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# Medial reward and lateral non-reward orbitofrontal cortex circuits change in opposite directions in depression

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## **Abstract**

The first brain-wide voxel-level resting state functional-connectivity neuroimaging analysis of depression is reported, with 421 patients with major depressive disorder and 488 controls. Resting state functional connectivity between different voxels reflects correlations of activity between those voxels and is a fundamental tool in helping to understand the brain regions with altered connectivity and function in depression.

One major circuit with altered functional connectivity involved the medial orbitofrontal cortex BA 13, which is implicated in reward, and which had reduced functional connectivity in depression with memory systems in the parahippocampal gyrus and medial temporal lobe, especially involving the perirhinal cortex BA 36 and entorhinal cortex BA 28. The Hamilton Depression Rating Scale scores were correlated with weakened functional connectivity of the medial orbitofrontal cortex BA 13. Thus in depression there is decreased reward-related and memory system functional connectivity, and this is related to the depressed symptoms. The lateral orbitofrontal cortex BA 47/12, involved in non-reward and punishing events, did not have this reduced functional connectivity with memory systems.

Second, the lateral orbitofrontal cortex BA 47/12 had increased functional connectivity with the precuneus, the angular gyrus, and the temporal visual cortex BA 21. This enhanced functional connectivity of the non-reward/punishment system (BA 47/12) with the precuneus (involved in the sense of self and agency), and the angular gyrus (involved in language) is thus related to the explicit affectively negative sense of the self, and of self-esteem, in depression. A comparison of the functional connectivity in 185 depressed patients not receiving medication and 182 patients receiving medication showed that the functional connectivity of the lateral orbitofrontal cortex BA 47/12 with these three brain areas was lower in the medicated than the unmedicated patients. This is consistent with the hypothesis that the increased functional connectivity of the lateral orbitofrontal cortex BA 47/12 is related to depression.

Relating the changes in cortical connectivity to our understanding of the functions of different parts of the orbitofrontal cortex in emotion helps to provide new insight into the brain changes related to depression, which are considered in the Discussion.

## Introduction

Major depressive disorder is ranked by the World Health Organization as the leading cause of years-of-life lived with disability (Drevets, 2007, Gotlib and Hammen, 2009, Hamilton *et al.* , 2013). Major depressive episodes, found in both major depressive disorder and bipolar disorder are pathological mood states characterized by persistently sad or depressed mood. Major depressive disorders are generally accompanied by: (a) altered incentive and reward processing, evidenced by amotivation, apathy, and anhedonia; (b) impaired modulation of anxiety and worry, manifested by generalized, social and panic anxiety, and oversensitivity to negative feedback; (c) inflexibility of thought and behavior in association with changing reinforcement contingencies, apparent as ruminative thoughts of self-reproach, pessimism, and guilt, and inertia toward initiating goal-directed behavior; (d) altered integration of sensory and social information, as evidenced by mood-congruent processing biases; (e) impaired attention and memory, shown as performance deficits on tests of attention set-shifting and maintenance, and autobiographical and short-term memory; and (f) visceral disturbances, including altered weight, appetite, sleep, and endocrine and autonomic function (Drevets, 2007, Gotlib and Hammen, 2009).

The ability to measure brain function using non-invasive neuroimaging techniques has greatly enhanced our understanding of this illness (Rigucci *et al.* , 2010). Patients with depression show impairments in the coordinated activity of several brain regions considered to be important for several domains of mental functioning such as emotional processing (amygdala, subgenual anterior cingulate and pallidum) (Disner *et al.* , 2011, Sheline *et al.* , 2010), self-referential processes (medial prefrontal cortex (MPFC), precuneus and posterior cingulate cortex) (Kuhn and Gallinat, 2013, Price and Drevets, 2010, Sheline *et al.* , 2010), cognitive functions such as memory (hippocampus, parahippocampal cortex) (Lorenzetti *et al.* , 2009), visual processing (fusiform gyrus, lingual gyrus and lateral temporal cortex) (Veer *et al.* , 2010), and attention processing (dorsolateral prefrontal cortex, anterior cingulate cortex, thalamus and insula) (Hamilton *et al.* , 2012).

Research into the pathophysiology of depression has included the analysis of possible differences in the functional connectivity of different brain areas to elucidate some of the brain changes that may relate to depression. Resting-state fMRI provides a task-free approach that removes some performance-related confounds, and provides a reliable measure of ‘baseline’ brain activity and connectivity (Gusnard *et al.* , 2001). The functional connectivity is measured by the correlation between the fMRI BOLD signals in different brain areas when in the resting state, that is when no task is being performed. The concept is that the correlations may reveal evidence about which brain systems may interact differently in neuropsychiatric disorders (Deco and Kringelbach, 2014). There have been a number of resting state functional connectivity studies on depression (Iwabuchi *et al.* , 2015, Wang *et al.* , 2012). Most studies do not include large numbers of participants, and therefore there are insufficient data to allow voxel-level analysis, though this can be very important in helping to reveal exactly which cortical systems may be connected differently in mental disorders (Cheng *et al.* , 2015). There is an urgent need to use methods that will allow large-scale pooling of data to increase the statistical power to obtain voxel-level analysis, as well as to reduce the impact of heterogeneity in the patient population. A meta-analysis of previous investigations of resting state functional connectivity in depression was based on seed based studies each with tens of participants, and concluded as follows (Kaiser *et al.* , 2015). “Major depressive disorder was characterized by hypoconnectivity within the frontoparietal network, a set of regions involved in cognitive control of attention and emotion regulation, and hypoconnectivity between frontoparietal systems and parietal regions of the dorsal attention network involved in attending to the

external environment. Major depressive disorder was also associated with hyperconnectivity within the default network, a network believed to support internally oriented and self-referential thought, and hyperconnectivity between frontoparietal control systems and regions of the default network. Finally, the MDD groups exhibited hypoconnectivity between neural systems involved in processing emotion or salience and midline cortical regions that may mediate top-down regulation of such functions.” For comparison, the present study included almost as many participants as this meta-analysis, was not forced because of small numbers of participants to rely on *a priori*, seed-based analyses, and was able given the voxel-based approach to focus on particular brain regions, rather than brain systems identified for example as the ‘default mode network’ or ‘fronto-parietal control systems’.

Given this background, the objective of this investigation is to perform the first investigation using a voxel-based unbiased brain-wide association study (BWAS) approach on resting-state functional magnetic resonance imaging (fMRI) data in patients with major depressive disorder. The BWAS approach is modeled along the lines of genome-wide association studies (GWAS) where large genetic data sets are pooled to identify significant genetic variations in specific disorders. An aim of this investigation is to include a large number of participants in this neuroimaging research, to enable voxel-level accuracy, and robustness of the findings (Button *et al.*, 2013). In this investigation, the voxel-level resolution of the functional connectivity enabled differences of functional connectivity to be measured in nearby but functionally different parts of the orbitofrontal, and to reveal to exactly which voxels in other brain areas there was altered functional connectivity. The voxel-level analysis enabled this advance to be made. The value of the unbiased approach was that it enabled the functional connectivity between every pair of voxels in the brain to be measured, so that the findings were not limited by prior hypotheses.

## **Methods**

### **Participants**

There were 421 patients with a diagnosis of major depression, and 488 controls. The patients were from Taiwan (Veteran General Hospital, Taipei), Dongei (Department of Psychiatry, First Affiliated Hospital of China Medical University and the Mental Health Center of Shenyang, China) and Xinan (First Affiliated Hospital of Chongqing Medical School in Chongqing, China). All participants were diagnosed according to the Diagnostic and Statistical Manual of Mental Disorder-IV criteria for major depressive disorder. Depression severity and symptomatology were evaluated by the Hamilton Depression Rating Scale (HAM-D, 17 items) (Hamilton, 1960) and the Beck Depression Inventory (BDI) (Beck and Beamesderfer, 1974). 185 of the patients were not receiving medication at the time of the neuroimaging. Table 1 provides a summary of the demographic information and the psychiatric diagnosis (showing how they were diagnosed) of the participants. Further details are provided in the Supplementary Material.

### **Image Acquisition and Preprocessing**

Data for resting state functional connectivity analysis were collected in 3T MRI scanners in an 8 min period in which the participants were awake in the scanner not performing a task using standard protocols described in the Supplementary Material.

Data preprocessing was performed using DPARSF (Chao-Gan and Yu-Feng, 2010) (<http://restfmri.net>) which is a toolbox based on the SPM8 software package. The first 10 EPI scans were discarded to suppress equilibration effects. The remaining scans of each subject

underwent slice timing correction by sinc interpolating volume slices, motion correction for volume to volume displacement, spatial normalization to standard Montreal Neurological Institute (MNI) space using affine transformation and nonlinear deformation with a voxel size of  $3 \times 3 \times 3 \text{ mm}^3$ , followed by spatial smoothing (8 mm Full Width Half Maximum FWHM). To remove the sources of spurious correlations present in resting-state BOLD data, all fMRI time-series underwent band-pass temporal filtering (0.01-0.1 Hz), nuisance signal removal from the ventricles, and deep white matter, and regressing out any effects of head motion using the Friston et al 24 head motion parameters procedure (Friston *et al.* , 1996). Finally, we implemented additional careful volume censoring (“scrubbing”) movement correction as reported by Power et al. (Power *et al.* , 2014) to ensure that head-motion artifacts are not driving observed effects. The mean framewise displacement (FD) was computed with FD threshold for displacement being 0.5. In addition to the frame corresponding to the displaced time point, 1 preceding and 2 succeeding time points were also deleted to reduce the ‘spill-over’ effect of head movements. Subjects with >10% displaced frames flagged were completely excluded from the analysis as it is likely that such high-level of movement would have had an influence on several volumes. Global signals were not regressed out (see Supplementary Material, where the results with global signal removal are referred to for completeness).

Any effects of gender ratio, years of education, and age between the patient and control groups were regressed out in the analysis. In fact, there were no differences in the gender ratios, though the number of years of education was lower in the patients than controls. Additional analyses showed for males vs females that the overall pattern of functional connectivity differences for patients vs controls were similar, and that the correlation of the functional connectivity changes between males and females was high (0.89,  $p < 0.0001$ ). Further, none of the functional connectivity link differences found between patients and controls was correlated significantly (FDR  $p < 0.05$ ) with the number of years of education. We also note that the Taiwanese sample included patients with depression in remission while under antidepressant treatment, and thus their scores on the Hamilton Depression Rating Scale (HAMD) assessment were in the low range.

### **Voxel-wise brain-wide association studies (vBWAS)**

Step 1: analysis within each imaging centre.

In the present study, each resting-state fMRI image included 47,619 voxels, which is based on the automated anatomical labeling (AAL2) atlas (Rolls *et al.* , 2015). For each pair of voxels, the time series were extracted and their correlation was calculated for each subject followed by z-transformation. Two-tailed, two-sample t-tests were performed on the 1,133,760,771 ( $47619 \times 47618 / 2$ ) Fisher’s z-transformed correlation coefficients to identify significantly altered functional links in patients with depression compared to controls within each imaging centre. The effect of age, gender ratios, education and head motion (mean FD) were regressed within each dataset in this step.

Step 2: combination of results from all imaging centres.

The Liptak-Stouffer z score method (Liptak, 1958) which is a well-validated method for multi-site datasets and has previously been used widely in multi-site MRI data analysis (Glahn *et al.* , 2008, Yu *et al.* , 2011) was then used to combine the results from the individual datasets. Specifically, the p-value of each functional connectivity result from two-sample t-test in step 1 was converted to its corresponding z score. This was calculated firstly as in equation:  $z_i = \Phi^{-1}(1 - p_i)$  , where  $\Phi$  is the standard normal cumulative distribution function and  $i$

represent the  $i$  site. Next, a combined  $z$  score for a functional connectivity was calculated using the Liptak-Stouffer formula:

$$Z = \frac{\sum_{i=1}^k w_i z_i}{\sqrt{\sum_{i=1}^k w_i^2}}$$

which follows a standard normal distribution under the null hypothesis; where  $w_i = \sqrt{\text{sample size}}$  is the weight of the  $i$  dataset. Finally, The  $Z$  is transformed into its corresponding p-value and a FDR procedure was used to correct for multiple comparisons.

Step 3: calculating a measure for the association of voxels.

A measure for the association ( $MA$ ) between a voxel  $i$  and the brain disorder was then defined as:  $MA = N_\alpha$ , where  $N_\alpha$  is the number of links between voxel  $i$  and every other voxel in the brain that have a p-value of less than  $\alpha$  (which in the present study with FDR correction was  $p < 0.01$ , corresponding to a p threshold of  $2.52 \times 10^{-7}$ ) in t-tests. A larger value of  $MA$  implies a more significant difference in functional connectivity.

For the functional connectivity of a voxel to be treated as significantly different ( $p < 0.01$ ) after FDR correction from another voxel, the significance level uncorrected had to be  $p < 2.52 \times 10^{-7}$ . The smallest p value found was approximately  $10^{-13}$ . Clusters with less than 10 voxels were not included to reduce the possibility of false positive results and to ensure that only consistent differences in functional connectivity were considered, following earlier practice (Hart *et al.*, 2012, Konrad *et al.*, 2006, Wittmann *et al.*, 2005).

Although the voxel-level brain-wide association study (BWAS) identifies all altered voxel-wise different functional connectivities in patients with depression, it is difficult to describe and show all of these changed links. Accordingly, to facilitate the description of the voxel-wise results, we conducted post-hoc cluster-wise analyses from each cluster of voxels returned by BWAS. It should be noted that all cluster-wise analyses are based on the findings of BWAS, and that it is the BWAS statistics only on which we rely. The cluster analyses just simplify the description of the different functional connectivities in depression.

### Clinical correlates

We also investigated whether the differences in functional connectivity between patients and controls were correlated with clinical variables (the Hamilton depression rating Scale (HAMD) (Hamilton, 1960), Beck Depression Inventory (BDI) (Beck and Beamesderfer, 1974), and illness duration (Bell-McGinty *et al.*, 2002, de Diego-Adelino *et al.*, 2014). We used the Liptak-Stouffer  $z$  score method (Liptak, 1958) to combine the data from the different neuroimaging sites for this analysis, for this provides a principled way to take into consideration possible differences in these measures between sites. Specifically, we calculated the partial correlation between the strength of each altered functional connection with HAMD, BDI score, and with illness duration after removing the effect of sex and age, in each individual centre, then we used the Liptak-Stouffer  $z$  score method to combine the results from the individual datasets.

### Results

The fMRI resting state functional connectivity analyses were performed with 421 patients with a diagnosis of major depression, and 488 controls, and this large population was sufficient to allow voxel-level analysis with fully corrected statistics.

**A Brain-Wide Association Study (BWAS) of voxels with different functional connectivity in depressed patients.** As shown in Figure 1 and Table 2, there were a number of voxel clusters with different functional connectivity (FC) in patients with depression compared to controls.

A large cluster of voxels (274) was in the left medial temporal lobe (MedTL) with peak at [X Y Z -27 -9 -36]. This cluster was in the parahippocampal gyrus, extending into the fusiform gyrus and inferior temporal and temporal pole areas, and indeed these voxels were classified as in areas in the AAL2 atlas (Rolls *et al.* , 2015) that included left hippocampus, parahippocampal gyrus, fusiform gyrus, middle temporal gyrus, temporal pole (middle temporal gyrus), and inferior temporal gyrus (Table 2). The voxel with the highest measure of association (*MA*, the number of voxels with which a voxel has a functional connectivity difference significant at  $p < 0.01$  (FDR correction)) was 284 (Table 2). It is clear from Fig. 1 that the majority of these voxels were in the perirhinal cortex BA 36, and the entorhinal cortex BA 28. There was a corresponding cluster on the right (with peak at [24 12 -39], Table 2).

A second large cluster of voxels was in the medial orbitofrontal cortex Brodmann Area 13 with peak at [-15 12 -15] (Table 2 and Fig. 1). In the AAL2 atlas this included left Olfactory, Rectus, OFCmed, OFCant, OFCpost, Insula, but the locations of these voxels as shown in Fig. 1 was in area 13 just extending anteriorly in area 11, according to the cytoarchitectonic designation (Öngür *et al.* , 2003) (see e.g. Fig. 4 in that paper, which shows that area 13 extends quite far posterior towards what topologically is close to the anterior ventral insula). There was a corresponding cluster on the right (with peak at [15 24 -18]).

A third cluster, with a high peak *MA* value of 136, was in lateral orbitofrontal cortex area 47/12 (Öngür *et al.* , 2003) with peak at [36 36 -12]. In Fig. 1 it can be seen in slices at Y=32, 35 and 37. It was in AAL2 region Frontal\_Inf\_Orb\_2\_R.

A fourth cluster was in the anterior cingulate cortex in the just supracallosal part with peak at [-6 36 21] (Fig. 1 and Table 2).

A fifth cluster was in the precuneus and adjoining posterior cingulate cortex with peak at [-6 -54 30] (Fig. 1 and Table 2).

A sixth cluster was in the left angular gyrus, with peaks at [-48 -60 21] and [-48 -69 42].

A seventh cluster was in the middle temporal gyrus, in a part that is BA 21 and is a high order temporal cortical visual area involved in processing objects and faces.

Other minor clusters in the thalamus and postcentral cortex are indicated in Table 2.

**Analysis of the functional connectivity links that were different in patients with depression.** To investigate the brain areas between which there was different functional connectivity in depression, and whether it was increased or decreased, the functional connectivity (FC) of the voxels with significant differences of FC (after FDR correction at  $p < 0.05$ , and within the voxel clusters shown in Table 2) were measured for each of the AAL2 regions within which the voxels were located. In this way, 23 regions of interest were identified, and the functional connectivity differences between the significantly different voxels in these regions are shown in Fig. 2 as a connectivity matrix.

First the altered functional connectivity of the medial orbitofrontal cortex, area 13, brain region is considered. The relevant voxels are in regions such as OFCmed, OFCant, OFCpost, Olfactory, Rectus, and Insula in the AAL2 atlas on the left and the right (Table 2). The voxels within this area 13 cluster have high positive correlations between them, and have generally the same pattern of altered functional connectivity in depression, so is described in the remainder of this paper as OFC13. As shown in Fig. 2, OFC13 has very significantly reduced functional connectivity with the Parahippocampal, Fusiform, Temporal-Pole and temporal\_Inf



areas (and many of the voxels in these areas are in the perirhinal cortex area 36 and the entorhinal cortex area 28, as shown in Fig. 1), which again act similarly in this investigation, so are referred to as the Medial Temporal Lobe (MedTL) cluster in the remainder of this paper. OFC13 also has reduced functional connectivity between the voxels in its different AAL2 regions (Fig. 2). Some parts of OFC13, in particular OFCPost, has increased functional connectivity with the precuneus.

Second, OFC47/12 on the right (Frontal\_Inf\_Orb\_2\_R in the AAL2 atlas) has *increased* functional connectivity with the left Angular gyrus, left Precuneus, and left and right Temporal\_Mid (e.g. [66 -15 -18], which is Brodmann area 21, temporal visual cortex). OFC47/12 does *not* have reduced functional connectivity with the parahippocampal areas (Fig. 2). This lateral orbitofrontal cortex network is therefore very different indeed in its change in functional connectivity in depression from the OFC13 network in the medial orbitofrontal cortex.

Third, the anterior cingulate cortex (in which the voxels are just supracallosal) has reduced functional connectivity in depressed patients with some temporal cortex areas including the fusiform gyrus, with the Angular cortex, and no difference in functional connectivity with most medial orbitofrontal areas (OFC13) (apart from a small increase with OFC\_Med\_R).

Other functional connectivity changes include increased thalamic connectivity with some medial orbitofrontal, and parahippocampal/temporal cortex regions, and the postcentral gyrus (Fig. 2).

**Clinical symptom correlates of the altered circuits.** As can be seen from Table 3, there were significant correlations ( $P < 0.05$  uncorrected) between some of the region of interest-wise functional links and the symptom severity scores and illness duration. Specifically, the HAMD (Hamilton Depression Rating Scale (Hamilton, 1960)) score was correlated with weakened functional connectivity between some of the areas within the medial orbitofrontal cortex (OFC13). Analysis of the subscores of the HAMD showed that links involving OFC13 were correlated with most of the 17 subscores apart from 10 and 15. Interestingly, links involving OFC47/12 were negatively correlated with H6 Insomnia (waking up early), and with H17 Insight.

The Beck Depression Inventory score (available only for the Xinan dataset of 183 patients) was also correlated with decreased functional connectivity between several of the medial orbitofrontal cortex OFC13 subregions and several of the Parahippocampal / Temporal subregions; and also with decreased functional connectivity of the temporal areas (Temporal\_Inf\_L and Temporal\_Pole\_L), and of Temporal\_Mid-R with the PostCentral gyrus (Table 3). (For the Xinan dataset, which includes both HAMD and BDI scores, the Pearson correlation coefficient between each ROI-wise Functional Connectivity and either the HAMD or the BDI reached 0.41 ( $p=1.6e-11$ ).)

The illness duration (Table 3) was negatively correlated with functional connectivity between the lateral orbitofrontal cortex OFC47/12 voxels and the left Angular gyrus and Temporal-Mid\_L cluster of Table 3. The illness duration was also correlated with weaker functional connectivity between the posterior part of the medial orbitofrontal cortex OFC13 cluster (specifically the part within Insula\_L in the AAL2 atlas) and some Parahippocampal/Temporal areas (Table 3). Illness duration was also correlated with weaker functional connectivity between the left Angular gyrus and the (supracallosal) Anterior Cingulate cortex. These correlations strengthen the interpretation of the changes in functional

connectivity in these regions found in patients with depression, in that these functional connectivities were related to the depression that was measured in these patients.

**Comparison of functional connectivity in medicated and unmedicated patients with depression.** Within the depressed group, 185 were not receiving medication, and 236 patients were receiving medication. Although it was not a primary aim of this investigation, and following a suggestion, the effects of medication were assessed by comparing the functional connectivity in 185 patients not receiving medication, and 182 patients receiving medication, from the Dongbei and Xinan datasets (see Supplementary Material for details including demographic and clinical details, and limitations). The medication consisted in most cases of selective serotonin reuptake inhibitors (SSRIs) including fluoxetine, paroxetine, sertraline, citalopram and escitalopram; or serotonin-norepinephrine reuptake inhibitors (SNRIs) such as venflaxine, or a tetracyclic antidepressant such as mirtazepine. The overall pattern of functional connectivity differences between patients and controls is similar for the unmedicated (Fig. S1A) and the medicated (Fig. S1B) subgroups of patients, providing evidence that the main differences between patients and controls shown in Figs. 1-3 were found in depressed patients whether or not they were receiving medication.

Although the overall pattern of functional connectivity is similar in the subgroup without medication (Fig. S1A) and with medication (Fig. S1B), to test for significant differences, a t-test was performed between these two functional connectivity matrices, with the results shown in Fig. S1C. As one of the main findings for differences of functional connectivity between patients and controls was increased functional connectivity of the lateral orbitofrontal cortex BA 47/12 with the pre-cuneus, angular gyrus and Mid-temporal gyrus (Figs. 2 and 3), and to relieve the burden of multiple comparisons, we tested in a pre-planned comparison whether these three functional connectivity links were weaker in medicated than in un-medicated patients. For the Frontal\_Inf\_Orb\_2R with precuneus link there is a significantly smaller functional connectivity in the medicated than the unmedicated group ( $t=2.17$ ,  $p=0.015$ , one-tailed test of the specific prediction in all 3 cases). For the Frontal\_Inf\_Orb\_2R with angular gyrus link there is a significantly smaller functional connectivity in the medicated than the unmedicated group ( $t=2.55$ ,  $p=0.005$ ). For the Frontal\_Inf\_Orb\_2R with temporal\_Mid\_L link there is a significantly smaller functional connectivity in the medicated than the unmedicated group ( $t=1.76$ ,  $p=0.039$ ). The results overall are thus consistent with the hypothesis that the increased functional connectivity of the lateral orbitofrontal cortex BA 47/12 with the precuneus, angular gyrus, and mid-temporal gyrus is related to depression, and that treatment with medication reduces the functional connectivity of these three links.

## Discussion

The main findings are first that one major circuit with altered functional connectivity in depression involves the medial orbitofrontal cortex BA 13, which is implicated in reward, and which had reduced functional connectivity in depression with memory systems in the parahippocampal gyrus and medial temporal lobe, involving especially the perirhinal cortex BA 36 and entorhinal cortex BA 28. The lateral orbitofrontal cortex BA 47/12, involved in non-reward and punishing events, did not have this reduced functional connectivity with memory systems, so that there is an imbalance in depression towards decreased reward-related memory system functionality. Second, BA 47/12 had increased functional

connectivity with the precuneus, the angular gyrus, and the temporal visual cortex BA 21. This enhanced functional connectivity of the non-reward/punishment system (BA 47/12) with the precuneus (involved in the sense of self and agency), and the angular gyrus (involved in language) is thus related to the explicit affectively negative sense of the self, and of self-esteem, in depression.

In a further analysis, it was shown that the overall pattern of functional connectivity differences between patients and controls is similar for the unmedicated (Fig. S1A) and the medicated (Fig. S1B) subgroups of patients, providing evidence that the main differences between patients and controls shown in Figs. 1-3 were found in depressed patients whether or not they were receiving medication. In preplanned comparisons, it was further shown that the functional connectivities of the right lateral orbitofrontal cortex BA 47/12 (Frontal\_Inf\_Orb\_2R ) with the precuneus, angular gyrus, and mid-temporal gyrus, the links highlighted in Fig. 3B, were reduced in the medicated patients compared to the unmedicated patients (Fig. S1C, with the statistics in the Supplementary Material). The results overall are thus consistent with the hypothesis that the increased functional connectivity of the lateral orbitofrontal cortex BA 47/12 with the precuneus, angular gyrus, and mid-temporal gyrus is related to depression, and that treatment with medication reduces the functional connectivity of these three links. In addition to these preplanned tests, it is notable that the medicated patients had a lower functional connectivity between the lateral orbitofrontal cortex and the medial orbitofrontal cortex (see Supplementary Material). These parts of the orbitofrontal cortex have a reciprocal relation with respect to their activations by rewards (medially) and by non-reward or loss laterally, and the smaller functional connectivity in medicated patients than unmedicated patients may be related to a change in this reciprocal relation. It is noted that limitations of this analysis of the effects of medication are that this was not a main aim of this investigation, that this is a cross-sectional not longitudinal comparison, and that the mean illness duration was 28.5 months in the unmedicated group and 58.6 months in the medicated group.

We now place these findings on functional connectivity differences in depression in the context of the known functions of the brain regions implicated in this investigation which include emotion-related, non-reward and punishment-related regions of the orbitofrontal cortex (Rolls, 2014, Rolls, 2016b), and of previous investigations into depression. The theory that depression is associated with the maladaptive responses to non-reward and punishment and hyposensitivity to reward has been extensively investigated (Eshel and Roiser, 2010, Rolls, 2016b, Russo and Nestler, 2013, Whitton *et al.* , 2015). At the psychological level, Beck's psychological theory of depression (Beck, 1979) and Seligman's learned helplessness model (Seligman, 1972), both focused around punishment and reward, and brain areas related to punishment and reward have become primary targets in psychotherapy (Beck, 2008). At the neural level, networks related to punishment and reward have been related to depression, and in some cases to monoamines (Felger *et al.* , 2015, Harmer and Cowen, 2013, Huys *et al.* , 2015, McCabe *et al.* , 2012).

Given this background, we first consider voxels in the medial parts of the orbitofrontal cortex shown in Fig. 1 that are within the OFC13 cluster. Fig. 2 shows that in depression the voxels with altered functional connectivity in these areas have reduced functional connectivity with the Parahippocampal/Temporal lobe/Fusiform cortical left and right clusters, especially involving the perirhinal cortex BA 36 and entorhinal cortex BA 28 as shown in Fig. 1. These parahippocampal areas are involved in memory, and inter alia provide a gateway to and from

the hippocampal memory system (Kesner and Rolls, 2015). Indeed, the medial and mid orbitofrontal cortex BA13 has direct reciprocal connections with the perirhinal cortex BA 36 (Kondo *et al.* , 2005), which in turn connects via the entorhinal cortex BA 28 to the hippocampus (Kesner and Rolls, 2015). There is extensive evidence that the human medial orbitofrontal cortex areas, including OFC13, is activated by rewarding stimuli that are subjectively pleasant (including pleasant odors, pleasant touch, pleasant flavor, and monetary reward) (Grabenhorst and Rolls, 2011, O'Doherty *et al.* , 2001, Rolls, 2014). The connections between the medial and mid orbitofrontal cortex BA 13 and the perirhinal cortex BA 36 (which in turn connects to the entorhinal cortex and thus to the hippocampus) provides a route for reward / emotion-related information to reach the hippocampus to become part of an episodic memory; and during later recall for the reward / emotion-related part of an episodic memory to be recalled to the orbitofrontal cortex (Kesner and Rolls, 2015, Rolls, 2014, Rolls, 2016a). It has therefore been suggested that there are weaker functional connectivity links in depression between brain areas involved in pleasant feelings and rewards with memory systems, and that this may be part of the mechanism of depression (Rolls, 2016b). This hypothesis is strengthened by the correlation between the symptoms of depression and the weakening of links between the medial orbitofrontal cortex OFC13 system and the parahippocampal / medial temporal lobe memory system areas as shown in Table 3. Consistent with the hypothesis, the anhedonia of depression can be related to decreased effects of pleasant rewarding stimuli in the medial orbitofrontal cortex during depression, effects that can be restored by antidepressants (Ma, 2015). Consistent with the importance of the orbitofrontal cortex in depression, gray matter volume reductions are found in this area in patients with depression (Ballmaier *et al.* , 2004).

Second, the lateral orbitofrontal cortex cluster OFC47/12 is in a region that is activated by many types of non-reward and unpleasant stimuli (Grabenhorst and Rolls, 2011, Rolls, 2014), including losing money (O'Doherty *et al.* , 2001), not receiving an expected social reward (Kringelbach and Rolls, 2003), and unpleasant odors. This region has very different changed functional connectivity in depression, with *increased* functional connectivity with the precuneus, angular gyrus, and middle temporal gyrus BA 21. The precuneus is a parietal region implicated in the sense of self and agency (Cavanna and Trimble, 2006), and the left (not right) angular gyrus / middle temporal gyrus is implicated in language processing (Cabeza and Nyberg, 2000). This has led to the hypothesis that this lateral non-reward / punishment system in OFC47/12 with its increased functional connectivity with self- and language-related systems relates to some of the symptoms of depression (Rolls, 2016b). The BA 21 region is high order visual cortex corresponding to the macaque inferior temporal visual cortex where faces and objects are represented (Rolls, 2012), and the increased functional connectivity of OFC47/12 with BA 21 may result in more affectively negative processing of visual inputs (Rolls, 2016b). Indeed, this increased functional connectivity between the inferior temporal visual cortex area 21 and the lateral orbitofrontal cortex OFC47/12 non-reward / punishment system may lead to depressed patients having difficulty in categorizing happy face stimuli as happy (Harmer and Cowen, 2013).

Consistent with the hypothesis of disturbed function of the orbitofrontal cortex in depression, there is increased regional cerebral blood flow in the ventrolateral orbitofrontal cortex area 47/12 in depression (Drevets *et al.* , 1992, Drevets *et al.* , 2004, Price and Drevets, 2010). In addition, overgeneral autobiographical memory manifests in individuals with major depressive disorder (MDD) tested during depressed (dMDD) or remitted phases (rMDD), and healthy individuals at high-risk for developing MDD. During specific autobiographical

memory recall, high risk individuals have increased activity relative to rMDDs and healthy controls in the ventrolateral prefrontal cortex (VLPFC) and lateral orbitofrontal cortex (Young *et al.* , 2015). The increased functional connectivity of the lateral orbitofrontal cortex (involved in non-reward and aversive processing), the precuneus (involved in the sense of self), and the angular gyrus (involved in language) in depression is of interest, for a sign of the start of a depressive episode may be negative thoughts about the self and low self-esteem, all expressed explicitly in language (Wegener *et al.* , 2015). It is notable that OFC47/12, the non-reward punishment area, has increased functional connectivity with each of these areas, but that they do not have increased connectivity with each other. The common hub to this system is the lateral orbitofrontal cortex OFC47/12.

In comparing the medial OFC13 (reward) and lateral OFC47/12 (non-reward) systems, there is evidence that they are very different systems, for the correlation between the functional connectivities within the different AAL2 regions of OFC13 was typically high ( $r=0.6-0.9$ ), and the functional connectivities of each of these areas with OFC47/12 were typically low ( $r=0.23-0.37$ ) ( $p<10^{-14}$ ). Both systems though may contribute to the lack of motivation that is frequent in depression. The medial orbitofrontal cortex / medial temporal lobe memory system reduced functional connectivity may contribute by making remembered rewards, the goals for action, less rewarding, and therefore less motivating (Rolls, 2014, Rolls, 2016b). The lateral orbitofrontal non-reward system with its increased functional connectivity may make non-reward more potent, and this facilitation would also be expected to check motivation by enhancing the inhibiting effects on behavior of non-reward and expected non-reward (Rolls, 2014, Rolls, 2016b).

The anterior cingulate cortex (in which the voxel clusters are just supracallosal) had reduced functional connectivity in depressed patients with some temporal cortex areas including the fusiform gyrus, and with the Angular cortex (Figs. 2a and 3a), and no difference in functional connectivity with most medial orbitofrontal areas (OFC13) (apart from a small increase with OFC\_Med\_R). This supracallosal part of the far anterior cingulate cortex is at the anterior end of a supracallosal cingulate region in which many unpleasant stimuli are represented (Grabenhorst and Rolls, 2011, Rolls, 2014), and is therefore implicated in mood (Rolls, 2014). This region is just above and behind the pregenual cingulate cortex area in which a few additional voxels with significantly different functional connectivity were found in the depressed group, and this pregenual cingulate region has representations of pleasant and rewarding stimuli (Grabenhorst and Rolls, 2011, Rolls, 2014), and is thereby also implicated in mood (Rolls, 2014). Interestingly, functional connectivity changes were not found in the subcallosal cingulate cortex including the subgenual cingulate cortex (with the area found here more ventral, in OFC13), though a few voxels with altered functional connectivity were found in the amygdala, with both these regions showing increased cerebral blood flow in depression (Drevets *et al.* , 1997, Price and Drevets, 2010).

We now consider the changes in functional connectivity in depression in other brain areas not typically associated with mood and emotion. The thalamus had increased functional connectivity with a number of cortical areas, as shown in Fig. 2, with the coordinate ([9 -27 9]) indicating that this is part of the medial pulvinar, which has temporal lobe connections including to visual temporal cortex areas (Johansen-Berg *et al.* , 2005). The medial thalamus has increased cerebral blood flow in depression (Price and Drevets, 2010).

It is interesting to relate these changes in functional connectivity to the level of activity in these different brain areas in patients with depression. Hyperactivation during affective

processing tasks has been described in the thalamus and parahippocampal gyrus (Miller *et al.* , 2015), and increased cerebral blood flow in patients with major depressive disorder has been found in the medial as well as the lateral orbitofrontal cortex (Drevets *et al.* , 1992, Price and Drevets, 2010).

Although changes have been found in some of these regions in previous studies in depression including the precuneus, angular gyrus, and hippocampal system (Sundermann *et al.* , 2014), the present study is statistically more powerful because of the large number of participants involved (421 patients with a diagnosis of major depression, and 488 controls), and therefore allows analysis at the voxel level, which as we have seen greatly facilitates the interpretation of the findings by enabling the functional connectivity to be related to the different functions of even nearby brain regions such as the medial and lateral orbitofrontal cortex.

### **Contributors**

Jianfeng Feng, Edmund T. Rolls, Peng Xie, Fei Wang and Ching-Po Lin contributed to the design of the study. Wei Liu, Yanqing Tang, Chu-Chung Huang, XinFa Wang, JunCai Pu, Shih-Jen Tsai and Albert C Yang contributed to the collection of the data. Wei Cheng, Edmund T. Rolls, Jiang Qiu, Yanqing Tang, Wei Liu, Jie Zhang, Lirong Zheng and Wei Lin contributed to the analysis of the data and the preparation of the manuscript. Edmund T. Rolls, Wei Cheng, and Jianfeng Feng participated in writing the paper. All collaborators had an opportunity to contribute to the interpretation of the results and to the drafting of the manuscript.

### **Declaration of interests.**

All authors declare no competing interests.

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Table 1. A summary of the demographic information and the psychiatric diagnosis in the present study.

| Sites   | Group             | Age (years)    | Sex (male/female) | Education (years) | Medication (yes / no) | HAMD        | Duration of illness | Mean FD        |
|---------|-------------------|----------------|-------------------|-------------------|-----------------------|-------------|---------------------|----------------|
| Taiwan  | Healthy           | 49.18±8.58     | 60 / 36           | 15.04 ± 3.83      | /                     | /           | /                   | 0.133 ± 0.054  |
|         | Patient           | 52.64±14.86    | 33 / 21           | 12.66 ± 3.95      | 54 / 0                | 9.34 ± 6.99 | 8.63 ± 6.92         | 0.116 ± 0.056  |
|         | Statistic (t / p) | -1.810 / 0.072 | 0.028 / 0.866     | 3.60 / 4.3e-4     |                       | /           | /                   | 1.833 / 0.0687 |
| Dongbei | Healthy           | 29.90 ± 11.89  | 87 / 51           | 14.22 ± 3.40      |                       |             |                     | 0.101 ± 0.040  |
|         | Patient           | 29.02 ± 10.49  | 61 / 24           | 11.80 ± 3.18      | 25 / 60               | 20.9 ± 8.79 | 1.04 ± 1.67         | 0.098 ± 0.039  |
|         | Statistic (t / p) | 0.554 / 0.580  | 1.611 / 0.204     | 5.25 / 3.7e-7     |                       | /           |                     | 0.591 / 0.555  |
| Xinan   | Healthy           | 39.65 ± 15.80  | 166 / 88          | 13.01 ± 3.89      | /                     | /           | /                   | 0.133 ± 0.063  |
|         | Patient           | 38.74 ± 13.65  | 183 / 99          | 11.91 ± 3.58      | 157 / 125             | 20.8 ± 5.87 | 4.16 ± 5.51         | 0.125 ± 0.054  |
|         | Statistic (t / p) | 0.719 / 0.472  | 0.013 / 0.911     | 3.41 / 6.9e-4     | /                     | /           | /                   | 1.729 / 0.084  |

Table 2. Coordinates of the peaks of the voxel clusters with different functional connectivity in patients with depression. Brodmann areas are provided where useful.

| Areas   | Abbreviation  | # Voxels | Peak MA value | MNI coordinates (Peak) |     |     |
|---|---------------|----------|---------------|------------------------|-----|-----|
| Hippocampus_L, ParaHippocampal_L, Fusiform_L, Temporal_Mid_L, Temporal_Pole_Mid_L, Temporal_Inf_L | MedTL_L       | 274      | 284           | -27                    | -9  | -36 |
| ParaHippocampal_R, Fusiform_R, Temporal_Pole_Mid_R  | MedTL_R       | 115      | 141           | 24                     | 12  | -39 |
| Olfactory_R, Rectus_R, OFCmed_R, OFCpost_R (BA 13)  | OFC13_R       | 140      | 209           | 15                     | 24  | -18 |
| Olfactory_L, Rectus_L, OFCmed_L, OFCant_L, OFCpost_L, Insula_L (BA 13)                            | OFC13_L       | 206      | 296           | -15                    | 12  | -15 |
| OFCmed_R (BA 13)  | OFC13_R_2     | 12       | 50            | 12                     | 60  | -21 |
| Temporal_Mid_R (BA 21)  | MidTG21_R     | 14       | 43            | 66                     | -15 | -18 |
| Frontal_Inf_Orb_2_R (BA 47/12)  | OFC47/12_R    | 11       | 136           | 36                     | 36  | -12 |
| Thalamus_R  | Thal_R        | 17       | 82            | 9                      | -27 | 9   |
| Cingulate_Ant_L (BA 24)   | ACC_L         | 43       | 86            | -6                     | 36  | 21  |
| Angular_L, Temporal_Mid_L (BA 39)   | Angular_L     | 15       | 18            | -48                    | -60 | 21  |
| Postcentral_L   | Postcentral_L | 20       | 21            | -60                    | -12 | 18  |
| Cingulate_Post_L, Precuneus_L   | Precuneus_L   | 24       | 15            | -6                     | -54 | 30  |
| Angular_L (BA 39)   | Angular_L_2   | 22       | 36            | -48                    | -69 | 42  |



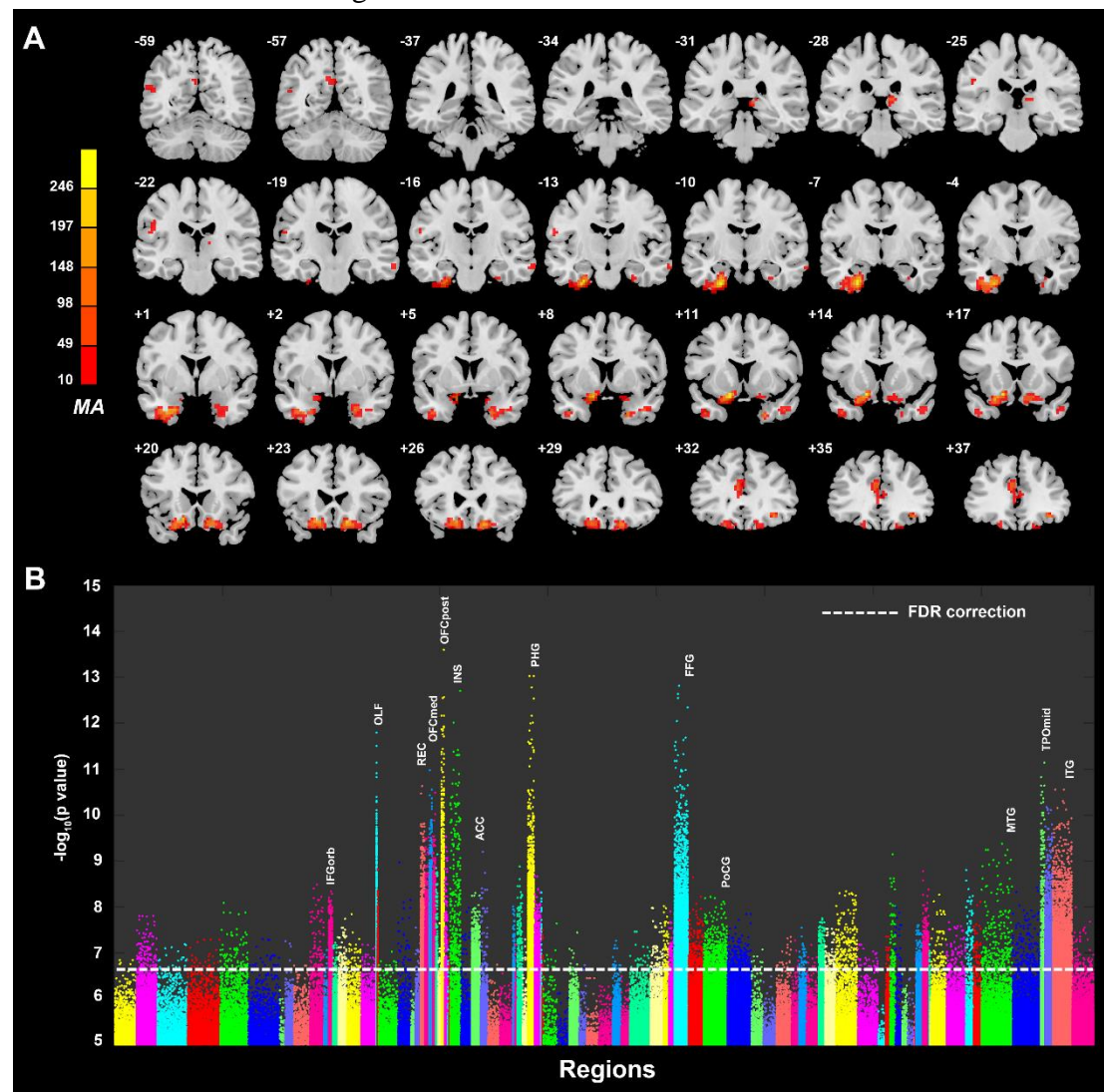
Table 3. Correlations between the functional connectivity links and the depression symptom severity scores.

| Functional connectivity |                     | Clinical variable | P value    | Correlation value |
|-------------------------|---------------------|-------------------|------------|-------------------|
| Olfactory_R             | OFCpost_R           | BDI               | 0.022249   | -0.14572          |
| Olfactory_R             | Temporal_Pole_Mid_R | BDI               | 0.041603   | -0.13001          |
| OFCmed_R                | ParaHippocampal_R   | BDI               | 0.044183   | -0.12843          |
| OFCpost_R               | ParaHippocampal_R   | BDI               | 0.044118   | -0.12846          |
| OFCpost_R               | Temporal_Pole_Mid_R | BDI               | 0.048206   | -0.12610          |
| Fusiform_L              | Temporal_Mid_R      | BDI               | 0.030704   | -0.13782          |
| Postcentral_L           | Temporal_Mid_R      | BDI               | 0.0027053  | -0.14063          |
| Temporal_Pole_Mid_L     | Temporal_Inf_L      | BDI               | 0.027426   | -0.11088          |
| Olfactory_L             | Rectus_L            | HAMD              | 0.0094015  | -0.13148          |
| Olfactory_L             | Rectus_R            | HAMD              | 0.026386   | -0.11273          |
| Olfactory_L             | OFCmed_L            | HAMD              | 0.0046205  | -0.14343          |
| Rectus_R                | OFCmed_L            | HAMD              | 0.038747   | -0.10504          |
| Frontal_Inf_Orb_2_R     | Angular_L           | Illness duration  | 0.01825    | -0.12418          |
| Frontal_Inf_Orb_2_R     | Temporal_Mid_L      | Illness duration  | 0.00077913 | -0.17688          |
| Insula_L                | ParaHippocampal_R   | Illness duration  | 0.016651   | -0.12658          |
| Insula_L                | Fusiform_L          | Illness duration  | 0.021031   | -0.12198          |
| Insula_L                | Temporal_Inf_L      | Illness duration  | 0.046867   | -0.10538          |
| Cingulate_Ant_L         | Angular_L           | Illness duration  | 0.046772   | -0.10438          |
| Postcentral_L           | Temporal_Pole_Mid_L | Illness duration  | 0.036223   | -0.11027          |

BDI: Beck Depression Inventory

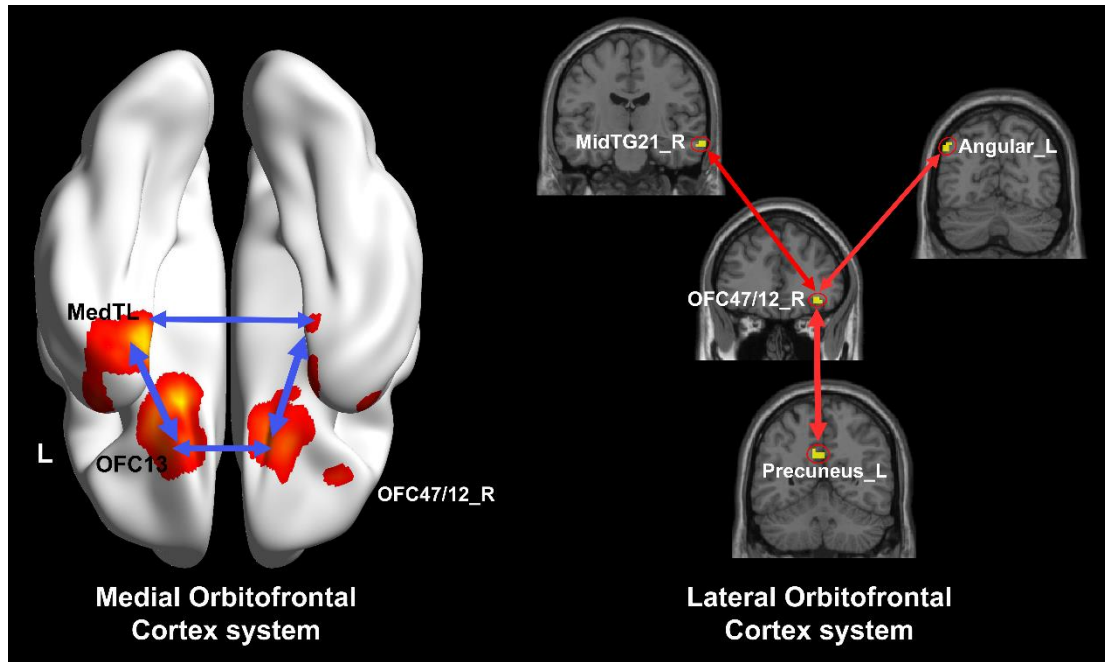
HAMD: Hamilton Depression Rating Scale

**Figure 1. Anatomical location of consistently different functional connectivity in depression obtained from voxel-based BWAS.** A) Voxels showing the largest number of whole brain voxel-level functional connectivity differences in patients with depression. Clusters of voxels containing more than 10 significant voxels are shown. The color bar represents the measure of association (*MA*) given by the number of significantly different functional connectivity links relating to each voxel. The right of the brain is on the right of each slice. Some of the different clusters are in the following range of Y values for the slices shown: MedOFC13 +37 to +8; LatOFC47/12\_R +37 to +32; medial temporal lobe MTL\_L +17 to -16; thalamus -25 to -31; precuneus -57 to -59; angular gyrus -57 to -59. B) Manhattan plot of voxel-based BWAS results with voxels grouped in accordance with the AAL2 atlas labels (Rolls *et al.* , 2015). The order of the bars is as shown in Table S1, and the width of each bar reflects the number of voxels in each AAL2 region.





**Figure 3.** The medial and lateral orbitofrontal cortex networks that show different functional connectivity in patients with depression. A decrease in functional connectivity is shown in blue, and an increase in red. MedTL –medial temporal lobe from the parahippocampal gyrus to the temporal pole; MidTG21\_R – middle temporal gyrus area 21 right; OFC13 – medial orbitofrontal cortex area 13; OFC47/12\_R – lateral orbitofrontal cortex area 47/12 right. The lateral orbitofrontal cortex cluster in OFC47/12 is visible on the ventral view of the brain anterior and lateral to the OFC13 clusters.



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