24 action on depression abstracts, oct '12

(Berman, Kross et al. 2012; Corrigan, Morris et al. 2012; Cuijpers, Driessen et al. 2012; Domar, Moragianni et al. 2012; Farahani and Correll 2012; Geschwind, Peeters et al. 2012; Guan, Fox et al. 2012; Husky, Olfson et al. 2012; Ilic, Reinecke et al. 2012; Kallestad, Hansen et al. 2012; Karlin, Brown et al. 2012; Kross, Gard et al. 2012; McCarney, Schulz et al. 2012; Merry and Stasiak 2012; Mundt, Vogel et al. 2012; Olino, Shankman et al. 2012; Peeters, Huibers et al. 2012; Poon, Sim et al. 2012; Rivas Rodriguez, Nuevo et al. 2012; Sheeber, Seeley et al. 2012; Spiers, Brugha et al. 2012; Stewart, Deliyannides et al. 2012; Troxel, Kupfer et al. 2012; Uher, Carver et al. 2012)

Berman, M. G., E. Kross, et al. (2012). ***"Interacting with nature improves cognition and affect for individuals with depression."*** J Affect Disord 140(3): 300-305. http://www.ncbi.nlm.nih.gov/pubmed/22464936

BACKGROUND: This study aimed to explore whether walking in nature may be beneficial for individuals with major depressive disorder (MDD). Healthy adults demonstrate significant cognitive gains after nature walks, but it was unclear whether those same benefits would be achieved in a depressed sample as walking alone in nature might induce rumination, thereby worsening memory and mood. METHODS: Twenty individuals diagnosed with MDD participated in this study. At baseline, mood and short term memory span were assessed using the PANAS and the backwards digit span (BDS) task, respectively. Participants were then asked to think about an unresolved negative autobiographical event to prime rumination, prior to taking a 50-min walk in either a natural or urban setting. After the walk, mood and short-term memory span were reassessed. The following week, participants returned to the lab and repeated the entire procedure, but walked in the location not visited in the first session (i.e., a counterbalanced within-subjects design). RESULTS: Participants exhibited significant increases in memory span after the nature walk relative to the urban walk, $p<.001$, $eta(p)(2)=.53$ (a large effect-size). Participants also showed increases in mood, but the mood effects did not correlate with the memory effects, suggesting separable mechanisms and replicating previous work. LIMITATIONS: Sample size and participants' motivation. CONCLUSIONS: These findings extend earlier work demonstrating the cognitive and affective benefits of interacting with nature to individuals with MDD. Therefore, interacting with nature may be useful clinically as a supplement to existing treatments for MDD.

Corrigan, P. W., S. B. Morris, et al. (2012). ***"Challenging the public stigma of mental illness: A meta-analysis of outcome studies."*** Psychiatr Serv 63(10): 963-973. http://www.ncbi.nlm.nih.gov/pubmed/23032675

OBJECTIVE Public stigma and discrimination have pernicious effects on the lives of people with serious mental illnesses. Given a plethora of research on changing the stigma of mental illness, this article reports on a meta-analysis that examined the effects of antistigma approaches that included protest or social activism, education of the public, and contact with persons with mental illness. METHODS The investigators heeded published guidelines for systematic literature reviews in health care. This comprehensive and systematic review included articles in languages other than English, dissertations, and population studies. The search included all articles from the inception of the databases until October 2010. Search terms fell into three categories: stigma, mental illness (such as schizophrenia and depression), and change program (including contact and education). The search yielded 72 articles and reports meeting the inclusion criteria of relevance to changing public stigma and sufficient data and statistics to complete analyses. Studies represented 38,364 research participants from 14 countries. Effect sizes were computed for all studies and for each treatment condition within studies. Comparisons between effect sizes were conducted with a weighted one-way analysis of variance. RESULTS Overall, both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults. For adolescents, the opposite pattern was found: education was more effective. Overall, face-to-face contact was more effective than contact by video. CONCLUSIONS Future research is needed to identify moderators of the effects of both education and contact.

Cuijpers, P., E. Driessen, et al. (2012). ***"The efficacy of non-directive supportive therapy for adult depression: A meta-analysis."*** Clin Psychol Rev 32(4): 280-291. http://www.ncbi.nlm.nih.gov/pubmed/22466509

The effects of non-directive supportive therapy (NDST) for adult depression have been examined in a considerable number of studies, but no meta-analysis of these studies has been conducted. We selected 31 studies on NDST from a comprehensive database of trials, examining psychotherapies for adult depression, and conducted meta-analyses in which NDST was compared with control groups, other psychotherapies and pharmacotherapy. We found that NDST is effective in the treatment of depression in adults (g=0.58; 95% CI: 0.45-0.72). NDST was less effective than other psychological treatments (differential effect size g=-0.20; 95% CI: -0.32 to -0.08, $p<0.01$), but these differences were no longer present after controlling for researcher allegiance. We estimated that extra-therapeutic factors (those processes operating in waiting-list and care-as-usual controls) were responsible for 33.3% of the overall improvement, non-specific factors (the effects of NDST compared with control groups) for 49.6%, and specific factors (the effects of NDST compared with other therapies) for 17.1%. NDST has a considerable effect on symptoms of depression. Most of the effect of therapy for adult depression is realized by non-specific factors, and our results suggest that the contribution of specific effects is limited at best.

Domar, A. D., V. A. Moragianni, et al. (2012). ***"The risks of selective serotonin reuptake inhibitor use in infertile women: A review of the impact on fertility, pregnancy, neonatal health and beyond."*** Human Reproduction. http://humrep.oxfordjournals.org/content/early/2012/10/31/humrep.des383.abstract

STUDY QUESTION What is the current literature on the safety and efficacy of selective serotonin reuptake inhibitor (SSRI) use in infertile women? SUMMARY ANSWER There is little evidence that infertile women benefit from taking an SSRI, therefore they should be counseled appropriately about the risks and be advised to consider alternate safer treatments to treat depressive symptoms.WHAT IS KNOWN ALREADY SSRI use is associated with possible reduced infertility treatment efficacy as well as higher rates of pregnancy loss, preterm birth, pregnancy complications, neonatal issues and long-term neurobehavioral abnormalities in offspring. STUDY DESIGN, SIZE, DURATION Review of existing literature. PARTICIPANTS/MATERIALS, SETTING, METHODS We conducted a review of all published studies that evaluate females with depressive symptoms who are taking antidepressant medications and who are experiencing infertility. MAIN RESULTS AND THE ROLE OF CHANCE Antidepressant use during pregnancy is associated with increased risks of miscarriage, birth defects, preterm birth, newborn behavioral syndrome, persistent pulmonary hypertension of the newborn and possible longer term neurobehavioral effects. There is no evidence of improved pregnancy outcomes with antidepressant use. There is some evidence that psychotherapy, including cognitive-behavioral therapy as well as physical exercise, is associated with significant decreases in depressive symptoms in the general population; research indicates that some forms of counseling are effective in treating depressive symptoms in infertile women. LIMITATIONS, REASONS FOR CAUTION Our findings are limited by the availability of published studies in the field, which are often retrospective and of small size. WIDER IMPLICATIONS OF THE FINDINGS Practitioners who care for infertility patients should have a thorough understanding of the published literature so that they can adequately counsel their patients.

Farahani, A. and C. U. Correll (2012). ***"Are antipsychotics or antidepressants needed for psychotic depression? A systematic review and meta-analysis of trials comparing antidepressant or antipsychotic monotherapy with combination treatment."*** J Clin Psychiatry 73(4): 486-496. http://www.ncbi.nlm.nih.gov/pubmed/22579147

OBJECTIVE: To perform a meta-analysis of antidepressant-antipsychotic cotreatment versus antidepressant or antipsychotic monotherapy for psychotic depression. DATA SOURCES: We performed an electronic search (from inception of databases until February 28, 2011) in PubMed/MEDLINE, Cochrane Library, and PsycINFO, without language or time restrictions. Search terms were (psychosis OR psychotic OR hallucinations OR hallucinating OR delusions OR delusional) AND (depression OR depressed OR major depressive disorder) AND (random OR randomized OR randomly). STUDY SELECTION: Eight randomized, placebo-controlled acute-phase studies in adults (N = 762) with standardized criteria-defined psychotic depression (including Research Diagnostic Criteria, DSM-III, DSM-IV, or ICD-10) were meta-analyzed, yielding 10 comparisons. Antidepressant-antipsychotic cotreatment was compared in 5 trials with 6 treatment arms (n = 337) with antidepressant monotherapy and in 4 trials with 4 treatment arms (n = 447) with antipsychotic monotherapy. DATA EXTRACTION: Primary outcome was study-defined inefficacy; secondary outcomes included all-cause discontinuation, specific psychopathology ratings, and side effects. Using random effects models, we calculated relative risk (RR) with 95% confidence intervals (CIs), number-needed-to-treat/harm (NNT/NNH), and effect size (ES). RESULTS: Antidepressant-antipsychotic cotreatment outperformed antidepressant monotherapy regarding less study-defined inefficacy (no. of comparisons = 6; n = 378; RR = 0.76; 95% CI, 0.59-0.98; P = .03; heterogeneity [I2] = 34%) (NNT = 7; 95% CI, 4-20; P = .009) and Clinical Global Impressions-Severity of Illness scores (no. of comparisons = 4; n = 289; ES = -0.25; 95% CI, -0.49 to -0.02; P = .03; I2 = 0%), with trend-level superiority for depression ratings (no. of comparisons = 5; n = 324; ES = -0.20; 95% CI, -0.44 to 0.03; P = .09; I2 = 10%), but not regarding psychosis ratings (no. of comparisons = 3; n = 161; ES = -0.24; 95% CI, -0.85 to 0.38; P = .45; I2 = 70%). Antidepressant-antipsychotic cotreatment also outperformed antipsychotic monotherapy regarding less study-defined inefficacy (no. of comparisons = 4; n = 447; RR = 0.73; 95% CI, 0.63-0.84; P < .0001; I2 = 0%) (NNT = 5; 95% CI, 4-8; P < .0001) and depression ratings (no. of comparisons = 4; n = 428; ES = -0.49; 95% CI, -0.75 to -0.23; P = .0002; I2 = 27%), while anxiety (P = .11) and psychosis (P = .06) ratings only trended toward favoring cotreatment. All-cause discontinuation and reported side-effect rates were similar, except for more somnolence with antidepressant-antipsychotic cotreatment versus antidepressants (P = .02). Only 1 open-label, 4-month extension study (n = 59) assessed maintenance/relapse-prevention efficacy of antidepressant-antipsychotic cotreatment versus antidepressant monotherapy, without group differences. CONCLUSIONS: Antidepressant-antipsychotic cotreatment was superior to monotherapy with either drug class in the acute treatment of psychotic depression. These results support recent treatment guidelines, but more studies are needed to assess specific combinations and maintenance/relapse-prevention efficacy.

Geschwind, N., F. Peeters, et al. (2012). ***"Efficacy of mindfulness-based cognitive therapy in relation to prior history of depression: Randomised controlled trial."*** The British Journal of Psychiatry 201(4): 320-325. http://bjp.rcpsych.org/content/201/4/320.abstract

Background There appears to be consensus that patients with only one or two prior depressive episodes do not benefit from treatment with mindfulness-based cognitive therapy (MBCT).AimsTo investigate whether the effect of MBCT on residual depressive symptoms is contingent on the number of previous depressive episodes (trial number NTR1084). Method Currently non-depressed adults with residual depressive symptoms and a history of depression (⩽2 prior episodes: n = 71; ⩾3 episodes: n = 59) were randomised to MBCT (n = 64) or a waiting list (control: n = 66) in an open-label, randomised controlled trial. The main outcome measured was the reduction in residual depressive symptoms (Hamilton Rating Scale for Depression, HRSD-17).ResultsMindfulness-based cognitive therapy was superior to the control condition across subgroups (β = −0.56, P<0.001). The interaction between treatment and subgroup was not significant (β = 0.45, P = 0.16). Conclusions Mindfulness-based cognitive therapy reduces residual depressive symptoms irrespective of the number of previous episodes of major depression.

Guan, K., K. R. Fox, et al. (2012). ***"Nonsuicidal self-injury as a time-invariant predictor of adolescent suicide ideation and attempts in a diverse community sample."*** J Consult Clin Psychol 80(5): 842-849. http://www.ncbi.nlm.nih.gov/pubmed/22845782

OBJECTIVE: Longitudinal data on adolescent self-injury are rare. Little is known regarding the associations between various forms of self-injurious thoughts and behaviors over time, particularly within community samples that are most relevant for prevention efforts. This study examined nonsuicidal self-injury (NSSI) as a time-invariant, prospective predictor of adolescent suicide ideation, threats or gestures, and attempts over a 2.5-year interval. METHOD: A diverse (55% female; 51% non-White) adolescent community sample (n = 399) reported depressive symptoms, frequency of NSSI, suicide ideation, threats or gestures, and attempts in 9th grade (i.e., baseline) and at 4 subsequent time points. Generalized estimating equations and logistic regressions were conducted to reveal the associations between baseline NSSI and the likelihood of each suicidal self-injury outcome postbaseline while controlling for depressive symptoms and related indices of suicidal self-injury as competing predictors. RESULTS: Baseline NSSI was significantly, prospectively associated with elevated levels of suicide ideation and suicide attempts, but not threats or gestures. Neither gender nor ethnicity moderated results. CONCLUSIONS: Above and beyond established risk factors such as depressive symptoms and previous suicidality, adolescent NSSI may be an especially important factor to assess when determining risk for later suicidality.

Husky, M. M., M. Olfson, et al. (2012). ***"Twelve-month suicidal symptoms and use of services among adolescents: Results from the national comorbidity survey."*** Psychiatr Serv. http://www.ncbi.nlm.nih.gov/pubmed/22910768

OBJECTIVE The study assessed the prevalence of suicidal ideation, suicide plans, and suicide attempts as well as patterns of mental health service use among adolescents. METHODS Data came from the National Comorbidity Survey-Adolescent Supplement, a nationally representative sample of 10,123 adolescents aged 13 to 18 years who participated in computer-assisted, face-to-face interviews between February 2001 and January 2004. Prevalences of suicidal thoughts and behaviors in the past year were determined. Past-year use of any mental health treatment and receipt of four or more visits from one provider among youths with suicidal ideation, plans, or attempts were also assessed. Associations were evaluated by using logistic regression. RESULTS During the course of 12 months, 3.6% of adolescents reported suicidal ideation without a plan or attempt, .6% reported a suicide plan without an attempt, and 1.9% made a suicide attempt. Overall, two-thirds of adolescents with suicidal ideation (67.3%) and half of those with a plan (54.4%) or attempt (56.9%) did not have any contact with a mental health specialist in the past year. Different predictors of use of care were identified for each group. CONCLUSIONS Adolescent suicidality often is untreated in the United States. Increased outreach efforts to improve treatment access for youths with suicidal ideation and attempts are needed.

Ilic, M., J. Reinecke, et al. (2012). ***"Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness."*** Int J Soc Psychiatry 58(3): 246-257. http://www.ncbi.nlm.nih.gov/pubmed/21421640

BACKGROUND: To date, there has been little research into effective strategies for preventing the detrimental effects of stigma on the well-being of people with mental illness. AIM: The present research set out to identify adaptive strategies for dealing with the stigma of mental illness. METHODS: On the basis of the responses of 355 people with mental illness (PWMI) a standardized questionnaire assessing 10 identity management strategies was developed. Participants also reported their personal experiences with stigma, depression and self-esteem. RESULTS: Hierarchical regression analyses showed that after controlling for depression and stigmatizing experiences, the strategies of community involvement, humour and positive ingroup stereotyping were related to higher self-esteem. Secrecy, selective disclosure and attempts at overcompensation or disproving stereotypes were related to lower self-esteem. The following strategies were unrelated to self-esteem: comparing the present social position of PWMI with that in the past, normalization of the illness within a medical model, information seeking and selective withdrawal. CONCLUSIONS: PWMI should be encouraged to seek support within their community and to develop a positive image of their ingroup.

Kallestad, H., B. Hansen, et al. (2012). ***"Impact of sleep disturbance on patients in treatment for mental disorders."*** BMC Psychiatry 12(1): 179. http://www.biomedcentral.com/1471-244X/12/179

(Free full text available): BACKGROUND: In clinical practice, sleep disturbance is often regarded as an epiphenomenon of the primary mental disorder. The aim of this study was to test if sleep disturbance, independently of primary mental disorders, is associated with current clinical state and benefit from treatment in a sample representative of public mental health care clinics. METHOD: 2246 patients receiving treatment for mental disorders in eight public mental health care centers in Norway were evaluated in a cross-sectional study using patient and clinician reported measures. Patients reported quality of life, symptom severity, and benefit from treatment. Clinicians reported disorder severity, level of functioning, symptom severity and benefit from treatment. The hypothesis was tested using multiple hierarchical regression analyses. RESULTS: Sleep disturbance was, adjusted for age, gender, time in treatment, type of care, and the presence of any primary mental disorder, associated with lower quality of life, higher symptom severity, higher disorder severity, lower levels of functioning, and less benefit from treatment. CONCLUSION: Sleep disturbance ought to be considered a stand-alone therapeutic entity rather than an epiphenomenon of existing diagnoses for patients receiving treatment in mental health care.

Karlin, B. E., G. K. Brown, et al. (2012). ***"National dissemination of cognitive behavioral therapy for depression in the department of veterans affairs health care system: Therapist and patient-level outcomes."*** J Consult Clin Psychol 80(5): 707-718. http://www.ncbi.nlm.nih.gov/pubmed/22823859

OBJECTIVE: The Department of Veterans Affairs (VA) health care system is nationally disseminating and implementing cognitive behavioral therapy for depression (CBT-D). The current article evaluates therapist and patient-level outcomes associated with national training in and implementation of CBT-D in the VA health care system. METHOD: Therapist competencies were assessed with the Cognitive Therapy Rating Scale (CTRS). Patient outcomes were assessed with the Beck Depression Inventory-II and the World Health Organization Quality of Life-BREF. Therapeutic alliance was assessed with the Working Alliance Inventory-Short Revised. Two-hundred twenty-one therapists have received training, and 356 veteran patients have received treatment through the VA CBT-D Training Program. RESULTS: Of therapists who have participated in the program, 182 (82%) completed all training requirements and achieved competency, reflected by a score of 40 on the CTRS. Of 356 patients, nearly 70% completed 10 or more sessions or improved sufficiently to stop therapy before the 10th session. Mean depression scores decreased by approximately 40% from initial to later treatment phase. Effect sizes of changes ranged from d = 0.39 to d = 0.74 for quality of life and from d = 0.47 to d = 0.66 for therapeutic alliance measures. CONCLUSION: National training in and implementation of CBT-D within the VA health care system is associated with significant, positive therapist training outcomes, as evidenced by increases in CBT core competencies. The implementation of the protocol by newly trained CBT-D therapists is associated with significantly improved patient outcomes, as evidenced by large decreases in depression and improvements in quality of life.

Kross, E., D. Gard, et al. (2012). ***""Asking why" from a distance: Its cognitive and emotional consequences for people with major depressive disorder."*** J Abnorm Psychol 121(3): 559-569. http://www.ncbi.nlm.nih.gov/pubmed/22708885

Although analyzing negative experiences leads to physical and mental health benefits among healthy populations, when people with depression engage in this process on their own they often ruminate and feel worse. Here we examine whether it is possible for adults with depression to analyze their feelings adaptively if they adopt a self-distanced perspective. We examined this issue by randomly assigning depressed and nondepressed adults to analyze their feelings surrounding a depressing life experience from either a self-distanced or a self-immersed perspective and then examined the implications of these manipulations for depressotypic thought accessibility, negative affect, implicit and explicit avoidance, and thought content. Four key results emerged. First, all participants were capable of self-distancing while analyzing their feelings. Second, participants who analyzed their feelings from a self-distanced perspective showed lower levels of depressotypic thought accessibility and negative affect compared to their self-immersed counterparts. Third, analyzing negative feelings from a self-distanced perspective led to an adaptive shift in the way people construed their experience--they recounted the emotionally arousing details of their experience less and reconstrued them in ways that promoted insight and closure. It did not promote avoidance. Finally, self-distancing did not influence negative affect or depressotypic thought accessibility among nondepressed participants. These findings suggest that whether depressed adults' attempts to analyze negative feelings lead to adaptive or maladaptive consequences may depend critically on whether they do so from a self-immersed or a self-distanced perspective.

McCarney, R. W., J. Schulz, et al. (2012). ***"Effectiveness of mindfulness-based therapies in reducing symptoms of depression: A meta-analysis."*** European Journal of Psychotherapy & Counselling 14(3): 279-299. http://www.tandfonline.com/doi/abs/10.1080/13642537.2012.713186

Mindfulness-based therapies are a recent development within the cognitive-behavioural tradition and an important element of the third wave cognitive behavioural therapy models. A number of these therapies could be considered to have mindfulness as a major component of the therapy. There has been a considerable growth of interest in these therapies with an accompanying increase in their evidence base. While a number of reviews have been conducted, these therapies were not comprehensively appraised. The most prominent of these therapies, mindfulness-based cognitive therapy, was developed to reduce relapse in recurrent depression. We conducted a meta-analysis which looked at therapies considered to have mindfulness as a major component. We investigated whether this group of therapies was effective in reducing current depressive symptomatology as measured by the Beck depression inventory (BDI). A total of 11 studies were included in the analysis. We found a significant mean reduction score in current depressive symptomatology, as measured by the BDI, of 8.73 points (95% confidence interval = 6.61, 10.86). We found evidence for the effectiveness of these major-component therapies in reducing levels of active depression. The robustness of these findings is discussed alongside the implications for research and practice within the context of the current literature.

Merry, S. N. and K. Stasiak (2012). ***"Preventing depression in adolescents."*** BMJ 345. http://www.bmj.com/content/345/bmj.e6720

The individual and societal costs of depressive disorder have been well documented, and the arguments for depression prevention programmes are compelling. The prevalence of depression rises steeply in mid-adolescence, so schools are a logical place to deliver prevention programmes. Several studies have investigated the efficacy of interventions aimed at preventing depression in adolescents, and meta-analyses have provided encouraging results. However, many studies have had methodological difficulties, including lack of attention controls. In a linked paper (doi:10.1136/bmj.e6058), Stallard and colleagues have reported the results of a large well conducted pragmatic randomised trial. They compared the resourceful adolescent programme—a group programme delivered in schools and based on cognitive behavioural therapy that has shown evidence of effect in universal samples of school students—with an attention control or usual classes. Facilitators were well trained, and the study was also appropriately powered and had excellent retention and follow-up rates. However, no demonstrable effect was seen, and the findings suggest that the intervention programme may actually have led to an increase in depressive symptoms. These findings are worrying, especially when meta-analyses have shown that depression prevention programmes are likely to be effective in adolescents. How can we interpret these results? ... We agree with Stallard and colleagues that it would be premature to roll out depression prevention programmes on the basis of current evidence, and that this would risk wasting precious public health resources. In addition, the study has highlighted the potential to do harm, something that has not been adequately considered to date. Where to next? The findings of more than 60 published studies suggest that depression could be reduced through prevention programmes based on cognitive behavioural therapy or interpersonal therapy. It is time for a new phase of research in which the most promising approaches are identified and tested against attention placebo conditions, or in head to head comparisons in studies designed with a view to practical implementation, with depressive episodes, not just depressive symptoms, as the outcome measure. An alternative approach would be to identify which parts of the programmes are effective, with a view to enhancing efficacy. We need to assess the potential for harm systematically. A collaborative international approach would help ensure that the large studies that are needed to show a difference in incidence of depressive disorder are undertaken. Technology may provide some answers. Programmes delivered on computer, mobile phone, or the internet have several advantages. They can be delivered with fidelity and at low cost to large numbers of people, and they can have built in measures that make investigation of effectiveness easier. Comparison with an active control condition could be done relatively easily. Although, many parts of the world, including some regions within high income nations, have poor internet access, provision of basic computers through local schools, libraries, or churches—and access to high speed internet—is probably feasible in many communities, and mobile phones are becoming ubiquitous. It seems sensible to use innovation and technology, including social media, to reach younger people. Furthermore, reducing the burden of depression in adolescents will require a broad framework approach. Several factors need to be investigated including the quality of early nurturing and the impact of parental depression, child trauma, child abuse, and poverty. Stallard and colleagues' study is a timely reminder of the need for caution, and for careful systematic research to underpin efforts to reduce the effect of this costly disorder. The process of developing effective public health interventions is often long, involving an iterative process of testing and then refining interventions. We should expect no less for depression prevention programmes.

Mundt, J. C., A. P. Vogel, et al. (2012). ***"Vocal acoustic biomarkers of depression severity and treatment response."*** Biol Psychiatry 72(7): 580-587. http://www.ncbi.nlm.nih.gov/pubmed/22541039

BACKGROUND: Valid, reliable biomarkers of depression severity and treatment response would provide new targets for clinical research. Noticeable differences in speech production between depressed and nondepressed patients have been suggested as a potential biomarker. METHODS: One hundred five adults with major depression were recruited into a 4-week, randomized, double-blind, placebo-controlled research methodology study. An exploratory objective of the study was to evaluate the generalizability and repeatability of prior study results indicating vocal acoustic properties in speech may serve as biomarkers for depression severity and response to treatment. Speech samples, collected at baseline and study end point using an automated telephone system, were analyzed as a function of clinician-rated and patient-reported measures of depression severity and treatment response. RESULTS: Regression models of speech pattern changes associated with clinical outcomes in a prior study were found to be reliable and significant predictors of outcome in the current study, despite differences in the methodological design and implementation of the two studies. Results of the current study replicate and support findings from the prior study. Clinical changes in depressive symptoms among patients responding to the treatments provided also reflected significant differences in speech production patterns. Depressed patients who did not improve clinically showed smaller vocal acoustic changes and/or changes that were directionally opposite to treatment responders. CONCLUSIONS: This study supports the feasibility and validity of obtaining clinically important, biologically based vocal acoustic measures of depression severity and treatment response using an automated telephone system. *(note: Several vocal-acoustic characteristics, namely speed, pauses, and pitch, were significantly correlated with the severity of depression, replicating the findings of the previous smaller study. In both studies, researchers found that more severely depressed patients tended to speak slower, take a longer time to complete the same number of words, and display longer pauses between words and sentences.)*

Olino, T. M., S. A. Shankman, et al. (2012). ***"Lifetime rates of psychopathology in single versus multiple diagnostic assessments: Comparison in a community sample of probands and siblings."*** J Psychiatr Res 46(9): 1217-1222. http://www.ncbi.nlm.nih.gov/pubmed/22739001

Lifetime prevalence rates of psychopathology vary a great deal depending on whether they are estimated from cross-sectional or prospective longitudinal studies, with the former yielding significantly lower rates. Such findings, however, come from comparisons of separate studies from different countries and cohorts. Here, we compare lifetime rates of psychopathology between a community sample of individuals assessed on multiple occasions to their siblings who completed only a single diagnostic evaluation. Data come from the Oregon Adolescent Depression Project. We included 442 original participants who completed four prospective diagnostic assessments over the course of fifteen years, and 657 of their siblings who completed a single lifetime assessment. Comparisons of rates of depressive, bipolar, anxiety, and substance use disorders were made using survival analysis. We found that rates of depressive disorders, specifically major depressive disorder, were elevated among individuals who completed multiple diagnostic assessments relative to individuals who completed a single lifetime assessment. We did not find significant differences in rates of aggregate anxiety, bipolar, or substance use disorders. Within a single cohort, cross-sectional surveys appear to underestimate the lifetime rates of major depression relative to prospective, longitudinal designs. This suggests that disorders with an episodic course may be under-reported in cross-sectional surveys. Rates of anxiety, bipolar, and substance use disorders did not differ across assessment methods. To further evaluate method effects on lifetime estimates of psychopathology, future work may benefit from comparing rates of retrospectively- and prospectively-derived diagnoses in individuals who are repeatedly assessed over a lengthy follow-up period.

Peeters, F., M. Huibers, et al. (2012). ***"The clinical effectiveness of evidence-based interventions for depression: A pragmatic trial in routine practice."*** J Affect Disord. http://www.ncbi.nlm.nih.gov/pubmed/22985486

BACKGROUND: Controversy persists about how effectively empirically-supported treatments for major depression work in actual clinical practice as well as how patients choose among them. We examined the acute phase effectiveness of cognitive therapy (CT), interpersonal psychotherapy (IPT), and combined psychotherapy-pharmacotherapy (PHT) in a naturalistic setting, allowing patients their choice of treatment. METHODS: The study compared CT (n=63), IPT (n=56), CT-PHT (n=34), and IPT-PHT (n=21) for 174 subjects with major depression in a secondary care mood disorders clinic. Patient preference, rather than randomization, determined treatment selection. The Beck Depression Inventory-II (BDI) was the primary outcome variable. Exclusion criteria were minimal. RESULTS: All treatments were associated with a reduction in depressive symptoms, with a 35% remission rate by week 26. Overall improvement was well within ranges reported in efficacy trials. On average, treatment effects of the different interventions straddled the same range, but moderation analyses revealed that BDI scores dropped faster in the first 16 weeks in patients who received CT alone than patients who received CT and pharmacotherapy, a pattern not found in patients who received IPT (with or without pharmacotherapy). LIMITATIONS: Limitations consist of a modest sample size, choice of treatment was made by participants which may have been influenced by many sources, and the absence of a non-active control group. CONCLUSIONS: This study supports the effectiveness of empirically-supported antidepressant treatments selected by patients in routine settings, and provides an indication that speed of therapeutic response may vary amongst treatments.

Poon, S. H., K. Sim, et al. (2012). ***"Evidence-based options for treatment-resistant adult bipolar disorder patients."*** Bipolar Disorders 14(6): 573-584. http://dx.doi.org/10.1111/j.1399-5618.2012.01042.x

Objectives: Many patients diagnosed with bipolar disorder (BD) respond incompletely or unsatisfactorily to available treatments. Given the potentially devastating nature of this prevalent disorder, there is a pressing need to improve clinical care of such patients. Methods: We performed a literature review of the research findings related to treatment-resistant BD reported through February 2012. Results: Therapeutic trials for treatment-resistant bipolar mania are uncommon, and provide few promising leads other than the use of clozapine. Far more pressing challenges are the depressive-dysthymic-dysphoric-mixed phases of BD and long-term prophylaxis. Therapeutic trials for treatment-resistant bipolar depression have assessed anticonvulsants, modern antipsychotics, glutamate [N-methyl-D-aspartate (NMDA)] antagonists, dopamine agonists, calcium-channel blockers, and thyroid hormones, as well as behavioral therapy, sleep deprivation, light therapy, electroconvulsive therapy (ECT), transcranial magnetic stimulation, and deep brain stimulation—all of which are promising but limited in effectiveness. Several innovative pharmacological treatments (an anticholinesterase, a glutamine antagonist, a calcium-channel blocker, triiodothyronine, olanzapine and topiramate), ECT, and cognitive-behavior therapy have some support for long-term treatment of resistant BD patients, but most of trials of these treatments have been methodologically limited. Conclusions: Most studies identified were small, involved supplementation of typically complex ongoing treatments, varied in controls, randomization, and blinding, usually involved brief follow-up, and lacked replication. Clearer criteria for defining and predicting treatment resistance in BD are needed, as well as improved trial design with better controls, assessment of specific clinical subgroups, and longer follow-up.

Rivas Rodriguez, M., R. Nuevo, et al. (2012). ***"Definitions and factors associated with subthreshold depressive conditions: A systematic review."*** BMC Psychiatry 12(1): 181. http://www.biomedcentral.com/1471-244X/12/181

(Free full text available): BACKGROUND: Subthreshold depressive disorders (minor and subthrehold depression) have been defined in a wide range of forms, varying on the number of symptoms and duration required. Disability associated with these conditions has also been reported. Our aim was to review the different definitions and to determine factors associated with these conditions in order to clarify the nosological implications of these disorders. METHODS: A Medline search was conducted of the published literature between January 2011 and September 2011. Bibliographies of the retrieved papers were also analysed. RESULTS: There is a wide heterogeneity in the definition and diagnostic criteria of minor and subthreshold depression. Minor depression was defined according to DSM-IV criteria. Regarding subthreshold depression, also called subclinical depression or subsyndromal symptomatic depression, between 2 and 5 depressive symptoms were required for the diagnosis, and a minimum duration of 2 weeks. Significant impairment associated with subthreshold depressive conditions, as well as comorbidity with other mental disorders, has been described. CONCLUSIONS: Depression as a disorder is better explained as a spectrum rather than as a collection of discrete categories. Minor and subthreshold depression are common conditions and patients falling below the diagnostic threshold experience significant difficulties in functioning and a negative impact on their quality of life. Current diagnostic systems need to reexamine the thresholds for depressive disorders and distinguish them from ordinary feelings of sadness.

Sheeber, L. B., J. R. Seeley, et al. (2012). ***"Development and pilot evaluation of an internet-facilitated cognitive-behavioral intervention for maternal depression."*** J Consult Clin Psychol 80(5): 739-749. http://www.ncbi.nlm.nih.gov/pubmed/22663903

OBJECTIVE: Develop and pilot an Internet-facilitated cognitive-behavioral treatment intervention for depression, tailored to economically disadvantaged mothers of young children. METHOD: Mothers (N = 70) of children enrolled in Head Start, who reported elevated levels of depressive symptoms, were randomized to either the 8-session, Internet-facilitated intervention (Mom-Net) or delayed intervention/facilitated treatment-as-usual (DI/TAU). Outcomes were measured using the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996); the Patient Health Questionnaire 9 (PHQ-9; Spitzer et al., 1999), Behavioral Observations of Parent-Child Interactions using the Living in Family Environments coding system (LIFE; Hops, Davis, & Longoria, 1995); the Dyadic Parent-Child Interaction Coding Systems (DPICS; Eyberg, Nelson, Duke, & Boggs, 2005); the Parent Behavior Inventory (PBI; Lovejoy, Weis, O'Hare, & Rubin, 1999); and the Parenting Sense of Competence scale (PSOC; Gibaud-Wallston & Wandersman, 1978). RESULTS: Mom-Net demonstrated high levels of feasibility as indicated by low attrition and high program usage and satisfaction ratings. Participants in the Mom-Net condition demonstrated significantly greater reduction in depression, the primary outcome, at the level of both symptoms and estimates of criteria-based diagnoses over the course of the intervention. They also demonstrated significantly greater improvement on a questionnaire measure of parent satisfaction and efficacy as well as on both questionnaire and observational indices of harsh parenting behavior. CONCLUSIONS: Initial results suggest that the Mom-Net intervention is feasible and efficacious as a remotely delivered intervention for economically disadvantaged mothers.

Spiers, N., T. S. Brugha, et al. (2012). ***"Age and birth cohort differences in depression in repeated cross-sectional surveys in england: The national psychiatric morbidity surveys, 1993 to 2007."*** Psychological Medicine 42(10): 2047-2055. http://dx.doi.org/10.1017/S003329171200013X

Background The National Psychiatric Morbidity Survey (NPMS) programme was partly designed to monitor trends in mental disorders, including depression, with comparable data spanning 1993 to 2007. Findings already published from this programme suggest that concerns about increasing prevalence of common mental disorders (CMDs) may be unfounded. This article focuses on depression and tests the hypothesis that successive birth cohorts experience the same prevalence of depression as they age. Method We carried out a pseudo-cohort analysis of a sequence of three cross-sectional surveys of the

English household population using identical diagnostic instruments. The main outcome was ICD-10 depressive episode or disorder. Secondary outcomes were the depression subscales of the Clinical Interview Schedule – Revised (CIS-R). Results There were 8670, 6977 and 6815 participants in 1993, 2000 and 2007 respectively. In men, the prevalence of depression increased between cohorts born in 1943–1949 and 1950–1956 [odds ratio (OR) 2.5, 95% confidence interval (CI) 1.4–4.2], then remained relatively stable across subsequent cohorts. In women, there was limited evidence of change in prevalence of depression. Women born in 1957–1963, surveyed aged 44–50 years in 2007, had exceptionally high prevalence. It is not clear whether this represents a trend or a quirk of sampling. Conclusions There is no evidence of an increase in the prevalence of depression in male cohorts born since 1950. In women, there is limited evidence of increased prevalence. Demand for mental health services may stabilize or even fall for men.

Stewart, J. A., D. A. Deliyannides, et al. (2012). ***"Can people with nonsevere major depression benefit from antidepressant medication?"*** J Clin Psychiatry 73(4): 518-525. http://www.ncbi.nlm.nih.gov/pubmed/22226407

BACKGROUND: Several meta- or mega-analyses suggest antidepressant medications should be given only to severely depressed patients. In our experience, mild depression benefits from medication. We reanalyzed 1 clinic's randomized placebo-controlled antidepressant studies, limiting analyses to patients with major depressive disorder (MDD) without severe illness, to determine whether nonsevere depression responds to antidepressant medication. DATA SOURCES: Archives of the Depression Evaluation Service outpatient clinic of the New York State Psychiatric Institute were searched for randomized, placebo-controlled antidepressant studies that were conducted between 1977 and 2009 and included patients having MDD and pretreatment Hamilton Depression Rating Scale (HDRS) scores < 23. STUDY SELECTION: Six placebo-controlled studies were found, including 8 active treatment arms and 1,440 patients. 825 patients were randomized and had MDD and an HDRS score < 23. DSM-III, DSM-III-R, or DSM-IV diagnostic criteria contemporary to each study were employed. DATA EXTRACTION: Treatments were compared within study and via a patient-level meta-analysis using analysis of covariance (ANCOVA) of HDRS end point scores adjusted for pretreatment score. The number needed to treat (NNT) was calculated from remission rates (HDRS end point score </= 7), which were compared by chi(2). Effect sizes were calculated from change in HDRS scores. Secondary analyses investigated the effect of chronicity and atypical features on treatment response. DATA SYNTHESIS: Three of 6 studies showed significant (P < .001) treatment effects by ANCOVA, and 4 of 6 studies showed significant (P < .04) differences in remission. The NNT ranged from 3 to 8. Effect sizes ranged from -0.04 to 0.8, with 4 of 8 greater than 0.4. The patient-level meta-analysis confirmed these results; neither chronicity nor atypical features significantly affected outcome. Secondary analyses utilizing global ratings and self-report mimicked the main findings. CONCLUSIONS: Several studies demonstrated significant antidepressant efficacy for patients having nonsevere MDD. Efficacy was not trivial, as NNT ranged from 3 to 8, a range accepted by researchers as sufficiently robust to recommend treatment. These findings suggest mild-moderate MDD can benefit from antidepressants, contrary to findings by several other meta- or mega-analyses.

Troxel, W. M., D. J. Kupfer, et al. (2012). ***"Insomnia and objectively measured sleep disturbances predict treatment outcome in depressed patients treated with psychotherapy or psychotherapy-pharmacotherapy combinations."*** J Clin Psychiatry 73(4): 478-485. http://www.ncbi.nlm.nih.gov/pubmed/22152403

OBJECTIVE: Insomnia and objectively measured sleep disturbances predict poor treatment outcomes in patients with major depressive disorder (MDD). However, prior research has utilized individual clinical trials with relatively small sample sizes and has focused on insomnia symptoms or objective measures, but not both. The present study is a secondary analysis that examines the degree to which insomnia, objective sleep disturbances, or their combination predicts depression remission following pharmacotherapy and/or psychotherapy treatment. METHOD: Participants were 711 depressed (DSM criteria) patients drawn from 6 clinical trials. Remission status, defined as a score of </= 7 on the Hamilton Depression Rating Scale (HDRS) over 2 consecutive months, served as the primary outcome. Insomnia was assessed via the 3 sleep items on the HDRS. Objectively measured short sleep duration (total sleep time </= 6 hours) and prolonged sleep latency (> 30 minutes) or wakefulness after sleep onset (> 30 minutes) were derived from in-laboratory polysomnographic sleep studies. Logistic regression predicted the odds of nonremission according to insomnia, each of the objective sleep disturbances, or their combination, after adjusting for age, sex, treatment modality, and baseline depressive symptoms. RESULTS: Prolonged sleep latency alone (OR = 3.53; 95% CI, 1.28-9.73) or in combination with insomnia (OR = 2.11; 95% CI, 1.13-3.95) predicted increased risk of nonremission. In addition, insomnia and sleep duration individually and in combination were each associated with a significantly increased risk of nonremission (P values < .05). CONCLUSIONS: Findings suggest that objectively measured prolonged sleep latency and short sleep duration independently or in conjunction with insomnia are risk factors for poor depression treatment outcome.

Uher, R., S. Carver, et al. (2012). ***"Non-steroidal anti-inflammatory drugs and efficacy of antidepressants in major depressive disorder."*** Psychological Medicine 42(10): 2027-2035. http://dx.doi.org/10.1017/S0033291712000190

Background It has been proposed that non-steroidal anti-inflammatory drugs (NSAIDs) may interfere with the efficacy of antidepressants and contribute to treatment resistance in major depressive disorder (MDD). This effect requires replication and a test of whether it is specific to serotonin-reuptake inhibiting (SRI) antidepressants. Method We tested the effect of concomitant medication with NSAIDs on the efficacy of escitalopram, a SRI antidepressant, and nortriptyline, a tricyclic antidepressant, among 811 subjects with MDD treated for up to 12 weeks in the GENDEP study. Effects of NSAIDs on improvement of depressive symptoms were tested in mixed-effect linear models. Effects on remission were tested in logistic regression. Age, sex, baseline severity and centre of recruitment were considered as potential confounding factors. Results Ten percent (n=78) of subjects were taking NSAIDs during the antidepressant treatment. Older subjects were significantly more likely to take NSAIDs. After controlling for age, sex, centre of recruitment and baseline severity, concomitant medication with NSAIDs did not significantly influence the efficacy of escitalopram [β=0.035, 95% confidence interval (CI) −0.145 to 0.215, p=0.704] or nortriptyline (β=0.075, 95% CI −0.131 to 0.281, p=0.476). Although slightly fewer subjects who took NSAIDs reached remission [odds ratio (OR) 0.80, 95% CI 0.49–1.31, p=0.383], this non-significant effect was reversed after controlling for age, sex, baseline severity and recruitment centre effects (OR 1.04, 95% CI 0.61–1.77, p=0.882). Conclusions NSAIDs are unlikely to affect the efficacy of SRI or other antidepressants. Concurrent use of NSAIDs and antidepressants does not need to be avoided.