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(Watanabe, Furukawa et al. 2011; Anderson, Willer et al. 2012; Boden, John et al. 2012; Cima, Maes et al. 2012; Daniel and Goldston 2012; Demeyer, De Lissnyder et al. 2012; Dunn, Fowler et al. 2012; Ellis and Goldston 2012; Ellis and Patel 2012; Fisher, Moffitt et al. 2012; Iffland, Sansen et al. 2012; Jarrett, Minhajuddin et al. 2012; Leung, Kim et al. 2012; Linehan, Comtois et al. 2012; Lloyd, Chalder et al. 2012; Macdonald, Higgins et al. 2012; Merry, Stasiak et al. 2012; Mitchell, Gehrman et al. 2012; Monroe and Harkness 2012; Morgan, Jorm et al. 2012; Murphy, Kapur et al. 2012; Paris 2012; Rawal and Rice 2012; Stanley and Brown 2012; Szasz, Szentagotai et al. 2012; van Aalderena, Dondersa et al. 2012; van den Hout, Rijkeboer et al. 2012; Varese, Barkus et al. 2012; Vess 2012; Wiborg, Knoop et al. 2012)

Anderson, C., R. Willer, et al. (2012). ***"The origins of deference: When do people prefer lower status?"*** J Pers Soc Psychol 102(5): 1077-1088. http://www.ncbi.nlm.nih.gov/pubmed/22369047

Although the desire for high status is considered universal, prior research suggests individuals often opt for lower status positions. Why would anyone favor a position of apparent disadvantage? In 5 studies, we found that the broad construct of status striving can be broken up into two conceptions: one based on rank, the other on respect. While individuals might universally desire high levels of respect, we find that they vary widely in the extent to which they strive for high-status rank, with many individuals opting for middle- or low-status rank. The status rank that individuals preferred depended on their self-perceived value to the group: when they believed they provided less value, they preferred lower status rank. Mediation and moderation analyses suggest that beliefs about others' expectations were the primary driver of these effects. Individuals who believed they provided little value to their group inferred that others expected them to occupy a lower status position. Individuals in turn conformed to these perceived expectations, accepting lower status rank in such settings.

Boden, M. T., O. P. John, et al. (2012). ***"The role of maladaptive beliefs in cognitive-behavioral therapy: Evidence from social anxiety disorder."*** Behaviour Research and Therapy 50(5): 287-291. http://www.sciencedirect.com/science/article/pii/S0005796712000344

Beliefs that are negatively biased, inaccurate, and rigid are thought to play a key role in the mood and anxiety disorders. Our goal in this study was to examine whether a change in maladaptive beliefs mediated the outcome of individual cognitive-behavioral therapy (CBT) for social anxiety disorder (SAD). In a sample of 47 individuals with SAD receiving CBT, we measured maladaptive interpersonal beliefs as well as emotional and behavioral components of social anxiety, both at baseline and after treatment completion. We found that (a) maladaptive interpersonal beliefs were associated with social anxiety at baseline and treatment completion; (b) maladaptive interpersonal beliefs were significantly reduced from baseline to treatment completion; and (c) treatment-related reductions in maladaptive interpersonal beliefs fully accounted for reductions in social anxiety after CBT. These results extend the literature by providing support for cognitive models of mental disorders, broadly, and SAD, specifically.

Cima, R. F. F., I. H. Maes, et al. (2012). ***"Specialised treatment based on cognitive behaviour therapy versus usual care for tinnitus: A randomised controlled trial."*** The Lancet 379(9830): 1951-1959. http://linkinghub.elsevier.com/retrieve/pii/S0140673612604693

Up to 21% of adults will develop tinnitus, which is one of the most distressing and debilitating audiological problems. The absence of medical cures and standardised practice can lead to costly and prolonged treatment. We aimed to assess effectiveness of a stepped-care approach, based on cognitive behaviour therapy, compared with usual care in patients with varying tinnitus severity. In this randomised controlled trial, undertaken at the Adelante Department of Audiology and Communication (Hoensbroek, Netherlands), we enrolled previously untreated Dutch speakers (aged >18 years) who had a primary complaint of tinnitus but no health issues precluding participation. An independent research assistant randomly allocated patients by use of a computer-generated allocation sequence in a 1:1 ratio, stratified by tinnitus severity and hearing ability, in block sizes of four to receive specialised care of cognitive behaviour therapy with sound-focused tinnitus retraining therapy or usual care. Patients and assessors were masked to treatment assignment. Primary outcomes were health-related quality of life (assessed by the health utilities index score), tinnitus severity (tinnitus questionnaire score), and tinnitus impairment (tinnitus handicap inventory score), which were assessed before treatment and at 3 months, 8 months, and 12 months after randomisation. We used multilevel mixed regression analyses to assess outcomes in the intention-to-treat population. This study is registered withClinicalTrials.gov, numberNCT00733044. Between September, 2007 and January, 2011, we enrolled and treated 492 (66%) of 741 screened patients. Compared with 247 patients assigned to usual care, 245 patients assigned to specialised care improved in health-related quality of life during a period of 12 months (between-group difference 0·059, 95% CI 0·025 to 0·094; effect size of Cohen's d=0·24; p=0·0009), and had decreased tinnitus severity (−8·062, −10·829 to −5·295; d=0·43; p<0·0001) and tinnitus impairment (−7·506, −10·661 to −4·352; d=0·45; p<0·0001). Treatment seemed effective irrespective of initial tinnitus severity, and we noted no adverse events in this trial. Specialised treatment of tinnitus based on cognitive behaviour therapy could be suitable for widespread implementation for patients with tinnitus of varying severity.

Daniel, S. S. and D. B. Goldston (2012). ***"Hopelessness and lack of connectedness to others as risk factors for suicidal behavior across the lifespan: Implications for cognitive-behavioral treatment."*** Cognitive and Behavioral Practice 19(2): 288-300. http://www.sciencedirect.com/science/article/pii/S1077722911001039

The rates of suicide attempts and death by suicide vary considerably over the lifespan, highlighting the influence of different contextual, risk, and protective factors at different points in development (Daniel & Goldston, 2009). Hopelessness and lack of connectedness to others are two factors that have been associated with increased risk for suicidal thoughts and behaviors across the lifespan. The primary purposes of this paper are to describe how hopelessness and lack of connectedness to others may contribute to risk for suicidal behaviors, and to outline empirically supported cognitive-behavioral interventions for these difficulties at three developmental periods during which suicidal behavior is prevalent: (a) adolescence and young adulthood, (b) middle adulthood, and (c) older adulthood. This paper is not intended as an exhaustive review, but rather an overview of selected developmental issues related to hopelessness and lack of connectedness to others as risk factors for suicidal behavior. Special emphasis is given to clinical implications for cognitive-behavioral interventions, which are illustrated through case conceptualizations and examples at each developmental period.

Demeyer, I., E. De Lissnyder, et al. (2012). ***"Rumination mediates the relationship between impaired cognitive control for emotional information and depressive symptoms: A prospective study in remitted depressed adults."*** Behaviour Research and Therapy 50(5): 292-297. http://www.sciencedirect.com/science/article/pii/S0005796712000435

Impaired cognitive control may be an important vulnerability factor for depression. Moreover, impairments in cognitive control have been proposed as a crucial process underlying ruminative thinking. The present study investigates the influence of impaired cognitive control for emotional information on rumination and depressive symptoms in a prospective design with a 1 year follow up in a clinical sample. Thirty remitted depressed adults completed the Internal Shift Task (IST), a measure of cognitive control of emotional information, at baseline. Moreover, questionnaires measuring rumination (RRS) and depressive symptoms (BDI-II) were administered. One year later participants were contacted again and asked to complete the BDI-II and RRS. Mediation analyses showed a significant influence of impaired cognitive control for emotional information at baseline on depressive symptoms one year later, which was fully mediated by rumination. These findings underscore the importance of cognitive control abilities as a process underlying rumination and as a vulnerability factor for depression. They can stimulate translational research to improve the effectiveness of interventions that aim to decrease vulnerability by targeting cognitive control.

Dunn, G., D. Fowler, et al. (2012). ***"Effective elements of cognitive behaviour therapy for psychosis: Results of a novel type of subgroup analysis based on principal stratification."*** Psychological Medicine 42(05): 1057-1068. http://dx.doi.org/10.1017/S0033291711001954

Background: Meta-analyses show that cognitive behaviour therapy for psychosis (CBT-P) improves distressing positive symptoms. However, it is a complex intervention involving a range of techniques. No previous study has assessed the delivery of the different elements of treatment and their effect on outcome. Our aim was to assess the differential effect of type of treatment delivered on the effectiveness of CBT-P, using novel statistical methodology. Method: The Psychological Prevention of Relapse in Psychosis (PRP) trial was a multi-centre randomized controlled trial (RCT) that compared CBT-P with treatment as usual (TAU). Therapy was manualized, and detailed evaluations of therapy delivery and client engagement were made. Follow-up assessments were made at 12 and 24 months. In a planned analysis, we applied principal stratification (involving structural equation modelling with finite mixtures) to estimate intention-to-treat (ITT) effects for subgroups of participants, defined by qualitative and quantitative differences in receipt of therapy, while maintaining the constraints of randomization. Results: Consistent delivery of full therapy, including specific cognitive and behavioural techniques, was associated with clinically and statistically significant increases in months in remission, and decreases in psychotic and affective symptoms. Delivery of partial therapy involving engagement and assessment was not effective. Conclusions: Our analyses suggest that CBT-P is of significant benefit on multiple outcomes to patients able to engage in the full range of therapy procedures. The novel statistical methods illustrated in this report have general application to the evaluation of heterogeneity in the effects of treatment.

Ellis, T. E. and D. B. Goldston (2012). ***"Working with suicidal clients: Not business as usual."*** Cognitive and Behavioral Practice 19(2): 205-208. http://www.sciencedirect.com/science/article/pii/S1077722911001428

In this introduction to a special series of articles on working with suicidal clients, we note that much of the recent growth in theory and research pertaining to suicidal individuals has been contributed by cognitive-behavioral theorists and researchers. This work has established that suicidal people manifest important cognitive vulnerabilities that can be addressed in therapeutic interventions specifically designed for them. Studies to date have produced outcomes that support this framework. We provide brief previews of the collection of articles that follow, which cover safety planning, protocols for evaluating risk, the utility of health behavior theory for informing treatment, mindfulness-based approaches for suicidality, developmental and family considerations, intensive inpatient CBT for individuals in the military, integrated interventions for substance abuse and suicidal behaviors, and coping with the impact of client suicide. We conclude that clinicians are now in a position to begin moving beyond a "therapy as usual" mindset in working with suicidal clients.

Ellis, T. E. and A. B. Patel (2012). ***"Client suicide: What now?"*** Cognitive and Behavioral Practice 19(2): 277-287. http://www.sciencedirect.com/science/article/pii/S1077722911000654

The loss of a client to suicide is a painful personal and professional experience for mental health providers. Whether trainee or experienced professional, the affected clinician often reports feeling overwhelmed and unprepared for the experience of client suicide, together with significant emotional distress and diminished work performance. In this article, we present a brief overview of the literature on the impact of client suicide and ideas for coping with the psychological and professional issues that typically arise. We also provide suggestions for managing the associated practical and administrative tasks, as well as resources for obtaining professional support and guidance in the wake of this tragic event.

Fisher, H. L., T. E. Moffitt, et al. (2012). ***"Bullying victimisation and risk of self harm in early adolescence: Longitudinal cohort study."*** BMJ 344: e2683. http://www.bmj.com/content/344/bmj.e2683

OBJECTIVES: To test whether frequent bullying victimisation in childhood increases the likelihood of self harming in early adolescence, and to identify which bullied children are at highest risk of self harm. DESIGN: The Environmental Risk (E-Risk) longitudinal study of a nationally representative UK cohort of 1116 twin pairs born in 1994-95 (2232 children). SETTING: England and Wales, United Kingdom. PARTICIPANTS: Children assessed at 5, 7, 10, and 12 years of age. MAIN OUTCOME MEASURES: Relative risks of children's self harming behaviour in the six months before their 12th birthday. RESULTS: Self harm data were available for 2141 children. Among children aged 12 who had self harmed (2.9%; n=62), more than half were victims of frequent bullying (56%; n=35). Exposure to frequent bullying predicted higher rates of self harm even after children's pre-morbid emotional and behavioural problems, low IQ, and family environmental risks were taken into account (bullying victimisation reported by mother: adjusted relative risk 1.92, 95% confidence interval 1.18 to 3.12; bullying victimisation reported by child: 2.44, 1.36 to 4.40). Victimised twins were more likely to self harm than were their non-victimised twin sibling (bullying victimisation reported by mother: 13/162 v 3/162, ratio=4.3, 95% confidence interval 1.3 to 14.0; bullying victimisation reported by child: 12/144 v 7/144, ratio=1.7, 0.71 to 4.1). Compared with bullied children who did not self harm, bullied children who self harmed were distinguished by a family history of attempted/completed suicide, concurrent mental health problems, and a history of physical maltreatment by an adult. CONCLUSIONS: Prevention of non-suicidal self injury in young adolescents should focus on helping bullied children to cope more appropriately with their distress. Programmes should target children who have additional mental health problems, have a family history of attempted/completed suicide, or have been maltreated by an adult.

Iffland, B., L. Sansen, et al. (2012). ***"Emotional but not physical maltreatment is independently related to psychopathology in subjects with various degrees of social anxiety: A web-based internet survey."*** BMC Psychiatry 12(1): 49. http://www.biomedcentral.com/1471-244X/12/49

(Full free text available) BACKGROUND:Previous studies reported that social phobia is associated with a history of child maltreatment. However, most of these studies focused on physical and sexual maltreatment whilst little is known about the specific impact of emotional abuse and neglect on social anxiety. We examined the association between emotional maltreatment, including parental emotional maltreatment as well as emotional peer victimization, and social anxiety symptoms in subjects with various degrees of social anxiety. METHODS:The study was conducted as a web-based Internet survey of

participants (N = 995) who had social anxiety symptoms falling within the high range, and including many respondents who had scores in the clinical range. The assessment included measures of child maltreatment, emotional peer victimization, social anxiety symptoms and general psychopathology. RESULTS:Regression and mediation analyses revealed that parental emotional maltreatment and emotional peer victimization were independently related to social anxiety and mediated the impact of physical and sexual maltreatment. Subjects with a history of childhood emotional maltreatment showed higher rates of psychopathology than subjects with a history of physical maltreatment. CONCLUSIONS:Although our findings are limited by the use of an Internet survey and retrospective self-report measures, data indicated that social anxiety symptoms are mainly predicted by emotional rather than physical or sexual types of victimization.

Jarrett, R. B., A. Minhajuddin, et al. (2012). ***"Cognitive reactivity, dysfunctional attitudes, and depressive relapse and recurrence in cognitive therapy responders."*** Behaviour Research and Therapy 50(5): 280-286. http://www.sciencedirect.com/science/article/pii/S0005796712000204

Dysfunctional attitudes can foreshadow depressive relapse/recurrence. Priming mood, through induction paradigms, is hypothesized to activate dysfunctional attitudes. Cognitive reactivity (CR) refers to mood-linked increases in dysfunctional attitudes after priming. Here we explored the extent to which CR as well as residual, unprimed, dysfunctional attitudes predicted depressive relapse/recurrence among depressed patients who responded to acute phase cognitive therapy (CT). Consenting adults, aged 18–70, with recurrent major depressive disorder (n = 523) participated in a two-site randomized controlled trial examining the durability of continuation phase treatments. Patients received 16–20 sessions of CT. Among the 245 incompletely remitted responders, 213 agreed to undergo a mood induction paradigm. After 8 months of continuation phase treatments, participants were followed an additional 24 months. Although the mood induction significantly lowered mood in 80% of responders, the expected CR was not evident. By contrast, higher unprimed dysfunctional attitudes following CT did predict relapse/recurrence over 20 and 32 months post-randomization. The findings of this large longitudinal study of incompletely remitted CT responders challenge the notion that it is necessary to prime mood in order to maximize dysfunctional attitudes' prediction of relapse and/or recurrence. While findings cannot be generalized beyond CT responders, they emphasize the clinical importance of reducing dysfunctional attitudes in preventing depression.

Leung, A. K.-y., S. Kim, et al. (2012). ***"Embodied metaphors and creative "acts"."*** Psychological Science 23(5): 502-509. http://pss.sagepub.com/content/23/5/502.abstract

Creativity is a highly sought-after skill. Prescriptive advice for inspiring creativity abounds in the form of metaphors: People are encouraged to "think outside the box," to consider a problem "on one hand, then on the other hand," and to "put two and two together" to achieve creative breakthroughs. These metaphors suggest a connection between concrete bodily experiences and creative cognition. Inspired by recent advances in the understanding of body-mind linkages in the research on embodied cognition, we explored whether enacting metaphors for creativity enhances creative problem solving. Our findings from five studies revealed that both physical and psychological embodiment of metaphors for creativity promoted convergent thinking and divergent thinking (i.e., fluency, flexibility, or originality) in problem solving. Going beyond prior research, which focused primarily on the kind of embodiment that primes preexisting knowledge, we provide the first evidence that embodiment can also activate cognitive processes that facilitate the generation of new ideas and connections.

Linehan, M. M., K. A. Comtois, et al. (2012). ***"Assessing and managing risk with suicidal individuals."*** Cognitive and Behavioral Practice 19(2): 218-232. http://www.sciencedirect.com/science/article/pii/S1077722911000599

The University of Washington Risk Assessment Protocol (UWRAP) and Risk Assessment and Management Protocol (UWRAMP) have been used in numerous clinical trials treating high-risk suicidal individuals over several years. These protocols structure assessors and treatment providers to provide a thorough suicide risk assessment, review standards of care recommendations for action, and allow for subsequent documentation of information gathered and actions taken. As such, it is a resource for providers treating high-risk populations across multiple contexts (e.g., primary care, outpatient psychotherapy, emergency department). This article describes both the UWRAP and UWRAMP. Taken together, these assessment and risk management tools include (a) assessment questions for gathering information to determine the level of risk, (b) action steps that can be taken to ensure safety, and (c) a companion therapist note where providers document their assessment and actions.

Lloyd, S., T. Chalder, et al. (2012). ***"Telephone-based guided self-help for adolescents with chronic fatigue syndrome: A non-randomised cohort study."*** Behaviour Research and Therapy 50(5): 304-312. http://www.sciencedirect.com/science/article/pii/S0005796712000459

The aim of this study was to gain preliminary evidence about the efficacy of a new telephone-based guided self-help intervention, based on cognitive-behavioural principles, which aimed to reduce fatigue and improve school attendance in adolescents with chronic fatigue syndrome (CFS). A non-randomised cohort design was used, with a two-month baseline period. Sixty-three 11–18 year-old participants recruited from a specialist CFS unit received the intervention. Participants received six half-hour fortnightly telephone sessions and two follow-up sessions. Fatigue and school attendance were the main outcomes and the main time point for assessing outcome was 6 months post-treatment. Using multi-level modelling, a significant decrease in fatigue was found between pre-treatment and 6 month follow-up, treatment effect estimate = – 5.68 (−7.63, −3.72), a large effect size (Cohen's d = 0.79). The decrease in fatigue between pre and post-treatment was significantly larger than between baseline and pre-treatment. A significant increase in school attendance was found between pre-treatment and 6 month follow-up, effect estimate = 1.38 (0.76, 2.00), a medium effect size (d = −0.48). Univariate logistic regression found baseline perfectionism to be associated with poorer school attendance at six-month follow-up. In conclusion, telephone-based guided self-help is an acceptable minimal intervention which is efficacious in reducing fatigue in adolescents with CFS.

Macdonald, G., J. P. Higgins, et al. (2012). ***"Cognitive-behavioural interventions for children who have been sexually abused."*** Cochrane Database Syst Rev 5: CD001930. http://www.ncbi.nlm.nih.gov/pubmed/22592679

(Free full text available): BACKGROUND: Despite differences in how it is defined, there is a general consensus amongst clinicians and researchers that the sexual abuse of children and adolescents ('child sexual abuse') is a substantial social problem worldwide. The effects of sexual abuse manifest in a wide range of symptoms, including fear, anxiety, post-traumatic stress disorder and various externalising and internalising behaviour problems, such as inappropriate sexual behaviours. Child sexual abuse is associated with increased risk of psychological problems in adulthood. Cognitive-behavioural approaches are used to help children and their non-offending or 'safe' parent to manage the sequelae of childhood sexual abuse. This review updates the first Cochrane review of cognitive-behavioural approaches interventions for children who have been sexually abused, which was first published in 2006. OBJECTIVES: To assess the efficacy of cognitive-behavioural approaches (CBT) in addressing the immediate and longer-term sequelae of sexual abuse on children and young people up to 18 years of age. SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (2011 Issue 4); MEDLINE (1950 to November Week 3 2011); EMBASE (1980 to Week 47 2011); CINAHL (1937 to 2 December 2011); PsycINFO (1887 to November Week 5 2011); LILACS (1982 to 2 December 2011) and OpenGrey, previously OpenSIGLE (1980 to 2 December 2011). For this update we also

searched ClinicalTrials.gov and the International Clinical Trials Registry Platform (ICTRP). SELECTION CRITERIA: We included randomised or quasi-randomised controlled trials of CBT used with children and adolescents up to age 18 years who had experienced being sexually abused, compared with treatment as usual, with or without placebo control. DATA COLLECTION AND ANALYSIS: At least two review authors independently assessed the eligibility of titles and abstracts identified in the search. Two review authors independently extracted data from included studies and entered these into Review Manager 5 software. We synthesised and presented data in both written and graphical form (forest plots). MAIN RESULTS: We included 10 trials, involving 847 participants. All studies examined CBT programmes provided to children or children and a non-offending parent. Control groups included wait list controls (n = 1) or treatment as usual (n = 9). Treatment as usual was, for the most part, supportive, unstructured psychotherapy. Generally the reporting of studies was poor. Only four studies were judged 'low risk of bias' with regards to sequence generation and only one study was judged 'low risk of bias' in relation to allocation concealment. All studies were judged 'high risk of bias' in relation to the blinding of outcome assessors or personnel; most studies did not report on these, or other issues of bias. Most studies reported results for study completers rather than for those recruited.Depression, post-traumatic stress disorder (PTSD), anxiety and child behaviour problems were the primary outcomes. Data suggest that CBT may have a positive impact on the sequelae of child sexual abuse, but most results were not statistically significant. Strongest evidence for positive effects of CBT appears to be in reducing PTSD and anxiety symptoms, but even in these areas effects tend to be 'moderate' at best. Meta-analysis of data from five studies suggested an average decrease of 1.9 points on the Child Depression Inventory immediately after intervention (95% confidence interval (CI) decrease of 4.0 to increase of 0.4; I(2) = 53%; P value for heterogeneity = 0.08), representing a small to moderate effect size. Data from six studies yielded an average decrease of 0.44 standard deviations on a variety of child post-traumatic stress disorder scales (95% CI 0.16 to 0.73; I(2) = 46%; P value for heterogeneity = 0.10). Combined data from five studies yielded an average decrease of 0.23 standard deviations on various child anxiety scales (95% CI 0.3 to 0.4; I(2) = 0%; P value for heterogeneity = 0.84). No study reported adverse effects. AUTHORS' CONCLUSIONS: The conclusions of this updated review remain the same as those when it was first published. The review confirms the potential of CBT to address the adverse consequences of child sexual abuse, but highlights the limitations of the evidence base and the need for more carefully conducted and better reported trials.

Merry, S. N., K. Stasiak, et al. (2012). ***"The effectiveness of sparx, a computerised self help intervention for adolescents seeking help for depression: Randomised controlled non-inferiority trial."*** BMJ 344: e2598. http://www.ncbi.nlm.nih.gov/pubmed/22517917

OBJECTIVE: To evaluate whether a new computerised cognitive behavioural therapy intervention (SPARX, Smart, Positive, Active, Realistic, X-factor thoughts) could reduce depressive symptoms in help seeking adolescents as much or more than treatment as usual. DESIGN: Multicentre randomised controlled non-inferiority trial. SETTING: 24 primary healthcare sites in New Zealand (youth clinics, general practices, and school based counselling services). PARTICIPANTS: 187 adolescents aged 12-19, seeking help for depressive symptoms, with no major risk of self harm and deemed in need of treatment by their primary healthcare clinicians: 94 were allocated to SPARX and 93 to treatment as usual. INTERVENTIONS: Computerised cognitive behavioural therapy (SPARX) comprising seven modules delivered over a period of between four and seven weeks, versus treatment as usual comprising primarily face to face counselling delivered by trained counsellors and clinical psychologists. OUTCOMES: The primary outcome was the change in score on the children's depression rating scale-revised. Secondary outcomes included response and remission on the children's depression rating scale-revised, change scores on the Reynolds adolescent depression scale-second edition, the mood and feelings questionnaire, the Kazdin hopelessness scale for children, the Spence children's anxiety scale, the paediatric quality of life enjoyment and satisfaction questionnaire, and overall satisfaction with treatment ratings. RESULTS: 94 participants were allocated to SPARX (mean age 15.6 years, 62.8% female) and 93 to treatment as usual (mean age 15.6 years, 68.8% female). 170 adolescents (91%, SPARX n = 85, treatment as usual n = 85) were assessed after intervention and 168 (90%, SPARX n = 83, treatment as usual n = 85) were assessed at the three month follow-up point. Per protocol analyses (n = 143) showed that SPARX was not inferior to treatment as usual. Post-intervention, there was a mean reduction of 10.32 in SPARX and 7.59 in treatment as usual in raw scores on the children's depression rating scale-revised (between group difference 2.73, 95% confidence interval -0.31 to 5.77; P=0.079). Remission rates were significantly higher in the SPARX arm (n = 31, 43.7%) than in the treatment as usual arm (n = 19, 26.4%) (difference 17.3%, 95% confidence interval 1.6% to 31.8%; P = 0.030) and response rates did not differ significantly between the SPARX arm (66.2%, n = 47) and treatment as usual arm (58.3%, n = 42) (difference 7.9%, -7.9% to 24%; P = 0.332). All secondary measures supported non-inferiority. Intention to treat analyses confirmed these findings. Improvements were maintained at follow-up. The frequency of adverse events classified as "possibly" or "probably" related to the intervention did not differ between groups (SPARX n = 11; treatment as usual n = 11). CONCLUSIONS: SPARX is a potential alternative to usual care for adolescents presenting with depressive symptoms in primary care settings and could be used to address some of the unmet demand for treatment.

Mitchell, M. D., P. Gehrman, et al. (2012). ***"Comparative effectiveness of cognitive behavioral therapy for insomnia: A systematic review."*** BMC Fam Pract 13(1): 40. http://www.ncbi.nlm.nih.gov/pubmed/22631616

ABSTRACT: BACKGROUND: Insomnia is common in primary care, can persist after co-morbid conditions are treated, and may require long-term medication treatment. A potential alternative to medications is cognitive behavioral therapy for insomnia (CBT-I). METHODS: In accordance with PRISMA guidelines, we systematically reviewed MEDLINE, EMBASE, the Cochrane Central Register, and PsycINFO for randomized controlled trials (RCTs) comparing CBT-I to any prescription or non-prescription medication in patients with primary or comorbid insomnia. Trials had to report quantitative sleep outcomes (e.g. sleep latency) in order to be included in the analysis. Extracted results included quantitative sleep outcomes, as well as psychological outcomes and adverse effects when available. Evidence base quality was assessed using GRADE. RESULTS: Five studies met criteria for analysis. Low to moderate grade evidence suggests CBT-I has superior effectiveness to benzodiazepine and non-benzodiazepine drugs in the long term, while very low grade evidence suggests benzodiazepines are more effective in the short term. Very low grade evidence supports use of CBT-I to improve psychological outcomes. CONCLUSIONS: CBT-I is effective for treating insomnia when compared with medications, and its effects may be more durable than medications. Primary care providers should consider CBT-I as a first-line treatment option for insomnia.

Monroe, S. M. and K. L. Harkness (2012). ***"Is depression a chronic mental illness?"*** Psychological Medicine 42(05): 899-902. http://dx.doi.org/10.1017/S0033291711002066

Over the past few decades, theory and research on depression have increasingly focused on the recurrent and chronic nature of the disorder. These recurrent and chronic forms of depression are extremely important to study, as they may account for the bulk of the burden associated with the disorder. Paradoxically, however, research focusing on depression as a recurrent condition has generally failed to reveal any useful early indicators of risk for recurrence. We suggest that this present impasse is due to the lack of recognition that depression can also be an acute, time-limited condition. We argue that individuals with acute, single lifetime episodes of depression have been systematically eclipsed from the research agenda, thereby effectively preventing the discovery of factors that may predict who, after experiencing a first lifetime episode of depression, goes on to

have a recurrent or chronic clinical course. Greater awareness of the high prevalence of people with a single lifetime episode of depression, and the development of research designs that identify these individuals and allow comparisons with those who have recurrent forms of the disorder, could yield substantial gains in understanding the lifetime pathology of this devastating mental illness.

Morgan, A. J., A. F. Jorm, et al. (2012). ***"Email-based promotion of self-help for subthreshold depression: Mood memos randomised controlled trial."*** The British Journal of Psychiatry 200(5): 412-418. http://bjp.rcpsych.org/content/200/5/412.abstract

Background: Subthreshold depression is common, impairs functioning and increases the risk of major depression. Improving self-help coping strategies could help subthreshold depression and prevent major depression. Aims: To test the effectiveness of an automated email-based campaign promoting self-help behaviours. Method: A randomised controlled trial was conducted through the website: www.moodmemos.com. Participants received automated emails twice weekly for 6 weeks containing advice about self-help strategies. Emails containing general information about depression served as a control. The principal outcome was depression symptom level on the nine-item Patient Health Questionnaire (PHQ-9) (trial registration: ACTRN12609000925246). Results: The study recruited 1326 adults with subthreshold depression. There was a small significant difference in depression symptoms at post-intervention, favouring the active group (d = 0.17, 95% CI 0.01–0.34). There was a lower, although non-significant, risk of major depression in the active group (number needed to treat (NNT) 25, 95% CI 11 to ∞ to NNT(harm) 57). Conclusions: Emails promoting self-help strategies were beneficial. Internet delivery of self-help messages affords a low-cost, easily disseminated and highly automated approach for indicated prevention of depression.

Murphy, E., N. Kapur, et al. (2012). ***"Risk factors for repetition and suicide following self-harm in older adults: Multicentre cohort study."*** The British Journal of Psychiatry 200(5): 399-404. http://bjp.rcpsych.org/content/200/5/399.abstract

Background Older adults have elevated suicide rates. Self-harm is the most important risk factor for suicide. There are few population-based studies of self-harm in older adults. Aims To calculate self-harm rates, risk factors for repetition and rates of suicide following self-harm in adults aged 60 years and over. Method We studied a prospective, population-based self-harm cohort presenting to six general hospitals in three cities in England during 2000 to 2007. Results In total 1177 older adults presented with self-harm and 12.8% repeated self-harm within 12 months. Independent risk factors for repetition were previous self-harm, previous psychiatric treatment and age 60–74 years. Following self-harm, 1.5% died by suicide within 12 months. The risk of suicide was 67 times that of older adults in the general population. Men aged 75 years and above had the highest suicide rates. Conclusions Older adults presenting to hospital with self-harm are a high-risk group for subsequent suicide, particularly older men.

Paris, J. (2012). ***"The outcome of borderline personality disorder: Good for most but not all patients."*** American Journal of Psychiatry 169(5): 445-446. http://dx.doi.org/10.1176/appi.ajp.2012.12010092

(Free full text available) One of the reasons why clinicians are reluctant to diagnose borderline personality disorder is the perception that patients with this disorder are doomed to chronicity. As discussed by Zanarini et al. (1) in this issue of the Journal, it is now well established that while outcome is heterogeneous, most patients do well, with the majority no longer meeting diagnostic criteria over time. Zanarini et al. buttress this conclusion with a unique 16-year prospective follow-up study of a large cohort of patients with borderline personality disorder. However, they emphasize that remission (defined as not meeting criteria for a formal diagnosis) is not equivalent to recovery. Personality disorders are amalgams of traits and symptoms, and even when symptoms remit, problematic traits can produce difficulty. That is probably why remission is more common than full recovery.

Rawal, A. and F. Rice (2012). ***"Examining overgeneral autobiographical memory as a risk factor for adolescent depression."*** Journal of the American Academy of Child and Adolescent Psychiatry 51(5): 518-527. http://linkinghub.elsevier.com/retrieve/pii/S0890856712002262?showall=true

Identifying risk factors for adolescent depression is an important research aim. Overgeneral autobiographical memory (OGM) is a feature of adolescent depression and a candidate cognitive risk factor for future depression. However, no study has ascertained whether OGM predicts the onset of adolescent depressive disorder. OGM was investigated as a predictor of depressive disorder and symptoms in a longitudinal study of high-risk adolescents. In addition, cross-sectional associations between OGM and current depression and OGM differences between depressed adolescents with different clinical outcomes were examined over time. A 1-year longitudinal study of adolescents at familial risk for depression (n = 277, 10-18 years old) was conducted. Autobiographical memory was assessed at baseline. Clinical interviews assessed diagnostic status at baseline and follow-up. Currently depressed adolescents showed an OGM bias compared with adolescents with no disorder and those with anxiety or externalizing disorders. OGM to negative cues predicted the onset of depressive disorder and depressive symptoms at follow-up in adolescents free from depressive disorder at baseline. This effect was independent of the contribution of age, IQ, and baseline depressive symptoms. OGM did not predict onset of anxiety or externalizing disorders. Adolescents with depressive disorder at both assessments were not more overgeneral than adolescents who recovered from depressive disorder over the follow-up period. OGM to negative cues predicted the onset of depressive disorder (but not other disorders) and depressive symptoms over time in adolescents at familial risk for depression. Results are consistent with OGM as a risk factor for depression.

Stanley, B. and G. K. Brown (2012). ***"Safety planning intervention: A brief intervention to mitigate suicide risk."*** Cognitive and Behavioral Practice 19(2): 256-264. http://www.sciencedirect.com/science/article/pii/S1077722911000630

The usual care for suicidal patients who are seen in the emergency department (ED) and other emergency settings is to assess level of risk and refer to the appropriate level of care. Brief psychosocial interventions such as those administered to promote lower alcohol intake or to reduce domestic violence in the ED are not typically employed for suicidal individuals to reduce their risk. Given that suicidal patients who are seen in the ED do not consistently follow up with recommended outpatient mental health treatment, brief ED interventions to reduce suicide risk may be especially useful. We describe an innovative and brief intervention, the Safety Planning Intervention (SPI), identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org), which can be administered as a stand-alone intervention. The SPI consists of a written, prioritized list of coping strategies and sources of support that patients can use to alleviate a suicidal crisis. The basic components of the SPI include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts and social settings as a means of distraction from suicidal thoughts; (d) utilizing family members or friends to help resolve the crisis; (e) contacting mental health professionals or agencies; and (f) restricting access to lethal means. A detailed description of SPI is described and a case example is provided to illustrate how the SPI may be implemented.

Szasz, P. L., A. Szentagotai, et al. (2012). ***"Effects of emotion regulation strategies on smoking craving, attentional bias, and task persistence."*** Behaviour Research and Therapy 50(5): 333-340. http://www.sciencedirect.com/science/article/pii/S000579671200037X

The goal of this study was to investigate the effects of different strategies for regulating emotions associated with smoking on subjective, cognitive, and behavioral correlates of smoking. Emotion regulation was manipulated by instructing participants to reappraise (n = 32), accept (n = 31), or suppress (n = 31) their emotions associated with smoking. The dependent measures included subjective reports of craving, negative affect, and attentional biases, as measured by a modified dot-probe task, and persistence during a task to measure distress tolerance. Individuals who were encouraged to reappraise the consequences of smoking showed diminished craving, lower negative affect, had reduced attentional biases for smoking-related cues, and exhibited greater task persistence than those who were instructed to accept and suppress their urge to smoke. These findings suggest that reappraisal techniques are more effective than acceptance or suppression strategies for targeting smoking-related problems.

van Aalderena, J. R., A. R. T. Dondersa, et al. (2012). ***"The efficacy of mindfulness-based cognitive therapy in recurrent depressed patients with and without a current depressive episode: A randomized controlled trial."*** Psychological Medicine 42(05): 989-1001. http://dx.doi.org/10.1017/S0033291711002054

Background: The aim of this study is to examine the efficacy of mindfulness-based cognitive therapy (MBCT) in addition to treatment as usual (TAU) for recurrent depressive patients with and without a current depressive episode. Method: A randomized, controlled trial comparing MBCT+TAU (n=102) with TAU alone (n=103). The study population consisted of patients with three or more previous depressive episodes. Primary outcome measure was post-treatment depressive symptoms according to the Hamilton Rating Scale for Depression. Secondary outcome measures included the Beck Depression Inventory, rumination, worry and mindfulness skills. Group comparisons were carried out with linear mixed modelling, controlling for intra-group correlations. Additional mediation analyses were performed. Comparisons were made between patients with and without a current depressive episode. Results: Patients in the MBCT+TAU group reported less depressive symptoms, worry and rumination and increased levels of mindfulness skills compared with patients receiving TAU alone. MBCT resulted in a comparable reduction of depressive symptoms for patients with and without a current depressive episode. Additional analyses suggest that the reduction of depressive symptoms was mediated by decreased levels of rumination and worry. : ConclusionsThe study findings suggest that MBCT is as effective for patients with recurrent depression who are currently depressed as for patients who are in remission. Directions towards a better understanding of the mechanisms of action of MBCT are given, although future research is needed to support these hypotheses.

van den Hout, M. A., M. M. Rijkeboer, et al. (2012). ***"Tones inferior to eye movements in the emdr treatment of ptsd."*** Behaviour Research and Therapy 50(5): 275-279. http://www.sciencedirect.com/science/article/pii/S0005796712000289

Eye Movement Desensitization and Reprocessing (EMDR) is an effective treatment for posttraumatic stress disorder (PTSD). During EMDR, patients make eye movements (EMs) while recalling traumatic memories, but recently therapists have replaced EMs by alternating beep tones. There are no outcome studies on the effects of tones. In an earlier analogue study, tones were inferior to EMs in the reduction of vividness of aversive memories. In a first EMDR session, 12 PTSD patients recalled trauma memories in three conditions: recall only, recall + tones, and recall + EMs. Three competing hypotheses were tested: 1) EMs are as effective as tones and better than recall only, 2) EMs are better than tones and tones are as effective as recall only, and 3) EMs are better than tones and tones are better than recall only. The order of conditions was balanced, each condition was delivered twice, and decline in memory vividness and emotionality served as outcome measures. The data strongly support hypothesis 2 and 3 over 1: EMs outperformed tones while it remained unclear if tones add to recall only. The findings add to earlier considerations and earlier analogue findings suggesting that EMs are superior to tones and that replacing the former by the latter was premature.

Varese, F., E. Barkus, et al. (2012). ***"Dissociation mediates the relationship between childhood trauma and hallucination-proneness."*** Psychological Medicine 42(05): 1025-1036. http://dx.doi.org/10.1017/S0033291711001826

Background: It has been proposed that the relationship between childhood trauma and hallucinations can be explained by dissociative processes. The present study examined whether the effect of childhood trauma on hallucination-proneness is mediated by dissociative tendencies. In addition, the influence of dissociative symptoms on a cognitive process believed to underlie hallucinatory experiences (i.e. reality discrimination; the capacity to discriminate between internal and external cognitive events) was also investigated. Method: Patients with schizophrenia spectrum disorders (n=45) and healthy controls (with no history of hallucinations; n=20) completed questionnaire measures of hallucination-proneness, dissociative tendencies and childhood trauma, as well as performing an auditory signal detection task. Results: Compared to both healthy and non-hallucinating clinical controls, hallucinating patients reported both significantly higher dissociative tendencies and childhood sexual abuse. Dissociation positively mediated the effect of childhood trauma on hallucination-proneness. This mediational role was particularly robust for sexual abuse over other types of trauma. Signal detection abnormalities were evident in hallucinating patients and patients with a history of hallucinations, but were not associated with pathological dissociative symptoms. Conclusions: These results are consistent with dissociative accounts of the trauma-hallucinations link. Dissociation, however, does not affect reality discrimination. Future research should examine whether other cognitive processes associated with both dissociative states and hallucinations (e.g. deficits in cognitive inhibition) may explain the relationship between dissociation and hallucinatory experiences.

Vess, M. (2012). ***"Warm thoughts."*** Psychological Science 23(5): 472-474. http://pss.sagepub.com/content/23/5/472.short

Recent work on embodied cognition has shown that perceptions of interpersonal intimacy are conceptually grounded in physical temperature. For example, holding warm (vs. cold) beverages increases perceptions of social proximity (IJzerman & Semin, 2009), and social isolation promotes perception of temperature as colder (Zhong & Leonardelli, 2008). Such results suggest that temperature and intimacy are psychologically interchangeable (cf. Williams & Bargh, 2008). Activating one, through either physical experience or semantic priming (e.g., IJzerman & Semin, 2010), produces changes in the other. Such results are also reminiscent of classic work on the importance of temperature for attachment bonds (Harlow, 1958), which means that they may be useful for understanding attachment processes. Might individuals with high levels of attachment anxiety, given their enhanced sensitivity to intimacy cues (Mikulincer, Birnbaum, Woddis, & Nachmias, 2000), also show an enhanced sensitivity to temperature cues? In the present research, I tested the hypothesis that attachment anxiety positively predicts sensitivity to temperature cues, with the aim of integrating research on associations between temperature and intimacy with perspectives on adult attachment ... Conclusion: This research was a preliminary examination of the relationship between attachment anxiety and sensitivity to temperature cues. Study 1 indicated that individuals with high levels of attachment anxiety desire physical warmth after reflecting on a distressing event, whereas Study 2 indicated that in individuals with high levels of attachment anxiety, exposure to warm-temperature cues increases satisfaction with their current romantic relationships. These results suggest that individuals with high levels of attachment anxiety may engage associations between temperature and intimacy as a

secondary regulatory strategy and may be especially influenced by such associations when evaluating their current romantic relationships. Thus, this research offers future researchers solid ground from which to explore the links between temperature experiences and attachment-relevant outcomes.

Watanabe, N., T. A. Furukawa, et al. (2011). ***"Brief behavioral therapy for refractory insomnia in residual depression: An assessor-blind, randomized controlled trial."*** J Clin Psychiatry 72(12): 1651-1658. http://www.ncbi.nlm.nih.gov/pubmed/21457679

OBJECTIVE: Insomnia often persists despite pharmacotherapy in depression and represents an obstacle to its full remission. This study aimed to investigate the added value of brief behavioral therapy for insomnia over treatment as usual (TAU) for residual depression and refractory insomnia. METHOD: Thirty-seven outpatients (mean age of 50.5 years) were randomly assigned to TAU alone or TAU plus brief behavioral therapy for insomnia, consisting of 4 weekly 1-hour individual sessions. The Insomnia Severity Index (ISI) scores (primary outcome), sleep parameters, and GRID-Hamilton Depression Rating Scale (GRID-HAMD) scores were assessed by blind raters and remission rates for both insomnia and depression were collected at 4- and 8-week follow-ups. The patients were recruited from February 18, 2008, to April 9, 2009. RESULTS: Brief behavioral therapy for insomnia plus TAU resulted in significantly lower ISI scores than TAU alone at 8 weeks ($P < .0005$). The sleep efficiency for the combination was also significantly better than that for TAU alone ($P = .015$). Significant differences were observed in favor of the combination group on both the total GRID-HAMD scores ($P = .013$) and the GRID-HAMD scores after removing the 3 sleep items ($P = .008$). The combination treatment produced higher rates of remission than TAU alone, both in terms of insomnia (50% vs 0%), with a number needed to treat (NNT) of 2 (95% CI, 1-4), and in terms of depression (50% vs 6%), with an NNT of 2 (95% CI, 1-5). CONCLUSIONS: In patients with residual depression and treatment refractory insomnia, adding brief behavioral therapy for insomnia to usual clinical care produced statistically significant and clinically substantive added benefits.

Wiborg, J. F., H. Knoop, et al. (2012). ***"Towards an evidence-based treatment model for cognitive behavioral interventions focusing on chronic fatigue syndrome."*** Journal of Psychosomatic Research 72(5): 399-404. http://www.sciencedirect.com/science/article/pii/S0022399912000451

Objective The purpose of the present study was to develop a treatment model for cognitive behavioral interventions focusing on chronic fatigue syndrome (CFS) based on the model of perpetuating factors introduced by Vercoulen et al. [Journal of Psychosomatic Research 1998;45:507–17]. Methods For this purpose, we reanalyzed the data of a previously conducted randomized controlled trial in which a low intensity cognitive behavioral intervention was compared to a waiting list control group. Structural equation modeling was used to test a treatment model in which changes in focusing on symptoms, perceived problems with activity, and sense of control over fatigue were hypothesized to mediate the effect of our intervention on fatigue severity and disability. Results In the final model, which had a good fit to the data, the effect of treatment was mediated by a decrease in perceived problems with activity and an increase in sense of control over fatigue. Conclusion Our findings suggest that cognitive behavioral interventions for CFS need to change the illness perception and beliefs of their patients in order to be effective.