needs a multidisciplinary and integrative approach, combining the best of drug therapy, biophysical techniques, and psychosocial interventions.

A common criticism that is made to sophisticated and lengthy psychotherapies is that they are difficult to implement in a community-care based system and may not be cost-effective. There have been several attempts to reduce the length and intensity of evidence-based psychoeducational packages, but most of those are unpublished because they failed. There is often a "wishful thinking" background in those aiming at designing an intervention that is effective and brief. It would be like learning a second language or to play a musical instrument with only a few sessions.

Cost-effectiveness is an issue but, if one counts indirect costs, it is likely that any intervention that works is actually cost-effective, especially when occupational outcome is concerned. There is some hypocrisy and discrimination in restricting access to sophisticated psychotherapies when access to complex and very expensive medical procedures, such as transplantation, is granted for most patients in the Western world. The paradox is that you can have a liver transplantation if you are 69 years old and abstinent for 3 months, but you cannot have access to the (psycho)therapy that will keep you abstinent for the rest of your life. Once again, there is no health without mental health.

Functional remediation is not just a fashionable therapy for bipolar disorder. Across the 21 sessions, the patients are walked through plenty of practical challenges and exercises that help them in improving their interpersonal, social and occupational skills. A major strength of this approach is that it fills the gap between neurocognitive processes and social skills, bringing in neuroscience to the traditional scope of social therapies. Hence, changes in the ability to deactivate the default mode network under neurocognitive challenges are expected in bipolar patients who have received this sort of therapy, and studies are ongoing to confirm that.

It is happening in many fields within psychiatry that traditional outcomes, such as psychotic, depressive, manic or anxious symptoms, are being replaced or perhaps upgraded with other targets that are more closely correlated with functioning[7]. Neurocognitive symptoms are the best example. Conditions such as major depression, which were never the focus of neuropsychological assessment except to exclude patients at risk of dementia, are now being studied using not only mood, but also processing speed, executive function and memory as primary outcomes[8]. Neuroimaging and neuropsychological assessments, among other biomarkers, will be increasingly incorporated into clinical trials. Clinical staging will become part of routine assessment[9]. The growing interest in distal outcomes such as functioning as opposed to quality of life or symptoms will run in parallel with molecular and translational psychopathology[10] and the explosion of personalized medicine as applied to mental health.

Functional remediation is a novel psychosocial intervention that has been found to improve the outcome of patients with bipolar disorder. In contrast with patient and family psychoeducation, cognitive-behavioral therapy, and interpersonal social rhythm therapy, the focus of this intervention is not improvement of mood or relapse prevention, but psychosocial adjustment. It proved to be effective in reducing global disability and enhancing interpersonal and occupational functioning. Albeit considered a therapy for late-stage, functionally impaired bipolar patients, there is huge interest in tailoring it for the prevention of cognitive and psychosocial impairment in recently diagnosed patients, following the principle that prevention is better than cure. The final aim is to allow people with bipolar disorder not only *to feel well*, but *to do well* and *to be well*. Getting closer.

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Mindfulness-based cognitive therapy for relapse prophylaxis in mood disorders

Relapse and recurrence are common and debilitating aspects of major depressive disorder. Furthermore, the risk of developing a chronic course of illness increases with each successive episode and, even among patients who achieve clinical remission, residual depressive symptoms are commonly reported. Maintenance antidepressant monotherapy is effective as long as it is continued, yet in practice side effect burden, tachyphylaxis, safety concerns and premature discontinuation can combine to push non-compliance rates as high as 40%[1]. Alternatives to long-term antidepressant monotherapy, especially those addressing mood outcomes in a broader context of well-being, may appeal to patients wary of continued intervention.

Studies have shown that, for a number of recovered depressed patients, mild dysphoria activates patterns of ruminative self-focus that can maintain and intensify the dysphoric state[2]. The task of relapse prevention, therefore, can be to pre-empt the establishment of these dysfunctional patterns. Mindfulness-based cognitive therapy (MBCT) was designed to achieve this aim by teaching formerly depressed patients how to be more aware of negative thoughts and feelings at times of potential relapse/recurrence, and to respond to those thoughts and feelings in ways that allow them to disengage from treating them as facts or identifying them with one's sense of self-worth. In order to increase its potential cost-efficiency, this strategy was designed as a group skills training approach rather than as an individual psychological therapy.

The MBCT program[3] integrates the practice of mindfulness meditation with the tools of cognitive therapy (CT). A significant component consists of formal meditation exercises such as the body scan, sitting and walking meditations, as well as mindful movement in the form of gentle yoga and stretching. The generalization of mindfulness skills to aspects of everyday life is supported through informal practices such as mindful eating; noticing body sensations, affect and thoughts during pleasant and unpleasant experiences; as well as taking a mindful approach to aspects of one's daily routine which are typically completed on "automatic pilot". A novel aspect is the addition of the "three-minute breathing space", a brief centering meditation exercise designed for use during times of emotional challenges or stress. The CT components include psychoeducation about depressive symptoms and discussion of the cognitive model, including automatic thoughts, and how thoughts are impacted by situations and moods. Participants are also encouraged to identify activities that generate a sense of pleasure or mastery, to be implemented during times of low mood.

The first four sessions of the 8-week program provide a framework for patients to learn to approach present moment experiences in a non-judgmental way. This message is conveyed tacitly through the formal meditation practices, which promote learning to focus (and re-focus as needed) attentional resources to anchors such as the breath and bodily sensations. This process facilitates the ability to observe the structure of one's internal experience as it arises in a given moment, with the intention not to judge the content, knowing that the "judgment" or "reaction" component of one's experience can be more detrimental than the raw experience itself. The skill to deconstruct experience in this way is then applied to depression, using exercises from CT that underscore how reactions to given situations can be colored by thought and interpretation. Thus, the understanding is cultivated that thoughts are not facts, and that thoughts, feelings and body sensations are often transient and dynamic aspects of experience.

In the fourth session, psychoeducation specific to depressive illness is formally introduced. In addition to information surrounding the nature of commonly discussed depressive symptoms (neurovegetative and mood), the types of negative thinking that are associated with depression are explored. Thus, individuals are encouraged to build upon their ability to detect the early warning signs of relapse, and to identify their unique "relapse signatures".

The latter four sessions of the program emphasize the development of a thoughtful and flexible response style for dealing with the signs and symptoms of relapse. The theme "thoughts are not facts" is the focus in the sixth session, which employs a CT exercise to illustrate how readily mood can impact thoughts. In the seventh session, relapse prevention strategies drawn from CT are discussed. The groundwork is laid for an individualized relapse prevention plan for each participant that includes the involvement of family members in an early warning system, keeping a list of highly effective pleasure and mastery activities, as well as noting familiar automatic thoughts and cognitive themes that have preceded relapse in the past.

Randomized controlled trials evaluating MBCT efficacy have found it to be superior to treatment as usual[4] and to perform as well as continuation antidepressant pharmacotherapy[5] in preventing depression relapse/recurrence. These outcomes are supported by a meta-analysis[6] reporting a relative risk reduction of 34% for those receiving MBCT. Of particular interest is that patients with recurrent depression (three or more past episodes) are more likely to benefit from treatment than those who have experienced only one or two episodes of illness.

In a recent study of 424 patients who were on a therapeutic dose of maintenance antidepressant pharmacotherapy, one half continued on this therapeutic regimen, while the other half was randomized to MBCT and discontinued their medication[7]. There were no differences in relapse/recurrence rates between the two groups (47% antidepressant vs. 44% MBCT) over a two year follow-up.

These findings, among others, have supported the adoption of MBCT within a broader matrix of mental health treatments for mood disorders. For example, the UK National Institute of Health and Care Excellence (NICE) Guidelines for preventing depressive recurrence include a recommendation to provide MBCT for patients who have experienced more than two prior depressive episodes.

It is surprising that relatively little is known about how MBCT prevention effects occur. According to one recent review, the most reliable pattern of change predicting outcome in MBCT is bivariate in nature: increases in mindfulness and metacognitive awareness of emotions are matched by decreases in rumination and worry[8]. These findings are consistent with qualitative interviews of patients, who describe developing a different type of relationship to sad moods, rather than their elimination altogether.

Expanding MBCT's public health impact will require addressing two outstanding issues. First, MBCT faces challenges to dissemination that are common to all psychotherapeutic treatments, including service costs, waiting lists, travel time and a shortage of trained therapists. Web-based psychological interventions offer one solution to many of these barriers. Mindful mood balance (MMB) is an online treatment which

provides high fidelity and widespread access to the core benefits of the in-person MBCT program[9]. Second, a clear understanding of the type and amount of practice required to achieve positive clinical outcomes still eludes the field. Perhaps the most reliable finding is that program benefits have been associated with formal (30-40 min) compared to informal (3-5 min) mindfulness practice[10]. As the evidence base evolves, it can be expected that the establishment of competency standards for clinicians working within the MBCT model will yield more targeted recommendations regarding optimum levels of practice density.

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Bodily distress disorder in ICD-11: problems and prospects

Classifying the disorders associated with burdensome somatic concerns has been a challenging exercise in psychiatric nosology[1]. The classifications of these conditions in ICD-10 and DSM-IV have not fared much better than earlier attempts[2]. Even though not exactly identical, these classifications were broadly similar and criticisms of either system are therefore generally applicable to both. Among the most salient criticisms are those relating to their utility in routine clinical practice. These include the rarity of the major categories of the group, both in the community and in general clinical practice, as well as the evidence suggesting poor diagnostic reliability[3].

A central feature of the definition of these disorders, that the symptoms are not due to physical or medical causes, has been criticized for being unreliable and for posing a fundamental nosological problem: defining a disorder on the basis of the absence of a feature rather than the presence of a problem[4]. Labels assigned to burdensome somatic preoccupations that have come to be seen as pejorative create another problem for clinical utility. Some patients object to the term "somatoform", which they think may imply that their symptoms are of doubtful clinical importance and are "in their heads" or not real. Furthermore, the notion that the symptoms are medically unexplained is often rejected by patients as essentially an issue of detection.

As part of the activities designed to lead to the approval of ICD-11 by the World Health Assembly in 2018, the World Health Organization, through its International Advisory Group[5], constituted the Somatic Distress and Dissociative Disorders Working Group, which, among other tasks, was asked to propose changes to the section on somatoform disorders in ICD-10. The Working Group has proposed a new and much simplified category of bodily distress disorder, which replaces all of ICD-10 categories within the group of somatoform disorders (F45.0) and, to a large extent, neurasthenia (F48.0), bringing these together under a single category. The only ICD-10 somatoform condition excluded from BDD is hypochondriasis (F45.2).

In the proposed new classification, bodily distress disorder is defined as "characterized by the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms, which may be manifest by repeated contact with health care providers. If a medical condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression. Excessive attention is not alleviated by appropriate clinical examination and investigations and appropriate reassurance. Bodily symptoms and associated distress are persistent, being present on most days for at least several months, and are associated with significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Typically, the disorder involves multiple bodily symptoms that may vary over time. Occasionally there is a single symptom – usually pain or fatigue – that is associated with the other features of the disorder" (this is the proposed brief definition for bodily distress disorder; for the format of ICD-11 diagnostic guidelines, see First et al[6]).

Responding to the same set of criticisms, the DSM-5 created a new grouping called Somatic Symptom and Related Disorders, in which the prototypic condition is somatic symptom disorder. Even though this diagnosis can be given to a condition with "one or more somatic symptoms", it nevertheless requires that "excessive thoughts, feelings, or behaviors are related to the somatic symptoms or associated health concerns". Specifically, for a diagnosis of somatic symptom disorder, at least one of three psychological criteria should be present: health anxiety, disproportionate and persistent concerns about the medical seriousness of the symptoms, and excessive time and energy devoted to the symptoms or health concerns.

In both the proposed bodily distress disorder and somatic symptom disorder, the most fundamental revision has been the abolition of the distinction between medically explained and medically unexplained somatic complaints. On the other