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## Synaptic plasticity in depression: Molecular, cellular and functional correlates

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### ABSTRACT

Synaptic plasticity confers environmental adaptability through modification of the connectivity between neurons and neuronal circuits. This is achieved through changes to synapse-associated signaling systems and supported by complementary changes to cellular morphology and metabolism within the tripartite synapse. Mounting evidence suggests region-specific changes to synaptic form and function occur as a result of chronic stress and in depression. The prefrontal cortex (PFC) and hippocampus represent the best studied regions where functional and structural findings are consistent with a deficit in long-term potentiation (LTP) and neuronal and glial growth at excitatory synapses. Correlating these changes may be those to glutamate receptors (AMPA and NMDARs), growth factor signaling (BDNF-TrkB) and several signal transduction pathways (NOS-NO, cAMP-PKA, Ras-ERK, PI3K-Akt, GSK-3, mTOR and CREB). In contrast other brain regions such as the amygdala may feature a somewhat opposite synaptic pathology including reduced inhibitory tone. Deficits in synaptic plasticity may further correlate disrupted brain redox and bioenergetics in stress and depression. Moreover, at a functional level region-specific changes to synaptic plasticity in depression may relate to maladapted neurocircuitry and parallel reduced cognitive control over negative emotion.

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**Abbreviations:** mPFC, medial prefrontal cortex; ACC, anterior cingulate cortex; DG, dentate gyrus; NAc, nucleus accumbens; AMPAR,  $\alpha$ -amino-3-hydroxy-5-methyl-4-isoxazole propionic acid receptor; NMDAR, N-methyl-D-aspartic acid receptor; VDCC, voltage-dependent calcium channel; mGluR, metabotropic glutamate receptor; D<sub>1</sub>, dopamine receptor type 1; 5-HT<sub>1A</sub>, serotonin receptor type 1A; TrkB, tyrosine kinase receptor 2; PSD-95, postsynaptic density protein 95; BDNF, brain-derived neurotrophic factor; VEGF, vascular endothelial growth factor; nNOS, neuronal nitric oxide synthase; iNOS, inducible nitric oxide synthase; cAMP, cyclic adenosine monophosphate; PKA, protein kinase A; MAPK, mitogen-activated protein kinase; MEK, MAPK kinase; ERK, extracellular signal-regulated kinase; PI3K, phosphoinositol-3-kinase; Akt, protein kinase B; GSK-3, glycogen synthase kinase-3; mTOR, mammalian target of rapamycin; CREB, cAMP response element-binding; SSRI, selective serotonin reuptake inhibitor; SSRE, selective serotonin reuptake enhancer; NRI, noradrenaline reuptake inhibitor; SNRI, serotonin-noradrenaline reuptake inhibitor; MAOI, monoamine oxidase inhibitor; TCA, tricyclic antidepressant; ECS, electroconvulsive seizure; snp, single-nucleotide polymorphism; CUMS, chronic unpredictable mild stress; CRS, chronic restraint stress; CIS, chronic immobilisation stress; SD, social defeat.

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65

## 66 1. Introduction

67 Depressive disorders impose a severe burden on inflicted individ-  
 68 uals and may be becoming increasingly prevalent in modern society  
 69 (Hidaka, 2012; Lépine and Briley, 2011; Mathers and Loncar, 2006).  
 70 These factors taken with the limited efficacy of current clinical mono-  
 71 aminergic antidepressants (Papakostas et al., 2007; Thase et al., 2005)  
 72 underscore the need for better understanding and treatment of these  
 73 disorders. Certainly depression is a complex and heterogeneous  
 74 condition, the neurobiology of which is increasingly associated with  
 75 diverse changes to multiple systems. For instance molecular and  
 76 cellular findings implicate neuroplastic, neurometabolic and neuro-  
 77 immune changes in depression (Kubera et al., 2011; Marsden, 2011;  
 78 Pittenger and Duman, 2008). Functional and structural neuroimaging  
 79 studies implicate changes to brain regions such as the prefrontal cor-  
 80 tex (PFC), anterior cingulate cortex (ACC), thalamus, hippocampus,  
 81 amygdala and basal ganglia in depression (Bora et al., 2012; Du et  
 82 al., 2012; Murrough et al., 2011; Price and Drevets, 2010). All of  
 83 these changes likely relate closely to altered synaptic form and func-  
 84 tion in depression, which itself may play a fundamental pathological  
 85 role. For instance, at the cellular level altered synaptic plasticity  
 86 could account for and correlate changes to signaling systems, cellular  
 87 morphology and even metabolic function. At a regional level such  
 88 changes may account for altered inter-regional connectivity and  
 89 regional activity. Whilst at a functional level these changes may  
 90 correlate altered cognition, cognitive bias and ultimately persistent  
 91 negative emotions. Accordingly a better appreciation of the synaptic  
 92 pathology in depression could facilitate a more integrated neurobio-  
 93 logical conceptualisation of this disorder and present opportunities  
 94 for more efficient treatment and prevention. To this end, this paper  
 95 aims to review the evidence implicating altered synaptic plasticity  
 96 in depression and to further characterise the major signaling path-  
 97 ways which may underlie changes to neuronal and glial plasticity.  
 98 Finally this paper closes with a brief discussion on the putative  
 99 functional implications of altered synaptic plasticity in depression.

100 Central to this paper are findings from human studies and  
 101 well-validated behavioural models. Human studies mainly constitute  
 102 those from post-mortem analyses; for a discussion on analysis  
 103 techniques and interpretive considerations see (Altar et al., 2009). Animal  
 104 studies typically use forms of stress, a well-accepted aetiological  
 105 factor in depression, to study the neurobiological correlates of  
 106 depressive-like behaviour. In particular the construct and behavioural  
 107 characteristics of chronic stress models (e.g. CMS and CUS) suggests  
 108 they are better representations of human depression than are acute  
 109 stress models (Willner, 2005). This is particularly important given  
 110 that acute stress and chronic stress often exert opposite effects on  
 111 neuroplasticity (Joëls and Krugers, 2007; Popoli et al., 2012). Accord-  
 112 ingly chronic stress models take precedence in this review; although  
 113 where a paucity of research exists, findings from other studies may be  
 114 discussed. It is also worth considering that even chronic stress models  
 115 of depression are still approximations with inherent variability  
 116 (Bergström et al., 2008; Schweizer et al., 2009) and translational limi-  
 117 tations. For instance the aetiology of human depression is likely  
 118 multi-factorial, consisting of genetic, psychological, metabolic and  
 119 immunological factors amongst others (Maes et al., 2011c; Marsden,  
 120 2011; Stanger et al., 2009; Szezyzyk et al., 2010). These other stressors

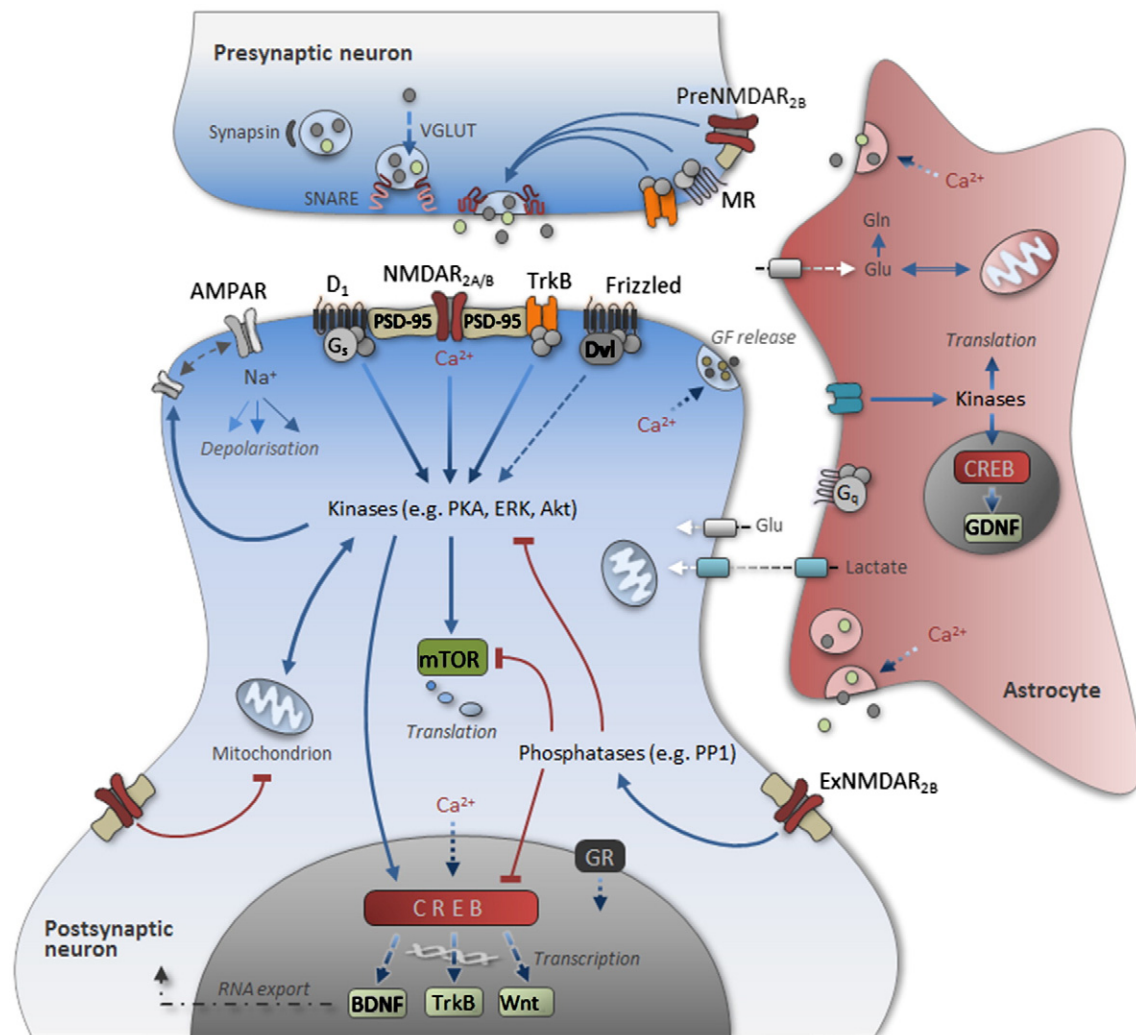
have not been so well-studied with regards to neuroplasticity in 121  
 depression at this time (Fig. 4). 122 Q2

## 2. Synaptic plasticity: basic mechanisms 123

### 2.1. Correlates of synaptic strength 124

Synapses are highly specialised structures which principally medi- 125  
 ate electro-chemical communication between neurons. Synaptic form 126  
 and function is highly dynamic in nature, and has been widely studied 127  
 as a cellular correlate of memory and learning. The best studied forms 128  
 of synaptic plasticity are long-term potentiation (LTP) and long-term 129  
 depression (LTD), which occur at both excitatory and inhibitory syn- 130  
 apses throughout the brain (Kullmann and Lamsa, 2011; Markram et 131  
 al., 2011; Méndez and Bacci, 2011). Experimentally LTP and LTD can 132  
 be induced via either frequency/rate-dependent stimulation (e.g. 133  
 HFS and LFS), spike-timing-dependent plasticity (STDP) protocols 134  
 or chemical induction (e.g. NMDA) protocols; whilst physiological 135  
 induction may involve a convergence of rate, timing and neuro- 136  
 modulator influence (Markram et al., 2011). At excitatory synapses 137  
 LTP and LTD have been shown to be reversible through further 138  
 less well studied forms of plasticity such as depotentiation and 139  
 dedepression respectively (Morishita and Malenka, 2008; Qi et al., 140  
 2012). Whilst synaptic plasticity is a widespread phenomenon in 141  
 the brain, the molecular and cellular mechanisms underpinning syn- 142  
 aptic plasticity remain best characterised within the hippocampus; 143  
 typically the Schaffer collateral pathway projecting from CA3 to excit- 144  
 atory pyramidal neurons in CA1. Accordingly the glutamatergic 145  
 synapse in the hippocampus represents the model synapse in this 146  
 paper herein. 147

The establishment of changes in synaptic strength involves both 148  
 pre- and postsynaptic mechanisms, and depends upon the movement 149  
 and synthesis of receptors and other synaptic proteins. Rapid changes 150  
 to plasticity, for instance during early-LTP (E-LTP), rely upon the 151  
 movement of pre-existing proteins; whilst late-LTP (L-LTP) requires 152  
 RNA translation (i.e. protein synthesis) (Slipczuk et al., 2009; Tang 153  
 et al., 2002) and changes to gene expression (Wu et al., 2007). LTD 154  
 also involves changes to protein metabolism and gene expression, 155  
 and likely in an oppositional manner (Li et al., 2010c; Mauna et al., 156  
 2011). The best studied molecular correlate of synaptic strength at 157  
 excitatory synapses is AMPAR expression. Synaptic potentiation in- 158  
 volves the addition of AMPARs containing GluR1, GluR2L and GluR4 159  
 subunits; whilst GluR2, GluR3 and GluR4c subunits participate in 160  
 AMPAR removal during LTD (Kessels and Malinow, 2009; Stornetta 161  
 and Zhu, 2011). Other glutamate receptors are also regulated during 162  
 activity-dependent plasticity. NMDAR synaptic responses most con- 163  
 sistently decrease with LTD (Morishita and Malenka, 2008); however 164  
 NMDARs undergo trafficking and changes to GluN2 subunit ratios fol- 165  
 lowing LTP and LTD (Peng et al., 2010). Similarly the expression of 166  
 certain mGluR types may also be bidirectionally regulated following 167  
 LTP and LTD (Cheyne and Montgomery, 2008; Manahan-Vaughan et 168  
 al., 2003). In addition many other protein types are modulated by 169  
 synaptic plasticity. For example the expression of presynaptic 170  
 proteins synapsin 1 and SNAP25, and dendritic CaMKII and MAP2 171  
 are all increased following hippocampal LTP (Roberts et al., 1998a, 172  
 1998b; Sato et al., 2000). 173

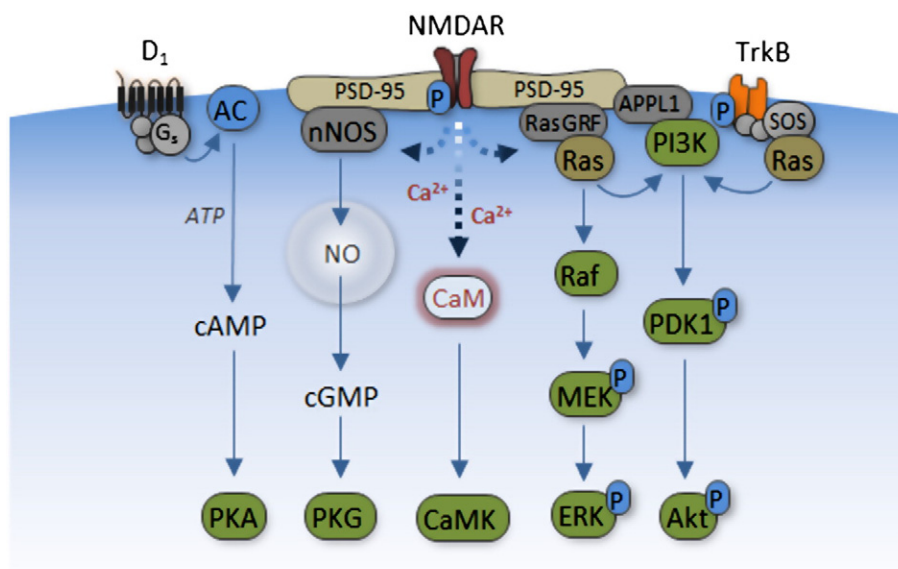


**Fig. 1.** The tripartite synapse and calcium ( $\text{Ca}^{2+}$ ) signaling in the hippocampus. On the presynaptic neuron, glutamate (Glu) is loaded into vesicles via vesicular glutamate transporters (VGLUTs). Neuronal activity triggers SNARE-dependent vesicle fusion and release of glutamate into the synaptic cleft. Glutamate binds to synaptic receptors (e.g. AMPARs and NMDARs) before being taken up by transporters into glia and neurons. Repeated postsynaptic AMPAR activation depolarises the neuron and allows for NMDAR activation, the resulting  $\text{Ca}^{2+}$  influx initiates changes to synaptic plasticity.  $\text{Ca}^{2+}$  influx leads to further release from internal stores and subsequent release of brain-derived neurotrophic factor (BDNF) and Wnt proteins. Signaling from NMDARs and growth factors (e.g. BDNF-TrkB and Wnt-Frizzled) converge and cooperate to activate various signaling pathways which regulate protein trafficking, translation and gene transcription. For instance during long-term potentiation (LTP) multiple signals converge to regulate AMPAR trafficking, and mammalian target of rapamycin (mTOR) translation and cAMP response element-binding (CREB) transcription pathways. In contrast, during long-term depression (LTD) intracellular phosphatase signaling leads to inhibition of mTOR and deactivation of CREB. Extrasynaptic NMDARs (GluN2B containing) represent a major mediator of negative neuroplastic signaling; associated pathways lead to CREB shut-off, disruption of mitochondrial function and potentially cell death. Astrocytes are also crucially involved in synaptic plasticity via the release of gliotransmitters and metabolic factors such as lactate. *Additional abbreviations:* Dvl, dishevelled protein; GF, growth factor; Gln, glutamine; PreNMDAR, presynaptic NMDAR; ExNMDAR, extrasynaptic NMDAR.

Changes to synaptic plasticity are further coordinated with those to structural plasticity within the tripartite synapse. On pyramidal neurons, LTP and LTD induce dendritic spine growth and retraction respectively, whilst AMPAR expression is positively related to the size of the spine head (Kasai et al., 2010). Presynaptic axonal bouton turn-over and morphology is also regulated by synaptic plasticity; LTP and LTD bidirectionally regulate bouton-spine association (Becker et al., 2008; Lushnikova et al., 2009). Furthermore changes to glial processes may also be a general component of synaptic plasticity (Haber et al., 2006). Indeed LTP alters astroglial numbers and volume, and ultimately increases coverage of excitatory synapses in the hippocampus (Lushnikova et al., 2009; Wenzel et al., 1991). Consistent with these structural changes to the tripartite synapse, neuronal and glial glutamate transporter expression is also up-regulated during early and late-LTP (Pita-Almenar et al., 2006).

## 2.2. Signaling systems involved in synaptic plasticity

Neurons, glia and many signaling systems participate in concert during synaptic plasticity. At an individual synapse, appropriate stimulation leads to the release of several neuro- and gliotransmitters (Chen et al., 2012a; Wenker, 2010) and the activation of various surface-level receptors. Most central to the initiation of synaptic plasticity is calcium ( $\text{Ca}^{2+}$ ) influx through ion channels. In particular the NMDAR fulfils the coincident detection requirements of Hebbian plasticity and serves as the canonical pathway leading to bidirectional changes in plasticity (Markram et al., 2011). The direction of NMDAR-dependent plasticity is influenced by many factors such as activation level, phosphorylation state, subunit composition and postsynaptic location. During neuronal activity  $\text{Ca}^{2+}$  influx through synaptic NMDARs and somatic VDCCs is accompanied by release from internal stores (Bengtson and Bading, 2012). These  $\text{Ca}^{2+}$  signals



**Fig. 2.** The NMDAR signaling complex: upstream signaling pathways mediating positive changes to neuroplasticity. Synaptic NMDAR activation allows  $\text{Ca}^{2+}$  influx and binding to calmodulin (CaM) which leads to activation of  $\text{Ca}^{2+}$ /calmodulin-dependent kinases (CaMK) as well as other signaling proteins. Neuronal nitric oxide synthase (nNOS) is held within close proximity of NMDARs through interactions with postsynaptic density protein 95 (PSD-95).  $\text{Ca}^{2+}$ /calmodulin binding to nNOS stimulates nitric oxide (NO) production (Feil and Kleppisch, 2008). NMDAR stimulation of the Ras-ERK1/2 pathway can be achieved by CaMK1-RasGRF (Li et al., 2006; Schmitt et al., 2005) and NO signaling (Gallo and Iadecola, 2011; Yun et al., 1998, 1999); NMDARs may also activate MEK5–ERK5 (Wang et al., 2006a). The PI3K–Akt pathway associates with the NMDAR–PSD-95 complex via adapter protein APPL1 (Wang et al., 2012). Activation of PI3K–Akt signaling may be achieved through CaM (Xu et al., 2007) and Ras (Castellano and Downward, 2011; Qin et al., 2005).  $\text{Ca}^{2+}$  influx through NMDARs may also stimulate the PKA pathway through activation of  $\text{Ca}^{2+}$ /calmodulin sensitive adenyl cyclases (AC). NMDARs co-localise with  $\text{D}_1$  receptors both of which may synergistically boost PKA signaling (Mockett et al., 2004). NMDARs also work synergistically with BDNF–TrkB signaling (Martin and Finsterwald, 2011; Xu et al., 2007; Yoshii and Constantine-Paton, 2010).

activate several intracellular signal transduction pathways crucial to synaptic plasticity, which will be discussed in more detail later.

Further crucial to NMDAR-dependent plasticity is co-operation with other signaling systems. Indeed induction of the translation and transcription machinery during L-LTP involves the coincident activation of several intracellular pathways (Kovács et al., 2007; Ma et al., 2011; Martin and Finsterwald, 2011; Tanaka et al., 2008). In particular intracellular  $\text{Ca}^{2+}$  signals following synaptic activity promote the secretion of growth factors such as BDNF (Jourdi et al., 2009; Kuczewski et al., 2009) and Wnt proteins (Chen et al., 2006; Li et al., 2012; Wayman et al., 2006). These proteins crucially co-operate with NMDARs to induce changes to neuroplasticity. With regard to the BDNF system; BDNF–TrkB signaling is involved in LTP, whilst proBDNF-p75<sup>NTR</sup> signaling may be recruited during LTD (Yoshii and Constantine-Paton, 2010). In addition some neuromodulator systems are also required for NMDAR-dependant plasticity.  $\text{D}_1$  receptor activation is required for LTP (Granado et al., 2008; Gurden et al., 2000; Navakkode et al., 2007), whilst  $\text{CB}_1$  receptors are involved in LTD (Corlew et al., 2009; Izumi and Zorumski, 2012). Other neuromodulators, including metabotropic monoamine systems (e.g. serotonin, dopamine and noradrenaline) which represent the typical targets of antidepressants, crucially modulate plasticity thresholds and characteristics (Ma et al., 2011; Pawlak et al., 2010; Polter and Li, 2010; Qin et al., 2005). Finally some neuromodulator receptors can mediate NMDAR-independent forms of plasticity (e.g. mGluR1/5 and 5-HT<sub>2</sub> (Zhong et al., 2008)).

Whilst the basic signaling mechanisms underlying synaptic plasticity at excitatory synapses have been best described in CA1, they are applicable to other hippocampal regions; a notable exception being CA2 (Caruana et al., 2012). Similarly these mechanisms are also conserved in other key brain regions implicated in depression such as the PFC (Cui et al., 2011; Sarantis et al., 2009; Sui et al., 2008). However different brain regions may have distinct characteristics which influence synaptic plasticity. Most notably there is a differential expression of NMDAR subunits in the lateral amygdala versus

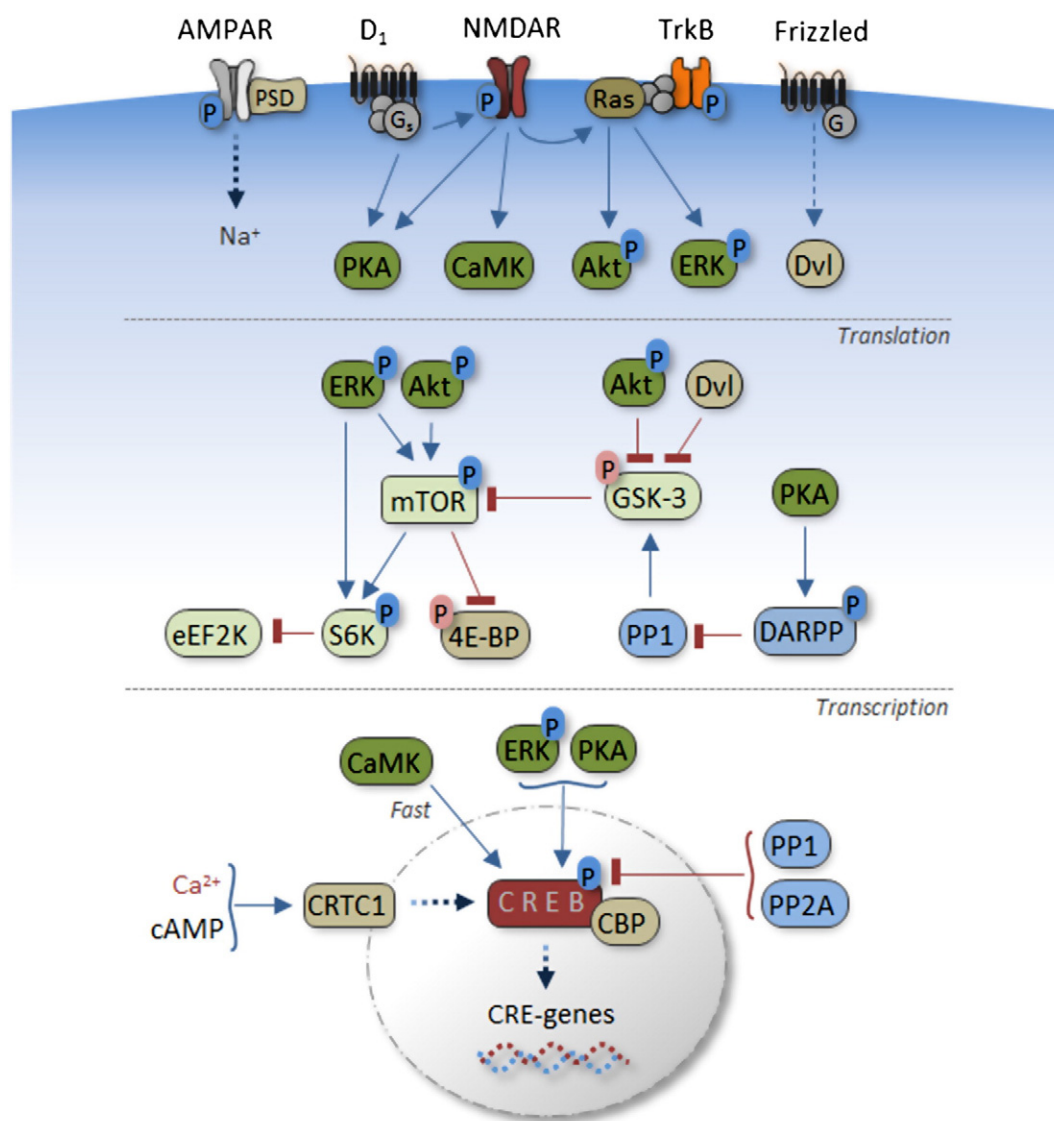
CA1, which will contribute to unique aspects of amygdala synaptic plasticity (Miwa et al., 2008).

### 3. Synaptic plasticity in stress and depression

#### 3.1. Chronic stress and antidepressant modulation of plasticity

Stress has profound effects on synaptic form and function; for other recent reviews on this topic see (Christoffel et al., 2011; Popoli et al., 2012; Sandi, 2011). Stress and glucocorticoid modulation of synaptic plasticity is mediated via activation of mineralocorticoid (MR) and glucocorticoid receptors (GR) (Fig. 1). Through these receptors stress and glucocorticoids exert direct effects on neurons and glia (Yu et al., 2011), and also increase glutamate release in brain regions such as the PFC, hippocampus, amygdala and nucleus accumbens (NAc) (Musazzi et al., 2011; Sandi, 2011). The effects of stress on synaptic plasticity are highly dependent upon brain region, stress type and time point measured (Joëls and Krugers, 2007). In particular whilst acute stresses have been reported to produce bidirectional effects on synaptic plasticity in several brain regions, chronic stress has a more unidirectional influence.

The effects of stress on synaptic and structural plasticity have been particularly well-studied in the hippocampus. CUS impairs LTP in DG and CA1 subregions (Alfarez et al., 2003); whilst chronic restraint stress (CRS) was found to impair LTP in CA3 (Pavlidis et al., 2002). Another study found that CMS facilitated LTD in CA1 (Holderbach et al., 2007). Disruption of hippocampal plasticity (CA1 and DG) by chronic stress is GR-dependent (Datson et al., 2012; Krugers et al., 2006). The negative effects of stresses on synaptic plasticity in the hippocampus can be prevented or reversed by monoaminergic antidepressants (Holderbach et al., 2007; Matsumoto et al., 2005). In addition stress facilitation of spike-timing-dependent LTD (tLTD) in CA1 can be reversed by the mood stabiliser lithium (Niehusmann et al., 2010). Consistent with changes to synaptic plasticity in the hippocampus, CMS disrupts neurogenesis in the dentate gyrus (DG)



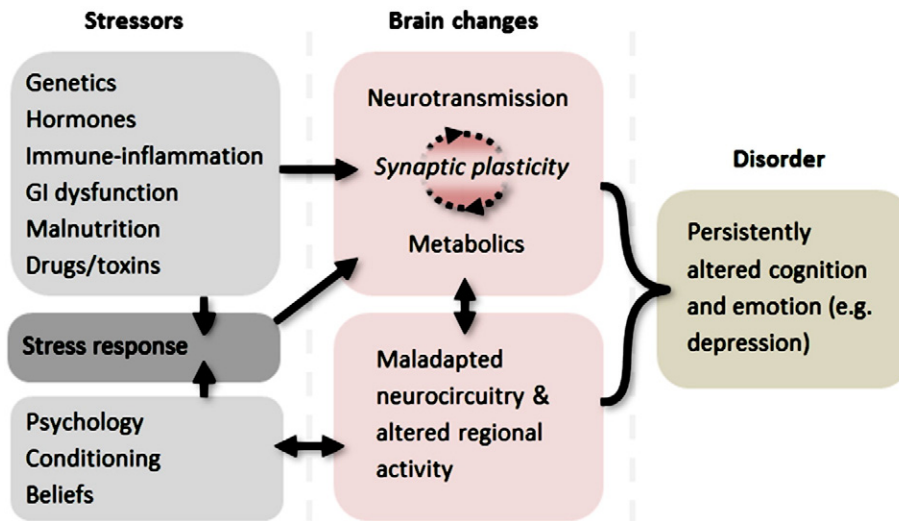
**Fig. 3.** Regulation of translation and transcription during hippocampal synaptic plasticity. Cooperation between upstream signaling pathways is required to modulate downstream systems regulating translation and transcription processes. Glycogen synthase kinase 3 (GSK-3) is inactivated by Wnt-frizzled signaling and protein kinase B (Akt)-phosphorylation at ser9, whereas GSK-3 can be dephosphorylated and activated by protein phosphatase 1 (PP1). This latter pathway may also interact with protein kinase A (PKA) which can phosphorylate DARPP, a potent inhibitor of PP1 (Abel and Nguyen, 2008). Suppression of GSK-3 activity facilitates activation of mammalian target of rapamycin (mTOR), activation of which is also dependent upon extracellular signal-regulated kinase (ERK) and Akt pathways. mTOR regulates transcription initiation through interactions with 4E-BP, S6K and eEF2K (Hoeffer and Klann, 2010). Activation of cAMP response element-binding (CREB)-dependent transcription involves the participation of multiple upstream pathways. CREB needs to be phosphorylated at ser133 to recruit CREB-binding protein (CBP). This phosphorylation may be initiated by a fast Ca<sup>2+</sup>/calmodulin-dependent kinase IV (CaMKIV) component and sustained by ERK (Wu et al., 2001); whilst PKA activity is also required (Abel and Nguyen, 2008). CREB activation further requires translocation of CREB-regulated transcription coactivator 1 (CRTC1) to the nucleus, which is dependent upon Ca<sup>2+</sup> (e.g. calcineurin and NO) and cAMP signaling pathways (Gallo and Iadecola, 2011; Kovács et al., 2007; Martin and Finsterwald, 2011). CREB can be deactivated by PP1 and protein phosphatase 2A (PP2A) pathways (Mauna et al., 2011). Additional abbreviations: Dvl, dishevelled protein.

(Holderbach et al., 2007) and promotes pyramidal dendrite atrophy in CA1, CA2 and CA3 (Luo and Tan, 2001); similarly chronic immobilisation stress (CIS) promotes pyramidal dendrite retraction in CA1 and CA3 in an NMDAR-dependent manner (Christian et al., 2011). Furthermore CMS may increase apoptotic rate in the hippocampus (Liu et al., 2010; Silva et al., 2008); which again may be NMDAR-dependent (Abrahám et al., 2006; Xiao et al., 2010). In contrast, antidepressants oppose the dendrite atrophy and increases in apoptosis markers induced by CMS in the hippocampus (Liu et al., 2010; Luo and Tan, 2001; Silva et al., 2008). A similar bidirectional regulation of astrocyte growth by chronic stress and antidepressants may also occur in the hippocampus (Czéh et al., 2006; Yu et al., 2011).

Consistent with changes to cellular function and morphology in the hippocampus chronic stress alters the expression of critical receptors and proteins involved in synaptic plasticity. For instance chronic

stresses lower the expression of AMPAR subunits (GluR1, 2 and 3), NMDAR subunits (GluN1 and 2B) (Cohen et al., 2011; Duric et al., 2012; Kiselycznyk et al., 2011; Yuan et al., 2011) and various synaptic proteins (e.g. synapsin 1 and PSD-95) (Alfonso et al., 2006; Cohen et al., 2011; Elizalde et al., 2010; Silva et al., 2008), whilst antidepressant treatments oppose these changes. Other studies report that chronic but not acute treatment with monoaminergic antidepressants increases the expression of several AMPAR subunits (Barbon et al., 2011), and AMPAR subunit synaptic expression in the hippocampus (Martínez-Turrillas et al., 2005, 2007).

The PFC is affected in a similar manner to the hippocampus by chronic stress. CUS/CMS protocols impair LTP induction in the PFC (Quan et al., 2011b), as well as hippocampus-PFC and thalamus-PFC pathways (Cerqueira et al., 2007; Quan et al., 2011a). Stress-induced disruption of LTP in the PFC is GR-dependent (Mailliet et al., 2008).



**Fig. 4.** A basic hierarchical scheme for the pathogenesis of depression. A variety of physical and psychological stressors associate with neuropsychiatric disorders. These stressors differentially affect the state and function of neurons and neuronal networks throughout the brain. Differential impact on cells and related ensembles/networks gives rise to maladapted brain circuitry. These regional-level changes may then associate with a persistent shift in cognition and emotion, and distinct conditions such as depression.

The negative effects of stresses on synaptic plasticity in the PFC can be restored by monoaminergic antidepressants (Dupin et al., 2006; Qi et al., 2009). Chronic stress also promotes pyramidal dendrite retraction in the mPFC in an NMDAR-dependant manner (Martin and Wellman, 2011). Moreover CUS increases the expression of the apoptosis protein caspase-3 in the cerebral cortex (Bachis et al., 2008), and disrupts glial metabolism and reduces GFAP expression in the PFC (Banar et al., 2010). Chronic stresses lower the expression of AMPAR subunits (GluR1, 2 and 3), NMDAR subunits (GluN2B) (Gourley et al., 2009; Li et al., 2011; Quan et al., 2011b) and various synaptic proteins in the PFC (Elizalde et al., 2010; Li et al., 2011; Ray et al., 2011) whilst antidepressant treatment was found to reverse some of these changes. Chronic but not acute treatment with monoaminergic antidepressants increases the expression of several AMPAR subunits in the PFC (Barbon et al., 2011). Furthermore the rapid antidepressant activity of ketamine, NMDAR<sub>2B</sub> and mGluR<sub>2/3</sub> antagonists is accompanied by increased GluR1 expression, synaptogenesis and spinogenesis in the PFC (Dwyer et al., 2012; Li et al., 2010b, 2011).

Not all brain regions respond the same way to chronic stress as the PFC and hippocampus, most notably the amygdala. A frequent finding is that CRS and CIS protocols which induce dendrite retraction in the PFC and hippocampus actually induce dendrite arborisation of pyramidal and spiny neurons in the basolateral amygdala (BLA) (Eiland et al., 2012; Vyas et al., 2002, 2006). Recently BDNF expression was shown to correlate the opposite structural changes induced by CIS in the hippocampus (CA3) and BLA (Lakshminarasimhan and Chattarji, 2012). Perhaps further consistent with these changes a repeat stress protocol was reported to decrease GluN2B expression in the dorsal hippocampus whilst increasing expression in the BLA (Kiselycznyk et al., 2011). However the potential for stress to induce cell-specific negative changes in the amygdala are emphasised by other studies. CRS decreases interneuron-related proteins and dendritic arborisation in the LA and BLA (Gilbert-Juan et al., 2011). In addition CUS has been reported to induce atrophy of bipolar neurons in the BLA (Vyas et al., 2002), and lower amygdala GluR1 phosphorylation (Chandran et al., 2012); however both these models failed to alter hippocampal parameters which contrasts other studies.

Finally some other brain regions may also respond differently to the PFC and hippocampus in response to stress. CRS was found to increase excitability and consequently enhance both LTP and LTD induction in the anterior cingulate cortex (ACC) (Ito et al., 2010). CUS disrupts endocannabinoid (eCB)-dependent forms of synaptic depression in the NAc (Wang et al., 2010).

### 3.2. The synaptic pathology in MDD

Grey matter reductions have been reported in many brain regions in MDD; for reviews see (Bora et al., 2012; Du et al., 2012; Price and Drevets, 2010). Cellular correlates of these reductions may include negative changes to both neurons and glia. Glial pathology in MDD includes decreases in glial size and number whilst neuronal pathology may relate more to cellular shrinkage and synapse loss (Banar et al., 2010; Price and Drevets, 2010). These changes most closely related to synaptic pathology in depression are reviewed below.

In the hippocampus lowered levels of neuropil (i.e. neuron and glial extensions) has been reported in MDD (Stockmeier et al., 2004). Lowered gene expression of synaptic proteins (e.g. synapsin, SNAP25, SAPs and MAPs) and AMPAR subunits (GluR1 and 3) was recently found in DG and CA1 subregions of the hippocampus (Duric et al., 2012). This study found no NMDAR transcript alterations in these regions; however lowered expression of the obligatory GluN1 NMDAR subunit has been reported in DG and CA3 in a previous study on MDD subjects (Law and Deakin, 2001). Lowered gene expression of the growth factors BDNF and VEGF has also been reported in DG and CA1 regions in MDD (Duric et al., 2010); both of which are required for hippocampal LTP (Licht et al., 2011; Yoshii and Constantine-Paton, 2010). In addition a dysregulation of growth factor receptor phosphorylation and expression was reported in the hippocampus of depressed suicide subjects (Dwivedi et al., 2009a); this included a relatively increased expression of p75<sup>NTR</sup>, which is notable since proBDNF-p75<sup>NTR</sup> signaling may facilitate hippocampal LTD (Yoshii and Constantine-Paton, 2010).

Findings in the PFC seem similar to those in the hippocampus. Reductions in neuronal and glial sizes have been reported in the PFC in MDD (Price and Drevets, 2010; Rajkowska et al., 1999). Lowered expression of several synaptic proteins (e.g. VGLUT1, synaptophysin, synapsin 1, RAB and SNAP25) have been reported in the DLPFC (Gilbert-Juan et al., 2012; Kang et al., 2012; Martins-de-Souza et al., 2012). Lowered expression of transcripts for NMDAR subunits (GluN1 and 2A) was also found in the DLPFC of MDD subjects (Beneyto and Meador-Woodruff, 2008). In addition lowered expression of the postsynaptic protein PSD-95 and NMDAR subunits (GluN2A and 2B) was found in the anterior PFC (Feyissa et al., 2009). As above in the hippocampus, growth factor receptors were also dysregulated in the PFC (BA9) (Dwivedi et al., 2009a).

Findings in the amygdala support a somewhat opposite synaptic pathology to the regions above. For instance a large increase in the

expression of PSD-95 (128%) and GluN2A (115%) was reported in the lateral amygdala of a set of mostly male depressed subjects (13 M/1 F) (Karolewicz et al., 2009). Increased VGLUT-1 levels have also been reported in the amygdala in MDD (Varea et al., 2012). In contrast BDNF levels and transcripts for interneuron-related peptides were decreased in the amygdala in female MDD subjects (Guilloux et al., 2011). Another study also recently found decreased levels of interneuron-related synaptic markers in the basolateral and basomedial amygdala in MDD (Varea et al., 2012). These findings taken with the effects of stress in the amygdala discussed earlier may suggest a divergent pathological outcome for different cell types in the amygdala in depression. One could speculate that interneuron atrophy and loss of glia might particularly account for the lowered amygdala volume reported in unmedicated depressed patients (Hamilton et al., 2008; Savitz et al., 2010).

Other studies implicate synaptic pathology in less well-studied brain regions in MDD. Altered expression of synaptic proteins have been found in the visual association cortex (Beasley et al., 2005), temporal lobe (BA21) (Aston et al., 2005; Glantz et al., 2010) and striatum (Kristiansen and Meador-Woodruff, 2005). Lowered expression of AMPAR (GluR1 and 3) and NMDAR (GluN2A and 2B) transcripts was found in the perirhinal cortex in MDD (Beneyto et al., 2007); notably this study found no alterations in the hippocampus. Finally lowered expression of GluN1 was reported in the superior temporal cortex in MDD (Nudmamud-Thanoi and Reynolds, 2004).

#### 4. Signaling pathways underlying altered plasticity in depression

##### 4.1. Signal transduction pathways involved in synaptic plasticity

A large array of signal transduction pathways are involved in synaptic plasticity. These pathways regulate processes including protein trafficking, translation and gene transcription to achieve functional and structural changes to plasticity. Signal transduction pathways involved in synaptic plasticity have been best studied with regards to hippocampal LTP. Central to the induction of LTP is propagation of an intracellular  $\text{Ca}^{2+}$  signal from synapse to nucleus. Along the way many signaling pathways are activated both directly and indirectly, in a spatial and temporal-dependent manner (Bengtson and Bading, 2012; Kim et al., 2011b). NMDARs crucially gate this  $\text{Ca}^{2+}$  signal during LTP. Following appropriate synaptic activity initial  $\text{Ca}^{2+}$  influx through NMDARs activates multiple pathways involved in LTP (Fig. 2). These include  $\text{Ca}^{2+}$ /calmodulin-dependent kinase (CaMK) isoforms (Bengtson and Bading, 2012), neuronal nitric oxide synthase (nNOS) signaling (Feil and Kleppisch, 2008), extracellular signal-regulated kinase (ERK), and protein kinase B (Akt) pathways (Patterson and Yasuda, 2011; Qin et al., 2005). In addition  $\text{Ca}^{2+}$ /calmodulin sensitive adenylyl cyclase (AC) isoforms which regulate the protein kinase A (PKA) pathway are also required for LTP (Abel and Nguyen, 2008; Kim et al., 2011b; Wang, 2003); accordingly NMDARs may increase cAMP-PKA signaling (Banko et al., 2004; Mockett et al., 2004; Valera et al., 2008; Wang, 2003).

Other surface-level signaling systems which couple to some of these pathways are also recruited during synaptic plasticity. In this regard BDNF-TrkB signaling has been best studied. BDNF release is dependent upon  $\text{Ca}^{2+}$  influx through NMDARs and VDCCs as well as further release from intracellular ryanodine-sensitive stores (Jourdi et al., 2009; Kolarow et al., 2007). Such intracellular  $\text{Ca}^{2+}$  release may involve nNOS-NO signaling (Lu and Hawkins, 2002). BDNF release is also dependent upon CaMKII and gated by PKA activity (Kolarow et al., 2007). In addition TrkB expression is increased by NMDAR signaling (Du et al., 2000), whilst TrkB phosphorylation is dependent on NO signaling (Gallo and Iadecola, 2011). Postsynaptic BDNF-TrkB signaling couples to activation of Ras-ERK, PI3K-Akt and phospholipase C (PLC) pathways. BDNF also acts presynaptically to promote further glutamate release (Yoshii and Constantine-Paton,

2010). Notably NMDAR and BDNF-TrkB signaling may cooperatively activate PI3K-Akt (Xu et al., 2007) and other downstream pathways (Martin and Finsterwald, 2011). Several G protein-coupled receptors also participate in synaptic plasticity. For instance NMDAR activation triggers the secretion of Wnt proteins which activate Frizzled receptors and regulate intracellular GSK-3 signaling. GSK-3 is a constitutively active kinase which must be inhibited during LTP. GSK-3 can be inhibited through phosphorylation by various kinases (Bradley et al., 2012); recently it was reported that Akt and Wnt-Frizzled signaling may converge to inhibit GSK-3 $\alpha$  during L-LTP in the mature rodent hippocampus (Ma et al., 2011) (Fig. 3). Other G protein-coupled receptors can modulate plasticity via regulation of the cAMP-PKA pathway. For instance D<sub>1</sub>-PKA signaling is required for LTP (Granado et al., 2008; Gurden et al., 2000; Navakkode et al., 2007). Further, the PKA pathway is also capable of activating ERK with which it may operate in parallel (Banko et al., 2004; Dwivedi and Pandey, 2011; Waltereit and Weller, 2003). Ultimately all these upstream signal transduction pathways initiated by surface-level receptors may engage in significant cross-talk and cooperation to induce synaptic plasticity. Certainly AMPAR subunit phosphorylation and trafficking during LTP involves all the pathways above.

The later stages of LTP are dependent upon both protein translation and gene transcription, which similarly involves the participation of multiple signaling pathways. During LTP, protein synthesis is required to supply new proteins for functional and structural changes to plasticity. In this regard the mammalian target of rapamycin (mTOR) pathway plays a central role in the regulation of translation initiation and is required for L-LTP expression in the hippocampus (Tang et al., 2002). mTOR is known to regulate both dendritic and somatic protein synthesis in neurons (Hoeffer and Klann, 2010). Examples of mTOR translation targets include CaMKII, MAP2, PSD-95 and GluR1 (Gong et al., 2006; Lee et al., 2005; Slipczuk et al., 2009). Various upstream signaling pathways have been shown to regulate mTOR activity. mTOR signaling is activated by ERK, PI3K-Akt, PDK1 and Tsc1/2 signaling (Hoeffer and Klann, 2010), whilst mTOR is inhibited under basal conditions by GSK-3 (Ma et al., 2011). Complementing the regulation of translation during LTP, the late phase of LTP is also dependent upon gene transcription. The best studied transcription factor involved in LTP is cAMP response element-binding protein (CREB) (Bengtson and Bading, 2012). CREB is a major hub of activity-dependant neuronal gene expression (Benito et al., 2011) and is required for the maintenance of L-LTP (Wu et al., 2007). Accordingly CREB target genes include those crucial to synaptic plasticity such as BDNF and its cognate receptor TrkB (Deogracias et al., 2004), Wnt2 (Wayman et al., 2006) and glutamate receptor subunits (Lau et al., 2004; Traynelis et al., 2010). CREB activation is a multistep process involving nuclear  $\text{Ca}^{2+}$  signaling and many of the signaling pathways described above (Fig. 3). Notably genomic glucocorticoid signaling may also directly regulate CREB (Anacker et al., 2011; Datson et al., 2012).

Less work has been done so far to elucidate the signal transduction pathways underlying LTD, and similarly these pathways have received less attention in depression. A full list of pathways involved in NMDAR-dependent LTD in the hippocampus to date is included in Supplement 1. Most similarly to LTP,  $\text{Ca}^{2+}$  and NOS signaling are involved in LTD (Feil and Kleppisch, 2008). Beyond this however LTD involves the recruitment of other signaling pathways and opposite regulation of many of those involved in LTP. Most centrally implicated in LTD are phosphatases such as protein phosphatase 1 (PP1) and 2 (PP2). These phosphatases work in opposition to the kinase-mediated phosphorylation during LTP. In particular PP1 dephosphorylates GSK-3 facilitating its increased activity during LTD (Peineau et al., 2007). Furthermore CREB is deactivated during hippocampal LTD and NMDAR<sub>2B</sub> activation via PP1, PP2A and GSK-3 pathways (Mauna et al., 2011; Szatmari et al., 2005). Consistent with the need for increased GSK-3 activity, the PI3K-Akt pathway is negatively

regulated by phosphatase and tensin homologue (PTEN) during LTD (Jurado et al., 2010). Moreover another PI3K isoform (PI3K $\gamma$ ) may actually play a role in LTD and signal independently of Akt; in this pathway PI3K $\gamma$  may activate P38MAPK (Kim et al., 2011a).

Changes to these signaling pathways above may underlie changes to functional and structural plasticity in depression. Several papers have individually reviewed some of the signal transduction pathways described above in mood disorders (Blendy, 2006; Dhir and Kulkarni, 2011; Dwivedi and Pandey, 2011; Li and Jope, 2010). However less work has been done to connect changes between all these pathways. As such the following sections will review changes occurring to some of these key pathways in depression, first in the PFC and hippocampus and subsequently other less well studied brain regions such as the amygdala and NAc. Changes to signal transduction pathways in the PFC, hippocampus and amygdala in humans and stress models are summarised in Table 1. Importantly changes to these pathways in depression may apply to neurons and/or glia. Indeed signaling pathways mediating changes to neurons are also common to glia (Arai and Lo, 2010; Ghosh et al., 2005; Kim et al., 2007; Kong et al., 2008; Murray et al., 2009) where they may mediate common functions. It is also worth noting that many signaling pathways are also subject to developmental regulation (Corlew et al., 2007; Larsen et al., 2011; Ma et al., 2011; Yang et al., 2009) which has particular relevance to behavioural models using immature rodents.

## 4.2. The PFC and hippocampus: signaling changes in depression

### 4.2.1. nNOS-NO

Two post-mortem studies found increased expression of nNOS in the hippocampus (CA1 and subiculum) in MDD subjects (Oh et al., 2010; Oliveira et al., 2008). In behavioural models CMS increases nNOS expression in the hippocampus (DG, CA1 and CA3), whilst inhibition of nNOS prevents the negative behavioural and neuroplastic effects of CMS (Lian and An, 2010; Yazir et al., 2012; Zhou et al., 2007, 2011); however it is notable that ERK was activated and iNOS was not in one of these models (Zhou et al., 2011) which contradicts other findings discussed later. In extension to findings in the hippocampus a chronic stress/neurosis model was also found to increase nNOS expression in the neocortex (Khovryakov et al., 2010). Attenuation of the NO signaling pathway has further been implicated in the antidepressant-like activity of various drug classes in acute tests (Dhir and Kulkarni, 2011; Krass et al., 2010; Zomkowski et al., 2010) and a chronic despair model (Kumar et al., 2010); although studies in better validated chronic stress models are lacking. Moreover whilst excessive endogenous NO generation robustly associates

with stress and depression, exogenous NO delivery has been found to reverse the depression-like behaviour and inhibition of neurogenesis induced by chronic stress (Hua et al., 2008); this contrary action likely reflects the bidirectional nature of NO signaling.

### 4.2.2. cAMP-PKA

Post-mortem studies have found lowered PKA subunit expression and activity in the PFC (BA10) in MDD/suicide (Dwivedi and Pandey, 2011; Shelton et al., 2009a, 2009b). Paralleling these findings, in behavioural models chronic glucocorticoid administration lowered PKA subunit expression and activity in the cortex and hippocampus (Dwivedi and Pandey, 2000); a learned helplessness paradigm was associated with similar changes (Dwivedi et al., 2004). In other CMS-type models PKA expression and activity decreases in the hippocampus, whilst antidepressants increase PKA activity in the PFC and hippocampus (Wang et al., 2006b; Wu et al., 2008; Zheng et al., 2008). Additionally acute treatment with both a TCA and NMDAR antagonist was found to boost pPKA in the PFC and hippocampus (Réus et al., 2011).

### 4.2.3. Ras-ERK

The ERK pathway represents the best studied MAPK signaling pathway in depression. Post-mortem studies have found evidence of decreased Raf-ERK1/2 signaling in the PFC and hippocampus in suicide/MDD (Duric et al., 2010; Dwivedi et al., 2001, 2006, 2009b; Yuan et al., 2010). In addition decreased hippocampal MEK5–ERK5 signaling was also found in suicide subjects (Dwivedi et al., 2007). Consistent with decreased ERK activity in depression increased expression of MAPK phosphatase (MKP), a negative regulator of the MAPK cascade, has also been reported. MKP-2 was increased in the PFC and hippocampus in depressed suicide subjects (Dwivedi et al., 2001) and MKP-1 increased in the hippocampus (DG and CA1) in MDD (Duric et al., 2010). Paralleling these findings behavioural models have been shown to modulate the ERK pathway. Indeed various chronic stresses can decrease ERK1/2 signaling in the PFC and hippocampus, which can be reversed by antidepressants (Duric et al., 2010; First et al., 2011; Gourley et al., 2008; Qi et al., 2006, 2008; Xiong et al., 2011). Further, a CUS model increased MKP-1 expression in the hippocampus (DG and CA3), whilst decreased levels were associated with stress resistance and antidepressant-like effects (Duric et al., 2010). Acute MEK inhibition has also been shown to induce depressive behaviour and block the behavioural effects of monoaminergic antidepressants (Duman et al., 2007). PFC ERK1/2 signaling is further crucial to the activity of rapid-acting antidepressants (Li et al., 2010b). However a few contrary findings to those above exist, a

**Table 1**

An overview of changes to signal transduction pathways in several brain regions in depression as determined by human and animal studies (citations in text). Symbols:  $\uparrow$ , increased activity;  $\downarrow$ , decreased activity.

| Brain region | Human studies: MDD   | Animal studies: chronic stress models  | Animal studies: antidepressant administration   |
|--------------|--|--|---|
| PFC          | $\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt<br>$\uparrow$ GSK-3 $\beta$<br>$\downarrow$ mTOR<br>$\downarrow$ CREB | $\uparrow$ nNOS (neocortex)<br>$\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt (frontal cortex)<br>$\uparrow$ GSK-3 $\beta$<br>$\rightarrow/\downarrow$ mTOR<br>$\downarrow$ CREB | $\downarrow$ PKA (SSRI, TCA, NMDAR antagonist)<br>$\uparrow$ ERK (SSRI, SSRE, NMDAR antagonist)<br>$\uparrow$ Akt (TCA, NMDAR antagonist, lamotrigine)<br>$\downarrow$ GSK-3 $\beta$ (SSRI, TCA, NMDAR antagonist)<br>$\uparrow$ mTOR (NMDAR & mGluR2/3 antagonists)<br>$\uparrow$ CREB (SSRI, TCA) |
| Hippocampus  | $\uparrow$ nNOS<br>$\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt<br>$\uparrow$ GSK-3 $\beta$<br>$\downarrow$ CREB   | $\uparrow$ nNOS<br>$\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt<br>$\uparrow$ GSK-3 $\beta$<br>$\downarrow$ CREB   | $\downarrow$ nNOS (neuropeptide Y)<br>$\uparrow$ PKA (SSRI, TCA, NMDAR antagonist)<br>$\uparrow$ ERK (SSRI, TCA)<br>$\uparrow$ Akt (SSRI, TCA, lamotrigine)<br>$\downarrow$ GSK-3 $\beta$ (SSRI, SNRI, lithium, NMDAR antagonist)<br>$\downarrow$ CREB (SSRI, SSRE, TCA)                            |
| Amygdala     | $\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt<br>$\downarrow$ mTOR?   | $\downarrow$ PKA<br>$\downarrow$ ERK<br>$\downarrow$ Akt<br>$\downarrow$ mTOR?   | $\uparrow$ PKA (TCA, NMDAR antagonist)<br>$\uparrow$ ERK (TCA)<br>$\uparrow$ Akt (TCA, lamotrigine)<br>$\downarrow$ CREB (SSRI, TCA, NMDAR antagonist)  |

couple of CUS models failed to alter ERK and Akt signaling in the PFC or hippocampus (Chandran et al., 2012; Li et al., 2009) whilst CMS increased hippocampal ERK activity (Zhou et al., 2011).

#### 4.2.4. PI3K-Akt

Several findings suggest lowered Akt activity may parallel lowered ERK activity in depression. Post-mortem studies have suggested there is lowered activity of the PI3K-Akt signaling pathway and increased PTEN levels in the ventral PFC in MDD/suicide (Karege et al., 2007, 2011). Vulnerability to CMS was associated with decreased hippocampal Akt signaling, which was reversed by antidepressant administration (Briones et al., 2012). Long-term corticosterone treatment was reported to increase PTEN and lower Flk1-PI3K-Akt-mTOR signaling in the frontal cortex (Howell et al., 2011). In extension to these findings various antidepressant classes have been shown to increase Akt signaling in the PFC and hippocampus (Abelaira et al., 2011; Li et al., 2010b; Okamoto et al., 2010).

#### 4.2.5. GSK-3

Consistent with reduced Akt activity, an increasing body of research associates depression with increased GSK-3 signaling. Increased GSK-3 $\beta$  expression correlated with nNOS expression in the post-mortem hippocampus of depressives (Oh et al., 2010). In addition decreased pGSK-3 $\beta$  and  $\beta$ -catenin has been reported in the ventral PFC of depressed individuals, suggesting increased GSK-3 $\beta$  activity (Karege et al., 2007, 2012). In contrast another study found no difference in the levels of GSK-3 $\beta$  and  $\beta$ -catenin in the PFC (Beasley et al., 2002); these findings may suggest GSK-3 $\beta$  activity rather than expression is most affected in MDD (Karege et al., 2007). In behavioural models GSK-3 has been shown to be affected by stress and antidepressants. For instance prenatal stress decreases GSK-3 $\beta$  phosphorylation in the frontal cortex (Szymańska et al., 2009). CMS increases GSK-3 $\beta$  expression the hippocampus (Silva et al., 2008). Another study found that chronic, but not acute, stress decreased levels of pGSK-3 $\beta$  and  $\beta$ -catenin in the mPFC, an effect reversed by chronic administration of an SSRI (Chen et al., 2012b). Various other studies have implicated inhibition of GSK-3 in the activity of antidepressants. GSK-3 $\beta$  phosphorylation is increased by selective 5-HT<sub>1A</sub> activation and monoaminergic antidepressants in the PFC (Li et al., 2004). Another study reported that monoaminergic antidepressants and ECS regulate components of the Wnt/ $\beta$ -catenin cascade (especially Wnt2) and increase GSK-3 $\beta$  phosphorylation in the hippocampus; furthermore local expression of Wnt2 in the hippocampus produced antidepressant-like responses (Okamoto et al., 2010). The antidepressant activity of ketamine is also associated with GSK-3 $\alpha/\beta$  inhibition in the cerebral cortex and hippocampus (Beurel et al., 2011).

#### 4.2.6. mTOR

The mTOR pathway is a relatively recent pathway to be associated with depression (Li et al., 2010b). A recent post-mortem study reported that mTOR signaling was decreased in the anterior PFC in MDD (Jernigan et al., 2011). Behavioural models have implicated the mTOR pathway in the effects of stress and antidepressant mechanisms. Long-term continuous corticosterone treatment was reported to dysregulate VEGF expression and decrease PI3K-Akt-mTOR signaling in the frontal cortex (Howell et al., 2011). However CUS did not alter PFC or hippocampal mTOR signaling in other studies (Chandran et al., 2012; Li et al., 2011). The rapid antidepressant activity of NMDAR antagonists was reported to involve ERK and Akt-dependant mTOR activation and reversal of a stress-induced decrease in synaptic proteins in the mPFC (Li et al., 2010b); a subsequent study extended these findings to a CUS model (Li et al., 2011). Increased mTOR signaling has further been reported to be involved in the rapid antidepressant-like activity of mGluR<sub>2/3</sub> antagonists (Dwyer et al., 2012). In particular BDNF-TrkB and mTOR signaling are involved in the sustained but not

acute activity of ketamine and mGluR<sub>2/3</sub> antagonists (Koike et al., 2011, 2012). In accordance with this another study did not find a requirement for increased hippocampal mTOR signaling in the rapid antidepressant activity of NMDAR antagonists, which was instead dependent upon rapid BDNF translation (Autry et al., 2011). In this study the behavioural studies were done at an earlier time point (30 min) than those above; different testing methods may also contribute to the contrasting results (Duman and Voleti, 2012). Another finding which requires reconciliation is that sub-chronic administration of rapamycin, the major mTOR inhibitor, has demonstrated antidepressant activity (Cleary et al., 2008). This paradoxical finding may relate to the acute testing involved and systemic rapamycin administration which might have indirect effects on the brain. Notably central administration of rapamycin had no effects in behavioural tests after chronic stress (Li et al., 2011).

#### 4.2.7. CREB

CREB represents the best studied transcription factor in depression. Post-mortem studies have suggested there is lowered CREB function in the PFC (Dwivedi et al., 2003; Pandey et al., 2007; Yamada et al., 1996; Yuan et al., 2010) and hippocampus (DG and CA1) in MDD/suicide subjects (Duric et al., 2010). Most behavioural studies using chronic stress models have also shown evidence of lowered CREB activity. CUS/CMS paradigms lower CREB activity in the PFC and hippocampus (DG) (Grønli et al., 2006; Li et al., 2009, 2010a), whilst antidepressants reverse these changes (Laifenfeld et al., 2005; Song et al., 2006; Wang et al., 2006b). Similarly other chronic stress models such as chronic forced swim (Qi et al., 2008), foot shock (Lin et al., 2008, 2009) and CRS (Alfonso et al., 2006) can also lower CREB activity. Other studies report that chronic antidepressant administration increases CREB activity in the PFC and hippocampus (DG and CA3) (Pinnock et al., 2010; Thome et al., 2000). In addition combined TCA and ketamine treatment increased CREB expression (Réus et al., 2011). Recently deletion of CRTC1 was also associated with multiple depression-like behaviours and reduced expression of BDNF/TrkB in the PFC (Breuillaud et al., 2012). Together these studies suggest lowered CREB function is important to depression; however several other behavioural models contradict those above. Chronic psychosocial stress (Böer et al., 2010) and several CRS models (Bravo et al., 2009; Miller et al., 2007; Reagan et al., 2007) have been reported to increase pCREB, which can be prevented/reversed by antidepressants. These reports highlight sensitivity to testing paradigms.

Taken together the signaling studies reviewed above clearly implicate general disruption of positive plasticity within subregions of the PFC and hippocampus in depression, which may apply to both neurons and glia. Indeed depression generally associates with increased nNOS activity, reduced activation of PKA, ERK and Akt pathways, increased activation of GSK-3 and perhaps more tentatively with reduced activation of mTOR and CREB (Table 1). The fragmented findings and differing methodology between studies prohibit a robust sub-region or cell-type specific corollary assessment of these signaling changes; however at a very basic regional level changes to signal transduction pathways in depression seem consistent with their interactions during synaptic plasticity in hippocampal neurons (Fig. 3). For instance PI3K-Akt signaling suppresses GSK-3 activity. Both mTOR and CREB are inhibited by GSK-3. mTOR activation involves both ERK and Akt pathways, and CREB activation involves PKA and ERK pathways. However interactions between the nNOS pathway and others are less clear. The nNOS pathway can mediate positive or negative changes to plasticity (Feil and Kleppisch, 2008), each of which may involve the activation of other pathways such as ERK and P38 respectively. Given the negative changes to neuroplasticity occurring in depression, how might nNOS signaling interact with other pathways discussed above? One possibility involves activation of extrasynaptic NMDARs which activate nNOS as well as various pathways mediating negative changes to plasticity (Hardingham and Bading, 2010; Xu et al., 2009). This

possibility is consistent with metabolic and glial pathology in depression which may ultimately reduce glutamate uptake, as discussed later.

In summary signaling studies in the PFC and hippocampus correlate other cellular changes reported in depression, which collectively are consistent with an overall reduction in positive changes to neuroplasticity (i.e. LTP, growth and resilience). Further, changes to other signaling pathways such as GSK-3, PTEN, CREB and caspase could be consistent with negative changes to neuroplasticity (i.e. LTD, retraction and vulnerability) (Jurado et al., 2010; Li et al., 2010c; Mauna et al., 2011). Importantly, alterations to all these pathways are likely representative of an overall shift in the molecular and cellular mechanisms mediating changes to synaptic and structural plasticity. Certainly other signaling proteins such as PKC, CaMKII, JNK and P38 have been implicated in stress and depression although have been omitted from this review due to a lack of studies in humans and/or chronic stress models. In addition the tight coupling between neurons and glia, and the marked glial pathology in depression (Banar et al., 2010) suggests alterations to common pathways are relevant to both cell types in the PFC and hippocampus.

#### 4.3. Other brain regions: the amygdala and NAC

As reviewed earlier several findings suggest the amygdala may have a different pathology to the PFC and hippocampus in depression. This may involve growth of some excitatory connections concurrent with loss of inhibitory ones. Only a few studies have reported on the activity of signal transduction pathways in the amygdala in depression. A maternal deprivation model linked increased amygdala MEK-ERK signaling with depressive-like behaviours (Huang and Lin, 2006). Expression manipulation studies have associated increased PKA and CREB activity in the BLA with anxiogenic and depressive-like behaviours (Keil et al., 2012; Wallace et al., 2004). A CUS paradigm was associated with lowered ERK, Akt and mTOR signaling and GluR1 phosphorylation in the amygdala (Chandran et al., 2012); notably these pathways were not altered in the PFC and hippocampus in this model. Given the oppositional changes that may occur in the amygdala in depression it is difficult to correlate these changes to structural studies. Overall changes in the amygdala may also be highly sensitive to stress type and depression duration. Interestingly various antidepressants may increase the activity of signaling pathways mediating positive changes to synaptic plasticity in the amygdala (Abelaira et al., 2011; Gourley et al., 2008; Réus et al., 2011; Thome et al., 2000) (Table 1). This action of antidepressants may account for the increased amygdala volume in medicated MDD and BD patients (Hamilton et al., 2008; Savitz et al., 2010). It would be interesting to see if this was the result of antidepressant-induced hypertrophy of GABAergic interneurons as discussed later.

The nucleus accumbens (NAC) is another important brain region to the neurobiology of depression. This region has mainly been studied with respect to expression manipulation studies, where some findings seem opposite to the hippocampus. For instance increasing expression of CREB and BDNF in the NAC has pro-depressive (e.g. anhedonia) effects whilst the reverse associates with antidepressant-like effects (Muschamp et al., 2011; Shirayama and Chaki, 2006). However some other recent findings might seem more similar to other brain regions. For instance increasing GSK-3 $\beta$  activity in the NAC increased pro-depressive behaviour (Wilkinson et al., 2011). In addition vulnerability to CUMS and resulting depressive behaviour was associated with decreased GDNF expression in the NAC (Uchida et al., 2011).

### 5. Metabolic dysfunction and synaptic plasticity in depression

#### 5.1. Energy metabolism

Changes to cellular plasticity may correlate those to metabolic systems in stress and depression; a preliminary discussion on this

important area is included here. Most centrally, neuroplasticity is intrinsically linked to energy metabolism in the brain (Cheng et al., 2010). Increasing research shows how energetic pathways are involved in multiple forms of synaptic plasticity. For instance glial-derived lactate is required for hippocampal L-LTP (Suzuki et al., 2011) and potentially facilitates memory formation (Newman et al., 2011). Astroglial ATP release and P2Y receptor activation mediates heterosynaptic LTD, a form of LTD which spatially sharpens LTP (Chen et al., 2012a). Moreover, early activation of the apoptosis pathway and caspase release from mitochondria is required for LTD in CA1 (Li et al., 2010c). The dependence upon energy for positive changes to plasticity is further emphasised by signaling-based control of mitochondrial function. Signaling pathways mediating positive changes to neuroplasticity (e.g. NMDAR, PKA, Akt and ERK) bolster mitochondrial function/redox, whilst the opposite may be true of those mediating negative changes (e.g. PP2A, GSK-3 and ExNMDAR) (Dhar and Wong-Riley, 2011; Dickey and Strack, 2011; Gimenez-Cassina et al., 2009; Hardingham and Bading, 2010; Liu et al., 2012; Valerio et al., 2011; Verburg and Hollenbeck, 2008).

Several studies suggest energy metabolism is impaired in depression. A CMS model was found to inhibit energy metabolism in the cerebral cortex and cerebellum, which was reversed by ketamine treatment (Rezin et al., 2009). A recent post-mortem study found altered expression of various proteins involved in oxidative phosphorylation and lowered ATP levels in the DLPFC of MDD subjects (Martins-de-Souza et al., 2012). Furthermore, a recent MRSI study found an inverse correlation between ventricular lactate and cortical glutathione in MDD, potentially linking disruptions in energy and redox (Shungu et al., 2012). Given the basic reciprocal and corollary relationships between neuroplasticity and energy, lowered energy metabolism would be particularly expected to hinder positive changes to synaptic plasticity. This could in part be mediated through early homeostatic signaling mechanisms. For instance lowered ATP levels promote extracellular adenosine 1 (A<sub>1</sub>) receptor activation and intracellular AMP-activated kinase (AMPK) activation. Indeed under low energy conditions AMPK inhibits the mTOR translation pathway (Potter et al., 2010). However under pathological conditions other mechanisms may be important such as disturbed glutamate uptake as discussed below.

#### 5.2. Redox

Cellular reduction-oxidation (redox) reactions also critically regulate synaptic plasticity. Moderate levels of reactive oxygen species (ROS) are actually required for LTP; however good antioxidant status is also required for efficient synaptic plasticity (Massaad and Klann, 2011). Accordingly signaling pathways mediating positive changes to neuroplasticity also buffer cellular antioxidant systems (Hardingham and Bading, 2010; Valerio et al., 2011). In contrast, lowered levels of critical antioxidants such as glutathione, or increased levels of ROS and reactive nitrogen species (RNS) impair synaptic plasticity (Massaad and Klann, 2011; Robillard et al., 2011). For example perturbed redox can directly restrict positive plasticity through oxidation of CaMKII (Bodhinathan et al., 2010).

Many behavioural and human studies now suggest redox is impaired in the brain and periphery in depression; for reviews see (Behr et al., 2012; Maes et al., 2011a). In particular depression severity and cognitive performance has been reported to correlate altered plasma redox markers in MDD patients (Talarowska et al., 2012a, 2012b). In behavioural models CMS induces oxidative stress in the cerebral cortex and hippocampus (Moretti et al., 2012). This oxidative stress likely results in part from activation of iNOS (Munhoz et al., 2008; Olivenza et al., 2000; Peng et al., 2012). Certainly chronic stresses induce iNOS expression in the cortex and hippocampus (CA1 and CA3) (Khovryakov et al., 2010; Lian and An, 2010; Olivenza et al., 2000; Peng et al., 2012), whilst iNOS inhibition prevents the negative neuroplastic and behavioural effects of chronic stress (Peng et al., 2012; Seo et al., 2012; Wang et al., 2012).

2008). NADPH oxidase may also contribute to stress-induced oxidative stress; this pathway is required for CRS-induced depressive behaviour (Seo et al., 2012). Finally the increased MAO-A activity in MDD (Meyer et al., 2009) might be a further source of ROS.

Brain oxidative stress in depression is likely to directly impair synaptic plasticity through modification of protein function as described above. In addition increased oxidative stress may also act indirectly through disruption of mitochondrial function; consistent with the inverse correlation between ventricular lactate and cortical glutathione in MDD (Shungu et al., 2012). For example pathological iNOS activation can inhibit cytochrome oxidase (Brown and Neher, 2010). Whilst chronic oxidative damage to cellular and mitochondrial lipids may impair cerebral blood flow (Shungu et al., 2012) and reduce efficiency of the electron transport chain (Nicolson, 2010; Nicolson and Ellithorpe, 2006). Moreover oxidative stress and depletion of glutathione may also impair brain methylation function (Waly et al., 2011). Together all these metabolic disturbances might promote various pathological processes which disrupt neuronal and glial plasticity. For instance disturbed glial metabolism might particularly hinder glutamate uptake and promote inappropriate recruitment of extrasynaptic NMDARs (Marsden, 2011); extrasynaptic NMDAR activation can restrict positive synaptic plasticity (Scimemi et al., 2009) and further induce negative changes to neuroplasticity (Hardingham and Bading, 2010). Certainly glutamate uptake is impaired in depression (Popoli et al., 2012) and iNOS inhibition prevented the impaired synaptic glutamate uptake in a repeat stress model (Olivenza et al., 2000). Taken together the studies above suggest changes to energy and redox in depression may precede and parallel those to synaptic plasticity; although further research is required to clarify this putative relationship.

## 6. What are the functional implications of altered synaptic plasticity in depression?

Altered synaptic plasticity in depression has major functional implications with regards to both cognition and emotion. What follows is a brief discussion on this topic, a deeper discussion being beyond the scope of this paper.

The studies reviewed throughout this paper most robustly support a state of disrupted positive plasticity in the PFC and hippocampus in depression, although less clear are the exact subregions affected and changes to other brain regions. The obvious immediate consequence of such disruption may be altered region-associated memory and learning, i.e. cognition. Indeed in behavioural models CUS disruption of LTP in the PFC is associated with learning and memory deficits (Quan et al., 2011b). Similarly CUS impairment of hippocampal-PFC plasticity was associated with impaired memory and behavioural flexibility (Cerqueira et al., 2007). In addition the reduction in BDNF and CREB signaling pathways in the PFC and hippocampus induced by CMS, CUS and learned helplessness paradigms is associated with impaired spatial learning and memory (Li et al., 2009; Song et al., 2006). Disruptions to short-term memory and hippocampal AMPAR subunit ratio (incl. low GluR1) have also been reported to correlate vulnerability to chronic social stress and resulting depressive-like behaviour (Schmidt et al., 2010). Perhaps consistent with these findings, in MDD cognitive deficits relating to concentration, attention, memory and other areas of executive function have been frequently although heterogeneously reported (Baune et al., 2010); for review see (Murrough et al., 2011).

Whilst an obvious logical link between synaptic plasticity and cognition exists, less well realised is the potential for altered synaptic plasticity to disrupt emotional memory and learning which may be key to mood disorders. In this regard negative synaptic changes in the PFC and hippocampus in depression will further interact with those in other brain regions. Indeed subregions of the PFC and hippocampus are heavily interconnected with one another and many other brain regions such as the amygdala. The interactivity between these regions has particularly been studied with respect to behavioural

fear conditioning and extinction paradigms. In these paradigms prelimbic (PL) and infralimbic (IL) mPFC, ventral hippocampus and BLA play dissociable roles (Peters et al., 2009; Sierra-Mercado et al., 2011). In the amygdala fear conditioning involves positive plasticity in the BLA (Merino and Maren, 2006) whilst increased amygdala GABAergic tone may be important for extinction (Mañko et al., 2011). PL and IL regions of the mPFC project differentially to the amygdala and distinctly drive fear expression and extinction respectively; a similar dichotomy exists for mPFC-NAc connectivity (Peters et al., 2009). Accordingly positive plasticity in the PFC correlates fear extinction (Lai et al., 2012), and enhancement of IL-mPFC and hippocampal synaptic plasticity is associated with enhanced retention of fear extinction (Abumaria et al., 2011).

This PFC-hippocampal-amygdala circuitry is likely dysfunctional in depression. For instance CRS disrupts inhibitory interneuron tone in the LA and BLA (Gilbert-Juan et al., 2011) and leads to amygdala hyperexcitability (Rosenkranz et al., 2010). Furthermore BLA activation is required for stress-induced disruption of hippocampal LTP (DG and CA1) (Kim et al., 2005; Li and Richter-Levin, 2012). As reviewed earlier MDD is associated with similar morphological changes in the amygdala, and increased amygdala activity and reactivity has also been reported (Price and Drevets, 2010). This increased amygdala activity in depression may also relate to inefficient PFC function. For instance in healthy human subjects left vmPFC grey matter thickness inversely correlates amygdala reactivity in response to emotional tasks (Foland-Ross et al., 2010). In MDD a disconnectivity has been reported between the PFC and amygdala. As such dysfunctional prefrontal-subcortical circuitry has been suggested to result in decreased cognitive control of emotion, resulting in the persistent negative emotional reactivity which characterises depression (Murrough et al., 2011). More recent studies are identifying altered connectivity between several other brain regions in MDD (Hamilton et al., 2011; Horn et al., 2010; Price and Drevets, 2010; Veer et al., 2010). It may be that this maladapted circuitry arises at least in part from altered synaptic plasticity.

With regards to treatment, antidepressants may achieve therapeutic benefit through direct control of limbic activity and through favourable modulation of inter-regional synaptic plasticity. For instance in the LA and BLA serotonin inhibits excitatory activity via stimulation of 5-HT<sub>2/3</sub> receptors on GABAergic interneurons (Jiang et al., 2009; Stein et al., 2000; Stutzmann and LeDoux, 1999). Furthermore, it could be speculated that this stimulation might promote LTP and growth of interneuron synapses which could then contribute to the increased amygdala volume in depressed patients receiving treatment (Hamilton et al., 2008; Savitz et al., 2010). Thus direct suppression of amygdala activity and disinhibition of other cortical regions could be important to the therapeutic activity of serotonergic drugs. In contrast other antidepressants may primarily promote PFC suppression of the amygdala. Certainly the activity of rapid-acting antidepressants such as NMDAR and mGluR<sub>2/3</sub> antagonists is dependent upon positive plasticity in the mPFC (Dwyer et al., 2012; Li et al., 2010b). In addition stimulation of the mPFC was also reported to have potent antidepressant-like effects in a chronic social defeat model (Covington et al., 2010). Ultimately beyond this basic circuitry many other brain regions will be involved. Interestingly the rapid and potent antidepressant activity of the NMDAR antagonist ketamine was found to be accompanied by synaptic potentiation in the somatosensory cortex in treatment-resistant depression patients (Cornwell et al., 2012). Certainly the putative links between synaptic plasticity, maladapted neurocircuitry, cognition and emotion in depression should be an area for future research.

## 7. Concluding discussion

The importance of neuroplasticity to the pathophysiology and treatment of depression is well-established (Duman and Voleti,

2012; Pittenger and Duman, 2008). The aim of this paper was to further add to the characterisation of altered plasticity in depression and specifically from the point of view of synaptic plasticity. Certainly evidence reviewed in this paper suggests region-specific changes to synaptic form and function occur in depression. The PFC and hippocampus represent the best studied regions where functional and structural findings are consistent with a deficit in LTP, and neuronal and glial growth at excitatory synapses. Correlating these changes may particularly be those to glutamate receptors (AMPA and NMDARs), growth factor signaling (BDNF-TrkB) and several signal transduction pathways (NOS-NO, cAMP-PKA, Ras-ERK, PI3K-Akt, GSK-3, mTOR and CREB). In contrast other brain regions such as the amygdala may feature a somewhat opposite synaptic pathology including reduced inhibitory tone. Deficits in synaptic plasticity may further correlate disrupted brain redox and bioenergetics in depression. Together region-specific alterations to neuroplasticity in depression likely contribute to the maladapted neurocircuitry associated with a persistent depressive phenotype. Accordingly antidepressant mechanisms may involve favourable modulation of synaptic plasticity and adjustment of neurocircuitry. Indeed modulation of key signaling pathways involved in synaptic plasticity is required for the antidepressant-like activity of drugs known to be effective in humans (Duman et al., 2007; Li et al., 2010b; Warner-Schmidt and Duman, 2007). However it is also possible that a short-coming of current clinical antidepressants may be an inability to restore normal synaptic function in certain brain regions, and this could underlie treatment resistance and/or persisting cognitive deficits after remission of mood-related symptoms.

## B.1 Box 1

### B.2 Outstanding questions (Consists of the bullet points below)

- What are the full subregion specific alterations to synaptic plasticity occurring in the PFC and hippocampus in depression? Furthermore what is the synaptic pathology in other less studied brain regions in depression such as the ACC, amygdala and NAc?
- Which other signal transduction pathways are robustly altered in depression; for instance which pathways associated with negative changes to neuroplasticity (e.g. proBDNF-p75<sup>NTR</sup>, PP1, PP2A, JNK and P38)?
- What are the interactions between NO signaling and other signaling pathways in depression?
- To which cell types (e.g. neurons, interneurons, astrocytes and microglia) do signaling changes apply in different brain regions?
- Which signaling pathways mediate changes to the expression of key neurotransmitter systems (i.e. metabolic enzymes, receptors and transporters) in depression?
- What are the full interactions between energy, redox and neuroplasticity in depression, particularly with regards to neuronal-glial interactions (e.g. glutamate/gaba-glutamine cycling)?
- What effects does disrupted synaptic plasticity have on inter-regional connectivity in depression?
- To what extent are aetiological factors other than stress (e.g. nutrition (Gómez-Pinilla, 2008; Scapagnini et al., 2012) and neuro-inflammation (Eyre and Baune, 2012; Khairova et al., 2009; Kubera et al., 2011)) responsible for altered synaptic plasticity in depression?
- To what extent do alterations to signaling pathways, neuroplasticity and neurocircuitry in depression overlap with other neuropsychiatric disorders and comorbid conditions?

The reconceptualisation of depression from the point of view of synaptic plasticity has its roots in a previous hypothesis (Marsden, 2011) and may be able to integrate and reconcile many findings. However many information gaps and questions still remain which could be better clarified by future research (Box 1). In particular a better understanding of the interactions between synaptic plasticity and neurocircuitry may aid in a more complete overall neurobiological understanding of mood disorders. Moreover a better understanding of the major genetic, environmental and pathophysiological factors impinging upon neuroplasticity will inform aetiology and pathological heterogeneity, and ultimately logical approaches to the prevention and treatment of neuropsychiatric disorders and comorbid conditions (Gardner and Boles, 2010; Maes et al., 2011b; Marsden, 2011).

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <http://dx.doi.org/10.1016/j.pnpbp.2012.12.012>.

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