

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.

Social Anxiety in Outpatients With Schizophrenia: A Relevant Cause of Disability

Pallanti S, Quercioli L, Hollander E

Background: Social anxiety is associated with a severe level of disability and is a frequent but often unrecognized feature in schizophrenia. The purpose of this study was to precisely define the assessment, impact, clinical correlates, and consequences of social anxiety in schizophrenia. The authors conducted a survey of schizophrenia patients and a comparison cohort of patients with social anxiety disorder. **Method:** Eighty consecutively enrolled outpatients with DSM-IV schizophrenia and a consecutive comparison group of 27 patients with social anxiety disorder were recruited from an institutional psychiatric practice. The patients were assessed with the Liebowitz Social Anxiety Scale, Social Adjustment Scale, Scale for the Assessment of Positive Symptoms, Scale for the Assessment of Negative Symptoms, and the Medical Outcomes Study 36-item Short-Form Health Survey. **Results:** Social anxiety scores of schizophrenia patients with comorbid social anxiety disorder (N = 29, 36.3%) did not differ from those of subjects with social anxiety disorder as their primary diagnosis. Schizophrenia patients without social anxiety disorder had significantly lower total scores on the Liebowitz Social Anxiety Scale and lower social and performance anxiety subscale scores than did the other 2 groups. Schizophrenia patients with social anxiety disorder had a higher lifetime rate of suicide attempts, greater lethality of suicide attempts, more past substance/alcohol abuse disorder, lower social adjustment, and lower overall quality of life. No differences in negative and positive symptom rates were found between schizophrenia patients with and without social anxiety disorder. **Conclusions:** Although unrelated to psychotic symptoms, social anxiety is a highly prevalent, disabling condition in outpatients with schizophrenia. The Liebowitz Social Anxiety Scale appeared reliable and adequate in assessing social anxiety disorder in patients with schizophrenia. This study will contribute to the search for operational guidelines and adequate next-step treatments for social anxiety disorder in schizophrenia patients if these data are confirmed.

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A Double-Blind Switch Study of Paroxetine and Venlafaxine in Obsessive-Compulsive Disorder

Denys D, van Megen HJGM, van der Wee N, et al.

Background: The treatment guidelines for obsessive-compulsive disorder (OCD) propose to switch serotonin reuptake inhibitors (SRIs) in case of refractoriness. However, no controlled research has been published yet that prospectively examined the effects of changing SRIs. This article describes the first double-blind switch study of 2 SRIs in patients with OCD. **Method:** 150 patients with primary OCD, according to DSM-IV criteria, were randomly assigned in a 12-week, double-blind trial to receive dosages titrated upward to 300 mg/day of venlafaxine (N = 75) or 60 mg/day of paroxetine (N = 75). Primary efficacy was assessed by the change from baseline on the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), and nonresponse was defined as less than 25% reduction on the Y-BOCS. After a 4-week tapering phase, 43 nonresponders were switched to 12 additional weeks of the alternate antidepressant, of which 16 patients received venlafaxine and 27 received paroxetine. **Results:** Eighteen of 43 patients benefited from a switch to the alternate SRI with a mean \pm SD decrease of at least 25% on the Y-BOCS. At the end of 12 weeks, responder rates were 56% for paroxetine (15/27) and 19% for venlafaxine (3/16). An intent-to-treat, last-observation-carried-forward analysis demonstrated a mean decrease on the Y-BOCS of 1.8 ± 3.5 in the venlafaxine group and 6.5 ± 7.1 in the paroxetine group. After 2 consecutive SRI trials, 109 of 150 patients (73%) achieved a Y-BOCS decrease of at least 25%. **Conclusion:** The results of the current study show that 42% of the nonresponders benefited from a crossover to the other SRI, and that paroxetine was more efficacious than venlafaxine in the treatment of nonresponders to a previous SRI trial. Switching SRIs in case of refractoriness may be considered a useful strategy for patients with OCD.

(*J Clin Psychiatry* 2004;65:37-43)

Primary Care Patients With Depression Are Less Accepting of Treatment Than Those Seen by Mental Health Specialists

Van Voorhees BW, Cooper LA, Rost KM, et al.

Background: This cross-sectional study investigated whether depressed patients treated exclusively in primary care settings report less need for care and less acceptability of treatment options than depressed patients treated in specialty mental health settings after up to 6 months of treatment. **Method:** Participants included 881 patients with major depression from 45 community primary care practices who had received mental health services in the previous 6 months and who enrolled in 3 of 4 Quality Improvement for Depression Collaboration Studies. Study participants were categorized into 1 of 2 patient groups: (1) those who received mental health services only from a primary care provider (45%) and (2) those who received services from a mental health specialist (55%) in the previous 6 months. **Results:** Those patients who received care exclusively from primary care providers had 2.7-fold the odds (95% confidence interval [CI] = 1.6 to 4.4) of reporting that no treatment was definitely acceptable and had 2.4-fold the odds (95% CI = 1.5 to 3.9) of reporting that evidence-based treatment options (antidepressant medication) were definitely not acceptable compared with those who received care from mental health specialists. Multiple logistic regression analysis was used to adjust for demographic, social/behavioral, economic, and depression severity factors. **Conclusions:** Patients with depression treated solely by primary care providers have beliefs and attitudes more opposed to care than those seen by mental health specialists. Differences in beliefs and attitudes may contribute to lower quality depression care observed in comparisons of primary care and specialty mental health providers.

(*J Gen Intern Med* 2003;18:991–1000)

Escitalopram Continuation Treatment Prevents Relapse of Depressive Episodes

Rapaport MH, Bose A, Zheng H

Background: Current guidelines for antidepressant use recommend 4 to 6 months of continuation treatment to prevent relapse of depression following symptom resolution. This study evaluates the efficacy and safety of continuation escitalopram treatment. **Method:** Outpatients diagnosed with DSM-IV major depressive disorder (male or female, aged 18 to 81 years) who had completed 8 weeks of randomized double-blind treatment with escitalopram, citalopram, or placebo entered an 8-week flexible-dose, open-label phase in which all patients received escitalopram (10–20 mg/day). This study was initiated November 3, 1999, and completed April 5, 2001. Patients who met responder criteria (score of ≤ 12 on the Montgomery-Asberg Depression Rating Scale [MADRS]) were randomly assigned in a 2:1 ratio to escitalopram (at the dose each patient was receiving at the end of the open-label phase) or placebo for 36 weeks of double-blind treatment. The primary efficacy variable was time to depression relapse (defined as MADRS score ≥ 22 or

discontinuation due to an insufficient therapeutic response) from the start of the double-blind treatment phase. **Results:** A total of 502 patients received open-label escitalopram treatment and had at least 1 MADRS assessment. A total of 274 evaluable subjects entered the double-blind treatment phase; 93 received placebo and 181 received escitalopram. Time to depression relapse was significantly longer ($p = .013$) and the cumulative rate of relapse was significantly lower in patients who received escitalopram (26% escitalopram vs. 40% placebo; hazard ratio = 0.56; $p = .01$). Escitalopram-treated subjects had significantly lower depression ratings than those of placebo-treated patients. Escitalopram continuation treatment was safe and well tolerated. Discontinuation rates due to adverse events were 7% for the placebo group and 4% for the escitalopram-treated group. **Conclusion:** Continuation treatment with escitalopram is effective in preventing relapse into an episode of major depressive disorder.

(*J Clin Psychiatry* 2004;65:44–49)

Stable Prediction of Mood and Anxiety Disorders Based on Behavioral and Emotional Problems in Childhood: A 14-Year Follow-Up During Childhood, Adolescence, and Young Adulthood

Roza SJ, Hofstra MB, van der Ende J, et al.

Background: In recent years, more attention has been paid to the distributions of the ages at onset of anxiety and mood disorders. Associations between behavioral and emotional problems in childhood and psychiatric disorders in adulthood have been described. The objective of this study was to predict the onset of anxiety and mood disorders from parent-reported behavioral and emotional problems in childhood across a 14-year period (i.e., childhood to young adulthood). **Method:** Parent-reported behavioral and emotional problems were obtained in 1983 from the Dutch general population using the Child Behavior Checklist for children and adolescents aged 14 to 16 years. At follow-up 14 years later, lifetime anxiety and mood diagnoses were obtained by a standardized interview of 1580 subjects. The incidence of anxiety disorders from childhood problems and demographic covariates were predicted using the Cox continuous-time proportional hazards models. **Results:** Anxiety disorders were significantly predicted by the social problems scale and the externalizing composite (i.e., aggressive behavior and delinquent behavior). Mood disorders were significantly predicted by high scores on the anxious/depressed scale and on the internalizing composite (i.e., anxious/depressed, somatic complaints, withdrawn). Anxiety disorders mainly started in childhood and early adolescence. The incidence of mood disorders, however, increased abruptly in adolescence and young adulthood. **Conclusions:** Study results indicate different developmental pathways for anxiety and mood disorders. Predictions on the basis of problem behavior remained stable during the 14-year period across adolescence and young adulthood. The results underscore the importance of early intervention and prevention of behavioral and emotional problems in childhood.

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