

EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

Does Antenatal Screening for Psychosocial Risk Factors Predict Postnatal Depression? A Follow-Up Study of 154 Women in Adelaide, South Australia

Edwards B, Galletly C, Semmler-Booth T, et al.

Aust N Z J Psychiatry 2008;42:51–55

Objective: This study examined the effectiveness of antenatal screening for psychosocial risk factors as a predictor of postnatal depression in women from socioeconomically deprived areas.

Method: The Antenatal Psychosocial Questionnaire (APQ) and the Edinburgh Postnatal Depression Scale (EPDS) were completed by 154 women. Antenatal psychosocial risk factors predictive of EPDS caseness were identified by logistic regression analysis. An EPDS score ≥ 10 or more was taken to indicate depression.

Results: Antenatal depression was more common than postnatal depression. Forty-four women (30%) met criteria for antenatal depression, while 33 women (22.6%) met criteria for postnatal depression. Twenty-one women (14.4%) endorsed depression both before and after delivery of their babies, and women who had antenatal depression were significantly more likely to be depressed postnatally. While antenatal psychosocial risk factors were endorsed at high rates, emotional abuse as a child was the sole item from the APQ that predicted postnatal depression.

Conclusion: Although antenatal screening for psychosocial risk factors was helpful in distinguishing antenatal problems, it was not useful in forecasting postnatal depression.

Expert Survey for the Management of Adolescent Depression in Primary Care

Cheung AH, Zuckerbrot RA, Jensen PS, et al., and the GLAD PC Steering Committee

Pediatrics 2008;121(1):e101–e107

Objective: Primary care professionals who confront the task of treating teenagers with mental health problems such as depression find little guidance, despite the fact that primary care clinics have become the de facto mental health clinics for this population. In the absence or scarcity of empirical literature, this study surveyed experts on key management issues regarding adolescent depression in primary care.

Method: Participants, who were identified through nonprobability sampling, included experts from family medicine, pediatrics, nursing, psychology, and child psychiatry. Focus groups with patients, families, and professionals and the research literature provided information from which the expert survey, which included sections on early identification, assessment and diagnosis, initial management, treatment, and ongoing management, was developed. Means, standard deviations, and confidence intervals were calculated for each survey item.

Results: Seventy-eight (96%) of 81 experts approached, 40 (53%) of whom were primary care professionals, consented to participate. Routine surveillance for youth at high risk for depression and the use of standardized measures as diagnostic aids were recommended by the experts. "Active monitoring" was deemed appropriate for treatment of recent-onset mild depression. For moderate depression without complicating factors such as comorbid illness, both medication and psychotherapy were considered acceptable treatment options. Fluoxetine was deemed the most appropriate antidepressant for use in this population. Patients who are started on antidepressant therapy should be followed within 2 weeks after initiation, experts agreed.

Conclusions: The identification and management of adolescent depression in the primary care setting are supported by survey results. In addition, results support referral and comanagement with specialty mental health professionals in specific situations. Despite the recent controversies around treatment, experts across both primary care and specialty mental health concluded that, under certain clinical circumstances, active monitoring, pharmacotherapy with selective serotonin reuptake inhibitors, and psychotherapy can be appropriate when initiated within primary care settings.

Evaluating Differential Item Functioning of the PRIME-MD Mood Module Among Impoverished Black and White Women in Primary Care

Hepner KA, Morales LS, Hays RD, et al.

Womens Health Issues 2008;18(1):53–61

Background: Accurate screening and diagnosis of depression are required for appropriate treatment. It is important to evaluate depression screening instruments for differential item functioning across diverse populations. The Primary Care Evaluation of Mental Disorders (PRIME-MD) is commonly used in primary care settings to screen for the most common psychiatric disorders, including depression. The purpose of this study was to determine whether items in the mood module of the PRIME-MD perform similarly in 2 high-risk populations: impoverished black and white women.

Method: Data from women receiving county health and welfare services were collected during screening for a randomized controlled trial of treatment for depression. Analyses are based on a sample of 3506 black (N = 3191) and white (N = 315) women who completed the PRIME-MD mood module. An item response theory approach to differential item functioning assessment was used to compare responses. Mean scores, missing data, and internal consistency reliability were also compared.

Results: None of the 9 items exhibited significant differential item functioning. Missing data rates and internal consistency reliability did not differ for the 2 groups. White women endorsed higher levels of depression compared with black women on 6 of the 9 items ($p < .05$), according to mean comparisons.

Conclusions: All items of the mood module of the PRIME-MD performed similarly for white and black women, these results suggest. Actual differences in DSM-IV depression symptoms between white and black women are responsible for differences in endorsed depressive symptomatology on the mood module.

Detecting Depression in the Aged: Is There Concordance Between Screening Tools and the Perceptions of Nursing Home Staff and Residents? A Pilot Study in a Rural Aged Care Facility

Johnston L, Reid A, Wilson J, et al.

Aust J Rural Health 2007;15(4):252–256

Objective: A lack of mental health specialists hinders recognition of depression in the elderly in rural and remote regions. In nursing homes, screening tools have been endorsed as more reliable than both nursing staff and residents in recognizing depression. The usefulness of screening tools is subject to continuing debate. Previous research has failed to address concordance between screening tools, nursing staff, and residents in recognizing depression. The present study sought to identify any significant difference in the proportion of depressed residents identified by recognition sources and evaluated the level of random corrected agreement between sources.

Method: In this cross-sectional, between-subjects study, 102 residents of aged care facilities in Wagga Wagga, Australia, mean \pm SD age = 85.19 \pm 7.09 years, were interviewed in their residential aged care facility. The main outcome measures were assessments by residents, nursing staff, the Geriatric Depression Scale (GDS-12R) and the Hamilton Rating Scale for Depression (HAM-D).

Results: Although the HAM-D and nursing staff professional opinion were not significantly different, both measures

were significantly different from the resident measures (GDS-12R and resident opinion). No more than a moderate level of chance corrected agreement between these sources, at best, was revealed by κ statistic analysis of outcome measures.

Conclusion: Because the different outcome measures might reflect qualitatively different constructs of depression, we suggest that health professionals who deal with depression in the elderly be cognizant of the disparity between recognition sources and subsequently consider a variety of them.

Insured and Noninsured Depressed Outpatients: How Do They Compare?

Lesser IM, Leuchter AF, Trivedi MH, et al.

Ann Clin Psychiatry 2007;19(2):73–82

Background: This study investigated relationships between clinical and demographic characteristics of depressed patients and source of payment for care in an attempt to confirm and extend findings from a previous study regarding the first 1500 participants enrolled in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. STAR*D had 2541 participants enrolled in later stages of the trial.

Method: We compared demographic and clinical characteristics and presenting symptoms among participants with public, private, or no insurance.

Results: Subjects with public insurance were older; more likely to be women, Hispanic, widowed or divorced, unemployed, and less educated; and more frequently seen in primary care; and had greater medical comorbidity and functional impairment and a later age at depression onset when compared with those having private or no insurance. In addition, publicly insured participants had a longer current episode but fewer episodes over their lifetime. Compared to participants with private insurance, both the publicly insured and uninsured subjects had poorer life satisfaction. With respect to several demographic characteristics and measures of severity, subjects without insurance fell between those with public and private insurance.

Conclusions: Although depressed outpatients with public insurance did not have a more severe depression per se, they evinced greater functional impairment. With a presentation that fell between subjects with public and private insurance, subjects without insurance seemed to be a heterogeneous group. Because participants with public insurance were overrepresented in primary care clinics, clinicians in these settings need to be particularly vigilant in identifying depression and treating it appropriately.

A Sham-Controlled Trial of the Efficacy and Safety of Twice-Daily rTMS in Major Depression

Loo CK, Mitchell PB, McFarquhar TF, et al.

Psychol Med 2007;37(3):341–349

Background: Because studies of repetitive transcranial magnetic stimulation (rTMS) in depression, which have generally involved once-daily treatment, have shown positive but modest clinical results, the present study examined the efficacy and safety of twice-daily rTMS over 2 weeks.

Method: This double-blind, sham-controlled trial of twice-daily rTMS (left prefrontal cortex, 10 Hz, 110% intensity, 1500 stimuli per session) over 2 weeks enrolled 38 depressed subjects. Blind raters, using the Montgomery-Asberg Depression Rating Scale (MADRS) as the primary outcome measure,

evaluated mood and neuropsychological functioning weekly. In addition, the raters assessed performance on the Hamilton Rating Scale for Depression and self-report measures. Twenty-two subjects continued with once-daily rTMS, to receive a total of 6 weeks of active rTMS, after the blind period.

Results: Participants evinced moderate treatment resistance. Participants receiving active treatment showed significantly greater improvement compared to those receiving sham on only 1 outcome measure (MADRS, $p < .05$) over the 2-week blind period. Participants evinced additional improvement over the 6 weeks of active rTMS. Neuropsychological test scores did not show significant change.

Conclusions: Administered twice daily, rTMS was effective and safe, with no adverse neuropsychological effects.

A Qualitative Study of Depression in Primary Care: Missed Opportunities for Diagnosis and Education

Saver BG, Van-Nguyen V, Keppel G, et al.

J Am Board Fam Med 2007;20(1):28–35

Purpose: Although depression is one of the most commonly chronic conditions in primary care, it continues to be substantially underdiagnosed and undertreated. We sought to better understand obstacles to diagnosis of and entering treatment for depression in primary care.

Method: Fifteen patients presently being treated for depression were recruited from primary care clinics in an academic medical center and an academic public hospital and interviewed, and those interviews were analyzed. Patients were asked about experiences with being diagnosed with depression and starting treatment, focusing on obstacles to diagnosis, patient perceptions of depression, and information issues related to treatment decisions.

Results: Patients noted many visits to primary care practitioners in which the subject of depression failed to be raised. Most patients had recurrent depression. Many reported receiving insufficient information about depression and its treatment options. In most cases, clinicians chose the course of treatment with little input from the patients.

Conclusions: Evidence of frequent missed diagnoses, substantial information gaps, and limited patient understanding and choice of treatment options was found in this sample of depressed patients. Quality improvement efforts should focus not only on screening and follow-up but also on patient education concerning depression and treatment options as well as on inquiring about patient treatment preferences.

Reducing Suicidal Ideation in Depressed Older Primary Care Patients

Unützer J, Tang L, Oishi S, et al,

for the IMPACT Investigators

J Am Geriatr Soc 2006;54(10):1550–1556

Objective: To ascertain the effect of a primary care-based collaborative care program for depression on suicidal ideation in older adults.

Method: In this randomized controlled trial, 1801 adults aged 60 and older with major depression or dysthymia were enrolled at 18 diverse primary care clinics. Patients randomly assigned to collaborative care had a depression care manager available who supported antidepressant medication manage-

ment prescribed by their primary care physician and supplemented that process with a course of Problem Solving Treatment in Primary Care for 12 months. Patients in the control arm received care as usual. Participants were independently evaluated for depression and suicidal ideation at baseline and 3, 6, 12, 18, and 24 months. The Structured Clinical Interview for DSM-IV (SCID), was the outcome measure for depression. The SCID and the Hopkins Symptoms Checklist were used to assess suicidal ideation.

Results: At baseline, 139 (15.3%) intervention participants and 119 (13.3%) controls reported suicidal ideation. Intervention subjects had significantly lower rates of thoughts of suicide than controls at 6 months (7.5% vs. 12.1%) and 12 months (9.8% vs. 15.5%). This advantage continued despite the fact that intervention resources were no longer available at 18 months (8.0% vs. 13.3%) and 24 months (10.1% vs. 13.9%). No completed suicides were reported in either group. A record of suicide attempts or hospitalization for suicidal ideation was unavailable.

Conclusion: This study identified primary care-based collaborative care programs for depression as one approach to reducing suicidal ideation and, potentially, the risk of suicide in older primary care patients.

Intervention Study of Exercise for Depressive Symptoms in Women

Craft LL, Freund KM, Culpepper L, et al.

J Womens Health (Larchmt) 2007;16:1499–1509

Background: Millions of women are affected by clinical depression annually. Most studies support the efficacy of exercise as a potential antidepressant. Although exercise also has the potential to lower the risk for physical comorbidities concomitant with depression, less is known about the types of exercise programs to which women with depressive symptoms will adhere. We sought to (1) compare 2 exercise programs, varying in their degree of structure, on improvements in physical activity and (2) compare the 2 exercise interventions on depressive symptoms, body composition, and fitness.

Method: This 3-month intervention study recruited women with depressive symptoms (physician diagnosed and confirmed with the Beck Depression Inventory [BDI]) residing in the greater Boston, Mass. area. Subjects were continuously enrolled between November 2005 and November 2006. Women were randomly assigned to either a clinic-based or home-based exercise intervention, with assessments at baseline and 3 months.

Results: Most participants ($N = 32$) were minority (81.4%); at baseline, they had moderate symptoms of depression (BDI, mean = 25.6, SD = 9.3) and were sedentary (mean = 35.8 minutes/week of moderate and vigorous activity, SD = 31.4). Strong improvements across time were indicated for gain scores for depressive symptoms (clinic-based, mean = -11.7; home-based, mean = -9.7) and physical activity (clinic-based, mean = 65.4; home-based, mean = 39.0). Both interventions were associated with improvements in time spent in physical activity and depressive symptoms, according to intent-to-treat analyses performed on 3-month data. Neither intervention had an effect on body composition or fitness.

Conclusions: Reductions in depressive symptoms and increased physical activity participation were found in participants in both exercise programs, suggesting that even a home-based program can benefit women with depressive symptoms.

The Effects of Memory, Attention, and Executive Dysfunction on Outcomes of Depression in a Primary Care Intervention Trial: The PROSPECT Study

Bogner HR, Bruce ML, Reynolds CF III, et al., and the PROSPECT Group

Int J Geriatr Psychiatry 2007;22(9):922–929

Objective: To characterize the effect of cognitive domains on depression remission and response in an intervention trial among older patients in primary care.

Method: Patients at 20 primary care practices were randomly assigned to usual care or to an intervention consisting of a depression care manager providing care for depression based on algorithms. These assessments included 599 adults aged 60 years and older with a diagnosis of depression. The 24-item Hamilton Rating Scale for Depression evaluated depression severity and remission. Our global measure of cognitive function was the Mini-Mental State Examination. The memory subscale of the Dementia Rating Scale was used to evaluate verbal memory. The digit span from the Wechsler Adult Intelligence Test was used to assess attention. The Stroop Color-Word test was used to evaluate response inhibition, one of the executive functions.

Results: Cognitive impairment did not affect the intervention, which was associated with improved remission and response rates. According to the Stroop Color-Word test, response inhibition appeared to significantly alter the intervention versus usual care difference in remission and response at 4 months. Patients in the intervention condition whose Stroop Color-Word test scores placed them in the poorest performance quartile at baseline were more likely to achieve remission of depression at 4 months than were comparable patients in usual care (odds ratio = 17.76, 95% CI = 3.06 to 103.1).

Conclusions: Although depressed older adults in primary care with executive dysfunction have low remission and response rates when receiving usual care, they benefit from depression care management.

The Relationship Between Beliefs About Depression and Coping Strategies: Gender Differences

Kelly MA, Sereika SM, Battista DR, et al.

Br J Clin Psychol 2007;46(3):315–332

Objective: A conceptual framework by which to investigate the relationship between beliefs about depressive illness and use of coping strategies is provided by Leventhal's common-sense model of illness representation. We investigated this association among depressed patients both across genders and in terms of gender differences.

Method: Self-report measures of beliefs about depression, emotional reaction to depression, beliefs about medications, and coping strategies used were solicited from depressed primary care patients prescribed antidepressants. We present baseline data from a longitudinal study. Canonical correlation analysis, a multivariate statistical method akin to principal component and regression analyses, was used to conduct primary data analyses. This method allows for parsimonious description of the association between 2 multivariate sets of variables (in

this case, beliefs about depression and coping strategies) by identifying pairs of linear combinations that account for the majority of the between association from the 2 sets of variables.

Results: One hundred eighty-nine depressed primary care patients (70.4% female) comprised the sample. Emotional reaction to depression is a major factor in determining coping strategies, according to our analyses. We found a relationship between greater emotional reaction to depression and maladaptive coping for men and women, while women showed further associations between greater observed control over depression and more adaptive coping techniques as well as between apprehension of effects of depression and problem solving.

Conclusions: Beliefs about depression may be associated with coping styles. Further, different perceptions of depression among men and women may affect the coping styles they adopt.

Enhanced Treatment for Depression in Primary Care: Long-Term Outcomes of a Psycho-Educational Prevention Program Alone and Enriched With Psychiatric Consultation or Cognitive Behavioral Therapy

Conradi HJ, de Jonge P, Kluiters H, et al.

Psychol Med 2007;37(6):849–862

Background: Because the long-term outcome of major depression is often unfavorable, and most cases of depression are managed by general practitioners (GPs), there is a need to improve treatment in primary care. This study assessed the long-term effects of enhancing usual care (UC) administered by a GP with 3 experimental interventions.

Method: In a randomized controlled trial conducted from 1998 to 2003, the main inclusion criterion was receiving GP treatment for a depressive episode. We compared (1) UC (N = 72) with UC enhanced with (2) a psychoeducational prevention (PEP) program (N = 112), (3) a psychiatrist-enhanced PEP (N = 37), and (4) brief cognitive behavioral therapy followed by PEP (CBT-enhanced PEP) (N = 44). During a 3-year follow-up period, depression status was evaluated quarterly.

Results: Pooled across groups, depressive disorder-free and symptom-free times during follow-up were 83% and 17%, respectively. Almost 64% of the patients had a relapse or recurrence. The median time to recurrence was 96 weeks, and the mean Beck Depression Inventory (BDI) score over 12 follow-up assessments was 9.6. Unexpectedly, patients receiving PEP had outcomes no better than patients administered UC. However, patients receiving psychiatrist-enhanced PEP and CBT-enhanced PEP reported lower BDI severity during follow-up than patients administered UC (mean difference 2.07 [95% CI = 1.13 to 3.00] and 1.62 [95% CI = 0.70 to 2.55], respectively) and patients administered PEP (mean difference 2.37 [95% CI = 1.35 to 3.39] and 1.93 [95% CI = 0.92 to 2.94], respectively).

Conclusions: The PEP program had no extra benefit compared to UC and may even have worsened outcome in severely depressed patients. Long-term outcome seems to be improved by enhancing treatment of depression in primary care with psychiatric consultation or brief CBT. Because the interventions were combined with the ineffective PEP program, however, these findings require replication.