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(Sloan, Feinstein et al. 2011; Tamir and Ford 2011; Antoni, Lutgendorf et al. 2012; Appleton 2012; Beaumont, Galpin et al. 2012; Blanco, Myers et al. 2012; Coryell, Fiedorowicz et al. 2012; Cosco, Doyle et al. 2012; Coyne and van Sonderen 2012; Cuijpers, Beekman et al. 2012; Goldberg and Huxley 2012; Hilbert, Bishop et al. 2012; Hunnicutt-Ferguson, Hoxha et al. 2012; Huntley, Araya et al. 2012; Jarosz, Colflesh et al. 2012; Kasen, Wickramaratne et al. 2012; Legate, Ryan et al. 2012; Manea, Gilbody et al. 2012; Menesini and Spiel 2012; Michels 2012; Nijdam, Gersons et al. 2012; Nijhof, Bleijenberg et al. 2012; Otto, Markman et al. 2012; Resick, Williams et al. 2012; Salloum and Overstreet 2012; Sánchez-Villegas, Toledo et al. 2012; Tamir and Ford 2012; Weisz, Chorpita et al. 2012; Westen, Shedler et al. 2012; Zietsch, Verweij et al. 2012)

Antoni, M. H., S. K. Lutgendorf, et al. (2012). "Cognitive-behavioral stress management reverses anxiety-related leukocyte transcriptional dynamics." Biological Psychiatry **71**(4): 366-372. http://www.sciencedirect.com/science/article/pii/S0006322311009656.

Background Chronic threat and anxiety are associated with pro-inflammatory transcriptional profiles in circulating leukocytes, but the causal direction of that relationship has not been established. This study tested whether a cognitive-behavioral stress management (CBSM) intervention targeting negative affect and cognition might counteract anxiety-related transcriptional alterations in people confronting a major medical threat. Methods One hundred ninety-nine women undergoing primary treatment of stage 0–III breast cancer were randomized to a 10-week CBSM protocol or an active control condition. Seventy-nine provided peripheral blood leukocyte samples for genome-wide transcriptional profiling and bioinformatic analyses at baseline, 6-month, and 12-month follow-ups. Results Baseline negative affect was associated with >50% differential expression of 201 leukocyte transcripts, including upregulated expression of pro-inflammatory and metastasis-related genes. CBSM altered leukocyte expression of 91 genes by >50% at follow-up (group × time interaction), including downregulation of pro-inflammatory and metastasis-related genes and upregulation of type I interferon response genes. Promoter-based bioinformatic analyses implicated decreased activity of NF-κB/Rel and GATA family transcription factors and increased activity of interferon response factors and the glucocorticoid receptor as potential mediators of CBSM-induced transcriptional alterations. Conclusions In early-stage breast cancer patients, a 10-week CBSM intervention can reverse anxiety-related upregulation of pro-inflammatory gene expression in circulating leukocytes. These findings clarify the molecular signaling pathways by which behavioral interventions can influence physical health and alter peripheral inflammatory processes that may reciprocally affect brain affective and cognitive processes. *MedicalXpress* - http://medicalxpress.com/news/2012-03-stress-breast-cancer-patients-affect.html - *comments "A team of researchers led by Michael H. Antoni, director of the Center for Psycho-Oncology Research at the University of Miami (UM) has shown that a stress management program tailored to women with breast cancer can alter tumor-promoting processes at the molecular level. The new study recently published in the journal Biological Psychiatry is one of the first to link psychological intervention with genetic expression in cancer patients. According to the study, the group-based Cognitive-Behavioral Stress Management (CBSM) intervention designed by the researchers affects which genes in the cells of the immune system are turned on and off, in ways that may facilitate better recovery during treatment for breast cancer, explains Antoni, professor of Psychology in the College of Arts and Sciences, and professor of Psychiatry and Behavioral Sciences and program leader of Biobehavioral Oncology at the Sylvester Comprehensive Cancer Center at the University of Miami Miller School of Medicine. "For the women in the CBSM groups, there was better psychological adaptation to the whole process of going through treatment for breast cancer and there were physiological changes that indicated that the women were recovering better," Antoni says. "The results suggest that the stress management intervention mitigates the influence of the stress of cancer treatment and promotes recovery over the first year." Previous research has shown that during times of adversity, our nervous and endocrine systems send signals to the immune system, which defends us from disease. In response, our body activates specific genes inside immune cells called white blood cells or leukocytes, Antoni explains. "For the women that participated in the intervention groups, the genes that signal the production of molecules associated with a healthy immune response, such as type I interferon were up-regulated—meaning they were producing more of these substances, compared to levels seen in the control group," Antoni says. "At the same time, the genes responsible for the production of substances involved in cancer progression, such as pro-inflammatory cytokines, chemokines and matrix metalloproteinases were down-regulated." CBSM is a 10-week group-based program developed at UM that combines relaxation, imagery and deep breathing, along with cognitive behavior therapy, which is designed to help patients reduce bodily tension, change the way they deal with intrusive stressful thoughts, decrease negative moods, and improve their interpersonal communication skills. In the study, 79 women undergoing primary treatment for stage 0-III breast cancer were randomized into a 10 week CBSM program or a psychoeducational control group in the weeks following surgery. Six month and 12-month follow up assessments were conducted. "You essentially have this timeframe in a woman's life where she is getting diagnosed with breast cancer, followed by surgery, then chemotherapy or radiation, and it's very stressful," Antoni says. "This can be an emotionally and physically exhausting period offering little opportunity for recovery. If stress affects the immune system in a negative way, then their recovery could be slowed down and those patients taking longer to recover may be at risk for poorer health outcomes. Conversely, if stress management intervention can reduce the impact of stress on the immune system then recovery may be hastened." The research team plans to follow the women in this cohort to see if CBSM intervention and its effects on leukocyte gene expression are predictive of reoccurrence and/or long term health outcomes."*

Appleton, K. (2012). "6 X 40 mins exercise improves body image, even though body weight and shape do not change." Journal of Health Psychology. http://hpq.sagepub.com/content/early/2012/02/08/1359105311434756.abstract.

Body weight, shape and body image were assessed in 16 males and 18 females before and after both 6 × 40 mins exercise and 6 × 40 mins reading. Over both conditions, body weight and shape did not change. Various aspects of body image, however, improved after exercise compared to before, while no changes were found over reading. These findings have implications for exercise promotion where a possible role for body image in exercise adherence is suggested, and confirm current theories of body image, where changes in body image are mediated by body perceptions as opposed to actual body indices.

Beaumont, E., A. Galpin, et al. (2012). "'Being kinder to myself ': A prospective comparative study, exploring post-trauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training." Counselling Psychology Review **27**(1): 31-42. http://dcop.bps.org.uk/publications/cpr.cfm.

Background/Aims/Objectives: This prospective, comparative outcome study was designed to contrast the relative impact of differing therapeutic interventions for trauma victims, carried out by the same therapist. Methods/Methodology: A non-random convenience sample (N=32) of participants, referred for therapy following a traumatic incident, were randomly assigned to receive up to 12 sessions of either Cognitive Behaviour Therapy (CBT), or CBT coupled with Compassionate Mind

Training (CMT). A repeated measures design was used and data was analysed using analysis of variance. Data was gathered pre-therapy and post-therapy, using three self-report questionnaires (Hospital Anxiety and Depression Scale; Impact of Events Scale; the Self-Compassion Scale). Results/Findings: Results supported two of the three original hypotheses. Participants in both conditions experienced a highly statistically significant reduction in symptoms of anxiety, depression, avoidant behaviour, intrusive thoughts and hyper-arousal symptoms post-therapy. Participants in the combined CBT and CMT condition developed statistically significant higher self-compassion scores post-therapy than the CBT-only group [$F(1,30)=4.657$, $p \leq .05$]. There was no significant difference between treatment groups. Discussion/Conclusions: The results suggest that CMT may be a useful addition to CBT for clients suffering with trauma-related symptoms. In conclusion, high levels of self-compassion are linked to a decrease in anxiety and depression and trauma-related symptoms.

Blanco, C., J. Myers, et al. (2012). "Gambling, disordered gambling and their association with major depression and substance use: a web-based cohort and twin-sibling study." Psychological Medicine **42**(03): 497-508. http://dx.doi.org/10.1017/S0033291711001401.

Background: Relatively little is known about the environmental and genetic contributions to gambling frequency and disordered gambling (DG), the full continuum of gambling-related problems that includes pathological gambling (PG). Method: A web-based sample (n=43 799 including both members of 609 twin and 303 sibling pairs) completed assessments of number of lifetime gambling episodes, DSM-IV criteria for PG, alcohol, nicotine and caffeine intake, and nicotine dependence (ND) and DSM-III-R criteria for lifetime major depression (MD). Twin modeling was performed using Mx. Results: In the entire cohort, symptoms of DG indexed a single dimension of liability. Symptoms of DG were weakly related to caffeine intake and moderately related to MD, consumption of cigarettes and alcohol, and ND. In twin and sibling pairs, familial resemblance for number of times gambled resulted from both familial–environmental (c2=42%) and genetic factors (a2=32%). For symptoms of DG, resemblance resulted solely from genetic factors (a2=83%). Bivariate analyses indicated a low genetic correlation between symptoms of DG and MD (ra=+0.14) whereas genetic correlations with DG symptoms were substantially higher with use of alcohol, caffeine and nicotine, and ND (ranging from +0.29 to +0.80). The results were invariant across genders. Conclusions: Whereas gambling participation is determined by shared environmental and genetic factors, DG constitutes a single latent dimension that is largely genetically determined and more closely related to externalizing than internalizing behaviors. Because these findings are invariant across genders, they suggest that the etiological factors of DG are likely to be similar in men and women.

Coryell, W., J. G. Fiedorowicz, et al. (2012). "Effects of anxiety on the long-term course of depressive disorders." British Journal of Psychiatry **200**(3): 210-215. http://bjp.rcpsych.org/content/200/3/210.abstract.

Background: It is well established that the presence of prominent anxiety within depressive episodes portends poorer outcomes. Important questions remain as to which anxiety features are important to outcome and how sustained their prognostic effects are over time. Aims: To examine the relative prognostic importance of specific anxiety features and to determine whether their effects persist over decades and apply to both unipolar and bipolar conditions. Method: Participants with unipolar (n = 476) or bipolar (n = 335) depressive disorders were intensively followed for a mean of 16.7 years (s.d. = 8.5). Results: The number and severity of anxiety symptoms, but not the presence of pre-existing anxiety disorders, showed a robust and continuous relationship to the subsequent time spent in depressive episodes in both unipolar and bipolar depressive disorder. The strength of this relationship changed little over five successive 5-year periods. Conclusions: The severity of current anxiety symptoms within depressive episodes correlates strongly with the persistence of subsequent depressive symptoms and this relationship is stable over decades.

Cosco, T. D., F. Doyle, et al. (2012). "Latent structure of the Hospital Anxiety And Depression Scale: A 10-year systematic review." Journal of Psychosomatic Research **72**(3): 180-184. http://www.sciencedirect.com/science/article/pii/S0022399911001942.

Objective To systematically review the latent structure of the Hospital Anxiety and Depression Scale (HADS). Methods A systematic review of the literature was conducted across Medline, ISI Web of Knowledge, CINAHL, PsycInfo and EmBase databases spanning articles published between May 2000 and May 2010. Studies conducting latent variable analysis of the HADS were included. Results Twenty-five of the 50 reviewed studies revealed a two-factor structure, the most commonly found HADS structure. Additionally, five studies revealed unidimensional, 17 studies revealed three-factor, and two studies revealed four-factor structures. One study provided equal support for two- and three-factor structures. Different latent variable analysis methods revealed correspondingly different structures: exploratory factor analysis studies revealed primarily two-factor structures, confirmatory factor analysis studies revealed primarily three-factor structures, and item response theory studies revealed primarily unidimensional structures. Conclusion The heterogeneous results of the current review suggest that the latent structure of the HADS is unclear, and dependent on statistical methods invoked. While the HADS has been shown to be an effective measure of emotional distress, its inability to consistently differentiate between the constructs of anxiety and depression means that its use needs to be targeted to more general measurement of distress.

Coyne, J. C. and E. van Sonderen (2012). "No further research needed: Abandoning the Hospital and Anxiety Depression Scale (HADS)." Journal of Psychosomatic Research **72**(3): 173-174. http://www.sciencedirect.com/science/article/pii/S0022399911003059.

Cosco and colleagues [this issue] provide a well done and transparently reported systematic review of the Hospital Anxiety and Depression Scale (HADS) literature of the past decade. They conclude that the underlying structure of the HADS is inconsistent across samples and highly dependent on the statistical methods used to establish that structure. The implication is that the HADS is not a dependable means of differentiating anxiety and depression for the purposes of assessing the absolute or relative levels of these variables. These results can also go far in explaining the confusing difficulties that have arisen in research concerning use of the HADS as the first stage of two-stage screening procedures of depression and anxiety disorders or case identification procedures ... There are abundant reasons why the field should move on, leave the HADS literature behind, and select any of a number of alternative instruments in its place. Tradition and the HADS still being the most widely used screening and assessment instrument with medically ill patients are insufficient reasons to continue to recommend it.

Cuijpers, P., A. T. F. Beekman, et al. (2012). "Preventing depression." JAMA: The Journal of the American Medical Association **307**(10): 1033-1034. http://jama.ama-assn.org/content/307/10/1033.short.

Depressive disorders erode quality of life, productivity in the workplace, and fulfillment of social and familial roles. In today's knowledge- and service-driven economies, the population's mental capital (ie, cognitive, emotional, and social skills resources required for role functioning) becomes both more valuable and more vulnerable to the effects of depression. Depressive disorders, severe mental illnesses that should not be confused with normal mood variations, are part of a vicious circle of poverty, discrimination, and poor mental health in middle- and low-income countries. These realities also have major economic ramifications: treatment costs of depression are soaring but are only a fragment of the costs of reduced productivity

due to depression. More than half of those with depression develop a recurrent or chronic disorder after a first depressive episode and are likely to spend more than 20% of their lifetime in a depressed condition.

Goldberg, D. and P. Huxley (2012). "At least 25% with a mental health problem is a conservative estimate." BMJ **344**. http://www.bmj.com/content/344/bmj.e1776.

There are enormous problems in deciding what counts as a mental disorder, but most epidemiologists use an official classification such as the international classification of diseases. We were responsible for providing evidence that the one year prevalence of mental disorders in community samples is about 250/1000. We obtained this figure by combining figures for cross sectional prevalence with admittedly speculative estimates of annual inceptions, so that a cross sectional rate of 180/1000 was inflated by assuming that about a third of that number would develop a new episode during the next year. Even at that time, we had excellent evidence that most episodes are of short duration (fewer than three months). Since then, surveys have asked people to remember their health over the previous year. By 2002 it was shown that survey results were yielding slight underestimates: the rate for the UK was then revised upwards to 270/1000, also taking into account rates reported by the Office for National Statistics. These rates did not include severe mental disorders, such as schizophrenia, bipolar disorder, or dementia, and neither did they include alcohol and drug dependence. These are annual rates, not lifetime rates—the concept of lifetime prevalence is necessary for studies of the genetics of mental disorders, but it is a highly questionable concept where common mental disorders are concerned. This is because it assumes that people not only can, but will, reveal information about minor disorders that occurred many years ago that they might have forgotten or suppressed. For this reason, we have never quoted figures for lifetime rates. However, for those who like to think in these terms, "at least 25%" is almost certainly a conservative estimate.

Hilbert, A., M. E. Bishop, et al. (2012). "Long-term efficacy of psychological treatments for binge eating disorder." British Journal of Psychiatry **200**(3): 232-237. http://bjp.rcpsych.org/content/200/3/232.abstract.

Background: The long-term efficacy of psychological treatments for binge eating disorder remains largely unknown. Aims: To examine the long-term efficacy of out-patient group cognitive–behavioural therapy (CBT) and group interpersonal psychotherapy (IPT) for binge eating disorder and to analyse predictors of long-term non-response. Method: Ninety people with binge eating disorder were assessed 4 years after treatment cessation within a randomised trial (trial registration: NCT01208272). Results: Participants showed substantial long-term recovery, partial remission, clinically significant improvement and significant reductions in associated psychopathology, despite relapse tendencies in single secondary outcomes. Body mass index remained stable. While the IPT group demonstrated an improvement in eating disorder symptoms over the follow-up period, the CBT group reported a worsening of symptoms, but treatments did not differ at any time point. Conclusions: The results document the long-term efficacy of out-patient CBT and IPT for binge eating disorder. Further research is warranted to elucidate the time course and mechanisms of change of these treatments for binge eating disorder.

Hunnicutt-Ferguson, K., D. Hoxha, et al. (2012). "Exploring sudden gains in behavioral activation therapy for major depressive disorder." Behaviour Research and Therapy **50**(3): 223-230. http://www.sciencedirect.com/science/article/pii/S0005796712000174.

Understanding the onset and course of sudden gains in treatment provides clinical information to the patient and clinician, and encourages clinicians to strive for these sudden clinical gains with their patients. This study characterizes the occurrence of sudden gains with Behavioral Activation (BA; Martell, Addis, & Jacobson, 2001), and the extent to which pre-treatment dysfunctional depressive thinking predicts sudden gains during treatment. We enrolled a sample of adults (n = 42) between ages 18–65 diagnosed with primary Major Depressive Disorder. All participants completed a 16-week course of BA, with clinical and self-report assessments at pre-, mid- and post-treatment. Results indicated that sudden gain and non-sudden gain participants showed differential improvement across treatment. No significant effects emerged for the dysfunctional cognitive style as a predictor of sudden gain status. Sudden gains may result from interaction of non-specific factors with the BA techniques implemented during early phases of therapy.

Huntley, A. L., R. Araya, et al. (2012). "Group psychological therapies for depression in the community: systematic review and meta-analysis." British Journal of Psychiatry **200**(3): 184-190. http://bjp.rcpsych.org/content/200/3/184.abstract.

Background: Psychological therapies have been shown to be effective in the treatment of depression. However, evidence is focused on individually delivered therapies, with less evidence for group-based therapies. Aims: To conduct a systematic review and meta-analysis of the efficacy of group-based psychological therapies for depression in primary care and the community. Method: We searched MEDLINE, Embase, PsycINFO, the Cochrane Central Register of Controlled Trials and the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group database from inception to July 2010. The Cochrane risk of bias methodology was applied. Results: Twenty-three studies were included. The majority showed considerable risk of bias. Analysis of group cognitive–behavioural therapy (CBT) v. usual care alone (14 studies) showed a significant effect in favour of group CBT immediately post-treatment (standardised mean difference (SMD) −0.55 (95% CI −0.78 to −0.32)). There was some evidence of benefit being maintained at short-term (SMD = −0.47 (95% CI −1.06 to 0.12)) and medium- to long-term follow-up (SMD = −0.47 (95% CI − 0.87 to −0.08)). Studies of group CBT v. individually delivered CBT therapy (7 studies) showed a moderate treatment effect in favour of individually delivered CBT immediately post-treatment (SMD = 0.38 (95% CI 0.09–0.66)) but no evidence of difference at short- or medium- to long-term follow-up. Four studies described comparisons for three other types of group psychological therapies. Conclusions: Group CBT confers benefit for individuals who are clinically depressed over that of usual care alone. Individually delivered CBT is more effective than group CBT immediately following treatment but after 3 months there is no evidence of difference. The quality of evidence is poor. Evidence about group psychological therapies not based on CBT is particularly limited.

Jarosz, A. F., G. J. H. Colflesh, et al. (2012). "Uncorking the muse: Alcohol intoxication facilitates creative problem solving." Consciousness and Cognition **21**(1): 487-493. http://www.sciencedirect.com/science/article/pii/S1053810012000037.

That alcohol provides a benefit to creative processes has long been assumed by popular culture, but to date has not been tested. The current experiment tested the effects of moderate alcohol intoxication on a common creative problem solving task, the Remote Associates Test (RAT). Individuals were brought to a blood alcohol content of approximately .075, and, after reaching peak intoxication, completed a battery of RAT items. Intoxicated individuals solved more RAT items, in less time, and were more likely to perceive their solutions as the result of a sudden insight. Results are interpreted from an attentional control perspective. (For more details see the BPS Digest at http://www.bps-research-digest.blogspot.co.uk/2012/03/mild-intoxication-aids-creative-problem.html).

Kasen, S., P. Wickramaratne, et al. (2012). "Religiosity and resilience in persons at high risk for major depression." Psychological Medicine **42**(03): 509-519. http://dx.doi.org/10.1017/S0033291711001516.

Background: Few studies have examined religiosity as a protective factor using a longitudinal design to predict resilience in persons at high risk for major depressive disorder (MDD). Method: High-risk offspring selected for having a depressed parent and control offspring of non-depressed parents were evaluated for psychiatric disorders in childhood/adolescence and at 10-year and 20-year follow-ups. Religious/spiritual importance, services attendance and negative life events (NLEs) were assessed at the 10-year follow-up. Models tested differences in relationships between religiosity/spirituality and subsequent disorders among offspring based on parent depression status, history of prior MDD and level of NLE exposure. Resilience was defined as lower odds for disorders with greater religiosity/spirituality in higher-risk versus lower-risk offspring. Results: Increased attendance was associated with significantly reduced odds for mood disorder (by 43%) and any psychiatric disorder (by 53%) in all offspring; however, odds were significantly lower in offspring of non-depressed parents than in offspring of depressed parents. In analyses confined to offspring of depressed parents, those with high and those with average/low NLE exposure were compared: increased attendance was associated with significantly reduced odds for MDD, mood disorder and any psychiatric disorder (by 76, 69 and 64% respectively) and increased importance was associated with significantly reduced odds for mood disorder (by 74%) only in offspring of depressed parents with high NLE exposure. Moreover, those associations differed significantly between offspring of depressed parents with high NLE exposure and offspring of depressed parents with average/low NLE exposure. Conclusions: Greater religiosity may contribute to development of resilience in certain high-risk individuals.

Legate, N., R. M. Ryan, et al. (2012). "Is coming out always a "good thing"? Exploring the relations of autonomy support, outness, and wellness for lesbian, gay, and bisexual individuals." Social psychological and personality science **3**(2): 145-152. http://spp.sagepub.com/content/3/2/145.abstract.

Prior research suggests that, on average, disclosing sexual identity (being "out") yields wellness benefits for lesbian, gay, and bisexual (LGB) individuals. LGB individuals vary, however, both in how much they disclose their sexual orientation in different social contexts and in the experiences that follow from disclosure. The present research examines this within-person variation in disclosure and its consequences as a function of the autonomy supportive versus controlling character of social contexts. LGB individuals rated experiences of autonomy support and control in the contexts of family, friends, coworkers, school, and religious community, as well how "out" they were, and their context-specific self-esteem, depression, and anger. Findings from multilevel modeling revealed that LGB individuals were more likely to disclose in autonomy supportive contexts. Additionally, whereas disclosure was associated with more positive well-being in autonomy supportive contexts, in controlling contexts it was not. Practical and research implications are discussed.

Manea, L., S. Gilbody, et al. (2012). "Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): a meta-analysis." CMAJ **184**(3): E191-196. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3281183/?tool=pubmed.

(Free full text available) BACKGROUND: The brief Patient Health Questionnaire (PHQ-9) is commonly used to screen for depression with 10 often recommended as the cut-off score. We summarized the psychometric properties of the PHQ-9 across a range of studies and cut-off scores to select the optimal cut-off for detecting depression. METHODS: We searched Embase, MEDLINE and PsycINFO from 1999 to August 2010 for studies that reported the diagnostic accuracy of PHQ-9 to diagnose major depressive disorders. We calculated summary sensitivity, specificity, likelihood ratios and diagnostic odds ratios for detecting major depressive disorder at different cut-off scores and in different settings. We used random-effects bivariate meta-analysis at cutoff points between 7 and 15 to produce summary receiver operating characteristic curves. RESULTS: We identified 18 validation studies (n = 7180) conducted in various clinical settings. Eleven studies provided details about the diagnostic properties of the questionnaire at more than one cut-off score (including 10), four studies reported a cut-off score of 10, and three studies reported cut-off scores other than 10. The pooled specificity results ranged from 0.73 (95% confidence interval [CI] 0.63-0.82) for a cut-off score of 7 to 0.96 (95% CI 0.94-0.97) for a cut-off score of 15. There was major variability in sensitivity for cut-off scores between 7 and 15. There were no substantial differences in the pooled sensitivity and specificity for a range of cut-off scores (8-11). INTERPRETATION: The PHQ-9 was found to have acceptable diagnostic properties for detecting major depressive disorder for cut-off scores between 8 and 11. Authors of future validation studies should consistently report the outcomes for different cut-off scores.

Menesini, E. and C. Spiel (2012). "Introduction: Cyberbullying: Development, consequences, risk and protective factors." European Journal of Developmental Psychology **9**(2): 163-167. http://dx.doi.org/10.1080/17405629.2011.652833.

(Accessible in free full text) This article is an introduction to a special issue of the European Journal of Developmental Psychology devoted to Cyberbullying. The authors comment: "With the increase and diffusion of modern technologies a new form of bullying has emerged among children and adolescents. Many researchers define it as cyberbullying, electronic bullying or internet bullying. With these terms we refer to voluntary and repeated assaults against a person through electronic means. These attacks can be: offensive e-mails or text messages; insults through chat rooms or instant messaging; photos or videos on mobile or web; exclusion from social networks or appropriation of others' credentials and identity information. Studies on cyberbullying are relatively recent, mainly published in the last ten years. These contributions have been focused on a first description of the phenomenon in relation to the medium used (mobile phone or internet) and on the possible link between traditional bullying and cyberbullying. As a global picture cyberbullying represents a threatening experience among young people in different Western countries, although it is showing different levels of prevalence in relation to different cultures, contexts and personal characteristics. From recent estimation, the percentages of children and adolescents involved in the problem can reach values close to 10% of 9- to 16-year-olds in Europe ... We conclude that this special issue offers important new findings on the development and consequences of cyberbullying and cyber-victimization and opens new and future directions of research.

Michels, R. (2012). "Diagnosing personality disorders." Am J Psychiatry **169**(3): 241-243. http://ajp.psychiatryonline.org/article.aspx?articleid=1028573.

(Available in free full text) In the past, one might have argued that the differential diagnosis of specific personality disorders made little difference, that it wasn't a useful clinical guide for individual patients. However, research has demonstrated differences in clinical course and prognosis among the several personality disorders, and the separate categories have been useful to the growing body of research on therapeutics. As we move toward DSM-5, it is clear that the clinical and research communities view personality disorders differently. The clinical community wants a system that is practical and workable in the real world and that focuses on the essence of each category. The research community wants to capture as much information as possible and to emphasize precise boundaries of categories rather than reifying core syndromes that may have more to do with tradition or theory than with patients. In this issue of the Journal, Westen et al. enter the fray with the goal of "bridging" science and practice. They claim that they are developing a "taxonomy" (the term Linnaeus introduced for classifying living things according to their natural relationships). DSM is more modest, claiming only to be a "nosology" (a classification of diseases). In fact, "nomenclature" (a system of names) might be even more appropriate. Westen and colleagues' important study is the most recent in a 15-year program of research that has established their position as an exemplar representing one important position in the dialogue of personality disorder diagnosis. Westen et al. argue that personality disorders are primarily

clinical concepts. The individual disorders are syndromes—clusters of meaningfully related characteristics that are recognized as syndromic entities, not as collections of independent phenomena. In explaining the concept, the authors use the metaphor of face recognition; it is relatively easy when we see a whole face but much more difficult if we are presented with an assortment of eyebrows, noses, chins, eyes, and mouths. Westen et al. have developed prototypic descriptions of eight personality disorders, two of "neurotic styles," and one of personality health ... The gap between researcher and practitioner in personality disorders may be fundamental—the diagnoses are used for different purposes. Westen et al. have provided a state-of-the-art strategy for constructing categories that reflect how clinicians think and that clinicians will find friendly to use. The architects of DSM-5 will have to decide how it should resolve the tensions between the clinical and research communities and their different goals in using the nosology.

Nijdam, M. J., B. P. R. Gersons, et al. (2012). "Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial." British Journal of Psychiatry **200**(3): 224-231. http://bjp.rcpsych.org/content/200/3/224.abstract.

Background: Trauma-focused cognitive–behavioural therapy (CBT) and eye movement desensitisation and reprocessing therapy (EMDR) are efficacious treatments for post-traumatic stress disorder (PTSD), but few studies have directly compared them using well-powered designs and few have investigated response patterns. Aims: To compare the efficacy and response pattern of a trauma-focused CBT modality, brief eclectic psychotherapy for PTSD, with EMDR (trial registration: ISRCTN64872147). Method: Out-patients with PTSD were randomly assigned to brief eclectic psychotherapy (n = 70) or EMDR (n = 70) and assessed at all sessions on self-reported PTSD (Impact of Event Scale – Revised). Other outcomes were clinician-rated PTSD, anxiety and depression. Results: Both treatments were equally effective in reducing PTSD symptom severity, but the response pattern indicated that EMDR led to a significantly sharper decline in PTSD symptoms than brief eclectic psychotherapy, with similar drop-out rates (EMDR: n = 20 (29%), brief eclectic psychotherapy: n = 25 (36%)). Other outcome measures confirmed this pattern of results. Conclusions: Although both treatments are effective, EMDR results in a faster recovery compared with the more gradual improvement with brief eclectic psychotherapy.

Nijhof, S. L., G. Bleijenberg, et al. (2012). "Effectiveness of internet-based cognitive behavioural treatment for adolescents with chronic fatigue syndrome (FITNET): a randomised controlled trial." The Lancet **379**(9824): 1412-1418. http://linkinghub.elsevier.com/retrieve/pii/S0140673612600257.

Chronic fatigue syndrome is characterised by persistent fatigue and severe disability. Cognitive behavioural therapy seems to be a promising treatment, but its availability is restricted. We developed Fatigue In Teenagers on the interNET (FITNET), the first dedicated internet-based therapeutic program for adolescents with this disorder, and compared its effectiveness with that of usual care. Adolescents aged 12?18 years with chronic fatigue syndrome were assigned to FITNET or usual care in a 1:1 ratio at one tertiary treatment centre in the Netherlands by use of a computer-generated blocked randomisation allocation schedule. The study was open label. Primary outcomes were school attendance, fatigue severity, and physical functioning, and were assessed at 6 months with computerised questionnaires. Analysis was by intention to treat. Thereafter, all patients were offered FITNET if needed. This trial is registered, number ISRCTN59878666. 68 of 135 adolescents were assigned to FITNET and 67 to usual care, and 67 and 64, respectively, were analysed. FITNET was significantly more effective than was usual care for all dichotomised primary outcomes at 6 months—full school attendance (50 [75%] vs 10 [16%], relative risk 4·8, 95% CI 2·7—8·9; p<0·0001), absence of severe fatigue (57 [85%] vs 17 [27%], 3·2, 2·1—4·9; p<0·0001), and normal physical functioning (52 [78%] vs 13 [20%], 3·8, 2·3—6·3; p<0·0001). No serious adverse events were reported. FITNET offers a readily accessible and highly effective treatment for adolescents with chronic fatigue syndrome. The results of this study justify implementation on a broader scale. Netherlands Organisation for Health Research and Development.

Otto, A. R., A. B. Markman, et al. (2012). "Taking more, now." Social psychological and personality science **3**(2): 131-138. http://spp.sagepub.com/content/3/2/131.abstract.

Impulsivity is a stable personality trait associated with myopic choice behavior that favors immediate rewards over larger, delayed rewards and is often characterized as maladaptive inside and outside of the laboratory. An alternative view suggests that the consequences of trait impulsivity depend on the nature of the task environment. On this view, the optimal level of impulsivity varies across task payoff structures. This hypothesis is tested in two dynamic decision-making tasks that differ in the relative payoffs of delayed and immediate rewards. In a task that favors delayed rewards to immediate rewards, high-impulsive participants perform worse than low-impulsive participants. In contrast, in a task that favors immediate rewards over delayed rewards, high-impulsive participants outperform low-impulsive participants. These results suggest a more nuanced conceptualization of trait impulsivity as it applies to rewards-related decision making that may help explain the variability observed in this trait across individuals.

Resick, P. A., L. F. Williams, et al. (2012). "Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors." J Consult Clin Psychol **80**(2): 201-210. http://www.ncbi.nlm.nih.gov/pubmed/22182261.

(Free full text from http://www.ptsd.va.gov/professional/articles/article-pdf/id37854.pdf) Objective: We conducted a long-term follow-up (LTFU) assessment of participants from a randomized controlled trial comparing cognitive processing therapy (CPT) with prolonged exposure (PE) for posttraumatic stress disorder (PTSD). Competing hypotheses for positive outcomes (i.e., additional therapy, medication) were examined. Method: Intention-to-treat (ITT) participants were assessed 5-10 years after participating in the study (M = 6.15, SD = 1.22). We attempted to locate the 171 original participants, women with PTSD who had experienced at least one rape. Of 144 participants located, 87.5% were reassessed (N = 126), which constituted 73.7% of the original ITT sample. Self-reported PTSD symptoms were the primary outcome. Clinician-rated PTSD symptoms, comorbid diagnoses, and self-reported depression were secondary outcomes. Results: Substantial decreases in symptoms due to treatment (as reported in Resick, Nishith, Weaver, Astin, & Feuer, 2002) were maintained throughout the LTFU period, as evidenced by little change over time from posttreatment through follow-up (effect sizes ranging from pr = .03 to .14). No significant differences emerged during the LTFU between the treatment conditions (Cohen's d = 0.06-0.29). The ITT examination of diagnostics indicated that 22.2% of CPT and 17.5% of PE participants met the diagnosis for PTSD according to the Clinician-Administered PTSD Scale (Blake et al., 1995) at the LTFU. Maintenance of improvements could not be attributed to further therapy or medications. Conclusions: CPT and PE resulted in lasting changes in PTSD and related symptoms over an extended period of time for female rape victims with extensive histories of trauma.

Salloum, A. and S. Overstreet (2012). "Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration." Behaviour Research and Therapy **50**(3): 169-179. http://www.sciencedirect.com/science/article/pii/S0005796712000022.

This study evaluated the differential effects of the Grief and Trauma Intervention (GTI) with coping skills and trauma narrative processing (CN) and coping skills only (C). Seventy African American children (6–12 years old) were randomly

assigned to GTI-CN or GTI-C. Both treatments consisted of a manualized 11-session intervention and a parent meeting. Measures of trauma exposure, posttraumatic stress symptoms, depression, traumatic grief, global distress, social support, and parent reported behavioral problems were administered at pre, post, 3 and 12 months post intervention. In general, children in both treatment groups demonstrated significant improvements in distress related symptoms and social support, which, with the exception of externalizing symptoms for GTI-C, were maintained up to 12 months post intervention. Results suggest that building coping skills without the structured trauma narrative may be a viable intervention to achieve symptom relief in children experiencing trauma-related distress. However, it may be that highly distressed children experience more symptom relief with coping skills plus narrative processing than with coping skills alone. More research on the differential effects of coping skills and trauma narration on child distress and adaptive functioning outcomes is needed.

Sánchez-Villegas, A., E. Toledo, et al. (2012). "Fast-food and commercial baked goods consumption and the risk of depression." Public Health Nutrition **15**(03): 424-432. http://dx.doi.org/10.1017/S1368980011001856.

Objective: Whereas the relationship between some components of diet, such as n-3 fatty acids and B-vitamins, and depression risk has been extensively studied, the role of fast-food or processed pastries consumption has received little attention. Design: Consumption of fast food (hamburgers, sausages, pizza) and processed pastries (muffins, doughnuts, croissants) was assessed at baseline through a validated semi-quantitative FFQ. Participants were classified as incident cases of depression if they reported a physician diagnosis of depression or the use of antidepressant medication in at least one of the follow-up questionnaires. Cox regression models were fit to assess the relationship between consumption of fast food and commercial baked goods and the incidence of depression. Setting: The SUN (Seguimiento Universidad de Navarra – University of Navarra Follow-up) Project, Spain. Subjects: Participants (n 8964) from a Spanish cohort.ResultsAfter a median follow-up of 6·2 years, 493 cases of depression were reported. A higher risk of depression was associated with consumption of fast food (fifth (Q5) v. first quintile (Q1): hazard ratio (HR) = 1·36; 95 % CI 1·02, 1·81; P trend = 0·003). The results did not change after adjustment for the consumption of other food items. No linear relationship was found between the consumption of commercial baked goods and depression. Participants belonging to consumption quintiles Q2–Q5 showed an increased risk of depression compared with those belonging to the lowest level of consumption (Q1; HR = 1·38; 95 % CI 1·06, 1·80). Conclusions: Fast-food and commercial baked goods consumption may have a detrimental effect on depression risk. *Deborah Brauser of Medscape - http://www.medscape.com/psychiatry - commented on 25 April: "Eating too much junk food may increase risk for depression, a large study suggests. In a cohort study of almost 9000 adults in Spain, those who consistently consumed "fast food," such as hamburgers and pizza, were 40% more likely to develop depression than the participants who consumed little to none of these types of food. In addition, investigators found that the depression risk rose steadily as more fast food was consumed. Participants who often ate commercial baked goods, such as croissants and doughnuts, were also at significant risk of developing this disorder. "We were not surprised with the results. Several studies have analyzed the association between fast food and commercial bakery consumption and physical diseases, such as obesity or coronary heart disease," Almudena Sánchez-Villegas, PhD, from the Department of Clinical Sciences at the University of Las Palmas de Gran Canaria and the Department of Preventive Medicine and Public Health at the University of Navarra in Pamplona, Spain, told Medscape Medical News. Dr. Almudena Sánchez-Villegas "With these results, a relatively new line of research is open. Limiting trans fatty acids content in several foods, avoiding the consumption of fast food and bakery, and increasing the consumption of other products such as vegetables, legumes, and fruits should be a primary goal for clinicians and public health makers," she added. The study is published in the March issue of Public Health Nutrition. Croissants, Doughnuts, and Muffins, Oh My! According to the investigators, depression affects around 121 million people throughout the world. Although "little is known about the role of diet in the development of depressive disorders," past studies have suggested that olive oil, B vitamins, and omega-3 fatty acids may play a preventative role, write the researchers. As reported by Medscape Medical News, Dr. Sánchez-Villegas and colleagues published a study last year in PLoS One that linked consumption of trans unsaturated fatty acids (TFA) to a significantly increased risk for depression. For the current study, they sought to specifically examine the role that consumption of fast food and processed food may play in the development of this disorder. The researchers examined data on 8964 adults from the Seguimiento Universidad de Navarra (SUN) Project, an ongoing diet and lifestyle tracking study that started in 1999. None of the SUN participants had been diagnosed with depression or had taken antidepressants before the start of the study. Exposures and outcomes were gathered through surveys mailed out biennially to the participants. A food frequency questionnaire was used to assess dietary intake. Fast food consumption was defined as total consumption of hamburgers, pizza, and hot dogs/sausages. Commercial baked goods consumption was defined as total consumption of croissants, doughnuts, and muffins. Incident depression and/or self-reported physician-made diagnosis of depression, antidepressant use, and demographic and lifestyle data were recorded on other questionnaires. Curb the Junk Food: Results showed that 493 of the participants were diagnosed with depression after a median follow-up of 6.2 years. Those who were found to have the highest levels of consumption of fast food showed a significantly higher risk of developing depression compared with those who had the lowest levels of consumption (adjusted hazard ratio [HR], 1.40; 95% confidence interval [CI], 1.05 - 1.86; P = .01). "Moreover, a significant dose-response relationship was found (P for trend = .001)," report the researchers. However, the researchers note that even small quantities of fast food were linked to a significantly higher risk for depression. Participants who often consumed commercial baked goods were also at increased risk of developing this disorder (adjusted HR, 1.43; 95% CI, 1.06 - 1.93). The investigators also found that the study participants with the highest consumption of fast food and of commercial baked goods were more likely to be single, less active, smoke, work more than 45 hours per week, and eat less fruits, vegetables, nuts, fish, and/or olive oil. "Although more studies are necessary, the intake of this type of food should be controlled because of its implications on both health (obesity, cardiovascular disease) and mental well-being," said Dr. Sánchez-Villegas. The researchers add that the legally permitted content of TFA in these foods "should be reviewed." "This Spanish team conducted very good, quality research and took considerable care to consider multiple possible causes of confounding, such as other factors that may explain both dietary habits and risk for depression," Felice Jacka, PhD, research fellow at Deakin University in Melbourne, Australia, told Medscape Medical News. "For example, they take into account many variables that may be proxies of health consciousness or overall health lifestyle, such as the use of seat belts, frequency of medical and dental checkups, and drunk driving, as well as marital status, smoking, alcohol consumption, and intake of nutrient-dense foods. The study sample is also large and well described, and the prospective cohort design affords the potential for investigating cause-effect relationships," she added. Dr. Jacka noted that the results support a previous study that she and her colleagues published recently in the American Journal of Psychiatry, which showed that women who consumed a diet higher in unhealthy and processed food were likely to be depressed. In a study published in the Australian and New Zealand Journal of Psychiatry, they reported the same results in a cohort of adolescents. The results of the current study "are also concordant with the two prospective studies in this field, in both adults and adolescents, reporting that unhealthy diets are associated with an increased risk for mental health problems over time," she reported. She added that although this study was rigorously conducted and is methodologically sound, "it is perhaps a shame that [it] does not have data on diagnoses of depression ascertained via clinical assessments. However, this is rare in large epidemiological studies, and the measures they have used have been shown to be valid." Dr. Jacka noted that because diet and mental health research is relatively new, it is often uncommon for clinicians to consider diet as an intervention target in clinical care. "However, this study adds to the rapidly growing and highly consistent body of literature*

suggesting that depression is another common, noncommunicable illness with a significant lifestyle component," she said. "As such, it is prudent for clinicians to assess and address the dietary as well as exercise habits of their patients, in addition to pharmacological and other established treatments."

Sloan, D. M., B. A. Feinstein, et al. (2011). "Efficacy of group treatment for posttraumatic stress disorder symptoms: A meta-analysis." Psychological Trauma: Theory, Research, Practice, and Policy. http://psycnet.apa.org/index.cfm?fa=search.displayRecord&id=C939E7BB-9340-FF99-AB5C-CB44E10D3AA5&resultID=1&page=1&dbTab=pa.

(Free full text available from http://www.ptsd.va.gov/professional/articles/article-pdf/id37918.pdf) Abstract: This study conducted a meta-analysis of published randomized clinical group trials for adult survivors of trauma to examine the efficacy of the group format. Effect sizes for posttraumatic stress disorder (PTSD) severity outcome were examined. Sixteen studies were included, with a total of 1686 participants. Results of a random effects model meta-analysis indicated that group treatments are associated with significant pre- to posttreatment reduction in PTSD symptom severity (within treatment d = .71, 95% CI [.51, .91]), and result in superior treatment effects relative to a wait list comparison condition (d = .56, 95% CI [.31, .82]). However, no significant findings were obtained for group interventions relative to active treatment comparison conditions (d = .09, 95% CI [−.03, .22]). Moderator analyses also indicated that gender and type of trauma moderated treatment effects for PTSD outcome, with smaller effect sizes associated with males relative to females and combined gender samples, and smaller effect sizes for combat and child sexual assault trauma samples relative to mixed-trauma sample studies. Taken together, group treatment for trauma symptoms is better than no treatment but not better relative to comparison conditions that control for nonspecific benefits of therapy. Additional work is needed to identify effective group treatments for PTSD, especially for patients with repeated or chronic traumatization.

Tamir, M. and B. Q. Ford (2011). "When feeling bad is expected to be good: Emotion regulation and outcome expectancies in social conflicts." Emotion. http://www.ncbi.nlm.nih.gov/pubmed/21728413.

According to the instrumental approach to emotion regulation, people may want to experience even unpleasant emotions to attain instrumental benefits. Building on value-expectancy models of self-regulation, we tested whether people want to feel bad in certain contexts specifically because they expect such feelings to be useful to them. In two studies, participants were more likely to try to increase their anger before a negotiation when motivated to confront (vs. collaborate with) a negotiation partner. Participants motivated to confront (vs. collaborate with) their partner expected anger to be more useful to them, and this expectation in turn, led them to try to increase their anger before negotiating. The subsequent experience of anger, following random assignment to emotion inductions (Study 1) or engagement in self-selected emotion regulation activities (Study 2), led participants to be more successful at getting others to concede to their demands, demonstrating that emotional preferences have important pragmatic implications.

Tamir, M. and B. Q. Ford (2012). "Should people pursue feelings that feel good or feelings that do good? Emotional preferences and well-being." Emotion. http://www.ncbi.nlm.nih.gov/pubmed/22309724.

Is it adaptive to seek pleasant emotions and avoid unpleasant emotions all the time or seek pleasant and unpleasant emotions at the right time? Participants reported on their preferences for anger and happiness in general and in contexts in which they might be useful or not (i.e., confrontations and collaborations, respectively). People who generally wanted to feel more happiness and less anger experienced greater well-being. However, when emotional preferences were examined in context, people who wanted to feel more anger or more happiness when they were useful, and people who wanted to feel less of those emotions when they were not useful, experienced greater well-being. Such patterns could not be explained by differences in the perceived usefulness of emotions, intelligence, perceived regulatory skills, emotional acceptance, social desirability, or general emotional preferences. These findings demonstrate that people who want to feel unpleasant emotions when they are useful may be happier overall.

Weisz, J. R., B. F. Chorpita, et al. (2012). "Testing Standard and Modular Designs for Psychotherapy Treating Depression, Anxiety, and Conduct Problems in Youth: A Randomized Effectiveness Trial." Arch Gen Psychiatry **69**(3): 274-282. http://archpsyc.ama-assn.org/cgi/content/abstract/69/3/274.

Context Decades of randomized controlled trials have produced separate evidence-based treatments for depression, anxiety, and conduct problems in youth, but these treatments are not often used in clinical practice, and they produce mixed results in trials with the comorbid, complex youths seen in practice. An integrative, modular redesign may help. Objective Standard/separate and modular/integrated arrangements of evidence-based treatments for depression, anxiety, and conduct problems in youth were compared with usual care treatment, with the modular design permitting a multidisorder focus and a flexible application of treatment procedures. Design Randomized effectiveness trial. Setting Ten outpatient clinical service organizations in Massachusetts and Hawaii. Participants A total of 84 community clinicians were randomly assigned to 1 of 3 conditions for the treatment of 174 clinically referred youths who were 7 to 13 years of age (70% of these youths were boys, and 45% were white). The study was conducted during the period from January 12, 2005 to May 8, 2009. Interventions Standard manual treatment (59 youths [34% of the sample]; cognitive behavioral therapy for depression, cognitive behavioral therapy for anxiety, and behavioral parent training for conduct problems), modular treatment (62 youths [36%]; integrating the procedures of the 3 separate treatments), and usual care (53 youths [30%]). Main Outcome Measures Outcomes were assessed using weekly youth and parent assessments. These assessments relied on a standardized Brief Problem Checklist and a patient-generated Top Problems Assessment (ie, the severity ratings on the problems that the youths and parents had identified as most important). We also conducted a standardized diagnostic assessment before and after treatment. Results Mixed effects regression analyses showed that modular treatment produced significantly steeper trajectories of improvement than usual care and standard treatment on multiple Brief Problem Checklist and Top Problems Assessment measures. Youths receiving modular treatment also had significantly fewer diagnoses than youths receiving usual care after treatment. In contrast, outcomes of standard manual treatment did not differ significantly from outcomes of usual care. Conclusions The modular approach outperformed usual care and standard evidence-based treatments on multiple clinical outcome measures. The modular approach may be a promising way to build on the strengths of evidence-based treatments, improving their utility and effectiveness with referred youths in clinical practice settings.

Westen, D., J. Shedler, et al. (2012). "An empirically derived taxonomy for personality diagnosis: bridging science and practice in conceptualizing personality." Am J Psychiatry **169**(3): 273-284. http://ajp.psychiatryonline.org/article.aspx?articleid=1032157.

OBJECTIVE: The authors describe a system for diagnosing personality pathology that is empirically derived, clinically relevant, and practical for day-to-day use. METHOD: A random national sample of psychiatrists and clinical psychologists (N=1,201) described a randomly selected current patient with any degree of personality dysfunction (from minimal to severe) using the descriptors in the Shedler-Westen Assessment Procedure-II and completed additional research forms. RESULTS: The

authors applied factor analysis to identify naturally occurring diagnostic groupings within the patient sample. The analysis yielded 10 clinically coherent personality diagnoses organized into three higher-order clusters: internalizing, externalizing, and borderline-dysregulated. The authors selected the most highly rated descriptors to construct a diagnostic prototype for each personality syndrome. In a second, independent sample, research interviewers and patients' treating clinicians were able to diagnose the personality syndromes with high agreement and minimal comorbidity among diagnoses. CONCLUSIONS: The empirically derived personality prototypes described here provide a framework for personality diagnosis that is both empirically based and clinically relevant.

Zietsch, B. P., K. J. H. Verweij, et al. (2012). "Do shared etiological factors contribute to the relationship between sexual orientation and depression?" Psychological Medicine **42**(03): 521-532. http://dx.doi.org/10.1017/S0033291711001577.

Background: Gays, lesbians and bisexuals (i.e. non-heterosexuals) have been found to be at much greater risk for many psychiatric symptoms and disorders, including depression. This may be due in part to prejudice and discrimination experienced by non-heterosexuals, but studies controlling for minority stress, or performed in very socially liberal countries, suggest that other mechanisms must also play a role. Here we test the viability of common cause (shared genetic or environmental etiology) explanations of elevated depression rates in non-heterosexuals. Method: A community-based sample of adult twins (n=9884 individuals) completed surveys investigating the genetics of psychiatric disorder, and were also asked about their sexual orientation. Large subsets of the sample were asked about adverse childhood experiences such as sexual abuse, physical abuse and risky family environment, and also about number of older brothers, paternal and maternal age, and number of close friends. Data were analyzed using the classical twin design. Results: Non-heterosexual males and females had higher rates of lifetime depression than their heterosexual counterparts. Genetic factors accounted for 31% and 44% of variation in sexual orientation and depression respectively. Bivariate analysis revealed that genetic factors accounted for a majority (60%) of the correlation between sexual orientation and depression. In addition, childhood sexual abuse and risky family environment were significant predictors of both sexual orientation and depression, further contributing to their correlation. Conclusions: Non-heterosexual men and women had elevated rates of lifetime depression, partly due to shared etiological factors, although causality cannot be definitively resolved.