17 action on depression abstracts, august '12

(Evans-Lacko, Brohan et al. 2012; Gale, Batty et al. 2012; Geulayov, Gunnell et al. 2012; Hilvert-Bruce, Rossouw et al. 2012; Jacka, Maes et al. 2012; Klevens, Kee et al. 2012; Lewis, Simons et al. 2012; Lewis 2012; Moritz, Schilling et al. 2012; Pasco, Jacka et al. 2012; Reavley, Mackinnon et al. 2012; Russ, Stamatakis et al. 2012; Saxon and Barkham 2012; Smits, Minhajuddin et al. 2012; Svendal, Berk et al. 2012; Wathen and MacMillan 2012; Woltmann, Grogan-Kaylor et al. 2012)

Evans-Lacko, S., E. Brohan, et al. (2012). ***"Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries."*** Psychological Medicine 42(08): 1741-1752. http://dx.doi.org/10.1017/S0033291711002558

Background Little is known about how the views of the public are related to self-stigma among people with mental health problems. Despite increasing activity aimed at reducing mental illness stigma, there is little evidence to guide and inform specific anti-stigma campaign development and messages to be used in mass campaigns. A better understanding of the association between public knowledge, attitudes and behaviours and the internalization of stigma among people with mental health problems is needed. Method This study links two large, international datasets to explore the association between public stigma in 14 European countries (Eurobarometer survey) and individual reports of self-stigma, perceived discrimination and empowerment among persons with mental illness (n=1835) residing in those countries [the Global Alliance of Mental Illness Advocacy Networks (GAMIAN) study]. Results Individuals with mental illness living in countries with less stigmatizing attitudes, higher rates of help-seeking and treatment utilization and better perceived access to information had lower rates of self-stigma and perceived discrimination and those living in countries where the public felt more comfortable talking to people with mental illness had less self-stigma and felt more empowered. Conclusions Targeting the general public through mass anti-stigma interventions may lead to a virtuous cycle by disrupting the negative feedback engendered by public stigma, thereby reducing self-stigma among people with mental health problems. A combined approach involving knowledge, attitudes and behaviour is needed; mass interventions that facilitate disclosure and positive social contact may be the most effective. Improving availability of information about mental health issues and facilitating access to care and help-seeking also show promise with regard to stigma.

Gale, C., G. Batty, et al. (2012). ***"Association of mental disorders in early adulthood and later psychiatric hospital admissions and mortality in a cohort study of more than 1 million men."*** Archives of General Psychiatry 69(8): 823-831. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2000

Context Mental disorders have been associated with increased mortality, but the evidence is primarily based on hospital admissions for psychoses. The underlying mechanisms are unclear. Objectives To investigate whether the risks of death associated with mental disorders diagnosed in young men are similar to those associated with admission for these disorders and to examine the role of confounding or mediating factors. Design Prospective cohort study in which mental disorders were assessed by psychiatric interview during a medical examination on conscription for military service at a mean age of 18.3 years and data on psychiatric hospital admissions and mortality during a mean 22.6 years of follow-up were obtained from national registers. Setting Sweden. Participants A total of 1 095 338 men conscripted between 1969 and 1994. Main Outcome Measure All-cause mortality according to diagnoses of schizophrenia, other nonaffective psychoses, bipolar or depressive disorders, neurotic and adjustment disorders, personality disorders, and alcohol-related or other substance use disorders at conscription and on hospital admission. Results Diagnosis of mental disorder at conscription or on hospital admission was associated with increased mortality. Age-adjusted hazard ratios according to diagnoses at conscription ranged from 1.81 (95% CI, 1.54-2.10) (depressive disorders) to 5.55 (95% CI, 1.79-17.2) (bipolar disorders). The equivalent figures according to hospital diagnoses ranged from 5.46 (95% CI, 5.06-5.89) (neurotic and adjustment disorders) to 11.2 (95% CI, 10.4-12.0) (other substance use disorders) in men born from 1951 to 1958 and increased in men born later. Adjustment for early-life socioeconomic status, body mass index, and blood pressure had little effect on these associations, but they were partially attenuated by adjustment for smoking, alcohol intake, intelligence, educational level, and late-life socioeconomic status. These associations were not primarily due to deaths from suicide. Conclusion The increased risk of premature death associated with mental disorder is not confined to those whose illness is severe enough for hospitalization or those with psychotic or substance use disorders.

Geulayov, G., D. Gunnell, et al. (2012). ***"The association of parental fatal and non-fatal suicidal behaviour with offspring suicidal behaviour and depression: A systematic review and meta-analysis."*** Psychological Medicine 42(08): 1567-1580. http://dx.doi.org/10.1017/S0033291711002753

Background Children whose parents die by, or attempt, suicide are believed to be at greater risk of suicidal behaviours and affective disorders. We systematically reviewed the literature on these associations and, using meta-analysis, estimated the strength of associations as well as investigated potential effect modifiers (parental and offspring gender, offspring age). Method We comprehensively searched the literature (Medline, PsycINFO, EMBASE, Web of Science), finding 28 articles that met our inclusion criteria, 14 of which contributed to the meta-analysis. Crude odds ratio and adjusted odds ratio (aOR) were pooled using fixed-effects models. Results Controlling for relevant confounders, offspring whose parents died by suicide were more likely than offspring of two living parents to die by suicide [aOR 1.94, 95% confidence interval (CI) 1.54–2.45] but there were heterogeneous findings in the two studies investigating the impact on offspring suicide attempt (aOR 1.31, 95% CI 0.73–2.35). Children whose parents attempted suicide were at increased risk of attempted suicide (aOR 1.95, 95% CI 1.48–2.57). Limited evidence indicated that exposure to parental death by suicide is associated with subsequent risk of affective disorders. Maternal suicidal behaviour and younger age at exposure were associated with larger effect estimates but there was no evidence that the association differed in sons versus daughters. Conclusions Parental suicidal behaviour is associated with increased risk of offspring suicidal behaviour. Findings suggest that maternal suicidal behaviour is a more potent risk factor than paternal, and that children are more vulnerable than adolescents and adults. However, there is no evidence of a stronger association in either male or female offspring.

Hilvert-Bruce, Z., P. J. Rossouw, et al. (2012). ***"Adherence as a determinant of effectiveness of internet cognitive behavioural therapy for anxiety and depressive disorders."*** Behaviour Research and Therapy 50(7–8): 463-468. http://www.sciencedirect.com/science/article/pii/S0005796712000708

Since 2009, the Clinical Research Unit for Anxiety and Depression (CRUfAD) has been providing primary care clinicians with internet cognitive behaviour therapy (iCBT) courses to prescribe to patients. Although these courses have demonstrated efficacy in research trials, adherence in primary care is less than half that of the research trials. The present studies pose three questions: first, do course non-completers drop out because of lack of efficacy? Second, can changes in delivery (e.g. adding choice, reminders and financial cost) improve adherence? Last, does clinician contact improve adherence? The results showed

that non-completers derive benefit before dropping out; that adding reminders, choice of course and timing, and financial cost can significantly improve adherence; and that clinician contact during the course is associated with increased adherence. It is concluded that improved adherence is an important determinant of effectiveness.

Jacka, F. N., M. Maes, et al. (2012). ***"Nutrient intakes and the common mental disorders in women."*** J Affect Disord 141(1): 79-85. http://www.ncbi.nlm.nih.gov/pubmed/22397891

BACKGROUND: There is an increasing recognition of the role of nutrition in depression and anxiety. Magnesium, folate and zinc have all been implicated in depressive illness, however there are few data on these nutrients in anxiety disorders and the data from population-studies are limited. AIMS: In a large, randomly-selected, population-based sample of women, this study aimed to examine the relationship between the dietary intakes of these three micronutrients and clinically determined depressive and anxiety disorders and symptoms. METHODS: Nutrient intakes were determined using a validated food frequency questionnaire. The General Health Questionnaire-12 measured psychological symptoms, and a clinical interview (Structured Clinical Interview for DSM-IV-TR, non-patient edition) assessed current depressive and anxiety disorders. RESULTS: After adjustments for energy intake, each standard deviation increase in the intake of zinc, magnesium and folate was associated with reduced odds ratio (OR) for major depression/dysthymia (zinc: OR=0.52, 95% confidence interval (CI) 0.31 to 0.88; magnesium: OR=0.60, 95% CI 0.37 to 0.96; folate: OR=0.66, 95% CI 0.45 to 0.97). There was also an inverse association between the intake of magnesium and zinc and GHQ-12 scores (zinc: zbeta=-0.16, 95% CI -0.29 to -0.04; magnesium: -0.14, 95% CI -0.26 to -0.03). These relationships were not confounded by age, socioeconomic status, education or other health behaviours. There was no relationship observed between any nutrient and anxiety disorders. CONCLUSION: These results demonstrate an association between the dietary intakes of magnesium, folate and zinc and depressive illnesses, although reverse causality and/or confounding cannot be ruled out as explanations.

Klevens, J., R. Kee, et al. (2012). ***"Effect of screening for partner violence on women's quality of life: A randomized controlled trial."*** JAMA 308(7): 681-689. http://dx.doi.org/10.1001/jama.2012.6434

Context Although partner violence screening has been endorsed by many health organizations, there is insufficient evidence that it has beneficial health outcomes. Objective To determine the effect of computerized screening for partner violence plus provision of a partner violence resource list vs provision of a partner violence list only on women's health in primary care settings, compared with a control group. Design, Setting, and Participants A 3-group blinded randomized controlled trial at 10 primary health care centers in Cook County, Illinois. Participants were enrolled from May 2009-April 2010 and reinterviewed 1 year (range, 48-56 weeks) later. Participants were English- or Spanish-speaking women meeting specific inclusion criteria and seeking clinical services at study sites. Of 3537 women approached, 2727 were eligible, 2708 were randomized (99%), and 2364 (87%) were recontacted 1 year later. Mean age of participants was 39 years. Participants were predominantly non-Latina African American (55%) or Latina (37%), had a high school education or less (57%), and were uninsured (57%).Intervention Randomization into 3 intervention groups: (1) partner violence screen (using the Partner Violence Screen instrument) plus a list of local partner violence resources if screening was positive (n = 909); (2) partner violence resource list only without screen (n = 893); and (3) no-screen, no-partner violence list control group (n=898). Main Outcome Measures Quality of life (QOL, physical and mental health components) was the primary outcome, measured on the 12-item Short Form (scale range 0-100, mean of 50 for US population). Results At 1-year follow-up, there were no significant differences in the QOL physical health component between the screen plus partner violence resource list group (n = 801; mean score, 46.8; 95% CI, 46.1-47.4), the partner violence resource list only group (n = 772; mean score, 46.4; 95% CI, 45.8-47.1), and the control group (n = 791; mean score, 47.2; 95% CI, 46.5-47.8), or in the mental health component (screen plus partner violence resource list group [mean score, 48.3; 95% CI, 47.5-49.1], the partner violence resource list only group [mean score, 48.0; 95% CI, 47.2-48.9], and the control group [mean score, 47.8; 95% CI, 47.0-48.6]). There were also no differences between groups in days unable to work or complete housework; number of hospitalizations, emergency department, or ambulatory care visits; proportion who contacted a partner violence agency; or recurrence of partner violence. Conclusions Among women receiving care in primary care clinics, providing a partner violence resource list with or without screening did not result in improved health.

Lewis, C. C., A. D. Simons, et al. (2012). ***"The role of early symptom trajectories and pretreatment variables in predicting treatment response to cognitive behavioral therapy."*** J Consult Clin Psychol 80(4): 525-534. http://www.ncbi.nlm.nih.gov/pubmed/22730951

OBJECTIVE: Research has focused on 2 different approaches to answering the question, "Which clients will respond to cognitive behavioral therapy (CBT) for depression?" One approach focuses on rates of symptom change within the 1st few weeks of treatment, whereas the 2nd approach looks to pretreatment client variables (e.g., hopelessness) to identify clients who are more or less likely to respond. The current study simultaneously examines these 2 lines of research (i.e., early symptom change and pretreatment variables) on the prediction of treatment outcome to determine the incremental utility of each potential predictor. METHOD: The sample consists of 173 clients (66.47% female, 92.49% Caucasian), 18-64 years of age (M = 27.94, SD = 11.42), receiving treatment for depression and anxiety disorders in a CBT-oriented psychology training clinic. RESULTS: The rate of change in depressive symptom severity from baseline over the 1st 5 treatment sessions significantly predicted treatment outcome. A contemplative orientation to change and medication status positively predicted early symptom change, whereas student status negatively predicted early symptom change. Higher levels of baseline anxiety, precontemplative readiness to change, and global functioning predicted lower levels of depressive symptom severity at termination. CONCLUSIONS: The findings suggest achieving rapid symptom change early in treatment may be integral to overall success. As such, therapists may wish to target factors such as readiness to change to potentially maximize rapid rate of symptom change and subsequent treatment outcome.

Lewis, G. (2012). ***"Psychological distress and death from cardiovascular disease."*** BMJ 345. http://dx.doi.org/10.1136/bmj.e5177

May be related in a dose-response manner, but it is not clear how to intervene: The association between psychiatric disorders and cardiovascular disease is often reported in observational studies, but the question of reverse causation has always loomed large. In a linked research study (doi:10.1136/bmj.e4933), Russ and colleagues investigated the association between psychological distress and death from cardiovascular disease (recorded on death certificates) by examining data on more than 60 000 people from 10 large cohort studies based on the Health Surveys for England. The authors excluded early deaths (in the first five years of follow-up) and therefore the likelihood of reverse causation. Although the possibility of confounding can never be completely excluded, after adjusting for several "lifestyle" factors and cardiovascular disease risk factors, the authors still found a dose-response association between psychological distress and death from cardiovascular disease. These findings add to evidence that suggests a causal association between psychological distress and cardiovascular disease. In the English health surveys used by Russ and colleagues, psychological distress was measured using the General Health Questionnaire (GHQ). This assessment of mental health status is widely used and shows good agreement with more detailed assessments of depression

and anxiety, conditions that are best represented along a continuum of severity in population studies. No obvious point separates people who report symptoms of depression or anxiety that meet diagnostic criteria from those who report similar symptoms below the diagnostic threshold. The current study found that an increased risk of cardiovascular disease exists along the whole of this continuum in a dose-response manner. Forty per cent of the sample scored at least 1 on the GHQ, and an association with subsequent death from cardiovascular disease was seen even at these low scores. The prevalence of depression and anxiety disorders is about 7.5% in the United Kingdom. It is now clear that an association between psychological distress and cardiovascular disease exists well below the threshold that would lead to a diagnosis of depression or anxiety or require specific treatment ... It is difficult to make the leap from the current observational evidence to suggesting that reducing stressors in the environment or changing the psychological interpretation of stressors will help to prevent cardiovascular disease. But, if psychological stress and distress are causes of cardiovascular disease, what implications does this have for prevention and treatment? For those people who meet diagnostic criteria for depression and anxiety, several effective psychological and drug treatments are available. However, what should be done about the much larger numbers of people who report symptoms on the depression-anxiety continuum but do not meet diagnostic criteria? Obvious sources of stress such as workplace stress could be modified. It is also worth considering how societal stresses related to inequalities and socioeconomic status might contribute to the incidence of cardiovascular disease. However, an attempt to produce a stress-free existence seems utopian and ignores the idea of "good stress." People vary greatly in their response to stressors, and some people even seek out stressors to provide a challenge and a sense of achievement. Avoiding stressors might also lead to more anxiety in the long run. A more useful approach could be to change the psychological interpretation of stressors, because this might reduce their biological impact. Cognitive behavioural therapy is, in part, designed to help people change the way they interpret stressors and thereby reduce the impact of stress. Individual and group cognitive behavioural therapy has been shown to be an effective treatment for depression and anxiety, but not, sadly, for preserving the health of the English football team's supporters. Even if we could improve our understanding and use of cognitive theories in the population to increase resilience to stressors, there is currently no evidence that these methods can be disseminated to the population at large to help people reduce perceived stress.

Moritz, S., L. Schilling, et al. (2012). ***"A randomized controlled trial of internet-based therapy in depression."*** Behaviour Research and Therapy 50(7–8): 513-521. http://www.sciencedirect.com/science/article/pii/S0005796712000757

Depression is among the most prevalent disorders worldwide. In view of numerous treatment barriers, internet-based interventions are increasingly adopted to "treat the untreated". The present trial (registered as NCT01401296) was conducted over the internet and aimed to assess the efficacy of an online self-help program for depression (Deprexis). In random order, participants with elevated depression symptoms received program access or were allocated to a wait-list control condition. After eight weeks, participants were invited to take part in an online re-assessment. To compensate for common problems of online studies, such as low completion rates and unclear diagnostic status, reminders and incentives were used, and clinical diagnoses were externally confirmed in a subgroup of 29% of participants. Relative to the wait-list group, program users experienced significant symptom decline on the Beck Depression Inventory (BDI; primary outcome), the Dysfunctional Attitudes Scale (DAS), the Quality of Life scale (WHOQOL-BREF) and the Rosenberg Self-Esteem Scale (RSE). Compared to wait-list participants, symptom decline was especially pronounced among those with moderate symptoms at baseline as well as those not currently consulting a therapist. Completion (82%) and re-test reliability of the instruments (r = .72–.87) were good. The results of this trial suggest that online treatment can be beneficial for people with depression, particularly for those with moderate symptoms.

Pasco, J. A., F. N. Jacka, et al. (2012). ***"Dietary selenium and major depression: A nested case-control study."*** Complement Ther Med 20(3): 119-123. http://www.ncbi.nlm.nih.gov/pubmed/22500660

OBJECTIVES AND METHODS: Alterations in redox biology are established in depression; however, there are no prospective epidemiological data on redox-active selenium in depression. We aimed to determine if low levels of dietary selenium are associated with an increased risk for de novo major depressive disorder (MDD). In this nested case-control study, women aged 20 years or more were identified from a randomly selected cohort being followed prospectively for the Geelong Osteoporosis Study. Cases were individuals with incident MDD, identified using the Structured Clinical Interview for DSM-IV-TR (SCID-I/NP); controls had no such history. Dietary selenium intake was measured using a food frequency questionnaire at baseline, together with anthropometric and lifestyle measures. RESULTS: Eighteen women who developed de novo MDD were classified as cases; there were 298 controls. Low dietary selenium intakes increased the likelihood of developing MDD; OR 2.74 (95%CI 0.95-7.89). After adjusting for age and SES, compared with a high selenium intake, a low intake (<8.9 mug/MJ/day) was associated with an approximate trebling of the likelihood for developing de novo MDD; OR 2.95 (95%CI 1.00-8.72). Smoking, alcohol consumption and physical activity did not confound the association. CONCLUSION: These data suggest that lower dietary selenium intakes are associated with an increased risk of subsequent de novo MDD. We propose that selenium's function as an antioxidant, and as a constituent of selenoproteins that are important in redox homeostasis, warrants further investigation as a risk factor for depression, and suggest a potentially novel modifiable factor in the primary prevention and management of depression.

Reavley, N. J., A. J. Mackinnon, et al. (2012). ***"Quality of information sources about mental disorders: A comparison of Wikipedia with centrally controlled web and printed sources."*** Psychological Medicine 42(08): 1753-1762. http://dx.doi.org/10.1017/S003329171100287X

Background Although mental health information on the internet is often of poor quality, relatively little is known about the quality of websites, such as Wikipedia, that involve participatory information sharing. The aim of this paper was to explore the quality of user-contributed mental health-related information on Wikipedia and compare this with centrally controlled information sources. Method Content on 10 mental health-related topics was extracted from 14 frequently accessed websites (including Wikipedia) providing information about depression and schizophrenia, Encyclopaedia Britannica, and a psychiatry textbook. The content was rated by experts according to the following criteria: accuracy, up-to-dateness, breadth of coverage, referencing and readability. Results Ratings varied significantly between resources according to topic. Across all topics, Wikipedia was the most highly rated in all domains except readability. Conclusions The quality of information on depression and schizophrenia on Wikipedia is generally as good as, or better than, that provided by centrally controlled websites, Encyclopaedia Britannica and a psychiatry textbook.

Russ, T. C., E. Stamatakis, et al. (2012). ***"Association between psychological distress and mortality: Individual participant pooled analysis of 10 prospective cohort studies."*** BMJ 345: e4933. http://www.bmj.com/content/345/bmj.e4933

(Free full text available): OBJECTIVE: To quantify the link between lower, subclinically symptomatic, levels of psychological distress and cause-specific mortality in a large scale, population based study. DESIGN: Individual participant meta-analysis of 10 large prospective cohort studies from the Health Survey for England. Baseline psychological distress measured by the 12 item General Health Questionnaire score, and mortality from death certification. PARTICIPANTS: 68,222

people from general population samples of adults aged 35 years and over, free of cardiovascular disease and cancer, and living in private households in England at study baseline. MAIN OUTCOME MEASURES: Death from all causes (n = 8365), cardiovascular disease including cerebrovascular disease (n = 3382), all cancers (n = 2552), and deaths from external causes (n = 386). Mean follow-up was 8.2 years (standard deviation 3.5). RESULTS: We found a dose-response association between psychological distress across the full range of severity and an increased risk of mortality (age and sex adjusted hazard ratio for General Health Questionnaire scores of 1-3 v score 0: 1.20, 95% confidence interval 1.13 to 1.27; scores 4-6: 1.43, 1.31 to 1.56; and scores 7-12: 1.94, 1.66 to 2.26; P<0.001 for trend). This association remained after adjustment for somatic comorbidity plus behavioural and socioeconomic factors. A similar association was found for cardiovascular disease deaths and deaths from external causes. Cancer death was only associated with psychological distress at higher levels. CONCLUSIONS: Psychological distress is associated with increased risk of mortality from several major causes in a dose-response pattern. Risk of mortality was raised even at lower levels of distress.

Saxon, D. and M. Barkham (2012). ***"Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk."*** J Consult Clin Psychol 80(4): 535-546. http://www.ncbi.nlm.nih.gov/pubmed/22663902

OBJECTIVE: To investigate the size of therapist effects using multilevel modeling (MLM), to compare the outcomes of therapists identified as above and below average, and to consider how key variables--in particular patient severity and risk and therapist caseload--contribute to therapist variability and outcomes. METHOD: We used a large practice-based data set comprising patients referred to the U.K.'s National Health Service primary care counseling and psychological therapy services between 2000 and 2008. Patients were included if they had received >/=2 sessions of 1-to-1 therapy (including an assessment), had a planned ending to treatment, and completed the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham et al., 2001; Barkham, Mellor-Clark, Connell, & Cahill, 2006; Evans et al., 2002) at pre- and post-treatment. The study sample comprised 119 therapists and 10,786 patients, whose mean age was 42.1 years (71.5% were female). MLM, including Markov chain Monte Carlo procedures, was used to derive estimates to produce therapist effects and to analyze therapist variability. RESULTS: The model yielded a therapist effect of 6.6% for average patient severity, but it ranged from 1% to 10% as patient non-risk scores increased. Recovery rates for individual therapists ranged from 23.5% to 95.6%, and greater patient severity and greater levels of aggregated patient risk in a therapist's caseload were associated with poorer outcomes. CONCLUSIONS: The size of therapist effect was similar to those found elsewhere, but the effect was greater for more severe patients. Differences in patient outcomes between those therapists identified as above or below average were large, and greater therapist risk caseload, rather than non-risk caseload, was associated with poorer patient outcomes. [Correction Notice: An Erratum for this article was reported in Vol 80(4) of Journal of Consulting and Clinical Psychology (see record 2012-16576-001). In the article's Appendix, the symbol β in line 1 of the model should be repeated in lines 3 and 4, rather than B.]

Smits, J. A., A. Minhajuddin, et al. (2012). ***"Outcomes of acute phase cognitive therapy in outpatients with anxious versus nonanxious depression."*** Psychother Psychosom 81(3): 153-160. http://www.ncbi.nlm.nih.gov/pubmed/22398963

OBJECTIVE: Compared to nonanxious depressed patients, anxious depressed patients respond less to pharmacotherapy, prompting consideration of alternate treatments. Based on the transdiagnostic principles of cognitive therapy (CT), we predicted that anxious depressed patients would respond as well to CT as nonanxious depressed patients. METHOD: Adults (n = 523) with recurrent major depressive disorder received 12-14 weeks of CT as part of the Continuation Phase Cognitive Therapy Relapse Prevention Trial. Anxious depressed patients (n = 264; 50.4%) were compared to nonanxious depressed patients (n = 259; 49.6%) on demographic variables, initial severity, attrition, and rates and patterns of response and remission. RESULTS: Anxious depressed patients presented with greater illness severity and had significantly lower response (55.3 vs. 68.3%) and remission rates (26.9 vs. 40.2%) based on clinician-administered measures. By contrast, smaller between-group differences for attrition, and for response (59.1 vs. 64.9%) and remission (41.7 vs. 48.7%) rates on self-report measures were not significant. Further, anxious depressed patients had greater speed of improvement on self-reported anxiety symptom severity and clinician-rated depressive and anxiety symptom severity measures. CONCLUSION: Consistent with prior reports, anxious depressed patients presented with greater severity and, following CT, had lower response and remission rates on clinician-administered scales. However, anxious depressed patients improved more rapidly and response and remission rates on self-report measures were not significantly different from nonanxious depressed patients. Our findings suggest that anxious depressed patients may simply need additional time or more CT sessions to reach outcomes fully comparable to those of less anxious patients.

Svendal, G., M. Berk, et al. (2012). ***"The use of hormonal contraceptive agents and mood disorders in women."*** J Affect Disord 140(1): 92-96. http://www.ncbi.nlm.nih.gov/pubmed/22537684

BACKGROUND: Mood disorders are a major cause of disability in developed countries, and contraceptive agents among the most widely used medications. The relationship between contraceptive agents and mood is unclear. The aim of this study was therefore to investigate the association between current contraception use and mood disorders in a random population-based sample of women. METHODS: This study examined epidemiological data obtained from 498 women aged 20-50year participating in the Geelong Osteoporosis Study (GOS). Mood disorders were diagnosed using a clinical interview (SCID-I/NP) and information on medication use and other lifestyle factors were documented. RESULTS: After adjusting for age and socioeconomic status (SES), women taking progestin-only contraceptive agents had an increased likelihood of a current mood disorder (OR 3.0 95%CI: 1.1-7.8, p=0.03). In contrast, women taking combined contraceptive agents had a decreased likelihood of a current mood disorder, adjusting this for age and SES (OR 0.3 95%CI: 0.1, 0.9 p=0.03). These findings were not explained by weight, physical activity level, past depression, number of medical conditions or cigarette smoking. LIMITATIONS: This study is cross-sectional, which precludes any determination regarding the direction of the relationships. CONCLUSIONS: These data suggest a protective effect of the combined contraceptive pill, and a deleterious effect of progestin only agents in regards to mood disorders.

Wathen, C. N. and H. L. MacMillan (2012). ***"Health care's response to women exposed to partner violence: Moving beyond universal screening."*** JAMA 308(7): 712-713. http://dx.doi.org/10.1001/jama.2012.9913

Partner violence is a serious social and health care issue that results in short- and long-term physical and psychological harm for women, their children, and their families. Consequently, an issue with which the health sector has struggled since partner violence was identified as a major public health problem in 19921 is how to best identify and respond to abused women in primary health care settings. In this issue of JAMA, the study by Klevens and colleagues2 provides important new evidence to inform recommendations for the clinical management of abused women. The results of this clinical trial should encourage shifting the focus away from universal screening (administering a standard set of questions to all patients) to case finding—identifying and providing appropriate clinical and social services to women who show signs and symptoms of abuse.

Woltmann, E., A. Grogan-Kaylor, et al. (2012). ***"Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, speciality, and behavioral health care settings: Systematic review and meta-analysis."*** Am J Psychiatry 169(8): 790-804. http://www.ncbi.nlm.nih.gov/pubmed/22772364

OBJECTIVE: Collaborative chronic care models (CCMs) improve outcome in chronic medical illnesses and depression treated in primary care settings. The effect of such models across other treatment settings and mental health conditions has not been comprehensively assessed. The authors performed a systematic review and meta-analysis to assess the comparative effectiveness of CCMs for mental health conditions across disorders and treatment settings. METHOD: Randomized controlled trials comparing CCMs with other care conditions, published or in press by August 15, 2011, were identified in a literature search and through contact with investigators. CCMs were defined a priori as interventions with at least three of the six components of the Improving Chronic Illness Care initiative (patient self-management support, clinical information systems, delivery system redesign, decision support, organizational support, and community resource linkages). Articles were included if the CCM effect on mental health symptoms or mental quality of life was reported. Data extraction included analyses of these outcomes plus social role function, physical and overall quality of life, and costs. Meta-analyses included comparisons using unadjusted continuous measures. RESULTS: Seventy-eight articles yielded 161 analyses from 57 trials (depression, N=40; bipolar disorder, N=4; anxiety disorders, N=3; multiple/other disorders, N=10). The meta-analysis indicated significant effects across disorders and care settings for depression as well as for mental and physical quality of life and social role function (Cohen's d values, 0.20-0.33). Total health care costs did not differ between CCMs and comparison models. A systematic review largely confirmed and extended these findings across conditions and outcome domains. CONCLUSIONS: CCMs can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.