath this variety, a new paper by Michael Norton and Francesca Gino, suggests there is a shared psychological mechanism - a comforting sense of increased control. Moreover, the researchers report that even non-believers can benefit (pdf via author website). Norton and Gino began by asking 247 participants recruited online (average age 33; 42 per cent were male) to write about a bereavement they'd experienced in the past, or a relationship that had ended. Half of them were additionally asked to write about a coping ritual they'd performed at the time. The main result here was that the participants who recalled their ritual reported feeling less grief about their loss. This was explained by their greater feelings of control, and wasn't to do with the simple fact they'd written more than the other participants. Relying on reminiscence in this way is obviously problematic from a research perspective, so for a follow-up Norton and Gino invited 109 students to their lab. Groups of 9 to 15 students were told that one of them would win a $200 prize, and to*

intensify the situation they were asked to write about what it would mean to them to win, and how they'd use the cash. One student was duly awarded the money and left. Half the remaining participants were then instructed to perform a 4-stage ritual: they drew their feelings about losing on a piece of paper, sprinkled salt on the drawing, tore it up, then counted to ten. The others acted as controls and simply drew their feelings on the paper. The key finding was that the ritual students subsequently reported experiencing less upset and anger than the controls at the fact they hadn't won the money, and this was largely explained by their greater feelings of control. Crucially, the comfort of the ritual was unaffected by how often participants reported conducting rituals in their lives or whether or not they believed in the power of rituals. It seems there's something about the process of going through a multi-stepped procedure that provokes in people feelings of control, above and beyond the role played by any associated religious or mystical beliefs. A third and final study was similar and clarified some issues - reading that some people sit in silence after a loss, and then sitting in silence themselves, did not bring comfort to participants who lost out in a lottery for $200. Reading that some people perform rituals after a loss also brought no comfort, unless the participants then went on to perform a ritual themselves. Norton and Gino said they did not mean to imply that human and monetary loss are equivalent, but they do think rituals may bring comfort in both situations via the shared mechanism of an increased sense of control. They added that more research was needed on the impact of specific forms of ritual in different contexts, but for now their results offered preliminary support "for Durkheim's contention that 'mourning is left behind, thanks to the mourning itself'; the rituals of mourning in which our participants engaged hastened the decline of the feeling of mourning that accompanies loss." An important caveat the researchers mentioned is that this research was with participants who are mentally well and so it doesn't speak to the issue of rituals that become dysfunctional and all consuming, as can happen in obsessive compulsive disorder. Norton and Gino's paper complements a study published last year that looked at people's beliefs about the factors likely to increase ritual efficacy, including repetition and number of procedural steps.")

Ravitz, P., W. J. Lancee, et al. (2013). ***"Improving physician-patient communication through coaching of simulated encounters."*** Acad Psychiatry 37(2): 87-93. http://www.ncbi.nlm.nih.gov/pubmed/23475235

OBJECTIVE Effective communication between physicians and their patients is important in optimizing patient care. This project tested a brief, intensive, interactive medical education intervention using coaching and standardized psychiatric patients to teach physician-patient communication to family medicine trainees. METHODS Twenty-six family medicine trainees (9 PGY1, 11 PGY2, 6 fellows) from five university-affiliated hospitals conducted four once-weekly, 30-minute videotaped interviews with "difficult" standardized patients. After each interview, trainees received 1 hour of individual coaching that incorporated self-assessment and skills-teaching from experienced psychiatrists. Two follow-up interviews with standardized patients occurred 1 week and an average of 6 months post-intervention. Trainee self-reported physician-patient communication efficacy was measured as a control 1 month before the intervention; during the month of the intervention; and an average of 6 months after the intervention. Coach-rated physician-patient communication competence was measured each week of the intervention. RESULTS Improvements in physician-patient communication were demonstrated. Self-efficacy for physician-patient communication improved significantly during the intervention, in contrast to no improvement during the control period (i.e., training-as-usual). This improvement was sustained during the follow-up period. CONCLUSIONS This innovative educational intervention was shown to be highly effective in improving trainee communication competence and self-efficacy. Future applications of this brief model of physician training have potential to improve communication competence and, in turn, can improve patient care.

RCP (2013). ***Whole-person care: From rhetoric to reality (achieving parity between mental and physical health)***, Royal College of Psychiatrists "Occasional Papers"**:** 1-96.

(Free full text available) In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems. There is an ambition for the NHS to put mental health on a par with physical health. However, the concept of parity in this context is not always well understood. In this report, an expert working group defines 'parity of esteem' in detail, and examines why parity between mental and physical health does not currently exist and how it might be achieved in practice. *(Jacqui Wise in the BMJ - http://www.bmj.com/content/346/bmj.f1973 - comments: "A report from the Royal College of Psychiatrists calls for parity between mental health and physical health—with equivalent levels of access to treatment and agreed standards on waiting times and crisis care. It points out that people with a severe mental illness have a reduction in life expectancy of between 15 and 20 years. It says that a "mental health treatment gap" exists, with only a minority of people with mental health problems, except those with psychosis, receiving any intervention. For example, only 24% of people with a common mental disorder and 28% of people with post-traumatic stress disorder get treatment, far less than the 91% of people with high blood pressure and 78% of people with heart disease. The report, which was commissioned by the Department of Health for England and the NHS Commissioning Board Authority, calls for greater funding for mental health services. Mental illness is responsible for the largest part of the disease burden in the United Kingdom, at 23%, whereas cardiovascular disease and cancer are each responsible for 16%. Only 11% of the NHS budget was spent on NHS services to treat mental health problems in 2010-11. The report calls on the government and the NHS Commissioning Board to work together to ensure parity between mental and physical health. The report also says there must be a greater focus on improving the physical health of people with mental health disorders. It calls on healthcare commissioners to focus on reducing smoking among people with mental illness and to act to reduce the high prevalence of type 2 diabetes and cardiovascular disease in psychiatric patients treated with antipsychotic drugs.").*

Sauer, S., H. Walach, et al. (2013). ***"Assessment of mindfulness: Review on state of the art."*** Mindfulness (N Y) 4(1): 3-17. http://dx.doi.org/10.1007/s12671-012-0122-5

Although alternative methods have been proposed, mindfulness is predominantly measured by means of self-assessment instruments. Until now, several scales have been published and to some degree also psychometrically validated. The number of scales reflects the widespread research interest. While some authors have started to compare the underlying concepts and operationalizations of these scales, up to now no overview has been presented describing, contrasting, and evaluating the different methodological approaches towards measuring mindfulness including questionnaires and alternative approaches. In light of this, the present article summarizes the state of mindfulness measurement. Recommendations on how current measurement practice may be improved are provided, as well as recommendations as to what measurement instruments are deemed to be most appropriate for a particular research context.

Schare, M. L. and K. P. Wyatt (2013). ***"On the evolving nature of exposure therapy."*** Behav Modif 37(2): 243-256. http://bmo.sagepub.com/content/37/2/243.abstract

Four articles examining methodological applications of exposure therapy and its limited dissemination were briefly reviewed. Methodological articles included those by Abramowitz et al., Gryczkowski et al., and Weiner and McKay, which addressed couple treatment of obsessive–compulsive disorder (OCD), modification of evidence-based anxiety treatments for

children, and novel exposure methods for depersonalization and derealization, respectively. The creative aspects of these innovations are highlighted as well as historical parallels in the empirical literature for both anxiety and other clinical phenomena. Underutilization and limited dissemination concerns are discussed in the context of the fourth article by Hipol and Deacon and as related to the field as a whole. A unique concept, exposaphobia, is hypothesized to explain the lack of clinicians' utilization of this technique, due to their own anxiety-driven inhibitions in using it. Suggestions for the future of exposure research and dissemination are made.

Sonuga-Barke, E. J., D. Brandeis, et al. (2013). ***"Nonpharmacological interventions for ADHD: Systematic review and meta-analyses of randomized controlled trials of dietary and psychological treatments."*** Am J Psychiatry 170(3): 275-289. http://www.ncbi.nlm.nih.gov/pubmed/23360949

OBJECTIVE: Nonpharmacological treatments are available for attention deficit hyperactivity disorder (ADHD), although their efficacy remains uncertain. The authors undertook meta-analyses of the efficacy of dietary (restricted elimination diets, artificial food color exclusions, and free fatty acid supplementation) and psychological (cognitive training, neurofeedback, and behavioral interventions) ADHD treatments. METHOD: Using a common systematic search and a rigorous coding and data extraction strategy across domains, the authors searched electronic databases to identify published randomized controlled trials that involved individuals who were diagnosed with ADHD (or who met a validated cutoff on a recognized rating scale) and that included an ADHD outcome. RESULTS: Fifty-four of the 2,904 nonduplicate screened records were included in the analyses. Two different analyses were performed. When the outcome measure was based on ADHD assessments by raters closest to the therapeutic setting, all dietary (standardized mean differences=0.21-0.48) and psychological (standardized mean differences=0.40-0.64) treatments produced statistically significant effects. However, when the best probably blinded assessment was employed, effects remained significant for free fatty acid supplementation (standardized mean difference=0.16) and artificial food color exclusion (standardized mean difference=0.42) but were substantially attenuated to nonsignificant levels for other treatments. CONCLUSIONS: Free fatty acid supplementation produced small but significant reductions in ADHD symptoms even with probably blinded assessments, although the clinical significance of these effects remains to be determined. Artificial food color exclusion produced larger effects but often in individuals selected for food sensitivities. Better evidence for efficacy from blinded assessments is required for behavioral interventions, neurofeedback, cognitive training, and restricted elimination diets before they can be supported as treatments for core ADHD symptoms.

Thornicroft, G., S. Farrelly, et al. (2013). ***"Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial."*** Lancet. http://www.ncbi.nlm.nih.gov/pubmed/23537606

BACKGROUND: The CRIMSON (CRisis plan IMpact: Subjective and Objective coercion and eNgagement) study is an individual level, randomised controlled trial that compared the effectiveness of Joint Crisis Plans (JCPs) with treatment as usual for people with severe mental illness. The JCP is a negotiated statement by a patient of treatment preferences for any future psychiatric emergency, when he or she might be unable to express clear views. We assessed whether the additional use of JCPs improved patient outcomes compared with treatment as usual. METHODS: Patients were eligible if they had at least one psychiatric admission in the previous 2 years and were on the Enhanced Care Programme Approach register. The study was done with 64 generic and specialist community mental health teams in four English mental health care provider organisations (trusts). Hypotheses tested were that, compared with the control group, the intervention group would experience: fewer compulsory admissions (primary outcome); fewer psychiatric admissions; shorter psychiatric stays; lower perceived coercion; improved therapeutic relationships; and improved engagement. We stratified participants by centre. The research team but not participants nor clinical staff were masked to allocation. This study is registered with ClinicalTrials.gov, number ISRCTN11501328. FINDINGS: 569 participants were randomly assigned (285 to the intervention group and 284 to the control group). No significant treatment effect was seen for the primary outcome (56 [20%] sectioned in the control group and 49 [18%] in the JCP group; odds ratio 0.90 [95% CI 0.58-1.39, p=0.63]) or any secondary outcomes, with the exception of an improved secondary outcome of therapeutic relationships (17.3 [7.6] vs 16.0 [7.1]; adjusted difference -1.28 [95% CI -2.56 to -0.01, p=0.049]). Qualitative data supported this finding. INTERPRETATION: Our findings are inconsistent with two earlier JCP studies, and show that the JCP is not significantly more effective than treatment as usual. There is evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients' preferences. The study therefore raises important questions about implementing new interventions in routine clinical practice. FUNDING: Medical Research Council UK and the National Institute for Health Research.

Trépanier, S.-G., C. Fernet, et al. (2013). ***"The moderating role of autonomous motivation in the job demands-strain relation: A two sample study."*** Motivation and Emotion 37(1): 93-105. http://dx.doi.org/10.1007/s11031-012-9290-9

Although job demands are known to be detrimental to employees' psychological health, research suggests that certain individual characteristics moderate this relationship to some extent. This two-sample study investigated whether autonomous motivation moderates the relationship between specific job demands (role overload, role ambiguity, and role conflict) and psychological distress. Hierarchical multiple regression analyses showed clear moderating effects, indicating that highly autonomously motivated employees experience less psychological distress in the presence of job demands than their less autonomously motivated counterparts. Theoretical and practical implications are discussed in light of the job demands–strain perspective and self-determination theory.

Usmani, Z. A., C. L. Chai-Coetzer, et al. (2013). ***"Obstructive sleep apnoea in adults."*** Postgraduate Medical Journal 89(1049): 148-156. http://pmj.bmj.com/content/89/1049/148.abstract

(Free full text available) Obstructive sleep apnoea (OSA) is characterised by repetitive closure of the upper airway, repetitive oxygen desaturations and sleep fragmentation. The prevalence of adult OSA is increasing because of a worldwide increase in obesity and the ageing of populations. OSA presents with a variety of symptoms the most prominent of which are snoring and daytime tiredness. Interestingly though, a significant proportion of OSA sufferers report little or no daytime symptoms. OSA has been associated with an increased risk of cardiovascular disease, cognitive abnormalities and mental health problems. Randomised controlled trial evidence is awaited to confirm a causal relationship between OSA and these various disorders. The gold standard diagnostic investigation for OSA is overnight laboratory-based polysomnography (sleep study), however, ambulatory models of care incorporating screening questionnaires and home sleep studies have been recently evaluated and are now being incorporated into routine clinical practice. Patients with OSA are very often obese and exhibit a range of comorbidities, such as hypertension, depression and diabetes. Management, therefore, needs to be based on a multidisciplinary and holistic approach which includes lifestyle modifications. Continuous positive airway pressure (CPAP) is the first-line therapy for severe OSA. Oral appliances should be considered in patients with mild or moderate disease, or in those unable to tolerate CPAP. New, minimally invasive surgical techniques are currently being developed to achieve better patient outcomes and reduce surgical morbidity. Successful long-term management of OSA requires careful patient education, enlistment of the family's support and the adoption of self-management and patient goal-setting principles.

Weiner, E. and D. McKay (2013). ***"A preliminary evaluation of repeated exposure for depersonalization and derealization."*** Behav Modif 37(2): 226-242. http://bmo.sagepub.com/content/37/2/226.abstract

Dissociative symptoms including depersonalization and derealization are commonly experienced by individuals suffering from panic disorder or posttraumatic stress disorder (PTSD). Few studies have been published investigating the specific treatment of these symptoms in individuals diagnosed with panic disorder or PTSD, despite evidence that the subset of individuals with panic disorder who experience depersonalization and derealization report more panic attacks as well as greater panic severity and functional impairment. Furthermore, it has been shown that these symptoms can impede treatment and recovery in PTSD. Finally, recent research has shown that interoceptive exposure generally enhances the efficacy of treatment outcome for PTSD and PTSD with comorbid panic. This study investigated the use of a novel interoceptive exposure technique for treatment of depersonalization and derealization in individuals with high anxiety sensitivity and/or symptoms of PTSD. Results indicated significant reductions on six of seven items as well as total score on an outcome measure of depersonalization and derealization. Thus, this technique appears to hold promise for utilization as a form of interoceptive exposure in the treatment of these symptoms.

Weiss, B. J., D. A. Hope, et al. (2013). ***"Heterocentric language in commonly used measures of social anxiety: Recommended alternate wording."*** Behavior Therapy 44(1): 1-11. http://www.sciencedirect.com/science/article/pii/S0005789412000901

(Free full text available) A number of self-report measures of social anxiety contain language that appears to assume heterosexuality. It is unclear how such items should be answered by individuals who are not exclusively heterosexual, which may lead to inaccurate measurement of symptoms, perpetuation of stigma, and alienation of respondents. More specific wording could improve measurement accuracy for sexual minorities as well as heterosexual respondents. Gender-neutral wording was developed for items containing the phrase "opposite sex" in commonly used self-report measures of social anxiety (Interaction Anxiousness Scale [Leary, 1983], Social Avoidance and Distress Scale [Watson & Friend, 1969], Social Interaction Anxiety Scale [Mattick & Clarke, 1998], and Social Phobia and Anxiety Inventory [Turner, Beidel, Dancu, & Stanley, 1989]). Undergraduate college students (N = 405; mean age = 19.88, SD = 2.05) completed measures containing original and revised items. Overall, results indicated that the alternate-worded items demonstrated equivalent or slightly stronger psychometric properties compared to original items. Select alternate-worded items are recommended for clinical and research use, and directions for future research are recommended.