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(Khajavi, Farokhnia et al. 2012; Blume-Marcovici, Stolberg et al. 2013; Cohen, Greenberg et al. 2013; da Silva, Gonçalves-Pereira et al. 2013; Ferrari, Somerville et al. 2013; Fledderus, Bohlmeijer et al. 2013; Hamdani, Doukhan et al. 2013; Hermes, Sernyak et al. 2013; IsHak, Christensen et al. 2013; IsHak, Greenberg et al. 2013; Jimenez-Solem, Andersen et al. 2013; Kumari, Head et al. 2013; Larsson, Aas et al. 2013; Mukuria, Brazier et al. 2013; Nock, Green et al. 2013; Norton and Gino 2013; Pitt, Lowe et al. 2013; Plant, Barker et al. 2013; Rai, Zitko et al. 2013; Ravitz, Lancee et al. 2013; RCP 2013; Spielmans, Berman et al. 2013)

Blume-Marcovici, A. C., R. A. Stolberg, et al. (2013). ***"Do therapists cry in therapy? The role of experience and other factors in therapists' tears."*** Psychotherapy (Chic). http://www.ncbi.nlm.nih.gov/pubmed/23398034

The subject of therapist's crying in therapy (TCIT) has been virtually ignored in the literature, with only 1 qualitative dissertation and 3 case studies devoted to the topic. This mixed-method survey study explored therapists' experiences with and attitude toward TCIT. Six hundred eighty-four U.S. psychologists and trainees filled out the survey online, revealing that 72% of therapists report having cried in therapy in their role as therapist. Data analysis indicated that the act of crying in therapy has less to do with personality or demographic factors (i.e., Big Five traits, sex, empathy) and more to do with the unique aspects of the therapy itself and the therapist's identity in the therapeutic context (theoretical orientation, clinical experience, affective tone of the session). Clinicians with more experience, who are older, cried more in therapy than novice clinicians, despite lower crying frequency in daily life, suggesting that more experienced therapists feel more comfortable allowing themselves to experience and/or express such emotions in therapy sessions. Psychodynamic therapists reported slightly higher rates of TCIT than cognitive-behavioral therapists despite no difference in crying in daily life. Despite significant differences in crying rates in daily life, male and female clinicians report similar rates of TCIT. Data regarding the relationship between TCIT and Big Five personality traits, empathy, and perceived consequences of TCIT are reported. *(The excellent BPS Research Digest - http://www.bps-research-digest.blogspot.co.uk/2013/03/older-more-experienced-therapists-cry.html - comments "How often do therapists cry in therapy and does it matter? For a profession that trades in emotions, you'd think these questions would have been tackled before. But as Amy Blume-Marcovici and her colleagues point out in their new paper, the issue has been strangely neglected. There's been plenty of research on crying medics, yet all we know about crying therapists comes from an ethics paper published in the 80s (56.5% of therapists said they'd cried in front of a client), and an unpublished qualitative study of ten psychodynamic psychotherapists for a doctoral thesis completed in the 90s. From their survey of 684 US psychological therapists - 75% women; age range 22 to 85; 35% CBT, 23% eclectic with psychodynamic emphasis, 19% eclectic without psychodynamic emphasis - Blume-Marcovici's group found that 72% of the sample had cried in therapy ever. Among these criers, 30% had cried in the last four weeks. Looking at the correlates of being a therapist who cries in therapy, it was older, more experienced therapists and those with a psychodynamic approach, who were more likely to be criers. Surprisingly perhaps, female therapists were no more likely to cry in therapy than male therapists, despite the fact that they reported crying more often in daily life than the men. This mismatch between crying in everyday life and crying in therapy was a consistent theme. Older therapists too cried less often in daily life than younger therapists, despite more crying with clients. Also, whereas crying in daily life is typically associated with negative emotion, in therapy it was associated not just with the therapists experiencing sadness (reported by 75% during their last therapy cry), but also with "feeling touched" (63%), warmth (33%), gratitude (15%) and joy (12%). "This suggests that tears that occur in the therapy situation are different in nature than tears shed in daily life," the researchers said. However, it's worth noting that, at their last time of crying in therapy, the therapists believed their clients were experiencing negative emotions like sadness, grief and powerlessness. Therapist personality was only weakly related to crying, with openness being the most relevant trait. More agreeable and extraverted therapists also showed a tendency towards crying more. The personality questionnaire used in this study was extremely brief, so it's tricky to read too much into these results. Ditto for therapist empathy, which showed an association with crying tendency, but not frequency or proneness, possibly due to the limitations of the empathy scale that was used. This research provides no objective data on the effect on clients of having a crying therapist. However, the therapists' belief was that their crying was either inconsequential (53.5%) or that it had changed their relationship with their client for the better (45.7%). Less than one per cent felt it had harmed their client. Referring to the literature on therapist self-disclosure, the researchers speculated that perhaps therapist crying has a positive impact when the therapist-client relationship is already strong, but can threaten that relationship when it is weak or negative. Blume-Marcovici and her colleagues called for more research on this neglected topic, and particularly for future studies to investigate the effect of therapist crying on client outcomes. They said their initial results are "meaningful" because they challenge the idea that "therapist crying in therapy is occurring due to the therapist being overwhelmed by intense negative emotions that arise in therapy, and instead signals a moment of potentially positive emotional connection, even if amid painful negative affect."*

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.

da Silva, J., M. Gonçalves-Pereira, et al. (2013). ***"Affective disorders and risk of developing dementia: Systematic review."*** The British Journal of Psychiatry 202(3): 177-186. http://bjp.rcpsych.org/content/202/3/177.abstract

Background Affective disorders are associated with cognitive disturbances but their role as risk factors for dementia is still not fully investigated. Aims To evaluate the risk of developing dementia in individuals with a history of affective disorder. Method We conducted a systematic review of case–control and cohort studies addressing the risk of developing dementia in people with affective disorders. To the best of our knowledge, this is the first systematic review that has included studies evaluating this risk specifically in people with bipolar disorder. Results Fifty-one studies were included. Most of the studies found an increased risk for developing dementia in individuals with depression. Greater frequency and severity of depressive episodes seem to increase this risk. The evidence is contradictory regarding whether there is a difference in risk in people with early- or late-onset depression. The few available risk estimates for dementia in people with bipolar disorder suggest an even higher risk than for those with depression. Conclusions Affective disorders appear to be associated with an increased risk of developing dementia, and one that is dependent on clinical and demographic variables. Depression may be both a prodrome and a risk factor for dementia. Future research should aim to elucidate the mechanisms that mediate these links.

Ferrari, A. J., A. J. Somerville, et al. (2013). ***"Global variation in the prevalence and incidence of major depressive disorder: A systematic review of the epidemiological literature."*** Psychological Medicine 43(03): 471-481. http://dx.doi.org/10.1017/S0033291712001511

Background Summarizing the epidemiology of major depressive disorder (MDD) at a global level is complicated by significant heterogeneity in the data. The aim of this study is to present a global summary of the prevalence and incidence of MDD, accounting for sources of bias, and dealing with heterogeneity. Findings are informing MDD burden quantification in the Global Burden of Disease (GBD) 2010 Study. Method A systematic review of prevalence and incidence of MDD was undertaken. Electronic databases Medline, PsycINFO and EMBASE were searched. Community-representative studies adhering to suitable diagnostic nomenclature were included. A meta-regression was conducted to explore sources of heterogeneity in prevalence and guide the stratification of data in a meta-analysis. Results The literature search identified 116 prevalence and four incidence studies. Prevalence period, sex, year of study, depression subtype, survey instrument, age and region were significant determinants of prevalence, explaining 57.7% of the variability between studies. The global point prevalence of MDD, adjusting for methodological differences, was 4.7% (4.4–5.0%). The pooled annual incidence was 3.0% (2.4–3.8%), clearly at odds with the pooled prevalence estimates and the previously reported average duration of 30 weeks for an episode of MDD. Conclusions Our findings provide a comprehensive and up-to-date profile of the prevalence of MDD globally. Region and study methodology influenced the prevalence of MDD. This needs to be considered in the GBD 2010 study and in investigations into the ecological determinants of MDD. Good-quality estimates from low-/middle-income countries were sparse. More accurate data on incidence are also required.

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.

Hamdani, N., R. Doukhan, et al. (2013). ***"A bipolar disorder patient becoming asymptomatic after adjunctive anti-filiarasis treatment: A case report."*** BMC Psychiatry 13(1): 81. http://www.biomedcentral.com/1471-244X/13/81

BACKGROUND: Evidence suggests that neurotropic infectious agents might be involved in bipolar disorder. So far, few have been written for the association between parasitic infection and bipolar disorder. Filariasis is a parasitic disease acting ruthlessly via mosquitos and affecting more than 120 million people worldwide. We present here, to our knowledge, the first description of a filariasis infected manic bipolar disorder patient fully improved in terms of psychiatric symptoms by anti-heminthic treatment. CASE PRESENTATION: The patient is a 31years-old man native of Congo. At inclusion, he presented a severe manic episode with dangerous behaviour unresolved by classic treatments. A diagnosis of filariasis bancrofti infection was made after the discovery of a systemic hypereosinophilia. Therefore, a bi-therapy of anthelmintics was conducted allowing a successful improvement with clear reduction of agitation and aggressive behaviours that could not be attributed to a modification of psychotropic treatments or filarial encephalopathy or acute disseminated encephalomyelitis. CONCLUSION: The ineffectiveness of psychotropic treatment of a manic episode requires the evaluation of co-morbid medical conditions such as infections which can interfere with adequate mood stabilizing medication. Filariasis by inducing chronic inflammation and immunopathologic reactions seems to play a major role in infected affective disorders patients by changing levels of cytokines of the Th1 system or indirectly damaging the brain tissue. The beneficial combination of antihelmintics and mood stabilizers, in this case, could be explained by the potential of such association to downregulate neuroinflammation and excitotoxicity processes.Altogether, these data pinpoint the requirement to explore the parasitic infectious status in case of bipolar disorder patients resistant to classic treatments and originating or living in endemic geographical areas.

Hermes, E. D., M. J. Sernyak, et al. (2013). ***"Prescription of second-generation antipsychotics: Responding to treatment risk in real-world practice."*** Psychiatr Serv 64(3): 238-244. http://www.ncbi.nlm.nih.gov/pubmed/23241613

OBJECTIVE: This study sought to determine the extent of providers' sensitivity to the presence of cardiometabolic disorders in the selection of second-generation antipsychotics. METHODS: As part of an academic detailing effort conducted between October 2007 and May 2009, all psychiatric providers at a single Veterans Affairs medical center completed a survey for every new prescription of an on-patent second-generation antipsychotic. The survey documented the drug prescribed, patients' sociodemographic data, psychiatric and comorbid diagnoses, and reasons for the prescription. The association between obesity, hypertension, hyperlipidemia, diabetes, and cardiovascular disease and the choice of antipsychotics with varying levels of cardiometabolic risk was evaluated. RESULTS: Data consisted of 2,613 surveys completed by 259 providers. Olanzapine, with

high cardiometabolic risk, and quetiapine and risperidone, with moderate risk, accounted for 79% of prescriptions. There was a significant (p<.001) association between the second-generation antipsychotic prescribed and obesity, hyperlipidemia, and diabetes but not hypertension or cardiovascular disease. The proportion of patients receiving olanzapine was only slightly smaller, by an average of 4 percentage points, among patients with cardiometabolic disorders than among patients without cardiometabolic disorders. The proportion of patients receiving aripiprazole, with little or no cardiometabolic risk, was consistently higher, by an average of only 2 percentage points, among patients with a cardiometabolic disorder versus without one. CONCLUSIONS: Although this study found a statistically significant sensitivity by providers to cardiometabolic risk, this sensitivity was neither robust nor uniformly statistically significant. More research into how providers use medication risk information when making treatment decisions may help improve the quality of care.

IsHak, W. W., S. Christensen, et al. (2013). ***"Sexual satisfaction and quality of life in major depressive disorder before and after treatment with citalopram in the STAR*D study."*** J Clin Psychiatry 74(3): 256-261. http://www.ncbi.nlm.nih.gov/pubmed/23561231

OBJECTIVE: Major depressive disorder (MDD) patients often experience impaired sexual satisfaction (ISS) and poor quality of life (QOL). Selective serotonin reuptake inhibitors (SSRIs), the first-line treatment for MDD, can cause sexual dysfunction, potentially worsening ISS and QOL. This study examined the impact of MDD and the SSRI citalopram on sexual satisfaction and QOL in level 1 of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial (July 2001-September 2006). METHOD: A retrospective analysis was conducted of the change in sexual satisfaction, as measured by item 9 of the Quality of Life Enjoyment and Satisfaction Questionnaire, the primary outcome measure, in 2,280 patients with DSM-IV-TR-defined MDD who were treated with citalopram for 12 weeks. The Quick Inventory of Depressive Symptomatology-Self Report was used to evaluate the impact of depression ratings on impaired sexual satisfaction and on QOL. RESULTS: Impaired sexual satisfaction was present in 64.3% of MDD patients at pretreatment, but that percentage declined to 47.1% at posttreatment with citalopram (P < .0001). Those who achieved remission had less ISS and better QOL. The prevalence of ISS in remitters was 21.2% versus 61.3% in nonremitters (P < 10-8). The mean +/- standard deviation score for remitters increased from 2.32 +/- 1.16 to 3.44 +/- 1.23 (P < 10-8; Cohen d = 0.81 [large effect size]), whereas in nonremitters it increased only from 1.99 +/- 1.08 to 2.19 +/- 1.19 (P < 10-8; Cohen d = 0.16). The difference between remitters and nonremitters was highly significant (P < 10-8). Regression analyses at pretreatment and posttreatment demonstrated significant associations between depressive symptoms and ISS (P < .0001) and between ISS and lower QOL (P < .0001) as well as an association between citalopram and increased probability of ISS and a poorer QOL in patients who continue to have moderate-to-severe depression. CONCLUSIONS: A majority of MDD patients have impaired sexual satisfaction, a symptom associated with poor QOL. Despite the sexual side effects of the SSR citalopram, treating depression to full remission was associated with improvements in sexual satisfaction and QOL.

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.

Jimenez-Solem, E., J. T. Andersen, et al. (2013). ***"SSRI use during pregnancy and risk of stillbirth and neonatal mortality."*** Am J Psychiatry 170(3): 299-304. http://www.ncbi.nlm.nih.gov/pubmed/23361562

OBJECTIVE: The authors investigated whether in utero exposure to selective serotonin reuptake inhibitors (SSRIs) increases the risk of stillbirth or neonatal mortality. METHOD: The authors conducted a population-based cohort study using the Danish Fertility Database to identify every birth in Denmark between 1995 and 2008. Time of exposure to SSRIs was calculated on the basis of standard treatment dosages and dispensed pack sizes according to the prescription register. Exposure was divided into first-, second-, and third-trimester exposure. Multivariate logistic regression models were used. RESULTS: The authors identified 920,620 births; the incidence of stillbirths was 0.45%, and the incidence of neonatal mortality was 0.34%. A total of 12,425 offspring were exposed to an SSRI during pregnancy. Stillbirth was not associated with first-trimester SSRI use (adjusted odds ratio=0.77, 95% CI=0.43-1.36), first- and second-trimester use (odds ratio=0.84, 95% CI=0.40-1.77), or first-, second-, and third-trimester use (odds ratio=1.06, 95% CI=0.71-1.58). Neonatal mortality was not associated with SSRI first-trimester use (odds ratio=0.56, 95% CI=0.25-1.24), first- and second-trimester use (odds ratio=0.90, 95% CI=0.37-2.17), or first-, second-, and third-trimester use (odds ratio=1.27, 95% CI=0.82-1.99). CONCLUSIONS: This study found no association between exposure to SSRIs during pregnancy and stillbirth or neonatal mortality.

Khajavi, D., M. Farokhnia, et al. (2012). ***"Oral scopolamine augmentation in moderate to severe major depressive disorder: A randomized, double-blind, placebo-controlled study."*** J Clin Psychiatry 73(11): 1428-1433. http://www.ncbi.nlm.nih.gov/pubmed/23146150

OBJECTIVE: To evaluate the antidepressant effect of oral scopolamine as an adjunct to citalopram. METHOD: In this randomized double-blind placebo-controlled study, patients were assessed in the outpatient clinics of 2 large hospitals from November 2011 to January 2012. Forty patients (18-55 years) with major depressive disorder (DSM-IV-TR criteria) and 17-Item Hamilton Depression Rating Scale (HDRS) score >/= 22 were randomly assigned to scopolamine hydrobromide (1 mg/d) (n = 20) or placebo (n = 20) in addition to citalopram for 6 weeks. HDRS score was measured at baseline and days 4, 7, 14, 28, and 42. The primary outcome measure was HDRS score change from baseline to week 6 in the scopolamine group versus the placebo group. Response was defined as >/= 50% decrease in HDRS score; remission, as HDRS score </= 7. RESULTS: Augmentation with scopolamine was significantly more effective than placebo (F(1,38) = 5.831, P = .021). Patients receiving scopolamine showed higher rates of response (65%, 13/20 at week 4) and remission (65%, 13/20 at week 6) than the placebo group (30%, 6/20 and 20%, 4/20, respectively; P = .027, P = .004, respectively). Patients in the scopolamine group showed higher rates of dry mouth, blurred vision, and dizziness than the placebo group. CONCLUSIONS: Oral scopolamine is a safe and effective adjunct for treatment of patients with moderate to severe major depressive disorder.

Kumari, M., J. Head, et al. (2013). ***"Maternal separation in childhood and diurnal cortisol patterns in mid-life: Findings from the whitehall ii study."*** Psychological Medicine 43(03): 633-643. http://dx.doi.org/10.1017/S0033291712001353

Background Animal studies suggest that maternal separation is associated with alterations in the hypothalamic–pituitary–adrenal (HPA) axis through effects that occur in a critical period following birth. Evidence for an association of the diurnal cortisol rhythm with maternal separation in humans is equivocal. Method We examined whether maternal separation in

childhood is associated with diurnal cortisol pattern in 3712 middle-aged men and women. Two aspects of cortisol release were examined: the cortisol awakening response (CAR) and the diurnal slope in cortisol throughout the day. Results Maternal separation in childhood was reported by 12% of participants. Those participants who reported maternal separation had a larger CAR and flatter slopes in cortisol levels compared to those who did not report maternal separation [adjusted mean CAR in those reporting no separation versus separation: 7.1, 95% confidence interval (CI) 6.7–7.5 v. 8.4, 95% CI 7.3–9.5, p = 0.02, corresponding to adjusted mean diurnal slope: −0.129 (95% CI −0.130 to −0.128) v. −0.126 (95% CI −0.128 to −0.124), p = 0.01]. In participants who reported maternal separation, the age of separation was not associated with either cortisol measure (p = 0.11). The association between maternal separation and slope in cortisol secretion was largely explained by smoking behaviour and marital status at the time of sample collection whereas that of the CAR was explained by childhood psychosocial, material factors and adult health behaviours. Conclusions Our findings suggest that maternal separation in childhood is associated with alterations in the diurnal cortisol pattern in middle age. These associations are predominantly accounted for by adult circumstances and behaviours.

Larsson, S., M. Aas, et al. (2013). ***"Patterns of childhood adverse events are associated with clinical characteristics of bipolar disorder."*** BMC Psychiatry 13(1): 97. http://www.biomedcentral.com/1471-244X/13/97

(Available in free full text) BACKGROUND: Previous studies in bipolar disorder investigating childhood trauma and clinical presentations of the illness have mainly focused on physical and sexual abuse. Our aim was to explore further the relationship between childhood trauma and disease characteristics in bipolar disorder to determine which clinical characteristics were most strongly associated with childhood trauma total score, as well as subtypes of adverse childhood events, including physical, sexual, emotional abuse and neglect. METHODS: 141 Patients with bipolar disorder were consecutively recruited, and disease history and clinical characteristics were assessed. History of childhood abuse was obtained using the Childhood Trauma Questionnaire (CTQ). Statistical methods used were factor analysis, Poisson and linear regression, and generalized additive modeling (GAM). RESULTS: The factor analysis of CTQ identified three factors: emotional abuse/ neglect, sexual abuse and physical abuse. There were significant associations between CTQ total score and earlier onset of illness, reduced level of psychosocial functioning (GAF; Global Assessment of Functioning) and decreased number of hospitalization, which mainly were due to the factor emotional abuse/neglect. Physical abuse was significantly associated with lower GAF scores, and increased number of mood episodes, as well as self-harm. Sexual abuse was significantly associated with increased number of mood episodes. For mood episodes and self-harm the associations were characterized by great variance and fluctuations. CONCLUSIONS: Our results suggest that childhood trauma is associated with a more severe course of bipolar illness. Further, childhood abuse (physical and sexual), as well as emotional abuse and neglect were significantly associated with accelerating staging process of bipolar disorder. By using specific trauma factors (physical abuse, sexual abuse and emotional abuse/neglect) the associations become both more precise, and diverse.

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.")

Pitt, V., D. Lowe, et al. (2013). ***"Consumer-providers of care for adult clients of statutory mental health services."*** Cochrane Database Syst Rev 3: CD004807. http://www.ncbi.nlm.nih.gov/pubmed/23543537

BACKGROUND: In mental health services, the past several decades has seen a slow but steady trend towards employment of past or present consumers of the service to work alongside mental health professionals in providing services. However the effects of this employment on clients (service recipients) and services has remained unclear. We conducted a systematic review of randomised trials assessing the effects of employing consumers of mental health services as providers of statutory mental health services to clients. In this review this role is called 'consumer-provider' and the term 'statutory mental health services' refers to public services, those required by statute or law, or public services involving statutory duties. The consumer-provider's role can encompass peer support, coaching, advocacy, case management or outreach, crisis worker or assertive community treatment worker, or providing social support programmes. OBJECTIVES: To assess the effects of employing current or past adult consumers of mental health services as providers of statutory mental health services. SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library 2012, Issue 3), MEDLINE (OvidSP) (1950 to March 2012), EMBASE (OvidSP) (1988 to March 2012), PsycINFO (OvidSP) (1806 to March 2012), CINAHL (EBSCOhost) (1981 to March 2009), Current Contents (OvidSP) (1993 to March 2012), and reference lists of relevant articles. SELECTION CRITERIA: Randomised controlled trials of current or past consumers of mental health services employed as providers ('consumer-providers') in statutory mental health services, comparing either: 1) consumers versus professionals employed to do the same role within a mental health service, or 2) mental health services with and without consumer-providers as an adjunct to the service. DATA COLLECTION AND ANALYSIS: Two review authors independently selected studies and extracted data. We contacted trialists for additional information. We conducted analyses using a random-effects model, pooling studies that measured the same outcome to provide a summary estimate of the effect across studies. We describe findings for each outcome in the text of the review with considerations of the potential impact of bias and the clinical importance of results, with input from a clinical expert. MAIN RESULTS: We included 11 randomised controlled trials involving 2796 people. The quality of these studies was moderate to low, with most of the studies at unclear risk of bias in terms of random sequence generation and allocation concealment, and high risk of bias for blinded outcome assessment and selective outcome reporting.Five trials involving 581 people compared consumer-providers to professionals in similar roles within mental health services (case management roles (4 trials), facilitating group therapy (1 trial)). There were no significant differences in client quality of life (mean difference (MD) -0.30, 95% confidence interval (CI) -0.80 to 0.20); depression (data not pooled), general mental health symptoms (standardised mean difference (SMD) -0.24, 95% CI -0.52 to 0.05); client satisfaction with treatment (SMD -0.22, 95% CI -0.69 to 0.25), client or professional ratings of client-manager relationship; use of mental health services, hospital admissions and length of stay; or attrition (risk ratio 0.80, 95% CI 0.58 to 1.09) between mental health teams involving consumer-providers or professional staff in similar roles.There was a small reduction in crisis and emergency service use for clients receiving care involving consumer-providers (SMD -0.34 (95%CI -0.60 to -0.07). Past or present consumers who provided mental health services did so differently than professionals; they spent more time face-to-face with clients, and less time in the office, on the telephone, with clients' friends and family, or at provider agencies.Six trials involving 2215 people compared mental health services with or without the addition of consumer-providers. There were no significant differences in psychosocial outcomes (quality of life, empowerment, function, social relations), client satisfaction with service provision (SMD 0.76, 95% CI -0.59 to 2.10) and with staff (SMD 0.18, 95% CI -0.43 to 0.79), attendance rates (SMD 0.52 (95% CI -0.07 to 1.11), hospital admissions and length of stay, or attrition (risk ratio 1.29, 95% CI 0.72 to 2.31) between groups with consumer-providers as an adjunct to professional-led care and those receiving usual care from health professionals alone. One study found a small difference favouring the intervention group for both client and staff ratings of clients' needs having been met, although detection bias may have affected the latter. None of the six studies in this comparison reported client mental health outcomes.No studies in either comparison group reported data on adverse outcomes for clients, or the financial costs of service provision. AUTHORS' CONCLUSIONS: Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services. There is low quality evidence that involving consumer-providers in mental health teams results in a small reduction in clients' use of crisis or emergency services. The nature of the consumer-providers' involvement differs compared to professionals, as do the resources required to support their involvement.

The overall quality of the evidence is moderate to low. There is no evidence of harm associated with involving consumer-providers in mental health teams. Future randomised controlled trials of consumer-providers in mental health services should minimise bias through the use of adequate randomisation and concealment of allocation, blinding of outcome assessment where possible, the comprehensive reporting of outcome data, and the avoidance of contamination between treatment groups. Researchers should adhere to SPIRIT and CONSORT reporting standards for clinical trials. Future trials should further evaluate standardised measures of clients' mental health, adverse outcomes for clients, the potential benefits and harms to the consumer-providers themselves (including need to return to treatment), and the financial costs of the intervention. They should utilise consistent, validated measurement tools and include a clear description of the consumer-provider role (eg specific tasks, responsibilities and expected deliverables of the role) and relevant training for the role so that it can be readily implemented. The weight of evidence being strongly based in the United States, future research should be located in diverse settings including in low- and middle-income countries.

Plant, D. T., E. D. Barker, et al. (2013). ***"Intergenerational transmission of maltreatment and psychopathology: The role of antenatal depression."*** Psychological Medicine 43(03): 519-528. http://dx.doi.org/10.1017/S0033291712001298

(Free full text available) Background Maternal experience of childhood maltreatment and maternal antenatal depression are both associated with offspring childhood maltreatment and offspring adjustment problems. We have investigated the relative impact of maternal childhood maltreatment and exposure to depression in utero on offspring maltreatment and psychopathology. Method The sample included 125 families from the South London Child Development Study. A prospective longitudinal design was used. Data on maternal childhood maltreatment, maternal antenatal depression (36 weeks of pregnancy), offspring childhood maltreatment (age 11 years) and offspring adolescent antisocial behaviour and depression (ages 11 and 16 years) were obtained from parents and offspring through clinical interview. Results Mothers who experienced childhood maltreatment were significantly more likely to be depressed during pregnancy [odds ratio (OR) 10.00]. Offspring of mothers who experienced only childhood maltreatment or only antenatal depression were no more at risk of being maltreated or having psychopathology; however, offspring of mothers who experienced both maternal childhood maltreatment and antenatal depression were exposed to significantly greater levels of childhood maltreatment and exhibited significantly higher levels of adolescent antisocial behaviour compared with offspring not so exposed. Furthermore, maternal childhood maltreatment accounted for a significant proportion of the variance in offspring childhood maltreatment in only those offspring exposed to depression in utero. Conclusions Maternal childhood maltreatment and maternal antenatal depression are highly associated. The co-occurrence of both insults significantly increases the risk of offspring adversity. The antenatal period is an optimum period to identify vulnerable women and to provide interventions.

Rai, D., P. Zitko, et al. (2013). ***"Country- and individual-level socioeconomic determinants of depression: Multilevel cross-national comparison."*** The British Journal of Psychiatry 202(3): 195-203. http://bjp.rcpsych.org/content/202/3/195.abstract

Background The prevalence and correlates of depression vary across countries. Contextual factors such as country-level income or income inequalities have been hypothesised to contribute to these differences. Aims To investigate associations of depression with socioeconomic factors at the country level (income inequality, gross national income) and individual (education, employment, assets and spending) level, and to investigate their relative contribution in explaining the cross-national variation in the prevalence of depression. Method Multilevel study using interview data of 187 496 individuals from 53 countries participating in the World Health Organization World Health Surveys.ResultsDepression prevalence varied between 0.4 and 15.7% across countries. Individual-level factors were responsible for 86.5% of this variance but there was also reasonable variation at the country level (13.5%), which appeared to increase with decreasing economic development of countries. Gross national income or country-level income inequality had no association with depression. At the individual level, fewer material assets, lower education, female gender, economic inactivity and being divorced or widowed were associated with increased odds of depression. Greater household spending, unlike material assets, was associated with increasing odds of depression (adjusted analysis). Conclusions The variance of depression prevalence attributable to country-level factors seemed to increase with decreasing economic development of countries. However, country-level income inequality or gross national income explained little of this variation, and individual-level factors appeared more important than contextual factors as determinants of depression. The divergent relationship of assets and spending with depression emphasise that different socioeconomic measures are not interchangeable in their associations with depression.

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.").

Spielmans, G. I., M. I. Berman, et al. (2013). ***"Adjunctive atypical antipsychotic treatment for major depressive disorder: A meta-analysis of depression, quality of life, and safety outcomes."*** PLoS Med 10(3): e1001403. http://dx.doi.org/10.1371%2Fjournal.pmed.1001403

(Free full text available) Background: Atypical antipsychotic medications are widely prescribed for the adjunctive treatment of depression, yet their total risk–benefit profile is not well understood. We thus conducted a systematic review of the efficacy and safety profiles of atypical antipsychotic medications used for the adjunctive treatment of depression. Methods and Findings: We included randomized trials comparing adjunctive antipsychotic medication to placebo for treatment-resistant depression in adults. Our literature search (conducted in December 2011 and updated on December 14, 2012) identified 14 short-term trials of aripiprazole, olanzapine/fluoxetine combination (OFC), quetiapine, and risperidone. When possible, we supplemented published literature with data from manufacturers' clinical trial registries and US Food and Drug Administration New Drug Applications. Study duration ranged from 4 to 12 wk. All four drugs had statistically significant effects on remission, as follows: aripiprazole (odds ratio [OR], 2.01; 95% CI, 1.48–2.73), OFC (OR, 1.42; 95% CI, 1.01–2.0), quetiapine (OR, 1.79; 95% CI, 1.33–2.42), and risperidone (OR, 2.37; 95% CI, 1.31–4.30). The number needed to treat (NNT) was 19 for OFC and nine for each other drug. All drugs with the exception of OFC also had statistically significant effects on response rates, as follows: aripiprazole (OR, 2.07; 95% CI, 1.58–2.72; NNT, 7), OFC (OR, 1.30, 95% CI, 0.87–1.93), quetiapine (OR, 1.53, 95% CI, 1.17–2.0; NNT, 10), and risperidone (OR, 1.83, 95% CI, 1.16–2.88; NNT, 8). All four drugs showed statistically significant effects on clinician-rated depression severity measures (Hedges' g ranged from 0.26 to 0.48; mean difference of 2.69 points on the Montgomery–Asberg Depression Rating Scale across drugs). On measures of functioning and quality of life, these medications produced either no benefit or a very small benefit, except for risperidone, which had a small-to-moderate effect on quality of life (g = 0.49). Treatment was linked to several adverse events, including akathisia (aripiprazole), sedation (quetiapine, OFC, and aripiprazole), abnormal metabolic laboratory results (quetiapine and OFC), and weight gain (all four drugs, especially OFC). Shortcomings in study design and data reporting, as well as use of post hoc analyses, may have inflated the apparent benefits of treatment and reduced the apparent incidence of adverse events. Conclusions: Atypical antipsychotic medications for the adjunctive treatment of depression are efficacious in reducing observer-rated depressive symptoms, but clinicians should interpret these findings cautiously in light of (1) the small-to-moderate-sized benefits, (2) the lack of benefit with regards to quality of life or functional impairment, and (3) the abundant evidence of potential treatment-related harm.