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.

Current and Past Maternal Depression, Maternal Interaction Behaviors, and Children's Externalizing and Internalizing Symptoms

Foster CJ, Garber J, Durlak JA

J Abnorm Child Psychol 2008 May;36(4):527–537

Background: The association of mothers' past depressive disorders, current depressive symptoms, and how mothers relate to their children and how well children adjust has not been well defined.

Method: We examined relations among past maternal depressive disorder, current depressive symptoms, current maternal interaction behaviors, and children's adjustment in a sample of 204 women and their young adolescent offspring (mean age = 11.86 years, SD = 0.55 years). Mothers either had (N = 157) or had not (N = 57) experienced at least 1 depressive disorder during the child's life. Mothers and children were videotaped (for later coding) participating in a problem-solving exercise.

Results: Mothers with current depressive symptoms and those with histories of chronic/severe depressive disorders evinced fewer positive behaviors toward their children; in addition, mothers with current depressive symptoms displayed more negative behaviors with their children. Mothers' current mood state partially mediated the relation between mothers' depression history and their behavior during the interaction with their child. Moreover, high levels of maternal negativity and low levels of positivity during the problem-solving exercise were associated with children's externalizing difficulties. The association between maternal depression and children's externalizing symptoms was partially mediated by maternal positivity.

Conclusions: The importance of providing parenting interventions for depressed mothers is emphasized by these results.

Prevalence and Risk Factors of Threshold and Subthreshold Psychiatric Disorders in Primary Care

Cwikel J, Zilber N, Feinson M, et al.

Soc Psychiatry Psychiatr Epidemiol 2008 Mar;43(3):184–191

Objective: Population and the type of measure used result in varying prevalence rates of mental health problems in primary care. We investigated the prevalence of a full range of mental health problems, including subthreshold diagnoses, and the sociodemographic risk factors for psychiatric disorders, among a population with low out-of-pocket expenditures for medical care in this study.

Method: A sample of 976 users of primary care in Israel between the ages of 25 and 75 years in 8 clinics throughout the country was administered 4 validated mental health assessment instruments, including the World Health Organization Composite International Diagnostic Interview-Short Form. The researchers estimated the prevalence rates of 7 psychiatric diagnoses, 2 "other mental health disorders" (somatization and disordered eating), and 5 subthreshold conditions.

Results: Depression and disordered eating (20.6% and 15.0%, respectively) were the most common types of morbidity, followed by somatization (11.8%) and general anxiety (11.2%). Among respondents, 31.1% had at least 1 psychiatric diagnosis, 24.3% had "other mental disorders," and 15.5% had subthreshold conditions. Conditions significantly more prevalent among women than men included panic attack, disordered eating, and somatization, as well as a global measure of any psychiatric diagnosis. Those in the age group 45 to 64 years, with less education and insufficient income, and the never married and separated/divorced and those not working had higher rates of psychiatric diagnoses. There were no significant differences in rates of prevalence of mental disorders between recent immigrants, veteran immigrants, and Israeli-born immigrants; between Arab and Jewish Israelis; or between secular or religious sectors of the population.

Conclusions: Posttraumatic stress disorder, somatization, and disordered eating behaviors are among the most common disorders in primary care for which this study establishes prevalence rates. That a more accurate picture of mental disorders in primary care requires an expanded assessment procedure is suggested by the presence of additional mental disorders found in our study.

Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence (The Combining Medications and Behavioral Interventions Study): Examination of Posttreatment Drinking Outcomes

Donovan DM, Anton RF, Miller WR, et al.

J Stud Alcohol Drugs 2008;69:5–13

Objective: This study was designed to evaluate the efficacy of pharmacologic and behavioral interventions across 1 year posttreatment in the Combining Medications and Behavioral Interventions Study.

Method: Recruited at 11 outpatient academic alcoholism-treatment clinics across the United States, 1383 alcohol-dependent subjects (428 women) participated in a randomized, double-blind, placebo-controlled trial. Subjects received 16 weeks of naltrexone or acamprosate or both medications and/or placebos combined with medical management (MM), with or without combined behavioral intervention (CBI); 1 group received CBI without pills or MM. Drinking behavior and clinical status were evaluated at the end of treatment (week 16) and at weeks 26, 52, and 68.

Results: Earlier treatment with active naltrexone, without active acamprosate or CBI or with active acamprosate plus CBI, and CBI with double placebo brought about a significantly higher percentage of days abstinent than double placebos with no CBI ($p < .05$). Having received CBI was associated with positive clinical response posttreatment compared with not having received CBI. Time to the first heavy-drinking day posttreatment ($p = .03$) was increased by prior treatment with naltrexone. Patients who had received CBI without MM or pills and those who had received MM and double placebo with or without CBI did not differ. None of the outcome measures showed significant main effects for acamprosate.

Conclusions: Previous treatment with MM and either CBI or naltrexone, or both, was associated with sustained efficacy beyond discontinuation, while treatment with acamprosate was not. Reasons for the maintained treatment gains with naltrexone and/or CBI and possible methods of prolonging them are discussed.

Effect of Age at Onset on the Course of Major Depressive Disorder

Zisook S, Lesser I, Stewart JW, et al.

Am J Psychiatry 2007;164:1539–1546

Objective: To evaluate whether a specific subgroup of major depressive disorder is defined by age at onset in 4041 participants who entered the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study.

Method: Outpatients aged 18 to 75 years with nonpsychotic major depressive disorder from both primary care and psychiatric care practices were enrolled in the study. Participants estimated the age at which they experienced the onset of their first major depressive episode at study entry. The population was divided into 5 age-at-onset groups: childhood onset (aged < 12 years), adolescent onset (aged 12–17 years), early adult onset (aged 18–44 years), middle adult onset (aged 45–59 years), and late adult onset (aged ≥ 60 years).

Results: No group clearly distinguished itself from another. Instead, we observed an apparent gradient, with earlier ages at onset associated with never being married, more impaired occupational and social function, poorer quality of life, greater medical and psychiatric comorbidity, a more negative view of the self and life, more lifetime depressive episodes and suicide attempts, and greater symptom severity and suicidal ideation in the index episode relative to those with later ages at onset of major depressive disorder.

Conclusions: Age at onset does not define distinct depressive subgroups, but earlier onset is related to multiple indicators of greater illness burden across a broad spectrum of indicators. There was no association between age at onset and a difference in treatment response to the initial trial of citalopram.

Patient Gender and Physician Practice Style

Bertakis KD, Azari R

J Womens Health (Larchmt) 2007 Jul–Aug;16(6):859–868

Background: The process of medical care and its outcomes may be affected by patient and physician gender. We sought to examine the influence of patient gender on what transpires during initial primary care visits. At the same time, we controlled for other variables already established as affecting the physician-patient interaction, e.g., physician gender and specialty, patient health status, pain, depression, obesity, age, education, and income.

Method: New patients (315 women, 194 men) were randomly assigned to care by 105 primary care physicians. During a previsit interview, sociodemographic information, self-reported health status and pain measures, a depression assessment, screening for alcoholism, history of tobacco use, and measured body mass index were collected. The entire medical visit was videotaped before being analyzed using the Davis Observation Code system.

Results: Patient gender did not significantly affect the visit length or work intensity (number of behavioral codes); women's visits, however, were typified by more discussions addressing the results of the therapeutic interventions, more preventive services, less physical examination, and fewer discussions about tobacco, alcohol, and other substance abuse.

Conclusions: Patient gender significantly affects the process of care. Gender-related considerations may affect medical decisions made by physicians. The delivery of gender-sensitive care demands systems for applying knowledge regarding these gender differences.

Managing Attention-Deficit/Hyperactivity Disorder in Primary Care: A Systematic Analysis of Roles and Challenges

Power TJ, Mautone JA, Manz PH, et al.

Pediatrics 2008 Jan;121(1):e65–e72

Objective: This study sought to examine the opinions of primary care providers concerning their roles and the challenges of managing attention-deficit/hyperactivity disorder (ADHD) and to assess differences between providers who serve families primarily from urban versus suburban settings.

Method: The ADHD Questionnaire was created to evaluate the views of primary care providers concerning the extent to which clinical activities involved in managing ADHD are apt and feasible in primary care. Participants were asked to rate each of 24 items of the questionnaire twice: first, indicating the aptness of the activity given sufficient time and resources and second, indicating feasibility in their actual practice. Aptness and feasibility for each item were rated on a 4-point scale.

Results: Four factors of clinical practice were identified by an exploratory factor analysis of primary care provider ratings of the aptness of clinical activities for managing ADHD: factor 1, evaluating ADHD; factor 2, administering mental health care; factor 3, recommending and overseeing approved medications; and factor 4, recommending nonapproved medications. On a 4-point scale (1 = not appropriate to 4 = very appropriate), mean ratings for items on factor 1, factor 2, and factor 3 were high, indicating that the corresponding areas of practice were regarded as highly appropriate. Feasibility problems were found on all factors, but especially factors 1 and 2. A significant interaction effect, indicating differences between aptness and feasibility as a function of setting (urban versus suburban), was identified on factor 1. The challenges of evaluating ADHD were greater for urban than for suburban primary care providers.

Conclusions: Primary care providers find their playing a role in the management of ADHD to be highly appropriate. Feasibility issues were particularly salient related to evaluating ADHD and administering mental health care. The results emphasize the need not only for further education of primary care providers but also for practice-based resources to support school communication and collaboration with mental health agencies, particularly those in urban practices.

Diagnosis of Common Mental Disorders by Using PRIME-MD Patient Health Questionnaire

Avasthi A, Varma SC, Kulhara P, et al.

Indian J Med Res 2008 Feb;127(2):159–164

Background: Common mental disorders (CMDs) usually go undiagnosed by primary care physicians in clinical settings. The Primary Care Evaluation of Mental Disorders (PRIME-MD) Patient Health Questionnaire (PHQ) has been demonstrated to facilitate diagnosis of most CMDs encountered in primary health care. Its utility in an Indian setting has not been assessed. We carried out this study in an Indian setting to assess the scope of psychiatric morbidity as measured by the PRIME-MD PHQ.

Method: A total of 500 consenting patients attending a medical outpatient department were recruited. All subjects were initially evaluated by the physician for presence of any physical illness and psychiatric disorder, and their sociodemographic data were gathered. Subjects were asked to complete the PRIME-MD PHQ. Illiterate subjects were assisted in completing the questionnaire by the research worker.

Results: Physicians found that 30.4% of the subjects had a psychological disorder at initial evaluation. The most common diagnostic category was anxiety disorders (15.8%), followed by depression (6%) and somatoform disorders (5.6%). Forty-two percent of subjects had at least 1 psychiatric diagnosis on the PHQ. Panic disorder (18.4%) was the most common psychiatric diagnosis, followed by other anxiety disorders (16.6%). When the diagnoses of physicians and the PHQ were compared, 105 of 152 cases (30.4% of the total cohort) suspected to have any psychological disorder by the physicians at the initial evaluation were found also to have a PHQ diagnosis. Two hundred forty-three of the 348 cases in which physicians did not suspect any psychiatric diagnosis were also negative in the PHQ screening. The correlation between physicians and PHQ diagnosis was significant.

Conclusion: Psychiatric morbidity in the general medical practice is high, and, in many cases, physicians either miss or misdiagnose psychiatric morbidity. The PHQ can be a useful screening instrument for psychiatric morbidity in primary care and general medical practice.

Outcomes and Predictors of Late-Life Depression Trajectories in Older Primary Care Patients

Cui X, Lyness JM, Tang W, et al.

Am J Geriatr Psychiatry 2008 May;16(5):406–415

Objectives: The naturalistic outcomes of depression in older primary care patients are poorly understood. We attempted to detect depressive trajectories over 2 years and to investigate specified outcome predictors established a priori.

Method: This 2-year observational cohort study was conducted at university-based and independent primary care practices in greater Rochester, N.Y. All patients older than 65 years were eligible to participate based on the day that they presented for care. Of 392 subjects enrolled, 316 (80.6%) completed study measures over a 2-year follow-up. Applying longitudinal cluster analysis to weekly depression status from the Longitudinal Interval Follow-Up Evaluation produced depression trajectories.

Results: We established 6 distinct trajectory clusters that followed clinically intuitive patterns. Subjects who were initially nondepressed or in the subsyndromal-to-minor depression range had a span of possible outcomes over 2 years, but the cluster initially near the major depression level remained at that level over time. Baseline depressive symptom severity, medical burden, and psychiatric functional status were reliable predictors of depression trajectory; previous history of depression and perceived social support also had predictive significance for some clusters.

Conclusion: Patients with more severe depressive symptoms have "real-world" outcomes that are discernibly poor. Because those with subsyndromal-to-mild forms of minor depression demonstrate diverse outcomes, clinicians might concentrate treatment efforts on those at highest risk of poor outcome, i.e., those with greater depressive symptoms and medical burden and lower psychiatric functioning and social support. The development of treatments to mitigate potentially modifiable risks such as deficits in social support might become the focus of preventive interventions research.

Childhood Adversity Predicts Earlier Onset of Major Depression But Not Reduced Hippocampal Volume

Lenze SN, Xiong C, Sheline YI.

Psychiatry Res 2008;162(1):39–49

Background: The severity and age at onset of depression, potentially mediated by greater vulnerability to an existing biochemical or neural mechanism, may be influenced by childhood adversity. That reduced hippocampal volume is a result of childhood adversity has been suggested by earlier studies. We investigated the association between childhood adversity, hippocampal volumes, and clinical characteristics in women recruited on the basis of depression history and not abuse experiences.

Method: The Childhood Experience of Care and Abuse interview was completed by 31 women with remitted unipolar depression and 24 psychiatrically healthy women. In addition, we obtained high resolution magnetic resonance imaging scans and hippocampal volumetric determination by stereological assessment.

Results: A relationship between childhood adversity and a history of recurrent depression and earlier age of depression onset was found. However, an association between childhood adversity and hippocampal volumes was not found in this sample with mild childhood adversity.

Conclusions: Additional factors may mediate the decreased hippocampal volume seen in major depressive disorder. In

order to more fully understand the interrelationships among childhood adversity, hippocampal morphology, neuroendocrine regulation, and other genetic and environmental factors influencing vulnerability to depression, additional research is indicated.

Direct and Indirect Links Between Childhood Maltreatment, Posttraumatic Stress Disorder, and Women's Health

Lang AJ, Aarons GA, Gearity J, et al.

Behav Med 2008 Winter;33(4):125–135

Objective: The associations among childhood maltreatment, sexual trauma in adulthood, posttraumatic stress disorder (PTSD), and health functioning in women were assessed by the authors.

Method: Self-report measures of childhood maltreatment, adult sexual trauma, PTSD symptoms, and current health functioning were completed by female Veterans Affairs (VA) primary care patients (N = 200). Models of the relationship among these variables were evaluated with structural equation modeling.

Results: Childhood nonsexual maltreatment and adult sexual assault were positively associated with PTSD. Childhood nonsexual maltreatment (beta = –0.20) and PTSD (beta = –0.75) were significantly associated with poorer physical and mental health functioning. Health functioning was negatively influenced by adult sexual assault through its association with PTSD. Thus, poor health outcomes associated with childhood maltreatment in women may be conveyed through PTSD.

Conclusions: Efforts to identify and treat PTSD in women who experienced childhood maltreatment with the aim of preventing or reducing poor health outcomes should be reinforced by these results.

Antenatal Risk Factors for Postnatal Depression: A Large Prospective Study

Milgrom J, Gemmill AW, Bilszta JL, et al.

J Affect Disord 2008 May;108(1–2):147–157

Background: Antenatal risk factors for postnatal depression in the Australian population, both singly and in combination, were assessed by this study. The National Postnatal Depression Program, part of the Australian National Depression Initiative known as beyondblue, collected risk factor data antenatally and evaluated depressive symptoms. Conducted in all 6 states of Australia and in the Australian Capital Territory between 2002 and 2005, this large prospective cohort study investigated perinatal mental health.

Method: The Edinburgh Postnatal Depression Scale (EPDS) and a psychosocial risk factor questionnaire covering key demographic and psychosocial information were used to screen pregnant women for symptoms of postnatal depression at antenatal clinics in maternity services around Australia.

Results: We collected antenatal EPDS data from 35,374 women (from a total of 40,333 participants), and 3144 (8.9%) of these had a score > 12. We subsequently attempted to follow up 22,968 women with a postnatal EPDS. Of 12,361 women who completed postnatal EPDS forms, 925 (7.5%) had an EPDS score > 12. The strongest independent antenatal predictors of a postnatal EPDS score > 12 were antenatal depression combined with a prior history of depression and a low level of partner support. The study was limited by the use of the EPDS (a self-report screening tool) as the measure of depressive symptoms rather than a clinical diagnosis and the rate of attrition between antenatal screening and the collection of postnatal follow-up data.

Conclusions: Antenatal depressive symptoms appear to be as common as postnatal depressive symptoms. Consistent with existing meta-analytic surveys, previous depression, current depression/anxiety, and low partner support were found to be key antenatal risk factors for postnatal depression in this large prospective cohort. Current depression/anxiety (and to some extent social support) can be targeted for intervention, as they may be amenable to change.

Anxiety and Depression Screening for Youth in a Primary Care Population

Katon W, Russo J, Richardson L, et al.

Ambul Pediatr 2008 May–Jun;8(3):182–188

Objective: A low rate of accurate identification of mental health disorders in youth by primary care physicians has been demonstrated in previous studies. The psychometric properties of 2 brief mental health screening questionnaires, the Mood and Feelings Questionnaire, short form, (MFQ-SF) and the Childhood Anxiety Sensitivity Index (ASI), were evaluated by this study in a large sample of youth.

Method: The psychometric properties (optimum cutoffs on receiver operator characteristic [ROC] curves, sensitivity, specificity, and positive and negative predictive values) of 2 brief anxiety and depression screens were compared with a gold standard structured psychiatric interview in a cohort of 1375 children and teenagers aged 11 to 17 years (779 with asthma, 596 randomly selected controls) enrolled in a health maintenance organization.

Results: On ROC analysis for screening youth for 1 or more DSM-IV anxiety or depressive disorders, both the MFQ-SF and ASI performed well. The MFQ-SF performed better on ROC analysis than the ASI for youth with major depression (area under the curve [AUC] = 0.84 vs. 0.77, respectively). ROC curves revealed that both the MFQ-SF and ASI performed only in the fair range (AUC = 0.76) for screening youth with anxiety disorders.

Conclusion: The MFQ-SF and ASI, 2 relatively brief questionnaires, performed well for screening youth for 1 or more DSM-IV anxiety or depressive disorders. For screening youth with major depression, the MFQ-SF performed better than the ASI. The accuracy of identification of mental health disorders in youth by primary care physicians could be improved by use of these instruments.

Barriers to Psychotherapy Among Depressed and Nondepressed Primary Care Patients

Mohr DC, Hart SL, Howard I, et al.

Ann Behav Med 2006;32(3):254–258

Background: Most depressed primary care patients indicate a preference for psychotherapy over antidepressants. Nevertheless, only 20% ever follow up, and, of these, half drop out of treatment when referrals for psychotherapy are made. This finding suggests substantial barriers to accessing psychotherapy. This study explored apparent barriers to psychotherapy in a sample of primary care patients and tested the hypothesis that these barriers would be more common among patients with depression.

Method: Patients from a large primary care service were sampled and mailed a survey. The survey included assessment of barriers using items identified in previous published research, which we refer to as Perceived Barriers to Psychotherapy (PBP). The Perceived Health Questionnaire-9 (PHQ-9) assessed depression.

Results: Two hundred ninety (32.1%) of the 904 surveys sent were returned. Two factors—practical barriers and emotional barriers—explaining 58.2% of the variance with an internal reliability of $\alpha = .79$ were produced by the PBP. Among all subjects, 59.5% endorsed at least 1 barrier that would make it very difficult or impossible to undergo psychotherapy. Depression was related to increased frequency of perceived barriers, with 74.0% of depressed patients reporting 1 or more barriers, versus 51.4% of nondepressed patients ($p = .008$). Only 11.1% of the participants reported perceived emotional barriers, but 56.6% of the sample endorsed 1 or more perceived practical barriers. Depression was consistently related to increased emotional barriers. Although practical barriers were not consistently related to depression, they were influenced by history of psychotherapy.

Conclusions: One or more perceived barriers that would interfere with or prevent initiation or regular attendance of psychotherapy were endorsed by most primary care patients. Perceived barriers were endorsed more often among depressed than nondepressed patients, so that depression was both an indication for psychotherapy and a barrier to participating in it.

Trauma Exposure and Posttraumatic Stress Disorder Among Primary Care Patients With Bipolar Spectrum Disorder

Neria Y, Olfson M, Gameroff MJ, et al.

Bipolar Disord 2008 Jun;10(4):503–510

Objective: This study sought to investigate associations between exposure to trauma, bipolar spectrum disorder (BD), and posttraumatic stress disorder (PTSD) in a sample of primary care patients.

Method: Measures including the Mood Disorders Questionnaire, the PTSD Checklist-Civilian Version, and the Medical Outcomes Study 12-Item Short Form Health Survey were used to interview a systematic sample (N = 977) of adult primary care patients from an urban general medicine practice.

Results: Patients who screened positive for BD (N = 96) were 2.6 times (95% CI = 1.6 to 4.2) as likely to report physical or sexual assault, and 2.9 times (95% CI = 1.6 to 5.1) as likely to screen positive for current PTSD, as those who screened negative for BD (N = 881). Comorbid PTSD was associated with significantly worse social functioning among those screening positive for BD. Selected background characteristics, current major depressive episode, and current alcohol/drug use disorder were controlled for in these results.

Conclusion: Trauma exposure was associated with BD in an urban general medicine setting, and the comorbidity of PTSD among patients with BD appeared to be common and clinically significant. An unmet need for mental health care in this specific population is suggested by these results, which are especially important in view of available treatments for BD and PTSD.

Events After Stillbirth in Relation to Maternal Depressive Symptoms: A Brief Report

Surkan PJ, Rådestad I, Cnattingius S, et al.

Birth 2008 Jun;35(2):153–157

Background: Actions taken after a stillbirth can affect long-term psychological morbidity. The authors sought to examine how infant bonding and maternal actions after stillbirth are associated with subsequent depressive symptoms.

Method: All 380 Swedish-speaking women who gave birth to singleton stillborn infants in Sweden in 1991 were identified with the population-based Swedish Medical Birth Register. Of these, 314 (83%) completed a postal questionnaire 3 years after the stillbirth. Items included actions taken to bond with the baby and demographic information. Relative risks estimated using multivariable regression were used to quantify the relationship between care-related factors and later maternal depressive symptoms.

Results: The authors observed an almost 7-fold increased risk of depressive symptoms for mothers who reported not being with their babies as long as they wished (adjusted risk ratio [RR] = 6.9, 95% CI = 2.4 to 19.8). Mothers with no later pregnancy were at higher risk for depressive symptoms (adjusted RR = 2.8, 95% CI = 0.9 to 8.4) compared with women who became pregnant again within 6 months. Mothers who experienced a stillbirth occurring with an infant who was third in the birth order had a 2-fold risk of elevated depressive symptoms compared with women who experienced a stillbirth in their first pregnancy (adjusted RR = 2.2, 95% CI = 0.8 to 6.4). In addition, women experiencing a stillbirth occurring in a fourth or later pregnancy had an almost 7-fold risk of depressive symptomatology (adjusted RR = 6.7, 95% CI = 2.2 to 20.5). No evidence of an association between other care-related actions and later maternal depressive symptoms was found.

Conclusions: The results suggest that a mother's subsequent depressive symptomatology may be influenced by her being with the stillborn baby for as long as desired and the birth order of the stillbirth. Women who had no subsequent pregnancy were at higher risk of depressive symptoms at 3 years' follow-up compared with those who became pregnant again within 6 months.