

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.

Problem-Solving Treatment for Depression Among Mexican Americans in Primary Care

Schmaling KB, Hernandez DV

J Health Care Poor Underserved 2008;19(2):466-477

Background: It is a public health priority, particularly in relation to racial/ethnic minorities and other underserved groups, to be able to identify and enhance access to evidence-based treatments for depressive disorders and other mental health problems.

Method: Eight sessions of an evidence-based behavioral treatment, problem-solving treatment for primary care (PST-PC), were offered to 146 Mexican American primary care patients who met diagnostic criteria for major depressive disorder, dysthymic disorder, or depressive disorder not otherwise specified.

Results: Depressive symptom scores decreased over time among participants who consented to treatment (N = 117). Participants who completed 4 or more sessions of PST-PC (N = 55), a minority of the group, had greater decreases in depressive symptom severity than participants who completed 3 or fewer PST-PC sessions (N = 62). Hopkins Symptom Checklist-20 scores declined a mean \pm SD 0.86 ± 0.97 and 0.40 ± 0.66 points for these groups, respectively ($p < .05$).

Conclusions: To improve engagement in treatments for depression, especially among Latinos in primary care, will require additional efforts.

Predictors of Well-Being in Bereaved Former Hospice Caregivers: The Role of Caregiving Stressors, Appraisals, and Social Resources

Burton AM, Haley WE, Small BJ, et al.

Palliat Support Care 2008;6(2):149-158

Objective: According to the most recent research, the relationship between caregiving and bereavement, both common life events, is complicated, and additional study is necessary to better understand their interaction.

Method: In this study, 50 spouses of hospice patients with end-stage lung cancer or dementia were evaluated while caregiving and again at a mean of 4 months after the death on a variety of measures, including caregiving stressors, appraisals, social resources, and well-being. In order to investigate which preloss factors were related to postloss depression, life satisfaction, and grief, a stress process model was employed.

Results: Patient diagnosis (cancer or dementia) and caregiver appraisals (stressfulness of functional impairment and positive aspects of caregiving) had no predictive value on any well-being outcomes. However, both higher depression and grief postloss were significantly predicted by fewer months caregiving. It was also the case that fewer social activities, smaller social networks, and lower satisfaction with social support were significantly related to higher postloss depression. Both the resource depletion and anticipatory grief hypotheses are supported by these results, which also suggest that short-term bereavement outcomes differ from factors that predict well-being while caregiving.

Conclusions: Whether long-term bereavement outcomes differ by baseline caregiving characteristics is a question that should be addressed in future research.

Screening for Intimate Partner Violence in a Pediatric Primary Care Clinic

Dubowitz H, Prescott L, Feigelman S, et al.

Pediatrics 2008;121(1):e85-e91

Objectives: To approximate the prevalence of intimate partner violence among parents at a pediatric primary care clinic and to assess the stability, sensitivity, specificity, positive and negative predictive values, and likelihood ratios of a very brief screen for intimate partner violence.

Method: The Parent Screening Questionnaire was completed by 200 parents (mostly mothers) bringing children less than 6 years of age for child health supervision in a primary care clinic. A brief screen for psychosocial problems developed

for the study, the Parent Screening Questionnaire, included 3 questions covering intimate partner violence. The computerized study protocol, which included the Parent Screening Questionnaire and the Revised Conflict Tactics Scale, was then completed by the mothers within 2 months. The Revised Conflict Tactics Scale was used to assess various combinations of the intimate partner violence questions.

Results: Twelve percent of the mothers gave affirmative answers to at least 1 of the screening questions. Responses on the standardized Revised Conflict Tactics Scale ranged from 9% reporting a physical injury in the past year to 76% reporting psychological aggression. The screening questions showed moderate stability. In relation to the "physically injured" Revised Conflict Tactics Scale subscale, 1 question—"Have you ever been in a relationship in which you were physically hurt or threatened by a partner?"—was most effective. Sensitivity was 29%, specificity was 92%, positive predictive value was 41%, and negative predictive value was 88%. The positive likelihood ratio was 3.8, and the negative likelihood ratio was 0.77.

Conclusions: The problem of intimate partner violence is a prevalent one. Some mothers who could benefit from additional evaluation and possible services can be identified with a very brief screen. Finding a more sensitive screen and investigating whether identifying intimate partner violence leads to interventions that benefit mothers, families, and children will require additional research.

Therapist-Assisted, Internet-Based Treatment for Panic Disorder: Can General Practitioners Achieve Comparable Patient Outcomes to Psychologists?

Shandley K, Austin DW, Klein B, et al.

J Med Internet Res 2008;10(2):e14

Background: Mental illness is a growing concern around the world. Managing disorders such as anxiety and depression is largely the domain of family doctors or general practitioners (GPs). However, GPs often have too little time and may lack the necessary training to adequately address the needs of patients with such disorders. Evidence-based Internet interventions comprise a potentially valuable resource for lessening the demands of care and the cost of managing mental health disorders within primary care settings and, at the same time, improving patient outcomes. The present study sought to extend the efficacy of a therapist-assisted Internet treatment program for panic disorder, Panic Online, by investigating whether comparable outcomes could be reached and sustained when Panic Online was supported by either GPs or psychologists.

Method: Via a natural groups design, 96 people with a primary diagnosis of panic disorder (with or without agoraphobia) completed the Panic Online program over 12 weeks. Either their GP (N = 53), who had received specialist training in cognitive behavioral therapy, or a clinical psychologist (N = 43) provided therapeutic assistance. A clinical diagnostic telephone interview, conducted by a psychologist, and a set of online questionnaires to evaluate panic-related symptoms were completed by participants at 3 time periods (pretreatment, posttreatment, and 6-month follow-up).

Results: Clinically significant improvements on measures of panic and panic-related symptomatology from pretreatment to posttreatment were achieved by participants in both treatment groups. Both groups were seen to improve significantly over time. While improvements for both groups were sustained at follow-up, the groups did differ significantly on 2 quality of life

domains: physical (F = 9.13, df = 1,82; p = .00) and environmental (F = 4.41, df = 1,82; p = .04). Those being treated by their GPs had a significantly higher attrition rate than those treated by a psychologist ($\chi^2 = 4.4$, df = 1; p = .02, N = 96).

Conclusions: On the basis of these findings, Internet-based interventions can be an effective adjunct to existing mental health care systems. As a result, these interventions may facilitate and improve the delivery of evidence-based mental health treatments to increasingly large population segments via primary care systems and through appropriately trained health professionals.

Screening for Parental Substance Abuse in Pediatric Primary Care

Lane WG, Dubowitz H, Feigelman S, et al.

Ambul Pediatr 2007 Nov-Dec;7(6):458-462

Objective: Parental alcohol and drug abuse may have significant deleterious effects on children. Few screening measures have been evaluated for use in the pediatric office despite the fact that screening in this setting is recommended. This study sought to validate a 2-question screening tool for parental substance abuse.

Method: A brief screening for psychosocial problems containing 2 substance abuse questions was completed by a total of 216 caregivers bringing children to a primary care clinic. Recruited caregivers returned within 2 months to assess reliability and validity of the questionnaire by completing a computerized study protocol that contained the brief screening questions and the substance abuse sections of the Composite International Diagnostic Inventory (CIDI).

Results: A problem with drugs or alcohol on the CIDI was acknowledged by 16% of caregivers. A "yes" response to either screening question had a sensitivity of 29%, a specificity of 95%, a positive predictive value of 17%, and a negative predictive value of 98% for drug abuse. For predicting alcohol abuse, values were 13%, 96%, 33%, and 87%, respectively.

Conclusions: Many, but not all, parents who may need intervention for problems with drugs and/or alcohol can be identified by brief screening in pediatric primary care. If such screening enables parents to acknowledge and receive treatment for substance abuse, children should benefit from it. Assessing whether the sensitivity of screening can be improved without sacrificing brevity requires additional research.

Validation and Standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the General Population

Löwe B, Decker O, Müller S, et al.

Med Care 2008;46(3):266-274

Background: Although the 7-item Generalized Anxiety Disorder Scale (GAD-7) is a practical self-report anxiety questionnaire that has proved valid in primary care, it has not yet been validated in the general population, and normative data are not available. This study examined the reliability, construct validity, and factorial validity of the GAD-7 in the general population and generated normative data.

Method: In this nationally representative face-to-face household survey conducted in Germany between May 5 and June 8, 2006, 5030 subjects (53.6% female) with a mean (SD) age of 48.4 (18.0) years provided responses to survey

questionnaires, including the GAD-7, the 2-item depression module from the Patient Health Questionnaire (PHQ-2), and the Rosenberg Self-Esteem Scale, and provided demographic characteristics.

Results: The 1-dimensional structure of the GAD-7 and its factorial invariance for gender and age were substantiated by confirmatory factor analyses. Internal consistency was identical across all subgroups ($\alpha = 0.89$). Intercorrelations with the PHQ-2 and the Rosenberg Self-Esteem Scale were $r = 0.64$ ($p < .001$) and $r = -0.43$ ($p < .001$), respectively. The mean (SD) GAD-7 anxiety scores of women were significantly higher than those of men (3.2 [3.5] vs. 2.7 [3.2]; $p < .001$), as the investigators expected. The investigators generated normative data for the GAD-7 for both genders and different age levels. Approximately 5% of subjects had GAD-7 scores of 10 or greater, and 1% had GAD-7 scores of 15 or greater.

Conclusions: The reliability and validity of the GAD-7 as a measure of anxiety in the general population are supported by these findings. A subject's GAD-7 score can now be compared with those determined from a general population reference group (i.e., the normative data provided in this study).

The Influence of Depressive Symptoms on Clinician-Patient Communication Among Patients With Type 2 Diabetes

Swenson SL, Rose M, Vittinghoff E, et al.

Med Care 2008;46(3):257-265

Background: Although depression is related to poor chronic illness outcomes, whether depression affects the quality of communication during the clinical encounter is unknown. The authors examined whether diabetes patients with depressive symptoms endorse worse clinician-patient communication, compared with those without depressive symptoms, and which areas of communication are impacted most.

Method: Two hundred thirty-one ethnically diverse, English-speaking patients with diabetes were surveyed to determine their experiences of communication with their primary care clinicians. Measures from the interpersonal processes of care (IPC) instrument were chosen to evaluate communication, and the 7 subscales were dichotomized into "optimal" or "sub-optimal" communication. The Clinical Epidemiologic Services for Depression (CES-D 10) was employed to classify patients as having no (CES-D 10 score < 10), mild (CES-D 10 score 10-14), or severe (CES-D 10 score > 14) depressive symptoms. Multivariable logistic regression was employed to assess the association between depressive symptoms and communication subscales.

Results: Severe depressive symptoms were endorsed by 35% of subjects. The presence of severe depressive symptoms was independently related to suboptimal communication in 4 of 7 subscales, compared with those with no depressive symptoms. The subscales were elicitation of patient problems, concerns, and expectations (adjusted odds ratio [AOR] = 2.94, 95% CI = 1.14 to 7.61); explanations of condition (AOR = 3.79, 95% CI = 1.41 to 10.21); empowerment (AOR = 2.98, 95% CI = 1.35 to 6.58); and decision-making (AOR = 2.56, 95% CI = 1.14 to 5.78).

Conclusions: Suboptimal clinician-patient communication across multiple domains of communication, particularly those entailing more interactive and "patient-centered" communication, is more likely to be endorsed by diabetes patients with severe depressive symptoms than those without depressive

symptoms. Additional studies of this association may reveal explanatory mechanisms and assist in guiding interventions for improvement.

Psychological Distress, Major Depressive Disorder, and Risk of Stroke

Surtees PG, Wainwright NW, Luben RN, et al.

Neurology 2008;70(10):788-794

Background: Studies have suggested that mood status is related to an increased risk of stroke, although mostly on the basis of symptom-defined measures of depression alone rather than diagnostic criteria that represent clinically important distress and impairment. We examined this relationship on the basis of a large population-based prospective cohort study.

Method: As part of the United Kingdom European Prospective Investigation Into Cancer-Norfolk study, 20,627 stroke-free participants, aged 41 to 80 years, were evaluated at baseline for major depressive disorder (MDD) and mental health well-being defined by the Mental Health Inventory (MHI-5).

Results: Five hundred ninety-five incident (fatal and non-fatal) stroke endpoints were registered during 8.5 years of follow-up. Neither past year nor lifetime MDD was related to stroke. After adjustment for age, sex, cigarette smoking, systolic blood pressure, cholesterol, obesity, preexisting myocardial infarction, diabetes, social class, education, hypertension treatment, family history of stroke, and antidepressant medication use, a 1 SD decrease in MHI-5 scale score (representing greater emotional distress) was associated with an 11% increased risk of stroke (hazard ratio = 1.11, 95% CI = 1.00 to 1.22). This association was consistent for men and for women, for fatal and nonfatal stroke, and conformed to a dose-response relationship.

Conclusions: Findings suggest that increased psychological distress may be related to elevated stroke risk, according to results from this large prospective cohort study. In this study, episodic major depressive disorder was not related to incident stroke.

The Impact of Trauma Exposure and Posttraumatic Stress Disorder on Health Care Utilization Among Primary Care Patients

Kartha A, Brower V, Saitz R, et al.

Med Care 2008 Apr;46(4):388-393

Background: Although trauma exposure and posttraumatic stress disorder (PTSD) increase health care utilization in veterans, how they affect utilization in other populations is uncertain. This study sought to investigate the relationship between trauma exposure and PTSD versus health care utilization in civilian primary care patients.

Method: This cross-sectional study examined English-speaking patients at an academic, urban primary care clinic. The Composite International Diagnostic Interview was used to determine trauma exposure and current PTSD diagnoses. Non-mental health outpatient and emergency department visits, hospitalizations, and mental health outpatient visits in the prior year from an electronic medical record were outcomes. Bivariate unadjusted and multivariable Poisson regressions adjusted for age, sex, income, substance dependence, depression, and comorbidities were among the analyses.

Results: Eighty percent of 592 subjects had ≥ 1 trauma exposure, and 22% had current PTSD. Subjects with trauma exposure had more mental health visits in adjusted regressions, (incidence rate ratio [IRR] = 3.9, 95% CI = 1.1 to 14.1) but no other increased utilization. This effect of trauma exposure was diminished after adjusting for PTSD (IRR = 3.2; 95% CI = 0.9 to 11.7). Patients with PTSD had increased hospitalizations (IRR = 2.2, 95% CI = 1.4 to 3.7), hospital nights (IRR = 2.6, 95% CI = 1.4 to 5.0), and mental health visits (IRR = 2.2, 95% CI = 1.1 to 4.1), although they did not have more outpatient and emergency department visits.

Conclusions: PTSD is associated with more hospitalizations, longer hospitalizations, and greater mental health care utilization in urban primary care patients. Trauma exposure is independently associated with greater mental health care utilization, but a portion of this association is mediated by PTSD.

Feelings of Anxiety and Symptoms of Depression in Community-Living Older Persons Who Avoid Activity for Fear of Falling

van Haastregt JC, Zijlstra GA, van Rossum E, et al.
Am J Geriatr Psychiatry 2008;16(3):186–193

Objectives: This cross-sectional study evaluated the presence of feelings of anxiety and symptoms of depression among older persons who avoid activity for fear of falling and investigated whether feelings of anxiety and symptoms of depression are independently related to the severity of fear of falling and activity avoidance related to fear

Method: Data were collected at 2 urban areas south of The Netherlands in this cross-sectional study. Participants included 540 community-dwelling people aged 70 years or older who reported fear of falling and associated activity avoidance. Self-administered questionnaires were used to collect data.

Results: Questionnaires revealed that 28.2% of participants with severe fear of falling had feelings of anxiety, while 26.1% of them had symptoms of depression. Of participants with severe fear-related activity avoidance, 28.5% had feelings of anxiety, and 22.6% had symptoms of depression. Participants with severe fear of falling were more likely to have feelings of anxiety and symptoms of depression than those with mild fear of falling, according to multivariate analyses. Moreover, respondents who indicated severe fear-related activity avoidance were more likely to have feelings of anxiety than those whose fear-related avoidance of activity was mild.

Conclusions: People with severe fear of falling and fear-related activity avoidance commonly have feelings of anxiety and symptoms of depression. Providing optimum treatment for this category of older persons demands vigilance for underlying anxiety disorders and depression.

Ethnic Differences in the Reliability and Validity of a Panic Disorder Screen

Johnson MR, Hartzema AG, Mills TL, et al.
Ethn Health 2007;12(3):283–296

Objective: The reliability and validity of the Brief Panic Disorder Screen (BPDS) in samples of African American and white primary care patients were compared in this study.

Method: Two hundred ninety-five patients scheduled to visit a primary care clinic for medical reasons completed the BPDS. In the context of a clinical interview, a psychiatrist confirmed

the presence or absence of a panic disorder diagnosis. Measures of reliability (internal consistency) and validity (criterion validity) were compared between the 2 ethnic subgroups.

Results: The BPDS showed greater reliability and validity in white populations than in African Americans. Even after group differences in key demographic variables were controlled for, this effect continued. In ethnic groups with and without panic disorder (PD), differences were evident. Low internal consistency was shown by the BPDS responses of African Americans with PD, while a high rate of false positive PD diagnoses was associated with higher than expected BPDS scores among African Americans without PD, especially regarding the degree of fear experienced during shortness of breath or heart palpitations.

Conclusions: The idea that cultural disparities in the language and meaning associated with anxiety disorders constitute an element of the difficulty of diagnosing PD accurately in primary care populations is supported by these results. Further study to provide an enhanced understanding of the cultural aspects of the anxiety experience is necessary. Such research would aid in the development of improved screening tools for panic and other anxiety disorders for ethnic minority primary care populations.

History of Depression, Depressive Symptoms, and Medial Temporal Lobe Atrophy and the Risk of Alzheimer Disease

Geerlings MI, den Heijer T, Koudstaal PJ, et al.
Neurology 2008;70(15):1258–1264

Background: Although depression may increase risk for Alzheimer disease (AD), it is unclear whether this risk is mediated by structural brain changes. The authors ascertained whether history of depressive episodes and presence of depressive symptoms were related to smaller hippocampal and amygdalar volumes and increased risk for incident AD.

Methods: Within the Rotterdam Scan Study, 503 persons, aged 60 to 90 years at baseline and without dementia, reported their history of depressive episodes. The Center for Epidemiologic Studies Depression Scale was used to evaluate depressive symptoms. Three-dimensional MRI was used to perform volumetric assessment of the hippocampus and amygdala. All subjects were followed for a mean of 6 years for development of AD, diagnosed according to National Institute of Neurological and Communicative Disorders and Stroke-Alzheimer's Disease and Related Disorders Association criteria.

Results: A history of depression was endorsed by a total of 134 subjects (26.6%). (An onset < 60 years was reported by 88, and 46 reported a late onset). A significant association with hippocampal or amygdalar volume for any of the depression parameters was not revealed when multiple linear regression analyses were performed. Thirty-three subjects developed AD during follow-up. Subjects with early-onset depression had an increased risk for AD (HR = 3.76; 95% CI = 1.41 to 10.06), independent of hippocampal and amygdalar volume, whereas this risk was 2.34 (95% CI = 0.82 to 6.69) in subjects with a late-onset depression, when Cox regression analyses were performed. Depressive symptoms at baseline were not related to increased risk for AD.

Conclusion: The risk for AD was increased by history of depression, and particularly by an early onset, but not by presence of depressive symptoms. Smaller hippocampal or amygdalar volumes did not mediate this risk.