

## Update of Psychiatrie SUMMARIES

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## مستجدات الطب النفسي ملخصات

جانفي - فيفري - مارس 2006

### GENERALIZED ANXIETY DISORDER (GAD)

#### GERIATRIC ANXIETY INVENTORY

##### DEVELOPMENT AND VALIDATION OF THE GERIATRIC ANXIETY INVENTORY.

**Authors :** Pachana NA, Byrne GJ, Siddle H, Koloski N, Harley E, Arnold E.

**Source :** Int Psychogeriatr. 2006 Jun 29;:1-12 [Epub ahead of print] Related Articles, Links

**Background:** Anxiety symptoms and anxiety disorders are highly prevalent among elderly people, although infrequently the subject of systematic research in this age group. One important limitation is the lack of a widely accepted instrument to measure dimensional anxiety in both normal old people and old people with mental health problems seen in various settings. Accordingly, we developed and tested of a short scale to measure anxiety in older people. **Methods:** We generated a large number of potential items de novo and by reference to existing anxiety scales, and then reduced the number of items to 60 through consultation with a reference group consisting of psychologists, psychiatrists and normal elderly people. We then tested the psychometric properties of these 60 items in 452 normal old people and 46 patients attending a psychogeriatric service. We were able to reduce the number of items to 20. We chose a 1-week perspective and a dichotomous response scale. **Results:** Cronbach's alpha for the 20-item Geriatric Anxiety Inventory (GAI) was 0.91 among normal elderly people and 0.93 in the psychogeriatric sample. Concurrent validity with a variety of other measures was demonstrated in both the normal sample and the psychogeriatric sample. Inter-rater and test-retest reliability were found to be excellent. Receiver operating characteristic analysis indicated a cut-point of 10/11 for the detection of DSM-IV Generalized Anxiety Disorder (GAD) in the psychogeriatric sample, with 83% of patients correctly classified with a specificity of 84% and a sensitivity of 75%. **Conclusions:** The GAI is a new 20-item self-report or nurse-administered scale that measures dimensional anxiety in elderly people. It has sound psychometric properties. Initial clinical testing indicates that it is able to discriminate between those with and without any anxiety disorder and between those with and without DSM-IV GAD.

#### KAVA & GAD

##### KAVA IN GENERALIZED ANXIETY DISORDER: THREE PLACEBO-CONTROLLED TRIALS.

**Authors :** Connor KM, Payne V, Davidson JR.

**Source :** Int Clin Psychopharmacol. 2006 Sep;21(5):249-53. Related Articles, Links

**Summary:** In this study, we evaluated the efficacy and safety of kava kava (Piper methysticum) in generalized anxiety disorder. Data were analyzed from three randomized, double-blind, placebo-controlled trials of kava, including one study with an active comparator (venlafaxine), in adult outpatients with DSM-IV generalized anxiety disorder. The pooled sample (n=64) included the following number of participants: kava, n=28; placebo, n=30; and venlafaxine, n=6. Given the comparability of the study designs, the data comparing kava and placebo were then pooled for further efficacy and safety analyses. No significant differences were observed between the treatment groups in any of the trials. In the pooled analyses, no effects were found for kava, while a significant effect in favor of placebo was observed in participants with higher anxiety at baseline. No evidence of hepatotoxicity was found with kava, and all of the treatments were well tolerated. Findings from these three controlled trials do not support the use of kava in DSM-IV generalized anxiety disorder.

#### ANXIETY & PULSE-WAVE VELOCITY

##### INCREASED PULSE-WAVE VELOCITY IN PATIENTS WITH ANXIETY: IMPLICATIONS FOR AUTONOMIC DYSFUNCTION.

**Authors :** Yeragani VK, Tancer M, Seema KP, Josyula K, Desai N.

**Source :** J Psychosom Res. 2006 Jul;61(1):25-31. Related Articles, Links

**Summary:** Decreased vagal function is associated with vascular dysfunction. In this study, we compared vascular indices and correlated heart rate and QT variability measures with vascular indices in patients with anxiety disorders and normal controls. We compared age- and sex-matched controls (n=23) and patients with anxiety (n=25) using the Vascular Profiler (VP-1000; Colin Medical Instruments, Japan), approved by the US Food and Drug Administration. Using this machine, we obtained ankle and brachial blood pressure (BP) in both arms (brachial), both legs (ankle), and carotid artery, and lead I electrocardiogram (ECG) and phonocardiogram. Using these signals, pulse-wave velocity (PWV), and arterial stiffness index % and preejection period can be calculated. We also obtained ECG sampled at 1000 Hz in lead II configuration in supine posture to obtain beat-to-beat interbeat interval (R-R) and QT interval variability for 256 s. Patients with anxiety had significantly higher carotid

mean arterial pressure (MAP) %, brachial-ankle PWV (BAPWV), arterial stiffness index %, MAP, and diastolic BP of the extremities compared to controls. We found significant negative correlations ( $r$  values from .4 to .65;  $P < .05$  to .007) between R-R interval high-frequency (0.15-0.5 Hz) power (which is an indicator of cardiac vagal function), and increased BAPWV and systolic BP of the extremities only in patients. We were unable to find such correlations in controls. We also found significant positive correlations between QT variability index (a probable indicator of cardiac sympathetic function) and MAP of the extremities and BAPWV only in the patient group. These findings suggest an important association between decreased vagal and increased sympathetic function, and decreased arterial compliance and possible atherosclerotic changes and increased BP in patients with anxiety.

### GAD & Comorbid Disease

#### ▪ GENERALIZED ANXIETY DISORDER: A COMORBID DISEASE.

**Authors :** Nutt D, Argyropoulos S, Hood S, Potokar J. Psychopharmacology Unit, University of Bristol, Bristol, United Kingdom. david.j.nutt@bristol.ac.uk

**Source :** Eur Neuropsychopharmacol. 2006 Jul;16 Suppl 2:S109-18. Epub 2006 Jun 5. Related Articles, Links

**Summary:** Generalized anxiety disorder (GAD) frequently occurs comorbidly with other conditions, including depression and somatic complaints. Comorbid GAD sufferers have increased psychologic and social impairment, request additional treatment, and have an extended course and poorer outcome than those with GAD alone; therapy should alleviate both the psychic and somatic symptoms of GAD without negatively affecting the comorbid condition. The ideal treatment would provide relief from both GAD and the comorbid condition, reducing the need for polypharmacy. Physicians need suitable tools to assist them in the detection and monitoring of GAD patients—the GADI, a new, self-rating scale, may meet this requirement. Clinical data have shown that various neurobiologic irregularities (e.g., in the GABA and serotonin systems) are associated with the development of anxiety. Prescribing physicians must take into account these abnormalities when choosing a drug. Effective diagnosis and treatment should improve patients' quality of life and their prognosis for recovery.

### GAD & Early Response

#### ▪ EARLY RESPONSE AND 8-WEEK TREATMENT OUTCOME IN GAD.

**Authors :** Rynn M, Khalid-Khan S, Garcia-Espana JF, Etemad B, Rickels K.

**Source :** *Depress Anxiety*. 2006 Jul 14; [Epub ahead of print] Related Articles, Links

**Objective :** Our objective was to compare the predictive value of early response to treatment outcome in patients with generalized anxiety disorder (GAD) treated with benzodiazepines, serotonin receptor (5HT-1A) partial agonists, or placebo. Data from two double-blind GAD studies were combined. Subjects were evaluated with the Hamilton Anxiety Scale (HAM-A) and the Clinical Global Impression of Improvement (CGI-I) scale over 8 weeks.

Categories of response at weeks 1 and 2 were defined by the HAM-A total score. Analyses of covariance and Kaplan-Meier survival analyses were the primary analyses used to assess 8-week end point treatment outcomes as a function of early improvement. HAM-A change from baseline to weeks 1 and 2 significantly predicted last observation carried forward (LOCF) response at week 8 for both medications and for placebo ( $P < .001$ ). Early improvement was a strong predictor for treatment outcome irrespective of whether active medication or placebo was the treatment agent. *Depression and Anxiety* 0:1-5, 2006. Published 2006 Wiley-Liss, Inc.

### ANXIETY IN MEN & MAX-PC

#### ▪ ASSESSING ANXIETY IN MEN WITH PROSTATE CANCER: FURTHER DATA ON THE RELIABILITY AND VALIDITY OF THE MEMORIAL ANXIETY SCALE FOR PROSTATE CANCER (MAX-PC).

**Authors :** Roth A, Nelson CJ, Rosenfeld B, Warshowski A, O'Shea N, Scher H, Holland JC, Slovin S, Curley-Smart T, Reynolds T, Breitbart W.

**Source :** *Psychosomatics*. 2006 Jul-Aug;47(4):340-7. Related Articles, Links

**Summary:** Identifying which men with prostate cancer might benefit from mental health treatment has proven to be a challenging task. The authors developed the Memorial Anxiety Scale for Prostate Cancer (MAX-PC) in order to facilitate the identification of prostate cancer-related anxiety. A revised version of this scale was tested in a more clinically varied population. Ambulatory men with prostate cancer (N=367) completed a baseline assessment packet that included the MAX-PC and other psychosocial questionnaires. The MAX-PC showed high internal consistency and concurrent and discriminant validity. Factor analysis identified three distinct factors for the MAX-PC that corresponded to the intended subscales (General Prostate Cancer Anxiety, PSA (prostate-specific antigen) Anxiety, and Fear of Recurrence). PSA levels were not correlated with anxiety overall; however, anxiety was significantly higher among patients whose PSA levels were changing (i.e., rising, falling, and unstable), versus those with stable PSA levels. Also, in a multivariate analysis, the change in PSA levels was a significant predictor of MAX-PC scores, but not Hospital Anxiety and Depression Scale (HADS) scores. These results indicate that the MAX-PC is a valid and reliable measure of anxiety that assesses aspects of anxiety unique to men with prostate cancer, and it may provide a more sensitive measure of anxiety than the HADS for this population.

### GAD & SERTRALINE

#### ▪ SERTRALINE TREATMENT FOR GENERALIZED ANXIETY DISORDER: A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY.

**Authors :** Brawman-Mintzer O, Knapp RG, Rynn M, Carter RE, Rickels K.

**Source :** *J Clin Psychiatry*. 2006 Jun;67(6):874-881. Related Articles, Links

**Objective:** This study assessed the efficacy and safety of sertraline in the treatment of generalized anxiety disorder (GAD). **Method:** The study was conducted from April 2000 to May 2002. Outpatients with DSM-IV GAD (N = 326) who satisfied inclusion/exclusion criteria and completed a 1-week screening phase were randomly assigned to 10-week double-blind treatment with flexible dosing of sertraline (50-200 mg/day) or placebo. The primary efficacy measure was change from baseline in Hamilton Rating Scale for Anxiety (HAM-A) total score. Response was defined as a 50% or greater decrease in HAM-A total score at endpoint. **RESULTS:** Sertraline produced a statistically significant reduction in anxiety symptoms, as measured by HAM-A total change scores ( $p = .032$ ), HAM-A psychic anxiety subscale ( $p = .011$ ), and Hospital Anxiety and Depression Scale-anxiety subscale ( $p = .001$ ). Response rates were significantly higher ( $p = .05$ ) for the sertraline group (59.2%) compared to the placebo group (48.2%). Sertraline was well tolerated, with only sexual side effects reported significantly more often by subjects receiving sertraline than those receiving placebo. **CONCLUSION:** Despite the relatively small between-group differences, study findings suggest a role for sertraline in the acute treatment of GAD.

placebo Nevertheless, this effect should be considered marginal since patients still meet the criteria of ED after treatment. Larger, parallel group studies are warranted.

## PTSD & SCI

### THE ROLE OF NEGATIVE COGNITIVE APPRAISALS IN PTSD SYMPTOMS FOLLOWING SPINAL CORD INJURIES

**Abstract :** This study aimed to investigate factors associated with persistent Post-Traumatic Stress Disorder (PTSD) in people with Spinal Cord Injury (SCI). In the context of a cognitive model, it sought to determine how influential cognitive appraisals were in predicting persistent PTSD when compared to other known predictor variables in the literature such as injury severity. A sample of 50 inpatients receiving rehabilitation for SCI who were 3–24 months post-injury were interviewed using a series of standardized measures of PTSD symptoms and diagnosis, post-traumatic cognitive appraisals, social support, and injury severity. For PTSD symptoms, significant relationships were found for greater injury severity, lower satisfaction with social support and more negative cognitions. Negative cognitions were found to predict variance in PTSD symptoms over and above the non-cognitive variables, although gender and injury severity were also predictors. The only significant predictor of PTSD diagnosis was the cognitive subscale "negative cognitions about the self". Cognitive appraisals were found to be important predictors of persisting PTSD in an SCI population. This supports the cognitive model of PTSD and the development of cognitive therapies for PTSD in this population.

**Keywords:** PTSD; cognitive appraisals; spinal cord injuries.

## EMDR & PTSD

### EYE MOVEMENT DESENSITIZATION AND REPROCESSING FOR POSTTRAUMATIC STRESS DISORDER: A PILOT BLINDED, RANDOMIZED STUDY OF STIMULATION TYPE.

**Authors :** Servan-Schreiber D, Schooler J, Dew MA, Carter C, Bartone P.

**Source :** Psychother Psychosom. 2006;75(5):290-7. Related Articles, Links

**Background:** Eye movement desensitization and reprocessing (EMDR) is becoming a recognized and accepted form of psychotherapy for posttraumatic stress disorder (PTSD). Yet, its mechanism of action remains unclear and much controversy exists about whether eye movements or other forms of bilateral kinesthetic stimulation contribute to its clinical effects beyond the exposure elements of the procedure. **METHODS:** Twenty-one patients with single-event PTSD (average Impact of Event Scale score: 49.5) received three consecutive sessions of EMDR with three different types of auditory and kinesthetic stimulation (tones and vibrations): intermittent alternating right-left (as commonly used with the standard EMDR protocol), intermittent simultaneous bilateral, and continuous bilateral. Therapists were blinded to the type of stimulation they delivered, and stimulation type assignment was randomized and counterbalanced. **RESULTS:** All three stimulation types resulted in clinically significant reductions of subjective units of distress (SUD). Yet, alternating stimulation resulted in faster reductions of SUD when only sessions starting with a new target memory were considered.

## POSTTRAUMATIC STRESS DISORDER (PTSD)

### Sildenafil, Erectile Dysfunction & PTSD

#### EFFECTIVENESS OF SILDENAFIL IN TREATING ERECTILE DYSFUNCTION IN PTSD PATIENTS: A DOUBLE-BLIND, PLACEBO-CONTROLLED CROSSOVER STUDY.

**Authors :** Orr G, Weiser M, Polliack M, Raviv G, Tadmor D, Grunhaus L.

**Source :** J Clin Psychopharmacol. 2006 Aug;26(4):426-30. Related Articles, Links

**Objective:** Post Traumatic Stress Disorder (PTSD) is known to be associated with Erectile Dysfunction (ED). Sildenafil citrate was shown to be effective treatment for ED among different clinical populations. However, to date, no placebo-controlled trial has assessed sildenafil's effectiveness for treating ED in PTSD patients. The goal of the present study was to address this question using a double-blind placebo controlled crossover design. **METHODS:** A four-week double-blind crossover trial of sildenafil (50 mg up to 100 mg per usage) versus placebo was conducted on 21 outpatients diagnosed with chronic PTSD accompanied by ED. Erectile function was assessed biweekly using the International Inventory of Erectile Function (IIEF). Depressive symptoms, PTSD symptoms and subjective well-being scores were assessed as well. **RESULTS:** Analysis of IIEF scores revealed a main effect of treatment phase ( $F = 33.361$ ,  $df = 2$ ,  $P < 0.000$ ). Pairwise comparisons showed that sildenafil IIEF scores (mean = 45.19 +/- 15.05) were significantly higher compared to baseline scores (mean = 20.00 +/- 12.32,  $P = 0.000$ ) and placebo scores (mean = 33.04 +/- 12.99). Compared to placebo, a significant improvement was also observed during the sildenafil phase in erectile function, orgasmic function and sexual desire. There was no significant change in depression, PTSD symptoms or subjective well-being. **CONCLUSION:** The results of this study suggest that sildenafil citrate treatment for ED in PTSD patients was accompanied with improvement of ED symptoms and was found to be significantly better than

**Conclusions:** There are clinically significant effects of the EMDR procedure that appear to be independent of the nature of the kinesthetic stimulation used. However, alternating stimulation may confer an additional benefit to the EMDR procedure that deserves attention in future studies.

## PTSD & Resilience

### RESILIENCE: RESEARCH EVIDENCE AND CONCEPTUAL CONSIDERATIONS FOR POSTTRAUMATIC STRESS DISORDER.

**Authors :** Hoge EA, Austin ED, Pollack MH.

**Source :** *Depress Anxiety*. 2006 Aug 4; [Epub ahead of print] Related Articles, Links

**Summary:** The growing recognition and occurrence of traumatic exposure in the general population has given increased salience to the need to understand the concept of resilience. More than just the "flip side" of a risk factor, the notion of resilience encompasses psychological and biological characteristics, intrinsic to an individual, that might be modifiable and that confer protection against the development of psychopathology in the face of stress. In this review, we provide some perspective on the concept of "resilience" by examining early use of the term in research on "children at risk" and discuss the relationship between risk and resilience factors. We then review psychological and biological factors that may confer resilience to the development of posttraumatic stress disorder (PTSD) following trauma, examine how resilience has been assessed and measured, and discuss issues to be addressed in furthering our understanding of this critical concept going forward. *Depression and Anxiety* 0:1-14, 2006. (c) 2006 Wiley-Liss, Inc.

## PTSD & DHEA

### CLINICAL CORRELATES OF DHEA ASSOCIATED WITH POST-TRAUMATIC STRESS DISORDER.

**Authors :** Yehuda R, Brand SR, Golier JA, Yang RK.

**Source :** *Acta Psychiatr Scand*. 2006 Sep;114(3):187-93. Related Articles, Links

**Summary:** Increased plasma dehydroepiandrosterone (DHEA) and dehydroepiandrosterone-sulfate (DHEAS) have been demonstrated in post-traumatic stress disorder (PTSD), but the documented beneficial effects of these steroids in enhancing mood and cognition, as well as neuroprotection, suggest their presence in PTSD may be associated with defensive rather than maladaptive effects. We, therefore, examined plasma DHEA, DHEAS, cortisol, and the DHEA/cortisol ratio in 40 male veterans with or without PTSD, and determined their relationships to PTSD symptom severity and symptom improvement.

The PTSD group showed significantly higher plasma DHEA and non-significantly higher DHEAS levels as well as a significantly lower cortisol/DHEA ratio, controlling for age. Regression analyses demonstrated that DHEA and DHEAS levels could be predicted by symptom improvement and coping whereas the cortisol/DHEA ratio was predicted by severity of childhood trauma and current symptom severity. That greater symptom improvement was related to DHEA levels may suggest for a role for these hormones in modulating recovery from PTSD.

## GABA PLASMA & PTSD

### RELATIONSHIP BETWEEN POSTTRAUMA GABA PLASMA LEVELS AND PTSD AT 1-YEAR FOLLOW-UP.

**Authors :** Vaiva G, Boss V, Ducrocq F, Fontaine M, Devos P, Brunet A, Laffargue P, Goudemand M, Thomas P.

**Source :** *Am J Psychiatry*. 2006 Aug;163(8):1446-8. Related Articles, Links

**Objective:** Gamma-aminobutyric acid (GABA) exerts a prominent effect on central adrenergic stress responses in times of high stress and has been associated with acute posttraumatic stress disorder (PTSD). The authors examined the association between low posttrauma plasma GABA levels and long-term PTSD.

**METHOD:** Plasma GABA levels were measured in 78 victims of road traffic accidents who met criteria for trauma exposure on arrival at a trauma department and were admitted for at least 3 days. Patients were assessed for PTSD and major depressive disorder at 6-week and 1-year follow-ups.

**RESULTS:** At 6 weeks and at 1 year, mean posttrauma GABA levels were significantly lower among subjects who met all or nearly all criteria for PTSD than among those who did not. Among patients who met all or nearly all criteria for PTSD at 6 weeks, 75% of those with posttrauma GABA levels above 0.20 mmol/ml no longer met criteria at 1 year. By contrast, among patients whose GABA levels were below 0.20 mmol/ml, 80% met all or nearly all criteria for PTSD at 1 year. Two-thirds of patients who met all or nearly all criteria for PTSD at 1 year also met criteria for major depressive disorder. **CONCLUSIONS:** A plasma GABA level above 0.20 mmol/ml may protect against chronic PTSD and may represent a marker of recovery from trauma.

## Panic Disorder (PD)

## Panic Attacks & RTMS

### EFFECTS OF REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) ON PANIC ATTACKS INDUCED BY CHOLECYSTOKININ-TETRAPEPTIDE (CCK-4).

**Authors :** Zwanzger P, Eser D, Volkel N, Baghai TC, Moller HJ, Rupprecht R, Padberg F.

**Source :** *Int J Neuropsychopharmacol*. 2006 Jul 3;:1-5 [Epub ahead of print] Related Articles, Links

**Summary:** Low-frequency (LF) rTMS shows beneficial effects in patients with depression and anxiety disorders. To explore its anxiolytic properties we investigated the effects of rTMS on experimentally induced panic attacks. Eleven healthy subjects underwent 1 Hz rTMS or sham rTMS over the right dorsolateral prefrontal cortex in a randomized cross-over protocol. Panic induction with 50 µg CCK-4 was carried out immediately after rTMS. Response to CCK-4 was assessed using the Acute Panic Inventory and the Panic Symptom Scale and measurements of heart rate, plasma ACTH and cortisol. All subjects reported a marked panic response following CCK-4 administration after both real and sham rTMS. Moreover, injection of CCK-4 induced a marked increase in heart rate, cortisol and ACTH concentrations. However, ANOVA showed no significant differences in any of the measures between both conditions. In contrast to the effects of pretreatment with alprazolam on CCK-4-induced panic in healthy subjects LF rTMS does not affect

CCK-4-induced panic and cortisol or ACTH release.

## DEPRESSION & CHRONIC PAIN

### ▪ PAIN AND DEPRESSION IN AGING INDIVIDUALS

**Authors :** Lucia Gagliese, PhD, CIHR

**Source :** Originally published in: Volume 9, Number 6, June 2006, Pages 403-407

**Summary:** Depression is highly prevalent among older adults with chronic pain living both in community and institutional settings. It is associated with decreased quality of life, including impairments in physical and social well-being. This article reviews the relationship between pain and depression. The potential mediating role of disability, life interference, and perceived control are described. Routine assessment of both pain and mood, using scales validated for this age group, is advocated. Finally, the importance of integrating pharmacological and psychological interventions for the management of pain and depression in the older adult is highlighted.

**Keywords:** chronic pain, depression, mood disturbance, assessment, management.

## VENLAFAXINE, PAROXETINE & PD

### ▪ A DOUBLE-BLIND STUDY OF THE EFFICACY OF VENLAFAXINE EXTENDED-RELEASE, PAROXETINE, AND PLACEBO IN THE TREATMENT OF PANIC DISORDER.

**Authors :** Pollack MH, Lepola U, Koponen H, Simon NM, Worthington JJ, Emilien G, Tzanis E, Salinas E, Whitaker T, Gao B.

**Source :** *Depress Anxiety*. 2006 Aug 7; [Epub ahead of print] Related Articles, Links

**Summary:** To date, no large-scale, controlled trial comparing a serotonin-norepinephrine reuptake inhibitor and selective serotonin reuptake inhibitor with placebo for the treatment of panic disorder has been reported. This double-blind study compares the efficacy of venlafaxine extended-release (ER) and paroxetine with placebo. A total of 664 nondepressed adult outpatients who met DSM-IV criteria for panic disorder (with or without agoraphobia) were randomly assigned to 12 weeks of treatment with placebo or fixed-dose venlafaxine ER (75 mg/day or 150 mg/day), or paroxetine 40 mg/day. The primary measure was the percentage of patients free from full-symptom panic attacks, assessed with the Panic and Anticipatory Anxiety Scale (PAAS). Secondary measures included the Panic Disorder Severity Scale, Clinical Global Impressions-Severity (CGI-S) and -Improvement (CGI-I) scales; response (CGI-I rating of very much improved or much improved), remission (CGI-S rating of not at all ill or borderline ill and no PAAS full-symptom panic attacks); and measures of depression, anxiety, phobic fear and avoidance, anticipatory anxiety, functioning, and quality of life. Intent-to-treat, last observation carried forward analysis showed that mean improvement on most measures was greater with venlafaxine ER or paroxetine than with placebo. No significant differences were observed between active treatment groups. Panic-free rates at end point with active treatment ranged from 54% to 61%, compared with 35% for placebo. Approximately 75% of patients given active treatment were responders, and nearly 45% achieved remission. The placebo response rate was 45% achieved remission. The placebo response rate was

slightly above 55%, with remission near 25%. Adverse events were mild or moderate and similar between active treatment groups. Venlafaxine ER and paroxetine were effective and well tolerated in the treatment of panic disorder. *Depression and Anxiety* 0:1-14, 2006. (c) 2006 Wiley-Liss, Inc.

## ATTENTIONAL BIAS, PD & SP

### ▪ ATTENTIONAL DISRUPTION IN THE PRESENCE OF NEGATIVE AUTOMATIC THOUGHTS

**Abstract:** The present study examined attentional disruption in the presence of negative automatic thoughts specific to panic and social anxiety. Participants with panic disorder ( $n = 18$ ), participants with social phobia ( $n = 19$ ), and nonanxious participants ( $n = 19$ ) completed a dichotic listening task in which they shadowed ambiguous passages heard in their dominant ear while ignoring lists of panic-related, social anxiety-related, or control automatic thoughts that were presented in their non-dominant ear. In addition, they completed a simultaneous simple reaction time task. Both patient groups made more shadowing distortions than the nonanxious group. Panic participants committed more shadowing omissions in trials in which they heard panic-related automatic thoughts as compared to trials in which they heard other automatic thoughts. Results suggest that both patient groups experienced some disruption on this demanding task but that only panic patients exhibited an anxiety-specific attentional bias.

**Keywords:** Attentional bias; dichotic listening; panic disorder; social phobia; cognition.

## CEREBRAL GLUCOSE, PD & CBT

### ▪ CHANGES IN CEREBRAL GLUCOSE UTILIZATION IN PATIENTS WITH PANIC DISORDER TREATED WITH COGNITIVE-BEHAVIORAL THERAPY.

**Authors :** Sakai Y, Kumano H, Nishikawa M, Sakano Y, Kaiya H, Imabayashi E, Ohnishi T, Matsuda H, Yasuda A, Sato A, Diksic M, Kuboki T.

**Source :** *Neuroimage*. 2006 Aug 2; [Epub ahead of print] Related Articles, Links

**Summary:** Several neuroanatomical hypotheses of panic disorder have been proposed focusing on the significant role of the amygdala and PAG-related "panic neurocircuitry." Although cognitive-behavioral therapy is effective in patients with panic disorder, its therapeutic mechanism of action in the brain remains unclear. The present study was performed to investigate regional brain glucose metabolic changes associated with successful completion of cognitive-behavioral therapy in panic disorder patients. The regional glucose utilization in patients with panic disorder was compared before and after cognitive-behavioral therapy using positron emission tomography with (18)F-fluorodeoxyglucose. In 11 of 12 patients who showed improvement after cognitive-behavioral therapy, decreased glucose utilization was detected in the right hippocampus, left anterior cingulate, left cerebellum, and pons, whereas increased glucose utilization was seen in the bilateral medial prefrontal cortices. Significant correlations were found between the percent change relative to the pretreatment value of glucose utilization in the left medial prefrontal cortex and those of anxiety and agoraphobia-related subscale of the Panic Disorder Severity Scale, and between that of the midbrain and

that of the number of panic attacks during the 4 weeks before each scan in all 12 patients. The completion of successful cognitive-behavioral therapy involved not only reduction of the baseline hyperactivity in several brain areas but also adaptive metabolic changes of the bilateral medial prefrontal cortices in panic disorder patients

### TEMPERAMENT, PD & SSRI

#### THE EFFECT OF TEMPERAMENT AND CHARACTER ON RESPONSE TO SELECTIVE SEROTONIN REUPTAKE INHIBITORS IN PANIC DISORDER.

**Authors :** Marchesi C, Cantoni A, Fonto S, Giannelli MR, Maggini C.

**Source :** Acta Psychiatr Scand. 2006 Sep;114(3):203-10. Related Articles, Links

**Summary:** In this prospective study, temperament and character were evaluated in patients with panic disorder (PD), before 1 year of medication therapy, to verify whether these factors influenced the outcome of treatment. Seventy-one PD patients were evaluated with the SCID-IV, the Temperament and Character Inventory (TCI), the SCL-90, the Ham-A and the Ham-D. Patients were treated with pharmacotherapy and were evaluated monthly over 1 year. Before treatment, non-remitted patients showed higher levels of harm avoidance (HA) and lower levels of persistence (P), self-directedness (SD) and cooperativeness (C), whereas remitted patients showed only higher levels of HA. After controlling the effect of the confounding variables, the likelihood to achieve remission was positively related to SD score (OR = 1.12; P = 0.002), particularly 'self-acceptance' SD dimension (OR = 1.30; P = 0.02). Our data suggest that in PD: i) the evaluation of personality, using the Cloninger's model, confirms the presence of personality pathology as one predictor of non-response to treatment; ii) in patients with low SD a combination of medication and cognitive-behaviour therapy should be the most effective treatment.

### PANIC ATTACKS & ADDICTION

#### PANIC ATTACKS, PANIC DISORDER, AND AGORAPHOBIA: ASSOCIATIONS WITH SUBSTANCE USE, ABUSE, AND DEPENDENCE.

**Authors :** Zvolensky MJ, Bernstein A, Marshall EC, Feldner MT.

**Source :** Curr Psychiatry Rep. 2006 Aug;8(4):279-85. Related Articles, Links

**Summary:** Anxiety and substance use disorders frequently occur. Despite the clinical importance of this co-occurrence, theory and research addressing the relations between anxiety-substance use disorder comorbidity remain limited. The present commentary is intended to briefly review and summarize key aspects of this literature, with a specific focus on panic-spectrum psychopathology (panic attacks, panic disorder, and agoraphobia) and its associations with tobacco, alcohol, and marijuana use, abuse, and dependence. A heuristic theoretical model for better understanding the panic-substance use relations also is offered. Extant data suggest clinically meaningful bidirectional associations are evident between panic problems and premorbid risk factors for such problems and various forms of tobacco, alcohol, and marijuana use. Key clinical implications and future directions

are outlined based upon the review.

### AFFECTIVE PROCESSING & DECISION-MAKING & PD

#### DIFFERENTIAL PERFORMANCE ON TASKS OF AFFECTIVE PROCESSING AND DECISION-MAKING IN PATIENTS WITH PANIC DISORDER AND PANIC DISORDER WITH COMORBID MAJOR DEPRESSIVE DISORDER.

**Authors :** Kaplan JS, Erickson K, Luckenbaugh DA, Weiland-Fiedler P, Geraci M, Sahakian BJ, Charney D, Drevets WC, Neumeister A.

**Source :** J Affect Disord. 2006 Jun 19; [Epub ahead of print] Related Articles, Links

**Summary:** Neuropsychological studies have provided evidence for deficits in psychiatric disorders, such as schizophrenia and mood disorders. However, neuropsychological function in Panic Disorder (PD) or PD with a comorbid diagnosis of Major Depressive Disorder (MDD) has not been comprehensively studied. The present study investigated neuropsychological functioning in patients with PD and PD + MDD by focusing on tasks that assess attention, psychomotor speed, executive function, decision-making, and affective processing. **METHODS:** Twenty-two unmedicated patients with PD, eleven of whom had a secondary diagnosis of MDD, were compared to twenty-two healthy controls, matched for gender, age, and intelligence on tasks of attention, memory, psychomotor speed, executive function, decision-making, and affective processing from the Cambridge Neuropsychological Test Automated Battery (CANTAB), Cambridge Gamble Task, and Affective Go/No-go Task. **RESULTS:** Relative to matched healthy controls, patients with PD + MDD displayed an attentional bias toward negatively-valenced verbal stimuli (Affective Go/No-go Task) and longer decision-making latencies (Cambridge Gamble Task). Furthermore, the PD + MDD group committed more errors on a task of memory and visual discrimination compared to their controls. In contrast, no group differences were found for PD patients relative to matched control subjects. **LIMITATIONS:** The sample size was limited, however, all patients were drug-free at the time of testing. **Conclusions:** The PD + MDD patients demonstrated deficits on a task involving visual discrimination and working memory, and an attentional bias towards negatively-valenced stimuli. In addition, patients with comorbid depression provided qualitatively different responses in the areas of affective and decision-making processes.

### PANIC DISORDER & CBT

#### POVERTY AND RESPONSE TO TREATMENT AMONG PANIC DISORDER PATIENTS IN PRIMARY CARE.

**Authors :** Roy-Byrne P, Sherbourne C, Miranda J, Stein M, Craske M, Golinelli D, Sullivan G.

**Source :** Am J Psychiatry. 2006 Aug;163(8):1419-25. Related Articles, Links

**Objective:** Despite well-established links between poverty and poor mental illness outcome as well as recent reports exploring racial and ethnic health disparities, little is known about the outcomes of evidence-based psychiatric treatment for poor individuals. **METHOD:** Primary care patients with panic disorder (N=232) who were participating in a randomized controlled trial comparing a cognitive behavior therapy (CBT) and pharmacotherapy intervention to usual care were divided into

those patients above (N=152) and below (N=80) the poverty line. Telephone assessments at 3, 6, 9, and 12 months were used to compare the amount of evidence-based care received as well as clinical and functional outcomes. RESULTS: Poor subjects were more severely ill at baseline, with more medical and psychiatric comorbidity. The increases in the amount of evidence-based care and reductions in clinical symptoms and disability were comparable in the two groups such that poorer individuals, although responding equivalently, continued to be more ill and disabled at 12 months. CONCLUSIONS: The comparable response of poor individuals in this study suggests that standard CBT and pharmacotherapy treatments for panic disorder do not need to be "tailored" to be effective in poor populations. However, the more severe illness both at baseline and follow-up in these poor individuals suggests that treatment programs may need to be extended in order to treat residual symptoms and disability in these patients so that they might achieve comparable levels of remission.

(Hospital Anxiety and Depression Scale, HADS), general quality of life (Short Form 12 Health Survey Questionnaire, SF-12) and asthmatic-specific quality of life (Living with Asthma, LAQ). RESULTS: While no considerable associations between anxiety and health care use were found, the associations between higher scores in depression and hospital visits as well as days of corticosteroid intake were significant. Furthermore, considerable variance in all subscales of quality of life questionnaires was explained by higher scores in depression, even when controlling for anxiety. For anxiety scores these associations were comparable, except for physical well-being. CONCLUSION: Depression is an important issue in asthma, as it is substantially related to quality of life and intake of corticosteroids, and marginally to hospitalization. Routine screening for depression should be considered in hospital and primary care.

### ACUTE STRESS & REWARD RESPONSIVENESS

#### ■ ACUTE STRESS REDUCES REWARD RESPONSIVENESS: IMPLICATIONS FOR DEPRESSION.

*Authors* : Bogdan R, Pizzagalli DA.

*Source* : Biol Psychiatry. 2006 Jun 23; [Epub ahead of print] Related Articles, Links

*Background*: Stress, one of the strongest risk factors for depression, has been linked to "anhedonic" behavior and dysfunctional reward-related neural circuitry in preclinical models.

*Methods*: To test if acute stress reduces reward responsiveness (i.e., the ability to modulate behavior as a function of past reward), a signal-detection task coupled with a differential reinforcement schedule was utilized. Eighty female participants completed the task under both a stress condition, either threat-of-shock (n = 38) or negative performance feedback (n = 42), and a no-stress condition.

*Results*: Stress increased negative affect and anxiety. As hypothesized based on preclinical findings, stress, particularly the threat-of-shock condition, impaired reward responsiveness. Regression analyses indicate that self-report measures of anhedonia predicted stress-induced hedonic deficits even after controlling for anxiety symptoms.

*Conclusions*: These findings indicate that acute stress reduces reward responsiveness, particularly in individuals with anhedonic symptoms. Stress-induced hedonic deficit is a promising candidate mechanism linking stressful experiences to depression.

### STRESS & Multiple Sclerosis

#### ■ RELATIONSHIP BETWEEN STRESS AND RELAPSE IN MULTIPLE SCLEROSIS: PART II. DIRECT AND INDIRECT RELATIONSHIPS.

*Authors* : Brown RF, Tennant CC, Sharrock M, Hodgkinson S, Dunn SM, Pollard JD.

*Source* : Mult Scler. 2006 Aug;12(4):465-75. Related Articles, Links

*Objective*: The aim of this two-year prospective study was to determine which factors were: (i) directly related and/or (ii) indirectly related to multiple sclerosis (MS) relapse. These factors included life-event stressors, disease, demographic, psychosocial and lifestyle factors. BACKGROUND: Relatively little attention has been paid to the role of non-clinical relapse

## ANXIETY DISORDERS

### COPD & ANXIETY OR DEPRESSION

#### ■ QUALITY OF LIFE IN PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND COMORBID ANXIETY OR DEPRESSION.

*Authors* : Cully JA, Graham DP, Stanley MA, Ferguson CJ, Sharafkhaneh A, Soucek J, Kunik ME.

*Source* : Psychosomatics. 2006 Jul-Aug;47(4):312-9. Related Articles, Links

*Summary*: The authors examined 179 veterans with chronic obstructive pulmonary disease (COPD) to determine the relative contribution of clinical depression and/or anxiety (Beck Depression and Beck Anxiety Inventories) to their quality of life (Chronic Respiratory Questionnaire and Medical Outcomes Survey Short Form). Multiple-regression procedures found that both depression and anxiety were significantly related to negative quality-of-life outcomes (anxiety with both mental and physical health quality-of-life outcomes, and depression primarily with mental health). When comorbid with COPD, mental health symptoms of depression and anxiety are some of the most salient factors associated with quality-of-life outcomes.

### DEPRESSION ANXIETY & ASTHMA PATIENTS

#### ■ ASSOCIATION OF DEPRESSION AND ANXIETY WITH HEALTH CARE USE AND QUALITY OF LIFE IN ASTHMA PATIENTS.

*Authors* : Kullowatz A, Kanniess F, Dahme B, Magnussen H, Ritz T.

*Source* : Respir Med. 2006 Aug 4; [Epub ahead of print] Related Articles, Links

*Introduction*: Demographic factors, symptom severity, and psychopathology, in particular anxiety and depression, are known to influence health care use and quality of life in asthma. Because depression and anxiety are typically correlated, we sought to explore whether depression specifically is associated with health care utilization and quality of life when effects of anxiety are controlled for. METHOD: In a cross-sectional questionnaire study, 88 asthma patients (46 women; age range 27-70 years) reported on symptoms and treatment of their disease, as well as anxiety and depression

predictors (other than stressful life-events) in MS, or factors that indirectly impact on the stress-relapse relationship. **METHODS:** A total of 101 consecutive participants with MS were recruited from two MS clinics in Sydney, Australia. Stressful life-events, depression, anxiety and fatigue were assessed at study-entry and at three-monthly intervals for two years. Disease, demographic, psychosocial and lifestyle factors were assessed at baseline. Patient-reported relapses were recorded and corroborated by neurologists or evaluated against accepted relapse criteria. **RESULTS:** MS relapse was predicted by acute stressor frequency counts, coping responses that utilized social support, and being born in Australia, but not by chronic stressors, disease, demographic, psychosocial or lifestyle factors. No factors were found to indirectly impact on the stress relapse relationship.

**Conclusions:** The number rather than severity of stressors was most important in relation to MS relapse risk, along with coping responses that utilized social support, suggesting that MS patients should avoid situations that are likely to generate multiple stressors or which provide few avenues for social support.

## STRESS & Multiple Sclerosis

### RELATIONSHIP BETWEEN STRESS AND RELAPSE IN MULTIPLE SCLEROSIS: PART I. IMPORTANT FEATURES.

**Authors :** Brown RF, Tennant CC, Sharrock M, Hodgkinson S, Dunn SM, Pollard JD.

**Source :** Mult Scler. 2006 Aug;12(4):453-64. Related Articles, Links

**Objective:** The aim of this two-year prospective study was to examine the relationship between multiple aspects of life-event stress and relapse in multiple sclerosis (MS) patients. **Background:** Few studies have defined the critical features of this life-event stress; for example, stressor duration, frequency, severity, disease-dependency, valency, or stressor constructs, such as the propensity to cause emotional distress/threat or the frustration of life goals. **METHODS:** 101 consecutive participants with MS were recruited from two MS clinics in Sydney, Australia. Stressful life events were assessed at study-entry and at three-monthly intervals for two years. Patient-reported relapses were recorded and corroborated by neurologists or evaluated against accepted relapse criteria. **RESULTS:** Acute events, but not chronic difficulties (CDs), predicted relapse occurrence: acute stressor frequency counts predicted greater relapse risk, along with low disability score (EDSS) and being male. We also confirmed the bi-directional stress-illness hypothesis: stressors predicted relapse, and relapse separately predicted stressors.

**Conclusions:** Life-event stress impacts to a small degree on MS relapse. The number and not the severity of acute stressors are most important; chronic stressors do not predict later relapse. Males and those with early stage disease are also at greater risk of relapse. MS patients should be encouraged to reduce acute stressors during times of high stress, and feel reassured that disease-related chronic stressors do not increase their relapse risk.

## Coping, Adolescence & SPA

### COPING WITH SOCIAL PHYSIQUE ANXIETY IN ADOLESCENCE.

**Authors :** Kowalski KC, Mack DE, Crocker PR, Niefer CB

Fleming TL.

**Source :** J Adolesc Health. 2006 Aug;39(2):275.e9-16. Related Articles, Links

**Summary:** To explore how adolescents cope with social physique anxiety. **METHODS:** Participants were 398 female (mean age of 15.4 years, SD = 1.3) and 223 male (mean age of 15.4 years, SD = 1.1) adolescents who provided open-ended responses to a self-identified situation in which they experienced social physique anxiety. A codebook of 24 dimensions was developed to code participants' coping strategies. Measures of state and trait social physique anxiety and coping function were also completed. **RESULTS:** Females had significantly higher mean values than males on social physique anxiety scales and emotion-focused coping function. Females reported a total of 1051 strategies and males reported 473 coping strategies. The most commonly reported coping strategies were behavioral avoidance (reported by 41.5% of females and 33.2% of males), appearance management (39.9% females, 24.4% males), social support (22.1% females, 17.1% males), cognitive avoidance (20.4% females, 18.7% males), and acceptance (19.6% females, 29.0% males). Social physique anxiety in the self-identified situation was related to both trait social physique anxiety ( $r = .44$ , females;  $r = .36$ , males) and the number of strategies reported ( $r = .21$ , females;  $r = .23$ , males). **CONCLUSIONS:** First, this study provides important insight into the wide range of cognitive and behavioral coping strategies adolescents use to manage social physique anxiety. Second, the development of the codebook that was necessary to code the adolescents' open-ended coping responses has the potential to act as a starting point as a taxonomy for coping in the body domain.

## ACUTE PSYCHOLOGIC STRESS & RECTAL MUCOSAL

### THE EFFECT OF ACUTE PSYCHOLOGIC STRESS ON SYSTEMIC AND RECTAL MUCOSAL MEASURES OF INFLAMMATION IN ULCERATIVE COLITIS.

**Authors :** Mawdsley JE, Macey MG, Feakins RM, Langmead L, Rampton DS.

**Source :** Gastroenterology. 2006 Aug;131(2):410-9. Related Articles, Links

**Background & Aims:** Recent studies suggest that life events and chronic stress increase the risk of relapse in inflammatory bowel disease. Our aim was to study the effects of acute psychologic stress on systemic and rectal mucosal inflammatory responses in patients with inactive ulcerative colitis (UC). **METHODS:** Twenty-five patients with inactive UC and 11 healthy volunteers (HV) underwent an experimental stress test. Ten patients with UC and 11 HV underwent a control procedure. Before and after each procedure, systemic inflammatory response was assessed by serum interleukin (IL)-6 and IL-13 concentrations, tumor necrosis factor (TNF)-alpha and IL-6 production by lipopolysaccharide (LPS)-stimulated whole blood, leukocyte count, natural killer (NK) cell numbers, platelet activation, and platelet-leukocyte aggregate (PLA) formation. In patients with UC, rectal mucosal inflammation was assessed by TNF-alpha, IL-13, histamine and substance P release, reactive oxygen metabolite (ROM) production, mucosal blood flow (RMBF) and histology. **RESULTS:** Stress increased pulse ( $P < .0001$ ) and systolic BP ( $P < .0001$ ). In UC, stress increased LPS-stimulated TNF-alpha and IL-6 production by 54% ( $P = .004$ ) and 11% ( $P = .04$ ), respectively, leukocyte count by 16% ( $P = .01$ ), NK cell count by 18% ( $P = .0008$ ), platelet activation by

65% ( $P < .0001$ ), PLA formation by 25% ( $P = .004$ ), mucosal TNF-alpha release by 102% ( $P = .03$ ), and ROM production by 475% ( $P = .001$ ) and reduced rectal mucosal blood flow by 22% ( $P = .05$ ). The control protocol did not change any of the variables measured. There were no differences between the responses of the patients with UC and HV.

**Conclusions:** Acute psychologic stress induces systemic and mucosal proinflammatory responses, which could contribute to exacerbations of UC in ordinary life.

## PERSONALITY & ANXIETY DISORDERS

### PERSONALITY AND ANXIETY DISORDERS.

**Authors :** Johns Hopkins

**Source :** Curr Psychiatry Rep. 2006 Aug;8(4):263-9. Related Articles, Links

**Summary:** Personality traits and most anxiety disorders are strongly related. In this article, we review existing evidence for ways in which personality traits may relate to anxiety disorders: 1) as predisposing factors, 2) as consequences, 3) as results of common etiologies, and 4) as pathoplastic factors. Based on current information, we conclude the following: 1) Personality traits such as high neuroticism, low extraversion, and personality disorder traits (particularly those from Cluster C) are at least markers of risk for certain anxiety disorders; 2) Remission from panic disorder is generally associated with partial "normalization" of personality traits; 3) Anxiety disorders in early life may influence personality development; 4) Anxiety disorders and personality traits are usefully thought of as spectra of common genetic etiologies; and 5) Extremes of personality traits indicate greater dysfunction in patients with anxiety disorders.

## ANXIETY DISORDERS & SERTRALINE

### A RANDOMIZED, CONTROLLED TRIAL OF THE EFFECTIVENESS OF COGNITIVE-BEHAVIORAL THERAPY AND SERTRALINE VERSUS A WAITLIST CONTROL GROUP FOR ANXIETY DISORDERS IN OLDER ADULTS.

**Authors :** Schuurmans J, Comijs H, Emmelkamp PM, Gundy CM, Weijnen I, van den Hout M, van Dyck R.

**Source :** Am J Geriatr Psychiatry. 2006 Mar;14(3):255-63. Related Articles, Links

**Objective:** This study is the first to investigate the relative effectiveness of cognitive-behavioral therapy (CBT) compared with a selective serotonin reuptake inhibitor (SSRI; sertraline) in a randomized, controlled trial on the treatment of anxiety disorders in older adults. **METHOD:** Eighty-four patients 60 years of age and over with a principal diagnosis of generalized anxiety disorder, panic disorder, agoraphobia, or social phobia were randomly assigned to one of three conditions: 15 sessions of CBT, pharmacologic treatment with an SSRI (sertraline; maximum dosage 150 mg), or a waitlist control group. Participants completed measures of primary outcome (anxiety) and coexistent worry and depressive symptoms at baseline, posttreatment, and at three-month follow up. **RESULTS:** Attrition rates were high in both treatment groups. Consequently, findings are based on a relatively small sample of completers ( $N = 52$ ). Although both CBT and sertraline led

to significant improvement in anxiety, worry, and depressive symptoms both at posttreatment and at three-month follow up, sertraline showed superior results on worry symptoms. Effect size estimates for CBT were in the small to medium range both at posttreatment (mean  $d = 0.42$ ) and at three-month follow up (mean  $d = 0.35$ ), whereas effect sizes for sertraline fell into the large range (posttreatment mean  $d = 0.94$  and three-month follow up mean  $d = 1.02$ ). The waitlist condition showed virtually no effects (posttreatment mean  $d = .03$ ).

**Conclusions:** Our findings strongly suggest that the pharmacologic treatment of late-life anxiety with SSRIs has not been given the proper attention in research to date.

## PREOPERATIVE ANXIETY & CHILDREN

### PREOPERATIVE ANXIETY, POSTOPERATIVE PAIN, AND BEHAVIORAL RECOVERY IN YOUNG CHILDREN UNDERGOING SURGERY.

**Authors :** Kain ZN, Mayes LC, Caldwell-Andrews AA, Karas DE, McClain BC.

**Source :** Pediatrics. 2006 Aug;118(2):651-8. Related Articles, Links

**Objective:** Findings from published studies suggest that the postoperative recovery process is more painful, slower, and more complicated in adult patients who had high levels of preoperative anxiety. To date, no similar investigation has ever been conducted in young children.

**METHODS:** We recruited 241 children aged 5 to 12 years scheduled to undergo elective outpatient tonsillectomy and adenoidectomy. Before surgery, we assessed child and parental situational anxiety and temperament. After surgery, all subjects were admitted to a research unit in which postoperative pain and analgesic consumption were assessed every 3 hours. After 24 hours in the hospital, children were discharged and followed up at home for the next 14 days. Pain management at home was standardized.

**RESULTS:** Parental assessment of pain in their child showed that anxious children experienced significantly more pain both during the hospital stay and over the first 3 days at home. During home recovery, anxious children also consumed, on average, significantly more codeine and acetaminophen compared with the children who were not anxious. Anxious children also had a higher incidence of emergence delirium compared with the children who were not anxious (9.7% vs 1.5%) and had a higher incidence of postoperative anxiety and sleep problems.

**Conclusions:** Preoperative anxiety in young children undergoing surgery is associated with a more painful postoperative recovery and a higher incidence of sleep and other problems.

## SAD & CHART REVIEW STUDY

### CLINICAL FEATURES AND TREATMENT OUTCOME IN JAPANESE PATIENTS WITH SOCIAL ANXIETY DISORDER: CHART REVIEW STUDY.

**Authors :** Shindo M, Shioiri T, Kuwabara H, Maruyama M, Tamura R, Someya T.

**Source :** Psychiatry Clin Neurosci. 2006 Aug;60(4):410-6. Related Articles, Links

**Summary:** The lifetime prevalence of social anxiety disorder (SAD) is high at 3-13%, but there have been only limited reports

investigating the clinical features of this disorder in a large number of Japanese patients. The authors have conducted a retrospective, chart review study of 52 patients with SAD and obtained the following results. (i) The proportion of SAD in first visit outpatients at the Department of Psychiatry, Niigata University Medical and Dental Hospital, Niigata, Japan, was 1.04%. The male : female ratio was 1:0.73, so male patients appeared to be more common in the sample. (ii) With regard to subtype, generalized type (73% of the patients) was more common than non-generalized type (27%). (iii) The mean age of onset was 18.6 +/- 7.8 years, and there was a trend towards onset of disease at a younger age in the generalized type compared to the non-generalized type. (iv) The most common chief complaint was anxiety and tension in front of others (40.4%). (v) Pharmacotherapy resulted in improvement in 63.5% of the patients. Treatment by fluvoxamine and alprazolam resulted in high response rates of more than 70%.

### ANXIETY & EXTERNALIZING DISORDERS

#### ▪ RELATIONSHIPS BETWEEN ANXIETY AND EXTERNALIZING DISORDERS IN YOUTH: THE INFLUENCES OF AGE AND GENDER.

*Authors* : Marmorstein NR.

*Source* : J Anxiety Disord. 2006 Jul 26; [Epub ahead of print] Related Articles, Links

*Summary*: Minimal information about the relationship between anxiety disorders and externalizing disorders in youth is available. This study examined relationships between different specific anxiety and externalizing disorders and examined whether these associations varied by age and gender. The Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) data set, consisting of youth from ages 9 to 17 recruited at four sites across the United States using a probability sampling method, was used. Results indicated that all externalizing disorders (attention-deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder) were positively related to a range of anxiety disorders. The magnitude of these associations tended to be stronger for males than for females (particularly for associations between social phobia and all externalizing disorders) and at younger, compared to older, ages (particularly for the association between oppositional defiant disorder and overanxious disorder). The cross-sectional positive relationships between externalizing and anxiety disorders vary somewhat based on gender, age, and which specific pair of disorders is examined; this may help explain the discrepant findings of previous research in this area.

### ANXIETY & PRIMARY CARE

#### ▪ ANXIETY IN PRIMARY CARE.

*Authors* : Demertzis KH, Craske MG.

*Source* : Curr Psychiatry Rep. 2006 Aug;8(4):291-7. Related Articles, Links

*Summary*: Anxiety disorders are common within primary care (PC) settings and are associated with patient functional impairment, distress, and high utilization of medical care services. Data from PC settings indicate that detection of anxiety disorders is low. Furthermore, adequate psychosocial and pharmacologic treatment of anxiety disorders in accordance with empirically validated guidelines

remains low in PC. When patients do receive treatment or referrals from their PC providers, a bias exists for pharmacologic over psychological interventions despite theoretical strengths, empirical evidence, and long-term cost efficiency supporting the use of psychotherapeutic interventions such as cognitive-behavioral therapy (CBT). Objectives of this article include increasing awareness of the prevalence of anxiety disorders in PC, impairment associated with anxiety disorders, issues of detection of anxiety in PC, treatment model and components of CBT, and data supporting the application of CBT to PC to improve patient functioning.

### ANXIETY DISORDERS

#### ▪ NEUROPROTEOMICS: RELEVANCE TO ANXIETY DISORDERS.

*Authors* : Uys JD, Stein DJ, Daniels WM.

*Source* : Curr Psychiatry Rep. 2006 Aug;8(4):286-90. Related Articles, Links

*Summary*: Despite advances in the treatment of anxiety disorders, there is a need for medications with greater efficacy and fewer side effects. Advances in techniques to facilitate high throughput, mass analysis of proteins potentially allows for new drug targets, with a shift in focus from membrane receptor proteins and enzymes of neurotransmitter metabolism to molecules in intracellular signal transduction and other pathways. A computerized literature search was done to collect studies on recently developed proteomic techniques and their application in psychiatric research. Particular techniques, such as two-dimensional electrophoresis, two-dimensional differential gel electrophoresis, isotope-coded affinity tags, and isotope tags for relative and absolute quantification, are reviewed. In addition, a combination of these techniques with MALDI-TOF/TOF and ESI-Q-TOF mass spectrometry analysis is discussed in relation to possible novel signaling pathways relevant to anxiety disorders, and to the development of biomarkers for the evaluation of these conditions.

### ANXIETY, DEPRESSION & RUMINATION

#### ▪ SOCIAL ANXIETY, DEPRESSIVE SYMPTOMS, AND POST-EVENT RUMINATION: AFFECTIVE CONSEQUENCES AND SOCIAL CONTEXTUAL INFLUENCES.

*Authors* : Kashdan TB, Roberts JE.

*Source* : J Anxiety Disord. 2006 Jul 19; [Epub ahead of print] Related Articles, Links

*Summary*: Using a self-presentation perspective, we hypothesized that during social interactions in which social attractiveness could be easily appraised by others, more socially anxious individuals would be more prone to ruminate and rumination would have more adverse emotional consequences. After assessing social anxiety and depressive symptoms, unacquainted college students participated in 45-min structured social interactions manipulated to induce personal self-disclosure or mimic superficial, small-talk. Affective experiences were assessed immediately after and 24h after social interactions. Results found that social anxiety was associated with negative post-event rumination more strongly among those with elevated depressive symptoms. Further, at higher levels of social anxiety, post-event rumination was associated with increases in NA following personal disclosure interactions and decreases in NA following small-talk interactions. Individuals with more depressive symptoms

experienced increases in NA following small-talk interactions, but not personal disclosure interactions. Contrary to expectation, positive relations between social anxiety and rumination were not mediated by self-presentation concerns during interactions. Fitting with relevant theory, findings implicated symptom and social contextual variables that moderate the affective consequences of rumination.

### CHILDREN, MEMORY DEFICITS & ANXIETY

#### MEMORY DEFICITS IN CHILDREN WITH AND AT RISK FOR ANXIETY DISORDERS.

**Authors :** Vasa RA, Roberson-Nay R, Klein RG, Mannuzza S, Moulton JL 3rd, Guardino M, Merikangas A, Carlino AR, Pine DS.

**Source :** *Depress Anxiety*. 2006 Jul 18; [Epub ahead of print] Related Articles, Links

**Summary:** There are limited data on the neurocognitive correlates of childhood anxiety disorders. The objective of this study was to examine whether visual and verbal memory deficits of nonemotional stimuli are (1) a shared feature of three common childhood anxiety disorders (social phobia, separation anxiety disorder, and generalized anxiety disorder) or whether these deficits are restricted to specific anxiety disorders, and (2) present in offspring who possess at least one of the following established risk factors for anxiety disorders, parental history of panic disorder (PD), or major depressive disorder (MDD). One hundred and sixty offspring, ages 9-20 years, were recruited from parents with lifetime diagnoses of PD, MDD, PD plus MDD, or neither illness. Different clinicians blindly administered semistructured diagnostic interviews to offspring and parents. Verbal and visual memory subtests of the Wide Range Assessment of Memory and Learning were administered to offspring. The results showed that offspring with ongoing social phobia demonstrated reduced visual but not verbal memory scores compared to those without social phobia when controlling for offspring IQ, separation anxiety disorder, and generalized anxiety disorder. No other offspring anxiety disorder predicted memory performance. Neither parental PD nor parental MDD was associated with offspring memory performance. These findings are relevant to understanding the phenomenology of childhood anxiety disorders and may provide insights into the neural circuits underlying these disorders. *Depression and Anxiety* 0:1-10, 2006. copy;Published 2006 Wiley-Liss, Inc.

### ASD & DISTRESSING INFORMATION

#### THE INFLUENCE OF DISTRESSING INFORMATION ON MEMORY IN ACUTE STRESS DISORDER

**Abstract :** Acute stress disorder (ASD) is purportedly characterized by impaired encoding of aversive material. In this study ASD, trauma-exposed non-ASD, and non-traumatized control participants (N = 45) were administered intermixed presentations of either distressing (i.e. disfigured) or neutral faces. For each presentation, two words were presented centrally to the image and two were presented peripherally. Participants were subsequently administered recall and recognition tests for the presented words. Participants recalled more words presented centrally to neutral images than those presented centrally to trauma images. Dissociative tendencies were negatively correlated with recognition of words centrally presented with distressing

stimuli. These findings are consistent with the proposal that dissociative reactions are associated with impaired memory for distress-related information.

**KeyWords:** Memory; trauma; dissociation; emotion.

### DISSOCIATION, ASD & HV

#### DISSOCIATION IN ACUTE STRESS DISORDER AFTER A HYPERVENTILATION PROVOCATION TEST

**Abstract :** This study investigated the relationship of hyperarousal and dissociation in acute stress disorder (ASD). Civilian trauma survivors with ASD (n = 17) and without ASD (n = 15) and non-traumatized controls (n = 14) completed a hyperventilation provocation test and were administered the Beck Anxiety Inventory, the Anxiety Sensitivity Index, the Dissociative Experiences Scale, the Peritraumatic Dissociative Experiences Questionnaire, the Physical Reactions Scale, and the Agoraphobic Cognitions Questionnaire. Individuals with ASD demonstrated more panic, dissociation, and maladaptive interpretations about their arousal during the hyperventilation than non-ASD or control participants. Dissociation was associated with anxiety sensitivity and peritraumatic panic attacks. These findings suggest that hyperarousal and dissociation are highly associated in ASD and that catastrophic attributions may play a mediating role in this relationship.

**Keywords:** ASD; arousal; dissociation; hyperventilation; cognition.

### MAGICAL THINKING, OCD & PD

#### MAGICAL THINKING IN OBSESSIVE-COMPULSIVE DISORDER, PANIC DISORDER AND THE GENERAL COMMUNITY

**Abstract :** Magical Ideation was examined in 71 individuals across four groups matched, where possible, for gender and age. These groups were: (1) Obsessive Compulsive Disorder (OCD) patients with cleaning compulsions (n = 11); (2) OCD patients with checking compulsions (n = 20); (3) panic disorder patients with minimal obsessive compulsive symptoms (n = 19); (4) a "normal" control group with minimal obsessive compulsive symptoms (n = 21). The Magical Ideation Scale (MI, Eckblad and Chapman, 1983), the Obsessive Compulsive Inventory-Short Version (OCI-SV; Foa et al., 2002) and the Maudsley Obsessional-Compulsive Inventory (MOCI, Hodgson and Rachman, 1977) were administered to all participants. A one-way Anova was conducted with four planned contrasts. As expected, the OCD groups obtained magical ideation scores higher than the normal subjects. This suggests that OCD patients engage in more magical thinking tendencies than non-anxious controls. Similarly, OCD participants obtained a mean magical ideation score significantly higher than the panic disorder group, suggesting that obsessional compulsive patients are more likely to exhibit magical thinking than individuals with panic disorder. Of note, panic disorder and control group means on MI did not differ significantly. Finally, individuals with obsessive cleaning compulsions displayed higher levels of magical thinking compared to individuals with obsessive checking compulsions, despite no difference in severity of their obsessive compulsive symptoms. This observation was counter to previous findings (Einstein and Menzies, 2004a; Einstein and Menzies, 2004b).

**Keywords:** Schizotypy; obsessive compulsive disorder; magical thinking.

## SEROTONIN , P.S.R &amp; AD

▪ **DEPLETING SEROTONIN ENHANCES BOTH CARDIOVASCULAR AND PSYCHOLOGICAL STRESS REACTIVITY IN RECOVERED PATIENTS WITH ANXIETY DISORDERS.**

*Authors* : Davies SJ, Hood SD, Argyropoulos SV, Morris K, Bell C, Witchel HJ, Jackson PR, Nutt DJ, Potokar JP.

*Source* : J Clin Psychopharmacol. 2006 Aug;26(4):414-8. Related Articles, Links

*Summary*: Serotonin-promoting drugs show cardioprotective properties in patients with anxiety or depression, but it is not known if this is a direct effect of increasing serotonin. We aimed to characterize the effect of serotonin manipulation through acute tryptophan depletion on cardiovascular and psychological responses to stress challenge in recovered patients with anxiety disorders. In 27 recovered patients with anxiety disorders (panic disorder treated by selective serotonin reuptake inhibitors (SSRIs) or cognitive behavioral therapy, social anxiety disorder treated by SSRIs), we performed a double-blind randomized crossover study. On 2 separate days, the subjects ingested an acute tryptophan-depleting (aTD) or nondepleting (nD) drink in random order and underwent a stress challenge at time of maximum depletion. Systolic blood pressure ( $P = 0.007$ ; diff = 9.0 mm Hg; 95% confidence interval (CI), 2.6-15.3 mm Hg) and diastolic blood pressure ( $P = 0.032$ ; diff = 5.7 mm Hg; 95% CI, 0.6-10.9 mm Hg) responses to stress were significantly greater under aTD than nD, as were the psychological responses to stress (for Spielberger state anxiety, difference in stress response between aTD and nD = 7.11;  $P = 0.025$ ). Blood pressure responses to stress showed no correlation with psychological responses. The significant increases in acute stress sensitivity in both cardiovascular and psychological domains on serotonin depletion suggest that serotonin is involved in the control of both cardiovascular and psychological aspects of the acute stress response. The lack of correlation in the difference between aTD and nD conditions in cardiovascular and psychological responses suggests that serotonin may have distinct effects on these 2 domains, rather than the cardiovascular responses being merely a secondary consequence of psychological changes.

## Anxiety, Depression &amp; Epilepsy

▪ **INTERICTAL ANXIETY AND DEPRESSION SYMPTOMS IN NIGERIANS WITH EPILEPSY: A CONTROLLED STUDY.**

*Authors* : Fatoye F, Mosaku KS, Komolafe M, Adewuya AO.

*Source* : Epilepsy Behav. 2006 Jul 21; [Epub ahead of print] Related Articles, Links

*Summary*: The goals of this study were to compare symptoms of anxiety and depression between patients with epilepsy and a healthy control group, and to determine the possible factors associated with clinically significant anxiety and depression symptoms in patients with epilepsy. One hundred and four adult Nigerians (52 with epilepsy and 52 matched healthy controls) were assessed with the Hospital Anxiety and Depression Scale (HADS). The results obtained indicated a statistically significant difference in anxiety and depression symptoms between patients with epilepsy and controls. The association between anxiety symptoms and polytherapy was significant ( $P=0.008$ ), as was the association between

depression symptoms and duration of epilepsy longer than 10 years ( $P=0.04$ ). Emotional problems are more common in patients with epilepsy than in the general population. Identifying and monitoring those with epilepsy of long duration and rational prescription of antiepileptic drugs are important in reducing the risk of affective problems.

## Bipolar Disorders (BD)

## BD &amp; Anxiety Disorders

▪ **PROSPECTIVE 12-MONTH COURSE OF BIPOLAR DISORDER IN OUT-PATIENTS WITH AND WITHOUT COMORBID ANXIETY DISORDERS.**

*Authors* : Otto MW, Simon NM, Wisniewski SR, Miklowitz DJ, Kogan JN, Reilly-Harrington NA, Frank E, Nierenberg AA, Marangell LB, Sagduyu K, Weiss RD, Miyahara S, Thas ME, Sachs GS, Pollack MH; STEP-BD Investigators.

*Source* : Br J Psychiatry. 2006 Jul;189:20-5. Related Articles, Links

*Summary*: The impact of anxiety disorders has not been well delineated in prospective studies of bipolar disorder. AIMS: To examine the association between anxiety and course of bipolar disorder, as defined by mood episodes, quality of life and role functioning.

*METHOD*: A thousand thousand out-patients with bipolar disorder were followed prospectively for 1 year.

*RESULTS*: A current comorbid anxiety disorder (present in 31.9% of participants) was associated with fewer days well, a lower likelihood of timely recovery from depression, risk of earlier relapse, lower quality of life and diminished role function over 1 year of prospective study. The negative impact was greater with multiple anxiety disorders.

*CONCLUSIONS*: Anxiety disorders, including those present during relative euthymia, predicted a poorer bipolar course. The detrimental effects of anxiety were not simply a feature of mood state. Treatment studies targeting anxiety disorders will help to clarify the nature of the impact of anxiety on bipolar course.

## DEPRESSION &amp; Zonisamide

▪ **AN OPEN PROSPECTIVE STUDY OF ZONISAMIDE IN ACUTE BIPOLAR DEPRESSION.**

*Authors* : Ghaemi SN, Zablotsky B, Filkowski MM, Dunn RT, Pardo TB, Isenstein E, Baldassano CF.

*Source* : J Clin Psychopharmacol. 2006 Aug;26(4):385-8. Related Articles, Links

*Objective*: To examine the effectiveness and safety of zonisamide in the treatment of acute bipolar depression. *Methods*: An open-label, prospective, nonrandomized, 8-week study conducted in bipolar outpatients (type I, type II, or not otherwise specified) with depressive symptoms. No patient was manic or mixed at study entry. Previous treatments were continued unchanged, but no new treatments were allowed. Montgomery Asberg Depression Rating Scale and the Mania Rating Scale from the Schedule of Affective Disorders and Schizophrenia-Change Version were used.

*Results*: Twenty patients (10 men, 10 women) with bipolar disorder (17 type I, 2 type II, 1 NOS), aged 38.1 +/- 8.81 years, received zonisamide at mean dose of 222.5 +/- 85.1 mg/d. Mean Montgomery Asberg Depression Rating Scale scores

improved significantly from baseline to endpoint (mean difference = -8.4, 95% confidence interval [4.1, 12.6],  $P = 0.001$ ). Ten patients (50%) terminated early due to adverse effects, mostly side effects including nausea/vomiting, cognitive impairment, and sedation. One patient experienced increased suicidal ideation, and one patient experienced hypomania.

**Conclusions:** This study suggests improvement of depressive symptoms in this sample with 8 weeks of open-label zonisamide treatment.

## AGITATED UMD

### ▪ AGITATED "UNIPOLAR" MAJOR DEPRESSION: PREVALENCE, PHENOMENOLOGY, AND OUTCOME.

**Authors :** Maj M, Pirozzi R, Magliano L, Fiorillo A, Bartoli L.

**Source :** J Clin Psychiatry. 2006 May;67(5):712-9. Related Articles, Links

**Objective:** This study aimed to explore how prevalent agitated "unipolar" major depression is, whether it belongs to the bipolar spectrum, and whether it differs from nonagitated "unipolar" major depression with respect to course and outcome.

**Method:** The study was conducted from January 1, 1978, to December 31, 1996. From 361 patients with major depressive disorder, the authors selected those fulfilling Research Diagnostic Criteria for agitated depression. These 94 patients were compared to 94 randomly recruited patients with nonagitated major depressive disorder regarding demographic and historical features, the clinical characteristics of the index episode, the percentage of time spent in an affective episode during a prospective observation period, and the 5-year outcome. Patients with agitated major depressive disorder who had at least 2 manic/hypomanic symptoms in their index episode were compared to the other patients with agitated major depressive disorder with respect to the same variables.

**Results:** Patients with agitated major depressive disorder were more likely to receive antipsychotics during their index episode and spent a higher proportion of time in an affective episode during the observation period compared with patients with nonagitated major depressive disorder. The presence of at least 2 manic/hypomanic symptoms in the index episode was associated with a higher rate of family history of bipolar I disorder, a higher score for suicidal thoughts during the episode, a longer duration of the episode, and a higher affective morbidity during the observation period.

**Conclusion:** The diagnosis of agitated major depressive disorder is not uncommon and has significant therapeutic and prognostic implications. The subgroup of patients with at least 2 manic/hypomanic symptoms may suffer from a mixed state and/or belong to the bipolar spectrum.

## BD, OLANZAPINE-FLUOXETINE

### ▪ A 24-WEEK OPEN-LABEL EXTENSION STUDY OF OLANZAPINE-FLUOXETINE COMBINATION AND OLANZAPINE MONOTHERAPY IN THE TREATMENT OF BIPOLAR DEPRESSION.

**Authors :** Corya SA, Perlis RH, Keck PE Jr, Lin DY, Case MG, Williamson DJ, Tohen MF.

**Source :** J Clin Psychiatry. 2006 May;67(5):798-806. Related Articles, Links

**Objective:** Olanzapine-fluoxetine combination has shown

efficacy in the acute treatment of depressive episodes in patients with bipolar I disorder. The present analyses examined the efficacy and safety of longer term treatment with olanzapine-fluoxetine combination or olanzapine monotherapy in a 6-month open-label extension study.

**Method:** 376 patients with DSM-IV bipolar I disorder, depressed, who completed an acute trial entered the open-label study and received 1 week of olanzapine monotherapy (5-20 mg/day). At all subsequent visits, patients could choose between olanzapine monotherapy or olanzapine-fluoxetine combination (6/25, 6/50, or 12/50 mg/day). Three treatment groups were defined retrospectively according to the medication course taken from week 1: olanzapine, olanzapine-fluoxetine combination, or switched. The efficacy measures were the Montgomery-Asberg Depression Rating Scale (MADRS), Clinical Global Impressions-Bipolar Version, and Young Mania Rating Scale. The study was conducted from July 2000 to May 2002.

**Results:** Among patients who started in remission, MADRS total scores did not change significantly from baseline to endpoint in the olanzapine-fluoxetine combination (0.8) or olanzapine (0.3) groups, but increased slightly in the switched (2.3,  $p = .02$ ) group. For patients who started in nonremission, MADRS total scores decreased significantly in all groups (olanzapine-fluoxetine combination: -5.7,  $p = .001$ ; olanzapine: -11.6,  $p = .004$ ; switched: -6.4,  $p = .015$ ). The majority of patients who entered the study in nonremission achieved remission (MADRS total score  $\leq 12$ ) during the trial (olanzapine-fluoxetine combination: 66.7%, olanzapine: 64.7%, switched: 62.5%). The overall rate of depressive relapse was 27.4%, and the overall incidence of mania emergence was 5.9%.

**Conclusions:** The present findings suggest that long-term treatment with olanzapine-fluoxetine combination may be a useful option for the management of depressive symptoms and carries a low risk of mania emergence.

## BD, LAMOTRIGINE & CITALOPRAM

### ▪ RANDOMIZED, DOUBLE-BLIND PILOT TRIAL COMPARING LAMOTRIGINE VERSUS CITALOPRAM FOR THE TREATMENT OF BIPOLAR DEPRESSION.

**Authors :** Schaffer A, Zuker P, Levitt A.

**Source :** J Affect Disord. 2006 Jun 30; [Epub ahead of print] Related Articles, Links

**Background:** Uncertainty exists regarding the best approach for treating bipolar depression among patients already receiving a first-line mood stabilizer. The aim of this pilot study was to compare adding a second mood stabilizer or an antidepressant at this treatment decision point.

**Methods:** Twelve-week, randomized, double-blind pilot trial comparing the addition of lamotrigine or citalopram for bipolar depressed patients on mood stabilizer medication. Change in depressive symptoms and risk of switch were examined. **Results:** Twenty subjects were randomized. Each treatment group experienced a significant mean reduction in total MADRS scores (citalopram Delta - 14.2,  $p=0.002$ ; lamotrigine Delta - 13.3,  $p=0.001$ ), and there was no significant difference between treatment groups ( $p=0.78$ ). Total response rates increased from 31.6% at week 6 to 52.6% at week 12. One out of ten patients in each group experienced a switch to hypomania.

**Limitations:** Small sample size. Lack of a placebo arm.

**Conclusions:** Results of this small trial suggest that both lamotrigine and citalopram appear to be reasonable choices as add-on acute treatment for bipolar depression, with response rates continuing to rise considerably past 6 weeks of treatment.

## MAJOR DEPRESSIVE DISORDER (MDD)

### SEVERE DEPRESSION & MST

#### ANESTHETIC CONSIDERATIONS FOR MAGNETIC SEIZURE THERAPY: A NOVEL THERAPY FOR SEVERE DEPRESSION.

**Authors :** White PF, Amos Q, Zhang Y, Stool L, Husain MM, Thornton L, Downing M, McClintock S, Lisanby SH.

**Source :** Anesth Analg. 2006 Jul;103(1):76-80, table of contents. Related Articles, Links

**Summary:** Electroconvulsive therapy (ECT) is a highly effective treatment for severe depression. However, its use is associated with significant posttreatment cognitive impairment. Magnetic seizure therapy (MST) was developed as an alternative therapy that could reduce postseizure side effects through the induction of more "focal" seizure activity. Using an open-parallel study design, we compared 20 case-matched patients undergoing a series of either ECT or MST procedures with respect to their anesthetic, muscle relaxant, and cardiovascular drug requirements, effects on cardiovascular and electroencephalographic bispectral index (BIS) values, and early recovery times. We found that MST was associated with a reduced time to orientation (4 +/- 1 versus 18 +/- 5 min;  $P < 0.01$ ) compared with ECT. To minimize residual muscle paralysis after MST, a reduction in the succinylcholine dosage (38 +/- 17 versus 97 +/- 2 mg;  $P < 0.01$ ) was required. The BIS values were higher before, and lower immediately after, the stimulus was applied in the MST (versus ECT) group. The Hamilton depression rating scale score was significantly reduced from the baseline value in both treatment groups; however, the posttreatment score was lower after the series of ECT treatments (6 +/- 6 versus 14 +/- 10;  $P < 0.05$ ). We conclude that MST was associated with a decreased requirement for muscle relaxants, reduced variability in the BIS values after seizure induction, and a more rapid recovery of cognitive function compared with ECT. Further studies are required to evaluate the antidepressant efficacy of MST versus ECT when they are administered at comparable levels of cerebral stimulation.

### DEPRESSION, TIANEPTINE & MYOCARDIAL INFARCTION

#### TREATMENT OF DEPRESSION IN PATIENTS WITH MYOCARDIAL INFARCTION WITH TIANEPTINE

**Authors :** Kachkovskii MA, Kriukov NN.

**AIM:** To study efficacy and acceptability of tianeptine in treatment of depression in patients with myocardial infarction (MI). **MATERIAL AND METHODS:** A group of 416 patients (253 men and 163 women) from 35 till 89 years old with MI was studied. Depression was diagnosed in 113 of them (27.2 %) by the use of Zung depression scale and CD-10 criteria. Tianeptine treatment was given to 55 patients (25-37.5 mg/day for 3.3 months), 58 patients were in control group. **RESULTS:** Tianeptine treatment of depression in patients with MI in 3-7 days led to decrease of feeling of depression and lowering of anxiety. Depression decreased in 9.4% patients of this group in 2 months. After 2 months depression was diagnosed in 55.7 % of patients who did not receive the antidepressant. During 1 year patients, who were treated by tianeptine, had 31% lower number of hospitalizations due to exacerbations of

cardiovascular diseases. Patients had a good tolerance of tianeptine treatment independently of age. **CONCLUSION:** Tianeptine treatment of depression in patients with MI is effective, safe, well tolerated by patients and allows to decrease number of hospitalizations because of complications of cardiovascular diseases during 1 year.

### DEPRESSION, ADOLESCENT & YOUNG ADULTHOOD

#### THE OUTCOME OF EPISODIC VERSUS PERSISTENT ADOLESCENT DEPRESSION IN YOUNG ADULTHOOD.

**Authors :** Steinhausen HC, Haslimeier C, Winkler Metzke C.

**Source :** J Affect Disord. 2006 Jun 30; [Epub ahead of print] Related Articles, Links

**Objective:** Study of the impact of episodic and persistent depression on psychosocial and mental functioning of young adults.

**Methods:** In a longitudinal representative community sample, four groups of subjects were identified who were depressed either in pre-adolescence, late adolescence or young adulthood or persistently depressed across time, and compared among each other and with a young adult control group. The 90th percentile on one or two self-reported symptom scales (i.e., the Center for Epidemiological Depression Scale (CES-D) or the Anxious/Depressed subscale of either the Youth Self-Report (YSR) or the Young Adult Self-Report (YASR)) served as the cut-off for the depression groups. Outcome was studied with regard to various psychosocial variables including life events, coping, self-related cognitions, size and efficiency of the social network, perceived parental behaviour, family relations and mental functioning.

**Results:** For the large majority of psychosocial variables, the persistent depression group showed the most abnormal scores. The YASR profile of mental functioning at outcome of the persistent depression group was also clearly distinguishable by higher scores from all other groups on the majority of scales. On a few scales, the young adult episodic group was not significantly different from the persistent depression group.

**Conclusion:** This study shows that persistent rather than episodic adolescent depression carries a risk for abnormal psychosocial and mental functioning in young adulthood. The study also reflects the burden of young adult depression.

### COMB, DROPOTUS & CBASP

#### DROPOUTS VERSUS COMPLETERS AMONG CHRONICALLY DEPRESSED OUTPATIENTS.

**Authors :** Arnow BA, Blasey C, Manber R, Constantino MJ, Markowitz JC, Klein DN, Thase M, Kocsis JH, Rush AJ.

**Source :** J Affect Disord. 2006 Jul 18; [Epub ahead of print] Related Articles, Links

**Background:** Premature termination is common among patients treated for depression with either pharmacotherapy or psychotherapy. Yet little is known about factors associated with premature treatment termination among depressed patients. **Methods:** This study examines predictors of, time to, and reasons for dropout from the 12-week acute phase treatment of nonpsychotic adult outpatients, age 18-75, with chronic major depression who were randomly assigned to nefazadone alone (MED), cognitive behavioral analysis system of psychotherapy alone (CBASP) or both treatments (COMB).

**Results:** Of 681 randomized study participants, 156 were in

defined as dropouts. Dropout rates were equivalent across the three treatments. Among dropouts, those in COMB remained in treatment (Mean=40 days) significantly longer than those either MED (Mean=27 days) or CBASP (Mean=28 days). Dropouts attributed to medication side-effects were significantly lower in COMB than in MED, suggesting that the relationship with the psychotherapist may increase patient willingness to tolerate side-effects associated with antidepressant medications. Ethnic or racial minority status, younger age, lower income, and co-morbid anxiety disorders significantly predicted dropout in the full sample. Within treatments, differences between completers and dropouts in minority status and the prevalence of anxiety disorders were most pronounced in MED. Among those receiving CBASP, dropouts had significantly lower therapeutic alliance scores than completers. LIMITATIONS: The sample included only individuals with chronic depression.

**Conclusions:** Predictors of dropout included baseline patient characteristics, but not early response to treatment. Ethnic and racial minorities and those with comorbid anxiety are at higher risk of premature termination, particularly in pharmacotherapy, and may require modified treatment strategies.

## MDD, Reboxetine And Venlafaxine XR

### ■ COMPARISON OF EFFICACY AND TOLERABILITY OF REBOXETINE AND VENLAFAXINE XR IN MAJOR DEPRESSION AND MAJOR DEPRESSION WITH ANXIETY FEATURES: AN OPEN LABEL STUDY.

**Authors :** Akkaya C, Sivrioglu EY, Akgoz S, Eker SS, Kirli S.

**Source :** Hum Psychopharmacol. 2006 Jul;21(5):337-45. Related Articles, Links

**Objective:** The aim of this study was to compare the efficacy and tolerability of reboxetine in the treatment of major depressive disorder (MDD) and MDD with anxiety features to venlafaxine XR.

**Method:** Patients with MDD, aging 18 between 65 years, were randomly allocated to two groups receiving either open-label venlafaxine XR capsules (n = 50) or reboxetine tablets (n = 43). Subjects were administered Hamilton Depression Rating Scale (HAM-D) and Hamilton Anxiety Scale (HAM-A) at baseline and 2, 4, 7, 10 weeks after the baseline visit.

**Results:** Response rates to antidepressant treatment were significantly higher in the venlafaxine XR group at 10th week. When patients having anxious depression were analysed separately; response rate for anxiety of reboxetine group was significantly higher at 7th week only. Mean number of side effects were significantly higher in reboxetine group. Only one subject in each group was dropped out due to side effect.

**Conclusion:** We may suggest that reboxetine is as effective and tolerable as venlafaxine XR in the treatment of MDD and MDD with anxiety features, and it may be considered a treatment option to venlafaxine XR.

## MDD & Duloxetine

### ■ DULOXETINE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER: SAFETY AND TOLERABILITY ASSOCIATED WITH DOSE ESCALATION.

**Authors :** Wohlreich MM, Mallinckrodt CH, Prakash A, Watkin JG, Carter WP.

**Source :** Depress Anxiety. 2006 Jul 14; [Epub ahead of print] Related Articles, Links

**Summary:** Duloxetine has demonstrated efficacy for the treatment of major depressive disorder (MDD) at a dose of 60mg/day (given once daily). Whereas the target dose for the majority of patients is 60 mg/day, higher duloxetine doses (up to 120 mg/day) have been studied using a twice-daily dosing schedule. To further investigate the pharmacological profile of duloxetine within a once-daily dosing regimen at doses above 60 mg, we examined the safety and tolerability of duloxetine during a dose escalation from 60 mg/day to 120 mg/day. This single-arm, non-placebo-controlled study incorporated a 7-week dose escalation phase, in which patients and investigators were blinded as to timing of dose increases, followed by an open-label extension phase of up to 2 years duration. Patients (age  $\geq 18$  years) meeting DSM-IV criteria for MDD (n=128) received placebo for 1 week, followed by duloxetine (60 mg/day) titrated after 1 week to 90 mg/day, and after a further week to 120 mg/day. The dose of 120 mg/day was then maintained for 4 weeks. The extension phase comprised an initial 6-week dose stabilization period, during which duloxetine was tapered to the lowest effective dose, followed by continuation therapy at the stabilized dose. We assessed safety using spontaneously reported treatment-emergent adverse events (TEAEs), changes in vital signs, electrocardiograms (ECGs), laboratory analytes, and visual analogue scales (VAS) for gastrointestinal (GI) disturbance. Efficacy measures included the 17-item Hamilton Rating Scale for Depression (HAM-D-17) total score, the Clinical Global Impression of Severity (CGI-S) and Patient Global Impression of Improvement (PGI-I) scales, and VAS assessments of pain severity and interference. The rate of discontinuation due to adverse events during the acute phase of the study was 15.6%. The most frequently reported TEAEs were nausea, headache, dry mouth, dizziness, and decreased appetite. The majority of TEAEs were associated with initial duloxetine dosing; further escalations in dose produced few additional adverse events. VAS measures of GI disturbance worsened significantly compared with baseline values after 1 week of duloxetine treatment. Subsequent assessments of GI disturbance, following dose escalation to 90 mg/day and 120 mg/day, showed either no significant difference or a significant improvement from baseline. Significant improvements ( $P < .001$ ) were observed in all assessed depression efficacy measures, and in five of six VAS pain outcomes, during acute phase treatment. During 2 years of extension phase therapy, the rate of discontinuation due to adverse events was 11.9%, and the only TEAEs reported by  $>10\%$  of patients were upper respiratory tract infection (13.1%), headache (10.7%), and insomnia (10.7%). Mean changes from baseline to the end of the extension phase in supine systolic and diastolic blood pressure were 3.8 and 0.5 mm Hg, respectively, and there were no reports of sustained hypertension. Mean increase in heart rate was 5.9 bpm, while patients exhibited a mean weight increase of 3.1 kg over 2 years of treatment. Results from this study suggest that rapid dose escalation of duloxetine (60 mg/day  $\rightarrow$  90 mg/day  $\rightarrow$  120 mg/day) is safe and tolerable. Despite weekly escalation, the majority of adverse events were mild and transient and occurred in the first week of duloxetine dosing (at 60 mg once daily). Long-term treatment at a stabilized duloxetine dose was associated with a relatively low incidence of TEAEs and treatment discontinuation due to adverse events. Time course profiles of body weight and heart rate showed modest increases during 2 years of treatment [ClinicalTrials.gov number, NC T000 42575]. Depression and

Anxiety 0:1-12, 2006. (c) 2006 Wiley-Liss, Inc.

## DEPRESSIVE SYMPTOMATOLOGY & WHIPLASH

### FREQUENCY, TIMING, AND COURSE OF DEPRESSIVE SYMPTOMATOLOGY AFTER WHIPLASH.

*Authors* : Carroll LJ, Cassidy JD, Cote P.

*Source* : Spine. 2006 Jul 15;31(16):E551-6. Related Articles, Links

*Summary*: STUDY DESIGN: Population-based incidence cohort. OBJECTIVE: To report the incidence, timing, and course of depressive symptoms after whiplash. SUMMARY OF BACKGROUND DATA: Evidence is conflicting about the frequency, time of onset, and course of depressive symptoms after whiplash.

*METHODS*: Adults making an insurance claim or seeking health care for traffic-related whiplash were followed by telephone interview at 6 weeks, and 3, 6, 9, and 12 months post-injury. Depressive symptoms were assessed at baseline and at each follow-up.

*RESULTS*: Of the 5,211 subjects reporting no pre-injury mental health problems, 42.3% (95% confidence interval, 40.9-43.6) developed depressive symptoms within 6 weeks of the injury, with subsequent onset in 17.8% (95% confidence interval, 16.5-19.2). Depressive symptoms were recurrent or persistent in 37.6% of those with early post-injury onset. Pre-injury mental health problems increased the risk of later onset depressive symptoms and of a recurrent or persistent course of early onset depressive symptoms.

*CONCLUSIONS*: Depressive symptomatology after whiplash is common, occurs early after the injury, and is often persistent or recurrent. This suggests that, like neck pain and headache, depressed symptomatology is part of the cluster of acute whiplash symptoms. Clinicians should be aware of both physical and psychological injuries after traffic collisions.

## DEPRESSION & PREDICTION OF RECURRENCE

### PREDICTION OF RECURRENCE IN RECURRENT DEPRESSION AND THE INFLUENCE OF CONSECUTIVE EPISODES ON VULNERABILITY FOR DEPRESSION: A 2-YEAR PROSPECTIVE STUDY.

*Authors* : Bockting CL, Spinhoven P, Koeter MW, Wouters LF, Schene AH; Depression Evaluation Longitudinal Therapy Assessment Study Group.

*Source* : J Clin Psychiatry. 2006 May;67(5):747-55. Related Articles, Links

*Objective*: Depression is a recurring disease. Identifying risk factors for recurrence is essential. The purpose of this study was to identify factors predictive of recurrence and to examine whether previous depressive episodes influence vulnerability for subsequent depression in a sample of remitted recurrently depressed patients.

*Method*: Recurrence was examined prospectively using the Structured Clinical Interview for DSM-IV Axis I Disorders in 172 euthymic patients with recurrent depression (DSM-IV) recruited from February 2000 through September 2000. Illness-related characteristics, coping, and stress (life events and daily hassles) were examined as predictors.

*Results*: Risk factors for recurrence were a high number of previous episodes, more residual depressive symptomatology and psychopathology, and more daily hassles. Factors with

both an increasing and decreasing pathogenic effect with increasing episode number were detected.

*Conclusion*: We found some support for dynamic vulnerability models that posit a change of vulnerability with consecutive episodes. Preventive interventions should be considered in patients with multiple recurrences, focusing on residual symptomatology and specific coping styles.

## TREATMENT RESISTANT DEPRESSION & ISTDP

### INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY OF TREATMENT-RESISTANT DEPRESSION: A PILOT STUDY.

*Authors* : Abbass AA.

*Source* : Depress Anxiety. 2006 Jul 14; [Epub ahead of print] Related Articles, Links

*Summary*: This pilot study examined the effectiveness of Intensive Short-term Dynamic Psychotherapy (ISTDP) in treatment-resistant depression (TRD). Ten patients with TRD were provided a course of ISTDP. Clinician and patient symptom and interpersonal measures were completed every 4 weeks, at termination, and in follow-up. Medication, disability, and hospital costs were compared before and after treatment. After an average of 13.6 sessions of therapy, all mean measures reached the normal range, with effect sizes ranging from 0.87 to 3.3. Gains were maintained in follow-up assessments. Treatment costs were offset by cost reductions elsewhere in the system. This open study suggests that ISTDP may be effective with this challenging patient group. A randomized, controlled trial and qualitative research are warranted to evaluate this treatment further and to examine its possible therapeutic elements. Depression and Anxiety 0:1-4, 2006. (c) 2006 Wiley-Liss, Inc.

## MDD, SOMATIC SYMPTOMS & FLUOXETINE

### SOMATIC SYMPTOMS IN OUTPATIENTS WITH MAJOR DEPRESSIVE DISORDER TREATED WITH FLUOXETINE.

*Authors* : Denninger JW, Papakostas GI, Mahal Y, Merens W, Alpert JE, Nierenberg AA, Yeung A, Fava M.

*Source* : Psychosomatics. 2006 Jul-Aug;47(4):348-52. Related Articles, Links

*Summary*: Among patients with major depressive disorder (MDD), physical and somatic symptoms are associated with a high degree of disability and healthcare utilization. However, little is known regarding the treatment of these symptoms with standard pharmacotherapy. To measure somatic symptoms of depression, the authors administered The Symptom Questionnaire (Kellner) before and after 8 weeks of open-label treatment with fluoxetine, 20 mg/day, in 170 MDD outpatients (mean age: 40.4 years). Somatic symptom scores decreased significantly after fluoxetine treatment. The degree of reduction in somatic symptoms was significantly and positively correlated with the degree of improvement in depressive symptoms as measured by the 17-item Hamilton Rating Scale for Depression (Ham-D). Somatic symptom scores at baseline did not predict the degree of reduction in Ham-D scores during treatment. However, fluoxetine-remitters had significantly lower somatic symptom scores at end-point than responders who did not remit. Taken together, these findings suggest that developing treatment strategies that successfully target somatic symptoms of depression may further improve the ability to treat depression to remission.

**MDD & Asthma**

▪ **AGE AT ONSET OF MAJOR DEPRESSION IN INNER-CITY ADULTS WITH ASTHMA.**

*Authors* : Solis OL, Khan DA, Brown ES.

*Source* : Psychosomatics. 2006 Jul-Aug;47(4):330-2. Related Articles, Links

*Summary*: Depression generally begins before Type II diabetes and coronary artery disease; however, no data are available on whether asthma or major depressive disorder (MDD) have an earlier onset. The age at onset of asthma and depression were collected from 85 adult asthma patients with current MDD. The mean ages at onset of asthma and MDD were 21.0 years and 28.8 years, respectively. Asthma preceded MDD in 62% of cases; MDD preceded asthma onset in 24% of cases; and asthma and MDD had a concurrent onset in 14% of the cases. In asthma patients, unlike patients with Type II diabetes and coronary artery disease, depression appears generally to occur after the onset of asthma.

**Depression, CHF & CPD**

▪ **COMPARISON OF MAJOR AND MINOR DEPRESSION IN OLDER MEDICAL INPATIENTS WITH CHRONIC HEART AND PULMONARY DISEASE.**

*Authors* : Koenig HG, Vandermeer J, Chambers A, Burr-Crutchfield L, Johnson JL.

*Source* : Psychosomatics. 2006 Jul-Aug;47(4):296-303. Related Articles, Links

*Summary*: Depressed medical inpatients with congestive heart failure (CHF) and/or chronic pulmonary disease (CPD) were examined to determine characteristics distinguishing major depression (N=413) from minor depression (N=587). Consecutively admitted patients age 50 or over were screened for depressive disorder with the Structured Clinical Interview for Depression (SCID-IV). CHF/CPD patients with major depression differed from those with minor depression not only on number and severity of depressive symptoms but also on race/ethnicity, comorbid psychiatric illnesses, dyspnea, life stressors, social support, and previous antidepressant therapy. CHF/CPD patients with major and minor depression have distinct psychosocial and physical characteristics that distinguish one from another.

**Upsloping & Myocardial Ischemia**

▪ **THE VALUE OF UPSLOPING ST DEPRESSION IN DIAGNOSING MYOCARDIAL ISCHEMIA.**

*Authors* : Polizos G, Ellestad MH.

*Source* : Ann Noninvasive Electrocardiol. 2006 Jul;11(3):237-40. Related Articles, Links

*Summary*: We evaluated the value of upsloping ST-segment depression in predicting the severity of myocardial ischemia. Comparison of the exercise electrocardiographic changes was made to myocardial perfusion images and coronary angiograms as the criteria for ischemia. We retrospectively reviewed 621 patients who underwent exercise technetium-99m tetrofosmin single photon emission computed tomography (SPECT) for the assessment of suspected or known coronary artery disease followed by coronary angiography within a 3-month period. The test sensitivity and

specificity of 1 mm horizontal or downsloping ST depression in predicting reversible ischemia as assessed by gated SPECT imaging (GSI) were 65% and 87%, respectively. The corresponding values were 67% and 94% compared to coronary angiography. The sensitivity and specificity of gated SPECT imaging compared to coronary angiography were 78% and 89%. On the other hand when 1 mm upsloping ST depression at 70 ms past the J-point was regarded as abnormal, along with horizontal and downsloping, the sensitivity and specificity were 82% and 90% compared to myocardial perfusion imaging, and 77% and 92% as assessed by coronary angiography. We conclude that upsloping ST-segment depression is associated with an increased risk of coronary artery disease and is a valuable predictor of myocardial ischemia.

**QRS, ST-SEGMENT & POSTEXERCISE RECOVER**

▪ **SIGNIFICANCE OF QRS DURATION CHANGES IN THE EVALUATION OF ST-SEGMENT DEPRESSION PRESENTING EXCLUSIVELY DURING THE POSTEXERCISE RECOVERY PERIOD.**

*Authors* : Michaelides AP, Furlas CA, Giannopoulos N, Aggeli K, Andrikopoulos GK, Tsioufis K, Massias SS, Stefanadis CI.

*Source* : Ann Noninvasive Electrocardiol. 2006 Jul;11(3):241-6. Related Articles, Links

*Background*: The aim of this study was to evaluate the contribution of QRS prolongation in the diagnosis of coronary artery disease (CAD) in patients with exercise-induced ST-segment depression exclusively during the recovery period. *Methods*: The study population consisted of 107 patients (90 males and 17 females) aged 39-70 (mean 59 +/- 7) years who underwent a treadmill exercise test using Bruce protocol and presented ST-segment depression limited to the recovery period. Angiographic data were available for all studied patients. *Results*: Among studied patients, 74 (69%) were found to have hemodynamically significant CAD, while the remaining 33 (31%) had normal coronary arteries. Concomitant QRS prolongation was revealed in 61 (82%) of the patients with angiographically documented CAD, while in 13 (18%) patients QRS duration remained unchanged. On the contrary, only 4 (12%) of the 33 patients with normal coronary arteries showed prolonged QRS duration during ST depression, while in the remaining 29 (88%) QRS duration remained unchanged.

*Conclusions*: The evaluation of the concomitant QRS duration changes may discriminate patients with truly ischemia-induced ST-segment depression limited to the recovery period.

**MDD, Prolactin & Fluoxetine**

▪ **SERUM PROLACTIN LEVELS AMONG OUTPATIENTS WITH MAJOR DEPRESSIVE DISORDER DURING THE ACUTE PHASE OF TREATMENT WITH FLUOXETINE.**

*Authors* : Papakostas GI, Miller KK, Petersen T, Sklarsky KG, Hilliker SE, Klibanski A, Fava M.

*Source* : J Clin Psychiatry. 2006 Jun;67(6):952-957. Related Articles, Links

*Objective*: To determine changes in serum prolactin levels in outpatients with DSM-IV-diagnosed major depressive disorder (MDD) following a 12-week open-label trial of fluoxetine. *Method*: 87 outpatients enrolled in the trial had serum prolactin levels determined at baseline and during their final visit (week 12 or discontinuation visit). In addition, serum testosterone

levels were measured in 44 of the 46 men during these 2 visits. Hyperprolactinemia was defined as a serum prolactin level greater than 16.5 ng/mL or 18.9 ng/mL for men and women, respectively. The study was conducted from September 1997 to March 2002.

**Results:** Of 80 patients with normal prolactin levels at baseline, 10 (12.5%) developed hyper-prolactinemia following fluoxetine treatment. Specifically, 2 (4.5%) of 44 men and 8 (22.2%) of 36 women with normal prolactin levels at baseline developed hyperprolactinemia following treatment with fluoxetine ( $p = .0174$  for between-gender difference). In addition, there was a significant increase in mean  $\pm$  SD serum prolactin levels following treatment with fluoxetine in all patients with normal baseline prolactin levels (6.4  $\pm$  3.4 to 10.0  $\pm$  7.0 ng/mL,  $p = .002$ ). There were no significant changes from baseline in testosterone levels in men following fluoxetine treatment (448.4  $\pm$  139.6 to 439.5  $\pm$  142.1 ng/dL,  $p > .05$ ; normal above 245 ng/dL), while none of the 44 men developed low testosterone levels following fluoxetine treatment.

**Conclusion:** 4.5% of men and 22.2% of women with MDD developed new onset hyper-prolactinemia following fluoxetine treatment.

### MDD & Bupropion XL

#### ▪ EXTENDED-RELEASE BUPROPION FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER PRESENTING WITH SYMPTOMS OF REDUCED ENERGY, PLEASURE, AND INTEREST: FINDINGS FROM A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY.

**Authors:** Jefferson JW, Rush AJ, Nelson JC, Vanmeter SA, Krishen A, Hampton KD, Wightman DS, Modell JG.

**Source:** J Clin Psychiatry. 2006 Jun;67(6):865-873. Related Articles, Links

**Objective:** This multicenter, double-blind, placebo-controlled study evaluated the efficacy and safety of extended-release bupropion (bupropion XL) in the treatment of major depressive disorder (MDD) with prominent symptoms of decreased energy, pleasure, and interest.

**Method:** Eligible adult outpatients meeting DSM-IV criteria for MDD were randomly assigned to bupropion XL 300 to 450 mg/day ( $N = 135$ ) or placebo ( $N = 139$ ) for 8 weeks. The primary efficacy measure, change from baseline on the 30-item Inventory of Depressive Symptomatology-Self Report (IDS-IVR-30) total score, was obtained using interactive voice response (IVR) technology. Secondary measures included change from baseline on the 30-item Inventory of Depressive Symptomatology-Clinician-Rated (IDS-C-30) total score and change in domain subset scores for energy, pleasure, and interest; for insomnia; and for anxiety. Response and remission rates were also calculated. Safety was assessed by withdrawal rates, adverse events (AEs), body weight, and vital signs. The study was conducted from June 24, 2003, to June 30, 2004.

**Results:** Bupropion XL was superior to placebo at endpoint in reducing the IDS-IVR-30 total score ( $p = .018$ ) and the energy, pleasure, and interest domain ( $p = .007$ ) and the insomnia domain ( $p = .023$ ) scores. IDS-C-30 outcomes were also significant ( $p < .001$ ;  $p < .001$ , and  $p = .008$ , respectively). Clinician-rated remission rates were significantly higher with bupropion XL than placebo (32% vs. 18%, IDS-C-30; 41% vs.

27%, IDS-IVR-30), as were response rates (50% vs. 35%, IDS-C-30; 53% vs. 38%, Clinical Global Impressions-Improvement of Illness). Most AEs were mild or moderate. The incidence of a  $\geq 7\%$  body weight loss was 3.7% with bupropion XL and 1.4% with placebo.

**Conclusion:** Bupropion XL was effective and well tolerated in MDD patients with decreased energy, pleasure, and interest

### MDD, PDs & Problem-Solving Ability

#### ▪ PROBLEM-SOLVING ABILITY AND COMORBID PERSONALITY DISORDERS IN DEPRESSED OUTPATIENTS.

**Authors:** Harley R, Petersen T, Scalia M, Papakostas GI, Farabaugh A, Fava M.

**Source:** *Depress Anxiety*. 2006 Jul 14; [Epub ahead of print] Related Articles, Links

**Summary:** Major depressive disorder (MDD) is associated with poor problem-solving abilities. In addition, certain personality disorders (PDs) that are common among patients with MDD are also associated with limited problem-solving skills. Attempts to understand the relationship between PDs and problem solving can be complicated by the presence of acute MDD. Our objective in this study was to investigate the relationships between PDs, problem-solving skills, and response to treatment among outpatients with MDD. We enrolled 312 outpatients with MDD in an open, fixed-dose, 8-week fluoxetine trial. PD diagnoses were ascertained via structured clinical interview before and after fluoxetine treatment. Subjects completed the Problem-Solving Inventory (PSI) at both time points. We used analyses of covariance (ANCOVAs) to assess relationships between PD diagnoses and PSI scores prior to treatment. Subjects were divided into three groups: those with PD diagnoses that remained stable after fluoxetine treatment ( $N=91$ ), those who no longer met PD criteria after fluoxetine treatment ( $N=119$ ), and those who did not meet criteria for a PD at any time point in the study ( $N=95$ ). We used multiple chi(2) analyses to compare rates of MDD response and remission between the three PD groups. ANCOVA was also used to compare posttreatment PSI scores between PD groups. Prior to fluoxetine treatment, patients with avoidant, dependent, narcissistic, and borderline PDs reported significantly worse problem-solving ability than did patients without any PDs. Only subjects with dependent PD remained associated with poorer baseline problem-solving reports after the effects of baseline depression severity were controlled. Patients with stable PD diagnoses had significantly lower rates of MDD remission. Across PD groups, problem solving improved as MDD improved. No significant differences in posttreatment problem-solving were found between PD groups after controlling for baseline depression severity, baseline PSI score, and response to treatment. Treatment with fluoxetine is less likely to lead to remission of MDD in patients with stable PDs. More study is needed to investigate causal links between PDs, problem solving, and MDD treatment response. *Depression and Anxiety* 0:1-6, 2006. (c) 2006 Wiley-Liss, Inc.

### MDD & Duloxetine

#### ▪ DULOXETINE EFFICACY FOR MAJOR DEPRESSIVE DISORDER IN MALE VS. FEMALE PATIENTS: DATA FROM 7 RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIALS.

**Authors:** Kornstein SG, Wohlreich MM, Mallinckrodt CH,

Watkin JG, Stewart DE.

**Source** : J Clin Psychiatry. 2006 May;67(5):761-70. Related Articles, Links

**Objective:** A number of studies have suggested potential gender differences in the efficacy of antidepressant medications. Pooled data from double-blind, placebo-controlled studies were utilized to compare the efficacy of duloxetine in the treatment of major depressive disorder (MDD) in male and female patients. **Method:** Efficacy data were pooled from 7 randomized, double-blind, placebo-controlled clinical trials of duloxetine. These studies represent all available data from U.S. acute-phase, placebo-controlled studies of duloxetine for the treatment of MDD. Patients (aged  $\geq 18$  years) meeting DSM-IV criteria for MDD received duloxetine (40-120 mg/day; men, N = 318; women, N = 578) or placebo (men, N = 242; women, N = 484) for up to 9 weeks. Efficacy measures included the 17-item Hamilton Rating Scale for Depression (HAM-D17) total score, HAM-D17 subscales (core, Maier, anxiety, retardation, sleep), the Clinical Global Impressions-Severity of Illness scale (CGI-S) and Patient Global Impression of Improvement scale (PGI-I), the Quality of Life in Depression Scale (QLDS), and Visual Analog Scales (VAS) for pain. The first patient visit was February 1, 1999, and the last patient visit was November 27, 2002.

**Results:** In both male and female patients, duloxetine produced significantly greater improvement in HAM-D17, CGI-S, and PGI-I when compared with placebo ( $p < .05$ ). Treatment-by-gender interactions did not reach statistical significance, indicating that the magnitude of duloxetine's treatment effects did not differ significantly between male and female patients. However, there was a trend for female patients to show a more robust response than male patients to both duloxetine and placebo. On the basis of VAS assessments of pain severity, duloxetine-treated female patients appeared to exhibit greater improvement than male patients, while women receiving placebo had smaller responses than placebo-treated men. Improvements in quality of life were significantly greater for both men ( $p = .006$ ) and women ( $p = .001$ ) receiving duloxetine than placebo and showed no significant difference by gender.

**Conclusion:** In this analysis of pooled data, the efficacy of duloxetine did not differ significantly in male and female patients.

## MDD, BPD & PT

### COMBINED TREATMENT OF MAJOR DEPRESSION IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER: A COMPARISON WITH PHARMACOTHERAPY

**Authors** : Bellino S, Zizza M, Rinaldi C, Bogetto F.

**Source** : Can J Psychiatry. 2006 Jun;51(7):453-60. Related Articles, Links

**Objective:** Combined treatment with psychotherapy and antidepressants is more effective than monotherapies. Recent data show that combined therapy has better results in patients with depression and Axis II codiagnosis. The aim of this study was to compare combined treatment using interpersonal psychotherapy (IPT) with pharmacotherapy alone in patients with depression and borderline personality disorder (BPD).

**Methods:** There were 39 consecutive outpatients diagnosed with BPD who presented with a major depressive episode enrolled in this study. They were randomly assigned to 1 of 2 treatment groups: fluoxetine 20 mg to 40 mg daily or fluoxetine 20 mg to 40 mg daily plus IPT 1 session weekly. Owing to

noncompliance, 7 patients dropped out. We assessed the 32 patients who completed the 24 weeks of treatment at baseline, Week 12, and Week 24, using a semistructured interview for clinical characteristics, the Clinical Global Impression Scale (CGI), the Hamilton Depression Rating Scale (HDRS), and the Hamilton Anxiety Rating Scale (HARS), and 2 self-report questionnaires, that is, the Satisfaction Profile (SAT-P) for quality of life and the 64-item Inventory for Interpersonal Problems (IIP-64). We performed statistical analysis, using univariate general linear models with 2 factors: duration and type of treatment. **Results:** Changes in remission rates, CGI, and HARS score did not differ between treatments. According to changes in the HDRS scores; changes in psychological functioning and social functioning scores on the SAT-P; and changes in vindictive or self-centred, cold or distant, intrusive or needy, and socially inhibited scores on the IIP-64, combined therapy was superior to fluoxetine alone.

**Conclusions:** Combined therapy with IPT is more effective than antidepressant therapy alone, both in treating symptoms of major depression and in improving dimensions of quality of life and interpersonal functioning.

## DEPRESSION, FEAR PERCEPTION & CORTISOL

### THE ASSOCIATION BETWEEN LEVELS OF CORTISOL SECRETION AND FEAR PERCEPTION IN PATIENTS WITH REMITTED DEPRESSION PREDICTS RECURRENCE.

**Authors** : Bouhuys AL, Bos EH, Geerts E, van Os TW, Ormel J.

**Source** : J Nerv Ment Dis. 2006 Jul;194(7):478-84. Related Articles, Links

**Summary:** This study examines the association between cortisol secretion and fear perception in remitted patients to identify mechanisms underlying risk for recurrence of depression. We hypothesized that the stronger the association between cortisol secretion and fear perception in persons with remitted depression, the more recurrence would be experienced. We also investigated whether high levels of cortisol and fear perception per se predict more recurrence. These effects were assumed to be stronger in women than in men. In a prospective design, we investigated 77 outpatients with remitted depression and related the association between their 24-hour urinary free cortisol secretion and fear perception (from ambiguous faces and from vocal expressions) to recurrence of depression within 2 years. We applied Cox regression models, partial correlations, and Fisher z tests. In 21 patients, depression recurred. Irrespective the channel of perception (eye or ear), the interaction between fear perception and cortisol secretion was significantly related to recurrence of depression. Patients high or low on both variables are more at risk. This increased risk was also reflected by a significant association between cortisol secretion and facial fear perception, but only among subjects who experienced recurrence. A trend in the same direction was found for vocal fear perception. Fear perception and cortisol secretion per se did not predict recurrence. No gender differences were found. The association between cortisol secretion and fear perception (probably indicative for altered fear circuits in the brain) constitutes a mechanism underlying risk for recurrence of depression.

## MDD & DSM-IV

### DIAGNOSING MAJOR DEPRESSIVE DISORDER V: APPLYING THE DSM-IV

#### EXCLUSION CRITERIA IN CLINICAL PRACTICE.

**Authors :** Zimmerman M, McGlinchey JB, Chelminski I, Young D.

**Source :** J Nerv Ment Dis. 2006 Jul;194(7):530-3. Related Articles, Links

**Summary:** To be diagnosed with DSM-IV major depressive disorder (MDD), a patient must meet five out of nine symptom criteria, one of which is depressed mood or pervasive loss of interest or pleasure. Once a patient has reached this symptom threshold, there are several exclusionary criteria that need to be passed to receive the diagnosis. The symptoms must cause significant distress or impairment in functioning, the symptoms cannot be caused by substance use or a general medical condition, and the symptoms cannot be better accounted for by bereavement. Finally, the presence of psychotic symptoms not coincident with the depressive symptoms excludes the diagnosis. We are not aware of any studies of psychiatric patients that have examined the impact of all of these exclusionary rules on the diagnosis of MDD in clinical practice. It is important for clinicians to know how often each of these factors might exclude the diagnosis of MDD so that they can be more or less vigilant to their presence. The goal of the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services project was to examine the impact of the DSM-IV exclusion rules on the diagnosis of MDD. In total, 38 (3.0%) of the 947 patients meeting the DSM-IV symptom inclusion criteria were excluded from a diagnosis of MDD or bipolar depression. These results suggest that the DSM-IV exclusion criteria for MDD had only a modest impact on diagnosis in psychiatric outpatients. It is likely that the results of a study of the impact of the DSM-IV depression exclusion criteria will depend on where the study is conducted. The potential influence of different settings on diagnostic exclusion is discussed.

#### MDD, Elderly & Cost- Effectiveness

##### COST-EFFECTIVENESS OF A DISEASE MANAGEMENT PROGRAM FOR MAJOR DEPRESSION IN ELDERLY PRIMARY CARE PATIENTS.

**Authors :** Bosmans J, de Bruijne M, van Hout H, van Marwijk H, Beekman A, Bouter L, Stalman W, van Tulder M.

**Source :** J Gen Intern Med. 2006 Jul 7; [Epub ahead of print] Related Articles, Links

**Summary:** Major depression is common in older adults and is associated with increased health care costs. Depression often remains unrecognized in older adults, especially in primary care. To evaluate the cost-effectiveness of a disease management program for major depression in elderly primary care patients compared with usual care. Economic evaluation alongside a cluster randomized-controlled trial. Consecutive patients of 55 years and older were screened for depression using the Geriatric Depression Scale and the PRIME-MD was used for diagnosis. General practitioners in the intervention group received training on how to implement the disease management program consisting of screening, patient education, drug therapy with paroxetine, and supportive contacts. General practitioners in the usual care group were blind to the screening results. Treatment in this group was not restricted in any way. Severity of depression, recovery from depression, and quality of life. Resource use measured over a 12-month period using interviews and valued using standard

costs. Differences in clinical outcomes between the intervention and usual care group were small and statistically insignificant. Total costs were \$2,123 in the intervention and \$2,259 in the usual care group (mean difference -\$136, 95% confidence interval: -\$1,194; \$1,110). Cost-effectiveness planes indicated that there were no statistically significant differences in cost-effectiveness between the 2 groups. This disease management program for major depression in elderly primary care patients had no statistically significant relationship with clinical outcomes, costs, and cost-effectiveness. Therefore, based on these results, continuing usual care is recommended.

#### DEPRESSION, DIABETES & MULTIPLE COMPLICATIONS

##### IMPROVING DEPRESSION CARE IN PATIENTS WITH DIABETES AND MULTIPLE COMPLICATIONS.

**Authors :** Kinder LS, Katon WJ, Ludman E, Russo J, Simon G, Lin EH, Ciechanowski P, Von Korff M, Young B.

**Source :** J Gen Intern Med. 2006 Jul 7; [Epub ahead of print] Related Articles, Links

**Summary:** Depression is common in patients with diabetes, but it is often inadequately treated within primary care. Competing clinical demands and treatment resistance may make it especially difficult to improve depressive symptoms in patients with diabetes who have multiple complications. To determine whether a collaborative care intervention for depression would be as effective in patients with diabetes who had 2 or more complications as in patients with diabetes who had fewer complications. The Pathways Study was a randomized control trial comparing collaborative care case management for depression and usual primary care. This secondary analysis compared outcomes in patients with 2 or more complications to patients with fewer complications. Three hundred and twenty-nine patients with diabetes and comorbid depression were recruited through primary care clinics of a large prepaid health plan. Depression was assessed at baseline, 3, 6, and 12 months with the 20-item depression scale from the Hopkins Symptom Checklist. Diabetes complications were determined from automated patient records. The Pathways collaborative care intervention was significantly more successful at reducing depressive symptoms than usual primary care in patients with diabetes who had 2 or more complications. Patients with fewer than 2 complications experienced similar reductions in depressive symptoms in both intervention and usual care. Patients with depression and diabetes who have multiple complications may benefit most from collaborative care for depression. These findings suggest that with appropriate intervention depression can be successfully treated in patients with diabetes who have the highest severity of medical problems.

#### DEPRESSION & CQI

##### IMPACTS OF EVIDENCE-BASED QUALITY IMPROVEMENT ON DEPRESSION IN PRIMARY CARE.

**Authors :** Rubenstein LV, Meredith LS, Parker LE, Gordon NP, Hickey SC, Oken C, Lee ML.

**Source :** J Gen Intern Med. 2006 Jul 7; [Epub ahead of print]

**Summary:** Related Articles, Links Previous studies testing continuous quality improvement (CQI) for depression showed no effects. Methods for practices to self-improve depression care performance are needed. We assessed the impacts of

evidence-based quality improvement (EBQI), a modification of CQI, as carried out by 2 different health care systems, and collected qualitative data on the design and implementation process. Evaluate impacts of EBQI on practice-wide depression care and outcomes. Practice-level randomized experiment comparing EBQI with usual care. Six Kaiser Permanente of Northern California and 3 Veterans Administration primary care practices randomly assigned to EBQI teams (6 practices) or usual care (3 practices). Practices included 245 primary care clinicians and 250,000 patients. Researchers assisted system senior leaders to identify priorities for EBQI teams; initiated the manual-based EBQI process; and provided references and tools. Five hundred and sixty-seven representative patients with major depression. Appropriate treatment, depression, functional status, and satisfaction. Depressed patients in EBQI practices showed a trend toward more appropriate treatment compared with those in usual care (46.0% vs 39.9% at 6 months,  $P=.07$ ), but no significant improvement in 12-month depression symptom outcomes (27.0% vs 36.1% poor depression outcome,  $P=.18$ ). Social functioning improved significantly (mean score 65.0 vs 56.8 at 12 months,  $P=.02$ ); physical functioning did not. Evidence-based quality improvement had perceptible, but modest, effects on practice performance for patients with depression. The modest improvements, along with qualitative data, identify potential future directions for improving CQI research and practice.

#### DEPRESSION, COGNITIVE IMPAIRMENT & PRIMARY CARE —

##### ▪ BRIEF REPORT: PATIENT COGNITIVE STATUS AND THE IDENTIFICATION AND MANAGEMENT OF DEPRESSION BY PRIMARY CARE PHYSICIANS.

**Authors :** Crane MK, Bogner HR, Rabins PV, Gallo JJ.

**Source :** J Gen Intern Med. 2006 Jul 7; [Epub ahead of print] Related Articles, Links

**Summary:** No known study has examined the role of patients' cognitive impairment in the identification and management of depression by primary care physicians. A cross-sectional survey conducted between 2001 and 2003. A sample of 330 adults aged 65 and older from Maryland primary care practices with complete information on cognitive and psychological status, and physician assessments. Primary care physicians were asked to rate cognition and depression on a Likert scale, as well as report management of depression within 6 months of the index visit. Patient interviews included standardized measures of psychological and cognitive status. Older adults identified as depressed by their physician were more likely to be identified as cognitively impaired (unadjusted odds ratio [OR]=3.71, [95% confidence interval] [CI] [1.93, 7.16]). Older adults identified as cognitively impaired had a tendency to be managed for depression (unadjusted OR=2.62, 95% CI [0.96, 7.19]). In adjusted multivariate models, these associations remained unchanged. When physicians identified a patient as cognitively impaired, they were more likely to identify the patient as depressed and to report treatment of the depression. An understanding of how physicians think about depression in the context of cognitive impairment is important for designing depression interventions for older adults.

#### MDD Escitalopram & Paroxetine

##### ▪ A COMPARATIVE STUDY OF THE EFFICACY OF LONG-TERM TREATMENT WITH ESCITALOPRAM AND PAROXETINE IN SEVERELY DEPRESSED PATIENTS.

**Authors :** Boulenger JP, Huusom AK, Florea I, Baekdal T, Sarchiapone M.

**Source :** Curr Med Res Opin. 2006 Jul;22(7):1331-41. Related Articles, Links

**Objective:** This randomised, double-blind, fixed-dose study evaluated the efficacy of escitalopram and paroxetine in the long-term treatment of severely depressed patients with major depressive disorder (MDD). RESEARCH DESIGN AND Methods: Patients with a primary diagnosis of MDD and baseline Montgomery-Asberg Depression Rating Scale (MADRS)  $\geq 30$  were randomised to 24 weeks of double-blind treatment with fixed doses of either escitalopram (20 mg) ( $n = 232$ ) or paroxetine (40 mg) ( $n = 227$ ). The primary analysis of efficacy was an analysis of covariance (ANCOVA) of change from baseline to endpoint (Week 24) in MADRS total score (last observation carried forward, LOCF).

Main outcome measures; results: At endpoint (24 weeks), the mean change from baseline in MADRS total score was -25.2 for patients treated with escitalopram ( $n = 228$ ) and -23.1 for patients with paroxetine ( $n = 223$ ), resulting in a difference of 2.1 points ( $p < 0.05$ ). The difference in the change in the MADRS total score (LOCF) was significantly in favour of escitalopram from Week 8 onwards. The proportion of remitters (MADRS  $\leq 12$ ) after 24 weeks was 75% for escitalopram and 67% for paroxetine ( $p < 0.05$ ). The results on the primary efficacy scale were supported by significantly greater differences in favour of escitalopram on the Hamilton Anxiety, Hamilton Depression and Clinical Global Impression-Improvement and -Severity scales. For very severely depressed patients (baseline MADRS  $\geq 35$ ), there was a difference of 3.4 points at endpoint in the MADRS total score in favour of escitalopram ( $p < 0.05$ ). The overall withdrawal rate for patients treated with escitalopram (19%) was significantly lower than with paroxetine (32%) ( $p < 0.01$ ). The withdrawal rate due to adverse events was significantly lower for escitalopram (8%) compared to paroxetine (16%) ( $p < 0.05$ ). There were no significant differences in the incidence of individual adverse events during treatment. **Conclusion:** Escitalopram is significantly more effective than paroxetine in the long-term treatment of severely depressed patients.

#### DEPRESSION & THYROID ILLNESS

##### ▪ LOWER TSH AND HIGHER T4 LEVELS ARE ASSOCIATED WITH CURRENT DEPRESSIVE SYNDROME IN YOUNG ADULTS.

**Authors :** Forman-Hoffman V, Philibert RA.

**Source :** Acta Psychiatr Scand. 2006 Aug;114(2):132-9. Related Articles, Links

**Objective:** The relationship of individual thyroid function indices to depression in those without a history of prior thyroid dysfunction is uncertain.

Method: We examined the relationship between thyroid-stimulating hormone (TSH) and thyroxine (T4) levels and current or lifetime history of depressive symptoms using information from 6869 participants, aged 17-39 years, in the Third National Health and Nutrition Examination Survey without history of thyroid-related illness.

Results: We found that lower TSH and higher T4 levels were associated with current depressive syndrome in men, but only higher T4 levels correlated with current depressive syndrome in women. Lifetime depressive syndrome was associated with neither TSH level nor T4 levels in men or women.

**Conclusion:** These findings suggest that transient or 'state dependent' changes are associated with depression in those without a history of thyroid illness. Further studies to discern whether these depression-associated changes represent distinct endophenotypes of depression should be encouraged.

## DEPRESSION & SUICIDE ATTEMPTS

### PLANNING OF SUICIDE ATTEMPTS AMONG DEPRESSED INPATIENTS AGES 50 AND OVER.

**Authors :** Conner KR, Duberstein PR, Beckman A, Heisel MJ, Hirsch JK, Gamble S, Conwell Y.

**Source :** J Affect Disord. 2006 Jul 8; [Epub ahead of print] Related Articles, Links

**Background:** Suicidal behavior is heterogeneous; suicide attempts can be impulsive (lower planned) or reflect forethought and preparation (higher planned). Lower planned and higher planned attempts may have different correlates that require different prevention strategies. Based on a model of suicide planning relevant to middle-aged and older adults, we tested the following hypotheses: physical illness burden, decreased functional capacity, hopelessness, and living alone are associated with suicide attempts that are more extensively planned; lower cognitive functioning is associated with suicide attempts that are more impulsive.

**Methods:** Subjects were 117 inpatients ages 50 and over diagnosed with major depression based on semi-structured clinical research interviews, the medical record, plus other records when available. All subjects had attempted suicide within 1 month of admission. The degree of planning prior to the suicide attempt was quantified using Beck's Suicide Intent Scale. Multivariate linear regression analysis identified correlates of planning.

**Results:** As hypothesized, lower cognitive functioning was associated with lower levels of planning. Contrary to the hypothesis, impaired physical self-care was associated with lower (not higher) planning. Results pertaining to living alone were equivocal.

**Limitations:** The study was limited by the cross-sectional research design and unclear generalizability to completed suicide or to racial/ethnic minorities.

**Conclusions:** Depressed patients with lower cognitive functioning and impairments in physical self-care may be especially vulnerable to impulsive suicidal behavior. The potential role of living alone in higher planned suicidal acts requires further investigation.

## UNIPOLAR DEPRESSION & PHARMACOTHERAPY

### COMBINATION PHARMACOTHERAPY IN UNIPOLAR DEPRESSION.

**Authors :** Ng F, Dodd S, Berk M.

**Source :** Expert Rev Neurother. 2006 Jul;6(7):1049-60. Related Articles, Links

**Summary:** It is estimated that between 60 and 80% of those with major depressive disorder do not achieve full symptomatic remission from first-line antidepressant monotherapy. Residual depressive symptoms substantially

impair quality of life and add to the risk of recurrence. It is now clear that depression would benefit from more vigorous treatment, in order to ameliorate its disease burden. While there are established algorithms in situations of treatment resistance, the use of combination pharmacotherapy in unipolar depression is a relatively under-investigated area of treatment and may be an effective and tolerable strategy that maximizes the available resources. This paper reviews the current evidence for combination pharmacotherapy in unipolar depression and discusses its clinical applications.

## SAD & BRIGHT LIGHT

### TREATMENT OF SEASONAL AFFECTIVE DISORDER.

**Authors :** Winkler D, Pjrek E, Iwaki R, Kasper S.

**Source :** Expert Rev Neurother. 2006 Jul;6(7):1039-48. Related Articles, Links

**Summary:** Seasonal affective disorder (SAD), winter type, is characterized by the regular annual onset of major depressive episodes during fall or winter, followed by spontaneous remission and sometimes hypomanic or manic episodes during spring and summer. SAD is clinically important, since approximately 2-5% of the general population in temperate climates are affected. Since the first description of the syndrome, researchers have made attempts to elucidate the pathophysiological background of SAD. Bright light therapy has been proposed as the treatment of choice for this disorder. However, numerous studies have also investigated suitable psychopharmacological treatments for SAD. This report is aimed to provide an overview on the clinical management and current therapeutic options for SAD.

## DEPRESSION & BDI-II

### RELIABILITY AND VALIDITY OF THE REVISED BECK DEPRESSION INVENTORY (BDI-II) : RESULTS FROM GERMAN SAMPLES.

**Authors :** Kuhner C, Burger C, Keller F, Hautzinger M.

**Source :** Nervenarzt. 2006 Jul 11; [Epub ahead of print] Related Articles, Links

**Background :** The Beck Depression Inventory (BDI) underwent revision in 1996 (BDI-II) with the goal of addressing DSM-IV depression criteria. The present study assessed psychometric properties of the German version of the BDI-II. Patients and methods: The BDI-II was translated into German and evaluated in a series of studies with clinical and nonclinical samples.

**Results:** The content validity of the BDI-II has improved by following DSM-IV symptom criteria. Internal consistency was satisfactorily high ( $\alpha \geq 0.84$ ), and retest reliability exceeded  $r \geq 0.75$  in nonclinical samples. Associations with construct-related scales (depression, dysfunctional cognitive constructs) were high, while those with nonsymptomatic personality assessment (NEO-FFI) were lower. The BDI-II differentiated well between different grades of depression and was sensitive to change.

**Conclusion:** The German BDI-II demonstrates good reliability and validity in clinical and nonclinical samples. It may now replace the older version of the BDI for assessing self-rated severity of depression and course of depressed symptoms under treatment.

## MDD & EMOTIONAL MEMORY

### ▪ ABNORMAL SIZE OF THE AMYGDALA PREDICTS IMPAIRED EMOTIONAL MEMORY IN MAJOR DEPRESSIVE DISORDER.

**Authors :** Weniger G, Lange C, Irle E.

**Source :** J Affect Disord. 2006 Aug;94(1-3):219-29. Epub 2006 Jun 5. Related Articles, Links

**Background:** Amygdala and hippocampus show significant structural abnormalities in major depressive disorder (MDD). Individuals with MDD have difficulties in emotional memory. A relationship between emotional memory deficits and structural abnormalities of amygdala and hippocampus in MDD has been proposed but not shown, yet.

**Methods:** The current study assessed memory for emotional faces in 21 young women with recent-onset MDD and 23 matched control subjects. All subjects underwent structural magnetic resonance imaging (3D-MRI) and a clinical and neuropsychological assessment.

**Results:** Depressive subjects had significantly enlarged amygdala size and significantly reduced hippocampal size compared with controls. Depressive subjects were significantly impaired in learning emotional facial expressions, with deficits being most pronounced for fearful, surprised and disgusted faces. Depressive subjects with amygdala volumes 1 SD or more above the mean of control subjects showed the strongest impairments. Correlation analyses revealed that larger left amygdala volumes were significantly related to worse memory performance and to higher anxiety scores of depressive subjects. Smaller left hippocampal volumes of depressive subjects were related to higher anxiety scores as well. **Limitations:** All MDD subjects were taking antidepressant medication at the time of the study. Longitudinal studies are needed to clarify whether the behavioral and/or volumetric abnormalities of MDD subjects can be attributed to medication or MDD or both.

**Conclusions:** It might be speculated that amygdala enlargement in young MDD subjects is correlated with amygdalar over-activation and resolves with antidepressant treatment, as was shown for amygdalar over-activation.

### DEPRESSION & CAD

#### ▪ DEPRESSION IN CORONARY ARTERY DISEASE: NOVEL PATHOPHYSIOLOGIC MECHANISMS AND THERAPEUTIC IMPLICATIONS.

**Authors :** Parissis JT, Fountoulaki K, Filippatos G, Adamopoulos S, Paraskevidis I, Kremastinos D.

**Source :** Int J Cardiol. 2006 Jul 3; [Epub ahead of print] Related Articles, Links

**Summary:** Depression is a common comorbid condition in patients with coronary artery disease and a well-documented risk factor for recurrent cardiac events and mortality. The exact mechanisms underlying the interplay between depression and ischemic heart disease remain poorly understood and the same is true for the most effective depression treatment for cardiac patients. This review summarizes current knowledge regarding the prognostic role of depression in patients with coronary artery disease, the pathophysiologic pathways involved, and the effects of antidepressant therapy on cardiovascular disease outcomes. With recent evidence suggesting that selective serotonin reuptake inhibitors may improve survival after myocardial infarction in patients with

depression, diagnosis and treatment of this co-morbidity may be essential for the clinical management of coronary artery disease.

### DEPRESSION & PARKINSON DISEASE

#### ▪ DISSOCIATING APATHY AND DEPRESSION IN PARKINSON DISEASE.

**Authors :** Kirsch-Darrow L, Fernandez HF, Marsiske M, Okun MS, Bowers D.

**Source :** Neurology. 2006 Jul 11;67(1):33-8. Related Articles, Links

**Objective:** To examine the hypothesis that apathy is a core feature of Parkinson disease (PD) and that apathy can be dissociated from depression.

**Methods:** Eighty patients with PD and 20 patients with dystonia completed depression and apathy measures including the Marin Apathy Evaluation Scale (AES), Beck Depression Inventory (BDI), and Centers for Epidemiologic Studies-Depression Scale (CES-D).

**Results:** There was a significantly higher severity and frequency of apathy in PD (frequency = 51%, 41/80) than in dystonia (frequency = 20%, 4/20). Apathy in the absence of depression was frequent in PD and did not occur in dystonia (PD = 28.8%, dystonia = 0%).

**Conclusions:** Patients with Parkinson disease (PD) experienced significantly higher frequency and severity of apathy when compared with patients with dystonia. Apathy may be a "core" feature of PD and occurs in the absence of depression.

### DEPRESSION, LIFE EVENTS & SWC

#### ▪ DISRUPTING LIFE EVENTS AND THE SLEEP-WAKE CYCLE IN DEPRESSION.

**Authors :** Haynes PL, McQuaid JR, Ancoli-Israel S, Martin JL.

**Source :** Psychol Med. 2006 Jul 12;:1-11 [Epub ahead of print] Related Articles, Links

**Background:** Social rhythm disruption life events are significant predictors of mood relapse in bipolar patients. However, no research has examined the relationship between these events and their hypothesized mechanism of action: disrupted sleep-wake patterns. The goal of this study was to test whether participants with major depressive disorder have a greater disruption of daily sleep and motor activity following disrupting life events when compared to normal controls. **Method:** Over the course of 2 weeks, 39 normal controls and 39 individuals with major depressive disorder completed life events interviews and wore actigraphs to obtain estimates of sleep/wake activity. **Results:** Statistically significant interactions indicated that the presence of at least one disrupting life event in the previous 4 months correlated with elevations in the amount of time spent awake after sleep onset [ $\beta=0.45$ ,  $\Delta F(1,73)=4.80$ ,  $p<0.05$ ], and decreases in the percentage of time spent asleep [ $\beta=-0.53$ ,  $\Delta F(1,73)=6.57$ ,  $p<0.05$ ], in depressed individuals but not in normal controls.

**Conclusions:** The results indicated that depressed individuals may be more susceptible to the effects of life events on sleep than normal controls. This is the first study to date to correlate life events with objective measures of sleep. However, prospective longitudinal research is necessary to clarify the temporal relationship among these variables.