Psychiatric Briefs

Child Sexual Abuse, Poor Parental Care and Adult Depression: Evidence for Different Mechanisms

Hill J, Pickles A, Burnside E, et al.

Background: Although depression during adulthood has been linked to both sexual abuse and poor parental care during childhood, data on the possible differences in the way these 2 childhood variables relate to adult depression are sparse. This study compared the relationship of child sexual abuse (CSA) and poor parental care to adult depression by measuring their effects and that of a third variable—intimate love relationships—on adult depression. ***Method:*** One hundred ninety-eight women aged 25 to 36 years from 5 primary care practices in Wirral, England, were interviewed for assessment of childhood experiences (using the Childhood Experience of Care and Abuse interview), quality of love relationships (using the Adult Personality Functioning Assessment), and presence of depression during adulthood (using the Schedule for Affective Disorders and Schizophrenia adapted to reflect DSM-IV criteria and Research Diagnostic Criteria). ***Results:*** Both CSA and poor parental care were both independently associated with DSM-IV depression and poor love relationships between the ages of 21 and 30 years, and poor love relationships were associated with depression during the same age period. Poor love relationships had a large impact on risk of depression in women with poor parental care during childhood, but did not affect risk of depression in women with CSA. ***Conclusions:*** Different mechanisms may exist behind adult depression following CSA and adult depression stemming from poor parental care.

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Anxiety Disorders Following Miscarriage

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Background: Several previous studies have established that miscarriage is a risk factor for depressive symptoms and disorder. By contrast, research on miscarriage as a possible risk factor for anxiety symptoms is inconclusive, and for anxiety disorders, sparse and uninformative. The current study examines the incidence of and relative risk for 3 DSM-III anxiety disorders (obsessive-compulsive disorder [OCD], panic disorder, and phobic disorders) within the 6 months following miscarriage. Adequate diagnostic data on other anxiety disorders were not available. ***Method:*** Using a cohort design, we tested whether women who miscarry are at increased risk for a first or recurrent episode of an anxiety disorder in the 6 months following loss. The miscarriage cohort consisted of women attending a medical center for spontaneous abortion (N = 229); the comparison group was a population-based cohort of women drawn from the community (N = 230). ***Results:*** Among miscarrying women, 3.5% experienced a recurrent episode of OCD, compared with 0.4% of community women (relative risk [RR] = 8.0; 95% confidence interval [CI] = 1.0 to 63.7). The relative risk for noncomorbid panic disorder was substantial (RR = 3.6), albeit not statistically significant (95% CI = 0.8 to 17.2). There was no strong evidence for increased risk for phobic disorders or agoraphobia, combined or considered separately, in the 6 months following loss. Relative risk for all 3 disorders combined was 1.5 (95% CI = 0.9 to 2.3). ***Conclusion:*** In this first miscarriage cohort study using a concurrent frequency-matched comparison group, miscarriage was a substantial risk factor for an initial or recurrent episode of OCD. Given statistical power limitations of this investigation, the current findings do not preclude a possible contribution of miscarriage to risk for other anxiety disorders.

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Effects of the Menstrual Cycle on Measures of Personality in Women With Premenstrual Syndrome: A Preliminary Study

Berlin RE, Raju JD, Schmidt PJ, et al.

Background: Previous studies suggest that women with premenstrual syndrome (PMS) differ from those without PMS in measures of personality. The purpose of this study was to measure the effect of menstrual cycle phase on personality variables in women with and without PMS. ***Method:*** The Personality Diagnostic Questionnaire-Revised (PDQ-R) was administered in both the follicular and luteal phases to women with PMS (according to National Institute of Mental Health PMS Workshop Diagnostic Guidelines) (N = 40). An asymptomatic control group (N = 20) as well as a symptomatic group of women with DSM-IV–diagnosed recurrent, non–menstrual-cycle-related brief depression (N = 20) also completed the questionnaire in both phases. ***Results:*** Only women with PMS demonstrated a significant increase in total PDQ-R score (reflecting overall personality disorder) from the follicular to the luteal phase ($p < .01$). Women with PMS had significantly higher total PDQ-R scores than the asymptomatic controls during both the follicular ($p < .05$) and luteal ($p < .01$) phases, whereas there was no significant difference between women with PMS and symptomatic controls during either phase. Subscale scores fit similar patterns, as did the number of women in each group meeting a cutoff score indicative of the presence of personality dysfunction. ***Conclusion:*** In this preliminary study, women with PMS were unique in demonstrating a menstrual cycle phase effect on PDQ-R score, while their scores in both phases were closer to symptomatic controls than asymptomatic controls. These findings suggest that personality disorder in women with PMS may have both state- and trait-related components.

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Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality

Silverman JG, Raj A, Mucci LA, et al.

Context and Objective: An estimated one fourth of women in the United States will experience intimate partner violence (IPV) during their lifetimes. Although research has consistently found younger age to be a risk factor for IPV, the lifetime prevalence of dating violence among adolescents has not been systematically identified in representative epidemiologic studies. This study estimated the lifetime prevalence of dating violence in adolescent girls, identified demographic characteristics of girls at greatest risk for such violence, and analyzed the relationship between history of dating violence and subsequent presence of health risks. ***Method:*** The lifetime prevalence of physical and/or sexual dating violence and whether such violence was associated with substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality were assessed in 9th- through 12th-grade adolescent girls in the 1997 (N = 1997) and 1999 (N = 2186) Massachusetts Youth Risk Behavior Surveys. ***Results:*** Physical and/or sexual dating violence was reported by approximately 20% of female respondents in both 1997 and 1999. Both surveys found that increased substance use (e.g., cocaine use; 1997: odds ratio [OR] = 4.7, 95% confidence interval [CI] = 2.3 to 9.6; 1999: or = 3.4, 95% CI = 1.7 to 6.7), unhealthy weight control behaviors (e.g., use of laxatives and/or vomiting; 1997: OR = 3.2, 95% CI = 1.8 to 5.5; 1999: OR = 3.7, 95% CI = 2.2 to 6.5), sexual risk behaviors (e.g., first sexual intercourse before 15 years of age; 1997: OR = 8.2, 95% CI = 5.1 to 13.4; 1999: OR = 2.4, 95% CI = 1.4 to 4.2), pregnancy (1997: OR = 6.3; 95% CI = 3.4 to 11.7; 1999: OR = 3.9, 95% CI = 1.9 to 7.8), and suicidality (e.g., attempted suicide; 1997: OR = 7.6, 95% CI = 4.7 to 12.3; 1999: OR = 8.6, 95% CI = 5.2 to 14.4) were associated with physical and sexual dating violence in adolescent girls. ***Conclusion:*** The risk for dating violence is high in adolescent girls, and girls who experience dating violence are more likely to display other health risk behaviors than those who do not experience dating violence.

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Management of Chronic Tension-Type Headache With Tricyclic Antidepressant Medication, Stress Management Therapy, and Their Combination: A Randomized Controlled Trial

Holroyd KA, O'Donnell FJ, Stensland M, et al.

Background: Chronic tension-type headache—tension-type headache that occurs at least 15 times per month for at least 6 months—is often treated with tricyclic antidepressants (TCAs), for which research trials have shown only modest efficacy. This placebo-controlled study evaluated the separate and combined clinical efficacy of tricyclic antidepressant therapy and brief stress management therapy for chronic tension-type headache. ***Method:*** Two hundred three adult subjects with chronic tension-type headache were assigned to 1 of 4 treatment groups: a TCA (amitriptyline, up to 100 mg/day, or nortriptyline, up to 75 mg/day; N = 53), placebo (N = 48), stress management therapy (3 sessions and 2 telephone contacts) plus placebo (N = 49), or stress management therapy plus a TCA (N = 53). The headache index, which was the mean of all diary ratings of headache severity (0–10) over a 1-month period, was the primary outcome measure and provided a measure of overall headache activity. Number of days per month with at least moderate pain (diary score ≥ 5), analgesic medication use, and scores on the Headache Disability Inventory were secondary outcome measures. ***Results:*** Larger reductions in headache activity, use of analgesic medication, and headache-related disability were found with monotherapy with a TCA or stress management therapy than with placebo, although TCA treatment produced a more rapid treatment effect than did the behavioral therapy. The combination of TCA treatment and stress management therapy led to clinically significant (≥ 50%) reduction in headache index scores more consistently (64% of subjects) than did monotherapy with a TCA (38%, p = .006), stress management therapy (35%, p = .003), or placebo (29%, p = .001). Combined therapy and the 2 individual active treatments produced similar results on the secondary outcome measures. ***Conclusion:*** Overall, combined treatment with a TCA and stress management therapy may be more effective in treating chronic tension-type headache than either treatment individually, although each monotherapy is modestly effective in treating this condition.

(JAMA 2001;285:2208–2215)

The Clinical Features of Bipolar Depression: A Comparison With Matched Major Depressive Disorder Patients

Mitchell PB, Wilhelm K, Parker G, et al.

Background: Despite a resurgence of interest in the treatment of bipolar depression, there have been few controlled studies of the clinical characteristics of this condition. Identification of any distinctive clinical "signatures" of bipolar depression would be helpful in determining treatment options in the clinical setting. ***Method:*** From a cohort of 270 inpatients and outpatients assessed in detail during a DSM-IV major depressive episode, 39 bipolar I disorder patients were identified and closely matched with 39 major depressive disorder patients for gender, age, and the presence or absence of DSM-IV melancholic subtype. Patients were compared on a broad range of parameters including the Hamilton Rating Scale for Depression (depression severity), 54 depressive symptoms, the Newcastle Endogenous Depression Diagnostic Index, 3 family history items, 2 physical health items, the CORE scale (psychomotor disturbance), and 5 history items. ***Results:*** Although the bipolar patients were no more severely depressed than the major depressive disorder controls, they were more likely to demonstrate psychomotor-retarded melancholic and atypical depressive features and to have had previous episodes of psychotic depression. These findings were largely duplicated even when the population was confined to those with DSM-IV melancholia. ***Conclusion:*** The clinical admixture of psychomotor-retarded

melancholic signs and symptoms, "atypical" features, and (less frequently) psychosis may provide a "bipolar signature" in clinical scenarios when there is uncertainty concerning the polarity of a depressive presentation.

(J Clin Psychiatry 2001;62:212–216)

Mood Disorder History and Personality Assessment in Premenstrual Dysphoric Disorder

Critchlow DG, Bond AJ, Wingrove J

Background: Menstrually related dysphoria is known to be associated with other affective disorders, notably major depressive disorder and puerperal depression. The relationship between premenstrual dysphoric disorder (PMDD) and maladaptive personality disorders and traits, however, is less established, at least in part because of the methodological and nosologic difficulties in the diagnosis of both PMDD and personality disorders. This study seeks to address this problem to elucidate the relationship between PMDD, other affective disturbances commonly experienced by women, and maladaptive personality. ***Method:*** Axis I and II disorders were examined using standardized instruments and stringent diagnostic criteria (DSM-IV and the International Personality Disorders Examination) in 34 women with DSM-IV PMDD and 22 healthy women without severe premenstrual mood changes. ***Results:*** Seventy-seven percent of the PMDD group had suffered from a past Axis I disorder in comparison with 17% of the control group. Two thirds of the parous women with PMDD had suffered from major depressive disorder in the puerperium. Personality disorder diagnoses were not highly represented in either group of women. The women with PMDD had significantly more obsessional personality traits ($p < .001$) but not absolute personality disorder diagnoses. ***Conclusion:*** Obsessional symptoms are known to cluster with the affective disorders and may reflect underlying temperamental and biological vulnerability. This study provides further evidence of the link between serotonergic dysregulation, personality vulnerability, and mood changes related to the female reproductive cycle.

(J Clin Psychiatry 2001;62:688–693)

A Randomized Effectiveness Trial of Collaborative Care for Patients With Panic Disorder in Primary Care

Roy-Byrne PP, Katon W, Cowley DS, et al.

Background: Panic disorder is often inadequately treated in primary care, and to date the effectiveness of interventions to improve quality of care for panic disorder in primary care has not been researched. This study compared the clinical effectiveness of treatment as usual with that of a treatment approach that included pharmacotherapy within the larger framework of collaborative care. ***Methods:*** Patients with DSM-IV panic disorder (N = 115) were randomly assigned to receive either usual care (N = 58) or the collaborative care intervention (N = 57). Collaborative care comprised treatment with the selective serotonin reuptake inhibitor paroxetine (up to 40 mg/day), education about panic disorder as well as paroxetine via a videotape and pamphlets, 2 scheduled visits with a psychiatrist, and systematic follow-up telephone calls (2 calls in the first 8 weeks and up to 5 calls between treatment months 3 and 12). Outcome variables, which included levels of panic (as measured by the Panic Disorder Severity Scale [PDSS]), anxiety sensitivity, depression, and disability as well as adequacy of medication, were assessed every 3 months via telephone interview. ***Results:*** Patients receiving collaborative care had lower PDSS scores than usual care patients at all assessment points, with a significantly lower score at 6 months ($p = .003$). Collaborative care patients also displayed greater improvement in measures of anxiety, depression, and disability, especially at 3 and 6 months. In addition, collaborative care patients were more likely than usual care patients to receive adequate medication for panic disorder and were more likely at 3 and 6 months to adhere to their medication regimen. ***Conclusions:*** A collaborative care intervention can increase patient adherence to medication regimens and can produce greater clinical and functional improvements compared with usual care in patients with panic disorder treated in the primary care setting, especially within the first 6 months of treatment.

(Arch Gen Psychiatry 2001;58:869–876)

Integrating Primary Medical Care With Addiction Treatment: A Randomized Controlled Trial

Weisner C, Mertens J, Parthasarathy S, et al.

Background: Although individuals with alcohol and other drug disorders have a high prevalence of medical and psychiatric conditions, medical and psychiatric care is seldom provided in conjunction with substance abuse treatment. This study evaluated the treatment outcomes and costs of a model of care in which medical and substance abuse treatments were integrated compared with a usual-care treatment model in which substance abuse and medical treatments were independent of each other. ***Method:*** Between April 1997 and December 1998, 592 adult men and women were randomly assigned to 8 weeks of group-based treatment, within a large health maintenance organization chemical dependency program, with either integrated care (N = 285), which included medical and psychiatric care within the addiction treatment program, or treatment as usual (N = 307), which provided primary health care separate from addiction treatment. Abstinence outcomes, health care utilization, and treatment costs 6 months after random assignment were compared between the 2 treatment models. In addition, the study measured the effect of integrated care on a subgroup of patients with substance abuse–related medical conditions (SAMCs; N = 341). ***Results:*** Overall, alcohol- and drug-related measures were improved in both treatment groups, with abstinence rates of 68% for patients in the integrated care group and 63% for those in the independent care group. In patients with SAMCs, abstinence rates were similar between treatment groups (66% with integrated care vs. 73% with independent care, $p = .23$), and integrated care was associated with slightly (but not significantly) higher monthly costs ($367.96 vs. $324.09). Among patients with SAMCs, however, abstinence rates were higher overall in the integrated care group (69%) than in the indepen-

dent care group (55%) (p = .006, odds ratio [OR] = 1.90, 95% confidence interval [CI] = 1.22 to 2.97); these higher abstinence rates were found in patients with medical SAMCs (OR = 3.38, 95% CI = 1.68 to 6.80) as well as those with psychiatric SAMCs (OR = 2.10, 95% CI = 1.04 to 4.25). Although the integrated care model incurred slightly higher total monthly costs than the independent care model ($470.81 vs. $427.95; p = .14) in patients with SAMCs, the higher abstinence rates associated with integrated care for patients in this group who had SAMCs fostered an incremental cost-effectiveness ratio per additional abstinent patient of $1581, a value considered cost-effective. ***Conclusions:*** Treatment that integrates addiction and medical services can benefit patients with SAMCs in terms of both medical condition and cost-effectiveness, a finding that is particularly important given the high rate of SAMCs among individuals with substance abuse disorders.

(JAMA 2001;286:1715–1723)

Development of Weight and Shape Concerns in the Aetiology of Eating Disorders

Gowers SG, Shore A

Background: Concerns about weight and shape are thought to precede the development of eating disorders such as anorexia and bulimia nervosa and are included in the ICD-10 and DSM-IV criteria for these disorders. The etiology of such eating disorders, however, has yet to be fully determined. ***Aims:*** The goals of this research were to (1) determine if prior weight and shape concerns were necessary for the development of eating disorders, (2) trace the pathway from concern about appearance to eating behaviors to disorders, and (3) identify the source of anxiety that may lead to eating disorders. ***Method:*** A review using the keywords *eating disorder, weight concern, shape concern,* and *aetiology* was conducted of the MEDLINE and Psychlit databases. Studies were included on the basis of recent publication, strength of quantitative findings, and originality of ideas. ***Results:*** Concerns about weight and shape usually, but not always, precede development of eating disorders. These concerns stem from biological factors (e.g., changes in percentage of body fat in girls during adolescence, presence of obesity), family factors (e.g., attitudes about eating and presence of eating disorders in parents and siblings, feeding practices), and sociocultural factors (e.g., social class, media influence). Although concern about appearance often leads to dieting, few individuals who diet later develop eating disorders. In addition, factors associated with need for restraint (such as perfectionism, moral and religious beliefs, and impulsivity), rather than with concern about appearance, may also lead to the development of eating disorders. ***Conclusions:*** Eating disorders tend to follow concerns about weight and appearance but also may stem from an individual's perceived need for restraint in some area of his or her life. Interventions that target the concerns that precede dieting and development of eating disorders may prove fruitful.

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Cost-Effectiveness of Practice-Initiated Quality Improvement for Depression: Results of a Randomized Controlled Trial

Schoenbaum M, Unützer J, Sherbourne C, et al.

Background: Despite the high rate of depression among patients treated in primary care, the quality of care for depressed primary care patients is low. This study compared the societal cost-effectiveness and impact on patients' employment associated with 2 practice-based quality improvement (QI) programs between June 1996 to July 1999. ***Method:*** Forty-six primary care clinics were randomly chosen to provide 1 of 3 treatment interventions to depressed patients (Composite International Diagnostic Interview criteria): usual care (N = 443 patients) and 1 of 2 QI intervention programs that provided training and education/assessment materials to treatment providers as well as either medication follow-up (QI-meds, N = 424) or psychotherapy administered by trained local professionals (QI-therapy, N = 489). Total health care costs, costs per quality-adjusted life-year (QALY), number of days with depression, and employment over 2 years were compared between usual care and the 2 intervention groups. ***Results:*** Although both the QI-meds and QI-therapy interventions were associated with increased annual medical care costs compared with usual care (QI-meds: average increase = $419, 11%; QI-therapy: average increase = $485, 13%), the increases were not significant (p = .35 for QI-meds, p = .28 for QI-therapy). Costs per QALY were within the range of many accepted medical interventions (range, $15,331 to $36,467 for QI-meds, $9478 to $21,478 for QI-therapy). Both QI-meds and QI-therapy were associated with fewer days with depression burden (QI-meds: 25 days, p = .19; QI-therapy: 47 days, p = .01) and more days of employment (QI-meds: 17.9 days, p = .07; QI-therapy: 20.9 days, p = .03) than usual care. ***Conclusions:*** Practice-initiated quality-of-care interventions for depressed primary care patients can markedly improve welfare of both patients and society as a whole. Although such interventions cost more than usual care, the burden of these costs may be lessened by the positive effect the interventions have on patients' employment.

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