

Psychiatric Briefs

Validation and Utility of a Self-Report Version of PRIME-MD

Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group

The Primary Care Evaluation of Mental Disorders (PRIME-MD) arose as a screening instrument, but its clinical application has been restricted by its administration time. This criterion standard study was undertaken between May 1997 and November 1998 to determine whether the self-administered PRIME-MD Patient Health Questionnaire (PHQ) is valid and useful for diagnosing mental disorders in primary care compared with the original clinician-administered PRIME-MD. Sixty-two primary care physicians (21 internal medicine, 41 family practice) assessed 3000 adult patients drawn from 8 U.S. primary care clinics. Of these, 585 patients were assessed by a mental health professional within 48 hours of completing the PHQ. Measures of outcome were PHQ diagnoses compared with diagnoses made independently by mental health practitioners, function status measures, disability days, health care utilization, and treatment/referral decisions. 825 (28%) of the 3000 patients and 170 (29%) of the 585 had a PHQ diagnosis. As with the original PRIME-MD, agreement between PHQ diagnoses and those made by mental health practitioners was good (for diagnosis of any 1 or more PHQ disorder, $\kappa = 0.65$; overall accuracy, 85%; sensitivity, 75%; specificity, 90%). Patients with PHQ diagnoses had more functional impairment and more disability days and used more health care resources than did those without PHQ diagnoses (for all group main effects, $p < .001$). It took much less time, on average, for the physician to review the PHQ than to conduct the original PRIME-MD (< 3 min for 85% vs. 16% of the cases). In spite of the fact that 80% of physicians reported that they would find regular use of the PHQ helpful, new management actions were enacted or planned for only 117 (32%) of the 363 patients with 1 or more PHQ diagnoses previously unidentified. This study suggests that the PHQ has diagnostic validity equivalent to the original clinician-administered PRIME-MD while being more efficient to use.

(JAMA 1999;282:1737-1744)

Childhood Risk Factors for Adults With Medically Unexplained Symptoms: Results From a National Birth Cohort Study

Hotopf M, Mayou R, Wadsworth M, et al.

This study hypothesized a positive relationship between physical illness in childhood and medically unexplained symptoms as an adult. To test this theory, a nested case-control study was performed within a prospective birth cohort study (The Medical Research Council National Survey of Health and Development). Individuals reporting 3 or more symptoms (approximately the top 5%) at age 36 years were screened for physical illness. Subjects lacking definite diagnoses of physical illness

($N = 191$) were compared with the rest of the sample ($N = 3107$) for childhood exposures. Reports of poor health in parents when subjects were aged 15 years were powerfully related to symptoms at age 36, and this relationship was independent of any current psychiatric disorder. Medically unexplained symptoms were associated with abdominal pain in childhood rather than with defined childhood illnesses. Symptoms without medical explanations seem to be related to previous familial illness and prior unexplained symptoms in the subjects. This relationship may mirror a learned process in which illness experience leads to symptom monitoring.

(Am J Psychiatry 1999;156:1796-1800)

Lithium Augmentation in Treatment-Resistant Depression: Meta-Analysis of Placebo-Controlled Studies

Bauer M and Döpfner S

Many controlled studies have investigated lithium augmentation of antidepressants to which depressed patients have been unresponsive. This meta-analysis evaluated the efficacy of lithium augmentation of conventional antidepressants. The authors tried to identify all placebo-controlled trials of lithium augmentation in refractory depression. Their search was confined to double-blind studies including patients who had been treated with lithium or placebo after failing to respond to conventional antidepressants. Other inclusion criteria were the use of accepted diagnostic criteria for depression and the use of response criteria based on the acceptable measurement of depression as an outcome variable. Trials were identified by searching MEDLINE, a search in the Cochrane Library, and an intensive hand search of reviews on lithium augmentation. Of 11 placebo-controlled, double-blind studies, 9 were included in the meta-analysis. The authors noted, after combining 3 studies with an aggregate total of 110 patients using a minimum lithium dose of 800 mg/day, or a dose adequate to bring lithium serum levels to ≥ 0.5 mEq/L, and treatment lasting at least 2 weeks, that the pooled odds ratio of response during lithium augmentation compared with placebo treatment response was 3.31 (95% CI = 1.46 to 7.53). The corresponding relative response rate was 2.14 (95% CI = 1.23 to 3.70), the absolute improvement in rate was 27% (95% CI = 9.8% to 44.2%), and the number of patients needed to be treated to obtain one more responder was 3.7. Six more studies—comprising an additional 234 patients—were identified that met inclusion criteria but whose subjects were treated with lithium augmentation for less than 2 weeks or with a lower lithium dose. Estimates were even higher when these studies were added. Lithium augmentation seems to be the most studied treatment option in refractory depression. Judging effectiveness, the authors conclude from this meta-analysis that lithium augmentation is the first-line treatment choice for the depressed patient who fails to respond to monotherapy.

(J Clin Psychopharmacol 1999;19:427-434)

Prevalence and 12-Month Outcome of Threshold and Subthreshold Mental Disorders in Primary Care

Pini S, Perkonig A, Tansella M, et al.

The authors examined the occurrence and 12-month outcome of mental disorders in a primary care setting. At an index period in 16 primary care clinics, 1555 primary care patients were screened. Of these, 457 were chosen to participate in second-phase screening with the Composite International Diagnostic Interview (CIDI); 250 patients completed the evaluation. One hundred sixteen of these subjects (49 ICD-10 and 67 subthreshold cases) completed the 12-month follow-up evaluation. The assessment revealed that 12.4% of consecutive primary care patients had a current ICD-10 disorder; subthreshold mental disorders appeared in 14.2%. Comorbid psychiatric disorders appeared in 45% of the original sample. Clinicians identified a mental disorder at baseline in 84.6% of subjects with depression comorbid with anxiety and in 44.8% of subthreshold cases. After 1 year, subthreshold cases went into remission at 3 times the rate of threshold cases. Psychopathology in subthreshold cases, however, failed to improve after 12 months. Baseline identification of mental disorder by the clinician was associated with a positive change in occupational disability and self-reported disability among threshold cases rather than with an improvement of psychopathology after 12 months. Although mental disorders occur often in the primary care setting, their outcome bears little relation to identification by the physician, and threshold cases have worse 12-month outcomes than subthreshold cases. Even so, a substantial variability in outcome appears to characterize different diagnostic subgroups in threshold and subthreshold cases alike.

(*J Affect Disord* 1999;56:37–48)

Clinical Determinants of Suicidal Ideation and Behavior in Geriatric Depression

Alexopoulos GS, Bruce ML, Hull J, et al.

This study sought to discover clinical characteristics by which to recognize elderly patients with depression at risk for suicidal ideation and to establish their prognosis. Suicidal ideation, past suicidal behavior, severity of depression, cognitive impairment, medical burden, disability, and social support were evaluated in 354 subjects with depression aged 61 to 93 years. Patients had face-to-face evaluations and telephone assessments for a mean \pm SD of 1.8 ± 2.2 years. Earlier suicide attempts with serious intent (OR = 2.82, 95% CI = 1.37 to 5.80), severity of depression (OR = 1.09, 95% CI = 1.03 to 1.16), and poor social support (OR = 1.77, 95% CI = 1.18 to 2.65) predicted suicidal ideation during the index period. Subjects with a severe index episode (OR = 1.05, 95% CI = 1.00 to 1.11), impaired instrumental activities of daily living (OR = 0.78, 95% CI = 0.67 to 0.93), and limited impairment in activities of daily living (OR = 1.53, 95% CI = 1.10 to 2.14) reported suicide attempts during the year before study entry. At the first assessment, severity of depression, previous attempts, and seriousness of suicidal intent predicted the course of suicidal ideation (concordance correlation, 0.78). During follow-up assessments, contemporaneous severity of depression was the strongest determinant of suicidal ideation

over time (concordance correlation, 0.88). The elderly who experience severe depression, have a history of suicide attempts with serious intent, and have poor social support are the most likely to have suicidal ideation; such individuals should be the targets of suitable interventions. Severity of depression is the most important determinant of suicidal ideation over time.

(*Arch Gen Psychiatry* 1999;56:1048–1053)

Effects of Triazolam at Three Phases of the Menstrual Cycle

Rukstalis M and de Wit H

The direct or indirect actions on neuronal receptors of ovarian hormones or their metabolites may affect responses to psychoactive drugs acting on the same central nervous system receptors. This study assessed the effect of menstrual cycle on the mood-altering and performance effects of a single oral dose of the benzodiazepine triazolam. At the follicular, periovulatory, and luteal phases of their menstrual cycles, 20 women were administered triazolam (0.25 mg orally) in a within-subject design. Among dependent measures were self-reported mood states, psychomotor performance, and plasma levels of triazolam, estradiol, progesterone, and allopregnanolone. As anticipated, most patients reported increased fatigue and decreased arousal and psychomotor performance. The 3 phases of the menstrual cycle affected neither plasma levels, mood effects, or performance effects of the triazolam dose. In this study, a useful methodology for the evaluation of responses to psychoactive drugs in women with normal menstrual cycles is illustrated. Our findings indicate that the effects of triazolam are highly stable across the cycle.

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Seasonal Affective Disorder Among Primary Care Attenders and a Community Sample in Aberdeen

Eagles JM, Wileman SM, Cameron IM, et al.

Owing to the absence of large published studies of the prevalence of seasonal affective disorder (SAD) in the U.K., this study was mounted to assess the prevalence of SAD among primary care patients. All such patients aged 16 to 64 years consulting general practitioners in Aberdeen, U.K., during January 1999 took the Seasonal Pattern Assessment Questionnaire (SPAQ). In addition, 600 matched patients who had not consulted general practitioners during January received the SPAQ in the mail. Patients who met SPAQ criteria for SAD were offered an interview to establish whether they also met criteria for SAD according to DSM-IV and the Structured Interview Guide for the Hamilton Rating Scale for Depression-Seasonal Affective Disorder Version (SIGH-SAD). Of 6161 patients consulting their primary care physicians in January, 4557 (74%) completed the SPAQ. Of these, 442 (9.7%) met SPAQ criteria for SAD. The rate of SAD did not differ between patients who had consulted their general practitioners and those who had been sent the SPAQ through the mail. Of 223 SAD patients invited to the further interview, 91 (41%) also met DSM-IV and SIGH-SAD criteria for SAD. This high prevalence of SAD among patients who consulted general practitioners in January is likely to extend to the community at large.

(*Br J Psychiatry* 1999;175:472–475)