Psychiatric Briefs

Prevention of Recurrent Postpartum Depression: A Randomized Clinical Trial

Wisner KL, Perel JM, Peindl KS, et al.

Background: Women who have suffered one episode of postpartum-onset major depression (PPMD) comprise a high-risk group for subsequent episodes. We conducted a double-blind, randomized clinical trial to test the efficacy of nortriptyline in the prevention of recurrent PPMD. ***Method:*** Nondepressed women who had at least one past episode of PPMD (Research Diagnostic Criteria) were recruited during pregnancy. Subjects were randomly assigned to nortriptyline or placebo. Treatment began immediately postpartum. Each subject was assessed for 20 sequential weeks with the Hamilton Rating Scale for Depression and Research Diagnostic Criteria for recurrence of major depression. ***Results:*** No difference was found in the rate of recurrence in women treated with nortriptyline compared with those treated with placebo. Of 26 subjects who took nortriptyline preventively, 6 (0.23, 95% exact confidence interval [CI] = 0.09 to 0.44) suffered recurrences. Of 25 subjects who took placebo, 6 (0.24, 95% exact CI = 0.09 to 0.45) suffered recurrence (Fisher exact p = 1.00). ***Conclusion:*** Nortriptyline did not confer additional preventive efficacy beyond that of placebo. The rate of recurrence of PPMD (one fourth of women) was unacceptably high.

(J Clin Psychiatry 2001;62:82–86)

Psychosocial and Psychiatric Risk Factors for Suicide: Case-Control Psychological Autopsy Study

Cheng ATA, Chen THH, Chen C-C, et al.

Background: Few data exist on the ways that psychosocial and psychiatric risk factors influence suicidal behavior. This study examined the effects of each of these types of risk factors, both individually and combined, on suicidality. ***Method:*** Each of 113 consecutive Taiwanese individuals who committed suicide was matched by age, gender, ethnicity, and area of residence with 2 living controls (total N = 226). Data gathered via psychological autopsy (comprising interviews with key informants) were compared with psychiatric and psychosocial data from the controls. ***Results:*** Multivariate conditional logistic regression analysis identified independent effects on suicide produced by 2 psychosocial risk factors—loss events (p = .001) and suicidal behavior in first-degree relatives (p = .022)—and 3 psychiatric risk factors—ICD-10 major depressive episode (p < .001), substance use disorder (p = .05), and emotionally unstable personality disorder (p = .034). No significant interactions were found between these independent risk factors. ***Conclusions:*** Life events associated with loss, especially the loss of a cherished idea, were associated with suicide, whereas non-loss events were not. Effective prevention of suicide may include identifying emotionally unstable subjects with family history of suicidality, especially subjects with comorbid alcohol or other substance dependence, and then providing intervention and management of loss events and major depression in those individuals.

(Br J Psychiatry 2000;177:360–365)

Gun Deaths in Rural and Urban Settings: Recommendations for Prevention

Dresang LT

Background: Firearms are involved in a large number of deaths in the United States. This study explores possible differences in gun type and intent between firearm deaths that occurred in rural and urban settings and proposes ways that primary care physicians can help prevent gun-related deaths. ***Methods:*** The 4271 gun-related deaths that occurred from 1990 to 1996 in Washington State were retrospectively grouped by setting (urban or rural), gun type (handguns, rifles, shotguns, or other), and intent (suicide, homicide, or accidental death). ***Results:*** Although rural settings had a higher percentage of firearm deaths from shotguns and rifles and a higher percentage of suicides and accidents than urban areas, in both settings, handguns were involved in more than half and suicides accounted for approximately two thirds of gun-related deaths. ***Conclusions:*** Primary care clinicians can use the clinical setting to introduce many gun-death prevention strategies. Because many gun-related deaths involved handguns and/or were suicides, physicians can help reduce firearm-related deaths by outlining the risks of owning a handgun and familiarizing current gun owners with prudent gun safety measures as well as incorporating suicide prevention interventions. Additional data on these strategies, as well as on strategies for preventing rifle- and shotgun-related deaths in rural areas, are needed.

(J Am Board Fam Pract 2001;14:107–115)

An Open Trial of Light Therapy for Women With Seasonal Affective Disorder and Comorbid Bulimia Nervosa

Lam RW, Lee SK, Tam EM, et al.

Objective: Many patients with seasonal affective disorder (SAD) have dysfunctional eating behaviors. Conversely, many women with bulimia nervosa have marked winter worsening of mood and bulimic symptoms. Controlled studies of light therapy in SAD and in bulimia nervosa have shown beneficial

effects on mood and binge/purge symptoms. We explored the clinical use of light therapy in women with SAD who also had comorbid bulimia nervosa. ***Method:*** Twenty-two female patients diagnosed using DSM-IV criteria with both bulimia nervosa and major depressive disorder with a seasonal (winter) pattern were treated with an open design, 4-week trial of light therapy (10,000 lux fluorescent light box with an ultraviolet filter, 30 to 60 minutes per day in the early morning). Patients were assessed before and after treatment with depression scales and with binge/purge diaries. ***Results:*** Light therapy resulted in significant improvement in mood, with a mean 56% reduction in 29-item Hamilton Rating Scale for Depression scores following treatment ($p < .001$). The frequency of binges and purges per week also significantly decreased ($p < .001$) from baseline by a mean of 46% and 36%, respectively. Two (9%) of 22 patients became abstinent of binge/purge episodes, compared with 10 (45%) of 22 patients who met criteria for remission of depressive symptoms. The light therapy was well tolerated by patients. ***Conclusion:*** These results suggest that therapeutic effects of light therapy on mood and bulimic symptoms in patients with SAD and comorbid bulimia nervosa are sustained over at least 4 weeks. However, the low abstinence rate in bulimic symptoms indicates that light therapy may be most effectively used as an adjunctive treatment to medications and/or psychotherapy for bulimia nervosa.

(J Clin Psychiatry 2001;62:164–168)

Protective Effect of Pregnancy in Women With Lithium-Responsive Bipolar Disorder

Grof P, Robbins W, Alda M, et al.

Background: A handful of reports suggest that women with some mood disorders remain well during pregnancy without receiving treatment. This study retrospectively examines the possible protective effect of pregnancy in women with RDC typical bipolar disorder, type I. ***Methods:*** Data for 28 women who had become pregnant after the onset of bipolar disorder were obtained from the International Group for the Study of Lithium-Treated Patients database. All pregnancies took place before the initiation of lithium prophylaxis, and all subjects later became responders to lithium. The number and duration of bipolar disorder episodes were compared within subjects before, during, and after pregnancy; comparisons were also made between subjects and 33 never-pregnant controls with bipolar disorder. ***Results:*** Subjects experienced significantly fewer ($p < .05$) and shorter ($p < .01$) bipolar episodes during pregnancy than either before or after pregnancy. Interindividual comparison with controls showed that subjects experienced one fourth the number and one eighth the length of episodes that would be expected. All episodes of bipolar disorder experienced during pregnancy occurred during the last 5 weeks predelivery. ***Conclusions:*** Although the inclusion of a homogenous subject group (all responders to lithium) may limit the generalizability of the results, the findings suggest that natural physiologic mechanisms associated with pregnancy may prevent recurrence of typical, lithium-responsive bipolar disorder, type I. Increased knowledge about the physiologic features of mood disorders and discovery of new, natural prophylactic agents to treat them may stem from further study of these underlying mechanisms.

(J Affect Disord 2000;61:31–39)

A Family Study of Major Depressive Disorder in a Community Sample of Adolescents

Klein DN, Lewinsohn PM, Seeley JR, et al.

Background: Most family studies of major depressive disorder (MDD) take a top-down approach, examining the rate of the disorder in offspring of adults with MDD; however, most children and adolescents with MDD have parents who do not have the disorder. This study employed a bottom-up approach in examining children and adolescents with MDD and their first-degree relatives. ***Methods:*** Probands included 3 groups of adolescents: 268 with history of DSM-III-R MDD, 110 with history of nonmood disorders but no MDD, and 291 with no history of mental illness through 18 years of age. All first-degree relatives (> 13 years) were assessed for psychiatric disorders via semi-structured direct and family history interviews, after which best-estimate DSM-IV diagnoses were derived. ***Results:*** Relatives of probands with MDD had higher rates of MDD (hazard ratio [HR] = 1.77, 95% confidence interval [CI] = 1.46 to 2.31) and dysthymia (HR = 1.79, 95% CI = 1.11 to 2.87) than relatives of the other proband groups, but, with the exception of alcohol abuse (HR = 1.29, 95% CI = 1.05 to 1.53), did not have higher rates of nonmood disorders. In addition, female relatives of MDD probands had a significantly higher rate of MDD than male relatives (HR = 1.41, 95% CI = 1.12 to 1.78), and the rate of MDD was higher in female than male relatives of female probands (HR = 1.79, 95% CI = 1.37 to 2.34). Although relatives of probands with anxiety and substance use disorders had elevated rates of those disorders, nonmood disorders in probands were not associated with higher rates of MDD in relatives. ***Conclusions:*** These findings are in line with earlier studies that found substantial familial aggregation of adolescent MDD and suggest that MDD is transmitted with a high degree of specificity. They also show a significant familial aggregation for most broad categories of nonmood disorders.

(Arch Gen Psychiatry 2001;58:13–20)

Use and Costs of Medical Care for Children and Adolescents With and Without Attention-Deficit/Hyperactivity Disorder

Leibson CL, Katusic SK, Barbaresi WJ, et al.

Background: The widespread prevalence of attention-deficit/hyperactivity disorder (ADHD) is in contradiction to the dearth of data on the associated medical costs for persons with the disorder. In this population-based cohort study conducted in Rochester, Minn., use and costs of medical care were compared between individuals with and without ADHD. ***Method:*** The study cohort comprised individuals born in Rochester from 1976 through 1982 who were still residing in Rochester in 1987 (N = 4880). Individuals with ADHD were identified using

school and medical records. Clinical diagnoses, likelihood and frequency of hospitalizations (both inpatient and outpatient), emergency department admissions, and total medical costs for all cohort members from 1987 through 1995 were obtained from a database that links data from the medical care institutions that serve the majority of Rochester residents. ***Results:*** ADHD had been diagnosed in 7.5% (N = 309) of the 4119 birth cohort members still residing in Rochester in 1995. Individuals with ADHD were more likely than those without ADHD to have had sustained major injuries (59% vs. 49%; p <.001) and to have received diagnoses for medical conditions, including asthma (22% vs. 13%; p < .001). Persons with ADHD, compared with persons without ADHD, had more inpatient hospitalizations (26% vs. 18%; p < .001), outpatient hospitalizations (41% vs. 33%; p = .006), and emergency department admissions (81% vs. 74%; p = .005). Individuals with ADHD incurred medical care costs from 1987 through 1995 (median = $4306) that were more than twice as high as those incurred by individuals without ADHD (median = $1994; p < .001), a difference found even among individuals not hospitalized or admitted to the emergency department. Differences between the ADHD and non-ADHD cohorts were independent of sex and age group. ***Conclusion:*** In addition to producing detrimental effects on social, behavioral, and academic outcomes, ADHD is associated with markedly increased use and costs of medical care.

(JAMA 2001;285:60–66)

The Detection and Treatment of Psychiatric Disorders and Substance Use Among Pregnant Women Cared for in Obstetrics

Kelly RH, Zatzick DF, and Anders TF

Objective: Few data exist on the recognition and treatment of mental disturbance in pregnant women. This study examined the frequency of psychiatric disorders, the documentation of these disorders in prenatal and delivery charts, the possible association between psychiatric disorders and patient demographic and obstetrical factors, and the relationship between presence of psychiatric disorders and underuse of prenatal care in women receiving prenatal care. ***Method:*** One hundred eighty-six women receiving prenatal care at a university-based obstetrics clinic underwent evaluation for current psychiatric disorders (ascertained by the patient self-report Primary Care Evaluation of Mental Disorders) and substance use (ascertained via the Alcohol and Drug CAGE questionnaires). Prior recognition, diagnosis, and treatment of psychiatric and substance use symptoms during prenatal care were identified by review of patients' medical charts, and associations between patient characteristics and documented recognition and treatment of mental disorders were determined. ***Results:*** A total of 70 (38%) of the patients screened positive for a psychiatric disorder and/or substance use. Among these, 43% of charts showed documentation of psychiatric symptoms; 18%, diagnoses; 35%, evaluations; and 23%, treatment. The likelihood that patients who screened positive for psychiatric disorders and/or substance use would receive a documented mental health evaluation was greater in women who had less education, were covered by the state-funded insurance plan, were not working outside the home, had no live-in partner, had inadequate antenatal care, had had more prior pregnancies and spontaneous abortions, and had longer hospital delivery stays. ***Conclusions:*** These data suggest that psychiatric disorders and substance use are underdetected in pregnant women. Because untreated mental and substance use disorders in pregnant women can have deleterious effects on both mothers and infants, additional research is warranted on the predictors and outcome of nonrecognition and nontreatment of these disorders during pregnancy.

(Am J Psychiatry 2001;158:213–219)

Effects of Nefazodone on Body Weight: A Pooled Analysis of Selective Serotonin Reuptake Inhibitor– and Imipramine-Controlled Trials

Sussman N, Ginsberg DL, and Bikoff J

Background: Evidence suggests that the newer antidepressant drugs may differ with respect to their effects on body weight, especially during long-term treatment. However, the published data about treatment-emergent weight change with the newer antidepressants are limited. Most reports of unexpected selective serotonin reuptake inhibitor (SSRI)-associated weight gain are anecdotal or from small controlled trials. To determine if differences exist among the newer antidepressants, the authors retrospectively analyzed data from clinical trials comparing nefazodone with SSRIs and with imipramine. ***Method:*** Weight change data supplied by Bristol-Myers Squibb from 6 completed clinical trials comparing the antidepressant nefazodone (N = 523) with 3 SSRIs, fluoxetine, sertraline, and paroxetine (N = 513), as well as 3 trials comparing nefazodone (N = 225) with the tricyclic antidepressant imipramine (N = 224) were analyzed. In all studies, nefazodone was found to be equal in efficacy to the comparator antidepressants. Studies that included both acute and long-term treatment phases were included in the analysis. Acute phases of the trials lasted either 6 or 8 weeks, and long-term phases varied in duration from 16 to 46 weeks. The analysis included summarizing the number and percentage of patients in each group with a ≥ 7% change in body weight from baseline at any point in the long-term and acute phases, at endpoint, and at week 16 of the long-term phases. ***Results:*** Using 7% or greater weight change as the measure of clinical significance, 4.3% of SSRI-treated patients had lost weight at any point in the acute phase versus 1.7% of those treated with nefazodone (p = .017). However, at any point during the long-term phase, significantly more SSRI-treated patients than nefazodone-treated patients showed a significant increase in body weight (17.9% vs. 8.3%; p = .003). At any point in the acute phase, significantly more imipramine-treated patients than nefazodone-treated patients had a 7% or greater increase in body weight (4.9% vs. 0.9%; p = .027), and for the long-term phase the comparison yielded 24.5% versus 9.5%. The difference during the long-term phase was statistically significant in women (p = .017), but not in men (p = .078) due to the small numbers of men in each group. ***Conclusion:*** SSRIs caused more weight loss during short-term treatment but more weight gain during long-term treatment. These results lend support to the observa-

tion that some antidepressants have a greater expected risk of weight gain than others during long-term therapy.

(J Clin Psychiatry 2001;62:256–260)

Obstetric Complications in Patients With Depression: A Population-Based Case-Control Study

Preti A, Cardascia L, Zen T, et al.

Background: Research has found a link between complications at birth and subsequent development of psychiatric disorders, including schizophrenia and affective disorders. This study sought to determine whether individuals with depression and related disorders were more likely to have experienced obstetric complications, especially complications with potential to cause brain damage, than individuals with no history of mental illness. ***Method:*** Obstetric chart data on sociodemographic characteristics of the mother, course of pregnancy, and course of birth for patients with DSM-III-R major depression, minor depression, or depression secondary to an anxiety disorder born in Padova, Italy, between 1964 and 1978 (N = 41) were compared with data for controls matched for gender, time of birth, parity of pregnancy, maternal age, and marital status (N = 41). ***Results:*** Compared with controls, patients were significantly more likely to be small for their gestational age (N = 22 vs. N = 11; $\chi^2 = 4.34$, p = .03) and to have experienced at least 1 obstetric complication (N = 35 vs. N = 25; $\chi^2 = 5.03$, p = .02) and were also more likely to have experienced more than 1 complication (mean = 2 vs. 1). Patients were not, however, more likely than controls to have experienced complications at birth with brain-damaging potential (N = 11 [26%] vs. N = 8 [19%]). ***Conclusions:*** Although the small sample size precluded the ability to isolate a specific risk factor, the lower birth weight found in patients versus controls indicates that risk for affective disorders in later life may be influenced by inadequate prenatal development. Severe, potentially brain-damaging obstetric complications were not identified more often in patients than in controls in this study, but the possibility that such severe complications may lead to subsequent development of affective disorders should not be ruled out.

(J Affect Disord 2000;61:101–106)

Substitution of an SSRI With Bupropion Sustained Release Following SSRI-Induced Sexual Dysfunction

Clayton AH, McGarvey EL, Abouesh AI, et al.

Background: We examine changes in sexual functioning and depressive symptoms in patients' transition from a selective serotonin reuptake inhibitor (SSRI), which induced both a therapeutic response and sexual dysfunction, to bupropion sustained release (SR) over the course of an 8-week trial. ***Method:*** The study included 11 adults (8 women and 3 men) who had a DSM-IV diagnosis of major depressive disorder in remission (Hamilton Rating Scale for Depression [HAM-D] score < 11) and were receiving an SSRI. Depression (using the HAM-D) and sexual dysfunction (using the Changes in Sexual Functioning Questionnaire) were assessed at baseline, 2 weeks after bupropion SR was added to the current antidepressant (combined treatment), 2 weeks after taper of the SSRI was initiated and completed, and after 4 weeks of bupropion SR monotherapy. T tests were performed to assess changes in depression and sexual function. ***Results:*** Patient participation dropped from the initial group of 11 at week 2 to 9 at week 4 and to 6 by week 8. Sexual functioning improved from week 0 (baseline) to week 2 and from week 2 to week 4. The patients showed no significant change in mean HAM-D scores in weekly comparisons during the study period; 55% of patients completed the substitution without significant adverse events or recurrence of depressive symptoms. ***Conclusion:*** Bupropion SR as a treatment for depression also alleviates sexual dysfunction due to SSRI treatment. Results show that sexual functioning improves after the addition of bupropion SR to SSRI treatment and continues to improve, after discontinuation of the SSRI, with bupropion SR treatment alone.

(J Clin Psychiatry 2001;62:185–190)

Conduct Disorder: Diagnosis and Treatment in Primary Care

Searight HR, Rottnek F, and Abby SL

Conduct disorder is common in childhood—it is found in about 6% to 16% of boys and 2% to 9% of girls—and its incidence increases as children grow into adolescence. Persistent antisocial behaviors (i.e., lasting > 6 months), including aggression to people or animals, destruction of property, deceitfulness, theft, and serious violations of rules, are common features of conduct disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). Although childhood- and adolescent-onset conduct disorder share many features, conduct disorder beginning in childhood, when untreated, has a poorer prognosis and often develops into adult antisocial personality disorder. Biological, familial, and psychosocial factors are all involved in the etiology of conduct disorder, and antisocial behavior on the part of a caregiver is an especially important risk factor. Several psychiatric disorders, including oppositional defiant disorder, attention-deficit/hyperactivity disorder, substance use and/or dependence, major depression, dysthymia, bipolar disorder, and intermittent explosive disorder, share clinical features with conduct disorder, thus necessitating careful differential diagnosis. Because family physicians frequently treat patients who have psychiatric disorders and refer many others to specialists, knowledge about conduct disorder on the part of family physicians can lead to early identification of and intervention for this widespread psychiatric syndrome. Intervention by family physicians can include counseling parents about communicating clearly with and encouraging the positive behavior of their children, as well as pharmacotherapy. Family physicians can also refer patients with conduct disorder for specialized psychotherapeutic treatment.

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