

Janus Christian Jakobsen: References

Chiesa, A., Serretti, A., & Jakobsen, J. C. (2012). Mindfulness: Top-down or bottom-up emotion regulation strategy? *Clinical Psychology Review*, 33, 82-96.
Notes: The beneficial clinical effects of mindfulness practices are receiving increasing support from empirical studies. However, the functional neural mechanisms underlying these benefits have not been thoroughly investigated. Some authors suggest that mindfulness should be described as a 'top-down' emotion regulation strategy, while others suggest that mindfulness should be described as a 'bottom-up' emotion regulation strategy. Current discrepancies might derive from the many different descriptions and applications of mindfulness. The present review aims to discuss current descriptions of mindfulness and the relationship existing between mindfulness practice and most commonly investigated emotion regulation strategies. Recent results from functional neuro-imaging studies investigating mindfulness training within the context of emotion regulation are presented. We suggest that mindfulness training is associated with 'top-down' emotion regulation in short-term practitioners and with 'bottom-up' emotion regulation in long-term practitioners. Limitations of current evidence and suggestions for future research on this topic are discussed
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Jakobsen, J. C., Hansen, J. L., Simonsen, E., & Gluud, C. (2012). The effect of adding psychodynamic therapy to antidepressants in patients with major depressive disorder. A systematic review of randomized clinical trials with meta-analyses and trial sequential analyses. *Journal of Affective Disorders*, 137, 4-14.
Notes: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Psychodynamic therapy may be a treatment option for depression, but the effects have only been limitedly assessed in systematic reviews. METHOD: Using Cochrane systematic review methodology, we compared the benefits and harms of psychodynamic therapy versus 'no intervention' or sham for major depressive disorder. We accepted any co-intervention, including antidepressants, as long as it was delivered similarly in both intervention groups. Trials were identified by searching the Cochrane Library's CENTRAL, MEDLINE via PubMed, EMBASE, Psychlit, Psyc Info, and Science Citation Index Expanded until February 2010. Two authors independently extracted data. We evaluated risk of bias to control for systematic errors. We conducted trial sequential analysis to control for random errors. RESULTS: We included five trials randomizing a total of 365 participants who all received antidepressants as co-intervention. All trials had high risk of bias. Four trials assessed 'interpersonal psychotherapy' and one trial 'short psychodynamic supportive psychotherapy'. Meta-analysis showed that psychodynamic therapy significantly reduced depressive symptoms on the 17-item Hamilton Rating Scale for Depression (mean difference -3.01 (95% confidence interval -3.98 to -2.03; $P < 0.00001$), no significant heterogeneity between trials) compared with 'no intervention'. Trial sequential analysis confirmed this result. LIMITATIONS: Our results are based on few trials with high risk of bias and a limited number of participants so our results may be questionable. CONCLUSIONS: Adding psychodynamic therapy to antidepressants

might benefit depressed patients, but the possible treatment effect measured on the Hamilton Rating Scale for Depression is small
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Jakobsen, J. C., Hansen, J. L., Simonsen, S., Simonsen, E., & Glud, C. (2012). Effects of cognitive therapy versus interpersonal psychotherapy in patients with major depressive disorder: a systematic review of randomized clinical trials with meta-analyses and trial sequential analyses. *Psychological Medicine*, 42, 1343-1357.
Notes: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetime at tremendous suffering and cost. Cognitive therapy and interpersonal psychotherapy are treatment options, but their effects have only been limitedly compared in systematic reviews. METHOD: Using Cochrane systematic review methodology we compared the benefits and harm of cognitive therapy versus interpersonal psychotherapy for major depressive disorder. Trials were identified by searching the Cochrane Library's CENTRAL, Medline via PubMed, EMBASE, Psychlit, PsycInfo, and Science Citation Index Expanded until February 2010. Continuous outcome measures were assessed by mean difference and dichotomous outcomes by odds ratio. We conducted trial sequential analysis to control for random errors. RESULTS: We included seven trials randomizing 741 participants. All trials had high risk of bias. Meta-analysis of the four trials reporting data at cessation of treatment on the Hamilton Rating Scale for Depression showed no significant difference between the two interventions [mean difference -1.02, 95% confidence interval (CI) -2.35 to 0.32]. Meta-analysis of the five trials reporting data at cessation of treatment on the Beck Depression Inventory showed comparable results (mean difference -1.29, 95% CI -2.73 to 0.14). Trial sequential analysis indicated that more data are needed to definitively settle the question of a differential effect. None of the included trial reported on adverse events. CONCLUSIONS: Randomized trials with low risk of bias and low risk of random errors are needed, although the effects of cognitive therapy and interpersonal psychotherapy do not seem to differ significantly regarding depressive symptoms. Future trials should report on adverse events
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Jakobsen, J. C., Lindschou, H. J., Storebo, O. J., Simonsen, E., & Glud, C. (2011). The effects of cognitive therapy versus 'treatment as usual' in patients with major depressive disorder. *PLoS ONE*, 6, e22890.
Notes: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Cognitive therapy may be an effective treatment option for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: Cochrane systematic review methodology, with meta-analyses and trial sequential analyses of randomized trials, are comparing the effects of cognitive therapy versus 'treatment as usual' for major depressive disorder. To be included the participants had to be older than 17 years with a primary diagnosis of major depressive disorder. Altogether, we included eight trials randomizing a total of 719 participants. All eight trials had high risk of bias. Four trials reported data on the 17-item Hamilton Rating Scale

for Depression and four trials reported data on the Beck Depression Inventory. Meta-analysis on the data from the Hamilton Rating Scale for Depression showed that cognitive therapy compared with 'treatment as usual' significantly reduced depressive symptoms (mean difference -2.15 (95% confidence interval -3.70 to -0.60; $P < 0.007$, no heterogeneity)). However, meta-analysis with both fixed-effect and random-effects model on the data from the Beck Depression Inventory (mean difference with both models -1.57 (95% CL -4.30 to 1.16; $P = 0.26$, $I(2) = 0$) could not confirm the Hamilton Rating Scale for Depression results. Furthermore, trial sequential analysis on both the data from Hamilton Rating Scale for Depression and Becks Depression Inventory showed that insufficient data have been obtained. DISCUSSION: Cognitive therapy might not be an effective treatment for major depressive disorder compared with 'treatment as usual'. The possible treatment effect measured on the Hamilton Rating Scale for Depression is relatively small. More randomized trials with low risk of bias, increased sample sizes, and broader more clinically relevant outcomes are needed
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Jakobsen, J. C., Hansen, J. L., Simonsen, E., & Gluud, C. (2011). The effect of interpersonal psychotherapy and other psychodynamic therapies versus 'treatment as usual' in patients with major depressive disorder. *PLoS ONE*, 6, e19044.
Notes: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Interpersonal psychotherapy and other psychodynamic therapies may be effective interventions for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: Cochrane systematic review methodology with meta-analysis and trial sequential analysis of randomized trials comparing the effect of psychodynamic therapies versus 'treatment as usual' for major depressive disorder. To be included the participants had to be older than 17 years with a primary diagnosis of major depressive disorder. Altogether, we included six trials randomizing a total of 648 participants. Five trials assessed 'interpersonal psychotherapy' and only one trial assessed 'psychodynamic psychotherapy'. All six trials had high risk of bias. Meta-analysis on all six trials showed that the psychodynamic interventions significantly reduced depressive symptoms on the 17-item Hamilton Rating Scale for Depression (mean difference -3.12 (95% confidence interval -4.39 to -1.86; $P < 0.00001$), no heterogeneity) compared with 'treatment as usual'. Trial sequential analysis confirmed this result. DISCUSSION: We did not find convincing evidence supporting or refuting the effect of interpersonal psychotherapy or psychodynamic therapy compared with 'treatment as usual' for patients with major depressive disorder. The potential beneficial effect seems small and effects on major outcomes are unknown. Randomized trials with low risk of systematic errors and low risk of random errors are needed
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Jakobsen, J. C., Hansen, J. L., Storebo, O. J., Simonsen, E., & Gluud, C. (2011). The effects of cognitive therapy versus 'no intervention' for major depressive disorder. *PLoS ONE*, 6, e28299.

Notes: BACKGROUND: Major depressive disorder afflicts an estimated 17% of individuals during their lifetimes at tremendous suffering and costs. Cognitive therapy may be an effective treatment option for major depressive disorder, but the effects have only had limited assessment in systematic reviews. METHODS/PRINCIPAL FINDINGS: We used The Cochrane systematic review methodology with meta-analyses and trial sequential analyses of randomized trials comparing the effects of cognitive therapy versus 'no intervention' for major depressive disorder. Participants had to be older than 17 years with a primary diagnosis of major depressive disorder to be eligible. Altogether, we included 12 trials randomizing a total of 669 participants. All 12 trials had high risk of bias. Meta-analysis on the Hamilton Rating Scale for Depression showed that cognitive therapy significantly reduced depressive symptoms (four trials; mean difference -3.05 (95% confidence interval (CI), -5.23 to -0.87; $P < 0.006$)) compared with 'no intervention'. Trial sequential analysis could not confirm this result. Meta-analysis on the Beck Depression Inventory showed that cognitive therapy significantly reduced depressive symptoms (eight trials; mean difference on -4.86 (95% CI -6.44 to -3.28; $P = 0.00001$)). Trial sequential analysis on these data confirmed the result. Only a few trials reported on 'no remission', suicide inclination, suicide attempts, suicides, and adverse events without significant differences between the compared intervention groups. DISCUSSION: Cognitive therapy might be an effective treatment for depression measured on Hamilton Rating Scale for Depression and Beck Depression Inventory, but these outcomes may be overestimated due to risks of systematic errors (bias) and random errors (play of chance). Furthermore, the effects of cognitive therapy on no remission, suicidality, adverse events, and quality of life are unclear. There is a need for randomized trials with low risk of bias, low risk of random errors, and longer follow-up assessing both benefits and harms with clinically relevant outcome measures
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Jakobsen, J. C. (2011). Review: interpersonal psychotherapy is effective as an acute or maintenance treatment for unipolar depression. *Evid.Based.Ment.Health*, 14, 108.