**![A picture containing food

Description automatically generated]()**

**7th October 2021 Level 4 Mental Health.**

[Contained within this document are links to video clips, quizzes, templates and academic evidence concerning mental health disorders]

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**Mental Health Day 2**

**YouTube Education Clips**

* Physiology of Stress [[Link]](https://youtu.be/eI_cPBXY0EQ)
* Depression & Anxiety: The Role of Exercise? [[Link]](https://youtu.be/4dnWbcQBeVo)
* Schizophrenia & The Role of Exercise? [[Link]](https://youtu.be/YWSCMx-4xTA)

**Links on How to Do the Case Study**

* Mental Health Case Study Instruction [[Link](https://youtu.be/Svo8qXdcl9A)]
* Referral Form [[Link](https://youtu.be/Svo8qXdcl9A)]
* PHQ- 9 [[Link](https://www.med.umich.edu/1info/FHP/practiceguides/depress/phq-9.pdf)]

**Video Clip 1**

Black dog link <https://youtu.be/XiCrniLQGYc>

I had a black dog and his name was depression. [Link](http://www.familyeducationgroup.com/wp-content/uploads/2015/10/Selfcare-Exercise-I-had-a-black-dog-Dans-Notes.pdf)

Sample Comments (**Serves no purpose of me including negative comments**). Interesting how we can type about our feelings but not say when no one knows our name!):

* ‘The "Black Dog" is a metaphor which was used by Winston Churchill (and perhaps others before him). Depression feels like a "living thing" to me, one that I need to tame and manage. Use of "black" to describe low mood is widespread; I have always thought this was about the night and fear of the dark, and not about the colour of skin, or fur. I find the "Black Dog" metaphor helpful and have never once thought of it when seeing a real black dog. No slight intended on anyone or anything black, but I do see that this may be an unintended consequence. I'd be happy to hear of a better metaphor that still captures the "living thing" sense, but without any of the negative connotations.’
* ‘This made me cry so much. It's important for people to know that depression is not merely feeling "gloomy" or "under the weather". It's an awful, awful illness that makes you feel scared of everything and everyone, of going to bed, getting up, meeting people or staying by yourself, and makes your heart as heavy as a stone and your life devoid of all pleasure.’
* ‘Seek help where? i have no one to speak to when i feel depressed and sad i go to sleep. Going to sleep with my anxiety and depression, burning heart, jealousy. People only think you are a weirdo if you open you heart.’
* ‘Most nights i wake up before 0400, and i just wait for someone to knock on my door with bad news. Sometimes i don't pick up mail for weeks and some days i never go outside my apartment. I go to work and i act all normal. I smile and i laugh, and that is the few moments i don't have a black dog biting my arm. I'm at my most happy when I’m out with friends or with my family. But i self medicate with alcohol, but no one notices.’
* ‘This video made a grown man cry. I've been crying in secret for over 35 years. The stigma for a man my even be that much worse. Easily brought to tears can be a symptom of depression. My objective mind knows that I have not too many reasons to cry. I also had TBI and was in a coma for two days. It is much easier to make that my #1 problem because it is documented and the communication deficits and seizures in he aftermath known. Depression is very serious and has been the biggest problem. TBI is also serious for me. But the latter not the former at least gets me less stigma.’
* To those with negative feedback or comments. ... are you really helping... or are you part of the problem?. What happens if this video gave someone a breath of fresh air an epiphany about their life, and then looking through the comments finds your negativity and feels weird because something you just slammed had helped them for even just a moment. congratulations you may have just ruined that persons day by putting a cloud back above their head.’

**Video Clip 2**

Jessie Pavelka Obese A Year To Save My Life (1min 4 seconds start) watch body language and reflection made.

<https://www.youtube.com/watch?v=FSGJhgJEJJs>

**Video Clip 3**

Millions of people around the world live with depression. “Living with a black dog” is a guide for partners, carers and sufferers of depression. It advises those living with and caring for people with depression on what to do, what not to do, and where to go for help.

<https://youtu.be/2VRRx7Mtep8>

**References to Original Sources**

* Löwe, B., Gräfe, K., Zipfel, S., Witte, S., Loerch, B. and Herzog, W., 2004. Diagnosing ICD-10 depressive episodes: superior criterion validity of the Patient Health Questionnaire. *Psychotherapy and psychosomatics*, *73*(6), pp.386-390. [Link](https://www.karger.com/Article/Abstract/80393)
* World Health Organization. (‎1993)‎. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. World Health Organization.[Link](https://apps.who.int/iris/bitstream/handle/10665/37108/9241544554.pdf?sequence=1&isAllowed=y) (or from Google Books [Link](https://books.google.co.uk/books?id=cnU0DgAAQBAJ&printsec=frontcover#v=onepage&q&f=false) )

**Most Recent Meta-Analyses Evidence On CBT** (Have summarised this in a line)

* Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A. and Dobson, K.S., 2013. A meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *The Canadian Journal of Psychiatry*, *58*(7), pp.376-385. [Link](https://journals.sagepub.com/doi/pdf/10.1177/070674371305800702)

**Summary/ Take home point**

CBT is **an effective treatment for adult depression**, although the effects may have **been overestimated until now**. CBT is also the most studied psychotherapy **for depression**, and thus has the greatest weight of evidence.

* Ballesio, A., Aquino, M.R.J.V., Feige, B., Johann, A.F., Kyle, S.D., Spiegelhalder, K., Lombardo, C., Rücker, G., Riemann, D. and Baglioni, C., 2018. The effectiveness of behavioural and cognitive behavioural therapies for insomnia on depressive and fatigue symptoms: a systematic review and network meta-analysis. Sleep medicine reviews, 37, pp.114-129. [Link](https://ora.ox.ac.uk/objects/uuid:cf56d606-d5f6-4c16-b241-7e051cd23640/download_file?file_format=pdf&safe_filename=Kyle%2Bet%2Bal%252C%2BThe%2Beffectiveness%2Bof%2Bbehavioural%2Band%2Bcognitive%2Bbehavioural%2Btherapies%2Bfor%2Binsomnia%2Bon%2Bdepressive%2Band%2Bfatigue%2Bsy.pdf&type_of_work=Journal+article)

**Summary/ Take home point**

Results showed significant **positive effects for individual face-to-face CBT**-I on depressive but **not on fatigue symptoms**, with high heterogeneity (large differences) between studies (so hard to provide strong suggestions). The **source of this variation**  was not identified even after including sex, age, comorbidity and risk of bias in sensitivity analyses. Findings highlight the need to reduce variability between study methodologies and suggest potential effects of individual face-to-face CBT-I on daytime symptoms. **More studies need to be performed to strengthen the evidence as discussed on Monday about issues with guidelines.**

* Arjadi, R., Nauta, M.H., Chowdhary, N. and Bockting, C.L.H., 2015. A systematic review of online interventions for mental health in low and middle income countries: a neglected field. Global Mental Health, 2.[Link](https://www.cambridge.org/core/services/aop-cambridge-core/content/view/C3109131F85566AECF47919620F837CB/S2054425115000102a.pdf/systematic_review_of_online_interventions_for_mental_health_in_low_and_middle_income_countries_a_neglected_field.pdf)

**Summary/ Take home point**

There is a shortage of studies examining the effect of online interventions in (low- and middle-income countries) LMICs, so we **cannot draw a firm conclusion on its effectiveness**. However, given the effectiveness of online interventions in **high income countries** and sharp increase of internet access in LMICs, online interventions **may offer** a potential to help reduce the ‘mental health gap’. More studies **are urgently needed** in LMICs.

* Barak, A. and Grohol, J.M., 2011. Current and future trends in internet-supported mental health interventions. *Journal of Technology in Human Services*, *29*(3), pp.155-196. [Link](https://s3.amazonaws.com/academia.edu.documents/50276013/Current_and_Future_Trends_in_Internet-Su20161112-4689-vz266e.pdf?response-content-disposition=inline%3B%20filename%3DCurrent_and_Future_Trends_in_Internet-Su.pdf&X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=ASIATUSBJ6BAKHXBMLV7%2F20200407%2Fus-east-1%2Fs3%2Faws4_request&X-Amz-Date=20200407T095343Z&X-Amz-Expires=3600&X-Amz-Security-Token=IQoJb3JpZ2luX2VjEK%2F%2F%2F%2F%2F%2F%2F%2F%2F%2F%2FwEaCXVzLWVhc3QtMSJGMEQCICjMdaP8%2FLUjeVxZxevX4BRuFSLGLLN1TkL3LZS%2FVSRcAiBI2PSIGr0VFOWRkgf4svEHDBMW89DfTwb60X410zLHdCq9Awi4%2F%2F%2F%2F%2F%2F%2F%2F%2F%2F8BEAAaDDI1MDMxODgxMTIwMCIMIxqcOqUY%2FqTizqmGKpEDpZu69xDSBpevG1z87O1w59pOxocZA6ClXb7EF9kcL%2BhAbVLmqCfkm1eZsNWxdZa2tJLX%2BvEarn1AJ%2FcVlOuIE4ELrcdbP28GFoPZEhYHW85OtvqeLrpyLHgxfwwUO1gQ46%2BRW%2Ffax2RC3m6fhtGwBCrV4ZlhzFvWevzctO2K8%2F6WstFmDPWp1hD3aEMPok7xAG4CyBAhc2CHJv7knkwWRxskGAlKQvUTSJ50MeuyJil3KnURDTiU%2FsGwBKEUgZRmBNxGIQ2lG4lNPT5SkhliCafM3GQVBrI%2FyWZQFVSHZpuSW0dgh%2FmbAiJ6avpRFq8vGXEf5oSKi6cl%2FxJF1%2FChEO8%2Bx4xxdfyTuVM5yyXPBYnqFYFO3cuwIxJP2xakarVLlvKyx%2FoyDsCKYnCpfx0ys6A74k2to3RnV8s8g%2BFuLGYfx4lg437lNzw6QM4r%2Bt30xgeKgmCkf0ge3Mev1RiBQtmGRBAkh0udnl9jWJMf1ZCY7cWZttcC5mXB9nTjBPS%2F1CeqfV4bOytTY88%2BNQD0PHYwx8Sw9AU67AGUCCzTAvCB%2B18FO3iw4G0a%2FmX4qRw5bAUU7IX9riaVat86vxdFdS1ADRH9tilh8TklqzdsyCZiadzIY9kjDyQUUtFsZzXEQrnJCnr3H4lxI%2FS2MKPxYT6ZffJqXxXizMYHJ%2BrViVbUwrHsxie%2B%2BGH6taDXXygowcjaRYu2bSGNbkCKllgXjrIqUHu7nTFJ3HH1jtQjKtzVsLNsHvq4994IE293I82zpWAq89lltEtrPCc1kk8l0ouPCscFkLcT8ko9qKtlw4knyJAyjP1GPXeH5VcwEzVA0GWr8RpMcOyTWow9%2BU2%2BaOdDBVembA%3D%3D&X-Amz-SignedHeaders=host&X-Amz-Signature=4199f072d8980e0a5f546df651a7187978a162a75b9b72152921f5550f024da3)

**Summary/ Take home point**

The use of texting or short message service (SMS), mobile communications, smart phone applications, gaming, and virtual worlds extends the intervention model into new environments **not always previously considered as intervention opportunities**. There is **strong evidence to support the effective use** and future development of a variety of online mental health applications. Slightly older study that people were thinking about this approach from 2011!!

Bell, M.J., Zeiler, M., Herrero, R., Kuso, S., Nitsch, M., Etchemendy, E., Fonseca-Baeza, S., Oliver, E., Adamcik, T., Karwautz, A. and Wagner, G., 2019. Healthy Teens@ School: Evaluating and disseminating transdiagnostic preventive interventions for eating disorders and obesity for adolescents in school settings. *Internet interventions*, *16*, pp.65-75. [Link](https://www.sciencedirect.com/science/article/pii/S2214782917301318)

**Summary/ Take home point**

* The Healthy Teens @ School study is a multi-country cluster-randomized controlled trial (**that’s good**) comparing the effectiveness of an **unguided, online, multi-level intervention for promoting a healthy lifestyle and reducing problematic eating behaviour, eating disorder and obesity risk among students aged 14 to 19 years with control condition**.
* The intervention is an adapted version of an evidence-based program developed in the USA (**StayingFi**t). Participants of the intervention group are assigned to either a “Weight Management” track or “Healthy Habits” track.
* The primary outcome is intuitive eating, secondary outcomes are eating disorder symptomatology, body image concerns, body mass index, food intake, physical activity, self-esteem, stress coping, depression, and anxiety.
* The results from this study will add to the understanding of how to address eating and weight related problems in adolescents and will shed light on the feasibility of implementing online prevention programs in school routine in Austria and Spain.
* As part of the larger ICare project this RCT will determine how an adapted version of StayingFit is disseminated within Europe.

**Maybe an area of Further Programme Intervention via Local Funders**

Perry, Y., Strauss, P. and Lin, A., **2018.** Online interventions for the mental health needs of trans and gender diverse young people. The Lancet Psychiatry, 5(2), p.e6. [Link](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30017-8/fulltext)

**Summary/ Take home point**

Although it is encouraging that the effectiveness of online interventions is well established in cisgender (gender corresponds with their birth sex) young people, and is emerging for sexual minority youth. There are **still no evidence-based interventions of this nature aimed specifically at gender diverse young people**. **Whether trans young people derive equal or less benefit—or potential harms—from these programmes compared with their cisgender peers is unknown.** The Trans Pathways survey showed that almost half of trans young people describe their gender in non-binary terms. Thus, whether the gender-binary nature of existing interventions affects their uptake, acceptability, or feasibility in trans young people is also unclear.

Jang, D. and Elfenbein, H.A., 2019. Menstrual cycle effects on mental health outcomes: a meta-analysis. *Archives of suicide research*, *23*(2), pp.312-332. [Link](https://www.tandfonline.com/doi/abs/10.1080/13811118.2018.1430638)

**Summary/ Take home point**

They conducted a meta-analysis of (pooling results from 32 papers), with an N of 3,791 subjects. They reported from pooled evidence that menstrual cycle: 26% greater risk of suicide deaths, 17% greater risk of suicide attempts, and 20% greater risk of **psychiatric admissions** at menstruation. They also observe **13% greater risk of psychiatric admissions during the premenstrual phase (suggesting a increased associated risk).** **Suicidal concept was unrelated to the stage of menstrual cycle.** Available evidence finds **serious and consequential mental health outcomes in the menstrual and premenstrual phases**.

**This is evolving research into depression and the need for NICE guidance. Please ensure you refer ONLY to 2004 guidance to ensure you meet assessment criteria.**

Wise, J., 2019. NICE guidance on depression: 35 health organisations demand “full and proper” revision. [Link](https://www.bmj.com/content/365/bmj.l2356)

Thornton, J., 2018. Depression in adults: campaigners and doctors demand full revision of NICE guidance. (Strong review statement with evidence made by McPherson [2019] University of Essex)

**What's wrong with the NICE depression guideline?**

In the joint stakeholder position statement referred to in the above article, six methodological issues were raised concerning the 2018 NICE draft depression guideline. These were: that patient experience research has been left out; that long-term outcome data has been left out; that chronic and complex forms of depression have been separated into misleading categories of depression; that severity has been misrepresented, disadvantaging people with the most severe forms of depression; that an experimental and confounded network meta-analysis has been used as a primary rather than supplementary basis for recommendations; that quality of life outcomes have been left out(1).

In a series of articles written with experts in the field, I have looked at some of these methodological issues in detail and provide an overview of this series here.

**1. Why should NICE include patient experience research?**

Prof Peter Beresford and I argue that NICE have conflated issues of patient involvement in the depression guideline development with patient choice and patient experience research (2). By choosing not to conduct a systematic review of patient experience research, a significant body of literature is being excluded. In a metasynthesis currently being undertaken with colleagues on patient experiences of psychological treatments for depression, I have identified 38 studies for inclusion, only one of which is mentioned in the draft NICE guideline. These studies should be reviewed by NICE along with a further review examining patient experiences of antidepressants. The guideline should also take into account experiences of carers. In a recent metasynthesis of carers’ experiences of depression, Jemma Priestley and I reviewed 15 studies, none of which have been taken into account in the guideline (3).

**2. Why should NICE examine long-term outcomes?**

Michael P. Hengartner and I have undertaken an analysis of long-term outcomes for the trials of treatments for long-term depression. We illustrate how and why NICE do so too (4). Although long-term evidence from RCTs is limited in volume, the findings from this set of data (that psychological therapies are superior to antidepressants in the long-term) is supported by a range of systematic reviews of other forms of evidence including naturalistic cohort studies and discontinuation trials. NICE have produced recommendations for depression treatment for 15 years now, ignoring this data and potentially contributing to the crisis of prescribed drug dependency now recognised by Public Health England (<https://phe-newsroom.prgloo.com/news/dependence-on-prescription-medicine>...).

**3. What’s wrong with subgrouping chronic forms of depression and misrepresenting severity?**

NICE have made fundamental philosophical errors in separating ‘treatment resistant depression’, ‘chronic’ and ‘complex’ depression(5). I argue that in making these distinctions without having full knowledge of individuals’ experiences, the argument that these sub-classifications of persistent forms of depression are clinically useful dissolves and becomes more like a game of Minecraft in which cuboids are built up into logically impossible structures. This applies to the separation of ‘mild’ and ‘severe’ depression which is based on a flawed approach and creates a false sense of certainty. There is therefore no good justification for artificially separating trials into these categories in the guideline and doing so leads to misleading recommendations.

**4. Why is quality of life important?**

NICE claim that it is not possible to look at quality of life outcomes because use of these measures is rare:

“We agree that measures of functioning and quality of life measures are important. However, these measures are relatively rarely reported. For this reason these measures were not prioritised for inclusion in the review protocols for this guideline.”(6)

An examination of the appendices to the draft guideline reveals that of the 124 trials reviewed in the treatment resistant and chronic depression categories alone, 58 (nearly half) use a quality of life or functioning measure. It is true that the specific measures used vary a great deal; there are 16 different measures among these trials. However, there were 13 different symptom outcome measures and NICE took all of these into account.

It is important to examine quality of life outcomes not least because NICE have consistently stated in their own scoping documents and previous guidelines that quality of life is an important outcome; quality of life is also a central pillar of government policy (e.g. No Health Without Mental Health). Moreover, service users often note that outcomes such as better relationships and better functioning matter more than symptom improvement. Although some of the measures typically used may not perfectly reflect service user priorities(7), it would indicate a move in the right direction to demonstrate commitment to examining patient preferred outcomes. NICE may consider that the results would not be any different; yet in a re-analysis of the first NICE depression guideline (2004), colleagues and I demonstrated that analysing quality of life outcome measures does produce different findings in reviews(8).

Some may take the view that ‘interfering’ in NICE guideline development is antithetical to the nature of our UK guideline body. Indeed NICE was established to be free from political interference and lobbying from pharmaceutical companies. However, Professor Maurice Sunkin QC and I make the case that the stakeholder consultation process is a critical element of quality assurance for NICE guidelines (9). Stakeholder consultation can only serve as a robust quality assurance process if legitimate methodological concerns raised by stakeholders during this process are taken into account and not brushed off as minor inconveniences. Moreover, as a public body, NICE is bound by English law to consult in good faith and not to have made decisions prior to the consultation.

**Taken together, it seems likely that unless the methodological concerns outlined are addressed in full in the next draft of the guideline, stakeholders may well continue to reject the guideline as unfit-for-purpose.**

**Supporting References made by McPherson (2019)**

* Rost, F. & McPherson, S. (2018). Joint stakeholder position statement on the NICE guideline for depression in adults. 2018. https://www.nsun.org.uk/news/stakeholder-position-statement-on-the-nice-...
* McPherson, S., & Beresford, P. (2019). Semantics of patient choice: how the UK national guideline for depression silences patients. Disability and Society, 1-7. doi:10.1080/09687599.2019.1589757
* Priestley, J., & McPherson, S. (2016). Experiences of adults providing care to a partner or relative with depression: A meta-ethnographic synthesis. Journal of Affective Disorders, 192, 41-49. doi:10.1016/j.jad.2015.12.011
* McPherson, S. & Hengartner, M.P. (2019). Long-term outcomes of trials in the NICE depression guideline. BJPsych Open, 5(5). https://doi.org/10.1192/bjo.2019.65
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* NICE. (2018). Consultation comments and responses – second consultation period. https://www.nice.org.uk/guidance/gid-cgwave0725/documents/consultation-c...
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* McPherson, S., Evans, C., & Richardson, P. (2009). The NICE Depression Guidelines and the recovery model: Is there an evidence base for IAPT?. Journal of Mental Health, 18(5), 405-414. Retrieved from http://dx.doi.org/10.3109/09638230902968258
* McPherson, S., & Sunkin, M. (2019). The Dobson–Rawlins pact and the National Institute for Health and Care Excellence: impact of political independence on scientific and legal accountability. The British Journal of Psychiatry. doi:10.1192/bjp.2019.121
* Competing interests: No competing interests

**Updated NICE guidance on depression should include the following information:**

Despite increased antidepressant prescriptions in recent years, reductions in suicides or all-cause mortality did not occur. [1][13]

Recent evidence reveals that administered antidepressants actually increase suicide risks by 2-5 times. [2][3][4][5][6][9]

A recent meta-analysis, level I evidence, clearly demonstrated that SSRIs double the risk of suicide and violence in adults. [4]

Antidepressants increase venous thromboembolisms. [14]

Antidepressants increase mortality in older adults with chronic obstructive pulmonary disease (COPD). [15]

Furthermore, antidepressants increase all-cause mortality by 33%! [10][11]

In a meta-analysis of 28 studies, 61% of patients treated with antidepressant pills still suffer from clinical depression after little more than a year. [16]

Another meta-analysis published in the British Journal of Psychiatry has found that even patients with the most severe depression can expect to get as much benefit from cognitive behavioural therapy (CBT) as those with less severe symptoms. [7]

Cognitive behavioural therapy halves the risk of repeated suicide attempts. [12]

Even Behavioural Activation effectively decreases depressive symptoms. [8]

**References**

[1] <http://www.bmj.com/content/355/bmj.i6761>

[2] <http://journals.sagepub.com/doi/pdf/10.1177/0141076816666805>

[3] <http://www.bmj.com/content/348/bmj.g3510>

[4] <http://www.bmj.com/content/352/bmj.i65>

[5] <http://nordic.cochrane.org/sites/nordic.cochrane.org/files/public/upload>...

[6] <http://www.bmj.com/content/355/bmj.i6103>

[7] <http://bjp.rcpsych.org/content/210/3/190.long>

[8] <http://www.bmj.com/content/356/bmj.j914>

[9] <http://www.bmj.com/content/358/bmj.j3697/rr-4>

[10] <https://brighterworld.mcmaster.ca/articles/antidepressants-associated-wi>...

[11] <https://www.ncbi.nlm.nih.gov/pubmed/28903117>

[12] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5650127/>

[13] <https://www.ncbi.nlm.nih.gov/pubmed/20952074>

[14] <https://www.ncbi.nlm.nih.gov/pubmed/30001640>

* Fox, K.R., 1999. The influence of physical activity on mental well-being. Public health nutrition, 2(3a), pp.411-418. [Link](http://beauty-review.nl/wp-content/uploads/2015/03/The-influence-of-physical-activity-on-mental-well-being.pdf)
* Biddle, S.J., Fox, K. and Boutcher, S. eds., 2003. Physical activity and psychological well-being. Routledge. [Link](https://books.google.co.uk/books?hl=en&lr=&id=Ct2AAgAAQBAJ&oi=fnd&pg=PP1&dq=pdf+Physical+activity+and+psychological+well-being.&ots=3jxPNmoCFg&sig=iVbRuQDpQr1twQuCFlW0ozJy5d4&redir_esc=y#v=onepage&q&f=false) (You get maybe 20 pages free [don’t by book])
* McPhie, M.L., 2017. The Influence of Physical Activity on Psychological Well-Being Among Adolescents and Emerging Adults. [Link](https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/34238/McPhie_Meghan_L_2017_PhD.pdf?sequence=2&isAllowed=y)

**Summary/ Take home point**

The results suggest that there may be several factors involved in explaining the improved psychosocial well-being associated with physical activity. The study findings are of relevance to researchers, clinicians, educators, and policy-makers, with important implications for informing school-based mental health promotion and intervention programs for youth.

* McNamee, J., Timken, G.L., Coste, S.C., Tompkins, T.L. and Peterson, J., 2017. Adolescent girls’ physical activity, fitness and psychological well-being during a health club physical education approach. European Physical Education Review, 23(4), pp.517-533. [Link](https://www.researchgate.net/profile/Jeff_Mcnamee2/publication/316639417_'It_doesn't_seem_like_PE_and_I_love_it'_Adolescent_girls'_views_of_a_health_club_physical_education_approach/links/59c96ec3a6fdcc451d54605f/It-doesnt-seem-like-PE-and-I-love-it-Adolescent-girls-views-of-a-health-club-physical-education-approach.pdf)

**Summary/ Take home point**

The study measured adolescent girls’ moderate to vigorous physical activity (MVPA), components of health- related physical fitness, and perceptions about themselves and physical activity (PA) during a 14-week programme. The Health Club (HC) approach produced high levels of MVPA. Pre/post physical fitness testing variables included height, weight, body mass index, waist measurement, sit and reach, grip strength, push-ups, sit-ups and a 10-minute walk test. Significant differences were found in participants’ flexibility and cardiovascular fitness at the conclusion of the 14-week programme. Participants reported **greater perceived control over their PA**, improvements in their **physical self- concept across several domains, more positive feelings about appearance and strength and more positive global statements about their physical selves at post-test.** The results of this study suggest that the HC approach is a promising approach that deserves further study.

* Bae, W., Ik Suh, Y., Ryu, J. and Heo, J., 2017. Physical activity levels and well-being in older adults. Psychological reports, 120(2), pp.192-205. [Link](http://midus.wisc.edu/findings/pdfs/1658.pdf)

**Summary/ Take home point**

The results showed that light physical activities were positively associated with physical health and life satisfaction in summer, whereas light physical activities and all dependent variables were positively correlated in winter. Furthermore, engaging in moderate physical activities was positively related only with physical health. Meanwhile, vigorous physical activities were not associated with life satisfaction, physical health, and positive affect in summer and winter.

* Kim, J., Lee, S., Chun, S., Han, A. and Heo, J., 2017. The effects of leisure-time physical activity for optimism, life satisfaction, psychological well-being, and positive affect among older adults with loneliness. Annals of Leisure Research, 20(4), pp.406-415. (Abstract) [Link](https://www.tandfonline.com/doi/abs/10.1080/11745398.2016.1238308)
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**Summary/ Take home point**

The effect of physical activity intensity on subjective well-being has not been well established. Study examined this relationship among 419 healthy adults using objective and subjective physical activity measurements (sample size varied among well-being assessments). For accelerometers, light-intensity physical activity positively associated with psychological well-being (number of subjects = 150) and **negatively associated with depression** (number of subjects = 99); moderate intensity negatively associated with pain severity (number of subjects = 419) and positively associated with psychological well-being; sedentary behaviour negatively associated with psychological well-being and positively associated with depression. Higher levels of sedentary behaviour are associated with lower subjective well-being.

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**Summary/ Take home point**

This study provides evidence that greater well-being may help sustain physical activity in the long term. These results suggest that improving well-being may be a useful addition to interventions aimed at increasing long-term physical activity participation.

All published ACSM Position Stands. These serve as guidelines for almost every organisation and included within textbooks etc. [Link to ALL](http://www.acsm.org/acsm-positions-policy/official-positions/ACSM-position-stands)

An ACSM Position Stand is an official pronouncement, developed using a specified evidence-based methodology, on significant societal issues that merit interdisciplinary consideration and consensus within the College. Joint Position Stands are similar to ACSM Position Stands, but are developed in concert with at least one other not-for-profit organization or governmental agency.

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**Summary/ Take home point**

A brief bout of moderate intensity exercise **may** provide some short‐term relief from alcohol urges during exercise**. Further studies are required** to replicate the present findings and to confirm whether any moderating effect of exercise on alcohol urges is sustained following exercise.

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