Be Cautious About Bringing Self-Destructive Adolescents Together

Group Therapy for Repeated Self-Harm in Adolescents: Failure of Replication of a Randomized Trial.

It remains unclear if adolescent group therapy targeting self-injurious behavior is efficacious, despite manual-based treatment strategies being implemented.

Objectives: Although often used, is group therapy for adolescents for the purpose of reducing self-injurious behaviors, effective? Reasons for dispute over this question involve mixed results, small samples, and mixed techniques. This large multisite trial, using a manual-based, group intervention, sought to shed more light on this question.

Participants/Methods: Eligible participants were between 12 and 16 years old and had been referred to mental health clinics and had at least 2 episodes of deliberate self-harm in the past year, with 1 episode in the past 3 months. Participants were randomized to either outpatient treatment as usual, which included case management, individual sessions, medication management and family sessions (routine care group), or to those services plus a specific group therapy (experimental arm). The group therapy was based on the same manual used in an often cited British study claiming efficacy of group work for these behaviors. It incorporates cognitive behavioral therapy (CBT), interpersonal psychotherapy, and social skills training approaches. There were 6 weekly group therapy sessions, with the option of continuing the sessions for 12 months. Themes addressed in the 6 sessions included school and peer relationships, family problems, anger management, depression and self harm, as well as hopelessness and feelings about the future. The primary outcome measure was repetition of self-harm. Secondary outcome measures included suicidal ideation, depression, disruptive behavior, alcohol and substance abuse, global ratings of psychiatric symptoms, and service use. Multiple instruments were used, including the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS), and the Children’s Global Assessment Scale (CGAS).

Results: 72 patients were either randomized to the experimental arm or routine care. Primary outcome data were obtained on 34 participants receiving routine care and 34 receiving group therapy. The study found that a greater portion of the experimental arm participants versus the routine care participants had engaged in some form of self-harm by 6 months. None of the secondary outcome measures in the study (including depression) reached statistical significance.

Conclusions: The previous British study’s findings of decreased self-harm in adolescents who received a specific manual-based group therapy program were not replicated in this larger, multisite Australian study, which utilized the same program.

Reviewer’s Comments: It is always reassuring to find a negative study published in a journal with a high impact rating. As the authors themselves noted, the data from this study needs to be available for future meta-analysis. That being said, it is still disappointing to not have more clear evidence to support targeted group therapy in adolescents. The fact that the group therapy treatment arm had a (barely) statistically significant higher self-harm rate may actually heighten caution about what could happen when you bring self-destructive adolescents together.

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Cognitive Behavioral Group Intervention Helps Prevent Depression in High-Risk Adolescents

Prevention of Depression in At-Risk Adolescents: A Randomized Controlled Trial.
Garber J, Clarke GN, et al:
JAMA; 301 (June 3): 2215-2224

Cognitive behavioral therapy groups targeting subsyndromal depressed adolescents, with parents who have a history of depression, helps prevent episodes of depression in the adolescents.

**Background:** With increasing appreciation of the early onset of a lifelong history of common psychiatric disorders, such as depression, and the possibility for early intervention and mood management in possibly altering the course of such a history, comes growing literature assessing the effectiveness of preventive approaches.

**Objective:** To examine a cognitive behavioral prevention intervention with adolescents at high familial risk for depression.

**Participants/Methods:** 316 adolescents with at least 1 parent or caretaker who had a recent major depressive episode were randomized to either a cognitive behavioral prevention program or to usual care. The adolescents themselves had either subsyndromal depression or a history of a prior episode of a depressive disorder. Subjects were excluded if they were either currently depressed or on an antidepressant. There were 4 different study sites in different states. The intervention initially involved 8 weekly, then 6 monthly cognitive behavioral group therapy sessions. Group therapy taught identification and restructuring of unrealistic and overly negative thoughts, as well as problem solving skills. Parent meetings were also conducted to inform the parents about the skills taught. Measuring instruments administered included the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) at 3 months and 9 months and the Longitudinal Interval Follow-up Evaluation (LIFE), which provided continuous assessment of symptoms.

**Results:** The rate and hazard ratio was lower for subjects in the cognitive behavioral prevention program (cognitive behavioral group) for new episode or incident depression. There were also lower overall depressive symptoms in the cognitive behavioral group. However, when parents were actively depressed at baseline, rates of adolescent incident depression did not differ significantly between the cognitive behavioral group and the usual-care group.

**Conclusions:** The cognitive behavioural prevention program resulted in 11% fewer depressive episodes as well as a decrease in self-reported depressive symptoms in adolescents who were at higher familial risk for depression.

**Reviewer’s Comments:** The greater risk of depression in children and adolescents from depressed parents has been well established and is probably due to both genetic and environmental effects of having depressed parents. This study helps demonstrate that well-designed and targeted cognitive behavioral group intervention can help prevent depression in these high-risk adolescents. The study also reinforces the need for adequately treating parental depression in order to more effectively prevent depression in their offspring.

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Highlights of What We See in Factitious Disorders

Axis I Comorbidity and Psychopathologic Correlates of Autodestructive Syndromes.

Compr Psychiatry; 50 (July-August): 327-334

Substance abuse/dependence is the only psychiatric comorbidity consistently found to be associated with more patients with self-destructive behaviors than those without.

**Background:** Deliberate self-harm (DSH) can be classified as involving direct behaviors that are overt, such as cutting, or indirect behaviors that are concealed, such as injecting a caustic agent to induce a medical procedure, as found with factitious disorder. Although self-harm is also commonly associated with borderline personality disorder, it can occur across a spectrum of pathology. There is a limited understanding of the comorbidities that occur with either overt or covert self-harm, although substance abuse, anxiety disorders, eating disorders, and affective disorders are most commonly cited. Substance abuse/dependence seems to be the most consistently reported.

**Objective:** To more precisely characterize self-harm behavior and its different manifestations based on Axis I comorbidity and other psychopathology.

**Participants/Methods:** 194 adult inpatients admitted to the psychosomatic medicine service in a hospital in Berlin for at least 7 days were included in the study. Every patient was assigned to a group based on whether there was evidence for self-destructive behavior or not. Comorbidities were assessed using a structured diagnostic interview tool and multiple self-report assessments for depression, anxiety, stress, optimism, and expectations of self. The primary outcome measures were differences in mental and behavioral diagnoses based on self-destructive parameters.

**Results:** 37 patients met the criteria for self-destructive behavior, 19 in the factitious group and 18 in the DSH group. The only significant difference between those with self-destructive behaviors and those without such behaviours was a higher incidence of substance abuse/dependence among the self-destructive behaviour patients. Comparing the factitious versus the DSH group, however, indicated that those with DSH had a significantly higher incidence of eating disorders and affective disorders. Overall, those with factitious behaviors had a lower number of comorbid diagnoses, even when compared with patients without any self-destructive behavior.

**Conclusions:** Patients with factitious illness behavior appeared less disordered in terms of the comorbidities assessed than those with DSH, and on certain measures, they appeared even less disordered in terms of assessed comorbidities than those without any self-destructive behavior.

**Reviewer's Comments:** This article highlighted what we see clinically in factitious disorders: the patients appear fairly healthy on the surface. They also appear fairly healthy on the assessment interviews. It would be useful to develop a prospective study accurately addressing the underlying pathology of factitious disorder, but this has remained challenging. This article was also an exercise in labelling. Just to reiterate, the difference between DSH and factitious illness behavior is the conscious intentionality and the openness of the behavior. I have always lumped all of this behavior into the phrase self-injurious behavior, but I think I will change that after reading this article.

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Does Number or Pattern Matter? The Fluctuation of Symptoms as a Clinical Variable

Capturing the Ebb and Flow of Psychiatric Symptoms With Dynamical Systems Models.
Odgers CL, Mulvey EP, et al:
Am J Psychiatry; 166 (May): 575-582

It appears methodologically possible to measure and track the pattern of the appearance of symptoms, and it also appears that such patterns, rather than number per se, can predict patient risk for violence.

Objectives: A highly consequential assumption throughout clinical research and practice is that levels of symptoms are the key predictive clinical feature of interest. While it is certainly reasonable to assume that increased symptoms are associated with increased impairment or disturbance, doing so (to the exclusion of factors) misses important evaluative and prognostic opportunities, specifically, how rapidly symptoms vary, and the pattern of that variation (e.g., whether that variation accelerates or dampens over time in any consistent pattern).

Participants/Methods: Eligible patients were among patients seen in the emergency room of an urban psychiatric facility who, on follow-up interview, showed a risk of violence in terms of having a history of heavy substance use during the previous 2 months, being involved in at least 1 threat or act of violence, and having a score ≥7 on the hostility subscale of the Brief Symptom Inventory. Subjects, and a collateral informant who each patient identified as knowing them well, agreed to participate in weekly symptom assessment interviews over 26 weeks. Symptoms were assessed using the 53-item self-report Brief Symptom Inventory. Interviews also assessed participant's involvement in violent incidents. The study outcome was the degree the pattern of symptom volatility predicted violence by subjects.

Results: Subjects varied widely with respect to frequency of symptom oscillation, from very rapid to extremely slow; 26.6% could be categorized as so-called rapid oscillators. Most subjects showed a dampening or stable pattern of oscillation of symptoms, but 28.7% experienced a pattern of ongoing amplification of symptoms. Rapid versus slow oscillators were 2.78 times more likely to be in a violent incident, and those with an amplifying pattern were 1.57 times more likely.

Conclusions: It appears possible to both capture dynamic models of symptoms in patients along dimensions of rapidity of change and the pattern of that rate of change predicts the likelihood of violent behavior in patients with histories of violence.

Reviewer's Comments: The utility and possibility of tracking more dynamic patterns of symptom appearance in addition to number or type of symptoms per se opens up a potentially important new dimension of clinical assessment as it already is in some approaches to disease management, such as symptom diaries in bipolar disorder.

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Long-Term Use of Tricyclic and SSRI Antidepressants Increases Risk of Diabetes

**Background:** Although multiple antidepressants have been reported to cause weight gain, the risk of the subsequent development of diabetes is unknown. Given the link between body mass changes and diabetes with atypical antipsychotics, similar theories have been proposed with antidepressants. One recent study found that an elevated risk of diabetes in patients using antidepressants was diminished with the prophylactic use of metformin.

**Objectives:** To identify whether there is an association between antidepressant use and an increased risk of diabetes and whether such an association is related to duration or dose of the antidepressant used.

**Design/Participants:** This was a case-control study of depressed patients seen in general practice settings in the U.K.

**Methods:** Each participant had to have received a prescription for a new antidepressant during the study period and be treated with only 1 type of medication. Exposure to antidepressants was grouped based on length of time and dose of medication. Cases were defined as those depressed participants who received a diagnosis of diabetes; controls were matched based on age, sex and year of study entry. Only adults at least 30 years old were included in order to reduce the chance of including Type I diabetes in the study.

**Results:** Over 165,000 patients were included, approximately 2,243 of whom developed diabetes. Each case was matched with 4 controls (nondiabetic, depressed patients). High baseline body mass index (BMI) was the strongest predictor of new-onset diabetes regardless of mood state or treatment. Recent use of antidepressants in higher-than-median daily doses for at least 2 years was associated with an 84% increased risk of developing diabetes. Other doses, other durations of usage, or former or past use were not associated with the same risk.

**Conclusions:** Recent, long-term use of both tricyclic and selective serotonin reuptake inhibitor (SSRI) antidepressants was associated with an increased risk of diabetes.

**Reviewer's Comments:** I like the premise of this article, using the findings of increased weight gain and subsequent diabetes in atypical antipsychotic drugs and seeing if that extrapolates to antidepressants. It is slightly more complicated with depression than psychosis, however, because SSRIs have more variable weight profiles within the class than antipsychotics and may even cause some weight loss initially and then weight gain over time. In addition, weight gain may not even be the connection with the development of diabetes; patients with depression have been found to have a 35% higher risk of diabetes than nondepressed people, regardless of treatment. And it may be the interaction between baseline BMI and the antidepressants here that is worth noting in practice. The diabetogenic consequences of our therapies appear to be a story that will be with us a long time.
Continuous Prenatal SSRI Tx Increases Risk of Preterm Birth in Women

Wisner KL, Sit DKY, et al:
Am J Psychiatry; 166 (May): 557-566

Sertraline is the most frequently used SSRI in pregnant women, followed by fluoxetine and citalopram or escitalopram.

Background: The effects of selective serotonin reuptake inhibitor (SSRI) treatment of pregnant women on preterm birth, birth weight, and minor physical anomalies is inconsistent as reported in the literature to date. The type of SSRI, the timing of exposure in the pregnancy, and differing study designs have made it difficult to make any definitive statements about neonatal risks.

Objectives: To determine if there is an association between SSRI treatment and untreated major depression during pregnancy with an increased risk of reduced maternal weight gain, lower birth weight, preterm birth, poor neonatal outcome, or minor physical anomalies.

Design: Prospective, observational study of pregnant women and their newborns.

Participants/Methods: 279 women recruited from Cleveland and Pittsburgh participated, with 85% of those reporting newborn data. Participants were grouped based on treatment and symptoms during pregnancy: no SSRI treatment and no depression; continuous SSRI exposure; continuous depression but no SSRI exposure; partial SSRI exposure; or partial depression with no SSRI exposure. Women with bipolar disorder, psychosis, or substance abuse were excluded. Women were evaluated for depression symptoms throughout the pregnancy and the newborns were evaluated 2 weeks postpartum.

Results: As expected, women without SSRI treatment or depression had lower depression scores. There was no association between SSRI exposure, either partial or continuous, with an increase in minor physical newborn anomalies. There was no relationship between SSRI treatment, depressive symptoms, and maternal weight gain, infant birth weight, NICU admissions, or Apgar scores. More preterm infants were born in the groups of women who received continuous SSRI exposure or had continuous prenatal depression.

Conclusions: There appears to be a higher risk of preterm birth in women who are either exposed to continuous prenatal SSRI treatment or experience continuous untreated major depression during pregnancy.

Reviewer's Comments: This study seemed to be attempting to help differentiate whether it is worse in terms of neonatal outcome for a woman to experience untreated depression or continuous SSRI treatment during pregnancy. The results indicate that there was little difference in terms of newborn outcomes. However, women who were treated with SSRIs had higher functioning status and lower depressive scores than those who were not treated. One might assume that, all other things being equal, it would be better for a pregnant woman to be treated and feel less depressed, especially in terms of later infant outcomes. Note that the results of this looked at preterm birth as the only outcome attributed to SSRI exposure, as opposed to other prominently reported studies that have found still rare, but statistically significant, increases in neonatal complications with SSRIs.

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Keep a Close Watch on Alzheimer's Patients Taking Olanzapine and Quetiapine

Zheng L, Mack WJ, et al:
Am J Psychiatry; 166 (May): 583-590

SGA use in patients with Alzheimer's disease is associated with weight gain in women (especially with olanzapine and quetiapine) and with girth increase and HDL decline with olanzapine.

**Objectives:** Most of the data and study on second-generation antibiotics' (SGAs) metabolic and cardiovascular effects have focused on younger or middle-aged subjects. Randomized trials of SGAs used specifically for dementia patients have tended not to look at metabolic parameters as outcomes of interest. The Clinical Antipsychotic Trials of Intervention Effectiveness-Alzheimer's Disease (CATIE-AD) study was established to explore the comparable effectiveness of SGAs (specifically olanzapine, quetiapine, and risperidone) on the psychiatric and behavioral symptoms of Alzheimer's disease. This study also gathered various metabolic parameters that allow for longitudinal follow-up of the impact of exposure to these medications on those outcomes.

**Methods:** Patients were able to enter up to 4 phases of treatment after being initially randomized to treatment with olanzapine, quetiapine, risperidone, or placebo. After randomization, subjects were followed at weeks 2, 4, 8, 12, 24, and 36 and were able to successively replace their therapy with another if clinically determined that a switch in treatment was needed. In addition to a range of clinical symptoms evaluated across the observation period, subjects also had body mass index (BMI), blood pressure, and hip circumference measured at each clinic visit and glucose, cholesterol, and lipid studies drawn at weeks 12, 24, and 36.

**Results:** 421 subjects were randomized initially. At baseline, patients presented with cardiovascular and metabolic conditions, with 46% already on hypertensives, 24% receiving cholesterol and triglyceride reducers, and were, on average, overweight. Given the design of the study, 43% had exposure to multiple SGAs. Overall, women showed statistically significant weight gain (0.14 pounds/week of use). All timeframes of exposure (<=12 weeks, 12 to 24 weeks, >=24 weeks) showed significantly greater odds of clinically significant weight loss (>7% increase from baseline) for those on SGAs compared to placebo or non-SGA use. Olanzapine and quetiapine were significantly associated with weight gain (0.12 pounds/week and 0.14 pounds/week, respectively). Olanzapine use was also associated with HDL decrease (-0.19 mg/dL per week) and increased girth (0.07 inches/week).

**Conclusions:** Use of SGAs in patients with Alzheimer's disease is associated with weight gain in women (especially with olanzapine and quetiapine) and girth increase, as well as HDL decline with olanzapine.

**Reviewer's Comments:** While experience with SGAs already provided reason for caution, the study here underscores the importance of close monitoring of Alzheimer's patients especially taking olanzapine and quetiapine for weight and metabolic changes that still impact patient health.

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Quetiapine XR Effective Monotherapy for Major Depressive Disorder

Extended Release Quetiapine Fumarate Monotherapy in Major Depressive Disorder: A Placebo- and Duloxetine-Controlled Study.
Cutler AJ, Montgomery SA, et al:
J Clin Psychiatry; 70 (April): 526-539

Quetiapine XR monotherapy appears effective in the treatment of major depressive disorder.

**Objective:** Quetiapine, approved by the Food and Drug Administration for a range of indications including acute and chronic schizophrenia and bipolar mania and in bipolar depression, has shown effects on depressive symptoms in schizophrenia and as an adjunct in the treatment of major depression.

**Design:** Therefore, it is considered here as a potential monotherapy in this double-blind, 8-week randomized trial.

**Participants/Methods:** Subjects were individuals diagnosed with major depressive disorder, confirmed by the Mini-International Neuropsychiatric Interview, and they had significant illness as measured by exceeding standard symptom scale cut off scores (Hamilton Rating Depression Scale [HAMD-17] total score >=22, HAM-D item 1 score >=2). After a 7- to 28-day enrollment and prior medication washout period, subjects were randomized to treatment with quetiapine XR 150 or 300 mg/day doses, duloxetine (60 mg/day), or placebo for 6 weeks. From weeks 6 to 8, drugs were tapered. Montgomery-Asburg Depression Rating Scale (MADRS) scores were followed each week with calculations by treatment arm of the total change in score, and those achieving response or remission (>=50% reduction in MADRS total from baseline, and a MADRS score <=8 at week 6, respectively. Some other clinical measures, such as the Clinical Global Impressions-Improvement (CGI) score, the Hamilton Rating Scale for Anxiety (HAM-A) and sleep quality, were also tracked.

**Results:** 612 patients were randomized. Adverse events (AEs) were the most common reason for withdrawal from treatment, affecting 19.7%, 15.1%, and 13.1% of the XR 150, XR 300, and duloxetine groups, respectively. Most common AEs for quetiapine were dry mouth, sedation, and somnolence. At week 6, the quetiapine groups and the duloxetine-treated group all showed significant reduction in baseline MADRS compared to placebo. Remission rates were significantly higher for quetiapine XR 300 mg and duloxetine, but not for XR 150. Response rates were significantly higher in all groups compared to placebo. HAM-D total, HAM-D item 1 (depression) Hamilton Anxiety scores also were significantly and comparably improved by the active treatments.

**Conclusions:** Quetiapine, and perhaps more effectively in its 300 mg does, appears effective against placebo and comparable to the medication duloxetine monotherapy in the treatment of major depressive disorder when followed over a 6-week course of treatment.

**Reviewer's Comments:** First as adjuncts and now perhaps as monotherapy, the antipsychotics are proving to be more than that. The kinds of side effects that have always captured the attention of clinicians and patients in the effective use of these medications may again prove a limiting factor. With that said, new agents are welcome, although this is just the first well-designed study yet to examine their effective use for this condition.

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Citalopram is ineffective in reducing repetitive behaviors in children and adolescents with autism spectrum disorders, consistent with prior randomized controlled SSRI trials.

**Background:** Repetitive behaviors, such as inflexible routines and stereotypic movements, in children with autism spectrum disorders (ASDs) can greatly interfere with functioning and are often refractory to pharmacologic treatment. Prior placebo-controlled studies of selective serotonin reuptake inhibitors (SSRIs) have demonstrated either no benefit, or very modest benefit, with adverse effects including hyperactivity, aggression, and irritability.

**Objective/Design:** To determine if citalopram is both safe and effective in children with ASDs who have repetitive behaviors using a randomized, double-blind design.

**Methods:** Eligible outpatient subjects were 5 to 17 years old, who met the criteria for autistic disorder, Asperger disorder, or pervasive developmental disorder not otherwise specified. The participants were then randomized to placebo, or citalopram, dosed from 2.5 mg to 20 mg/day. The upward dosage titration was by no more than 2.5 mg weekly or biweekly, depending on the subject's weight. The trial lasted 12 weeks; 149 patients were randomized equally to placebo or citalopram. The primary outcome measure was the Clinical Global Impression, Severity of Illness Scale (CGI-I) scale. The main secondary outcome measure was the Children's Yale-Brown Obsessive Compulsive Scales modified for Pervasive Developmental Disorders (CYBOCS-PDD). Another assessment measure was the Aberrant Behavior Checklist-Community version, used here primarily to detect other behavioral changes as a result of active treatment.

**Results:** The study found that there was no significant difference in the proportion of CGI-I responders between the placebo and citalopram groups. There was also no difference in score reduction on the CYBOCS-PDD from baseline. There were, however, significantly increased adverse events in the citalopram group including increased energy level, impulsiveness, decreased concentration, hyperactivity, all occurring between approximately 20% and 30% of the citalopram-treated subjects, and no relationship was found between citalopram dosage or measured citalopram level and clinical response.

**Conclusions:** In this subject population of patients with ASDs, citalopram demonstrated no significant efficacy over placebo, and also caused significant adverse effects, such as aggression and irritability.

**Reviewer's Comments:** The findings of this study are unfortunately not surprising. Despite the fairly widespread use of SSRIs for repetitive behaviors in children with ASDs, the evidence is simply not there for clear benefit. Perhaps the greater concern is the adverse events associated with SSRIs in the ASD population, as demonstrated by this study. The resulting increased anger and agitation could result in further decline in functioning, and, even worse, possibly decrease the ability to implement behavioral programs or maintain the current level of care.

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ADHD Treatment: What's Old Is New Again

Long-Term Safety and Efficacy of Guanfacine Extended Release in Children and Adolescents With Attention-Deficit/Hyperactivity Disorder.

Sallee FR, Lyne A, et al:
J Child Adolesc Psychopharmacol; 19 (June): 215-226

Guanfacine, in a newly developed extended release form, has demonstrated efficacy and tolerability, alone and in combination with psychostimulants, in the treatment of ADHD.

Background: Guanfacine is a primarily antihypertensive selective a2A-adrenoreceptor agonist that has been used for over 15 years as an alternative to clonidine in the treatment of attention-deficit/hyperactivity disorder (ADHD). This study was sponsored by Shire Pharmaceuticals, the manufacturer of guanfacine XR.

Objective/Design: To determine if guanfacine maintains efficacy and safety for the treatment of ADHD in a 2-year, open-label, extension trial of 2 initial trials (one of which was double-blinded, placebo-controlled).

Methods: 262 subjects diagnosed with ADHD were enrolled from 2 antecedent trials. One of the antecedent trials was a phase 3 pivotal trial to establish the safety and efficacy of guanfacine XR. All subjects were started on guanfacine XR at 1 mg/day and some were titrated upwards to 2, 3, or 4 mg/day, and some were also taking psychostimulants. The primary instrument for efficacy reassessments was the ADHD Rating Scale-IV, and secondary measures included the Clinical Global Impressions of Improvement Scale (CGI-I) and the Conners' Parent Rating Scale-Revised short form (CPRS-R). Subjects were also assessed for safety, utilizing vital sign measurements, electrocardiograms, laboratory tests, and physical examinations.

Results: The overall mean baseline ADHD-RS-IV total score of the antecedent studies was 38.3. At the 2-year end point for this study, the ADHD-RS-IV mean total scores were 13.2 for combined treatment (psychostimulants and guanfacine XR), and 19.4 for guanfacine XR alone. Only the combination treatment medications group achieved the end point considered to be remission on the ADHD-RS-IV. Mean improvement was maintained at 12, 14, and 24 hours post-dose. In terms of safety findings, there were minimal overall changes in blood pressures. However, there was decreased diastolic blood pressure (DBP; <50 mm Hg) in 27.7% of children and 67.6% of adolescents (DBP <60 mm Hg). Five subjects experienced a syncopal episode on the medication, with most of these episodes also related to fever, dehydration, or a prior history of light headedness. There were no significant ECG changes. Most sedation was mild and resolved.

Conclusions: 2-year safety and efficacy for guanfacine treatment of ADHD was successfully established in this study, both in combination with psychostimulants and as monotherapy.

Reviewer's Comments: Unfortunately, this study was not designed to statistically analyze the differences in efficacy and tolerability of the combined medication group and the guanfacine-only group. The authors do suggest that this information would be helpful for future studies, but it is somewhat disappointing that the analyses were not presented with the data gathered so far. There is also a need for an active comparator arm of stimulants as monotherapy, which would help demonstrate the actual benefit of adding guanfacine XR to psychostimulant treatment.

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Good Idea to Continue the Practice of Workplace Mandates

Substance Use, Symptom, and Employment Outcomes of Persons With a Workplace Mandate for Chemical Dependency Treatment.

Weisner C, Lu Y, et al:
Psychiatr Serv; 60 (May): 646-654

The main types of treatment mandates in this country are a result of employer, welfare, or criminal justice pressure.

Background: The goal for individuals who are mandated into substance abuse treatment by the courts or their employers is not that they will have improved results over those who enter treatment voluntarily, but that they will have similar results. This is primarily because those who are forced into treatment are less self-motivated than those who choose treatment and self-motivation is a huge part of successful recovery. With or without a mandate, patients who suffer dually from substance abuse or dependence and mental illness typically have worse outcomes.

Objectives: To explore the short- and long-term consequences of workplace mandates for employers, patients and families, including psychiatric outcomes.

Participants/Methods: The data for this study came from an observational study of adults admitted to an outpatient chemical dependency recovery program in northern California from 1997 to 1998. They were followed up at 1 year and 5 years. Participants were randomly assigned to receive either integrated primary care through the program or standard primary care and were divided among the day treatment and the outpatient, group-based arms of the recovery program. In terms of analysis for this study, patients who had workplace mandates for treatment were compared to those who did not. Information collected throughout the study included readmission rates, treatment adherence, addiction severity, and psychopathology.

Results: Of the 448 employed participants, 17% had workplace mandates. Individuals with workplace mandates had lower depression rates and lower rates of alcohol dependence than those who were not mandated. Overall, outcome measures were similar between the 2 groups, although when length of stay was controlled for (because those with mandates had a longer length of stay), workplace mandates predicted abstinence at 1 and 5 years. Longer length of stay was the most important predictor for better outcomes. Those with mandates perceived drug treatment as less important than did those without mandates.

Conclusions: Patients in treatment as a result of a workplace mandate maintained treatment longer and as a result, had better abstinence rates and similar other outcomes as those without a mandate.

Reviewer's Comments: Although motivation is probably the single most important factor in substance abuse treatment success, coercing and forcing people into treatment through a workplace mandate can at least have similar outcomes as for those who voluntarily seeks treatment. Perhaps the mandate helps patients hit rock bottom, or perhaps it clarifies the serious consequences of drug use. Whatever the mechanism, it is probably a good idea to continue the practice of workplace mandates, especially since substance abuse and dependence can have such catastrophic effects on work performance and the people affected by that work.

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Determining the Length of Tx for PMDD With Sertraline

Time to Relapse After Short- or Long-Term Treatment of Severe Premenstrual Syndrome With Sertraline.

Freeman EW, Rickels K, et al:
Arch Gen Psychiatry; 66 (May): 537-544

Severity of symptoms at baseline and remission during treatment best predict outcomes in determining duration of SSRI treatment for PMDD.

Background: Premenstrual syndrome (PMS) is one of the most common health problems that women of reproductive age describe, and its more severe form, premenstrual dysphoric disorder (PMDD), can be highly impairing, but is also responsive to serotonin reuptake inhibitors. The Food and Drug Administration has approved both sertraline and fluoxetine, for example, for that indication. Yet the evidence that supports that use has generally involved following patients for relatively short-term follow-up periods, such as 3 months. Thus not only long-term course with treatment, but understanding when treatment can be discontinued, is not well studied.

Objective: To compare relapse rates and time to relapse between patients on short-term as opposed to longer-term courses of treatment for PMDD with sertraline.

Methods: Eligible subjects met criteria for PMDD and met screening cut off scores on the validated Daily Symptom Report (DSR). After a period that included a 1-month administration of placebo to verify continued elevated scoring so as to confirm the stability of the diagnosis, subjects were randomized to a short- and a long-term treatment group and all received treatment with sertraline during the luteal phase. After 4 months of treatment, subjects switched to the short-term group and blinded to their status, started receiving placebo until month 12, at which time the long-term group was also switched, without their knowledge, to placebo for another 6-month observation and follow-up period. Throughout these 18 months, both groups were scored for the presence of PMDD.

Results: 174 subjects were randomized. Improvement, as defined by >=50% decline in the DSR score, occurred overall in 72% of subjects, with most of the improvement within the first 8 weeks (62% by the second month). As opposed to the long-term group, the short-term group experienced had greater relapse by 8 months (60% vs 41%), and the time to relapse was also longer (8 months vs 4 months). Baseline severity of symptoms was a statistically significant predictor of relapse irrespective of treatment group. When looking at the first 6 months when each group was taking placebo (months 5 to 10 for short-term and months 13 to 18 in long-term) 33% of the long-term versus 51% of the short-term patients experienced relapse, a statistically significant difference.

Conclusions: Relapse rates are greater and time to relapse smaller for those with short-term (4 months) versus long-term (12 months) treatment with sertraline for PMDD, with baseline severity predicting relapse irrespective of treatment duration.

Reviewer's Comments: This study does not support a specific guideline as to minimum duration of treatment, but it does start to offer certain guiding clinical dimensions to making such decisions with patients, though ones which are likely generally intuitive anyway. Real remission during treatment, more moderate baseline severity, and effective treatment for a year appear to be factors that might help patients considering discontinuation.
Community Screening for Depression in High-Risk Individuals Yields Few Benefits

Screening for Depression in High-Risk Groups: Prospective Cohort Study in General Practice.
Baas KD, Wittkampf KA, et al:
Br J Psychiatry; 194 (May): 399-403

Community screening efforts for depression may yield far too few actual cases interested in treatment to be worthwhile, perhaps depending though on the design of the screening.

Background/Objectives: We know that depression is common in the community, and that perhaps 50% of those living with the disorder have not been identified by the healthcare system. There are also now many sensitive survey tools for screening cases of depression in the community. The authors of this study thus implemented a screening process for high-risk individuals identified through the practices of General Practitioners (GP) in the Netherlands.

Participants/Methods: Databases from GP practices in a specified area were reviewed to identify patients meeting the high-risk definition of having presented within the last 3 months with a specific mental health problem in the prior 3 months, people with somatic complaints persisting at least 90 days without medical cause, and those lying in a highest 10% outlier category of frequency of GP visits. These patients were mailed a Patient Health Questionnaire (PHQ-9) depression screen. For those scoring >=10, a telephone-administered Structured Clinical Interview for DSM-IV Axis I disorders (SCID-1) was performed to verify a diagnosis of major depression, in which case the subject and their GP were advised that the patient make an appointment with their GP to address this issue.

Results: 1687 high-risk individuals were identified among 3 health centres and surveyed; 826 (49%) returned the PHQ, but only 780 gave consent for subsequent contact. Of those 780, 29% scored >=10; 173 of those were able to complete the SCID interview, of which 71 met the criteria for major depression. Of those 36 who already were in treatment, 14 refused treatment, and 4 did not follow-up, leaving 17 of an original 1687 invited for, and 780 participating in, the screening survey, leaving the number needed-to-screen in order to treat 1 not yet diagnosed case of depression at 118.

Conclusions: A community self-completed survey given to patients drawn as potentially high risk for depression from GP case lists, yielded very few cases of new, treatment-interested cases of verified major depressive disorder.

Reviewer's Comments: Despite acknowledging the importance of tightly linking treatment access to case-finding for success of any screening effort, this study did not, in my view, practice what it preached. Successful integration of treatment within primary care (as the authors point out) need more immediate connections between being diagnosed and followed up, often with a mid-level care manager. That was not done here. Though the authors might rightfully in their defense argue that this was because they wanted to indeed test a different model than a clinic-based one for identifying cases, it also seems to me that they still handicapped the value of doing so by limiting their definition of people who could benefit from intervention, those meeting a SCID definition of major depression, rather than just the PHQ cut-off, which can relate to significant morbidity itself.

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Child Violence Victims May Later Victimize Others

Wilson HW, Stover CS, Berkowitz SJ:
J Child Psychol Psychiatry; 50 (July): 769-779

Childhood victims of violence are more likely to develop antisocial behaviors later in life.

Background/Objective: Previous cross-sectional or retrospective studies suggest that maltreated and violence-exposed children are more likely to have arrest records for antisocial behavior as they age. Dr. Wilson and colleagues conducted a meta-analysis further exploring the association of childhood violence exposure and later antisocial behavior. The study also looks at the design of the studies analyzed, whether cross-sectional with retrospective data or prospective and how the design influences the findings.

Methods: In deciding the inclusion criteria for the studies into the meta-analysis, the authors found the most challenging aspect to be deciding what to include for childhood violence. Studies were included in which the actual nature of the violence was explored, and not just quantified as rates of violence. A total of 18 studies were included, 8 of which were prospective, with a total sample size of 18,245. The authors then used a system to code for the type of violence.

Results: Studies with victims of violence yielded a greater effect size overall than studies with witnesses of violence. The effect magnitude for the relationship between childhood violence exposure and adolescent violent offending was moderate (and the association with nonviolent offending was small). There were no significant gender differences.

Conclusions: The relationship between violence and antisocial behavior is stronger when victimization, not just exposure, is assessed. Studies with a prospective design find smaller associations than cross-sectional studies.

Reviewer’s Comments: This meta-analysis focused on studies that investigated the association of violence exposure and clearly defined antisocial behaviors, as found in arrest records or reporting from families. It did not include studies that explored the impact of childhood violence exposure on psychosocial and developmental outcomes, which have found that witnessing violence is equal to victimization. The effect of violence exposure and antisocial behaviors in adolescence and young adulthood may be more of a moderate effect, and mostly includes actual victimization. It is not very surprising that prospective studies yielded smaller associations as they tended to use police records as outcome data, and in cross-sectional studies there tends to be more recollection bias with, perhaps, families over-reporting antisocial activity.

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Restricted Fetal Growth Associated With Later Psychosis-Like Symptoms

Association of Measures of Fetal and Childhood Growth With Non-Clinical Psychotic Symptoms in 12 Year-Olds: The ALSPAC Cohort.

Thomas K, Harrison G, et al:
Br J Psychiatry; 194 (June): 521-526

There appears to be an association between restricted fetal growth and later development of psychosis-like symptoms, possibly relating to risk factors from in-utero events.

**Background/Objective:** The Avon Longitudinal Study of Parents and Children (ALSPAC) cohort in England is 10 times larger than the well known Dunedin cohort, with 6455 children followed since their birth in 1991 and 1992. This unique longitudinal follow-up study has been used to explore a range of individual and familial characteristics in early childhood with later development of psychiatric symptoms. This paper specifically examines the associations of body size at birth and childhood psychosis-like symptoms at 12 years of age.

**Methods:** Using a semi-structured interview, called the PLIKSi, the children were rated for nonclinical psychotic symptoms, including hallucinations, delusions, and thought control disturbances. Statistical analyses were then made between the symptoms reported, and birth weights and length, as well as the ponderal index, which measures for infant adiposity. Questionnaires during the antenatal period assessed for other possible confounders, including maternal smoking. Also, the children had their IQ assessed using the Wechsler Intelligence Scale for Children (WISC)-III, to see if there is an association with lower IQ and psychosis-like symptoms.

**Results:** The prevalence of definite psychosis-like symptoms was seen in 144 (4.9%) boys and 198 (6.5%) girls. There was an 18% reduction in the odds of psychosis-like symptoms in relation to a 1 standard deviation increase in birth weight (controlled for age and gestation). There was no significant association with IQ.

**Conclusions:** This study presents reasonably strong evidence that restricted fetal growth, indexed by low birth weight, short birth length and low ponderal index, are associated with an increased risk of psychosis-like symptoms at 12 years old.

**Reviewer's Comments:** This study solely assessed for psychosis-like symptoms, as the authors pointed out. These symptoms can be a result of multiple disorders, including mood and anxiety disorders, such as post-traumatic stress disorder. However, this study provides further evidence for the neurodevelopmental hypothesis of psychotic disorders, which typically begin to appear in adolescence. The so called first hit in the neurodevelopmental hypothesis appears to occur in-utero. These children will be followed for other prodromal indicators of a psychotic illness, such as decline and withdrawal and will surely be an ongoing source of information to further explore neurodevelopmental hypotheses with respect to psychiatric risk.

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Black-White Disparities Persist in Psychiatric Hospitalization in United States

Overrepresentation of Black Americans in Psychiatric Inpatient Care.
Snowden LR, Hastings JF, Alvidrez J:
Psychiatr Serv; 60 (June): 779-785

Whites have a higher lifetime prevalence of mental illness; however, schizophrenia is more common in black populations.

Background: Data from varied studies have indicated that black Americans receive more inpatient mental health treatment than non-Hispanic whites. Multiple theories are in place about why this may be, including socioeconomic disparities, fear of hospitalization that limits compliance with outpatient services, and the stigma of mental illness, which is experienced in different ways across cultures. The question remains whether this disparity in hospitalization is warranted based on actual mental health needs. Black Americans do not all have similar ancestries, and differences in their region of origin may have an important impact on their rates of psychiatric hospitalization. For example, Caribbean-born blacks utilize mental health services, in general, more than African-American blacks.

Objectives: To investigate whether black Americans, sub-grouped into Caribbean or African-American descent, are more likely than whites to receive inpatient psychiatric care.

Methods: Data from the National Survey of American Life and the National Comorbidity Survey Replication, conducted in the early 2000's and designed to gather data about ethnic and cultural influences on mental disorders and to identify physical, mental and socioeconomic conditions of black Americans, was used. Interview data from 3,570 African Americans, 1,621 blacks of Caribbean descent, and 4,180 whites was compiled. Primary outcome data was lifetime psychiatric hospitalization (including for substance abuse/dependence) based on ethnicity, controlling for multiple sociodemographic variables, a history of mental illness, and/or counselling or psychotherapy. Of note, schizophrenia-spectrum illnesses were not included in the surveys.

Results: African Americans and Caribbean blacks were significantly more likely to be psychiatrically hospitalized despite having significantly lower rates of psychiatric disorders than whites. After controlling for multiple variables, U.S.-born Caribbean blacks had the highest odds of being hospitalized and foreign-born Caribbean blacks and whites had the lowest rates. Interestingly, outpatient psychotherapy was associated with a higher rate of hospitalization, likely indicating outpatient services following discharge.

Conclusions: Black-white disparities remain in psychiatric hospitalization in the U.S. that are not clearly explained by the prevalence of psychiatric illness.

Reviewer’s Comments: On the surface, it seems that the findings from this study indicate that black Americans are psychiatrically hospitalized in disproportionate numbers to white Americans. However, consider that schizophrenia, a major reason for hospitalization, was not included as a diagnosis in the surveys and is more prevalent in blacks than whites. This may explain some of the findings. Another point to note is that the surveys used were all based on self-report; combining these data with demographic and diagnostic information from actual inpatient facilities would make for more meaningful results. But remember that the numbers in this study were huge, so that even if the results are not that impressive, they are probably valid.

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Improved Cognition--SGA or Re-Test Effects

Changes in Neurocognitive Function in Patients With Schizophrenia After Starting or Switching to Amisulpride in Comparison With the Normal Controls.

Ahn YM, Lee KY, et al:
J Clin Psychopharmacol; 29 (April): 117-123

While amisulpride might improve specific cognition, overall it underscores how many prior studies have probably confused re-test effects with actual treatment effects.

**Background:** Research thus far appears to show that second-generation antipsychotic (SGA) agents have superior impact on cognitive deficits in schizophrenia as opposed to first-generation antipsychotic (FGA) agents, but that these effects seem to appear in certain and not all cognitive domains and may vary by compound. Amisulpride, with some unique features distinguishing it from other SGAs (namely selective dopamine [D]2 and D3 antagonists), has shown improvement effects for example on working memory, attention, and auditory, short-term, and visuospatial recognition memory. However, studies with this drug, and importantly often for all such effectiveness trials, might suffer from the fact that before and after cognitive testing means repeat exposure of subjects to the same assessments that can enhance outcomes simply by the subject now being familiar with (rehearsed) the assessment. The authors argue that not only control groups are needed, but health controls to best measure the contribution of this practice effect. In addition, trials often show interval change over short periods of time.

**Objective:** To assess the impact of amisulpride on cognitive domains over 1-year follow-up period and with a health control comparison group.

**Methods:** From facilities in Korea, patients with a DSM-IV-verified diagnosis of schizophrenia were identified who otherwise needed a change in treatment due to side effects or treatment ineffectiveness. Patients were dosed on amisulpride based on clinical judgment of need. Patient-subjects and controls participated in comprehensive neuropsychological test batteries including assessments of general intelligence, working memory, executive function, verbal and nonverbal memory, attention, and psychomotor speed. This battery was administered at baseline, at 8 weeks, and then at 1 year.

**Results:** The intent-to-treat group included 33 males and 24 females (patient group), and 28 males and 32 females were included in the control group. Both groups showed improvements over time. However, when comparing the effect size differences in the 2 groups, it appears that most of the improvement had to be attributed to practice effects, as improvement in controls exceeded that in patients. Some tasks (specifically the Wechsler Intelligence Vocabulary subtest and Trail Making Test performance) appeared uniquely related to treatment experience.

**Conclusions:** Improvement in cognition seen with antipsychotic use appears in this study largely, though not completely, attributable to practice effect.

**Reviewer's Comments:** This study helps explain the repeated, but still variable and patchy findings of a role for SGAs on cognitive deficits in schizophrenia as an issue of method (ie, adequate controls for the improvement that can come from just being exposed to repeat cognitive testing).

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Another Imaginative Way of Asking if Treatment Improves Cognition in Psychotic Illness

Cognitive Effectiveness of Olanzapine and Risperidone in First-Episode Psychosis.


Risperidone and olanzapine appear to improve cognition among first-episode, drug-naive patients, but the specific treatment, sequence, and perhaps even duration of treatment may show similar effects.

**Background:** While cognitive impairment in schizophrenia is well known, preferred treatment strategies are not. Evidence is mixed regarding the comparative effects of first and second-generation agents, and recent reports, including one included in this edition of *Practical Reviews in Psychiatry*, suggest that practice effects that result from repeat administration of neuropsychological tests in studies may be responsible for much of the finding of improvement in treatment studies.

**Objective:** This study approaches tries to get a different handle on preferred treatment approaches by comparing change in cognitive performance among first-episode, treatment-naive patients treated with olanzapine or risperidone, those who need to switch off from either treatment, and those who discontinued treatment. They also used baseline data to investigate possible prognostic indicators of good cognitive response.

**Methods:** Eligible subjects were screened first-episode drug-naive patients. At baseline and 6 months, they participated in a neuropsychological battery assessing attention, executive function, information processing, and memory. Initial screening included structured assessment of psychiatric symptoms. Subjects were initially randomized to either olanzapine or risperidone treatment. Patients were followed clinically and could change medications or discontinue. Over the 6 months, 29 followed treatment with risperidone, 22 with olanzapine, 16 changed to another antipsychotic from their original one, and some discontinued treatment and did not receive medication during the last 3 months of observation.

**Results:** Cognitive measures improved in all groups, with no differences in improvement among the 4 groups. Nearly 50% of all patients showed improvement in their Global Cognitive Score at 6-months with improvement among neuropsychological tests ranging from 17% to 54%. Poor performance on baseline testing and low premorbid IQ and school performance predicted poor cognitive response across groups.

**Conclusions:** For first-episode patients, improvement in cognition with treatment did not differ among those treated with olanzapine, risperidone, switched from either, or discontinued with no receipt of medication during the past 3 of 6 months of observation. Instead, poorer baseline cognitive performance, premorbid IQ, and school performance best explained poor cognitive response.

**Reviewer’s Comments:** In yet another imaginative way of asking whether treatment improves cognitive performance among patients with psychotic illness, this study unclearly adds much to the clinical picture other than blurring it further. Treatment briefly provided and then discontinued, and with or without continuous use of an SGA, appears here to respond similarly. The lack of a clear control group makes distinguishing such response as really equivocal across such treatment histories as opposed to reflecting what would have happened without any treatment hard to do.

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Patients With Psychiatric Illness in Primary Care Settings Are Being Undertreated

Psychiatric Treatment Received by Primary Care Patients With Panic Disorder With and Without Agoraphobia.

Marcks BA, Weisberg RB, Keller MB:
Psychiatr Serv; 60 (June): 823-830

According to estimates, >40% of people with panic disorder go untreated.

Background: Panic disorder has a lifetime prevalence rate of 4.7% in the U.S. It is a particularly challenging disorder to treat because of high recurrence rates, high comorbidity and service utilization, and high rates of treatment in primary care settings. Estimates are that as many as 80% of cases of panic disorder first present to a primary care clinician. But even in psychiatric settings, panic disorder is still under-recognized and undertreated. This is despite a large array of medications and evidence-based psychotherapies, such as cognitive behavioural therapy (CBT), that are available.

Objectives: First, to examine differences in psychiatric treatment received in primary care settings for patients with panic disorder with and without agoraphobia. Second, to identify variables (sociodemographic and clinical) that might impact receiving psychiatric medication or psychotherapy.

Methods: 235 people with panic disorder, 150 of whom had agoraphobia, were drawn from the Primary Care Anxiety Project, conducted from 1997 to 2001 in 15 primary care settings throughout New England. Participants received a battery of assessments at intake, including diagnostic screening, mental health treatment questionnaires regarding medication and psychotherapies, and, for those not receiving treatment, a form designed to explore why they were not getting treatment. Information from the 2 groups of individuals with panic disorder was compared and analyzed.

Results: 38% of patients were not receiving treatment. Patients with agoraphobia were significantly more likely to be receiving treatment than those without agoraphobia. While selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs) were the most commonly prescribed medications for both groups overall, patients with agoraphobia received significantly more benzodiazepines than those without agoraphobia. In terms of psychotherapy, supportive and dynamic modalities were most commonly used. There were no significant differences between groups about reasons for not receiving treatment. The most commonly cited reason was a patient not wanting to use medications or psychotherapy for emotional problems.

Conclusions: Not only are there differences in treatment of primary care patients with panic disorder with and without agoraphobia, but a large percentage are not even receiving adequate care or any care at all.

Reviewer's Comments: The results of this study highlight what we all probably know, which is that patients with psychiatric illness in primary care settings are being undertreated. It is interesting, though, that of those receiving psychotherapy, lower percentages received the only empirically-tested modality (CBT) as compared to dynamic or supportive therapies. Although I am not an expert on panic disorder, it does seem that if this illness is a significant cause of distress and service utilization (such as emergency rooms and primary care clinics), it makes sense that efforts should be directed at better disseminating information about not only the need for treatment, but the need for appropriate and effective treatments.

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Dysregulation of Frontostriatal Circuits-Associated With Disorders of Self-Regulatory Control?

Functional Disturbances Within Frontostriatal Circuits Across Multiple Childhood Psychopathologies.
Marsh R, Maia TV, Peterson BS: Am J Psychiatry; 166 (June): 664-674

The frontostriatal pathways in the brain are found to have anatomical and functional disturbances in disorders of self-regulation, including Tourette's syndrome, bulimia, anorexia, and OCD.

Objective: The frontostriatal circuits project from supplementary motor, anterior cingulate, and part of frontal and prefrontal cortices, through the stratum and nucleus accumbens. This paper reviews the findings between disturbances in these circuits and disorders of self-regulatory control, specifically eating disorders, Tourette's, and obsessive-compulsive disorder (OCD).

Methods: The authors reviewed neuroimaging for the presence of abnormalities in frontostriatal circuits in children, adolescents, and adults who are diagnosed with anorexia nervosa, bulimia nervosa, Tourette's syndrome, and OCD. Many of the functional neuroimaging involved experimental paradigms, such as the Stroop task (where you are asked to read the color independently of the color that the word is typed).

Results: In Tourette's disorder, there are often decreased caudate volumes, and larger dorsolateral prefrontal cortices. Larger dorsolateral prefrontal volumes are associated with less severe tic symptoms, and may be compensatory. Portions of the frontostriatal circuit are modulated by dopamine, which may explain the efficacy of antipsychotics. In OCD, increased signals with making errors on the functional neuroimaging tasks are associated with worse symptoms, which may result in compulsions. In Tourette's, the frontostriatal circuits involve more motor and premotor cortices, whereas in OCD, they involve more of the limbic system, such as the anterior cingulate. In bulimia, patients responded impulsively and made more errors on an analogue of the Stroop task, with higher activation in the prefrontal and anterior cingulate. This activation did not modulate performance. However, follow-up functional imaging studies on anorexia patients whose improvement showed that the symptomatic improvement was associated with increased activation in prefrontal cortex with food images, perhaps reflecting and resulting in better control of the resulting anxiety.

Conclusions: The dysregulation of frontostriatal circuits appear to be a central mechanism in these disorders of self-regulatory control, and changes in this system appear to be associated with improved symptom control.

Reviewer's Comments: As the authors noted themselves, although many of these disorders are often comorbid, why do individuals who have impairments in the frontostriatal regions not develop all of these disorders? Future studies should continue to investigate the neuroimaging changes associated with symptomatic improvement and treatment algorithms, and even perform repeat scanning into adulthood.

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Frustrated Families of Patients With First-Break Psychosis--We Can Do Better

Families’ Experience With Seeking Treatment for Recent-Onset Psychosis.


More comprehensive and integrated family-based services for patients with first-episode psychosis is associated with better outcomes and improved relationships between families and mental health providers.

Objective: In retrospective studies, families of patients who developed chronic schizophrenia reported feeling not well informed during treatment for the initial psychotic episode of a family member. In focus groups, families reported that they could have benefited from multifamily psychoeducational groups in which patients are not present. This study involves surveys of families with a family member who has recently been diagnosed with a nonaffective psychotic disorder.

Methods: Open-ended audiotaped interviews were conducted with family members of 13 in-patients with recent-onset nonaffective psychosis. The patient ages ranged from 16 to 24 years of age, and most were male. They were diagnosed with a primary psychotic disorder, including schizoaffective disorder. All patients had first received treatment in the previous year. The interviews of the family members included questions about the usefulness of interventions. Qualitative data analysis was conducted on the information gathered using audiotapes of the interviews.

Results: Per the authors, themes that emerged from the narratives were remarkably similar, involving trajectories of symptoms, attributions, help seeking, interactions with the mental health system, and expectations for the future. The families voiced frustration with navigating the system, while still being in a state of shock about the diagnosis.

Conclusions: The authors list various examples from the family interviews, including direct quotes, which demonstrate the level of fear, anger, and frustration by families in this time of crisis with first-break psychosis of a family member. Families wanted to be better informed of how to handle the exacerbations of psychosis in the future and also desired messages of hope for fuller recovery.

Reviewer’s Comments: It is imperative that providers make a good first impression to these families at this entry point into the mental healthcare system. Otherwise, providers may create lasting fear and mistrust of mental health services. The authors point to more integrated and comprehensive services in Australia and Europe for patients with first-episode psychosis. These programs have rapid home-based assessments, younger (or peer) counselor staffing, social and vocational services, assertive outreach, and family services. These types of programs have been associated with fewer hospitalizations and better clinical outcomes.

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