A collaborative-care model for managing bipolar disorder had improved outcomes that appeared to be at least in part due to improved concordance with treatment guidelines.

**Background:** Collaborative care describes a programmatic approach to treatment that relies on active patient engagement, proactive follow-up, and mid-level providers (in this case a nurse care manager) who track adherence, alert a physician (here a designated psychiatrist) to changes in condition, and act as supports in implementing the care guidelines.

**Objective:** To determine whether the proven success of a collaborative care program for bipolar patients can be attributed to improved compliance with treatment guidelines.

**Participants/Methods:** In 11 participating VA medical centers, 306 veterans hospitalized for bipolar disorder were randomly assigned at discharge to 3 years of treatment in a collaborative care program for bipolar illness or usual care. Eligible subjects had significant illness, with at least 3 hospitalizations in the previous 5 years. The collaborative-care intervention involved patient self-management skills training through education groups, clinical practice guidelines in a usable format, and continuity and access to treatment enhanced by assignment to a nurse care manager affiliated with a designated psychiatrist. At baseline and at 6-month intervals for 3 years, data for each patient were gathered as to medical utilization, such as pharmacy use, laboratory tests ordered, visits, etc. Dosages and serum levels of medications were obtained in part to assess compliance with guidelines. The study most specifically focused on the guidelines that covered decisions with respect to antimanic medication choices.

**Results:** Concordance with antimanic treatment guidelines was significantly greater in the collaborative-care group than in the usual-care group over the 3-year period. Interestingly, adherence to the relevant guidelines dropped over time in both groups. At study onset, concordance was approximately 55% for both patient groups. By the third year, rates were 40% for the collaborative care group and 20% to 30% for the usual-care group.

**Conclusions:** Treatment within a multiple-component collaborative care model significantly improved sustained long-term compliance with accepted treatment guidelines for bipolar disorder.

**Reviewer's Comments:** The finding that concordance with guidelines for a given patient's care declined over time in both programs, underscores the challenge over time in patients with a chronic disorder to remain freshly alert to the relevance of these guidelines in care. (Reviewer-Gary S. Belkin, MD).

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Keywords: Collaborative Care

Print Tag: Refer to original journal article
Among patients with bipolar disorder, those with high global anxiety are likely to experience more time in depressive episodes than are those with lower global anxiety.

**Background:** Bipolar-disorder patients with high anxiety tend to have poor treatment responses, more suicidal behavior, shorter euthymic episodes, and longer times to remission than those without prominent anxiety. This seems also to be the case for patients with depression and significant comorbid anxiety.

**Objective:** To determine the effects of anxiety on outcome in bipolar I and II disorders.

**Methods:** Data for this study were taken from the National Institute of Mental Health Collaborative Depression Study, for which patients with major depression, bipolar disorder, and schizoaffective disorder were recruited from 1978 to 1981. Each participant was given a set of structured interviews at study initiation and followed up regularly for 20 years. The data that were pulled for this study were on those subjects who had presented with bipolar or schizoaffective disorder. Symptoms were rated from none to severe, and the subjects were grouped based on the episode at intake; either manic, depressed, or cycling. The primary outcome measure was the persistence of depressive episodes based on demographic variables, nonanxiety comorbidity, and 4 measures of anxiety: panic attacks, an anxiety disorder (excluding post-traumatic stress disorder), somatic anxiety, and psychic anxiety.

**Results:** 427 participants from the initial study were available for inclusion in the current study. Among the patients, 284 who had manic episodes (either at intake or subsequently) had shorter depressive episodes than did those individuals with hypomanic or depressive episodes. In terms of anxiety measures, global anxiety (a combination of somatic and psychic anxiety) was significantly associated with time spent in depressive episodes; but panic attacks and anxiety disorders were not. When combining intake episode with anxiety, those with mania at intake and low levels of anxiety spent 12.4% of the following weeks in depressive episodes; whereas those with high levels of anxiety spent 18.8% of subsequent time in depressive episodes. This was significant and extended to 10 years of follow-up, becoming a trend, but not statistically significant, in the last 10 years of the study.

**Conclusions:** Among patients with bipolar disorder, those with high global anxiety experienced more time in depressive episodes than did those with lower global anxiety, over a 20-year follow-up period.

**Reviewer's Comments:** The importance of the findings from this study relate to prognosis and treatment. If a patient presents in your office with mania and high anxiety, you may want to consider an antidepressant in addition to a mood stabilizer for maintenance treatment. If anxiety is not featuring prominently, a mood stabilizer may be enough for maintenance. The major problem with just accepting the results from this study, however, is that the study did not control for treatment. Almost all participants were getting some kind of medication treatment, and the impact of this on the outcomes of the study is not known. (Reviewer-Elizabeth Ford, MD).

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Keywords: Anxiety, Bipolar Disorder

Print Tag: Refer to original journal article
Research Backs Clinical Experience - Risperidone Is Effective in Pediatric Bipolar Disorder

Risperidone for the Treatment of Acute Mania in Children and Adolescents With Bipolar Disorder: A Randomized, Double-Blind, Placebo-Controlled Study.

Haas M, DelBello MP, et al:
Bipolar Disord 2009; 11 (November): 687-700

For older children and adolescents with bipolar disorder, dosing risperidone at 0.5 to 2.5 mg appears to be sufficiently efficacious in the short term, with minimal short-term side effects.

Background: Severe mood dysregulation, or bipolar disorder, in children and adolescents is persistent and can substantially alter normal psychosocial development of young children, contributing to greater risk of development of behavioral, academic, social, and legal problems and greater risk for suicide and substance abuse. Although lithium is approved for use in mania in adolescents, there are no controlled data supporting its efficacy in the pediatric population. Other recent controlled studies have been unable to demonstrate efficacy for divalproex sodium and oxcarbazepine.

Objective: To confirm what smaller uncontrolled studies have found: that risperidone is an effective and safe treatment for bipolar I disorder in older children and adolescents.

Design/Methods: This 3-week, randomized, double-blind, parallel-group, placebo-controlled multicenter trial was conducted at 21 U.S. sites. The subjects were 169 children and adolescents, ages 10 to 17 years, who met DSM-IV criteria for bipolar I disorder. Subjects were randomly assigned to 1 of 3 treatment groups for a period of 3 weeks: risperidone 0.5 to 2.5 mg daily, risperidone 3.0 to 6.0 mg daily, or placebo. Subjects were then titrated up to the maximum dose tolerated per the dosing limits of each treatment group. The primary efficacy measure was the change in the Young Mania Rating Scale (YMRS) total score from baseline to day 21. Extrapyramidal effects and akathisia were also assessed utilizing standardized instruments.

Results: Significant and similar clinical improvement was observed with both risperidone dosing groups, based on the change in YMRS from baseline. The risperidone groups continued to improve over the course of the 3-week study; and at the end point, 44.9% in the lower-dose risperidone group, 41.7% in the 3- to 6-mg risperidone group, and 15.8% in the placebo group achieved a sustained response. No dose-response relationship was observed. However, there was a dose-dependent increase in the percentage of subjects who experienced somnolence or fatigue. The percentage of subjects with extrapyramidal-symptom–related adverse events was 25.0% in the 3- to 6-mg group versus 8.0% in the 0.5- to 2.5-mg group and 5.0% of those on placebo. The risperidone group also demonstrated a dose-dependent increase in prolactin levels.

Conclusions: In children and adolescents with bipolar disorder, risperidone appears to be a treatment with a large effect size for efficacy and just a few short-term side effects at the lower dosing range of 0.5 to 2.5 mg/day.

Reviewer's Comments: This study helps to provide clear supportive evidence for risperidone use, which has been increasing for children with bipolar or severe mood-dysregulation over the past 10 years. The most troubling side effects, weight gain and metabolic changes, however, could not be measured adequately in this study due to the short trial duration of 3 weeks. (Reviewer-John G. Koutras, MD).

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Keywords: Bipolar Disorder, Risperidone

Print Tag: Refer to original journal article
Aripiprazole 10 mg daily appears effective for child bipolar manic or mixed moods and at 30 mg may have some more benefit, but with increased weight gain.

**Background:** Most published data on atypical antipsychotic use in pediatric populations are from small, open-label, non-placebo-controlled studies.

**Objective:** This is the first randomized, double-blind placebo-controlled trial of aripiprazole treatment of bipolar I disorder in pediatric subjects with a manic or mixed episode.

**Methods/Participants:** This 4-week trial was conducted in 59 sites in the United States. The 237 subjects were aged 10 to 17 years and met DSM-IV criteria for bipolar I disorder with current manic or mixed episodes, with or without psychotic features. All subjects had a Young Mania Rating Scale (YMRS) total score of at least 20 at baseline. Exclusionary criteria included bipolar II disorder, bipolar disorder not otherwise specified, autism-spectrum disorders, schizophrenia or schizoaffective disorders, or substance abuse. Subjects were randomly assigned to either aripiprazole 10 mg/day or aripiprazole 30 mg/day, with matching placebo groups. Aripiprazole dosing started at 2 mg/day with rapid upward titration. The primary outcome measure was the YMRS. Secondary measures included the Clinical Global Impressions Scale-Bipolar Version (CGI-BP) and the Children's Depression Rating Scale-Revised (CDRS-R). These outcome measures were assessed weekly and at end point.

**Results:** On the YMRS, both aripiprazole groups separated from the placebo group, beginning at the first-week assessment. At 4 weeks, remission, which was stringently defined as a YMRS score of no more than 12 and CGI-BP no more than 2, was achieved by 25% of the aripiprazole 10-mg group, 48% of the aripiprazole 30-mg group, and only 5% of the placebo group. There were no significant improvements on the CDRS, so no effectiveness was demonstrated for depressive symptoms. Somnolence and extrapyramidal symptoms were more commonly reported in the aripiprazole 30-mg group than in the aripiprazole 10-mg group. Weight gain appeared to be less with the 10-mg group. Serum prolactin levels were actually decreased in both groups; and electrocardiogram results, including QTC intervals, had no significant changes.

**Conclusions:** Aripiprazole appears to provide rapid relief of acute manic symptoms in pediatric patients with bipolar disorder, although it carries with it the risk of some extrapyramidal symptoms and weight gain.

**Reviewer's Comments:** Long-term mood stability is the holy grail of treatment of bipolar disorder. There was an option for subjects in this study to be followed for longer-term outcome with aripiprazole treatment. I am looking forward to reviewing those results with you in the future. (Reviewer-John G. Koutras, MD).

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Keywords: Aripiprazole

Print Tag: Refer to original journal article
Asenapine offers another second-generation antipsychotic treatment option for acutely manic/mixed bipolar disorder, with a sublingual formulation that may ensure compliance if directly monitored in administration.

**Background:** Asenapine is a newly FDA-approved second-generation antipsychotic, with a high degree of affinity for antagonistic actions at multiple serotonergic receptors, including 5-HT₂ subtypes, but not at 5HT₁. Asenapine also has effective antagonism at D₂ and D₃ receptors, as well as multiple alpha-adrenergic receptors and histaminergic receptors, but not muscarinic cholinergic receptors.

**Objective:** To demonstrate efficacy for asenapine in bipolar mania and to obtain FDA approval.

**Design:** 3-week randomized, double-blind multicenter trial.

**Methods:** Adult patients with a DSM-IV diagnosis of bipolar I disorder who were experiencing manic or mixed episodes were eligible for participation. Other inclusion criteria were a Young Mania Rating Scale (YMRS) of at least 20 and a current manic or mixed episode for a duration of 3 months or less. Patients who had a psychotic disorder, substance abuse, or rapid-cycling bipolar disorder were excluded. Subjects (n=480) were randomly assigned to one of 3 treatment groups: asenapine, olanzapine, or placebo. Asenapine was dosed at 10 mg BID and only decreased to 5 mg BID if there were issues with tolerability. The mean dose of asenapine was 18 mg, and the mean dose of the olanzapine parallel group was approximately 16 mg. The primary outcome measure was the YMRS; secondary outcomes included the Clinical Global Impressions Scale-Bipolar version (CGI-BP) and the Montgomery-Asberg Depression Rating Scale (MADRS).

**Results:** Superiority over placebo in the YMRS was demonstrated as early as day 2 with olanzapine and day 4 with asenapine. The Number Needed to Treat (NNT) value for asenapine was 6 and for olanzapine was 5. Only olanzapine showed significant separation from placebo on the MADRS. Extrapyramidal symptoms were similar between the 2 agents.

**Conclusions:** Asenapine appears to be efficacious in the treatment of bipolar I manic or mixed states, although weight gain may be a concern.

**Reviewer's Comments:** The olanzapine arm was utilized to ensure that the subjects responded to atypical antipsychotic treatments in general, so direct comparisons between olanzapine and asenapine were not made. The clearly larger effect size for olanzapine compared with asenapine suggests that if statistical comparisons were made, olanzapine might have proven to be more effective. In this very short 3-week trial, 6% of asenapine patients gained a significant amount of weight; the olanzapine group had twice the percentage. (Reviewer-John G. Koutras, MD).

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Keywords: Bipolar Disorder, Asenapine, Olanzapine

Print Tag: Refer to original journal article
Several studies have found that 80% to 90% of postpartum women report unwanted intrusive thoughts following delivery.

**Background:** Several reports have indicated that the perinatal period can increase a woman's risk for development of obsessive-compulsive disorder (OCD) or worsening of already existent symptoms. The prevalence rate of OCD in the general population is 2%. Although the lifetime prevalence of this disorder is not well documented for postpartum women, there are several studies that indicate that aggressive obsessions, such as thoughts of harming one's infant, feature prominently in postpartum OCD. These kinds of obsessions are also common in postpartum depression. Some have suggested that because obsessive-compulsive symptoms, although not necessarily the disorder, have commonly occurred in nonpsychiatric postpartum samples; such symptoms may actually be a normal response to parenthood. Identifying which women are most at risk carries obvious importance, as it involves the health of the mother and the safety and development of the infant.

**Objective:** To examine the prevalence of postpartum OCD and its symptoms in a Latin American population.

**Methods/Participants:** This was a descriptive study in which 400 women, between 2 and 26 weeks postpartum, were recruited from 2 public hospitals and a private office in Recife, Brazil from 2007 to 2008. Each participant underwent a structured interview that included sociodemographic questions, the OCD section of the Mini International Diagnostic Interview tool, the Yale-Brown Obsessive-Compulsive Scale Symptom Checklist, and the Structured Clinical Interview for DSM-IW Axis I Disorders to assess for comorbid depression.

**Results:** The average age of the participants was 27 years, and the majority was married. Some obsessive-compulsive symptoms postpartum were reported by 63.5% of the subjects. Among 9% that met criteria for OCD, 2% appeared to be new onset. Women with prior psychiatric illness, obstetric complications, and other medical illness were most at risk for OCD postpartum. The most common obsessions involved thoughts of aggression and contamination; the most common compulsions involved cleaning or checking rituals. There was a 9-times greater incidence of aggressive obsessions in postpartum women with OCD than those without.

**Conclusions:** This study demonstrates that in a Latin American population, women have an increased risk of obsessive-compulsive disorder or obsessive-compulsive symptoms in the postpartum period.

**Reviewer’s Comments:** The authors raise some theories about why OCD might be triggered postpartum, including the impact of estrogen, progesterone, and oxytocin. However, what I wanted to learn was whether there might be any cultural differences that could account for the higher rate of postpartum OCD. Frequently, quoted prevalence rates of psychiatric illness involve U.S. populations. The authors make mention of the Latin American population only twice in the article, once to note that this is probably the first study of its kind done with this population. As cultural beliefs factor strongly into many presentations of psychiatric illness, it would have been useful to read the authors’ theories about whether cultural factors may have made an impact on the results. (Reviewer-Elizabeth Ford, MD).

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Keywords: Postpartum

Print Tag: Refer to original journal article
**Diagnostic Tools Show Language Dependence**

Inconsistencies in Diagnosis and Symptoms Among Bilingual and English-Speaking Latinos and Euro-Americans.

Díaz E, Miskemen T, et al:

Psychiatr Serv 2009; 60 (October): 1379-1382

Culture and ethnic background may influence reporting or omission of symptoms in our patients.

**Background:** Latinos have higher rates of seeking treatment for depression than Euro-Americans and have been reported to have higher rates of major depression diagnoses. Differences in symptom report and severity have been noted based on the language used during diagnostic interviews; however, these differences have been inconsistent.

**Objective:** To answer two specific questions. (1) Do Latinos have higher rates of major depression than Euro-Americans when structured interviews are conducted? (2) Are the diagnoses reported consistent with general symptom and functioning profiles of Latinos?

**Participants/Methods:** 259 participants aged 18 to 45 years were enrolled in the study from 3 sites: one in New Jersey, one in Texas, and one in California. It is not clear from the article whether these sites were outpatient, inpatient, or a combination of both. Among the participants, 46% were non-Latino Euro-Americans and 54% were Latino. In the Latino group, 32% of the patients were bilingual and the rest were English-speaking only. Each participant completed a diagnostic interview in English and released their medical records to the researchers. Actuarial measures used included the DIGS (Diagnostic Interview for Genetic Studies), MADRS (Montgomery-Asberg Depression Rating Scale), YMRS (Young Mania Rating Scale), and the SAPS (Scale for the Assessment of Positive Symptoms). Using all of the above information, appropriate diagnoses were assigned to each participant, and statistical analyses focused on the differences between 3 groups: bilingual Latinos, those who spoke English only, and Euro-Americans.

**Results:** Bilingual Latinos were much more likely to be diagnosed with major depression than either of the other 2 groups (47% compared with 19% in the English-only Latino group and 17% in the Euro-American group). Bilingual Latinos had significantly lower mania scores than the other 2 groups. The level of functioning was not significantly different among the 3 groups as measured by the GAF score.

**Conclusions:** Bilingual Latinos were diagnosed more with major depression and less with bipolar disorder than English-speaking Latinos or Euro-Americans. The latter 2 groups had similar diagnostic profiles.

**Reviewer’s Comments:** The findings from this study indicate that there might be a connection between Spanish language or culture on diagnostic interview reporting; such that manic symptoms are given less importance or are detected less frequently, and depressive symptoms are given more importance or are detected more frequently. A study of Latino adolescents hospitalized for major depression indicated that more than half of them met criteria for bipolar disorder. It is also important to consider the ethnic background of the clinical interviewer and whether this has an impact on the diagnostic information interpreted. Unfortunately, this study did not have a Spanish-speaking–only group; nevertheless, it highlights how English-dependent, and possibly Euro-American–culture dependent, our diagnostic tools are. (Reviewer-Elizabeth Ford, MD).

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**Keywords:** Latinos, Diagnosis

Print Tag: Refer to original journal article
Vigabatrin shows promise for cocaine dependence

Randomized, Double-Blind, Placebo-Controlled Trial of Vigabatrin for the Treatment of Cocaine Dependence in Mexican Parolees.

Brodie JD, Case BG, et al:

Am J Psychiatry 2009; 166 (November): 1269-1277

Vigabatrin shows effectiveness compared with placebo for short-term impact on cocaine use, but still works only for a minority of those who use it.

Cocaine addiction incurs enormous social costs. There has not yet been a pharmacological treatment for this disorder that has made a substantial impact on use. The addictive effects of cocaine have been linked to mesoencephalic dopamine reward pathways. Cocaine raises dopamine in the striatum, an effect associated with reward behaviors in animal models and pleasure in humans. Gamma-amino-butyric acid (GABA) blunts much of this cocaine-induced extracellular dopamine increase. Vigabatrin is an irreversible inhibitor of GABA-transaminase that catabolizes GABA in synapses and thus effectively blocks cocaine-induced dopamine release. Two small open trials of vigabatrin showed sustained abstinence for brief periods for approximately half of those treated.

Objective: This study represents the first randomized, placebo-controlled study of vigabatrin in cocaine-dependent subjects.

Participants: Parolees of a Mexico City prison, a very high-risk group for cocaine dependence, were recruited through their parole center. Eligible subjects had to actively meet criteria for DSM-IV-defined cocaine dependence and have urine evidence of use, but be urine-negative for heroin and methamphetamine.

Methods: Subjects were reimbursed $7 per treatment. Screening assessment included scores on Hamilton screens for anxiety and depression. Urine toxicology and symptom scores were followed regularly through the 9-week observation. End-of-trial abstinence and intervals of abstinence were measured.

Results: At the end of the trial, 28% of vigabatrin users versus 7.5% of controls were abstinent. Weekly abstinence did not differ until weeks 7 and 9. Among those subjects who also reported recent use of alcohol at baseline, the impact of vigabatrin was even greater: 43.5% versus 6.3% were abstinent at 9 weeks. Other symptom score scales and reported cocaine craving did not differ between control and treatment groups. There were no reported serious adverse events.

Conclusions: Vigabatrin appears significantly more effective than placebo for cocaine dependence, especially among those also using alcohol, but still only among a minority of patients.

Reviewer's Comments: These are still very small numbers, small periods of abstinence observed, and perhaps targeted effectiveness. Nonetheless, given the paucity of available treatments for a hugely important disorder, larger and longer work will hopefully be done soon. (Reviewer-Gary S. Belkin, MD).

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Keywords: Cocaine Dependence, Vigabatrin

Print Tag: Refer to original journal article
Proclivity to violence and alcohol use may be more bidirectionally reinforcing, rather than one behavior being a precursor risk for the other.

**Background:** Urban adolescents are at high risk both for violence and alcohol use. The data are more complex as to the relationship between these behaviors, however. Alcohol's brain effects can enable aggression, a violent lifestyle can encourage alcohol use, the two may be mutually reinforcing, or the relationship between the two could be spurious. They may appear related only because they are each related to other common risk factors, such as poverty. Longitudinal studies are needed to tease these possibilities apart, and those that have been done to date have had mixed results.

**Objective:** To address the relationship between alcohol use and violence among young African Americans as they mature and to broaden the number of common risk factors taken into account to include such measures as academic achievement, peer use, and family stability.

**Methods:** The study uses data from an 8-year longitudinal study of substance use among public high school students in urban Michigan, who were at risk for dropping out of school. This sample of African-American youth was followed annually for 4 years and then 4 years later was assessed with a range of tools. These included a structured interview to gather sociodemographic and family composition information. Standard scales were used to measure severities of violent behavior, alcohol use, drug-dealing behavior, parental violent behavior and drug use, family conflict, peer violence and drug use, and depression as rated by use of 6 items of the Brief Symptom Inventory. School performance was obtained from school records.

**Results:** There was an overall a trend of increasing alcohol use and decreasing violence from high school into early adulthood. Alcohol use increased faster among men than women. Among both men and women, early violent behavior predicted later alcohol use. However, over time, changes in one behavior were associated with changes in the other.

**Conclusions:** These results support a bidirectional hypothesis, whereby alcohol use and violent behavior can mutually reinforce each other, but where reduction in one also facilitates reduction in the other.

**Reviewer's Comments:** The implications of such findings from these kinds of studies reinforce investments in both alcohol and violence risk-reduction efforts and interventions, and perhaps encourage efforts that combine targeting both issues, as well as early intervention in at-risk adolescents. (Reviewer-Gary S. Belkin, MD).

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Keywords: Alcohol Use, Violence, African-Americans

Print Tag: Refer to original journal article
A stepped-care guideline-driven care model appears to be a feasible and effective alcohol intervention within a primary-care practice.

Objective: To evaluate a stepped-care approach to a brief alcohol-use intervention, in which a care guideline specified different intensity levels of intervention. Patients passed through each level depending on their response to a previous, less intense level.

Methods: Eligible subjects were consecutive male patients attending 6 primary care clinics in South Wales who completed the Alcohol Use Disorders Identification Test with a score of 8 or more, and/or met ICD-10 criteria for alcohol use disorder, and/or reported hazardous levels of drinking as measured by cutoff scores on a standardized tool for calculating recalled use. Patients were randomly assigned to the stepped program or to receive a 5-minute advice session from a nurse on the need to reduce use and a self-help booklet describing where to receive care. In the stepped program, Step 1 was a 40-minute behavior-change counseling session with invited follow-up for another session 28 days later. Those who then exceeded a set threshold of reported drinking frequency were referred to Step 2, which was a maximum of four 50-minute sessions of motivational enhancement therapy over a month, after which, once again, exceeding certain thresholds could prompt movement to Step 3, which was a referral to specialist intervention. A range of standard measures at baseline and at 6 months after randomization included scales of recalled use and dependence, readiness for change, problems related to drinking, self-efficacy, and quality-of-life years (QALYs).

Results: 58 subjects were assigned to the minimal intervention, and 54 received stepped care. At 6 months, both groups had reduced alcohol use substantially from baseline. Reductions in alcohol-related problems and dependence decreased and self-efficacy increased in both groups, without significant differences between them. There were also no significant group differences in terms of quality of life or other mental health symptoms. Motivation to change was significantly greater in the stepped-care intervention group. Over the 6 months, the minimal-intervention group incurred substantially greater overall costs than did the stepped-care group, leaving the stepped intervention showing significantly greater value per QALY gained.

Conclusions: A stepped-care intervention showed greater cost-effectiveness than a minimal brief intervention strategy in primary care, in an effort to apply brief interventions to patients screened for alcohol use disorders.

Reviewer's Comments: This is a puzzling study. A brief talking to and sharing of information apparently had an effect that was similar to a stepped ensemble of more elaborate, albeit still brief, motivational interventions, but did not have greater cost-effectiveness. The reasons for greater costs among those in usual care, despite the greater cost of the stepped intervention itself, were not well clarified. (Reviewer-Gary S. Belkin, MD).

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Keywords: Alcohol, Stepped Care

Print Tag: Refer to original journal article
Attention-deficit/hyperactivity disorder may be a risk factor for Internet addiction, because the Internet allows for quicker, stronger, and more powerful sensory stimulation that fits well with ADHD learning and cognitive styles.

**Background:** Internet addiction is being considered as a new diagnosis for inclusion in DSM-V, given the growing number of individuals with problematic Internet use. A random phone survey in the United States indicated that 0.3% to 0.7% of the population suffers from this problem. Internet addiction is thought to be phenomenologically similar to impulse-control and addictive disorders. Compelling aspects of Internet use include disinhibition, extreme and anonymous intimacy, loss of boundaries, and timelessness. These are all related to feelings of detachment or dissociation.

**Objective:** To increase the understanding of the prevalence and features of Internet addiction in Italy, with the particular hypothesis that dissociative symptoms would be significantly associated with the severity of Internet addiction.

**Design/Participants:** This was a descriptive clinical study on 50 adult outpatients who self-referred to an outpatient psychiatric clinic and agreed to participate.

**Methods:** Those who admitted to overusing the Internet were given the Young's Internet Addiction Scale, adapted from the scale used for pathological gambling. Based on this scale, the group was separated into those without, with possible, and with definite Internet addiction (defined as a score of 70 or higher). Those who met criteria for addiction were given an additional battery of tests, including the Dissociative Experience Scale, the Hamilton anxiety and depression scales, the Yale-Brown Obsessive Compulsive Severity Scale (Y-BOCS) for obsessive-compulsive disorder, the Conner's scale for attention-deficit/hyperactivity disorder, and the Structured Clinical Interviews for DSM-IV for diagnostic clarification.

**Results:** Depression was the most common reason for self-referral. Fifteen subjects met criteria for Internet addiction. The average age of this group was 23 years, with an average of 42 hours/week spent on the Internet. Women spent significantly more time chatting, and men spent significantly more time playing interactive games. None of these subjects had impulse control or addictive disorders; although all but 2 had another comorbid DSM-IV diagnosis, the most common being anxiety-spectrum disorders. The number of hours spent/week was associated with higher clinical severity and higher perception of disrupted familial relationships. Dissociative symptoms were associated with more hours spent on the Internet, higher Y-BOCS scores, higher clinical severity scores, and greater familial disruption.

**Conclusions:** Dissociative symptoms seem to be an important part of Internet addiction; however, they were not directly associated with Internet Addiction Scale scores in this study.

**Reviewer’s Comments:** This article is useful in terms of gaining a better understanding of how the psychiatric community is starting to conceptualize Internet addiction. However, the small sample makes the results very difficult to interpret. The authors were looking closely at dissociative symptoms and their relationship with Internet addiction. I would have liked to have seen dissociative characteristics for the nonaddicted and possibly-addicted groups as well. With only 15 subjects completing the full battery of tests, there just are not enough data to draw powerful conclusions. (Reviewer-Elizabeth Ford, MD).

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Keywords: Internet Addiction

Print Tag: Refer to original journal article
Minorities have less access to medical care than non-Hispanic whites, and the care that they do receive is of lesser quality.

**Background:** Treatment delay is an important consideration in first-episode psychosis, as research has shown it to be associated with worse outcomes and higher family burden. Studies from various international sites, including the United States, have reported that the duration of untreated psychosis is longer in countries with less financial stability. This likely means that a major factor in obtaining treatment is the ability to afford it. The number of uninsured persons in the United States has increased considerably in the last 10 years, disproportionately among young adults and those below the poverty line. Although access to insurance is clearly important, other factors involved in the delay of treatment of psychosis have not been as thoroughly explored. **Objective:** To examine the effects on duration of untreated psychosis of 3 variables: insurance, financial problems, and barriers to care other than financial troubles. **Participants:** 42 patient-family dyads (patients with first-episode nonaffective psychosis and at least one family member who provided information about barriers to care and financial troubles) were included from 3 urban, public-sector inpatient psychiatric units from 2004 to 2008. The population was predominantly African-American, poor, and uninsured. **Methods:** Each dyad received an assessment that identified the length of time of untreated psychosis, the mode of onset (acute, subacute, or chronic), some sociodemographic information, insurance and financial information, and barriers to care that included lack of transportation, lack of directions, difficulty getting time off work, patient resistance, and insurance. **Results:** The mean age of the 42 patients was 22 years. Most were men, were single, lived with a family member, and had schizophrenia. The duration of untreated psychosis was significantly longer for those without insurance than those who were insured (42.5 vs 22.5 weeks) and longer for those with financial problems than those without (59 vs 18 weeks). Those with zero or one barrier to care were 5 times more likely to be hospitalized than those with 4 to 6 barriers to care. **Conclusions:** The health-services level variables examined in this study all increased the duration of untreated psychosis in the sample of young, disadvantaged, African-American patients. **Reviewer's Comments:** This study highlights the large disparities in care among different ethnic and socioeconomic groups in this country. It also highlights how access to insurance plays a significant role in how long it takes for someone with first-episode psychosis to get treatment. Unfortunately, those with first breaks are often young, just aging out of their parents’ or public children's insurance, and have less chance of being stably employed with their own insurance. Whatever you think about the health care debates in this country, it is clear that lack of insurance among a very vulnerable population is contributing to delays in receiving treatment. (Reviewer-Elizabeth Ford, MD).

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**Keywords:** Psychosis, African-Americans, Insurance

**Print Tag:** Refer to original journal article
Alcoholics Anonymous meeting sites are usually located in city centers or middle class neighborhoods, whereas Narcotics Anonymous meeting sites are usually located in areas with high concentrations of drug sales and use.

**Background:** Surprisingly little research has focused on geographic and environmental factors in treatment outcomes for persons with mental illness and substance use disorders. However, substance use in particular is strongly related to the environment in which one lives and the access to drugs of abuse. Neighborhood context, or looking at geography and its impact on behavior, has been explored related to violence, crime, physical health, and depression.

**Objective:** To use neighborhood and individual characteristics to look at treatment compliance and rehospitalization rates in a dually diagnosed population.

**Design/Participants:** This was a retrospective analysis and chart review of 380 dual-diagnosis patients treated on an acute inpatient psychiatric unit in Philadelphia between 2002 and 2003.

**Methods:** All patients were referred for outpatient care and 12-step programs in the community upon discharge. The patients’ discharge addresses were mapped to proximity to various locations, such as Alcoholics Anonymous and Narcotics Anonymous meeting sites, deli outlets that sell alcohol, and vacant housing sites, using geographic information systems software. Individual variables that were used in the analysis included sociodemographic information, psychiatric diagnostic information, and criminal history. The primary outcome variables were whether the patient attended a follow-up appointment within 30 days and rehospitalization rate within a year.

**Results:** Overall, 43% of patients kept their outpatient appointments within 30 days and 51% were rehospitalized within a year. For treatment continuity, bizarre behavior, positive drug screen for opiates, high rates of vacant housing, and areas far from Alcoholics Anonymous meeting sites were associated with lower compliance with outpatient appointments. For rehospitalization, being Hispanic, being admitted to the psychiatric emergency room, living close to a Narcotics Anonymous meeting site, and low education attainment level in the community were all associated with increased readmission. **Conclusion:** Exploration of neighborhood factors in treatment compliance is an important clinical and research goal, particularly in the dually diagnosed population with mental illness and substance abuse.

**Reviewer’s Comments:** Despite the limitations of the study, such as measuring rehospitalization rate based only on return to the same hospital, I found this to be an elegant and compelling study. The idea of mapping a discharge location as it relates to various points of interest, such as drug sale zones or vacant housing lots, seems an appropriate way to explore issues of treatment compliance and risk of relapse. I am surprised that more research like this has not been done, and I wonder whether it has something to do with increased availability of GPS and geographic mapping software that makes pinpointing locations more user-friendly. I would highly recommend that everyone read this article. (Reviewer-Elizabeth Ford, MD).

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Keywords: Substance Use Disorders, Community Influence

Print Tag: Refer to original journal article
STAR-D provided a range of key findings, most prominent of which is that the range of commonly used strategies for treating depression appear comparable in the face of nonremission.

**Background:** STAR*D (Sequenced Treatment Alternatives to Relieve Depression) was a large, highly prominent effort to explore the comparative efficacy of different common treatment strategies used successively in response to persistent symptoms of depression. The initial phase, or Level 1, was use of citalopram. Those still with threshold symptoms could, at Level 2, switch to bupropion, venlafaxine, sertraline, or cognitive therapy; or they could augment their Level-1 treatment with bupropion, buspirone, or therapy. The group of those failing cognitive therapy could choose a Level-2a option—bupropion or sertraline—and then proceed from there. Those still with threshold symptoms after their Level 2 treatment could receive, in Level 3, a switch to mirtazapine or nortriptyline; or they could augment their Level 2 treatment with lithium or T3 thyroid hormone. Those who still needed another trial, in Level 4, could switch to tranylcypromine or a combination of mirtazapine and venlafaxine. A score of papers came out of each of these levels comparing outcomes with the different options, as well as overall outcomes, predictive features of response to one treatment or another, etc.

**Objective:** To summarize the key lessons learned from the STAR*D program.

**Results:** Clear moderators or predictors of treatment failure did not emerge at any level to guide treatment choice. Furthermore, no particular switch or augmentation strategy appeared substantially superior at any level. The main differences were tolerability and side effects. Through the 4 levels, the theoretical overall remission rate was 67%. The bulk of this occurred early. Depending on the measure used, remission was approximately 30% at Level 1, approximately 25% at Level 2, and 10% to 15% at the remaining levels. Care in Level 1 was comparable whether someone was treated in primary care or by a psychiatrist. Approximately half of those who remitted did so after 6 weeks of treatment, 40% needed 8 or more weeks.

**Conclusions:** For patients with depression not in remission, several commonly used switching and augmentation practices appear comparable, with similar effects and effectiveness, with unfortunately no clear predictors of response. Study of remission requires some patience and a time investment of 6 weeks or more, in maintaining a therapeutic trial.

**Reviewer's Comments:** The treatment options patients received were based on preference, not randomization, which made it hard to compare strategies directly but which reflected real practice conditions. The practical lessons from this large effort appear to be that use of a key decision point, prescribed treatment length, and trial choice sequence rules can be feasibly used, guide care, and have comparable effectiveness. (Reviewer-Gary S. Belkin, MD).

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Keywords: STAR*D

Print Tag: Refer to original journal article
Consider using standardized measures, such as the HAM-D, to help predict antidepressant treatment response by using 30% reduction in scores at 3 weeks as a cutoff in the depressed elderly.

**Objective:** There have been 3 antidepressant studies in depressed elderly patients in which final remission of depression is predicted based on early response. In these studies, the early response has been based on a percentage reduction in Hamilton Depression Rating Scale scores 3 to 4 weeks after the initiation of the antidepressant. These studies were either open studies or combined results from more than 1 randomized controlled trial. **Objective:** To compare different methods of predicting final remission based on early response to an antidepressant.

**Design:** Double-blind, randomized controlled trial.

**Methods:** The study sample consisted of 81 depressed inpatients, aged 60 years and older. The patients met DSM-IV criteria for major depression and had a mean score of 32.9 on the Montgomery Asberg Depression Rating Scale (MADRS) and 24.4 on the Hamilton Depression Rating Scale (HAM-D). Nearly half of the patients had psychotic features as well. Severity of depression was calculated at weeks 1, 3, 5, 7, 9, and 12 with the HAM-D and the MADRS. The patients were treated with either nortriptyline or venlafaxine, and no differences were found between the 2 medication groups, so they were pooled in the analysis. After 12 weeks of treatment, 27.2% of patients achieved remission according to the HAM-D and 32.1% according to the MADRS. The highest percentage of patients correctly classified as achieving remission at end point is found using at least a 50% cutoff in depression scores of either the HAM-D or MADRS at week 5.

**Conclusions:** Patients not having at least a 30% reduction in depression score on standardized measures at week 3, or at least 50% at week 5, should be considered for a change in treatment as the chance of achieving full remission varies between 4.5% and 18.2%.

**Reviewer's Comments:** Deciding when to switch an antidepressant in depressed patients who do not appear to be minimally responsive in the first weeks of treatment is one of the major challenges in clinical practice. The stakes can be even higher for the depressed elderly, as they can have rapid weight loss and significant decline in functioning, including decreased compliance and/or accuracy with their total medication regimen and other health needs. This study is not clear as to how the psychotic symptoms were treated; this would potentially affect antidepressant response if there were no combination treatment with antipsychotic medication. (Reviewer-John G. Koutras, MD).

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**Keywords:** Depression, Antidepressants

**Print Tag:** Refer to original journal article
COVR Scale Can Predict Violence Over Long Term

Assessing Risk of Future Violence Among Forensic Psychiatric Inpatients With the Classification of Violence Risk (COVR).

Snowden RJ, Gray NS, et al:

Psychiatr Serv 2009; 60 (November): 1522-1526

A tool developed as part of a complex predictive study of community violence risk after discharge, was shown to be predictive of violence in a long-term forensic facility.

Background: The prediction of risk of community violence is a critical but difficult clinical task. Several screening tools have been developed to try to stratify patient risk. The Classification of Violence Risk (COVR) screen was developed from the MacArthur Risk Assessment Study in the United States. That study examined a wide range of variables in 1000 inpatient discharges and long-term follow-up, to identify highly predictive features found in inpatients for their subsequent community violent behavior. Some of the studied predictive features, such as psychopathy-scale score, are not the most common or convenient kinds of things to query as a matter of course in inpatient practice. Therefore, a more streamlined but highly correlative version, COVR, was developed.

Objectives: To determine how applicable, and thus perhaps how valid, the COVR scale is, by using it, not in a general inpatient and community sample, but in a forensic psychiatric inpatient population in a long-term, medium-security setting to predict subsequent violence.

Methods: COVR and another widely used and replicated inpatient risk instrument, the Violence Risk Appraisal Guide (VRAG), were administered to each patient residing in a medium-security psychiatric forensic facility in the United Kingdom. Prospectively, over the following 6 months, occurrences of aggressive behavior were recorded and coded as aggression to things/property, physical/to other persons, or verbal. The predictive power of the initial score of each screen was calculated and compared.

Results: The mean occurrence of verbal aggression was 10 incidents per 100 days. For physical aggression, it was 1.7 incidents/100 days, and for aggression to things, it was a mean of 1.2 events/100 days. Both scales showed statistically significant correlations with later aggression in the 0.45 to 0.57 range, across all three types of aggression for the VRAG, and across verbal and physical aggression for the COVR.

Conclusions: The Classification of Violence Risk scale showed good, generally comparable, predictive value overall and compared with another established screen in the domains of verbal and physical aggression.

Reviewer's Comments: Inpatient units across the country now have a range of instruments to supplement risk assessment. However, what this and other studies usually do not examine is indeed the practicable use, not the validity, of these instruments, eg, should these highlight clinical attention? Set a line in the sand for no discharge? Such screens can be a blessing or a curse without more feasibility studies of their use and impact on practice and decision-making. (Reviewer-Gary S. Belkin, MD).

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Keywords: Violence Prediction, COVR

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A large part of why suicides might cluster in families is not just the shared risk for depression but the shared risk for cluster-B traits that exacerbate that risk.

**Background:** Suicide seems to aggregate in families. A family history is a risk factor for relatives to commit or attempt suicide, perhaps increasing likelihood by fivefold. Do genes matter here? If so, is that connection by the shared inheritance risk for depression, or some other traits? As other research has implicated impulsive-aggressive cluster-B personality features in suicide behavior and has indicated that such features have a heritable component.

**Objective:** This study seeks to explore the relationship between suicide and family history.

**Participants:** The study comprised relatives of 51 persons who died by suicide while depressed, relatives of 34 persons with major depression but no suicide history, and relatives of 35 community members with neither depression nor suicide histories in their families.

**Methods:** The subjects were assessed to compare personal histories of suicidal behavior, history of psychiatric disorder, and evaluation of personality features.

**Results:** Those who had relatives who committed suicide had higher levels themselves of reported suicidal behaviors (10.8%) compared with relatives of persons with nonsuicidal depression histories (6.5% of whom reported suicidal behaviors) and those with neither family histories (3.4%). Significantly elevated levels of cluster-B traits were found in the relatives of suicides, and familial predisposition to suicide was related to level of cluster-B traits. Cluster-B traits also aggregated along certain familial, and thus presumably, inheritance patterns.

**Conclusions:** The inheritance patterns of suicide and depression overlap but appear distinct. The inheritance of suicide risk appears not fully independent of but mediated in part by elevated cluster-B traits in the family.

**Reviewer’s Comments:** This study reinforces the practice of assessing personal and family history of aggressive-impulsive behavior patterns, especially in patients with depression or possible suicidal tendencies. (Reviewer-Gary S. Belkin, MD.)
Hoarding, and to a slightly lesser degree, ordering behaviors, appear to be familial with or without the presence of obsessive-compulsive disorder in a family member.

**Background:** Obsessive-compulsive disorder (OCD) is a familial disorder. Twin studies have suggested heritability estimates of 45% to 85% in identical twin children and 27% to 47% in identical twin adults for OCD, with negligible shared environmental effects. It is also very possible that some OC symptoms are more familial than others; these symptoms have appeared in first-degree relatives who do not meet full criteria for OCD at significantly higher rates than in the general population. Previous studies suggest that symmetry/ordering and hoarding, and to a lesser extent obsessions/checking, are OCD dimensions that are more familial.

**Objective:** To ascertain whether OC symptom dimensions are correlated within nonclinical families (parent-daughter dyads), and, if present, which specific OC dimensions correlate.

**Methods:** Approximately 700 undergraduates of 2 Spanish universities were approached about participating in a study on psychological factors in families. The final sample consisted of 184 triads, daughters and their mothers and fathers. The parents and their daughter were administered the Obsessive-Compulsive Inventory–Revised (OCI-R), and negative affect was measured using the Positive and Negative Affect Scales (PANAS).

**Results:** Multiple regression models revealed that the OC-symptom dimensions of ordering and hoarding breed true in mother-daughter dyads. The familiarity tended to be greater with mothers, although ordering and hoarding also had the strongest correlations for fathers and their daughters. However, only symptoms in the mothers predicted symptoms in the offspring.

**Conclusions:** Obsessive-compulsive symptom dimensions have a familial aggregation, probably in part genetic and environmental. The strongest association is for hoarding and ordering.

**Reviewer’s Comments:** This study demonstrates that hoarding, especially, is strongly familial, independent of the presence of distinct OCD. There is increasing evidence in the literature that hoarding as a symptom dimension in OCD is associated with increased comorbidity, reduced insight, poor response to psychological and pharmacological treatment, and specific neurobiological correlates. (Reviewer-John G. Koutras, MD).
Cognitive enhancement therapy used in early schizophrenia appears to have sustained effects on performance and function.

**Background:** The cognitive deficits in schizophrenia contribute substantially to the diminished functional capabilities experienced by this patient group. As with increasing efforts to identify patients for pharmacological treatment as early as possible, to perhaps blunt the degree of functional decline associated with the disease; there have been similar efforts to apply cognitive remediation interventions as early as possible, to perhaps delay or diminish those impairments and associated functional consequences.

**Objective:** This study reports on early use of cognitive enhancement therapy (CET) in prospectively followed cognitive, and overall functional, impairment.

**Participants:** Subjects at screening needed to show significant cognitive and social disability in the Cognitive Style and Social Cognition Eligibility Interview instrument. Patients with early disease in schizophrenia or schizoaffective disorder (mean, 3.19 years) were eligible to participate.

**Methods:** Subjects were randomized to CET (n= 34) or supportive therapy comparison groups (n=24). CET consisted of approximately 60 hours of computer-assisted neurocognitive training focusing on attention, memory, and problem solving skills, as well as participation in 45-minute group sessions focusing on experiential learning for success in interpersonal interactions. The supportive-therapy group involved stress management and psychoeducational components. Most patients received second-generation antipsychotic medications in both groups. All subjects were regularly assessed over 2 years on measures of clinical symptoms, quality of life, social cognition, processing speed, memory and executive functioning, and social adjustment.

**Results:** 58 subjects were randomly assigned to the treatment arms. After 2 years, CET showed a moderate advantage (d=0.48) over the support-group alternative in terms of enhanced neurocognition; and strong advantage (d=1.0) on measures of social cognition, cognitive style, and social adjustment. CET patients were more likely to be employed (54% vs 18%) and had statistically improved measures of social and vocational functioning and activities of daily living compared with those in supportive therapy only (in addition to pharmacotherapy for both groups).

**Conclusions:** In patients with schizophrenia, relatively early-onset use of a cognitive enhancement therapy intervention resulted in sustained and substantial improvement in social cognition measures and functional performance, and discernible though less pronounced advantage with respect to neurocognition.

**Reviewer's Comments:** What seems especially valuable about this paper is the apparent link between apparent improvement in social cognition and actual functional and vocational level. The degree this is due to the early use of a CET approach is implied but not clearly established. There was no direct comparison with a more chronic group, but the study does encourage use of such techniques as part of regular treatment early on. (Reviewer-Gary S. Belkin, MD).
On fMRI, stimulants appear to cause changes in brain regions that are involved in decreasing mind-wandering, better matching ADHD patients to healthy children.

**Background:** Functional imaging studies have demonstrated with fair consistency that the striatum, the anterior cingulate cortex, the prefrontal cortex, and the inferior frontal gyrus have decreased activation in children with attention-deficit/hyperactivity disorder (ADHD) compared with healthy controls, during tasks that require attention and inhibitory control.

**Objective:** To determine whether stimulants in youths with stimulant-responsive ADHD result in activation of the above brain regions that more closely approximates the activation of healthy controls during a task that requires selective attention and inhibitory control.

**Participants:** Participants included 16 children, ages 7 to 18 years, who were documented robust responders to ADHD medications, and 20 healthy comparison subjects. All participants in the ADHD group met criteria for ADHD combined type.

**Methods:** The ADHD youths were scanned twice with functional MRI: once while medicated with stimulants (methylphenidate or dextroamphetamine) and once unmedicated. The healthy comparator youths were scanned once. Scanning was conducted while all participants were administered the Stroop Color and Word Test, which tests for inhibitory control (eg, correctly pressing a button whenever one sees the word *blue*, in whichever color ink, and not pressing it when another color’s name, such as *red* appears in blue ink).

**Results:** Participants in the ADHD and comparison groups both activated prefrontal, anterior cingulate, and parietal cortices; basal ganglia; and the thalamus. Comparing brain activation in unmedicated youths with ADHD and comparison subjects revealed significantly less prominent deactivation in the ADHD group than in the comparison group in the ventral anterior cingulate gyrus. These abnormalities were not detected in the ADHD group when they were on stimulants.

**Conclusions:** In children with attention-deficit/hyperactivity disorder, stimulants appear to normalize activation in brain regions, particularly the ventral anterior cingulate cortex, associated with suppression of mind-wandering in tasks requiring sustained attention.

**Reviewer’s Comments:** The ventral anterior cingulate cortex interconnects the orbitofrontal cortex, temporal pole, amygdala, ventral striatum, and hypothalamus. It is an anatomic crossroads that contributes to motivational processes for goal-directed behaviors. It is encouraging to see that stimulants appear to normalize aspects of these pathways, particularly the lateral prefrontal cortex. It would be interesting to test whether nonstimulant ADHD medications, such as atomoxetine, have similar fMRI activity profiles. (Reviewer-John G. Koutras, MD).

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Keywords: Stimulants

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Smoking Linked to Suicide in Bipolar Patients

*Cigarette Smoking is Associated With Suicidality in Bipolar Disorder.*

Ostacher MJ, LeBeau RT, et al:

Bipolar Disord 2009; 11 (November): 766-771

Carefully screen for suicidal ideation and history of suicide attempts in bipolar patients who smoke cigarettes.

**Background:** Compared to only 12.8% of the general population, 35.5% of those with bipolar I disorder and 33.4% of those with bipolar II meet criteria for nicotine dependence in the prior 12 months. Furthermore, an association has been found between bipolar-disorder patients who smoke and a higher likelihood of suicide attempts, independent of substance abuse and anxiety disorder comorbidity. A study of adolescents with bipolar disorder also found that cigarette smoking was independently associated with suicide attempts and substance use disorders.

**Objective/Design:** This prospective longitudinal study in a clinical sample of patients with bipolar disorder examined impulsivity, smoking, and suicidal ideation for a 9-month period. This research is an ancillary project to the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD).

**Participants/Methods:** A total of 116 participants from STEP-BP were included in the study. The subjects were administered the Suicidal Behaviors Questionnaire (SBQ) and the Barratt Impulsiveness Scale (BIS). They also completed questionnaires on current smoking.

**Results:** Of the 116 participants, 85 (73%) were nonsmokers and 31 (27%) were smokers. Current smoking was associated with higher suicidality as evidenced by higher SBQ score. Smoking at baseline also significantly predicted higher SBQ score at 9-month follow-up. However, an exploratory regression analysis, which adjusted the SBQ scores with BIS scores, demonstrated that the relationship between the current SBQ score and smoking status were no longer statistically significant, suggesting that smoking and suicidality are more related to overall impulsivity than to each other. There were some suicide attempts during the study, and there appeared to be a more than fivefold greater likelihood for suicide attempts if the patient was a smoker.

**Conclusions:** Current cigarette smoking is a predictor of suicidal behavior and ideation in patients with bipolar disorder, but these behaviors appear to be partially attributed to overall impulsivity.

**Reviewer’s Comments:** The findings indicate that smoking may in fact be a "smoke signal" of sorts, alerting clinicians to the possibility that smoking in patients with bipolar disorder may demonstrate greater impulsivity, creating a potential lethal situation with underlying suicidality. It has been fairly well established that anxiety conditions, such as panic disorder, also increase the likelihood of a suicide attempt. Smoking increases with increased anxiety, so anxiety levels may also be a factor, besides just impulsivity, in the association with smoking and suicidality in bipolar-disorder patients. This association with anxiety was not explored in this study. (Reviewer-John G. Koutras, MD).

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Keywords: Suicide, Cigarette Smoking

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