EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

Antidepressants: Update on New Agents and Indications

Ables AZ, Baughman OL III

The last 20 years has witnessed the introduction of several new antidepressants into the U.S. market. Prominent among these new agents are the selective serotonin reuptake inhibitors (SSRIs), which have become the treatment of choice for depression. SSRIs are also useful in treating obsessive-compulsive disorder, panic disorder, and social phobia, and they have recently been indicated for posttraumatic stress disorder, premenstrual dysphoric disorder, and generalized anxiety disorder (GAD). The serotonin-norepinephrine reuptake inhibitor venlafaxine extended release has also received U.S. Food and Drug Administration approval for treatment of GAD. Other newer, non-SSRI agents include mirtazapine, which stimulates the release of serotonin and norepinephrine, and nefazodone. Selection of the appropriate antidepressant agent for a given patient should be based on the agent's pharmacologic profile, secondary actions, and tolerability. Antidepressant treatment is sometimes associated with sexual dysfunction; this dysfunction can be addressed by reducing the antidepressant dosage, switching to another antidepressant agent, or adding another medication to treat the sexual side effects. Patients who are partially or completely resistant to antidepressant treatment may benefit from augmentation with lithium or triiodothyronine. The likelihood of antidepressant discontinuation syndrome or antidepressant withdrawal can be reduced by tapering antidepressant medication.

(Am Fam Physician 2003;67:547–554)

Patient Pain: Its Influence on Primary Care Physician-Patient Interaction

Bertakis KD, Azari R, Callahan EJ

Background and Objectives: In response to increasing awareness that appropriate pain management is vital to successful health care delivery, researchers have begun to examine the effects of patient pain on medical encounters. The ways that pain may affect physician-patient interaction during medical visits were examined in this study. ***Method:*** Visits with primary care physicians were videotaped for 509 randomized new adult patients. Before the visit, self-reported patient pain was measured using the Visual Analog Scale and the Medical Outcomes Study Short Form-36 pain scale, and data on patient demographics were gathered. The Davis Observation Code was used to analyze physician practice style during the visit. ***Results:*** As determined via regression analyses, patient pain during the medical visit was associated with a greater amount of the physician's time allotted for technical tasks and a smaller amount for preventive services and other activities designed to encourage active participation by patients in their own health care. ***Conclusions:*** The physician-patient interaction and its outcomes may be influenced by patient pain. Awareness is needed on the part of primary care physicians that their patient care may underemphasize patients' active involvement in their own care and lack focus on providing disease prevention.

(Fam Med 2003;35:119–123)

Estrogen Administration Does Not Reduce the Rate of Recurrence of Affective Psychosis After Childbirth

Kumar C, McIvor RJ, Davies T, et al.

Background: High rates of postpartum relapse occur in women with histories of bipolar or schizoaffective disorder. These relapses may be triggered by the postdelivery fall in circulating estrogen through alteration of central neurotransmitter (especially dopaminergic) systems. This study tested the hypothesis that estrogen administration after childbirth would prevent postpartum relapse and would alter dopamine receptor sensitivity. ***Method:*** Twenty-nine pregnant women with a Research Diagnostic Criteria diagnosis of hypomania (bipolar II), mania (bipolar I), or schizoaffective disorder participated in an open clinical trial. Three transdermal dose regimens of estrogen (17β-estradiol) were tested. Starting doses were 200 (N = 13), 400 (N = 3), and 800 (N = 13) μg/day, begin-

ning within 48 hours after delivery and reduced by one half every 4 days for a total of 12 days. On the fourth day after starting estradiol therapy (before relapse occurred), subjects participated in a neuroendocrine challenge test that measured the sensitivity of the central nervous system (tubero-infundibular) dopaminergic system (plasma prolactin and growth hormone responses to apomorphine). ***Results:*** Estradiol at all dose regimens did not reduce the rate of relapse. However, of the 12 women who relapsed, those who had taken the highest dose of estradiol (800 μg/day) needed less subsequent psychotropic medication (fewer chlorpromazine equivalents) and were discharged sooner than those who had taken either of the 2 lower doses. No differences in neuroendocrine responses to apomorphine were detected between women receiving the high-dose and the lower-dose regimens. ***Conclusion:*** The results do not support the hypothesis that a fall in circulating concentrations of estrogens precipitates relapse in subjects at risk of postpartum affective psychosis. The use of prophylactic estrogen in such circumstances is therefore highly questionable.

(J Clin Psychiatry 2003;64:112–118)

Impact of the ICD-10 Primary Health Care (PHC) Diagnostic and Management Guidelines for Mental Disorders on Detection and Outcome in Primary Care: Cluster Randomised Controlled Trial

Croudace T, Evans J, Harrison G, et al.

Background: The goal of this study was to evaluate the effect of local adaptation and dissemination of the 1996 World Health Organization (WHO) ICD-10 Primary Health Care (PHC) Guidelines for Diagnosis and Management of Mental Disorders in a pragmatic randomized controlled trial (RCT), a evaluation hitherto not made. ***Method:*** This pragmatic, pair-matched, cluster RCT involved 30 primary care practices. Primary outcomes were detection of minor psychiatric morbidity (sensitivity) at the practice level and 3-month clinical outcomes for cases (determined using the General Health Questionnaire [GHQ]). ***Results:*** Compared with practices offering usual care, practices that incorporated the PHC guidelines were less specific but more sensitive in identifying psychological morbidity; differences were not significant. No differences were found between patients in practices using the guidelines and patients from those providing usual care in 12-item GHQ scores at 3-month follow-up or in the proportion whose illness constituted cases, and no differences in secondary outcomes were found. ***Conclusions:*** Detection rates and outcomes for mental disorders are most likely not changed by attempts to influence clinician behavior through a process of adaptation and extension of guidelines.

(Br J Psychiatry 2003;182:20–30)

Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking

Foster SE, Vaughan RD, Foster WH, et al.

Context and Objectives: Estimates have been made of the amount and proportion of alcohol consumed by underage and adult drinkers; more accurate estimates are possible, however, and the economic impact of these proportions remains to be explored. This study aimed to accurately estimate the rates of underage drinking and adult excessive drinking and to describe consumer expenditures linked to these two categories of alcohol consumption. ***Method:*** Amount of alcohol consumed by both underage drinkers (12–20 years of age, identified using 1999 versions of the National Household Survey of Drug Abuse [NHSDA], Monitoring the Future, and the Youth Risk Behavior Survey [YRBS]) and adult excessive drinkers (≥ 21 years of age, identified using the 1999 NHSDA and the Behavioral Risk Factor Surveillance Survey [BRFSS]) as a proportion of total alcohol consumed and the proportion of consumer expenditures on alcohol among these 2 groups were calculated. A total of 217,192 persons aged 12 years or older were included in the study. ***Results:*** According to the YRBS, 50% of 12- to 20-year-olds drink; an estimated 52.8% of adults drink, per data from the BRFSS. An estimated 4.21 billion drinks were consumed each month, 19.7% of which were consumed by underage drinkers. A total of 30.4% of adult drinking was excessive (i.e., > 2 drinks per day). In 1999, total consumer expenditure on alcohol was $116.2 billion, of which $22.5 billion was attributed to underage drinking and $34.4 billion to adult excessive drinking. ***Conclusion:*** According to these data, 50.1% of alcohol consumption and 48.9% of consumer expenditure on alcohol can be accounted for by underage drinking and adult excessive drinking.

(JAMA 2003;289:989–995)

Using Chronic Pain to Predict Depressive Morbidity in the General Population

Ohayon MM, Schatzberg AF

Background: An apparent association exists between pain syndrome and depression. In this study, the prevalence of chronic painful physical conditions (CPPCs; ≥ 6 months' duration), including joint/articular, limb, or back pain, headaches, and gastrointestinal diseases, was assessed and the relationship of CPPCs to major depressive disorder was examined. ***Methods:*** A total of 18,980 subjects aged 15 to 100 years representative of the general populations of the United Kingdom, Germany, Italy, Portugal, and Spain were contacted by telephone in a cross-sectional random-sample survey. Telephone interviews incorporated the Sleep-EVAL system, responses to which constituted the main outcome measure. Questions about both mental disorders and medical conditions were included in the interviews. Questions regarding medical treatment, consultations, and/or hospitalizations for medical conditions and a list of 42 diseases elicited data on painful physical conditions. ***Results:*** A total of 17.1% of all subjects interviewed reported having at least 1 CPPC (95% CI = 16.5% to 17.6%), and 16.5% of subjects had at least 1 depressive symptom (sadness, depression, hopelessness, loss of interest, or lack of pleasure; 95% CI = 16.0% to 17.1%); of the subjects reporting at least 1 symptom of depression, 27.6% had at least 1 CPPC. A diagnosis of major depressive disorder was made for 4.0% of subjects; of these, 43.4% had at least 1 CPPC, which was 4 times the rate for subjects without major depressive disorder (odds ratio [OR] = 4.0, 95% CI = 3.5 to 4.7). CPPC was strongly associated with major depressive disorder in a logistic regression model (for CPPC alone, OR = 3.6; for CPPC + nonpainful medical condition, OR = 5.2); an independent contribution was made to diagnosis of major depressive disorder by 24-hour presence of pain (OR = 1.6). ***Conclusions:*** The duration of depressive mood is increased by the presence of CPPCs. Systematic evaluation for depression should be made for patients seeking consultation for a CPPC.

(Arch Gen Psychiatry 2003;60:39–47)

Can Long-Term Treatment With Antidepressant Drugs Worsen the Course of Depression?

Fava GA

Background: The possibility that antidepressant drugs, while effectively treating depression, may worsen its course has received inadequate attention. ***Method:*** A review of the literature suggesting potential depressogenic effects of long-term treatment with antidepressant drugs was performed. A MEDLINE search was conducted using the keywords *tolerance, sensitization, antidepressive agents,* and *switching*. This was supplemented by a manual search of Index Medicus under the heading "antidepressant agents" and a manual search of the literature for articles pointing to paradoxical effects of antidepressants. ***Results:*** A number of reported clinical findings point to the following possibilities: very unfavorable long-term outcome of major depression treated by pharmacologic means, paradoxical (depression-inducing) effects of antidepressant drugs in some patients with mood and anxiety disturbances, antidepressant-induced switching and cycle acceleration in bipolar disorder, occurrence of tolerance to the effects of antidepressants during long-term treatment, onset of resistance upon rechallenge with the same antidepressant drug in a few patients, and withdrawal syndromes following discontinuation of mood-elevating drugs. These phenomena in susceptible individuals may be explained on the basis of the oppositional model of tolerance. Continued drug treatment may recruit processes that oppose the initial acute effects of a drug and may result in loss of clinical effect. When drug treatment ends, these processes may operate unopposed, at least for some time, and increase vulnerability to relapse. ***Conclusion:*** The possibility that antidepressant drugs may worsen the course of depression needs to be tested, even though its scientific exploration is likely to encounter considerable methodological and ideological difficulties. The clinical implications of this hypothesis in depression are considerable. Antidepressant drugs are crucial in the treatment of major depressive episodes. However, appraisal of paradoxical effects that may occur in susceptible patients during long-term treatment may lead to more effective use of the drugs.

(J Clin Psychiatry 2003;64:123–133)

Medical Outcome of Pregnancy in Women With Psychotic Disorders and Their Infants in the First Year After Birth

Howard LM, Goss C, Leese M, et al.

Background: Little research has been conducted into the health of infants whose mothers have psychotic disorders. This study investigated prenatal care of mothers with history of psychotic disorders, obstetric outcomes, and the health of their infants after birth. ***Method:*** This was a matched, controlled cohort study that used the General Practice Research Database. Comparisons were made between women who gave birth from 1996 through 1998 (N = 199) and their infants, and a control group of women matched for age and general practice (N = 787) and their infants. ***Results:*** A higher proportion of stillbirths (OR = 4.03, 95% CI = 1.14 to 4.25, p = .03) and neonatal deaths (p < .001) were found for women with psychotic disorders. No between-group age difference was found at antenatal booking. Attendance for infant immunizations 90 to 270 days after birth was less likely for mothers with psychotic disorders than for mothers in the control group (RR = 0.94, 95% CI = 0.88 to 0.99, p = .03). No significant difference between groups was found in rates of accidents or hospital contacts for infants. ***Conclusions:*** Because women with a history of psychotic disorder exhibit a higher risk of stillbirth and neonatal death, health care professionals should focus on optimal obstetric care. Infants who live with mothers with psychotic disorders do not differ significantly from infants of mothers without such disorders in physical health.

(Br J Psychiatry 2003;182:63–67)

Diagnosis of Eating Disorders in Primary Care

Pritts SD, Susman J

Significant morbidity and mortality among adolescent females and young women are caused by eating disorders, especially anorexia nervosa and bulimia nervosa. Devastating medical and psychological consequences—including death, osteoporosis, growth delay, and developmental delay—can result from eating disorders. Better outcomes follow prompt diagnosis. In addition to a thorough medical history, which is the best means of detecting an eating disorder, screening can include the integration of simple questions about patients' perceived need for dieting into routine visits and viewing physical findings such as low body mass index, amenorrhea, bradycardia, gastrointestinal disturbances, skin changes, and changes in dentition as clues to the possible presence of eating disorders. Targeted laboratory testing can rule out medical illness in patients with possible eating disorders. Family physicians are in the position to identify and diagnose eating disorders and to coordinate professionals from various disciplines, including psychiatrists and nutritionists, who together can successfully treat patients with these disorders.

(Am Fam Physician 2003;67:297–304, 311–312)

Randomized Controlled Trial of Different Models of Care for Nursing Home Residents With Dementia Complicated by Depression or Psychosis

Brodaty H, Draper BM, Millar J, et al.

Objective: To compare the outcomes of 3 interventions for the management of dementia complicated by depression or psychosis: psychogeriatric case management, general practitioners with specialist psychogeriatric consultation, and standard care for nursing home residents. ***Method:*** The sample for this 12-week randomized controlled trial consisted of 86 subjects with dementia from 11 Sydney, Australia, nursing homes, of whom 34 had depression, 33 had depression and psychosis, and 19 had psychosis. All participants received full psychiatric assessments and physical examinations. Information was obtained from the residents' families and nursing home staff. Depression measures included the Even Briefer Assessment Scale for Depression, Hamilton Rating Scale for Depression, Cornell Scale for Depression in Dementia, and Geriatric Depression Scale. Psychosis measures included the Behavioral Pathology in Alzheimer's Disease Rating Scale, Neuropsychiatric Inventory, and Scale for the Assessment of Positive Symptoms. Data were obtained from nursing home records on prescription of psychotropic medication and demographic information. Management plans were formulated by a multidisciplinary team before random assignment to interventions. ***Results:*** All 3 groups improved from pretreatment to posttreatment on depression scales for depression groups and psychosis scales for psychosis groups. Mode of management appeared to make no difference

in rate or amount of improvement; neither of the treatment group–by-time interactions were significant. Neither use of antidepressants nor use of antipsychotics predicted depression or psychosis outcomes. ***Conclusion:*** Participation in the study was associated with improvement in depression and psychosis, perhaps because of the presence of a psychogeriatric team, the increased attention focused on residents, or the generalization of active intervention techniques to control subjects. A formula-driven psychogeriatric team case management approach was not significantly more effective than a consultative approach or standard care. This study demonstrates the difficulties and feasibility of conducting service-oriented research in nursing homes.

(J Clin Psychiatry 2003;64:63–72)

Stigma by Association: Psychological Factors in Relatives of People With Mental Illness

Östman M, Kjellin L

Background: Relatives of individuals with mental illness can experience the same stigma that the ill individuals themselves feel. Interactions between psychiatric service providers and family members of mentally ill persons can be improved through understanding how stigma shapes family members' psychological response to the ill individual and their contact with psychiatric services. This study sought to explore psychologically significant factors related to stigma experienced by relatives. ***Method:*** In this multicenter study conducted in Sweden, investigators interviewed 162 relatives of patients in acute-care psychiatric wards, with interview questions focusing on psychological factors related to stigma. ***Results:*** Psychological factors of stigma by association were experienced by a majority of the relatives. Thoughts that the patient would be better off dead were reported by 18% of the relatives, and suicidal thoughts were experienced by 10%. Relatives who themselves had mental illness were more likely to experience stigma by association. Such stigma was, however, not affected by background characteristics of patients. ***Conclusions:*** The negative effects of psychological factors related to stigma by association in relatives of mentally ill persons necessitate intervention.

(Br J Psychiatry 2002;181:494–498)

Predictors and Correlates of Suicide Attempts Over 5 Years in 1,237 Alcohol-Dependent Men and Women

Preuss UW, Schuckit MA, Smith TL, et al.

Objective: Past research has found that several factors—including sociodemographic variables, a more severe course of alcoholism, additional substance use disorders, and psychiatric comorbidity—to be related to a history of suicide attempts in individuals with alcohol dependence. In this 5-year prospective study, attributes related to suicide attempts were examined in alcohol-dependent persons who were seeking treatment. A distinction was made between substance-induced and independent psychiatric disorders in determining psychiatric comorbidity. ***Method:*** The study sample included 1237 alcohol-dependent subjects from the Collaborative Study on the Genetics of Alcoholism. Data were gathered from subjects via semistructured interviews at initial evaluation and 5-year follow-up; baseline interviews elicited clinically relevant information, and follow-up interviews targeted suicidal behavior, aspects of alcohol dependence, and drug use. ***Results:*** Prior suicide attempts were more likely in alcohol-dependent subjects who attempted suicide during the follow-up period (N = 56) than in those without suicide attempts (N = 1181). As determined using univariate analysis, additional factors related to future suicide attempts in this population included younger age, being separated or divorced, other drug dependence, substance-induced psychiatric disorders, and indicators of a more severe course of alcoholism. Future attempts were not predicted by gender. ***Conclusions:*** This study identified factors contributing to a small yet significant amount of the variance for future suicidal behavior in alcohol-dependent individuals.

(Am J Psychiatry 2003;160:56–63)

Antidepressants and Driver Impairment: Empirical Evidence From a Standard On-the-Road Test

Ramaekers JG

Background and Method: The current review summarizes the major results from all published studies from 1983 to 2000 (9 double-blind, crossover, placebo-controlled studies in healthy volunteers and 1 double-blind, baseline-controlled study in patients) that have determined the effects of antidepressants on actual driving performance using a standard test. That test measures driving impairment from vehicular "weaving" (i.e., standard deviation of lateral position [SDLP]) during 1 hour of on-the-road driving in normal traffic. ***Results:*** Changes in SDLP after acute doses of sedating antidepressants (i.e., amitriptyline, imipramine, doxepin, and mianserin) were comparable to those seen in drivers conducting the same test with a blood alcohol concentration of 0.8 mg/mL or more. Driving performance of subjects returned to placebo levels after 1 week of treatment, except after treatment with mianserin, for which the impairing effect lasted unabated over treatment. Nocturnal doses of sedating antidepressants (i.e., dothiepin, mianserin, and mirtazapine), however, did not produce residual driving impairment when measured the next day. Nonsedating antidepressants (i.e., moclobemide, fluoxetine, paroxetine, venlafaxine, and nefazodone) generally did not affect SDLP. However, SDLP rose to unacceptable levels after administration of combinations of nonsedating antidepressants and benzodiazepines with incompatible pharmacokinetic profiles. Correlational analyses demonstrated that conventional tests of psychomotor performance or self-ratings of side effects did not strongly predict antidepressant effects on SDLP. Regression analysis revealed a strong linear relation between antidepressant effects in the standard driving test and the number of patients reporting somnolence in clinical trials with the same antidepressants. ***Conclusion:*** Application of actual driving tests remains essential to conclusively defining the potential hazard of drugs for driving.

(J Clin Psychiatry 2003;64:20–29)