NATIONAL NETWORK of DEPRESSION CENTERS

# NNDC Virtual Conference Poster Submission Guidelines

The 13th Annual NNDC Conference will be held September 21-22, 2021 – and this year we have gone virtual, again! The Conference Program Committee welcomes all conference attendees to submit a poster related to depressions and bipolar illnesses, particularly those that fit the conference theme. Posters can be submitted to one of three categories:

1. Basic Science
   All areas of research are welcome, but posters dealing with approaches (both biological and psychosocial) to understanding mood disorders, new or repurposed treatments and technologies, monitoring strategies with the potential to improve patient outcomes, or objective measures like biometrics, neuroimaging, bloodwork, or genetics are encouraged.
2. Clinical Programs
   Unified efforts are the best way to expedite technological innovation, dissemination of new information, and translation of research into clinical practice. Posters in this category might showcase multidisciplinary programs, demonstrate the efficacy of collaborations beyond academic boundaries, or deal with clinical assessments like patient questionnaires, clinical diagnoses, or clinical interviews.
3. COVID-19 Research
   As much of the research community is feeling the impact of COVID-19 in many ways, we anticipate many of our members are developing new projects or modifying approaches for ongoing research to study the profound effects of COVID-19 on mood and psychological health. We welcome posters detailing work in this timely and important area.

A $500 prize will be awarded to the best poster in each category

## A Virtual Poster Session? Here's How it Works

The virtual poster session will be split into two 45-minute time blocks, one each following the main conference program at approximately 4:45pm ET on September 21 and 22. Posters will be assigned to one of the two sessions prior to the event, with exact timing to be confirmed closer to the event dates. Abstracts for all posters will be made available for conference attendees on the NNDC website. Posters will be presented during virtual Q&A sessions with attendees during the assigned time.

Presenters who wish to host a virtual Q&A session must provide their own Zoom link; these will be collected prior to the event and made available to attendees via a secure web page only on the day of the poster session. Presenters may instead choose to provide only their email contact information for questions from conference attendees.

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# Frequently Asked Questions

## How do I submit a poster?

Poster abstracts will be collected using a simple online form located on the NNDC Annual Conference website which will be open on **Tuesday, June 15th at 8:00am ET** until **Sunday, August 15th at 11:59pm ET.** Abstracts must be submitted as word documents of one half to one full page in length and should include **background**, **methods**, **results**, and **conclusion(s)**; please do not include tables or figures in your abstract. See examples of abstract formatting from last year's conference below.

To access the poster submission form, visit:
**https://form.jotform.com/211593909569167**

## Can I see examples of previous posters?

Feel free to peruse the 2020 Virtual Conference Poster Directory to see the presentations from last year's conference.

## Who can present a poster?

All attendees are welcome to submit a poster, but poster presenters must be the author or co-author. Posters from commercial or for-profit entities are available only to conference sponsors.

## How many posters can I present?

Only one poster per individual will be accepted; posters submitted by representatives of commercial or other for-profit or non-academic entities will be limited to one per entity/organization.

## How will I know my poster has been accepted?

Poster acceptance notifications will be sent out to those who met the August 15th submission deadline by Tuesday, August 24.

## When is the poster session?

The poster session will be split into two 45-minute time blocks, tentatively scheduled for 4:45 pm ET each on September 21 and 22. Actual timing will be confirmed closer to the event dates. Posters will be assigned to one of the two available sessions prior to the event.

## How will I present my poster?

Poster presenters will host individual Zoom meetings during the scheduled blocks of time. The Zoom links will be shared with conference attendees in advance, along with poster titles and abstracts, so attendees can drop into as many poster presentations as they want! For those who are uncomfortable with Zoom, there will also be an email only option with no presentation.

## Examples of Abstract Formatting

### Depressive symptoms and course are associated with early-relapse in opioid-dependent individuals treated with extended-release naltrexone but not buprenorphine-naloxone

Christopher J Hammond MD PhD[1*]; Ariel Pollack[1]; Leslie Miller MD[1*]; Grace Park MPH[1]; Annabel Kady[1]; Kevin Wenzel PhD[2]; Marc Fishman MD[1,2]
1. Department of Psychiatry & Behavioral Sciences, Johns Hopkins University, Baltimore, MD 21224
2. Mountain Manor Treatment Center, Baltimore, MD 21229
* presenting authors

Background: Major Depressive Disorder (MDD) and depressive symptoms commonly co-occur with opioid use disorder (OUD) and have complex relationships with OUD treatment outcomes.[1,2] For example, co-occurring depression has been associated with both worse[1] and better[2] OUD treatment outcomes in opioid-dependent individuals. Some of the variance in this association may be due to individual differences in the response to medications for OUD treatment (MOU). In the present study, we examined differences in depression severity and in the associations between depression severity and opioid relapse in opioid-dependent adults randomized to receive one of two commonly prescribed, pharmacologically-distinct medications - extended-release naltrexone (XR-NTX), an opioid antagonist, and sublingual buprenorphine-naloxone (BUP-NAL), a partial opioid agonist. Methods: Effects of depression and treatment condition on opioid relapse were examined using data from a 24-week open-label, randomized controlled, comparative effectiveness study comparing XR-NTX versus BUP-NAL for opioid relapse prevention (NIDA CTN-0051).[3] In the study, 570 opioid-dependent adults (169 females, mean age = 33.9 years) were randomly assigned to 24-weeks of XR-NTX (4ml, 380 mg naltrexone base IM every 4 weeks) or Bup/Nal (SL, daily dose range = 8-24 mg), with both treatment arms offered weekly behavioral therapy. Depressive symptoms were assessed via the 17-item Hamilton Depression Scale (HAM-D). XR-NTX and BUP-NAL groups did not differ in age, sex, education, or on HAM-D scores at baseline (bsl). Logistic regression models examined whether depressive symptoms (continuous variable) or MDD diagnosis (categorical, based on HAM-D cutoff scores at bsl) were predictive of early-relapse secondary to medication induction failure and opioid-relapse events by week-24. Results: 26% of participants met criteria for moderate-to-severe MDD at bsl. 204 [72%] of 283 participants in the XR-NTX group and 270 [94%] of 287 in the BUP-NAL group were early-relapsers. In the total sample, HAM-D scores at week-24 ($\beta = 0.07$, $p < 0.001$) were associated with early-relapse and a number of depression x treatment condition interactions were identified [txt con x HAM-D $_{bsl}$ ($\beta = 0.03$, $p < 0.001$); txt con x MDD diagnosis $_{bsl}$ ($\beta = 0.33$, $p = 0.02$); and txt con x HAM-D scores $_{week\text{-}24}$ ($\beta = 0.05$, $p < 0.001$)]. Post-hoc analyses showed a general pattern of increased depression severity being associated with early-relapse in the XR-NTX but not the BUP-NAL group. Conclusions: Depressive symptoms and disorders represent an important treatment target in individuals with OUD. We found that depression severity was associated with early-relapse and that in opioid-dependent individuals with co-occurring depressive symptoms or MDD that the type of medication received influenced the likelihood of early-relapse. The presence of moderate-to-severe MDD at bsl and increased depressive symptoms during OUD treatment were predictive of induction failure with XR-NTX but not BUP-NAL. Individual differences in the severity of depression during XR-NTX treatment could be due to differences in risk genes (e.g. ORPM1) or childhood adversity, both of which influence inter-individual response to naltrexone. While preliminary and requiring replication, our results suggest that MOU with BUP-NAL may be the treatment of choice in individuals with OUD who have co-occurring depression.

1. Kosten TR, Rounsaville BJ, Kleber HD. A 2.5-Year Follow-up of Depression, Life Crises, and Treatment Effects on Abstinence Among Opioid Addicts. Arch Gen Psychiatry. 1986;43(8):733–738. doi:10.1001/archpsyc.1986.01800080019003
2. Subramaniam GA, Warden D, Mihajuddin A, Fishman MJ, Stitzer ML, Adinoff B, et al. Predictors of Abstinence: National Institute of Drug Abuse Multisite Buprenorphine/Naloxone Treatment Trial in Opioid-Dependent Youth. J Am Acad Child Adolesc Psychiatry; 2011,50(11):1120-118.
3. Lee JD, Nunes DV, Novo P, Bachrach K, Bailey G, et al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicenter, open-label, randomized controlled trial. Lancet. 2018;391 (10118):309-318.

## Comorbid anxiety disorders and quality of life among patients with bipolar disorder

Marsal Sanches, MD, PhD[1], Giovana B. Zunta-Soares, MD[1], Sudhakar Selvaraj, MD, Ph.D[1], and Jair C. Soares, MD, PhD[1].
[1]UT Center of Excellence on Mood Disorders, Department of Psychiatry and Behavioral Sciences, McGovern Medical School, Houston, Texas

Background: Anxiety disorders are highly prevalent among patients with bipolar disorder (BD), and seem to be associated with serious functional impairment and higher rates of morbidity. We carried out a study analyzing the impact of comorbid anxiety disorders on the quality of life of BD patients. Methods: The sample consisted of 81 adult outpatients (30 males/51 females, mean age± SD=35.98 ± 13.88 years) who met DSM-IV-R criteria for BD (52 BD type I, 17 BD type II, and 12 BD NOS). The diagnosis of BD and the presence of comorbid anxiety disorders was established through the administration of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Quality of Life was measured through the World Health Organization Quality of Life scale (WHOQOL-100). Initially, a two-step cluster analysis was performed, utilizing the different domains of the (WHOQOL-100). The resulting clusters were compared as for the rates of comorbid anxiety disorder. In addition, we utilized analysis of covariance to compare bipolar patients with and without anxiety disorders in regard to their quality of life scores, with age, gender, and mood state as covariates. Results: 40 BD patients met criteria for comorbid anxiety disorders, and 27 met criteria for more than one disorder. The most prevalent anxiety disorders identified were PTSD (n=19), GAD (n=13), panic disorder (n=13), agoraphobia (n=10), and social anxiety disorder (n=10). The two-step cluster analysis revealed two different clusters of patients, respectively, with high and low quality of life scores. Anxiety Disorders were significantly more prevalent in the low quality of life group (63.8% versus 36.9%, p=0.015). Moreover, the comparison between patients with and without comorbid anxiety disorders through ANCOVA revealed lower quality of life scores among patients with an associated diagnosis of anxiety disorder with respect to the physical health (40.95 ± 14.78 vs 51.71 ± 13.27; F=8.93, d.f. 1/71, p<0.01), psychological health (44.60 ± 24.02 vs 55.02 ± 15.53; F=8.68, d.f. 1/71, p<0.01), and environment (57.93 ± 20.19 vs. 73.19 ± 14.69; F=18.5, d.f. 1/71, p<0.01) domains of the WHOQOL scale, even when mood state was included as a covariate. Conclusions: Our results suggest that comorbid anxiety disorders are associated with substantial impairment in quality of life among patients with BD. The systematic assessment and management of anxiety in BD patients represent a promising and important area for clinical interventions and research.

# Screening for Perinatal Depression using the CAT-MH™ in Urban-Dwelling African American and Hispanic Women

Wenzel ES[1,2], Dowty S[2], Bernabé BP[2], Pezley L[2], Gibbons RD[3], Maki PM[1,2]

[1]Department of Psychology, University of Illinois at Chicago, Chicago, IL
[2]Women's Mental Health Research Program, Department of Psychiatry, University of Illinois at Chicago, Chicago, IL
[3]Center for Health Statistics and Departments of Medicine and Public Health Sciences, University of Chicago, Chicago, IL

Background: Approximately 12% of women experience depression during pregnancy or the postpartum, or perinatal depression (PND). Underserved minority women experience high rates of PND, but low rates of follow-up for referral and treatment. To address this health disparity, we implemented a computerized adaptive test (CAT-MH™), which includes a diagnostic screen for MDD (CAD-MDD™) tailored for PND, and a measure of severity of depressive symptoms (CAT-DI). We examined and compared rates of PND and symptom severity on CAT-MH™ and PHQ-9, and measured concordance of CAT-MH™ measures with PHQ-9 in African-American and Hispanic women. Methods: A total of 179 pregnant women (49% African-American; 30% Latina) from an urban university obstetrics outpatient clinic were evaluated at 416 visits using CAT-MH™ as part of a longitudinal study on perinatal mental health. Rates of PND and depressive symptom severities were calculated, and the relationship between PND outcome and method of screening (CAD-MDD™, PHQ-9 (cut-off score$\geq$10)) was determined using Chi-Square analysis. Linear associations between CAT-DI severity scores and PHQ-9 scores were determined by Pearson correlation. Results: The average overall PND rate per visit on CAD-MDD™ was 14.95% (17.9% in African-Americans and Latinas), with 4% in the moderate/severe categories on CAT-DI. The rate per visit on average of PND on the PHQ-9 was 10.8% (9.9% in African-Americans and Latinas). There was a trend toward an association between screening measure and PND outcome, with CAD-MDD™ detecting higher incidence of PND compared to PHQ-9 ($p=.09$). CAT-DI and PHQ-9 scores significantly correlated ($r=0.70$, $p<.001$). Results were similar in minority women. Conclusions: CAD-MDD™ detected higher rates of PND than the PHQ-9, particularly for minority women. Psychiatric diagnostic interviews are underway to compare the sensitivity of the two measures. These data support the continued future use of the CAT-MH™ in screening for perinatal mental health.