

Cognitive Crosstalk in ADHD

Children with attention deficit hyperactivity disorder (ADHD) are less able than healthy children to inhibit inappropriate responses and suppress cognitive interference. Not much is known about the brain activity underlying these problems. Vaidya et al. (p. 1605) measured brain functioning in children with ADHD and healthy children as they performed one task requiring response inhibition and another testing interference suppression. During both tasks, the frontal cortex and caudate nucleus of the children with ADHD were activated less than those of the healthy children. Although the magnitude of response differed, the locations of activation in the frontal and temporal cortices during interference suppression were similar in the two groups. The response inhibition task, on the other hand, demonstrated differences in functional anatomy between groups. Medication history was not responsible for these disturbances because most children with ADHD had not received drug treatment.



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Images in Psychiatry (p. 1604)

Suicide Attempts Run in the Family

Evidence that suicidality runs in families has come largely from patients' recall. Lieb et al. (p. 1665) provide confirmation from a representative community sample. In the community-based Early Development Stages of Psychopathology study, 933 subjects 14–17 years old were interviewed in 1995 and were contacted again twice over the next 3–4 years. Their mothers were asked about their history of suicidal thoughts and suicide attempts. Offspring of mothers who had thought about suicide did not have higher rates of suicide attempts than offspring of suicide-free mothers, but offspring of mothers who had actually attempted suicide did have higher rates of suicidal thoughts and attempted suicide.

Genetic factors have been implicated in the transmission of suicidality, but imitation is another possibility and is consistent with the relationship of offspring suicidality to the mother's attempted suicide but not suicidal thoughts.

Treating ADHD: What's It Worth?

Attention deficit hyperactivity disorder (ADHD) is a major public health problem with substantial economic costs. The Multimodal Treatment Study of Children With ADHD compared the effectiveness of four treatments. Jensen et al. (p. 1628) now report on which treatment gave the biggest bang for the buck. The clear-cut answer is medication management. Although the combination of medication management and intensive behavioral treatment was somewhat more effective in the 14-month study, medication management alone was clearly superior to behavioral treatment alone and to routine community care. In addition, it cost far less—to bring a child with ADHD to normal functioning, medication management cost \$360 more than community care, whereas combined treatment cost \$15,993 more. Combination treatment is more effective for some children with additional psychiatric disorders, however, and may be more cost-effective for them.

Confused Counting by Bipolar Patients

Patients with bipolar disorder have cognitive problems that persist even after mood regulation. Strakowski et al. (p. 1697) compared brain activation in stable bipolar patients and healthy subjects during a counting task involving cognitive interference. A screen displayed the word “one,” “two,” “three,” or “four” or multiple instances of the same word. In the control condition the number of instances matched the word, and in the interference condition it was discordant with the word. Each person was asked to press the button representing the number of words shown. The healthy subjects slowed down when presented with discordant words, but their responses were more accurate than those of the bipolar patients, who did not slow down. The two groups had similar activation in the brain regions usually associated with interference tasks, but the bipolar patients showed differences in several regions involved in error detection, response inhibition, and conflict resolution. These differences may reflect the underlying dysfunction of bipolar mood disorder.

Sociological Roots of Psychosis

Schizophrenia is more frequent in people with lower social status, but which is cause and which is effect? To evaluate social adversity for psychotic patients without the influence of the overt diagnosed psychotic illness itself, Wicks et al. (p. 1652) used Swedish data registries to determine five social indicators during childhood for individuals who were later hospitalized for schizophrenia or other psychoses. Four of the childhood factors were independently related to schizophrenia and to other psychoses: rented apartment, single-parent household, parental unemployment, and social welfare benefits. Further, the likelihood of illness increased with each additional social risk factor. These associations do not explain the mechanisms by which social adversity increases the risk of psychotic illness. Stress is a possible mediator; it may be that high stress plus genetic predisposition can lead to schizophrenia or other psychosis.

