DBSA-CA NEWS

Depression and Bipolar Support Alliance–California
(formerly California Depressive and Manic-Depressive Association)

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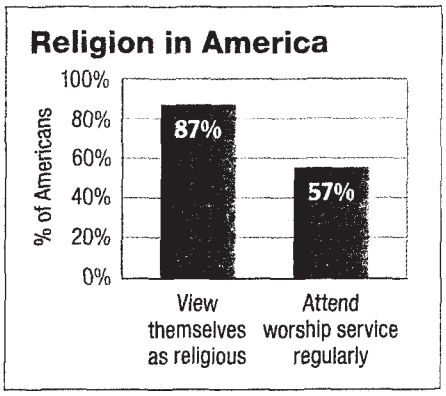
The spiritual side of recovery

Some tips for clinicians about how to support patients



In some ways, spirituality and religion have together become the "third rail" of the mental health field: Clinicians may think these topics are so highly charged that they keep their distance and avoid talking with patients about their spiritual or religious beliefs.

Yet patients may feel quite differently, and might welcome an opportunity to talk. The Pew Forum on Religion and Public Life has reported that 87% of Americans consider themselves to be religious, while 57% attend some type of worship service on a regular basis. Likewise, a *Newsweek/Beliefnet* poll found that 88% of Americans who responded described themselves as spiritual, religious, or both. Although there is no way to know how many respondents were struggling with their mental health, it is likely that many patients find that spiritual practices help them to cope, particularly if they are working hard to manage severe and ongoing problems such as addiction, unusual stress, or mental illness. Moreover, understanding a patient's spirituality may also provide helpful insights into that patient's value system or relationship to authority—which can be helpful to the clinician.

Recognizing the importance of spirituality, the Joint Commission (formerly known as the Joint Commission on Accreditation of Health-care Organizations) now requires that hospitals, mental health centers, and other participating organizations have clinicians assess clients' spiritual beliefs and needs, with the goal of improving treatment and services. It should be noted that the regulation has its critics. The directive may not be as important in highly technical aspects of medical care as it is in primary care or mental health. Clinicians in private practice obviously don't have to adhere to Joint Commission requirements.

Even so, for a variety of reasons, many clinicians may find themselves wondering how to support the spiritual aspect of a patient's recovery.

In a special issue of the *Psychiatric Rehabilitation Journal* earlier this year, several authors explored the topic of spirituality and mental health treatment from various perspectives. They also offered practical suggestions about how to ensure that spirituality becomes part of the treatment plan for those patients who want it to be.

*Continued on page 3 (***Spritual Side)**

Antidepressants Were Most Commonly Prescribed Medication in 2005; Outpatient Visits Related to Depression ~ Up 48% From 1995

The U.S. Centers for Disease Control and Prevention (CDC) said that prescriptions for antidepressants reached 118 million, making that class of drug the most commonly prescribed medication in 2005. The percentage of emergency and hospital outpatient department (OPD) visits made in 2005 by adults 18 years and older with depres-sion indicated on the medical record increased by 48% over *1995.* Of the 90.4 million OPD visits in 2005, 10.3% were specifically for depression. Depression screening was provided in about 1.4% of visits. The percentage of visits with depression indicated on the medical record as the primary complaint varied by age group as follows:

• 8.5% of visits by people below the age of 45 were depression-related

• 14.6% of visits by people aged 45 to 64, were depression related

• 9.0% of visits by people over the age of 65 were depression-related

This prescription data was included in a report entitled "National Hospital Ambulatory Medical Care Survey: 2005 Outpatient Department Summary" by Kimberly Middleton, B.S.N., M.P.H.; Esther Hing, M.P.H.; and Jianmin Xu, M.S., Division of Health Care Statistics in the CDC. The data presented in the report were collected in the 2005 National Hospital Ambulatory Medical Care Survey (NHAMCS), a national probability sample survey of visits to emergency and hospitals outpatient departments of non-federal, short-stay, and general hospitals in the United States. Sample data were weighted to produce annual national estimates. There were a total of 194.6 million prescriptions written at OPD visits in 2005.

The full text of "National Hospital Ambulatory Medical Care Survey: 2005 Outpatient Department Summary" by Kimberly Middleton, B.S.N., M.P.H, et al, was published in Advance Data from Vital Health and Statistics (No. 389). The text may be accessed through the *OPEN MINDS* Industry Resources Library at www.openminds. com!indres/ O73007cdcphpponchs.htm

Source: Open Minds
September 2007

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Medicaid Beneficiaries With Co-Occurring Mental Health & Substance Use Disorders Have High Inpatient & Emergency Department Use Rates

Medicaid beneficiaries with co-occurring mental health and substance use disorders use inpatient and emergency department services at high rates in five states studied. Co-occurring disorders may decrease the likelihood of cornmunity-based treatment for those with less severe mental disorders and for those with severe mental illness. Policies focusing only on services provided through community settings may miss a significant proportion of people with co-occurring disorders.

These are findings of a study entitled "Treatment for Co-Occurring Mental and Substance Use Disorders in Five State Medicaid Programs" by Robin E. Clark, Ph.D., Mihail Samnaliev, Ph.D., and Mark P. McGovern, Ph.D. The researchers reviewed 1999 claims and encounter data for adult Medicaid beneficiaries under the age of *65* with psychiatric or substance use disorders in Arkansas, Colorado, Indiana, New Jersey, and Washington.

The groups were divided into those with and those without a diagnosed substance use disorder. Within the group, a total of 92,355 people had a psychiatric disorder, 34,158 had a substance use disorder, and 14,256 had co-occurring psychiatric and substance use disorders. They estimated the likelihood of a person in each category would receive treatment in the following settings: community-based, inpatient facilities, emergency departments, or hospital outpatient departments.

In all five states, beneficiaries with severe mental illness, (defined as schizophrenia, bipolar disorder, or major depression), and a substance use disorder had a greater likelihood of inpatient, emergency department, and hospi-tal-based outpatient psychiatric treatment than those with severe mental illness alone. In four of the five states, both severe and less severe mental illness and co-occurring substance use disorder were less likely to receive community-based treatment than those with mental illness alone. In three of the five states, people with less severe psychiat-ric disorders and co-occurring substance use disorder had a higher likelihood of receiving inpatient treatment and emergency department use. Arkansas was the one state in which co-occurring disorders did not reduce the odds of receiving community-based mental health treatment.

The full text of "Treatment for Co-Occurring Mental and Substance Use Disorders in Five State Medicaid Programs" was published in Psychiatric Services (58:942-948, July 2007). An abstract of the study may be viewed on-line at http:// ps.psychiatryonline.org/c gi/content/ abstract/ps;58/7/942 (accessed July 26. 20O7~.

Source: Open Minds
September 2007

Research Provides Insight Into the Chemistry of Fear

In experiments involving mice, re-searchers at MIT's Picower Institute for Learning and Memory and Howard Hughes Medical Institute report that they have identified a chemical pathway that may underlie the persistence of debilitating fear following a traumatic event.

The researchers used genetically engineered mice in which production of a chemical known as Cdk5, produced in the hippocampus, a part of the brain involved in storing memories, can be controlled through the addition of doxycycline (a common antibiotic) in the diet. The mice were placed in a new environment and exposed to mild foot shocks— in other words, subjected to classic Pavlovian fear conditioning—which resulted in a normal "freezing in place" response.

Later, when the mice were repeatedly re-exposed to the location where the foot shocks occurred, the mice with greater-than-normal Cdk5 1evels continued to freeze in fear longer than the mice in which production of this chemical was inhibited, indicating that Cdk5 may provide a molecular mechanism underlying the retention or erasure of fear.

If the work is replicated, this could point the way toward developing a drug to treat debilitating fear.

Reference

Sananbenesi F, et al. "A Hippocampal Cdk5 Pathway Regulates Extinction of Contextual Fear:" *Nature Neuroscience* (July 15, 2007; advance online publication).

Source: Harvard Health Letter
October, 2007

SPIRITUAL SIDE *(Continued from page 1)*

Although these guidelines aren't "evidence-based" they may serve as helpful hints to those wondering how to proceed.

Ask but don't judge. The Joint Commission requires clinicians to ask about spiritual beliefs at the time of assessment, so that a patient's beliefs can become part of the treatment plan (see "Questions to ask"). Beyond knowing what to ask, clinicians may have to overcome their own discomfort or even aversion to spiritual matters so that they can take the patient's views seriously. Even harder, clinicians may have to suspend their own beliefs in order to respond sympathetically to what may seem foreign or bizarre.

Consult with clergy. Mental health professionals, family members, and friends may not know how to support the patient, because they either don't share the patient's spiritual views or because they know little about a particular practice. Get to know clergy and other spiritual leaders in the community, and consult them occasiona1ly. Or ask the patient for suggestions about who to talk with.

*Continued on page 4 (***Spritual Side)**

SPIRITUAL SIDE *(Continued from page 3)*

Make spirituality part of the recovery plan. If spirituality or religion is important to the person seeking treatment, then it's very helpful to find a way to integrate it into the recovery plan along with other more traditional elements such as medication, psychotherapy, and cognitive behavioral therapy. For example, a practicing Catholic who is struggling with an addiction may find it helpful to attend Mass on a daily basis rather than weekly.

Blanch A. "Integrating Religion and Spirituality in Mental Health: The Promise and the Challenge" *Psychiatric Rehabilitation Journal* (2007), Vol. 30, No. 4, pp. 251—60.

Pallot RD. "Spirituality and Religion in Recovery: Some Current Issues," *Psychiatric Rehabilitation Journal* (2007), Vol. 30, No. 4, pp. 261—70.

Questions to ask

If you're wondering how to get the conversation going about spirituality with your patients, the sample questions below may help.

- How do you express your spirituality? Is prayer important to you?
- What is the name of your clergy member, minister, chaplain, pastor, rabbi—or some other spiritual leader—and is it all right to contact that person for more information about your spiritual practices?
- Do you attend some type of religious service on a regular basis?
- How do you find inner strength to deal with suffering and adversity? Do you rely on a particular person, or follow a specific practice to gain strength?
- Do you have specific spiritual goals?
- How does faith help you cope with illness and suffering?
- What type of spiritual support do you want as part of your treatment plan?

Source: HARVARD MENTAL HEALTH LETTER October, 2007

Service employees top list of depressed

GOVERNMENT REPORT:

Overall, 7 percent of U.S. workers have suffered from the mental disease

BY KEVIN FREKING

THE ASSOCIATED PRESS

WASHINGTON – People who tend to the elderly, change diapers and serve up food and drinks have the highest rates of depression among U.S. workers.

Overall, 7 percent of full-time workers battled depression in the past year, according to a government report available Saturday.

Women were more likely than men to have had a major bout of depression, and younger workers had higher rates of depression than their older colleagues.

Almost 11 percent of personal care workers, which includes child care and helping the elderly and severely disabled with their daily needs, reported depression lasting two weeks or longer.

During such episodes there is loss of interest and pleasure, and at least four other symptoms surface, including problems with sleep, eating, energy, concentration and self-image.

Workers who prepare and serve food — cooks, bartenders, waiters and waitresses — had the second-highest rate of depression among full-time employees at 10.3 percent. In a tie for third were healthcare workers and social work~ ers at 9.6 percent.

The lowest rate of depeession, 4.3 percent, occurred in the job category that covers engineers, architects and surveyors.

Government officials tracked depression within 21 major occupational categories. They combined data from 2004 through 2006 to estimate episodes of depression within the past year. That information came from the National Survey on Drug Use and Health, which registers lifetime and past year depression bouts.

Depression leads to $30 billion to $44 billion in lost productivity annually, said the report from the Substance Abuse and Mental Health Services Administration. The report was available Saturday on the agency's Web site, http://oas.samhsa.gov

*Continued on page 5 (***Depressing Jobs)**

DEPRESSING JOBS

A look at depression rates among full time workers categorized by job

PERSONAL CARE AND SERVICE	10.8
FOOD PREP AND SERVING	10.3
COMMUNITY AND SOCIAL SERVICES; HEALTH CARE	9.6
ARTS, DESIGN, ENTERTAINMENT, SPORTS AND MEDIA	9.1
EDUCATION, TRAINING AND LIBRARY	8.7
OFFICE AND ADMINISTRATIVE SUPPORT	8.1
BUILDING AND GROUNDS MAINTENANCE	7.3
FINANCIAL;SALES	6.7
LEGAL; TRANSPORTATION AND MATERIAL MOVING	6.4
MATHEMATICAL AND COMPUTER SCIENTISTS	6.2
PRODUCTION	5.9
MANAGEMENT	5.8
FARMING, FISHING AND FORESTRY	5.6
PROTECTIVE SERVICE	5.5
CONSTRUCTION AND EXTRACTION	4.8
MAINTENANCE; LIFE, PHYSICAL AND SOCIAL SCIENCE	4.4
ENGINEERING, ARCHITECTURE AND SURVEYORS	4.3

SOURCE: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.

Talk Therapy Pivotal for Depressed Youth

By BENEDICT CAREY

A talking cure for depression called cognitive behavior therapy appears to cancel the risk of suicidal thinking or behavior associated with taking antidepressant medication, according to the most comprehensive and long-running study to date of depression treatment among adolescents.

The study, which followed for a year more than 600 adolescents being treated for chronic depression, found that four in five recovered entirely, or nearly so, when treated over nine months with medication, talk therapy or a combination of the two.

Patients taking medication showed significant signs of improvement up to six weeks earlier than those who received talk therapy alone, but were about twice as likely to report feeling suddenly suicidal. The combination of the two therapies, the authors found, produced the most rapid recovery and protected against sudden suicidal urges.

For several years experts have been debating the risks to children and adolescents who take antidepressants like Prozac and Paxil. In 2004, health regulators required that all labels for antidepressants carry prominent warnings that the drugs were associated with increased risks of suicidal thinking and behavior in young patients, a link that many psychiatrists say has been blown out of proportion, scaring off patients who could benefit from drug treatment.

In this study, antidepressants lowered the risk of suieidal~thoughts and actions over all, but significantly less so than talk therapy.

"What this study shows, convincingly and for the first time, is that there are very good options for a child who is thought to be at risk for suicidal thinking," said Kevin Stark, a psychologist at the University of Texas, who was not involved with the research. "Psychosocial therapies do work on their own, with time. But they also help prevent relapse, and this shows that they can help make drug treatment safer."

In the study, which began in 1999, researchers recruited 654 youths ages 12 to 17 who had been moderately to severely depressed for up to a year or longer. The adolescents were randomly assigned to be treated with Prozac, the antidepressant made by Eli Lilly; cognitive behavioral therapy for a weekly hour long session; placebo pills; or a combination of Prozac and talk therapy.

After 12 weeks, about three in four of the patients receiving both talk therapy and medication were rated as "much better" or "very much better," and two-thirds taking just the drug fared just as well. Talk therapy by itself was no better than the placebo.

After four months, about two-thirds of those receiving any treatment were rated as much or very much improved — significantly better than a typical response to placebo pills.

By nine months, 8 in 10 adolescents had shaken off their depression, entirely or almost entirely, no matter the treatment.

Talk therapy was a safer alternative. Almost 15 percent of the patients taking just Prozac reported what were, described as "suicidal events," mainly talk and thoughts of suicide so alarming that doctors called in the patients and, often, altered dosages.

The rate of such events for those receiving just cognitive behavior therapy was 6 percent. The results for combination therapy were about the same.

"The message is that medication accelerates recovery, but cognitive therapy protects against these bad reactions, and the combination is the best option," said Dr. John March, chief of~chief and adolescent~psychiatry at the Duke University Medical Center and the principal investigator for the study.

The talk therapy promoted changes in behavior like getting patients out of bed and doing something that they enjoy, like playing basketball or going to a party. It also provided cognitive therapy, in which patients are taught to diffuse poisonous assumptions like "I'm a loser" or "I'll never get a girlfriend."

Experts say it is not easy to find specialists in this therapy outside large cities. The techniques have been widely published in manuals and books, and Dr. March said a good therapist could usually work such techniques into a treatment plan.

"The trick," he said, "is to be an intelligent consumer and find a skilled therapist who's willing to work with you on these methods."

Source: New Yock Times
Otober 2, 2007
As seen in: NAMI Tulare County
November 2007

DEPRESSING JOBS *(Continued from page 4)*

The various job categories tracked could be quite broad, with employees grouped in the same category seemingly having little in common.

For example, one category included workers in the arts, media, entertainment and sports. In the personal care category, a worker caring for toddlers at a daycare center would have quite a different job from a nursing aide who helps an older person live at home rather than in a nursing home.

Just working full-time would appear to be beneficial in preventing depression. The overall rate of depression for full-time workers, 7 percent, compares with the 12.7 percent rate registered by those who are unemployed.

Source: Riverside Press-Enterprise
October 14, 2007

Common Genetic Factors May Underlie Bipolarity and Anxiety Comorbidity

Study findings suggest that bipolarity shares common genetic factors with comorbidity for panic disorder, obsessive-compulsive disorder, and social phobia.

Steven Dilsaver (Rio Grande City Community Mental Health Mental Retardation Clinic, Texas, USA) and colleagues found that adolescents with bipolar disorder were more likely to have anxiety disorders than their peers with major depressive disorders, and the presence of one anxiety disorder increased the odds of having another.

Moreover, a dose-response relationship was detected between the number of anxiety disorders and measures of illness severity and familial loading for affective illness.

Dilsaver and co-workers interviewed 313 Latino adolescents using the dinician version of the Structured Clinical Interview for DSM-IV. Information on the participants' family histories was also collected.

In all, 36.7% of individuals had bipolar disorder and 447% had major depressive disorder (MDO), while 18.5% had no affective illness and served as controls.

Patients with bipolar disorder were 4.4 times more likely to have panic disorder than individuals with MDD, and 5.1 times and 3.3 times more likely to have OCD and social phobia, respectively.

In turn, MDD patients were more likely to have these disorders than controls, with respective odds ratios of 4.2,11.1, and 14.3.

The presence of any anxiety disorder increased the chances of having another one. For example, OCD and social phobia increased the odds of having panic disorder 10- and five-fold, respectively.

Among the patients with bipolar disorder, but not those with MDD, the presence of panic disorder and social phobia comorbidity increased the risk of suicidal thoughts. Social phobia also increased the risk of suicide attempts.

For both bipolar and MOD patients, the risk of psychosis was increased if patients had all three anxiety disorders.

Furthermore, having a first-degree relative with bipolar disorder almost tripled the likelihood of panic disorder developing, and increased the risk of social phobia 3.7-fold. The risk of developing these anxiety disorders also increased among those who had a first-degree relative with any mood disorder, but to a lesser extent. In contrast, a family history of bipolar disorder or any mood disorder was not associated with OCD.

"The results are compatible with the hypothesis that heavy familial-genetic loading for affective illness in juveniles is associated with bipolarity, cumulative anxiety disorder comorbidity, suicidality, and psychosis," say Dilsaver eta! in the *Journal of Affective Disorders.*

They condude: "Anxiety comorbidity patterns in both adolescent and adult bipolar disorder might provide a future avenue for understanding the underlying genetic factors in the development of affective spectrum disorders."

Source: Psychiatry MattersMD/News Watch January 5, 2007

Antidepressants Under Scrutiny Over Efficacy

Sweeping Overview Suggests Suppression of Negative Data Has Distorted View of Drugs

By David Armstrong and Keith J. Winstein
THE WALL STREET JOURNAL *ONLINE*
January 17, 2008

The effectiveness of a dozen popular antidepressents has been exaggerated by selective publication of favorable results according to a review of unpublished data submitted to the Food and Drug Administration.

As a result, doctors and patients are getting a distorted view of how well blockbusteer antidepressants like **Wyeth**'s Effexor and **Pfizer** Inc.'s Zoloft really work, researchers asserted in this week's New England Journal of Medicine.

Since the overwhelming amount of published data on the drugs show they are effective, doctors unaware of the upublished data are making inappropriate prescribing decisions that aren't in the best interest of their patients, according to researchers led be Erick Turner, a psychiatrist at Oregon Health & Science University. Sales of antidepressants total about $21 billion a year, according to IMS Health.

ACCENTUATE THE POSITIVE

A review of research submitted to the FDA:

- Of 74 studies reviewed, 38 were judged to be positive by the FDA. All but one were published, researchers said.
- Most of the studies found to have negative or questionable results were not published, researchers found.

Source: The New England Journal of Medicine

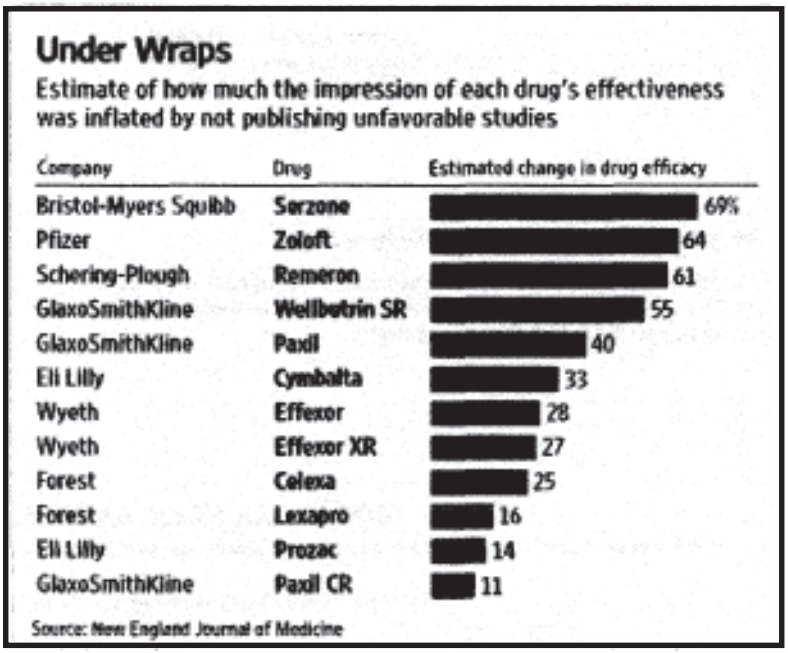
Wyeth and Pfizer declined to comment on the study results. Both companies said they had committed to disclose all study results, although not necessarily in medical journals. **GlaxoSmithKline** PLC, maker of Welibutrin and Paxil, said it has posted the results of more than 3,000 trials involving 82 medications on its Web site, and also has filed information on 1,060 continuing trials at a federal government Web site.

Schering-Plough Corp., whose Organon Corp. unit markets Remeron, and **Eli Lilly** & Co., which makes Prozac, said their study results were indeed published — not individually, but as part of larger medical articles that combined data from more than one study at a time. The New England Journal study counted a clinical trial as published only if it was the sole subject of an article. "Lilly has a policy that we disclose and publish all the results from our clinical trials, regardless of the outcomes from them," a Lilly spokeswoman said.

Pharmaceutical companies are under no obligation to publish the studies they sponsor and submit to the FDA, nor are the researchers they hire to do the work. The researchers publishing in the New England Journal were able to identify unpublished studies by obtaining and comparing documents filed by the companies with the FDA against databases of medi-

*Continued on page 7 (***Under Scrutiny**)

UNDER SCRUTINY *(Continued from page 6)*



cal publications.

"There is no effort on the part of the FDA to withhold or to not post drug review documents," an FDA representative said. For newer drugs, information is posted online "as soon as possible." Older documents aren't always available online and efforts to add those files to the Web are slowed by "a lack of resources," the agency said, acknowledging that there is a backlog in complying with records requests.

A total of 74 studies involving a dozen antidepressants and 12,564 patients were registered with the FDA from 1987 through 2004. The FDA considered 38 of the studies to be positive. All but one of those studies was published, the researchers said.

The other 36 were found to have negative or questionable results by the FDA. Most of those studies —22 out of 36 — weren't published, the researchers found. Of the 14 that were published, the researchers said at least 11 of those studies mischaracterized the results and presented a negative study as positive.

Five Trials

For example, Pfizer submitted five trials on its drug Zoloft to the FDA, the study says. The drug seemed to work better than the placebo in two of them. In three other trials, the placebo did just as well at reducing indications of depression. Only the two favorable trials were published, researchers found, and Pfizer discusses only the positive results in Zoloft's literature for doctors.

One way of turning the study results upside down is to ignore a negative fmding for the "primary outcome" — the main question the study was designed to answer — and highlight a positive secondary outcome. In nine of the negative studies that were published, the authors simply omitted any mention of the primary outcome, the researchers said.

The resulting publication bias threatens to skew the medical professional's understanding of how effective a drug is for a particular condition, the researchers say. This is particularly significant as the growing movement toward "evidence-based medicine" depends on analysis of published studies to make treatment decisions.

Colleagues' Questions

Dr. Turner, who once worked at the FDA reviewing data on psychotropic drugs, said the idea for the study was triggered in part by colleagues who questioned the need for further clinical drug trials looking at the effectiveness of antidepressants.

"There is a view that these drugs are effective all the time," he said. "I would say they only work 40% to 50% of the time," based on his reviews of the research at the FDA, "and they would say, 'What are you talking about? I have never seen a negative study." Dr. Turner, said he knew from his time with the agency that there were negative studies that hadn't been published.

The suppression of negative studies isn't a new concern. The tobacco industry was accused of sitting on research that showed nicotine was addictive, for instance. The issue has come up before notably with antidepressants: In 2004, the

*Continued on page 8 (***Under Scrutiny)**

UNDER SCRUTINY *(Continued from page 7)*

New York state attorney general sued GlaxoSmithKline for alleged fraud, saying it suppressed studies showing that the antidepressant Paxil was no better than a placebo in treating depression in children. Glaxo denied the charge and eventually settled with the attorney general. The company later posted on its Web site the full reports of all of the studies of Paxil in children.

But publication of negative studies is an issue that cuts across all medical specialties. And it has engendered some strong reactions in the medical-research world: To make it harder to conceal negative findings, an association of medical journal editors began requiring in 2005 that clinical trials be publicly disclosed at the outset to be considered for publication later. The system isn't foolproof, since manufacturers often run exploratory studies without registering them and can selectively disclose favorable results. The rule only applies to studies intended for publication in a medical journal.

Some studies that don't eventually get published are registered with online trial registries, including the federal government's www.clinicaltrials.gov. Nonetheless, many studies still aren't being registered or reported, says Kay Dickersin, the director of the Center for Clinical Trials at the Johns Hopkins Bloomberg School of Public Health. "We need something more meaningful," she said. "The average person has no idea that www.clinicaltrials.gov is not comprehensive."

The New England Journal study also points to the need for the FDA to disclose more information about the studies it receives, says Robert Hedaya, a professor of clinical psychiatry at Georgetown University Hospital. He said it was "disturbing" that the information on the negative studies wasn't made widely available by the FDA.

The FDA does post information, including unpublished studies, for some drugs on its Web site, says Dr. Turner. But information that hasn't yet made it online is hard to come by. Dr. Turner said he made public records requests for information not on the Web site more than a year ago, but the requests have gone largely unfulfilled. He said he was able to get some of the FDA's information on unpublished studies from other researchers who acquired it from the agency through their own record requests.

The 'Effect Size'

In this week's study, the researchers found that failing to publish negative findings inflated the reported effectiveness of all 12 of the antidepressants studied, which were approved between 1987 and 2004. The researchers used a measurement called effect size. The larger the effect size, the greater the impact of a treatment.

The average effect size of the antidepressant Zoloft rose 64% by the failure to publish negative or questionable data on the drug, the researchers found.

Source: THE WALL STREET JOURNAL ONLIN
January 17, 2007

Worm study shows antidepressant may lengthen life

By Maggie Fox, Health and Science Editor
Novemeber 21, 2007, Reuters

An antidepressant may help worms live longer by tricking the brain into thinking the body is starving, U.S. researchers reported on Wednesday.

The drug, called mianserin, extended the life span of the nematode Caenorhabditis elegans by about 30 percent, the researchers reported in the journal Nature. They hope to find out if the same mechanism can help people live longer.

Three other compounds, including another antidepressant, have similar effects, said Michael Petrascheck of the Fred Hutchinson Cancer Research Center in Seattle. But the life-extending benefits come at a cost.

"Weight gain and increased appetite seems to be one of the side effects. It is one of the reasons these are not such popular antidepressants," Petrascheck said in a telephone interview.

Many studies have shown that slightly starving certain animals — reducing how much they eat by about 30 percent — can cause them to live longer.

It is not entirely clear if this occurs in humans, but researchers are keen to duplicate the beneficial effects of calorie restriction without the misery of going hungry.

Howard Hughes Medical Institute researcher Linda Buck and colleagues were looking for drugs that might do this.

C. elegans is a roundworm, or nematode, much studied because despite its tiny size, its biology is similar to that of humans and other animals.

Buck's team did a random search through 88,000 different drug compounds to see if any of them happened to make

*Continued on page 9 (***Worm Study***)*

Clip and Keep!

Educational Resources

American Psychiatric Association
202 / 682-6220 • www.psych.org
American Psychological Association
800 / 374-2721 • www.apa.org
Advocacy Center
800 / 342-0823 • www.advocacycenter.com
Child & Adolescent Bipolar Foundation
847 / 256-8525 • www.bpkids.org
DBSA-California
(909) 780-3366
National Alliance for the Mentally Ill (NAMI)
800/ 950-6264 • www.nami.org
National Association for the Dually Diagnosed
800/ 331-5362
National Depression and Bipolar Support Alliance
800 / 826-3632 • DBSAlliance.org
National Family Caregivers Association
301 / 942-6430
National Foundation for Depressive Illnesses
800 / 248-4344
National Institute of Mental Health
800 / 421-4211 • www.nimh.nih.gov
Panic Disorder Line:
800 / 64PANIC
800 / 647-2642
Anxiety Disorder Line:
888 / 826-9438
National Mental Health Association
800 / 989-6642 • www.nmha.org
Confidential depression screening:
www.depression-screening.org

GAMBLING PROBLEMS

(Cont'd. from page 9, column 3)

The researchers concluded that screening for problem gambling is warranted, especially among people with substance abuse problems.

The study, which appeared in the *Journal of Affective Disorders* in September, was titled "Problem gambling in bipolar disorder: Results from the Canadian Community Health Survey." ~

Source: bp Magazine Fall, 2007

WORM STUDY *(Continued from page 8)*

C. elegans live longer.

They found four drugs that extended life span by 20 percent to 30 percent. The drug with the strongest effect was mianserin, in a class of drugs known as tetracyclic antidepressants.

It blocks brain cell signaling by the neurotransmitter or message-carrying chemical serotonin, which is linked with mood and appetite.

The drug is used in Europe under several brand names, including Bolvidon, Norval and Tolvon but not usually in the United States. It can cause aplastic anemia and other effects on immune system cells.

Buck's team found that in addition to interfering with serotonin in the worm, it also blocked receptors for another neurotransmitter, octopamine.

They said some other research suggests that serotonin and octopamine may complement one another — with serotonin signaling the presence of food and octopamine signaling starvation.

Buck said it is possible that mianserin drug tips the balance in the direction of octopamine, tricking the brain into thinking it has been starved.

Petrascheck said another antidepressant, mirtazapine, had similar effects. An antihistamine and migraine drug

called cyproheptadine as well as a compound not used in people called methiothepin also affected serotonin and extended worm life span.

They tested other popular antidepressants that affect serotonin and found they did not make the worms live longer.

He is worried that people will rush to take the drugs in the hope of living longer.

"It is a stretch from a worm to a human being," Petrascheck said.

(Reporting by Maggie Fox, editing by Will Dunham and David Wiessler)

Source: YAHOO! News November 22, 2007

Gambling Problems Linked to Disorder

September 1, 2007, TORONTO, Ontario---People with bipolar I disorder are more than twide as likely to develop problem gampling than people without the disorder, new research has found.

Researchers with the University of Toronto, the University Health Network, Statistics Canada, and the University of Cincinnati looked at problem gambling rates in nearly 37,000 people. Those with bipolar were more than twice as likely to have a problem as the general public. Being male, not having a post-' secondary education, and having a drug or alcohol dependence were each associated with a higher rate of problem gambling.

*Continued on page 9, column 3 (**Gambling Problems**)*

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Help with Medi-Cal mental health services.

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