Generalized Anxiety Disorder (GAD)

* Pooled analysis of venlafaxine XR efficacy on somatic and psychic symptoms of anxiety in patients with generalized anxiety disorder.

**Authors:** Meoni P, Hackett D, Lader M. - Wyeth Research, Paris, France.

**Source:** Depress Anxiety. 2004;19(2):127-32.

**Summary:** We evaluated the relative efficacy of venlafaxine XR on the psychic versus somatic symptoms of anxiety in patients with generalized anxiety disorder as determined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Data were pooled and analyzed from 1,841 patients with generalized anxiety disorder who participated in five short-term (8-week) double-blind, multicenter, placebo-controlled studies, two of which had long-term (6-month) extensions. Somatic and psychic anxieties were studied using the Hamilton rating scale for anxiety (HAM-A) factor scores. We examined response rates (> or =50% improvement over baseline severity score) in the overall population and in patients with mainly somatic symptomatology at baseline (somatizers). Venlafaxine XR significantly reduced factor scores for both psychic and somatic HAM-A factors compared with placebo, from the first and second weeks of treatment, respectively. Patients treated with venlafaxine XR had significantly higher rates of response than patients receiving placebo on the psychic (58% vs. 38%, P<.001 at week 8; 66% vs. 35% at week 24, P<.001) and somatic (56% vs. 43%, P<.001 at week 8; 67% vs. 47% at week 24, P<.001) factors of the HAM-A. There was a TreatmentXFactor interaction (P<.027) in response rates: Patients treated with venlafaxine showed similar psychic and somatic anxiety response rates, whereas placebo-treated patients showed higher somatic compared with psychic response rates. Somatizers showed similar rates of response to the total population for the somatic factor of the HAM-A in either treatment group. Patients with generalized anxiety disorder treated with venlafaxine XR showed similar absolute rates of response on somatic and psychic symptoms, but relative to patients treated with placebo, more improvement in psychic than somatic symptoms.

Posttraumatic Stress Disorder (PTSD)

* Prevalence of PTSD among Palestinian children in Gaza Strip

**Authors:** Samir Qouta, PhD - Eyad El Sarraj, MD

**Source:** Arabpsynet Journal; 2004 Apr-May-June;2:8-14.

**Summary:** This research study aimed to get acquainted with the prevalence of PTSD, and other psychological suffering among Palestinian children living under severe conditions during the last two and half years of the Al-Aqsa Intifada. The sample consists of 944 children whom age ranged between 10-19 years. The group excluded those with previous mental health problems. In this research, trauma scale, PTSD scale, the Child Posttraumatic Stress Index, the Children’s PTSD-symptoms, The CPTS-Ri and open questions had been used as tools. The results indicated that 32.7% of the children started to develop acute PTSD symptoms that need psychological intervention, while 49.2% of them suffered from moderate level of PTSD symptoms. Also the results showed that the most prevalent types of trauma exposure for children are for those who had witnessed funerals (94.6%), witnessed shooting (83.2%), saw injured or dead who were not relatives (66.9%), and saw family members injured or killed (61.6%).

* Current concepts in pharmacotherapy for posttraumatic stress disorder

**Authors:** Schoenfeld FB, Marmar CR, Neylan TC.

**Source:** Psychiatr Serv. 2004 May;55(5):519-31.

**Summary:** This article describes current approaches to the pharmacologic treatment of posttraumatic stress disorder (PTSD) and reviews the classes of pharmacologic agents used in the treatment of PTSD. Pharmacotherapy for PTSD that is comorbid with other psychiatric disorders is highlighted. METHODS: The primary-source literature was reviewed by using a MEDLINE search. Secondary-source review articles and chapters were also used. Results from studies of the psychophysiology of PTSD are outlined in the review to help inform treatment choices. The review gives more consideration to controlled studies than to open clinical trials. Recommendations for treatment are evidence based. RESULTS: AND DISCUSSION: A growing body of evidence demonstrates the efficacy of pharmacologic treatment for PTSD. The effectiveness of the selective serotonin reuptake inhibitors sertraline and paroxetine in large-scale, well-designed, placebo-controlled trials resulted in their being the first medications to receive approval from the U.S. Food and Drug Administration for the treatment of PTSD. Observation of psychophysiolgic alterations associated with PTSD has led to the study of adrenergic-inhibiting agents and mood stabilizers as therapeutic agents. Controlled clinical trials with these classes of medication are needed to determine their efficacy for treating PTSD. Finally, the choice of medication for treating PTSD is often determined by the prominence of specific PTSD symptoms and the pattern of comorbid psychiatric conditions.

* Sleep in lifetime posttraumatic stress disorder: a community-based polysomnographic study

**Authors:** Breslau N, Roth T, Buxton E, Kapke A, Schultz L, Roehrs T. - Department of Epidemiology, College of Human Medicine, Michigan State University, East Lansing 48824, USA.

**Source:** Arch Gen Psychiatry. 2004 May;61(5):508-16

**Summary:** On standard measures of sleep disturbance, no differences were detected between subjects with PTSD and control subjects, regardless of history of trauma or major depression in the controls. Persons with PTSD had higher rates of brief arousals from rapid eye movement (REM) sleep. Shifts to lighter sleep and wake were specific to REM and were significantly different between REM and non-REM sleep (F(1,278) = 5.92; P =.02). CONCLUSIONS: We found no objective evidence for clinically relevant sleep disturbances in PTSD. An increased number of brief arousals from REM sleep was detected in subjects with PTSD. Sleep complaints in PTSD might represent amplified perceptions of brief arousals from REM sleep.

Arabpsynet Journal : Nº 2–April – May – June 2004
Panic Disorder (PD)

- Personality disorder & social anxiety predict delayed response in drug and behavioral treatment of panic disorder

Authors: Berger P, Sachs G, Ameling M, Holzinger A, Bankier B, Katschinski H. Department of Psychiatry, Division of Social Psychiatry, University of Vienna, Austria. peter.berger@akh-wien.ac.at

Source: J Affect Disord. 2004 May;80(1):75-8

Summary: The aim of this study was to analyze the impact of pretreatment characteristics and personality disorders on the onset of response in the treatment of panic disorder. METHODS: The data of 73 out-patients with panic disorder who had completed at least 6 weeks of a randomized trial of 24 weeks of either paroxetine only or paroxetine combined with cognitive group-therapy were analyzed in a Cox proportional hazards model. RESULTS: The likelihood of having responded to treatment (defined by a CGI rating of improvement) was more than twice as high for patients without a personality disorder or social phobia than for Patients with a personality disorder or social phobia. CONCLUSIONS: We suggest that patients with these characteristics do benefit from prolonged treatment, and they may profit from an additional treatment focused on social anxiety.

- Sertraline versus paroxetine in the treatment of panic disorder: an acute, double-blind noninferiority comparison.

Authors: Bandelow B, Behnke K, Lenoir S, Hendriks GJ, Alkin T, Goebel C, Clary CM. - Department of Psychiatry & Psychotherapy, University of Gottingen, von-Siebold-Strasse 5, D-37505 Gottingen, Germany. bbandel@gwdg.de

Source: J Clin Psychiatry. 2004 Mar; 65(3) :405-13

Summary: Several classes of medications have demonstrated efficacy in panic disorder, but direct comparison of 2 proven treatments is still uncommon. The purpose of this study was to compare sertraline and paroxetine in the acute treatment of panic disorder. METHOD: Adult outpatients with panic disorder with or without agoraphobia (DSM-IV and ICD-10 criteria) were randomly assigned in double-blind fashion to 12 weeks of treatment with flexible doses of sertraline (titrated up to 50-150 mg/day; N = 112) or paroxetine (titrated up to 40-60 mg/day; N = 113). Patients were then tapered off medication over 3 weeks. The primary analysis was a noninferiority analysis of Panic and Agoraphobia Scale (PAS) scores. Secondary measures included panic attack frequency and the Clinical Global Impressions-Improvement scale (CGI-I) (with responders defined as those with a CGI-I score < or = 2). Data were collected from January 2000 to June 2001. RESULTS: Sertraline and paroxetine were associated with equivalent levels of improvement on the PAS total score, as well as on all secondary outcome measures. Eighty-two percent of patients taking sertraline versus 78% of those taking paroxetine were CGI-I responders at endpoint. Numerically more patients on paroxetine treatment compared with sertraline treatment discontinued due to adverse events (18% vs. 12%; NS), and a significantly higher proportion of paroxetine patients showed > or = 7% weight gain (7% vs. < 1%; p <0.5). During the taper period, the proportion of panic-free patients increased by 4% with sertraline but decreased by 11% with paroxetine (p <0.5). CONCLUSION: Sertraline and paroxetine had equivalent efficacy in panic disorder, but sertraline was significantly better tolerated and was associated with significantly less clinical worsening during taper than paroxetine.

Anxiety Disorders

- Pregnancy complications associated with childhood anxiety disorders.

Authors: Hiroshfield-Becker DR, Biederman J, Faraone SV, Robin JA, Friedman D, Rosenthal JM, Rosenbaum JF. Pediatric Psychopharmacology Program, Massachusetts General Hospital, Cambridge, Massachusetts.

Source: Depress Anxiety. 2004;19(3):152-62

Summary: To determine whether perinatal complications predict childhood anxiety disorders independently of parental psychopathology, we systematically assessed pregnancy and delivery complications and psychopathology in a sample of children (mean age=6.8 years) at high risk for anxiety disorders whose parents had panic disorder with (n=138) or without (n=26) major depression, and in contrast groups of offspring of parents with major depression alone (n=47), or no mood or anxiety disorders (n=95; total N=306). Psychopathology in the children was assessed by structured diagnostic interviews (K-SADS), and pregnancy and delivery complications were assessed using the developmental history module of the DICA-P. Number of pregnancy complications predicted multiple childhood anxiety disorders independently of parental diagnosis (odds ratio=1.6 [1.4-2.0]). This effect was accounted for by heavy bleeding requiring bed-rest, hypertension, illness requiring medical attention, and serious family problems. Associations remained significant when lifetime child mood and disruptive behavior disorders were covaried. Results suggest that prenatal stressors may increase a child’s risk for anxiety disorders beyond the risk conferred by parental psychopathology alone.

- Venlafaxine in the treatment of anxiety disorders

Authors: M Katzman


Summary: Venlafaxine extended-release (Efflexor®XR, Wyeth-Ayerst Co.) is a novel, dual acting serotonin–norepinephrine reuptake inhibitor antidepressant, which inhibits the synaptic reuptake of both serotonin and norepinephrine. Controlled trials have demonstrated the efficacy and safety of venlafaxine in the treatment of anxiety disorders including social anxiety disorder, generalized anxiety disorder, post-traumatic stress disorder, panic disorder and obsessive–compulsive disorder. Generally well-tolerated with side effects that usually abate with continued treatment, venlafaxine is an important alternative to the selective serotonin reuptake inhibitors for patients with anxiety disorders.

- Standard versus extended Cognitive Behavior Therapy for Social Anxiety Disorder: A Randomized-Controlled Trial

Authors: James D. Herbert a1 c1, Alyssa A. Rheingold a2, Brandon A. Caudiano a3 and Valerie H. Myers a4 / a1 Drexel University, USA / a2 Medical University of South Carolina, USA / a3 Brown University School of Medicine, USA / a4 Pennington Biomedical Research Center, USA


Summary: Although cognitive behavior therapy (CBT) has been shown to be generally effective in the treatment of social anxiety disorder (SAD), not all individuals respond to treatment,
and among those who do respond the degree of improvement is sometimes far from optimal. Little research has examined the impact of variations in the format of treatment delivery in this area. Participants were randomly assigned to either a standard, 12-session CBT program for generalized SAD in which treatment was delivered in successive weekly sessions (standard treatment) or a similar program in which the 12 sessions were delivered over 18 weeks (extended treatment). Intent-to-treat analyses revealed that the standard treatment program resulted in superior outcome in terms of self-rated symptom and impairment levels, categorical ratings of responder status, and lower dropout rates. Analyses of treatment completers only revealed comparable gains between the two conditions by post-treatment. However, the standard treatment condition revealed a more rapid improvement in magnitude initially. These findings suggest no benefit from extending the course of CBT treatment over a greater length of time, and suggest that such extension may in fact substantially increase the likelihood of premature termination.

Key Words: Social Anxiety Disorder; social phobia; cognitive behavior therapy; cognitive restructuring; exposure therapy; extended treatment.

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Bipolar Disorders (BD)

* STATE OF THE ART IN THE MANAGEMENT OF BIPOLAR DISORDER*

Authors: Ahmed Okasha


Summary: In this paper there is a revision of the classification and prevalence of mood disorders, with the emphasis on the higher rates of prevalence of Bipolar Disorders in recent studies. The clinical phenomenology is updated with some discussion of the misunderstood classification and inconsistent diagnosis and treatment worldwide. The management in psychiatry generally and in Bipolar disorder in particular has been discussed. The pharmacotherapy of Bipolar Disorder is reviewed. Lithium, Novel antipsychotics and the management of acute mania or mixed episodes as well as acute depression and rapid cycling also maintenance treatment is clarified, without forgetting the importance of psychosocial intervention. The conclusion calls for more research in the field.

* A REVIEW OF ACUTE TREATMENTS FOR BIPOLAR DEPRESSION.*

Authors: Silverstone PH, Silverstone T. Departments of Psychiatry & Neuroscience, University of Alberta, Edmonton, Alberta, Canada; Department of Psychiatry, University of London, London, UK; Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.


Summary: Bipolar patients generally spend much more time in the depressed phase of their illness than the manic phase, and there are many more bipolar type II and bipolar spectrum disorder patients than there are bipolar type I. Additionally, there is a significant risk of suicide in bipolar patients when depressed. The treatment of the depressed phase of bipolar disorder is therefore a matter of some priority. Here, we review current evidence supporting the use of five groups of treatments: anti-depressants; lithium; anti-convulsants (valproate, and carbamazepine, lamotrigine, gabapentin); anti-psychotics; and other treatments (electroconvulsive therapy, benzodiazepines, sleep-deprivation, and dopamine agonists).

From this review, it is apparent that the literature regarding the treatment of bipolar depression is significantly limited in several key areas. Nonetheless, from the evidence currently available, the treatments with the best evidence for efficacy are selective serotonin reuptake inhibitors (SSRIs) and lamotrigine. There is also some evidence in favour of bupropion and moclobemide. Although lithium and olanzapine monotherapies can also be beneficial, they appear less efficacious than antidepressants. One of the major concerns about treatment with antidepressants has been the risk of precipitating a switch into mania. However, recent studies suggest that, if a mood stabilizer and antidepressant are given concurrently, then the risk of switching is minimized. There is also recent evidence for an independent antidepressant action for at least one atypical antipsychotic. Therefore, the conclusion from this review, in contrast to previous suggestions, is that a combination of an atypical antipsychotic and either an SSRI or lamotrigine may provide a useful first-line treatment for depressed bipolar disorder patients. Further research is clearly required to examine this approach and compare it with other possible treatment options.

* PSYCHOTIC SYMPTOMS IN PEDIATRIC BIPOLAR DISORDER*

Authors: Pavuluri MN, Herbener ES, Sweeney JA. Center for Cognitive Medicine, University of Illinois at Chicago, USA. mpavuluri@psych.uic.edu

Source: J Affect Disord. 2004 May;80(1):19-28

Summary: There is under-recognition or misdiagnosis of pediatric bipolar disorder with psychotic features. It is of major public health importance to recognize psychosis in bipolar disorder. METHOD: Original research on phenomenological description of psychosis and external validators including family history, longitudinal course and treatment effects are systematically reviewed. Age differences, sampling, and interview methods of the studies on pediatric bipolar disorder that reported psychotic features are compared. Critical differentiating features between pediatric bipolar disorder and pediatric schizophrenia are summarized given the presence of overlapping psychotic features. RESULTS: Prevalence of psychotic features in pediatric bipolar disorder ranged from 16 to 87.5% based on age and methodological differences. The most common psychotic features are mood congruent delusions, mainly grandiose delusions. Psychotic features appear in the context of affective symptoms in pediatric bipolar disorder as opposed to schizophrenia where psychotic symptoms are independent of them. Family history of affective psychosis aggregated in probands with bipolar disorder. Limitations: There is discrepancy in clinical appraisal of what constitutes psychosis and pediatric bipolar disorder, apart from the differences in methodology and nature of the samples. CONCLUSION: Clinicians must be vigilant in identifying psychosis in pediatric bipolar disorder, especially when there is a positive family history of psychosis.

* MELANCHOLIC OUTPATIENT DEPRESSION IN BIPOLAR-II VS. UNIPOLAR*

Authors: Benazzi F. E. Hecker Outpatient Psychiatry Center, Ravenna, Italy. f.benazzi@fo.nettuno.it

Source: Prog Neuropsychopharmacol Biol Psychiatry. 2004
Arabpsynet Journal : Nº 2-April - May - June 2004

May;28(3):481-5

Summary: DSM-IV melancholic major depressive episode (MDE) in bipolar II disorder (BP-II) is understudied. Study aim was to compare melancholic MDE in BP-II vs. unipolar major depressive disorder (MDD) on diagnostic validators and clinical features. METHODS: Consecutive 39 BP-II and 34 unipolar MDD outpatients in a private practice were interviewed (off psychopharmacotherapy) with the Structured Clinical Interview for DSM-IV, as modified by Benazzi and Akiskal [J. Affect. Disord. 73 (2003) 1], when presenting for treatment of MDE. DSM-IV criteria of melancholic features specifier were followed. Variables studied were index age, gender, age at onset of the first MDE, number of MDE recurrences, severity (measured by GAF, index MDE psychotic features, index MDE symptoms lasting more than 2 years, Axis I comorbidity), index MDE and melancholic symptoms, bipolar family history. Diagnostic validators were onset, family history, course of illness, and clinical picture. RESULTS: BP-II melancholic MDE, vs. MDD melancholic MDE, had significantly lower age at onset and more bipolar family history. Psychomotor agitation was significantly more common in BP-II melancholic MDE, but was present only in 43.5%. Psychomotor retardation was more common in MDD melancholic MDE at a trend level, but was present only in 20.5%. CONCLUSIONS: Psychomotor agitation was more common in BP-II melancholic MDE vs. unipolar MDD, while previous studies on bipolar I (BP-I) had usually found more retardation. The difference could be related to BP-I and BP-II being at least partly distinct disorders. The relatively low frequency of psychomotor change does not seem to support the view that this is the core feature of melancholia. Differences on diagnostic validators (most importantly family history) further support the distinction of melancholic MDE between BP-II and MDD, and support DSM-IV classification.

* Defining and identifying early onset bipolar spectrum disorder.

Authors: Quinn CA, Fristad MA.

Source: Curr Psychiatry Rep. 2004 Apr; 6(2):101-7

Summary: Early onset bipolar spectrum disorder (EOBPSD) is difficult to diagnose because of symptom overlap with other disorders and nearly ubiquitous comorbidity. A thorough assessment of EOBPSD should include the following: 1) a timeline of the child's development, from birth to present, showing the episodic nature of EOBPSD; 2) a structured clinical interview determining comorbid and differential diagnosis; 3) a family history genogram to ascertain familial loading and environmental stressors, which informs case conceptualization; 4) depression and mania rating scales to assess symptom severity and track treatment outcome; 5) global rating scales to obtain cross-informant data and inform broad-based treatments; and 6) a current mood log to document baseline functioning and track treatment outcome. Examples of a timeline, family history genogram, and current mood log are presented. This comprehensive approach to assessing EOBPSD, a severe and possibly lifelong disorder, is strongly advocated. No scale, instrument, or technique alone is adequate to diagnose EOBPSD.

* Psychological treatment for bipolar disorders A review of randomised controlled trials.

Authors: Gutierrez MJ, Scott J. - Psychological Treatments Research, Institute of Psychiatry, Denmark Hill, 96, London.


Summary: The increased acceptance of stress-vulnerability models of severe mental disorders and of brief evidence-based psychological treatments in their treatment has finally led to increased interest in the role of psychotherapies in bipolar disorders. This paper reviews the results from randomised controlled trials of psychological therapies as an adjunct to standard medications. The evidence suggests that the addition of a psychological therapy may significantly reduce symptoms, enhance social adjustment and functioning, and reduce relapses and hospitalisations in patients with bipolar disorder. However, the methodological problems in the published randomised controlled trials and the heterogeneity in the outcomes achieved (some therapies reduce manic but not depressive relapses, others have the opposite effect) suggests that further studies are required to fully establish the place of these approaches in day to day practice.

**Major Depressive Disorder (MDD)**

"Defining and identifying early onset bipolar spectrum disorder.

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**Major Depressive Disorder (MDD)**

* ملاحظة: المزودة الجزيئية للتelpersغ هو معدلات الاحتكار في عالم العادات الكامل.


www.arabicebm.com:8080
**Quantitative Electroencephalography (qEEG) to Discriminate Primary Degenerative Dementia from Major Depressive Disorder**

**Authors:** DESLANDES, Andréa, VEIGA, Heloisa, CAGY, Mauricio et al.


**Summary:** Electroencephalography (EEG) can be a valuable technique to assess electrophysiological changes related to dementia. In patients suspected of having dementia, the EEG is often quite informative. The sensitivity of the EEG to detect correlates of psychiatric disorders has been enhanced by means of quantitative methods of analysis (quantitative EEG). Quantitative features are extracted from, at least, 2 minutes of artifact-free, eyes closed, resting EEG, log-transformed to obtain Gaussianity, age-regressed, and Z-transformed relative to population norms (Neurometrics database). Using a subset of quantitative EEG (qEEG) features, forward stepwise discriminant analyses are used to construct classifier functions. Along this vein, the main objective of this experiment is to distinguish profiles of qEEG, which differentiate depressive from demented patients (n = 125). The results showed that demented patients present deviations above the control group in variables associated to slow rhythms: Normed Monopolar Relative Power Theta for Cz and Normed Bipolar Relative Power Theta for Head. On the other hand, the deviation below the control group occurs with the variable associated to alpha rhythm: Normed Monopolar Relative Power Alpha for P3, in dementia. Using this method, the present investigation demonstrated high discriminant accuracy in separating Primary Degenerative Dementia from Major Depressive Disorder (Depression).

**Keywords:** qEEG; neurometrics; Alzheimer's disease; depression.

**Mood Stabilizers (MS)**

**Summary:** This study aimed to provide preliminary data on the tolerability and effectiveness of citalopram for patients with dysthymic disorder. Twenty-one adult subjects meeting DSM-IV criteria for dysthymic disorder were enrolled in this 12-week open-label study, of whom 15 had pure dysthymia (e.g. no major depression in the past 2 years). Citalopram was initiated at 20 mg/day, and increased to a maximum of 60 mg/day. Response was defined as 50% or greater drop in score on the Hamilton Depression Rating Scale (HDRS) and a Clinical Global Impressions-I score of 1 ('very much improved') or 2 ('much improved'). Of these 15 pure dysthymic disorder subjects, all completed the trial, and 11 (73.3%) were treatment responders. All paired sample t-tests were highly significant, demonstrating significant average improvement on all measures of symptomatology and functioning. Scores on the 24-item HDRS decreased from 22.3+/-4.3 at baseline to 9.1+/-7.8 at week 12 [t(14)=6.1, P<0.001]. In addition, improvement was noted in self-reported measures of temperament and social functioning. The average final dose of citalopram was 39 mg/day. Side-effects were reported by nine of 15 subjects (60%), most frequently gastrointestinal symptoms (n=5), dry mouth (n=5) and sexual side-effects (n=3). These findings suggest the effectiveness and tolerability of citalopram in treating dysthymic disorder. Double-blind prospective studies are needed comparing citalopram both to placebo and to other medications, assessing both initial and sustained response to treatment.
**Clozapine: A Mood Stabilizer in Chronic Resistant Bipolar Affective Disorder**

**Authors:** Abdurazak ALHAMAD / Associate Professor and Consultant - Department of Psychiatry Medical College King Saud University - alhamad@ksu.edu.sa

**Source:** Arab Journal of Psychiatry November 2003 (14;2)

**Summary:** Clozapine is an atypical dibenzodiazepine antipsychotic drug, which was approved widely for resistant cases of schizophrenia, but as yet not for resistant bipolar affective disorder (BAD), despite some researchers suggesting its use in the long-term treatment of resistant bipolar affective disorder. This paper presents a prospective monitored evidence over a five-year period for this claim, using all previously used outcome measures in the same setting in Saudi BAD patients.

Eleven patients consecutively admitted with chronic BAD to King Khalid University Hospital (KKUH) were tried on at least two mood stabilizers, separately or in combination, one of them lithium for at least two years. Improvement outcome was assessed using the Brief Psychiatric Rating Scale (BPRS), the Clinical Global Impression (CGI), the Quality of Life Scale (QLS) and the Extrapyramidal Symptom Rating Scale (ESRS). Also work status, suicidality, the number of admissions, the number of attendances to accident and emergency (A/E) rooms and the number of relapses were measured before and after treatment.

All above measures showed statistically significant improvement all through the period of the study except the QLS measure.

This report, in spite of the small number of patients studied, presents reasonable evidence for the long-term efficacy of Clozapine monotherapy in chronic resistant BAD patients.

**Key words:** Clozapine, chronic resistant bipolar affective, Saudi Arabia.

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**Depression Mood Stabilization: Novel Concepts and Clinical Management**

**Authors:** Joseph R. Calabrese, MD

**Summary:** A role for lamotrigine as a depression mood stabilizer is now recognized internationally. According to the World Federation of Societies of Biological Psychiatry (WFSBP) 2002 guidelines, the first line of treatment for bipolar depression should usually be a combination of a mood stabilizer (lithium or lamotrigine) and an antidepressant (bupropion or a selective serotonin reuptake inhibitor [SSRI]). [1] Furthermore, lamotrigine may be recommended for maintenance in rapid cycling.[2]
The 2002 revision of the American Psychiatric Association guidelines recommends lamotrigine as an alternative to lithium for first-line treatment of acute bipolar depression; as an alternative to lithium or valproate for initial treatment of rapid cycling; and as a possible alternative to lithium or valproate for BPD maintenance therapy.[3] (Note: lamotrigine is currently US Food and Drug Administration [FDA] approved only for maintenance therapy of bipolar I disorder [BP I].)[4]

The depression study included both bipolar and unipolar patients who were hospitalized with acute depression, stabilized, and then randomized to receive lithium, imipramine, or placebo for 2 years. Among the 31 bipolar patients who received either lithium or placebo, lithium was significantly more effective in preventing new mood episodes. During months 5 to 24, depression occurred in 12% of the lithium group and 55% of the placebo group. Mania occurred in 12% of the lithium group and 33% of the placebo group. Thus, lithium prevented both manic and depressive episodes.[9]

More recently, the prophylactic efficacy of lamotrigine, compared with lithium and placebo, was evaluated in 2, 18-month, randomized, double-blind trials, prospectively designed for pooled analysis. In one trial (GW606/2006), 175 patients with recent manic episodes were randomized; in the other (GW605/2003), 463 patients with recent depressive episodes were randomized. In each trial individually, as well as in the pooled analysis, lithium primarily delayed relapse into mania, while lamotrigine primarily delayed relapse into depression.[5,7] Thus, lithium and lamotrigine appear to complement each other, suggesting that they might be used together prophylactically in patients at risk for both types of mood episodes.

* Mood Stabilizers: A Proposed Reclassification

**Authors:** Erik Herman, MD

**Source:** Current Medical Research and Opinion

**Summary:** Slide 1. Lamotrigine: A Depression Mood Stabilizer

Most mood stabilizers were initially investigated for use in mania, and have not been well studied in bipolar depression. Until recently, there was no systematic effort to develop mood stabilizers for the depressed phase of bipolar disorder (BPD). Thus, there has been a lack of well-evaluated treatment options for bipolar depression, which has been especially problematic for patients with rapid cycling.[1]

Slide 2. Reconceptualizing Bipolar Disorder

To highlight this unmet need, a reconceptualization of BPD has been proposed, in which euthymia is defined as the baseline. Mania, hypomania, and mixed states are "above baseline," while depression and subsyndromal depression are "below baseline."[1]

Slide 3. ‘Class A’ Mood Stabilizers

Based on this conceptualization, 2 classes of mood stabilizers can be defined. Class A consists of agents that stabilize mood from above baseline - in other words, agents that have antimanic properties without inducing or worsening depression.

Slide 4. ‘Class B’ Mood Stabilizers

Class B consists of agents that stabilize mood from below baseline - in other words, agents that have antidepressant properties without inducing mania or cycle acceleration.[1]

Conventional mood stabilizers - lithium and the anticonvulsants, carbamazepine (off-label use) and valproate or divalprox - are primarily antimanic agents, but do appear to have some antidepressant activity.[2] Of these agents, lithium probably comes closest to meeting the definition of both a Class A and a Class B mood stabilizer.[1] However, in acute treatment of bipolar depression, response to lithium is often delayed or incomplete.[1,3] In lithium prophylaxis, depressive breakthrough is usually more of a problem than manic breakthrough.[4] and several placebo-controlled trials have failed to show significant efficacy in preventing depressive relapses.[5-8] Lithium appears to be most effective in classical BPD, and less effective in atypical variants, such as rapid cycling.[1]

On the other hand, the anticonvulsant lamotrigine may be considered the prototype of a Class B mood stabilizer.[5] In clinical trials it has been shown to benefit acute bipolar depression without inducing mania or cycle acceleration; it also prevents depressive relapse. Lamotrigine was approved in 2003 by the US Food and Drug Administration (FDA) for long-term maintenance treatment of BPD.

Other anticonvulsants, including gabapentin, topiramate, and levetiracetam, have been used off-label in BPD. Gabapentin has anxiolytic properties, and may be a useful adjunct, particularly in patients with comorbid anxiety;[9] however, controlled data do not support its use as monotherapy for either mania or depression.[10] Controlled data for topiramate are scarce. One randomized study failed to show an acute antimanic effect (as monotherapy); another randomized study suggested an acute antidepressant effect (as an adjunct to mood stabilizer therapy).[11] However, topiramate has also been observed to induce depression in some epilepsy patients.[7] Levetiracetam (added on to previous treatment) has shown promise in stabilizing both mania and depression in case reports of refractory rapid cycling,[12] but there have been no controlled trials with this agent.

Antidepressants, though widely used to treat bipolar depression, do not meet the criteria for Class B mood stabilizers because they can potentially induce switching into mania and cycle acceleration. Tricyclic antidepressants appear to carry the highest risk,[13] while newer agents, such as selective serotonin reuptake inhibitors (SSRIs) and bupropion, have been associated with low rates of switching in most (but not all) reports.[2,13,14] However, treatment-emergent mania has been reported with all major antidepressant classes.[15] An estimated 20% to 40% of bipolar patients may be at risk,[13] especially those with rapid cycling.[4,7,14] Naturalistic observations suggest that concurrent use of mood stabilizers may reduce the risk by as much as 50%. [15] Antidepressants are not recommended as monotherapy for bipolar depression.[16]

* Lamotrigine is Helpful in Preventing Depressive Relapses in Bipolar Disorder

**Authors:** Laurie Barclay, MD -Reviewed by Gary D. Vogn, MD


**Summary:** Feb. 18, 2004 — Lamotrigine (LTG) is better than placebo or lithium for preventing depressive relapses in bipolar disorder, according to a presentation at the International Congress of Biological Psychiatry held in Sydney, Australia, from Feb. 9-13.

"The results of this study suggest that [LTG] is the only medication that has better efficacy in preventing depressive relapse," lead author Lakshmi N. Yatham, MBBS, FRCPc, MRCpsych, told Medscape. Dr. Yatham is a professor of psychiatry and Michael Smith Foundation Senior Scholar at the University of British Columbia.
the University of British Columbia in Vancouver, Canada. "This has important clinical implications, as all medications currently used for prophylaxis of bipolar disorder have better efficacy in preventing mania than depression."

Lithium, which is commonly used to treat bipolar mania, is also thought to have antidepressant activity. Based on the results of two clinical trials in bipolar I disorder that enrolled 463 currently or recently depressed patients and 175 currently or recently manic patients, the investigators compared the effects of 18 months of prophylactic treatment with placebo (PBO), lithium (Li), and LTG.

Compared with placebo, LTG treatment resulted in fewer recently manic patients who required intervention for depression (LTG 14%, Li 22%, PBO 30%; P = .034 for LTG vs. PBO); reported depressive adverse events (LTG 0%, Li 4%, PBO 3%); met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), criteria for depression (LTG 10%, Li 17%, PBO 28%; P = .024 for LTG vs. PBO), or had Hamilton Depression Rating Scale (HAM-D) scores greater than 20 (LTG 3%, Li 11%, PBO 19%; P = .011 for LTG vs. PBO).

In recently depressed patients, the treatment groups did not differ significantly in the incidence of depressive symptoms. Intervention for depression was required in 39% of the PBO group, 34% of the LTG group, and 38% of the Li group. The corresponding proportions for reported depressive adverse events were 2%, 4%, and 3%; for DSM-IV depression, the proportions were 36%, 31%, and 36%; and for HAM-D greater than 20 were 26%, 22%, and 18%, respectively.

The authors suggest that because LTG can protect against depressive symptoms in currently or recently manic patients, administration of LTG should be considered during or shortly after stabilization of mania, before depressive symptoms occur.

"Clinicians can combine lamotrigine with lithium or atypical antipsychotics for achieving optimal control of both depression and mania," Dr. Yatham said.

**Lamotrigine in Mood Disorders**

*Authors*: Ben Green

*Source*: Current Medical Research and Opinion

*Summary*: Lamotrigine is an anticonvulsant drug with good efficacy and safety in the treatment of epilepsy. There is now substantial evidence that lamotrigine is also useful in treating resistant depression, rapid cycling bipolar affective disorder, depressive episodes in bipolar affective disorder and in the maintenance phase or prophylaxis of bipolar affective disorder. There are possible roles in managing mood changes in borderline personality disorder, reducing chronic pain and treating schizoaffective disorder.

The general range of doses found effective in affective disorders is from 50 to 300 mg daily. Clinical use seems to involve a titration of dose upwards over several weeks until the desired effect is obtained.

However, further definitive double-blind, randomised controlled trials against gold standard treatments are required.

Lamotrigine has a preferable side-effect profile compared to standard agents for bipolar affective disorder such as lithium or carbamazepine. Further research is certainly warranted and, given its tolerability, could point to lamotrigine as the treatment of choice for some affective disorders.

**Barcelona Bipolar Eating Disorder Scale (BEDS): a self-administered scale for eating disturbances in bipolar patients.**

*Authors*: Torrent C, Vieta E, Crespo J, Gonzalez-Pinto A, Del Valle J, Olivares J, Rodriguez A, De Arce C, Sanchez-Planell L, Colom F; Programa de Trastornos Bipolares. Hospital Clinic-IDIBAPS. Barcelona

*Source*: Actas Esp Psiquiatr. 2004 May;32(3):127-131

*Summary*: The presence of eating disorders in bipolar population is not rare, with rates over 10%, according to the few available epidemiologic studies, however the literature on this issue is still scarce. An even higher percentage of bipolar individuals suffer from serious problems related to eating behavior without fulfilling criteria for DSM-IV eating disorder. Methods. The Bipolar Eating Disorders Scale (BEDS) was designed on the basis of the existing eating scales, adjusted to the characteristics of bipolar disorders from the complaints of our sample of patients (n=350). Subsequently, a group of experts made the selection of the most representative and independent items in order to obtain a short, 10-item scale, aimed at assessing the intensity and frequency of eating dysfunctions in the bipolar population and not at diagnosis. We administered the scale to a healthy control group (n=55) to evaluate feasibility and to determine the cut-off score. Results. The BEDS is a 10-item simple, self-administered scale. Average time of completing this scale is about 1.13 min (1 min, 21 seconds) +26 seconds. Median score was 6 and the mean score was 6.6 with a standard deviation of 3.7, this being the reason why the cut-off point was found to be around 13 points. Patients receiving scores over 13 may require an individualized intervention to evaluate which were the main difficulties and to propose treatment. Conclusions. The BEDS allows for a rapid and effective evaluation of both the intensity and the frequency of eating dysfunctions in bipolar patients in order to perform an adequate intervention for the specific needs of each one of the patients.

**Treatment of bulimia nervosa in a primary care setting**

*Authors*: Walsh BT, Fairburn CG, Mickley D, Sysko R, Parides MK. - Department of Psychiatry, College of Physicians and Surgeons of Columbia University, New York, NY 10032, USA.


*Summary*: The authors’ goal was to determine whether treatments known to be effective for bulimia nervosa in specialized treatment centers can be used successfully in primary health care settings. They examined the benefits of two treatments for bulimia: 1) fluoxetine, an antidepressant medication, and 2) guided self-help, an adaptation of cognitive behavior therapy. METHOD: Ninety-one female patients in two primary care settings were randomly assigned to receive fluoxetine alone, placebo alone, fluoxetine plus guided self-help, or placebo and guided self-help. RESULTS: The majority of the patients did not complete the treatment trial; many patients found the treatment program too demanding, but others indicated it was not sufficiently intensive. Patients assigned to fluoxetine attended more physician visits, exhibited a greater reduction in binge eating and vomiting, and had a greater improvement in psychological symptoms than those assigned to placebo. There was no evidence of benefit from guided self-help. CONCLUSIONS: The treatment of patients with bulimia nervosa in a primary care setting is
hampered by a high dropout rate. Guided self-help, a psychological treatment based on cognitive behavior therapy, appears ineffective, but treatment with fluoxetine is associated with better retention and substantial symptomatic improvement.

* Eating Disorders in Mid-Childhood

**Authors:** Irene Chatoor, MD, and Jaclyn Surles, BA

**Source:** Primary Psychiatry. 2004;11(4):34-39

**Summary:** Most literature on the subject of eating and feeding disorders has focused primarily on feeding difficulties in infants and young children and on eating disorders in adolescents and young adults. This article examines eating disorders in mid-childhood, specifically during the preadolescent elementary school age, an area that has undergone relatively little scrutiny. Specific symptoms and diagnostic criteria for infantile anorexia, sensory food aversions (both starting during infancy or early childhood), and posttraumatic eating disorder are described, and the presentation of anorexia nervosa and bulimia nervosa in children is discussed. The specific treatment for each of these five eating disorders is outlined and the need for family therapy for children with eating disorders is emphasized.

* Anorexia Nervosa and Gender Identity Disorder in Biologic Males: A Report of Two Cases.

**Authors:** Winston AP, Acharya S, Chaudhuri S, Fellowes L.


**Summary:** Gender identity disorder is a rare disorder of uncertain etiology. The emphasis on body shape in this disorder suggests that there may be an association with anorexia nervosa. METHOD: We report two cases of anorexia nervosa and gender identity disorder in biologic males who presented to an eating disorders service. RESULTS: One was treated successfully as an outpatient and subsequently underwent gender reassignment surgery. The other patient required admission and prolonged psychotherapy. DISCUSSION: Differences between the two cases are discussed. Issues of gender identity should be considered in the assessment of male patients presenting with anorexia nervosa. Copyright 2004 by Wiley Periodicals, Inc. Int J Eat Disord 36: 109-113, 2004.

Schizophrenia

* Clock-Reading in Patients with Schizophrenia: A 3-Burst Methodology

Wahlbeck K, Cheine M, Essai M A.


**Source:** www.arabicebm.com

**Abstract:** This methodology was designed to assess the ability of patients with schizophrenia to read clocks. The method measures the patient's ability to read the time on a clock with three bursts. Each burst consists of a 30-second period during which the patient is required to read as many clocks as possible. The results can be compared with those of normal controls. This methodology has been found to be useful in assessing the cognitive function of patients with schizophrenia and in monitoring the effectiveness of treatment.

**Arabpsyinet Journal:** N° 2-April - May - June 2004
* Adverse effects of risperidone and haloperidol treatment in schizophrenia.  
**Authors**: Yen YC, Lung FW, Chong MY. - Department of Psychiatry, Military Kaohsiung General Hospital, 2 Chung Cheng 1st Road, Kaohsiung, 802, Taiwan.  
**Summary**: Side effects of pharmacological treatment in schizophrenia continue to be a major issue in spite of the development of new antipsychotics. The aim of this study is to explore the adverse effects of conventional and atypical antipsychotic drugs and their associated factors. METHODS: Over 3 months, 41 patients with schizophrenia were randomized to treatment with risperidone 1-12 mg (n=21) or haloperidol 2-20 mg (n=20) daily. Efficacy was assessed by improvement of psychotic symptoms, measured on the Positive and Negative Syndrome Scale (PANSS). The safety and tolerability were assessed with the Extrapyramidal Symptom Rating Scale, the UKU Side-Effect Rating Scale and clinical laboratory assessments. RESULTS: Each treatment reduced psychotic symptoms. PANSS total scores, positive scores, and general psychopathology scores declined as trial went on without significant differences between the two groups. While PANSS negative scores improved better in the risperidone group than in the haloperidol group. The tolerability of antipsychotics was statistically significantly better in the risperidone than in the haloperidol-treated patients. The most frequent adverse effects for both groups were tremor and rigidity. Antipsychotics, their doses, and hyperprolactinemia predict short-term extrapyramidal side effects. Serum prolactin levels could predict parkinsonism and dyskinesia severity. However, dyskinesia was best predicted by the doses of neuroleptics. The predictive factor of dystonia was the antipsychotic drug itself. After adjusting drug doses and concomitant medications, side effects could be markedly improved. CONCLUSIONS: This study suggested that risperidone was superior to haloperidol in improving negative symptoms and better tolerated during the 12 weeks' treatment of schizophrenia. Serum prolactin levels could predict the severity of parkinsonism and dyskinesia.

* General and specific cognitive deficits in schizophrenia.  
**Authors**: Dickinson D, Iannone VN, Wilk CM, Gold JM. Veterans Affairs Capitol Health Care Network, Mental Illness Research, Education, and Clinical Center, 10 North Greene Street, Suite 6A, Baltimore, MD 21201, USA.  
**Summary**: It is controversial whether the cognitive deficit in schizophrenia is better characterized as generalized or as reflecting relatively independent deficits in different cognitive domains. The issue has implications for assessment practice, intervention design, and the exploration of schizophrenia.

genetics. METHODS: We used a specialized structural equation modeling approach, single common factor analysis, to explore the relative importance of generalized versus independent cognitive deficits in schizophrenia. Eighteen subtest scores from the Wechsler Adult Intelligence Scale-III and the Wechsler Memory Scale-III were included in the analysis. We analyzed these data for 97 schizophrenia or schizoaffective disorder outpatients and 87 healthy control subjects. RESULTS: Approximately two thirds of the overall effect of a schizophrenia diagnosis on cognitive performance was mediated through a single common factor. The Wechsler subtest scores showed almost uniformly strong relationships with this factor. The independent associations of group status with the subtest scores were smaller in magnitude and only selectively significant. CONCLUSIONS: The relatively greater magnitude of illness effects mediated through the common factor in this analysis, compared with the specific, independent effects, suggests that a generalized cognitive deficit is a core feature of schizophrenia.

* Sulpiride treatment of Cotard's syndrome in schizophrenia.  
**Authors**: Shirasati H, Ito M, Hayashi H, Otani K. Department of Psychiatry, Yonezawa City Hospital, Yonezawa 992-8502, Japan.  
**Source**: Prog Neuropsychopharmacol Biol Psychiatry. 2004 May;28(3):607-9  
**Summary**: A 33-year-old male suffering from schizophrenia developed the typical symptoms of Cotard's syndrome, i.e., various delusions of negation and severe depressive symptoms. Atypical symptoms such as delusions of persecution and control related to body parts were also observed. These symptoms gradually improved by the treatment with sulpiride 300 mg/day. In the course of improvement of Cotard's syndrome, the patient developed Capgras syndrome. This report suggests that sulpiride is effective for Cotard's syndrome in schizophrenia. It also suggests that the symptoms of Cotard's syndrome are modified according to basic disorders, and this syndrome has a close connection with Capgras syndrome.

**Premenstrual Dysorphic Disorder (PMDD)**

* Premenstrual Disorders: Advances in Treatment Disclosures  
**Authors**: Shaila Misri, MD, FRCPC  
**Source**: The 1st World Congress on Women's Mental Health, Berlin, Germany - March 2001.  
**Summary**: 2% to 9% of women are affected by severe mood and physical symptoms during the luteal phase of their menstrual cycles; these women suffer from PMDD. The DSM-IV outlines the criteria for PMDD as a specific clinical syndrome. Major depression and PMDD are interrelated: women with depression are more likely to suffer from PMDD, and women with a history of PMDD are at higher risk of developing an episode of depression. A dysfunction of the serotonin transporter gene may play a role in PMDD. The efficacy of the SRI antidepressants for the treatment of PMDD has been established. Newer medications such as venlafaxine are currently under investigation. Medication has a rapid onset of action in PMDD sufferers,
usually within the first month of treatment and often within
the first few days; it targets both physical and mood
symptoms.

Longer-term treatment (9 menstrual cycles) with SRI
antidepressants seems to reduce the risk of symptom
recurrence. Women treated with an SRI medication for 3
cycles or less often relapse after discontinuation within 1
cycle.

Quality of life is severely diminished in women who suffer
from moderate PMS and PMDD. Treatment with an SRI
medication for 3 antidepressants seems to reduce the risk of symptom
recurrence. Women treated with an SRI medication for 3
months or less often relapse after discontinuation within 1
cycle. Quality of life is severely diminished in women who suffer
from moderate PMS and PMDD. Treatment with an SRI
medication for 3

Additional references were identified from the bibliographies of the retrieved articles.

Data Synthesis: PMS refers to a group of menstrually related
disorders that are estimated to affect up to 40% of women
of childbearing age. The varied symptoms of PMS include mood
swings, tension, anger, irritability, headache, bloating, and
increased appetite with food cravings. PMS symptoms occur
during the luteal phase of the menstrual cycle and remit with
the onset of menstruation or shortly afterward. Approximately 5%
of women with PMS suffer from PMDD, a more disabling and
severe form of PMS in which mood symptoms predominate.

Because no tests can confirm PMS or PMDD, the diagnosis
should be made on the basis of a patient-completed daily
symptom calendar and the exclusion of other medical disorders.
The causes of PMS and PMDD are uncertain, but are likely
associated with aberrant responses to normal hormonal
fluctuations during the menstrual cycle. For most women,
symptoms can be relieved or reduced through lifestyle
interventions, such as dietary changes and exercise, and drug
therapy with hormonal or psychotropic agents. For PMDD,
selective serotonin reuptake inhibitors have recently emerged
as first-line therapy. Certain dietary supplements, including
calcium, also may be an option for some women.

Conclusion: PMS and PMDD are complex but highly treatable
disorders. Pharmacists can improve the recognition and
management of these common conditions by providing patient
education on premenstrual symptoms and counseling women
on lifestyle interventions and pharmacotherapy to relieve their
discomfort.

Postpartum Depression (PPD)

Hoffbrand S, Howard L, Crawley H

Postpartum Depression (PPD)

Hoffbrand S, Howard L, Crawley H

www.arabicebm.com
**Treatment of Postpartum Depression**

**Authors:** Barbara L. Parry, MD  
**Source:** Primary Psychiatry. 2004;11(3):48-51  
**Summary:** Postpartum mood disorders are often unrecognized and undertreated. They can present as maternity blues or baby blues, a major depressive episode with features of melancholia, or postpartum psychoses. Untreated postpartum depression in the mother is particularly distressing, as it can impair the neurocognitive development of the child. However, a range of therapeutic modalities are available that have reasonable safety and efficacy in breastfeeding women. New nonpharmacologic treatment strategies include sleep and light therapies that potentially offer benefit within days and do not have the potential adverse effects that are of concern with some pharmacologic interventions.

**Interpersonal Psychotherapy for Antenatal & Postpartum Depression**

**Authors:** Lisa S. Segre, PhD, Scott Stuart, MD, and Michael W. O’Hara, PhD  
**Source:** Primary Psychiatry. 2004;11(3):52-56,66  
**Summary:** Despite its prevalence, postpartum depression is frequently not detected. Primary care physicians (PCPs) are often a woman’s only contact with healthcare professionals. These professionals have a vital role in the screening and treatment of depressed women; therefore it is necessary that PCPs be aware of assessment issues and effective treatments. This article describes the use of interpersonal psychotherapy (IPT), a timelimited and empirically validated treatment for perinatal depression, in terms of the relevant clinical issues for pregnant or postpartum women. During the assessment phase, the symptoms of depression must be disentangled from the normal physical states of pregnancy and the postpartum, and an accurate diagnosis must be made. During the initial and intermediate phases of treatment, interpersonal problems that are common to the perinatal period are addressed. Given the risk for future depressive episodes, provisions for future treatment must be established prior to the conclusion of therapy. With these adaptations, IPT can be modified for effective use with perinatal women. As a result, PCPs may gain an increased understanding of both an effective treatment and the salient interpersonal issues for these women.

**Challenges in Identifying and Diagnosing Postpartum Disorders**

**Authors:** Leslie Born, MSc, PhD, Dawn Zinga, PhD, and Meir Steiner, MD, PhD, FRCP  
**Source:** Primary Psychiatry. 2004;11(3):29-36  
**Summary:** Perinatal mental illness is underdiagnosed and may have serious consequences for both the mother and the infant. Early screening and identification are crucial. - Risk factors for postpartum mental illness include depressed or anxious mood during pregnancy, personal or family history of psychiatric disorder (especially in first-degree relatives and including alcoholism), unplanned pregnancy, perinatal sleep deprivation, and major psychosocial stressors.

**Can Postpartum Depression Be Predicted?**

**Authors:** Michael W. O’Hara, PhD, & Laura L. Gorman, PhD  
**Source:** Primary Psychiatry. 2004;11(3):42-47  
**Summary:** Postpartum depression (PPD) is a mental health problem that carries substantial risk for women, children, and families. Depression may emerge during pregnancy and carry over into the postpartum period or develop soon after delivery and even many months later. Numerous studies have been undertaken to determine the etiology of PPD and to identify risk factors during pregnancy that may predict its occurrence. Risk factors measured during pregnancy that show the strongest relation to PPD include current and past depression and anxiety disorder, negative stressful life events, marital discord, and poor social support. Many of these risk factors have been incorporated into scales and are used to screen women during pregnancy and to select high-risk women for prevention trials. In general, these instruments do identify a group of women with substantial increased risk for PPD over the base rate and can serve as a basis for a conversation between a woman and her healthcare provider. Despite their positive attributes, these instruments tend to overidentify women at risk and at the same time miss many women who go on to experience a PPD.

**Identifying Depression in the First Postpartum Year: Guidelines for Office-Based Screening and Referral**

**Authors:** Peindl KS, Wisner KL, Hanusa BH. Department of Psychiatry and Human Behavior, Jefferson College of Medicine, Thomas Jefferson University, Philadelphia, PA 19107, USA.  
**Source:** J Affect Disord. 2004 May;80(1):37-44  
**Summary:** Some 10-15% of women experience postpartum-onset major depression (PPMD). The objective of this study was to determine if the Edinburgh Postnatal Depression Scale (EPDS) is an effective screen for major depression (MD).

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prospectively. The outcome of the study was identification of a recurrence of major depression in the first year postpartum by a clinical interview and the EPDS. We had the unique opportunity to examine the relationship between EPDS scores and PPMD. METHODS: Participants were pregnant women who had experienced an episode of previous PPMD but were well during their index pregnancy. This study was part of a double-blind, randomized clinical trial in which new mothers received nortriptyline or placebo within 24 h following delivery for prevention of PPMD. Recurrence of depression was established according to Research Diagnostic Criteria. Participants completed the EPDS weekly through 20 weeks postpartum and into a 1-year follow-up phase. RESULTS: Out of 50 women, 13 experienced recurrence of MD in the first 20 weeks postpartum with a total of 20 out of 50 recurring in the first year. The EPDS score of >9 at week 4 postpartum identified 60% of women who nurtured in the first 20 weeks and 80% who recurred in the first postpartum year. Limitations: The study population included only women who had a previous episode of postpartum depression. The generalizability to all women is limited. CONCLUSIONS: The EPDS is an effective depression screen for women who had a previous episode of PPMD. Clinical guidelines are provided for use of the EPDS to identify MD in the first postpartum year in primary care settings.

Women Depression

* Prematurity at birth & adolescent depressive disorder


Summary: Association between prematurity/low birthweight and adolescent depressive disorder studied using a case-control design within a prospective cohort study of 2032 adolescents. Odds for depressive disorder were 11-fold (95% CI 2-62) higher for the premature/low-birthweight participants after regression adjustment for major confounding factors. For premature/low-birthweight females, cumulative rates of depressive disorder over 30 months were 15.2% (95% CI 11.1-20.5) v. 1.8% (95% CI 1.6-2.1) in those with normal birthweight. Physiological adaptations in utero before full term may be implicated causally in some cases of depression in adolescence.

* Special issues in the management of depression in women.

Authors: MacQueen G, Chokka P.

Source: McMaster University, Hamilton, Ontario. macqueng@mcmaster.ca

Summary: Depression is more prevalent in women than in men, which may be related to biological, hormonal, and psychosocial factors. Four depressive conditions are specific to women: premenstrual dysphoric disorder (PMDD), depression in pregnancy, postpartum depression, and depression related to perimenopause or menopause. Antidepressant therapy with selective serotonin reuptake inhibitors and venlafaxine has demonstrated efficacy in PMDD. Both continuous and intermittent dosing regimens were effective at usual but not at low dosages. Despite reluctance of some women to take medication for depression during pregnancy and breastfeeding, substantial evidence suggests that antidepressants are safe and efficacious during these periods, while untreated depression has negative consequences for both mother and child. In peri- or postmenopausal women with depression, estrogen may enhance the effects of antidepressant medications, although a pooled analysis of data in women aged 50 years or over treated with venlafaxine found that remission rates were similar in those who were taking estrogen and those who were not. The management of women with depression can be done safely and effectively using antidepressants and alternative interventions throughout the life cycle.

* Neonate characteristics after maternal use of antidepressants in late pregnancy.

Authors: Kallen B. Tornblad Institute, University of Lund, Lund, Sweden. embryol@embryol.lu.se


Summary: Exposure to antidepressants during the third trimester of pregnancy has been associated with an increased risk for adverse birth outcomes, including preterm birth, respiratory distress, and hypoglycemia. OBJECTIVE: To investigate neonatal outcomes in 997 infants (987 mothers) after maternal use of antidepressants based on prospectively recorded information in antenatal care documents. RESULTS: An increased risk for preterm birth (odds ratio [OR], 1.96) and low birth weight (OR, 1.98) was verified, but the gestational week-specific birth weight was increased not only after exposure to tricyclic antidepressants. An increased risk for a low Apgar score (OR, 2.33), respiratory distress (OR, 2.21), neonatal convulsions (OR, 1.90), and hypoglycemia (OR, 1.62) was found, the latter especially after exposure to tricyclic drugs, but no significant effect on the frequency of neonatal jaundice was seen (OR, 1.13). Most effects seemed not to be selective serotonin reuptake inhibitor drug specific, and outcomes after exposure to paroxetine hydrochloride were not worse than after exposure to other selective serotonin reuptake inhibitors. CONCLUSIONS: Neonatal effects after maternal use of antidepressant drugs during late pregnancy were seen. Selective serotonin reuptake inhibitors may be the drugs of choice during pregnancy.

* A pilot study of brief interpersonal psychotherapy for depression among women

Authors: Swartz HA, Frank E, Shear MK, Thase ME, Fleming MA, Scott J. Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania 15213, USA. swartzha@msx.upmc.edu


Summary: A matched-case-control study compared eight-week outcomes between a group of 16 depressed women who received brief (eight-session) interpersonal psychotherapy and a group of 16 who received a selective serotonin reuptake inhibitor (sertraline). Women who met DSM-IV criteria for major depression and who had a score above 15 on the Hamilton Rating Scale for Depression were treated openly with brief interpersonal psychotherapy and were matched on key variables with women being treated with sertraline. Linear mixed-effects regression models were used to compare groups on measures of symptoms and functioning during eight weeks of treatment. Both groups improved significantly over
time, with large effect sizes. However, contrary to expectations, the women who received psychotherapy improved more quickly than those who received sertraline.

**Menopausal Depression (MD)**

* Challenge of Menopausal Depression*
Authors: By Roberta Friedman
Source: PRI-MED WEST
Summary: ANAHEIM, CA -- May 14, 2004 -- Depression commonly accompanies menopause and in fact is more common in the perimenopausal years. Treatment is challenging given the new take on hormonal treatments commonly accompanies menopause and in fact is more common in the perimenopausal years. Women who are at risk for depression in their menopausal years are those who have been depressed before, who have hot flashes, and who are in disrupted marriage or employment situations.

Doctors are left fairly empty handed when trying to help women with approved, evidence-based therapy for menopausal depression that relies on hormones. For instance, said Dr. Carlson, a trial of transdermal estrogen gave good results compared to placebo, even independent of whether or not any hot flashes were present. Yet unopposed estrogen, she said, is "not viable in the long term, and we don’t know the effect of adding progesterone."

Analysis of quality of life findings in the WHI study showed no differences, but this was for the older women of the study population, who were a mean age of 64 years, Dr. Carlson said. "People use this [finding] to say we should never give women who develop depression, perimenopausally, hormone replacement," Dr. Carlson said.

She added that women who are not having hot flashes should try selective serotonin reuptake inhibitors (SSRIs), and that if they are having lots of hot flashes, they should consider low dose hormones or SSRIs.

**Women Mental Health (WMH)**

* Relationship of Sexual Assault History to Somatic Symptoms and Health Anxiety in Women*
Authors: Stein MB, Lang AJ, Laffaye C, Satz LE, Lenox RJ, Dresselhaus TR. - Veterans Affairs San Diego Healthcare System and the University of California San Diego, La Jolla, CA, USA.
Summary: Prior reports have pointed to a link between traumatic experiences and health consequences in women. The objective of this study was to determine whether there is an association between sexual assault history and measures of somatic symptoms and illness attitudes in a sample of female Veterans Affairs primary care patients, a group in whom high rates of sexual trauma have been reported. We conducted a cross-sectional study of a representative sample of 219 women in a Veteran’s Affairs primary care outpatient clinic. Sexual assault history, somatic symptoms and health

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anxiety were assessed by self-report questionnaire. Multivariate analyses were used to examine relationships between sexual assault exposure and these outcomes. Ninety-seven women (43.9%) reported experience(s) of sexual assault (i.e., rape, attempted rape or being made to perform any type of sexual act through force or threat of harm). Sexual assault was associated with a significant increase in somatization scores, physical complaints across multiple symptom domains and health anxiety. Sexual assault was also a significant statistical predictor of having multiple sick days in the prior 6 months and of being a high utilizer of primary care visits in the prior 6 months. These data confirm a strong association between sexual trauma exposure and somatic symptoms, illness attitudes and healthcare utilization in women. Causal mechanisms cannot be inferred from these data. Studies in other cohorts are warranted.

**Clinical Utilization of Atypical Antipsychotics in Pregnancy and Lactation (July/August).**

**Authors:** Gentile S. ASL Salerno 1, Head of Mental Health Center District n. 4 Piazza Galdi, 84013 Cava de’ Tirreni (SA), Italy, fax 39 089 4455440, salvatore_gentile@libero.it

**Source:** Ann Pharmacother. 2004 May 18

**Summary:** To analyze the available literature regarding the safety of atypical antipsychotics in pregnancy and lactation in order to recommend evidence-based strategies for pharmacologic management of psychosis in these conditions. DATA SOURCES: We summarized the results from articles identified via MEDLINE/PubMed/TOXNET (1993-January 31, 2004), using the key terms pregnancy, lactation, breast-feeding human milk, psychotropic drugs, atypical antipsychotics, olanzapine, quetiapine, risperidone, clozapine, ziprasidone, and aripiprazole. STUDY SELECTION AND DATA EXTRACTION: Retrospective studies, clinical observations, and case reports regarding the 6 atypical antipsychotics mentioned above were selected and analyzed. Extensive manual review of pertinent journals and textbooks was also performed. DATA SYNTHESIS: Reviewed studies show that olanzapine and clozapine apparently do not increase the teratogenic risk if administered to pregnant women, while evidence on quetiapine, risperidone, aripiprazole, and ziprasidone is still limited. In contrast, available information is not able to exclude unwanted serious effects associated with the use of all atypical antipsychotics on mother-infant dyads. Furthermore, more than a few studies suggest increased hyperglycemic risk for pregnant women related to atypical antipsychotic therapy during gestation. Finally, published evidence about the effects on long-term infant neurodevelopment of drug exposure through both placenta and breast milk is represented only by sporadic case reports. CONCLUSIONS: It is well known that potential consequences of an untreated psychotic episode may be severe and may lead to the mother attempting suicide and/or infanticide. For these reasons, clinicians need to help mothers weigh both fetal and neonatal risks of exposure to drugs against the potential risk they and their infant may incur if the psychiatric illness is not treated. On the other hand, atypical antipsychotics in pregnancy and breast-feeding do not show evident advantages in safety when compared with typical neuroleptic agents. Therefore, we suggest that the most relevant parameters for selecting the best clinical option for pregnant and breast-feeding women with schizophrenia and related disorders remain strongly related to 3 main points: (1) cautious evaluation of the risk/benefit ratio of fetal and neonatal drug exposure, (2) degree of severity of maternal psychiatric illness, and (3) careful preliminary choice of drugs characterized by a balanced safety/efficacy profile.

**Biological Psychiatry**

*The Role of Psychiatric Genetics in Pediatric Psychopharmacology*

**Authors:** Kutaibe Chaley

**Source:** The Arab Journal of Psychiatry – 2004 May;15(1) : 17-25

**Summary:** Psychiatric genetics is relevant to psychopharmacology in many respects. First it is undeniable current state of knowledge that, genes make youths susceptible to psychiatric disorders. This has been shown for Attention Deficit/Hyperactivity Disorder, Depression, Autism, Tourette's Syndrome, Mood Disorders in general, Anxiety, Bipolar Disorder, Learning Disabilities and Conduct Disorder. In fact, it is fairly certain that the D4 Dopamine receptor gene is a susceptibility gene for Attention Deficit/Hyperactivity Disorder. For Learning Disabilities, there is a consistent finding on Chromosome 6, that a gene that is as of yet unknown is involved in Learning Disabilities. Breakthroughs are being made in Autism, Bipolar Disorders. This is amazing when we consider that 20 to 30 years ago psychiatric disorders were considered to be reactions to environmental events. We have really moved very far beyond that in psychiatric genetics. While genes control many brains systems, these mediate therapeutic response, drug metabolism and side effects. So, the question for the future is: "To what degree can psychiatric genetic studies help clarify these points?" Finally, there is a possibility that genetic studies may also set the foundation for primary prevention. The genetic variance would predict drug response, molecular genetic diagnosis, can gene improve psychiatric diagnoses, and then primary prevention.

**Depression in Aging Men:** The Role of Testosterone.

**Authors:** Carnahan RM, Perry PJ. - Clinical & Administrative Pharmacy, College of Pharmacy, University of Iowa, Iowa City, Iowa, USA.

**Source:** Drugs Aging. 2004;21(6):361-76.

**Summary:** Age-related decline in testosterone levels is associated with a number of mild, nonspecific symptoms, including depressive symptoms. The relationship between depressive symptoms and testosterone levels is confounded by numerous factors, including medical illness, obesity, smoking, alcohol use, diet and stress, and is thus complex. Studies have not consistently supported an integral role of reduced testosterone levels in major depressive disorder, although levels may often be reduced in men with treatment-refractory depression and older men with dysthymia. Low testosterone levels may also increase the risk of incident depression in older males, although this may depend upon androgen receptor genetic polymorphisms. Testosterone replacement has demonstrated short-term tolerability and efficacy in augmenting antidepressants to alleviate treatment-refractory depression in adult males. Case studies support the potential need for maintenance therapy to maintain response. In a placebo-controlled trial, testosterone monotherapy was not effective in treating major depressive disorder in men with...
hypogonadism. However, in an open-label, noncomparative study, testosterone monotherapy appeared effective in treating late-onset but not early-onset major depressive disorder in older males. Testosterone therapy is not without potential for adverse effects, the most worrisome of which is the worsening of pre-existing prostate carcinoma. Oral, short- and long-acting parenteral, and transdermal patch and gel formulations are available. Testosterone has demonstrated usefulness in the treatment of a number of depressed populations, but further studies are needed to fully elucidate its role in the treatment of depressive syndromes in the aging male.

* The Biology and Pathophysiology of Peripartum Psychiatric Disorders
Authors: Vivette Glover, MA, PhD, DSc, & Martin Kammerer, MD
Source: Primary Psychiatry. 2004;11(3):37-41
Summary: Cortisol, progesterone, and estrogen increase to high levels by the end of pregnancy and show a sharp reduction on parturition. These hormones are known to have large psychoactive effects, and it is likely that some women with affective disorders over the peripartum period are especially sensitive to these changes. In a subgroup of women, postpartum depression has been associated with the presence of thyroid autoantibodies during pregnancy. It is important to differentiate the different types of mood disorders that occur over this time in order to understand their biological bases. Parturition can trigger the "blues," which is a mild lability of mood associated with crying; the "highs," which is a mild hypomania; or postpartum psychosis. A family history of manic depression is a strong risk factor for postpartum psychosis; there is also evidence for genetic vulnerability to a puerperal trigger. Both severe blues and highs are risk factors for later depression. Symptoms of anxiety and depression are as common during pregnancy as during postpartum. Some episodes of depression and/or anxiety start during pregnancy and resolve postpartum; others are triggered for the first time by parturition. These are likely to have different biological bases, possibly related to the functioning of hypothalamic-pituitary-adrenal axis of the individual.

Restless Legs Syndrome (RLS)

* Restless Legs Syndrome
Authors: Lesage S, Earley CJ.
Summary: In the past 10 years, restless legs syndrome (RLS) has gained recognition as a common sleep disorder. There are several therapeutic options in treating patients with RLS. RLS causes significant sleep disturbance and negatively impacts on patient quality of life. Pharmacologic treatment can result in improved sleep and quality of life issues. RLS patients should be evaluated for iron deficiency anemia; iron replacement in deficient patients may lead to a resolution of symptoms or may reduce the severity of their symptoms. For patients with daily symptoms, the initial therapy is dopamine agonists. Low doses given in the evening or 2 hours before bed provide adequate relief of symptoms for many RLS patients. Augmentation can be seen with all dopamine agents, but is most prevalent with levodopa. Levodopa therapy is best used for milder intermittent symptoms or in aggravating situations, such as long car rides. Opiates and antiepileptics remain a beneficial therapy for RLS and are useful in patients who experience pain as part of their RLS. Newer anticonvulsants may provide additional treatment options, but they have yet to undergo clinical trials. Intravenous iron also may provide relief of RLS symptoms; however, dosing and safety issues have not been fully evaluated in a RLS population.

* Topiramate Use as Treatment in Restless Legs Syndrome
Authors: Perez A; Servicio de Psiquiatría. Complejo Hospitalario Xeral-Cies. Vigo (Pontevedra)
Summary: Restless legs syndrome is an underdiagnosed disorder of unknown etiology, that generates severe sleep and life quality disturbances. In its therapeutic approach, drugs with very different action mechanisms and variable results have been used. Methods. Nineteen outpatients diagnosed of restless legs syndrome were studied observationally. A semi-structured interview was carried out and physical variables (weight, arterial pressure and heart rate), sensitive and motor symptoms, effective dose of topiramate, side effects and fulfillment of the treatment at 30, 60 and 90 days were studied. Results. The patients studied, with an average age of 62.052 +/- 6.22 years, showed improvement in sensitive and motor symptoms, as well as non-significant reductions in cardiovascular parameters. The mean effective dose of topiramate was established at 42.1 +/- 18.7 mg. A significant reduction in weight stands out among the side effects. Conclusions. Topiramate is profiled as an effective treatment in restless legs syndrome, with good tolerability and minimal side effects. Actas Esp Psiquiatr 2004;32(3):132-137

Sleep Disorders (SD)

* Sleep, Sleep Apnea, and Epilepsy
Authors: Bazil CW. The Neurological Institute, Columbia University, 710 West 168 Street, New York, NY 10032, USA. cwb11@columbia.edu
Summary: Sleep disorders occur commonly in patients with epilepsy, and can be responsible for symptoms of daytime somnolence and also can contribute to the intractability of epilepsy. The most important aspect of treating sleep disorders, especially sleep apnea, is the recognition of the problem. In a busy clinical practice, symptoms of sleep disorders are frequently overlooked or mistaken. Whenever sleep disruption or excessive daytime somnolence is potentially problematic, the patient should be referred to a sleep specialist. If indicated, diagnostic testing performed (usually polysomnography with or without multiple sleep latency tests). The author also recommends that all patients receive basic counseling about sleep hygiene, because its principles are often helpful to patients in general. Even in the absence of a sleep disorder, the choice of an anticonvulsant can be partly tailored to the sleep needs of the patient, with alerting drugs (lamotrigine and felbamate) dosed early in the day and relatively sedating agents (phenobarbital and phentoin) dosed later or at bedtime.

Alzheimer Diseases (AD)

* Donepezil for Alzheimer's Disease

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in Clinical Practice - The DONALD Study. A Multicenter 24 - Week Clinical Trial in Germany


Summary: This multicenter open-label clinical trial was designed to investigate the safety and efficacy of donepezil, a selective acetylcholinesterase inhibitor, in the treatment of Alzheimer’s disease (AD) in routine clinical practice in Germany. A total of 237 patients with mild-to-moderate AD were treated with donepezil for 24 weeks, 186 completed the study according to the protocol. In the complete group, mean MMSE score for efficacy showed an improvement from baseline of +1.6 points at week 12 (95% CI +1.1 to +2.1) and of +1.1 points at week 24 (95% CI +0.5 to +1.7). In more than 80% of the patients, global tolerability was rated to be very good or good. There were only insignificant effects on ECG of +1.1 points at week 24 (95% CI +0.5 to +1.7). In more than 95% of patients treated with donepezil for 24 weeks, 186 completed the study according to the protocol. The study confirms the results obtained in previous double-blind trials, which showed that donepezil is effective and well tolerated in patients with mild-to-moderately severe AD. Copyright 2004 S. Karger AG, Basel.

* Effects of Cholinergic Drugs and Cognitive Training on Dementia.
Authors: Requena C, Lopez Ibor MI, Maestu F, Campo P, Lopez Ibor JJ, Ortiz T. - Universidad de Leon (Area de Psicologia), Leon, Madrid, Spain.


Summary: A study was performed on patients with Alzheimer’s disease (AD) in order to evaluate the efficacy of a combined treatment (donepezil plus cognitive training) in both cognitive processes and affective states. Eighty-six subjects, 25 men and 61 women, with an average age of 75.58 years, were studied. Almost all the subjects had a basic educational level. Donepezil was administered at a dose of 10 mg daily along with cognitive treatment involving images of everyday life and reminiscence music; the sessions took place on Monday to Friday and lasted three quarters of an hour. The study lasted 12 months. Subjects underwent test-retest with the following tests: Mini-Mental State Examination (MMSE), the cognitive subscale of the Alzheimer’s Disease Assessment Scale (ADAS-cog); the Geriatric Depression Scale (GDS) and the overall deterioration scale (FAST). The results showed that subjects receiving the combined treatment had a better response than those who did not receive any cognitive training. These subjects’ MMSE score decreased by 3.24 on average. The affective symptomatology of those receiving only drug treatment improved whereas the cognitive processes did not.

**Geriatric Psychiatry**

* Special issues in the management of depression in older patients
Authors: Rabheru K. - Department of Psychiatry, University of Western Ontario, London. Kiran.Rabheru@sjhc.london.on.ca


Summary: Major depressive disorder is frequently undiagnosed and untreated in older patients. Grief, pain, sleep issues, concurrent medications, altered physiology, and the presence of comorbid medical and psychiatric conditions can complicate the management of depression in older patients. Remission should be the goal of therapy in treating depression in the elderly, just as it is in younger patients, to maximize the impact of treatment on quality of life. Managing depression in older patients can be done effectively with the antidepressant therapies currently available, including selective serotonin reuptake inhibitors (SSRIs), venlafaxine, and mirtazapine. Comorbid medical conditions, which are common among older patients, can have a significant impact on depression and vice versa. Antidepressant therapy with SSRIs has demonstrated efficacy and tolerability in patients at high risk for cardiovascular events and stroke and in those with vascular dementia or Alzheimer’s disease. Care should be taken to choose antidepressants with no or minimal effects on glucose levels in patients with diabetes. In addition, venlafaxine has demonstrated beneficial effects on the relief of the pain of diabetic neuropathy. Venlafaxine, mirtazapine, and the SSRIs have demonstrated efficacy and tolerability in older patients, while tricyclic antidepressants have also demonstrated efficacy; however, tolerability can be a problem. Depression is not a natural part of the aging process, as some still believe. The review of current data indicates that the goal of management can and should be full remission. Further, the use of newer agents is safe and effective in this population, as long as one considers the pharmacokinetics and pharmacodynamic properties and inherent biological differences in the elderly population when selecting appropriate therapy.

**Cognition & Late-Life Depression**
Authors: Christopher F. Murphy, PhD, and George S. Alexopoulos, MD

Source: Primary Psychiatry. 2004;11(5):54-58

Summary: It is not uncommon for older patients to present with symptoms of both depression and cognitive impairment. Proper diagnoses in such cases are complicated by overlap- ping symptoms, heterogeneity of syndromes, and impaired self-report. What follows is a discussion of the literature on the clinical and etiological association of late-life depress-sive syndromes, cognitive dysfunction, and dementia. Assessment and treatment strategies are discussed with the recommendation that when presented with a depressed elderly patient with cognitive impairment, the clinician should evaluate both the psychiatric symptoms and signs and the cognitive impairment. Careful tracking of both depressive and cognitive features and well-targeted, long-term pharmacotherapy and psychosocial interventions can help reduce the burden on these compromised patients.

**Assessment and Management of Depression in Older Adults**
Authors: Linda H. Harpole, MD, MPH, and John W. Williams Jr, MD, MHScc

Source: Primary Psychiatry. 2004;11(5):31-36

Summary: Approximately 5% to 10% of older patients who visit a primary care provider suffer from clinically significant depression. Making the diagnosis in the older population can be challenging, as the cardinal symptom of depression, depressed mood, is less prominent than symptoms such as...
loss of interest and enjoyment in life, anergia, sleepless-ness, and loss of appetite. Significant barriers to successful treatment exist in this popu-lation, including patient resistance to accepting the diagnosis and its perceived stigma, the inappropriate attribution of depressive symptoms to natural aging, and the primary care physician’s lack of time and resources to provide adequate treatment. Primary care physicians should make special efforts to screen for depression in their older patients, and once identified, provide education and close follow-up, with the goal of achieving remission from depressive symptoms. Collaborative care models, incorporating patient education, case management, and liaison mental health care, which were developed to overcome some of the barriers to successful treatment of depression in older adults, have proven to be successful. Elements of these models can be incorporated into current practice with the goal of improving the quality of depression care in older adults.

Psycho-oncology

* Psychiatric disorders in oncology: recent therapeutic advances and new conceptual frameworks.

Authors: Ronson A. - Institut Jules Bordet Supportive Care Clinic, Brussels Belgium.


Summary: PURPOSE OF REVIEW: Major advances achieved in anticancer treatment have resulted in significant increases in cancer patients’ survival periods. At the same time, growing awareness of the psychologic impact of the diagnosis and treatment of cancer on quality of life has created the need for deeper insights into the adjustment process, its disorders, and effective strategies for the treatment of psychiatric morbidity. The wider availability of brain imaging techniques and other neurobiologic tools is creating major opportunities for a scientific understanding of psychodynamic processes.

RECENT FINDINGS: Several elements indicate a stress-system activation in response to cancer. The existence of traumatic stress-like syndromes has received increasing support. Structural brain imagery has revealed volumetric alterations of the amygdala, a major participant in emotional and fear responses. Hypotheses about functional modifications at the hypothalamic-pituitary-adrenal axis level may have significant implications for the identification, treatment, and even prevention of psychopathology. Finally, longitudinal studies assessing psychologic adjustment confirm the need for psychosocial and pharmacologic interventions.

SUMMARY: Our understanding of the cancer experience at the emotional and cognitive levels remains insufficient, leading to weakly positive results of psychosocial intervention models. The use of antidepressant medication has received substantial empiric and scientific support, but a risk of antidepressant-induced carcinogenesis has not been excluded, which should keep clinicians from overprescribing attitudes. Finally, improving the quality of doctor-patient communication and the psychologic impact of carrying a genetic marker of cancer risk should be the focus of further attention.

Attention Deficit Hyperactivity Disorder (ADHD)

* The use of antidepressants to treat attention deficit hyperactivity disorder in adults

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Tardive Dyskinesia

* Tardive dystonia induced by atypical neuroleptics: a case report with olanzapine


Summary: We report the case of a 17-year-old-boy with schizophrenia who developed tardive dystonia after 9 months of treatment with olanzapine. This case and the relevant literature show that when neuroleptic treatment is indicated, switching to another atypical neuroleptic might be helpful for both tardive dystonia and schizophrenia. In such a case, clozapine appears to be the first-line therapeutic option.

* Lower risk for tardive dyskinesia associated with second-generation antipsychotics: a systematic review of 1-year studies.

Authors: Correll CU, Leucht S, Kane JM. - Department of Psychiatry Research, Zucker Hillside Hospital, North Shore-Long Island Jewish Health System, Schneider Children's Hospital, Glen Oaks, NY 11004, USA. ccorrell@lij.edu


Summary: Based on lower rates of acute extrapyramidal side effects associated with second-generation antipsychotics, compared to first-generation antipsychotics, and based on preliminary data, second-generation antipsychotics are expected to cause less tardive dyskinesia than first-generation antipsychotics. This hypothesis was examined in a systematic
review of studies involving open or controlled treatment with any second-generation antipsychotic. METHOD: Studies of treatment with second-generation antipsychotics lasting > or =1 year and reporting on new cases of tardive dyskinesia or dyskinesia were systematically reviewed. RESULTS: In 11 studies, 2,769 patients received treatment with risperidone (five studies, N=1,235), olanzapine (two studies, N=610), quetiapine (two studies, N=386), amisulpride (one study, N=331), or ziprasidone (one study, N=207) for a weighted mean and median duration of 263 and 306 days, respectively. Study designs were double blind and randomized (N=3); open-label extensions of double-blind, randomized trials (N=4); and open label (N=4). Of the four trials that had a comparator (all involving adults with schizophrenia spectrum disorders), three used haloperidol (N=408) and one used placebo (N=71). Studied populations included children (N=77), adults (N=1,419), adults and elderly persons (N=794), and exclusively patients age 54 years or older (N=479). The weighted mean annual incidence of tardive dyskinesia for second-generation antipsychotics was 0% in the children, 0.8% (range=0.0%-1.5%) in the adults, 6.8% in the mixed adult and elderly population, and 5.3% (range=0.0%-13.4%) in the patients age 54 years and older, compared to 5.4% (range=4.1%-7.4%) in adults treated with haloperidol. CONCLUSIONS: Results from 11 long-term studies support the idea that second-generation antipsychotics have a reduced risk for tardive dyskinesia, compared to first-generation antipsychotics, although the doses of haloperidol used in the comparator studies were relatively high. More carefully designed studies, ideally lasting beyond 1 year and comparing the effects of different second-generation antipsychotics in patients who have never taken first-generation antipsychotics, are needed to estimate the true risk. It would not appear premature for clinicians to consider these findings in making long-term treatment decisions.

**Mirtazapine is effective in the prophylactic treatment of chronic tension-type headache**

**Authors:** Bendtsen L, Jensen R. Danish Headache Center, University of Copenhagen, and Department of Neurology, Glostrup University Hospital, Copenhagen, Denmark.

**Source:** Neurology. 2004 May 25;62(10):1706-11

**Summary:** The tricyclic antidepressant amitriptyline is the only drug with prophylactic efficacy for chronic tension-type headache. However, amitriptyline is only moderately effective, with headache reduction of approximately 30%, and treatment is often hampered by side effects. Mirtazapine is a relatively new so-called noradrenergic and specific serotoninergic antidepressant, which is more specific and therefore generally better tolerated. OBJECTIVE: To evaluate the efficacy of mirtazapine. METHODS: Twenty-four nondepressed patients with chronic tension-type headache were included in a randomized, double-blind, placebo-controlled, crossover trial. All patients had tried numerous other treatments. Mirtazapine 15 to 30 mg/day or placebo was each given for 8 weeks separated by a 2-week wash-out period. RESULTS: Twenty-two patients completed the study. The primary efficacy variable, area-under-the-headache curve (AUC; duration x intensity), was lower during treatment with mirtazapine (843) than during treatment with placebo (1,275) (p = 0.01). Mirtazapine also reduced the secondary efficacy variables headache frequency (p = 0.005), headache duration (p = 0.03), and headache intensity (p = 0.03) and was well tolerated. CONCLUSIONS: Mirtazapine reduced AUC by 34% more than placebo in difficult-to-treat patients. This finding is clinically relevant and may stimulate the development of prophylactic treatments with increased efficacy and fewer side effects for tension-type headache and other types of chronic pain.

**Neuroleptic Malignant Syndrome (NMS)**


**Source:** Przegl Lek. 2003 ;60(4):299-301

**Summary:** Neuroleptic malignant syndrome (NMS) is the most dangerous side effect of phenothiazines therapy. In the period of time from 1995 to 2002 in the Intensive Toxicological Unit there were five patients, 3 men and 2 women, aged from 25 to 62 (average 44.2) years-old, admitted from the regional inpatients psychiatric units with the diagnosis of pneumonia and/or sepsis. The patients about 48-72 hours after admittance were given some phenotazine derivatives (promazine, perphenazine, clozapine, pipamperon) and/or butyrophenone (haloperidol) because of psychotic state. Altered consciousness, muscle rigidity, hyperpyrexia (39.0-41.0 degrees C), sweating, tachycardia (120-150/min.), tachypnoea (respiratory rate more than 25/min.) and high level of creatine kinase activity (23,751-112,288 U/l) dominated. Only one patient had clinical picture of pneumonia. Because of the rapid development of acute respiratory failure, respirathorotherapy was initiated and continued for 8 and 10 days in two patients respectively. Transient thrombocytopenia (26,000/microliter) in one subject was observed. The neuroleptic drug was withdrawn and intensive supportive care with administration of bromocriptine (15-20 mg/24 h) was provided. None of the doctors told the patients about the possibility of NMS during phenothiazines therapy.

**Psychophysiology**

**Update on stress and depression: the role of the hypothalamic-pituitary-adrenal (HPA) axis**

**Authors:** MELLO, Andrea de Abreu Feijó de, MELLO, Marcelo Feijó de, CARPENTER, Linda L et al.

**Source:** Rev. Bras. Psiquiatr., Oct. 2003, vol.25, no.4, p.231-238, ISSN 1516-4446.

**Summary:** Over the past 50 years, relationships between stress and the neurobiological changes seen in psychiatric disorders have been well-documented. A major focus of investigations in this area has been the role of the hypothalamic-pituitary-adrenal (HPA) axis, both as a marker of stress response and as a mediator of additional downstream pathophysiologic changes. This review examines the emerging literature concerning the relationship between stress, HPA axis function, and depression, as well as the role of early life stress as an important risk factor for HPA axis dysregulation. The more recent studies reviewed suggest that...
the prominence of HPA axis hyperactivity in adults with depressive and anxiety disorders may constitute a link between the occurrence of adversity in childhood and the development of adult psychopathology.

**Electroconvulsive Therapy (ECT)**

*World Psychiatric Association Position Statement on the Use and Safety of Electroconvulsive Therapy*

**Authors:** Mohammed T. Abou-saleh, Yiannis G. Papakostas, Iannis M. Zervas, George N. Christodoulou

**Source:** The Arab Journal of Psychiatry – 2004 May;15(1): 26-35

**Summary:** This position statement on the use and safety of electroconvulsive therapy (ECT) has been prepared on behalf of the WPA Section on Biological Psychiatry at the request of the Executive Committee of the WPA. The statement is informed by available evidence and reference will be made to guidelines produced by a number of authoritative bodies, including the American Psychiatric Association, the Royal College of Psychiatrists, the UK National Institute of Clinical Excellence (NICE) and the World Federation of Societies of Biological Psychiatry. Moreover, for depressive disorders particular reference will be made to the recently published systematic review and meta-analysis by the UK ECT Review Group (2003).

**Psychotropic Drugs**

*Increased Mania Risk (Symbyax) Reduces Depression / Anxiety in Bipolar Patients Without Increased Mania Risk*

**Authors:** Bruce Sylvester

**Source:** NEW YORK, N.Y. – May 7, 2004

**Summary:** A combination of olanzapine and fluoxetine HCl (Symbyax) reduces core mood symptoms of depressive and anxiety without increasing risk of inducing mania in bipolar patients, researchers said during a presentation of 2 studies here on May 6th at the American Psychiatric Association Annual Meeting.

Symbyax is the only treatment approved by the Food and Drug Administration for the treatment of depressive phase bipolar disorder.

"We saw 2 important things in these studies," said the lead investigator for both studies, Sara Corya, MD, lead researcher, Lilly Research Labs, Indianapolis, Indiana. "[Montgomery-Asberg Depression Rating Scale] score improvements [showed] mean core mood improvements, not only improvements in somatic symptoms of depression. And Symbyax subjects achieved relatively greater improvement in depression and anxiety symptoms when compared to placebo or olanzapine subjects – and did not show increased treatment-emergent mania. The last point is a very important one for clinical practice, where the fear of inducing mania with these patients is understandably high."
**Atypical Depression, Atypical Temperament, and a Differential Antidepressant Response to Fluoxetine and Nortriptyline.**

*Authors*: Joyce PR, Mulder RT, McKenzie JM, Luty SE, Cloninger CR. - Department of Psychological Medicine, Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand.

*Source*: Depress Anxiety. 2004;19(3):180-6

*Summary*: We examined the personality characteristics of depressed patients with and without atypical depression. Of 195 depressed outpatients in a randomized treatment trial of fluoxetine or nortriptyline, 16 met DSM-IV criteria for atypical depression. We compared the personality traits and disorders in those with and without atypical depression. In atypical depression, fluoxetine was superior to nortriptyline. On the Temperament and Character Inventory, those with atypical depression had high attachment, low persistence, and high anticipatory anxiety. A temperament construct of these dimensions was associated with a differential antidepressant response, regardless of other atypical features. A temperament derived measure of "rejection sensitivity" defines a group of depressed patients with a differential antidepressant response, regardless of reversed vegetative symptoms.

**Clozapine in Drug Induced Psychosis in Parkinson’s Disease: A Randomised, Placebo Controlled Study with Open Follow Up.**

*Authors*: Pollak P, Tison F, Rascol O, Destee A, Pere JJ, Senard JM, Durif F, Bourdeix I. Department of Neurology, University Hospital of Grenoble, 38043 Grenoble Cedex 9, France. pierre.pollak@ujf-grenoble.fr


*Summary*: To compare the efficacy and safety of clozapine in drug induced psychosis in Parkinson’s disease (PD). METHODS: A four week, randomised, double blind, parallel comparison of clozapine and placebo, followed by a 12 week clozapine open period, plus a one month period after drug discontinuation, in 60 patients with PD. The primary efficacy outcome was the «clinical global impression scale» (CGI); the positive subscore of the «positive and negative syndrome scale» (PANSS) was used as the secondary efficacy parameter and the «unified Parkinson’s disease rating scale» (UPDRS) and the «mini mental test examination» (MMSE) as safety outcomes. RESULTS: The mean (SD) dosage of clozapine was 35.8 (12.5-50) mg at the end of the double blind period. The mean (SD) scores on the CGI improved by 1.8 (1.5) for the clozapine group compared with 0.6 (1.1) for the placebo group (p = 0.001). The mean (SD) positive subscore of PANSS improved by 5.6 (3.9) for the clozapine group (0.8 (2.8) for the placebo group; p < 0.0001). At the end of the open period, 25 patients had completely recovered from delusions and hallucinations, and 19 experienced a relapse within one month after the clozapine washout period. The UPDRS motor and MMSE mean scores did not change significantly in either group. Somnolence was more frequent with clozapine than with placebo. CONCLUSIONS: Clozapine at a mean dose lower than 50 mg/day improves drug induced psychosis in PD without significant worsening of motor function, and the effect wears off once the treatment stops.

**Considerations in the Combination of Clozapine and Benzodiazepines**


*Source*: Nervenarzt. 2004 Mar 23 [Epub ahead of print]

*Summary*: Serious adverse events and even sudden death have been reported during administration of the combination of clozapine and benzodiazepines. However, this combination does not necessarily result in increased frequency of serious adverse events. Thus it is not regarded as an absolute contraindication and might be useful in distinct clinical situations, e.g., during the occurrence of a malignant neuroleptic syndrome, "catatonic dilemma," or severe agitation during clozapine treatment. In the following report, certain suggestions on how to deal with this combination therapy are provided which may provide a basis for discussion that ultimately may lead to the formulation of guidelines for this combination therapy. Such guidelines may help psychiatrists in dealing with this combination in clinical situations. Moreover, the formulation of such guidelines would help with forensic issues in case of serious adverse events occurring during this combination therapy.

**Seizure Secondary to Citalopram Overdose.**

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*Summary*: Selective serotonin reuptake inhibitors (SSRIs) are widely used in the community for treating many forms of mental illness. Citalopram, a newer generation SSRI, is commonly prescribed but, despite its low toxicity profile, has a danger of seizure and dysrhythmias in overdose. This case report documents the key aspects in treatment of a citalopram overdose resulting in a seizure and an episode of supraventricular tachycardia (SVT). The seizure was successfully treated with benzodiazepines. The SVT was terminated with administration of adenosine. We review the literature and make recommendations on treatment of citalopram overdose.

**The Effects of Antidepressants on Human Sexuality**

*Authors*: Ania H. Clayton, MD, and Sara G. West, MD

*Source*: Primary Psychiatry. 2003;10(12):62-70

*Summary*: Focus Points
- Antidepressant medications affect sexual functioning through specific mechanisms of action.
- Antidepressant-associated sexual dysfunction (SD) may contribute to medication nonadherence or diminished quality of life.
- Many factors may contribute to SD in depressed patients, including residual symptoms of depression, medical illness, substance abuse, psychosocial factors, and medications.
- Algorithms may be helpful in the assessment and treatment of SD associated with antidepressant therapy.

*Abstract*: Sexual dysfunction has become an increasingly important and recognized contributor to the side-effect profile in patients treated with antidepressant medications. The
condition may take several forms and must be differentiated from a prior or unrelated condition. The effects of each class of antidepressants differ based on their mechanisms of action. There exist a number of options for relief of sexual dysfunction associate with the use of antidepressants.

**ATYPICAL ANTIPI SCPHOTICS AND RISK OF CEREBROVASCULAR ACCIDENTS**

**Authors:** Herrmann N, Mamdani M, Lancelot KL

**Source:** Am J Psychiatry. 2004 Jun;161(6):1113-5

**Summary:** Randomized controlled trials have suggested that at least one atypical antipsychotic may be associated with an increased risk of stroke in older people with dementia. This study examined the association between atypical antipsychotic use and stroke in the elderly. METHOD: The authors conducted a retrospective population-based cohort study of patients over the age of 66 by linking administrative health care databases. Three-cohorts-users of typical antipsychotics, risperidone, and olanzapine were identified and compared. RESULTS: Subjects treated with typical antipsychotics (N=1,015) were compared with those given risperidone (N=6,964) and olanzapine (N=3,421). Model-based estimates adjusted for covariates hypothesized to be associated with stroke risk revealed relative risk estimates of 1.1 (95% CI=0.5-2.3) for olanzapine and 1.4 (95% CI=0.7-2.8) for risperidone. CONCLUSIONS: Olanzapine and risperidone use were not associated with a statistically significant increased risk of stroke compared with typical antipsychotic use.

**COMPARATIVE EFFECT OF ATYPICAL AND CONVENTIONAL ANTIPI SCPHOTICS ON NEUROCognition IN FIRST-EPISODE PSYCHOSIS**

**Authors:** Keefe RS, Seidman LJ, Christensen BK, Hamer RM, Sharma T, Sitkskoorn MM, Lewine RR, Yurgelun-Todd DA, Gur RC, Tohen M, Tollefson GD, Sanger TM, Lieberman JA

**Source:** Am J Psychiatry. 2004 Jun;161(6):985-95

**Summary:** The effect of antipsychotic medication on neurocognitive function remains controversial, especially since most previous work has compared the effects of novel antipsychotic medications with those of high doses of conventional medications. This study compares the neurocognitive effects of olanzapine and low doses of haloperidol in patients with first-episode psychosis. METHOD: Patients with a first episode of schizophrenia, schizoaffective disorder, or schizoaffective disorder (N=167) were randomly assigned to double-blind treatment with olanzapine (mean modal dose= 9.63 mg/day) or haloperidol (mean modal dose=4.60 mg/day) for the 12-week acute phase of a 2-year study. The patients were assessed with a battery of neurocognitive tests at baseline and 12 weeks after beginning treatment. RESULTS: An unweighted neurocognitive composite score, composed of measures of verbal fluency, motor functions, working memory, verbal memory, and vigilance, improved significantly with both haloperidol and olanzapine treatment (effect sizes of 0.20 and 0.36, respectively, with no significant difference between groups). A weighted composite score developed from a principal-component analysis of the same measures improved to a significantly greater degree with olanzapine, compared with haloperidol. Anticholinergic use, extrapyramidal symptoms, and estimated IQ had little effect on the statistical differentiation of the medications, although duration of illness had a modest effect. The correlations of cognitive improvement with changes in clinical characteristics and with side effects of treatment were significant for patients who received haloperidol but not for patients who received olanzapine. CONCLUSIONS: Olanzapine has a beneficial effect on neurocognitive function in patients with a first episode of psychosis. However, in a comparison of the effects of olanzapine and low doses of haloperidol, the difference in benefit is small.
more for an exposure session or leaves their private practice for the exposure training.

### The Impact of Psychological Psychotherapy on Anxiety Provoking Dizziness in Panic Disorder with Agoraphobia

**Authors:** N. Heinrichs, K. Hahlweg, C. Moschner, K. Wessel, W. Fiegenbaum

**Source:** Verhaltenstherapie 2003; 13:244-252 (DOI: 10.1159/000075840)

**Summary:** Dizziness is frequently reported as a typical somatic complaint in panic disorder with agoraphobia. However, it is unclear, how often dizziness is experienced as anxiety provoking, and to what extent fear of dizziness affects treatment success. The present study examined the frequency and the influence of behavior therapy on anxiety provoking dizziness in patients with panic disorder with agoraphobia. Patients and Methods: 398 agoraphobics with panic disorder participated in the study. To analyze the impact of psychotherapy on dizziness, patients were classified into four groups depending on anxiety provoking dizziness (strong/weak) before or after treatment (pre/post). Results: Fear of dizziness was the most frequent somatic complaint in these patients at the beginning of the treatment. According to different self-rating scales, all four groups improved considerably with treatment. However, the group that reported dizziness as very anxiety provoking before treatment but no longer anxiety provoking after treatment yielded the strongest overall therapy effect. The other three groups did not differ in their overall benefit from treatment. Similar effects were found if different somatic sensations such as heart palpitations or hard breathing were selected. Discussion: The frequency of fear of dizziness emphasizes its relevance in this patient sample. It is therefore important that practitioners be informed about possible differential diagnoses that may include this fear. However, fear of dizziness did not take a special role in treatment outcome because treatment efficacy depended on losing the fear of disorder-typical physical symptoms in general, not specifically the fear of dizziness.

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